We are WHH & We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WHH Trust Board Meeting Part 1

Wednesday 26 January 2022
10.00am -12.00pm
Via MS Teams

AGENDA
Meeting of the Trust Board Part 1 (held in Public)
Wednesday 26 January 2022, 10.00 pm – 12.00 pm
Via MS Teams

AGENDA REF	ITEM	PRESENTER	PURPOSE	TIME	
BM/22/01/01	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	10.00	Verb
BM/22/01/02 PAGE 06	Minutes of the previous meeting held on 24 November 2021	Steve McGuirk, Chairman	Decision	10:02	Enc
BM/22/01/03 PAGE 20	Actions & Matters Arising • Action Log • Glossary of Terms • Board meeting dates	Steve McGuirk, Chairman	Assurance		Enc
BM/22/01/04	Chief Executive's Report (to follow)	Simon Constable, Chief Executive	Assurance	10:05	Enc
BM/22/01/05	Chairman's Report	Steve McGuirk, Chairman	Information	10:10	Verb
	Quality People Sustainability				
BM/22/01/06	COVID-19 Situation Report (to follow)	Simon Constable Chief Executive	To note for assurance	10:15	Enc
BM/22/01/07 PAGE 23	Integrated Performance Dashboard and Committee Assurance Reports	All Executive Directors	To note for assurance	10:25	Enc
	(a) Quality Dashboard including	Daniel Moore			Enc
PAGE 86	• Safe Staffing and Assurance Report	Chief Operating Officer	To note for assurance		
PAGE 97	• Safe staffing response to current Omicron wave	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO & Paul Fitzsimmons, Executive Medical Director			Enc Enc
PAGE 137	(b) Committee Assurance Reports - Quality Assurance Committee – (i) 07.12.2021 & (ii) 11.01.2022	Margaret Bamforth Committee Chair	To note for assurance		Enc
	People Dashboard	Michelle Cloney Chief People Officer	To note for assurance		
PAGE 147	(c) Committee Assurance Report – Strategic People Committee 19.01.2022	Julie Jarman Committee Chair	To note for assurance		
	Sustainability Dashboard	Andrea McGee Chief Finance Officer & Deputy CEO	To note for assurance		
PAGE 153	(d) Committee Assurance Reports – Finance and Sustainability Committee (i) 22.12.2021 & (ii) 19.01.2022)	Terry Atherton Committee Chair	To note for assurance		
PAGE 162	(e) Committee Assurance Reports - Audit Committee 19.11.2021	Mike O'Connor Committee Chair	To note for assurance		

	(f) Committee Assurance Report – Clinical Recovery Oversight Committee (*meetings stood down due to operational pressures*)	**Terry Atherton Committee Chair**	**To note for assurance**		

Quality

BM/22/01/08 PAGE 165	**Moving to Outstanding (M2O) Update Report**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**To note for assurance**	**11:15**	**Enc**

Sustainability

BM/22/01/09 PAGE 173	**Use of Resources Q3 Report**	**Andrea McGee Chief Finance Officer & Deputy CEO**	**To note for assurance**	**11:20**	**Enc**

People

BM/22/01/10 PAGE 194	**Vaccination as a Condition of Deployment (VCOD)**	**Michelle Cloney Chief People Officer**	**To discuss and approve**	**11:25**	

GOVERNANCE

BM/22/01/11 PAGE 260	**Strategic Risk Register + BAF**	**John Culshaw Trust Secretary**	**To discuss and approve**	**11:40**	**Enc**

SUPPLEMENTARY PAPERS

MATTERS FOR APPROVAL

	ITEM	**Lead (s)**	**Committee Ref**			
BM/22/01/12 PAGE 03	**Scheme of Reservations & Delegations and Standing Financial Instructions Update**	**Andrea McGee Chief Finance Officer & Deputy CEO**	**Committee**	Audit Committee	**11:50**	**Enc**
			Agenda Ref.	AC/21/11/84		
PAGE 5	**i Scheme of Reservation and Delegation (SORD**		**Date of meeting**	18.11.2021		
PAGE 39	**Ii Standing Financial Instructions Update**		**Summary of Outcome**	Approved		
BM/22/01/13 PAGE 101	**Cyle of Business – Quality Assurance Committee**	**John Culshaw Trust Secretary**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	QAC/21/10/235		
			Date of meeting	5.10.21		
			Summary of Outcome	Approved		

MATTERS FOR NOTING FOR ASSURANCE

	ITEM	**Lead (s)**				
BM/22/01/14 PAGE 106	**Infection Prevention and Control Board Assurance Framework Compliance Bi-monthly Report**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**			**Enc**
			Agenda Ref.	**N/A**		
			Date of meeting			
			Summary of Outcome			
BM/22/01/15 PAGE 146	**Learning From Experience Q2 Report**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Quality Assurance Committee		**Enc**
PAGE 172	**i Presentation**		**Agenda Ref.**	QAC/21/12/310		
			Date of meeting	7.12.21		

			Summary of Outcome	Noted		
BM/22/01/16 **PAGE 173**	**Guardian of Safe Working Q3 Report**	**Paul Fitzsimmons Executive Medical Director**	**Committee**	Strategic People Committee		**Enc**
			Agenda Ref.	SPC/22/01/03		
			Date of meeting	19.01.2022		
			Summary of Outcome	Noted		
BM/22/01/17 **PAGE 182**	**Charities Commission Checklist (annual update report)**	**Pat McLaren Director of Communications & Engagement**	**Committee**	Charitable Funds Committee		**Enc**
			Agenda Ref.	CFC/21/12/92 (c)		
			Date of meeting	09.12.21		
			Summary of Outcome	Noted		
BM/22/01/18 **PAGE 187**	**Maternity and Neonatal Safety Champions Guideline**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.			
			Date of meeting	11.01.2022		
			Summary of Outcome	Noted		
BM/22/01/19 **PAGE 193**	**Warrington Hospital Catering Unit Hot Water Supply**	**Dan Moore Chief Operating Officer**	**Committee**			**Enc**
			Agenda Ref.			
			Date of meeting			
			Summary of Outcome			
BM/22/01/20 **PAGE 199**	**Non Executive Directors – Champion Roles**	**John Culshaw Trust Secretary**	**Committee**			**Enc**
			Agenda Ref.			
			Date of meeting			
			Summary of Outcome			

BM/22/01/21	**Any Other Business**	**Steve McGuirk, Chairman**	**N/A**		**Ver**
Date of next meeting - Wednesday 30 March 2022					

Conflicts of Interest

At any meeting where the subject matter leads a participant to believe that there could be a conflict of interest, this interest must be declared at the earliest convenient point in the meeting. This relates to their personal circumstances or anyone that they are of at the meeting.

- Chairs should begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s) on completion of a Declaration of Interest Form.
- The Vice Chair (or other non-conflicted member) should Chair all or part of the meeting if the Chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.
- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect interests:**
  Where an individual has a close association[1] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

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DRAFT

Warrington and Halton Teaching Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 24th November 2021 via MS Teams

Present	
Terry Atherton (TA)	Deputy Chair, Non-Executive Director
Simon Constable (SC)	Chief Executive
Margaret Bamforth (MB)	Non-Executive Director
Anne Robinson (AR)	Acting Executive Medical Director
Michael O'Connor	Non-Executive Director
Daniel Moore (DM)	Chief Operating Officer
Andrea McGee (AMcG)	Chief Finance Officer & Deputy Chief Executive
Cliff Richards (CR)	Non-Executive Director
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse & Deputy CEO and Director of Infection Prevention & Control (DIPC)
Anita Wainwright (AW)	Non-Executive Director
In Attendance	
Lucy Gardner (LG)	Director of Strategy & Partnerships
Jayne Downey (JD)	Associate Non-Executive Director
Dave Thompson (DT)	Associate Non-Executive Director
John Culshaw (JC)	Trust Secretary
Jen McCartney(JMcC)	Patient Experience & Inclusion Manager (item 148 only)
Paula Gunner (PG)	Senior Executive Assistant (minutes)
Apologies	
Steve McGuirk (SMcG)	Chairman
Michelle Cloney (MC)	Chief People Officer
Pat McLaren (PMcL)	Director of Communications & Engagement
Julie Jarmin (JJ)	Non-Executive Director (Designate)
Adrian Carridice-Davids	Associate Non-Executive Director
Observing Members of the public 1	N Holding Lead Governor S Fitzpatrick, J Howe, C McKenzie, A Robinson, A Kinross, P Bradshaw Public Governors, Dan Birtwistle, Staff Governor, N Newton Partner Governor, 4 Staff members

BM/21/11/148	**Digital Patient Story**, The story had been received and discussed at the September Quality Assurance Committee. KSJ introduced Jan McCartney, Patient Experience Manager to showcase the work taking place since around the management of diabetes in children and young adults who may be at risk of not managing their diabetes in an appropriate way. The Board then heard from Chloe Cunliffe employed by the Trust as a Diabetes Youth Worker to support Young people with Diabetes to better manage the condition and to engage and support them with their health and wellbeing through the following: • Diet • Exercise • Movie nights

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	• Youth Club • X Box nights • Football • Dog walks Next Steps • Collaboration with Warrington Borough Council • Working on allotments • Providing these patients with the self-esteem, self-confidence and courage with this enhanced support to ensure better health outcomes. AW noted the collaboration with Warrington Borough Council and asked if there are plans to work with other organisations and connect into schools. Jen McCartney answered that yes there would be plans for work with other organisations and Warrington Borough Council is the start of this. DT commented that he has contacts with other Warrington Youth Clubs, and he would be happy to discuss with Jen McCarthy outside this meeting. MB added that this presentation has already been presented to the Quality Assurance Committee to progress the idea of digital patient stories and this is an excellent initiative with more to come forward. Deputy Chairman thanked Jen McCartney for this patient story and this excellent initiative. He also requested that Jen pass on to Chloe the Board's thanks and best wishes for her dedication to this excellent project and which shows the Trust tackling health inequalities in the community, the service should be very proud of Chloe.
BM/21/11/149	<u>Welcome, Apologies & Declarations of Interest</u> The Deputy Chairman welcomed all to the meeting noting apologies and advising of the new Non-Executive Directors and Associate Non-Executive Directors attending the meeting: • Julie Jarmin, Non-Executive Director (Apologies) who will be taking on the Chair of the Strategic People Committee (SPC) • Michael O'Connor, Non-Executive Director Chair of the Audit Committee • Jayne Downey, Associate Non-Executive Director • Dave Thompson, Associate Non-Executive Director • Adrian Carridice-Davids, Associate Non-Executive Director (Apologies) The Deputy Chairman also noted there are a number of observers at the meeting some of whom are attending for their development. The Deputy Chairman informed the meeting that this would be AW last Public Board meeting as she is leaving the Trust at the end of December 2021. The Deputy Chairman thanked AW for providing her HR experience to the Trust Board, for Chairing the SPC and supporting the Finance & Sustainability Committee and NED colleagues over the last 7

	years and wished her the very best in whatever AW moves onto. AW thanked the Deputy Chair saying that she has been very privileged and proud to have worked with Warrington & Halton Teaching Hospitals NHS FT over the last 7 years and she is retiring. AW will be meeting with JJ to handover the Chairmanship of the SPC. There were no declarations of interests regarding the agenda items raised.
BM/21/11/150	**Minutes of the meeting held 29th September 2021** The minutes of the meeting held on 29th September 2021 were recorded as a correct record of the meeting.
BM/21/11/151	**Actions and Matters Arising.** The action log and updates noted and recorded.
BM/21/11/152	**Chief Executive's Report** The comprehensive report was taken as read. The Chairman asked if colleagues had any questions to raise these when SC joined the meeting. No questions raised. **The Board noted the report.**
BM/21/11/153	**Chairman's Report** The Deputy Chair reported that since the last public board Steve McGuirk, Chairman and himself had attended a wide range of meeting in Cheshire & Merseyside and the North West. Deputy Chair informed the Board of the first Shadow Board which took place yesterday (23rd November 2021) and commented that it will be interesting to compare how they have dealt with items from this agenda discussed there. The Trusts Annual Members Meeting will be held today at 4pm- 5.30pm via MS Teams. **The Board noted the update.**
BM/21/09/154	**COVID-19 Overview Report** SC presented the report which detailed the Trus'ts robust operational and reporting procedures in place to respond to the COVID-19 Pandemic. The Trust Executive Team receives a daily Executive Summary which includes data outlining key information pertinent to the command and control of the pandemic. The Deputy Chair asked colleagues if they had any questions regarding the report. No questions were raised. **The Board noted the report.**
BM/21/09/155a	**IPR Dashboard and IPR Key Issues** The Chief Executive introduced the report, requesting an update on response to the increased ED demand and mitigating actions, Sepsis performance for Quality and Performance portfolios.

	Quality - KSJ reported on the current position with regard to Sepsis screening for Emergency patients within 1 hour the Trust achieved 69% in October an improvement from 64% in September against a target of 90%. Sepsis screening for inpatients the Trust achieved 76% in October an improvement from 69% against a target of 90%. KSJ added that this is not where we would like to be and therefore an improvement plan is in place and is being monitored at the weekly Sepsis meeting. There has been a focus on Sepsis Education and training. KSJ explained that having pre-constituted anti-biotics has helped and has made at 15% - 20% in administering within 1 hour, although these cannot be used on all Sepsis patients and the Trust still have to make up some anti-biotics. KSJ explained that the increase in the numbers of patients coming into ED has prompted additional resource being moved to that department 11WTE nurses to support the increased capacity. CR asked do you really know the cause of the delay for screening for sepsis at the point of suspicion in ED. KSJ answered that John Goodenough, Deputy Chief Nurse has spent 2 days looking at the pathway to understand this. The data on patients shows that too many are being put down as having sepsis when it is not and training in ED is being carried out to ensure the identification of Sepsis correctly. Working with both AQuA and the Quality Academy teams around the gaps in Doctor training. JD asked how harm from sepsis is included in the quality assurance process. KSJ explained that there has been a look back at the harm in DATIX aligned to sepsis and this review will be presented to the Quality Assurance Committee. MO asked about ambulance handovers and KSJ explained that with regards to the process for ambulance handovers the Trust is doing really well nationally and is top of the pack in Cheshire & Merseyside. A lot of work had been done in this area using the Manchester Triage process to ensure patients are directed to the most appropriate area in ED. KSJ explained that last week the Trust did have a halt moment due to the number of 999 calls which were higher than normal, COVID-19 patients in the department and therefore KSJ,AR and DM called the Halt moment with an ambulance divert requested to another Trust, a call out to Trust staff to help out in ED while this difficult situation was managed. AR commented that the North West Ambulance Services (NWAS) do have a pre-alert system for a patient's suspected of sepsis although not all patients yet have the ambulance handover sheets. Access & Performance There are 17 access performance indicators rated Red in October, DM highlighted the following: – Issue raised by the CBU team patients regarding patients waiting 72 hours to be

seen at fracture clinic demand overtook capacity but remedial work has taken place including additional clinics (some consultants had come off the on-call rota or dropped fracture clinical sessions) and the use of virtual fracture clinics which have been used effectively at other Trust for some time. All patients are now within the timeframes for fracture clinic

- ED ambulance handovers 120 patients experienced a delayed handover in October a deterioration from 81 patients in September against a target of 0.
- Long Length of Stay last month increased to 146 they are patients who are medically optimised and do not need to be in an acute setting. Warrington Borough Council are struggling with their domiciliary care and is looking at an increase in rates of pay for these staff in line with Halton Borough Council. DM explained how the number of patients waiting for Domiciliary Care / Care Home affect the hospital capacity and flow. DM explained that discussion on ongoing with the system and the Trust to look at reducing the amount of beau racy in the system and DM added that the Trust will be running its usual programme of Home for Christmas to help patients return to their own homes before 24th December 2021. DM also added that there is a pot of funding circa £1m which is clearly provides an opportunity and DM will report back to the Board in due course on this.

DT informed DM that he has access to direct support staff who help people in their own homes and that some of these staff have asked if there are any additional hours for them to work. If the criteria could be changed then these staff could be used to help bolster the Domiciliary Care sector for the next 6-8 weeks. DM and JT do discuss outside of the meeting.

MB said she would like to pick up on discharge summaries and the 7-day standard. DM explained that there have been changes in Lorenzo and these changes will make is easier for Doctors when signing off the discharge summaries. This is still not working in all areas and there are still some issue to sort out.

CR commented that there have been substantial quality improvements e.g. No MRSA and VTE is at 95.3%.

AW asked about any ICS funding which may be available at ICS or Partner level. DM informed the Board that Home for Christmas would be run again the two weeks prior to Christmas to help patients back into their own homes and looking at what is available with regards to care home availability. Reducing the length of stay for patients in the Trust will allow for flow and bed capacity.

Monthly Nurse Staffing Report

KSJ advised / explained the report in the pack is for August and September 2021 and forms part of the assurance requirements which are presented to Strategic People Committee and the onto Board and provides assurance on how nurse staffing is managed in the Trust daily. The report also contains a review of the safe care acuity and

dependency data in the Trust

The Trust continues to manage its bed occupancy and staff in a responsive way the use of off framework agency staff has been minimised.

Sickness absence for August 2021was at 5.83% which shows a slight decrease from June / July 5.95%. Although September shows an increase to 6.8% and the costs of agency/banks nursing is detailed in the report it should be noted that staffing levels are review on a daily basis to determine the additional staffing required ensuring patient safety.

MB raised the issue of staff sickness in NICU. KSJ explained that there has been a focus on paediatric nurse recruitment, Deborah Carter is overseeing this.

CR asked how the movement of staff around the wards impacts on Team working. KSJ explained that it is difficult and that some wards have more flexibility with regards to the movement of staff. CR asked if the international nurses are having an impact on the country's they are coming from within their health care systems. KSJ answered that no that is not the case.

The Trust Board noted the content of the report.

Quality Assurance Committee (QAC) Assurance Report 05.10.2021 and 02.11.2021.
MB highlighted the following from the report:

- ED Response Group the committee noted the progress to date a high- level summary to be shared with QAC.
- Presentation received by QAC from Neil Bailey regarding Acute Kidney Injury (AKI) further presentation in 6 months

People – The Chief Executive stated that the people dashboard it taken as read and asked colleagues if they had any questions. No questions were raised.

Strategic People Committee (SPC) Assurance Report 17.11.2021 -
AW again thanked the Board and chairing the SPC and working with a super Executive Team for the past 7 years.

Key Issues were highlighted as follows:

- There were 15 policies which had been reviewed and approved by the SPC on 17th November 2021. Thank You to the HR department this has been a huge task.
- Updates were received which encompass the People and Equality Diversity and inclusion Strategies

Sustainability – There three indicators rated Red in October
AMcG presented the H2 for the second half of the year and also a change to the capital programme which requires Board approval.

- Capital Programme – the actual spend year to date is £3.9m which is £2.7m

below the planned spend of £6.7m. However, the Trust has committed orders of £7.9m.

- Agency Spending – the year to date spend of £6.8m is £1.4m above the plan of £5.5m.
- Cost savings schemes (recurrent) - compared to plan, the recurrent forecast is £2.1m against a plan of £4.8m. Further work to increase identification of CIP schemes is underway across the Trust.
- The criteria for the ERF has been amended for H2, which now uses completed Referral to Treatment (RTT) activity as the baseline for the ERF calculation. ERF performance remains at system level; therefore, the system must also achieve the overall performance target of 89.00% before any additional income is released. **Table 2** details the RTT performance against target for October 2021.
- The Capital Programme for 2021/22 has been approved at £19.6m. In month 7 the Trust received an increase of £0.1m for donated equipment. The Capital programme has therefore increased to £19.7m. **Table 3** provides a high-level summary.

The Board:

- **Noted, reviewed and discussed the report.**
- **Noted the increase in the Capital programme of £0.1m in relation to donated equipment.**
- **Noted the schemes approved as an emergency by the Chief Finance Officer/Deputy Chief Executive in Table 5.**
- **Approved the Orthopaedic Doors scheme to be funded from contingency outlined in Table 5.**

Proposed New KPI's

- Fracture Clinic Patients seen within 72 hours
- % of all outpatient's activity delivered remotely via telephone or video consultation this is a new indicator on the NHSE/I System Oversight Framework.

The Board:

- **Approved the additional KPI to be included in the Access & Performance section of the IPR as outlined in Table 6 of the report**
- **The Board noted the contents of the IPR Report.**

Finance & Sustainability Committee (FSC) (20.10.2021 & 17.11.2021.

MB presented the FSC Chair's Committee assurance report on behalf of TA who is chairing the Board. MB highlighted the following:

- Thank you to AMcG and her team for making the H1 and H2 planning regime understandable which provided added assurance.
- Unidentified CIP lot of work still to do especially with a greater CIP challenge in H2 with the current risk of £1.7m.
- FSC has oversight on the digital programme and work is ongoing to update the OBC following feedback from NHSE/I.

Clinical Recovery Oversight Committee (CROC) 14.10.2021 & 16.11.2021

MB presented the FSC Chair's Committee assurance report on behalf of TA who is chairing the Board. MB highlighted the following:

- Harm Review discussion around P codes took place.

	– There are 360 reviews outstanding – RTT waiting list total size 22060 which does not include ASI and RAS patients. Additional activity requirements are being reviewed a part of H2 planning. – Diagnostic – Radiology & Endoscopy both have staffing issues. Cardio-respiratory echoes and stress echoes demand modelling show a deficit of 12 sessions per week which will require an increase of 2 WTE to mee the current demand.

BM/21/11/156	**Moving to Outstanding Update Report** The report was taken as read, providing an update on CQC compliance, 'Red Flags' and operational matters. • CQC monitored 72 indicators in September 2021. o 84% (60/72) of the Trust's indicators were in line with the national average. 7% (5/72) were better than the national average. o 7% (5/72) were below the national average. o 1% (1/72) was much better than the national average. o 1% (1/72) was worse than the national average. • All indicators that are declining or below the national average are monitored through the Red Flags report. In September 2021 there were 28 indicators in total outstanding that are being monitored through the Red Flags report, an increase of 3 when compared to August 2021. • The new indicators relate to the number of whistleblowing concerns received from the CQC (2 Trust wide), a 12-hour breach (UEC) and Ambulance Turnaround times over 60 minutes (UEC). The Ambulance Turnaround indicator is performing above national average. Further assurance for these indicators is outlined at 2.1.1 below. • A summary overview of all indicators is below in Appendix 1. Key points are: o 43% of indicators (12/28) are improving, compared to 36% (8/25) in September 2021. o 57% of indicators (16/28) are declining which is a positive position, an impr4% (4/28) of the declining indicators are above or in line with the national average. These are ratio of ward managers to staff, immediate managers, team working and ambulance turnaround times. o improvement from 60% (15/25) in September 2021. o 4% (4/28) of the declining indicators are above or in line with the national average. These are ratio of ward managers to staff, immediate managers, team working and ambulance turnaround times. • The Trust have had two whistleblowing concerns raised with the CQC (August 2021 and September 2021). Work is underway to help develop staff awareness of the role of the CQC whilst highlighting the internal escalation processes available. • Ambulance Turnaround times are much better than the national average (6.7% vs 14.4%) • In relation to the 12-hour breach, operational pressures due to activity levels

	have impacted on the ED. The case has had a rapid incident review with no harm identified. This paper will continue to be provided on a bi-monthly basis to the Quality Assurance Committee. • **The Board reviewed, noted and discussed the report and assurance provided of monitoring in place.**

BM/21/11/157	**COVID-19 Overview Report** The COVID-19 pandemic has brought unprecedented challenge for all healthcare providers to ensure the timely delivery of safe care. At WHH, this has been underpinned by robust governance processes to ensure that decisions have been made collectively with appropriate oversight from Ward to Board. KSJ explained that this paper will describe the Trust approach to the management of the pandemic with each wave (1-3) noted alongside phases referenced as 'gateways'. Each gateway will describe the work undertaken to provide assurance of safety throughout the pandemic for both patients and staff. This is evidenced in a number of ways including: • Risk assessments. • Pathways. • Policies. • Standard Operating Procedures (SOPs). The Trust response to the COVID-19 pandemic has been underpinned by a robust governance framework ensuring that decisions have been made collectively across a range of senior disciplines including: • Medical Team • Nursing & Midwifery Team • Allied Health Professionals • Infection Prevention & Microbiology Teams • Operational Management Teams • Governance, legal and Statutory Teams • Occupational Health & Human Resources Teams • Finance & Procurement Teams • Palliative Care Team This has enabled timely escalation to the Strategic Oversight Group as necessary with oversight at the at modified Board as part of robust governance arrangements, as described in the paper. The Deputy Chair commented that this is an extremely comprehensive report with more documents behind this report to show the Trust robust governance arrangements throughout the pandemic. The report will also stand the Trust in good stead if there is a COVID-19 inquiry in the future.

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	The Board discussed the report.
BM/21/11/158	**Use of Resources Q2 Report** The Trust continues to progress improvement in its Use of Resource both internal and in collaboration with system wide partners, however COVID-19 has impact on progress. The paper outlines the current status of the Use of Resources Dashboard; however, it should be noted that a number of the indicators have not be updated on the Model Hospital. – The following movements have taken place on the UoRA Dashboard since Quarter 1: – Radiology Cost Per Report – the Trust has moved from Red to Green (the last update to this indicator prior to this quarter was in March 2018). The Trust's radiology team has repatriated a number of modalities including Vascular which has resulted in a lower cost per report. – Costs per WAU (Nursing, Medical & AHP) – These metrics have been moved to the "legacy" area of the Model Hospital which means these are no longer being updated. Therefore, these metrics have been removed from the UoRA dashboard. The national corporate benchmarking exercise took place in Q2 2021/22. This report will provide the Trust with an up to date position in relation to costs of corporate services and how the Trust benchmarks against national and peer medians based on 2020/21. The Trust is awaiting the final report. • **The Board noted the content of the report.**
BM/21/11/159	**WHH as an anchor** <u>Update on health inequalities, social value and the green agenda</u> • Healthy, Happy and Thriving Communities baseline presentation that was shared with the Board in June 2021 and outlines how WHH will structure our change journey as an anchor institution around the three pillars of social value, green agenda and health inequalities. • The domains through which WHH can align interventions to grow organisational maturity as an anchor institution and achieve social value, deliver the NHS Green Plan objectives and/or address health inequalities are proposed, along with ten core objectives to underpin WHH's journey as an anchor institution. • The work already underway (which has previously been shared) has now been translated into tangible actions and anticipated outcomes. Additionally, work has progressed to develop actions for advancing the Trust's work as an anchor institution. • Three delivery plans are emerging, which when successfully implemented over the coming months, will mark a step change in the Trust's role as an anchor institution. • It should be noted that some activities, an example being procurement, can only be achieved through collaboration with region and the emerging ICS structure, while others can be progressed at place or independently by the Trust. These distinctions will be made within delivery plans and interdependencies will be appropriately monitored. Timescales for delivery will need to reflect what can be done with autonomy and what will require wider collaboration and therefore less direct control while the wider system reforms.

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	• Draft Green Plan The Climate Change Act 2008 set the UK mandatory target to reduce carbon emissions to net zero by 2050. The NHS is the largest public sector employer and contributes 4-5% of the UK's carbon emissions. The NHS has set the target to achieve net zero by 2040. The "For a Greener NHS" campaign was launched in 2020 by NHS England. We are required to have an approved Green Plan to deliver our net-zero targets by March 2021. While this is a nationally mandated programme, the Trust has a strategic commitment to developing and expanding on its role as an anchor organisation. The Green Plan will form a core pillar of this programme. WHH has worked in partnership with WRM Sustainability to assess the Trust's current position and develop an implementation plan to achieve our emissions targets. The Board recognised the tremendous amount of work which has gone into WHH as an anchor and these reports are comprehensive and still a work in progress. • **The Trust Board noted the progress on the Green Plan.**
BM/21/11/160	**Engagement Dashboard Q2 Report** The Deputy Chairman advised that in the absence of PMcL the report would be taken as read and asked colleagues if they had any questions. There were no questions raised. **The report was noted.**
BM/21/11/161	**Strategic Risk Register and Board Assurance Framework (BAF)** The report was taken as read. JC highlighted the following for the Board to review and consider proposals for the BAF since the last meeting and the rationale. At the Quality Assurance Committee on 5th November 2021, it was agreed that the description of risk **#224** should be amended as described in the paper to provide greater clarity and be reflective of the current circumstances: Board also reviewed notable updates to existing risks #224, 1215, 1273, 1272, 1275 1289, 115, 134, 1134, 1207, 125, 1108, 1274, 1331, 1290. • **The Board reviewed and noted the BAF and Strategic Risk Register providing assurance of processes for oversight, scrutiny, management and escalation of strategic and corporate risks.** **The Board approved:** • **The proposed amendments outlined above and the updates to existing risks.**

BM/21/11/162	**Runcorn Shopping City Public Consultation Outcome Report** In July 2019, Halton Borough Council (HBC) secured £1m through the Liverpool City Region Town Centre Commission to develop schemes to further regenerate Halton Lea. The Trust has worked in partnership with HBC to develop a scheme as part of this bid to create an out of hospital health hub within Runcorn Shopping City. The Trust proposed relocating its Audiology and Ophthalmology outpatient service from Halton Hospital to this health hub and relocate its Dietetics service from Halton Hospital and St Paul's to this hub also. As this was a significant service change – i.e. cease provision at current location and commence provision at Runcorn Shopping City formal public consultation was required in line with the Gunning Principles. The Trust worked in partnership with Commissioners NHS Halton and NHS Warrington CCG to conduct a period of pre-consultation engagement and preparation work before carrying out formal public consultation. The Halton Health Performance Board (scrutiny) received and approved the consultation plans. The outcomes of the consultation follow in this report. A comprehensive equality impact assessment was also carried out and is included in the appendices. We are grateful to the 569 respondents who took the time to share their views which have been incorporated in the further design and development of the service. The Deputy Chair commented that this is a project which take healthcare to the people. **The Board noted:** • **The outcome report from the Runcorn Shopping City Public Consultation.**
BM/21/11/163	**Breast Screening Consultation** The Warrington, Halton, St. Helens and Knowsley Breast Screening Service (WHSKBSS) provides routine breast screening, diagnostic and onward referral services to a population of approximately 92,000 from across the four boroughs. The current service is provided from Warrington, Halton, and St Helens and Knowsley. The cost of the capital programme is estimated to be £1.8m and has been approved in the capital programme for 2021/22. In July 2021 works were completed at CSTM creating the new breast unit. The final phase of this project, subject to consultation outcomes, is to enable the co-location of screening services in Warrington in a single location, Bath Street, enabling delivery of the Trusts estates priority to remove all clinical services from the Kendrick Wing of Warrington Hospital. Public Consultation for this final phase is due to commence in January 2022. LG asked the Board to note the intention to go to public consultation for consolidation and expansion of breast screening services at Bath St, Warrington and relocation of breast screening services from Kendrick Wing Warrington Hospital. The Deputy Chair commented that this is an exemplar example of how to undertake a

	public consultation. • **The Board noted the outcome of the Breast Screening Consultation report and the intention to go out to consultation to consolidation and expansion of breast screening services and the relocation from Kendrick Wing to Bath Street, Warrington.**
MATTERS FOR APPROVAL/RATIFICATION	
BM/21/11/164	**GMC Re-validation Annual Report incl. Statement of Compliance** The Trust maintains the list of doctors for whom it is the designated body. There has been a change in the responsible officer since the paper was presented to SPC IN September 2021. Dr Anne Robinson took over the role from Dr Alex Crowe on 8/11/2021. 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 Board **ratified** the GMC Re-validation Annual Report incl. Statement of Compliance Approved at the Strategic People Committee on 22nd September 2021.

BM/21/11/165	**Board Sub Committee Terms of Reference for Ratification** – Finance & Sustainability Committee – Quality Assurance Committee The Board **ratified** the Board Sub Committee Terms of Reference approved by the Finance & Sustainability Committee on 21st September 2021 and Quality Assurance Committee on 21st October 2021.

BM/21/11/166	**Changes to the Constitution** The Board **ratified** the amendment – Governor Responsibilities approved at Council of Governors on 11th November 2021.

MATTERS FOR NOTING FOR ASSURANCE	
BM/21/11/167	**Infection Prevention and Control Board Assurance Framework** This report had been reviewed, discussed and noted by Quality Assurance Committee on 2nd November 2021. **The Board noted the report.**
BM/21/11/168	**Infection Prevention and Control (DIPC Q2) Report** This report had been reviewed, discussed and noted by Quality Assurance Committee on 2nd November 2021. **The Board noted the report.**

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BM/21/09/169	**Mortality Review Q2 Report** UTI Trust is an outlier and will review with regards to catheter care management of these cohort of patients and report back to Quality Assurance Committee. SC did state that this may be a coding issue, but the review will bring this out. This report had been reviewed, discussed and noted by Quality Assurance Committee on 2nd November 2021. **The Board noted the report.**
BM/21/09/170	**Guardian of Safe Working Q2 Report** This report had been reviewed, discussed and noted by Strategic People Committee on 17th November 2021. **The Board noted the report.**
BM/21/09/171	**Patient Safety Strategy** This report had been reviewed, discussed and noted by Quality Assurance Committee on 2nd November 2021. **The Board noted the report.**
BM/21/09/172	**Any Other Business** None discussed the meeting closed.
	Next meeting to be held: Wednesday 26th January 2022

Signed …… Date ……

Chairman ……..

BOARD OF DIRECTORS ACTION LOG

Warrington and Halton Teaching Hospitals NHS Foundation Trust

AGENDA REFERENCE	BM/22/01/03	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	26th January 2022

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
	26.05.2021	Any other business	Dedicated Board session to discuss how the Trust can contribute to local boroughs 'Green' agenda	**Chairman / Director of Strategy & Partnerships/ Chief Operating Officer**	**30.03.2022**		Draft Green Plan to be submitted to Cheshire & Merseyside in January 2022. The final plane to be submitted to Finance & Sustainability Committee & Board in March 2022.	
	26.05.2021		Facilitated Board session – to discuss wider health inequalities contribution from WHH.	**Chairman/ Director of Strategy & Partnerships**	**TBC**		Initial session taken place. Update report to September Board. Deferred to November	BM/21/05/

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/21/09/125 a	29.09.2021	Nurse Staffing Report	Amended report to be circulated post meeting	**Chief Nurse & Deputy CEO**		**29.09.2021**	Report circulated	

RAG Key

	Action overdue or no update provided		Update provided and action complete		Update provided but action incomplete

GLOSSARY OF TERMS

CEO	Chief Executive	QIPP	Quality, Innovation, Productivity + Prevention
ANP	Advanced Nurse Practitioner	**RTT**	Referral To Treatment
AQP	Any Qualified Provider		
BAF	Board Assurance Framework		
BCF	Better Care Fund	**StH&KHT**	St Helens & Knowsley Hospitals Trust
CBU	Clinical Business Unit	SFIs	Standing Financial Instructions
CCG	Clinical Commissioning Group	SLR	Service Line Reporting
CHC	Continuing Health Care	SORD	Scheme of Reservation and Delegation
CIP	Cost Improvement Plan	SIs	Serious Incidences
COO	Chief Operating Officer	SJRs	Structured Judgement Reviews
COI	Conflicts of Interest ***(or Register of Interest)***	STF	Sustainability Transformation Fund
CNST	Clinical Negligence Scheme for Trusts		
CNO	Chief Nursing Officer		
CRR	Corporate Risk Register	**WDES**	Workforce Disability Equality Standard
CQC	Care Quality Commission	WEAR	Workforce Employment Assurance Report
CQUIN	Commissioning for Quality and Innovation	WRES	Workforce Race Quality Standard
DIPC	Director Infection Prevention + Control		
DoH	Department of Health	AC	Audit Committee
DTOC	Delayed Transfers of Care	CFC	Charitable Funds Committee
ED+I	Equality, Diversity + Inclusion	FSC	Finance + Sustainability Committee
EoL	End of Life	SPC	Strategic People Committee
ESD	Early Supported Discharge	QAC	Quality Assurance Committee
EDs	Executive Directors	COG	Council of Governors
FTSU	Freedom To Speak Up		
FT	Foundation Trust		
GoSW	Guarding of Safe Working	SEOG	Strategic Executive Oversight Group
HCAIs	Health Care Acquired Infections	CPG	Capital Planning Group
HEE	Health Education England	FRG	Finance Resources Group
HWBB	Health + WellBeing Board	PSCEC	Patient Safety + Clinical Effectiveness Cttee
IAPT	Integrated Access Point to Treatment	PEC	Patient Experience Committee
JSNA	Joint Strategic Needs Assessment	PPSRG	Premium Pay Spend Review Group
KLOE	Key Line of Enquiry	RRG	Risk Review Group
KPI	Key Performance Indicators	OP	Operational People Committee
MIAA	Mersey Internal Audit Agency	SDDG	Strategic Development + Delivery Group
NCA	Non-Contracted Activity	GEG	Governors Engagement Group
NED	Non Executive Director	QiC	Quality in Care
NEL	Non Elective	CQAG	Complaints Quality Assurance Group
NHSE/I	NHS England/NHS Improvement	H&SSC	Health + Safety Sub Committee
OSC	Overview and Scrutiny Committee	EoLSG	End of Life Steering Group
PbR	Payment by Results	MRG	Mortality Review Group
PHE	Public Health England		
PPA	PPA Prescription Pricing Authority		

Trust Board

DATES 2022-2023

All meetings to be held in the Trust Conference Room

Date of Meeting	Agenda Settings	Deadline For Receipt of Papers	Papers Due Out
2022			
Wednesday 26 January	Thursday 6 January (EXECS)	Monday 17 January	**Wednesday 19 January**
Wednesday 30 March	Thursday 10 March (EXECS)	Monday 21 March	**Wednesday 23 March**
Wednesday 25 May	Thursday 5 May (EXECS)	Monday 16 May	**Wednesday 18 May**
Wednesday 27 July	Thursday 7 July (EXECS)	Monday 18 July	**Wednesday 20 July**
Wednesday 28 September	Thursday 8 September (EXECS)	Monday 19 September	**Wednesday 21 September**
Wednesday 30 November	Thursday 10 November (EXECS)	Monday 21 November	**Wednesday 23 November**
2023			
Wednesday 25 January	Thursday 22.12 or 5.1.23	Monday 16 January	**Wednesday 18 January**
Wednesday 29 March	Thursday 9 March	Monday 20 March	**Wednesday 22 March**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/04**			
SUBJECT:	**Chief Executive's Briefing**			
DATE OF MEETING:	26th January 2022			
AUTHOR(S):	Simon Constable, Chief Executive			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO BAF RISK:	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

SUBJECT	Chief Executive's Briefing	AGENDA REF:	BM/22/01/04

1) BACKGROUND/CONTEXT

This report provides the Trust Board with an overview of matters on a range of strategic and operational issues since the last meeting on 24th November 2021, some of which are not covered elsewhere on the agenda for this meeting.

2) KEY ISSUES

2.1 Current COVID-19 Situation Report

As at the time of writing, 24th January 2022, we have a total of 59 COVID-19 positive inpatients (14 days or less since their first positive sample); 4 of those patients are in critical care. In total, 112 of our inpatients have tested positive at any time during their admission (7 of these in critical care). A week previously those COVID totals were 76 and 122 respectively. We have discharged a total of 2947 patients with COVID-19 to continue their recovery at home. Sadly, a total of 603 patients with COVID-19 have died in our care.

In terms of community numbers, after a sharp rise in December 2021, new daily COVID-19 cases remain high but continue to fall. In the latest 7 days fully published (11th January – 17th January) in Warrington there were 947 cases per 100,000 people (the average area in England had 935); 1983 new cases were reported in that week, down 1688 compared with the previous week. In Halton, there were 1061 cases per 100,000 people; 1377 new cases in that week, down 1141 compared with the previous week.

Vaccination of our boroughs (aged 12s and over) has achieved 84% for the first dose, 78% for the second dose and 61% for the booster in Warrington; for Halton, the figures are 81%, 75% and 56% respectively.

2.2 Overview of Trust Performance

For the first time this month, I have included a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete datasets. In this case, this is month 9, December 2021. Further detail is provided in the Integrated Performance Dasboard and associated Committee Assurance Reports.

The last few weeks have once again continued to see urgent and emergency care under real pressure across the North West and Cheshire and Merseyside; WHH has been no different. The sharp rise in COVID-19 burden in December has significantly impacted patient flow, and staff sickness absence both inside and outside of hospital, also affecting our partners, especially with care home closures. Emergency Department attendances at Warrington have also been high, although the acuity of COVID-19 patients has not been as significant as in previous waves with fortunately less demand for oxygen and critical care.

As a result patient flow has been a real challenge over the last few weeks, despite best efforts with two big patient flow and discharge campaigns: Home For Christmas (December 2021) and New Year New Start (January 2022). Whilst both of these campaigns have had a positive

impact and enabled us to safely navigate our way through the Christmas and New Year bank holiday fortnight, as well as the early part of 2022, our super-stranded position of patients with a length of stay greater than 21 days has peaked at the extraordinary level of 170 in the week commencing 17th January 2022. Those patients who do not meet the 'criteria to reside' has also been uncomfortably in the 25-30% range.

The significant and sustained operational challenges of the increased demand in the non-elective pathway and poor patient flow has seen a deterioration in performance as a result. However, we remain approximately in the 'middle of the pack' with regards to all types and Type 1 emergency activity according to national and regional benchmarking data for this performance standard. We have also continued our elective programme.

Total staff absence, including COVID-19 related-absence remains the most challenging 'People' metric at the current time. The Omicron variant has had a significant impact with total staff absence peaking at approximately 11%. This is a higher figure than we have had for all but wave 1 of the pandemic, reflecting the increase in community COVID-19 prevalence and its impact on staff self-isolation.

2.3 Cheshire & Merseyside System Development

The C&M Integrated Care System moves towards a statutory footing, although this has now been delayed until 1st July 2022. We have continued to be involved at all levels of development, including the development of partnerships at a place level for both our boroughs as well as leadership of the C&M-wide system. We also play an active role in the Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative; Ann Marr is the lead chief executive and Linda Buckley is the Managing Director. I continue to play a role as medical lead chief executive for the hospital cell as it it transitions into the CMAST model, as well as an interim medical representative on the C&M System Transition Board, pending the formal appointment of the ICS Medical Director.

2.4 Vaccination as a Condition of Deployment (VCOD) regulations

Thanks to the enthusiastic take-up by us all, and the extraordinary efforts by our WHH COVID-19 Vaccination Team, we have one of the best COVID-19 vaccination rates for NHS staff in the country. Less than 7% of WHH staff remain fully unvaccinated. That number is improving all the time.

From 1st April 2022, it will become law that all NHS workers, who have either incidental or direct face-to-face contact with patients in a (CQC-regulated) patient care setting, must be fully vaccinated to continue to be deployed in their usual roles. In other words, if individuals are not fully vaccinated (and, for the purposes of the regulations, this currently means two doses) by 1st April 2022 they will no longer be able to work in their usual role. Although the Trust will of course support individuals through potential VCOD redeployment, redeployment is not guaranteed. If individuals decide to remain unvaccinated and if no VCOD redeployment opportunities are available, a possible outcome is that employment will cease, effective 1st April 2022.

This means the first dose must be received by 3rd February 2022 in order to have the second dose in time for the 1st April deadline.

These regulations do not apply to individuals who are medically exempt (and there are only a very small number of reasons for medical exemption); medical exemptions must be applied through HM Government's 119 service. Individuals who are pregnant, or have recently given birth, receive a temporary exemption from the regulations until 16 weeks after giving birth.

I understand that those who have not yet had the vaccination course may have strong reasons for not doing so, on health, religious or personal belief grounds. However, it is our responsibility as an NHS Foundation Trust to implement the law. We will continue to actively encourage vaccine uptake amongst all WHH staff and will be supporting them in doing so. We have been running a series of VCOD Q&A sessions, led by myself. Additionally, line managers will be holding online drop in sessions. We will put on further sessions, including, 1 to 1s where necessary.

2.5 Ambulance Handover and Turnaround Times

An initiative between ourselves and North West Ambulance Service has resulted in significant reductions in the amount of time it takes to transfer a patient from an ambulance to the care of our Emergency Department Team. Since implementing a dedicated ambulance reception process, we are is now delivering handover times of 15 minutes or less in over half of all ambulance arrivals. In the first working week of January 2022, 95% of the 326 ambulance-delivered admissions to our Emergency Department were processed (turned-around) in 30 minutes or under – significantly better than the England average of 77%. The statistics show that Warrington Hospital has not only the best overall ambulance handover times in the region but also one of the region's most improved performances – rising from 69% of patients processed under 30 minutes two years ago to 95% today.

Although a small change, by speeding up the handover time, we are not only improving the patient experience but we are enabling the ambulance crews to reduce their time at Warrington – giving them more time to other urgent calls, which is really important for patients waiting for an ambulance at home. This is an important measure for patient safety across the whole system.

2.6 The Thank You Awards 2021

Congratulations must got to all the winners and finalists in December's Thank You Awards. A list of all the winners and finalists are below:

- ***Star of the Future***, sponsored by Law by Design
  Chloe Cunliffe

  Silver Award – Claire Beard
  Bronze Award – Laura James
  Highly Commended – Lucy Garnett

- ***Wingman Team Care and Support***, sponsored by Seymour John and Causeway Electrical
  Mental Health and Wellbeing Team

Silver Award – Angela Millward
Bronze Award – Allen Hornby and Sarah Brennan
Highly Commended – Denise Dugdale

- ***Inclusion Advocate***, sponsored by Jagtar Singh & Associates
  Lynn Shaw

  Silver Award – Joanne Maskell
  Bronze Award – Mandy Glover
  Highly Commended – Claire Beard

- ***Innovation and/or Quality Improvement***, sponsored by Patchwork
  Maternity Team River

  Silver Award – Respiratory/ICU/Acute Care Team/Physiotherapy Collaborative
  Bronze Award – Vaccination Team

- ***Leadership***, sponsored by NHS Professionals
  Ailsa Gaskell-Jones

  Silver Award – Jill Tomlinson
  Bronze Award – Ellen Quinn
  Highly Commended – Diane Matthew, Ruth Heggie, Anne Harrison

- ***Volunteer of Year***, sponsored by Portakabin
  The Wingmen

  Silver Award – Tony Weetman
  Bronze Award – Forget me Not Garden Volunteers

- ***Student/Trainee of Year***, sponsored by Essential Healthcare, Greiner and Jenkinsons
  Erin Schofield

  Silver Award – Joanne Flynn
  Bronze Award – Christopher Cunliffe

- ***Supporting Excellence in Patient Care***, sponsored by JMBC
  Mortuary Team

  Silver Award – Estates
  Bronze Award – Chaplaincy
  Highly Commended – Medical Engineering

- ***Excellence in Patient Care***, sponsored by Hill Dickinson
  Breast Team

  Silver Award – Children's Diabetes

Bronze Award – Interventional Radiology
Highly Commended – Emergency Department

- ***Outstanding Contribution***, as chosen by the Chief Executive
  Diane Matthew

  Also commended were:
  Integrated Medicine and Community/Discharge Team
  PACU, CSTM Ward and Theatres

2.7 Visiting

COVID- 19 has brought many challenges for our staff and our patients. Since March 2020 restrictions have been in place across the NHS which has meant that in many cases patients have not been able to receive a visit from their loved ones whilst in hospital. This is even more important when community prevalence rates have been so high, as has been the case with the latest Omicron variant.

We recognise the value of seeing loved ones whilst in hospital and how this enhances the wellbeing and experience for all for our patients and at here at WHH the opportunity to reintroduce visiting for our patients is something that is under constant review. In the meantime, we are continuing to review opportunities to support the emotional wellbeing of our patients in its many forms.

The current exemptions to visiting restrictions are as follows:

- One carer that is supporting someone with a mental health issue such as dementia, a learning disability or autism or other similar complex conditions where not being present would cause the patient to be distressed.
- Patients at the end of their life.
- Women in labour - one birthing partner.
- Pregnant women undergoing ultrasound scan - Partner may accompany.
- Neonatal Unit - both parents.
- Children's Unit - One parent or appropriate adult visiting a child at one time, interchangeable.
- In exceptional cases consideration should be given to individual requests following a comprehensive risk assessment and support from the Senior Nursing Team.

2.8 COVID-19 Inquiry Stop Notice

From the beginning of the pandemic we have been aware that there will be national inquiry into COVID-19. The inquiry will focus not only on healthcare but also on education, the furlough scheme and travel and tourism amongst others. The purpose of the inquiry is to understand the challenges in greater detail with learning obtained and shared nationally, should a pandemic be encountered in future years.

At present the Terms of Reference have not been released but I will ensure that regular updates are provided Trust-wide. The inquiry will be led and supported by the Trust's Governance Team where information will be held and collated in preparation for any requested submission to the inquiry. The focus of the inquiry will be around the decisions

made to keep both patients and staff safe through what we know has been the most challenging time that the NHS has ever faced. It is also an opportunity to demonstrate and evidence the innovative methods of working that have been undertaken during this time.

It is extremely important that we start to prepare for this now and that all documents are saved and shared with the Governance Team dating back to January 2020. This maybe information held on computer systems, memory devices or mobile phones amongst others.

2.9 Farewell to The Wingmen

In November, the Warrington Wingman Lounge opened for the very last time, 18 months after we started. Since then, the Wingman Lounge has had nearly 44,000 visits from our staff. In total, there have been 87 volunteers from both the flight deck and the cabin. Our lounge has been one of the most successful in the country since Project Wingman began.

The Wingman Crew didn't know us, but they came and lived every single one of our values every day. They brought us hope and cheered us on that this would pass; as indeed it did, albeit in the waves along to the new 'normal' we find ourselves in. They shared stories of what we see as their 'glamorous' lifestyles, the places they've flown to and the luxury stopovers they have had. They shared what it was like to be in highly stressful situations and keep people safe. We shared that too.

Whether they realise it or not, what they have done, as volunteers in the midst of a crisis, has been truly amazing, especially in the face of such uncertainty and disruption in their own lives. We didn't want to see them go. However, there is a legacy that lives on and that is The Wingman Wellbeing Lounge.

2.10 Special Days/Weeks for professional groups

Since our last Board meeting in November 2021, a number of topics, professional or interest groups or disciplines have had special days or weeks marked locally, nationally or internationally. WHH has recognised, embraced and celebrated all of these.

World Antibiotic Awareness Week: 18th – 26th November 2021
Carers' Rights Day: 25th November 2021
World AIDS Day: 1st December 2021

2.11 Local political leadership engagement

Since the last Board meeting both the Chairman and I have continued regular communication and updates with our local political leadership, through the chief executives of both Warrington Borough Council and Halton Borough Council and the respective council leaders. I have also continued to be in regular communication with all four of our local Westminster MPs – Derek Twigg MP (Halton), Mike Amesbury MP (Weaver Vale), Charlotte Nichols MP (Warrington North) and Andy Carter MP (Warrington South). I have been updating them on the WHH situation; similarly they have asked questions on behalf of their constituents. All of our senior stakeholders are active participants and members of our New Hospitals Strategic Oversight Group.

2.12 Employee Recognition

In the summer of last year we announced the start of a slightly different approach to the Employee of the Month and Team of the Month awards scheme that we used to run pre-pandemic, and that we suspended in 2020. These have become the 'You Made a Difference' awards.

You Made a Difference Award (October 2021) – Ward A6, Pam Ward and Carol Baskett

Ward A6, Matron Carol Baskett and Pam Ward, Trusted Assessor, won the WHH 'You Made a Difference Award' for October. A6, Carol and Pam were nominated due to their brilliant team working which enabled them to provide excellent patient care, particularly for a lady living with dementia. The teams supported the patient during her stay at WHH, and worked to find the best residence for her upon discharge, improving her quality of life and supporting her to continue on her recovery journey.

You Made a Difference Award (November 2021) – Tom Owens, Security Officer

Tom Owens, Security Officer, was awarded the 'You Made a Difference Award' for November 2021. Through his quick thinking and actions, and going above and beyond in his role, Tom helped to save the life of a patient last autumn. Following this incident, changes have been implemented that will support others in doing the same. Tom demonstrated such presence of mind and quick thinking, most certainly making a difference to the life of the patient, as well as creating an initiative for future patients needing similar support.

The winners of my own award since my last Board report have been the following:

Chief Executive Award (November 2021): Paediatric Team

This was a long overdue award for a whole team approach to looking after a very challenging set of highly specialised circumstances in a young man who was on the ward in the autumn.

Chief Executive Award (December 2021): Marcia Harris

I made an award to Marcia Harris, healthcare assistant, for something she did outside of work earlier in 2021. On 20th August 2021, Marcia was leaving her home in Warrington to travel to work in Halton PACU; a car accident had occurred and Marcia pulled over to assist. This is where she witnessed an elderly man been pinned against his car bonnet by a man holding a knife. She tried to calm the situation down and at one point he held the knife to Marcia's throat. Her act of heroism at this time quite probably saved lives. Subsequently, on 22nd November the man with the knife was convicted and handed a five year prison sentence. Marcia was commended by the judge, for bravery and being a good Samaritan.

Chief Executive Award (December 2021): Layla Alani

Layla Alani, Director of Integrated Governance & Quality, has been given a Chief Executive Award for her leadership throughout the pandemic, keeping us all safe with a conscientious attention to detail, careful stewardship of the regulations at the same time as helping us make continuous improvements in our processes and outcomes.

Chief Executive Award (January 2022): Angela Millward

I have also been pleased to present Angela Millward in radiology a Chief Executive Award for her outstanding support of colleagues during the last year or so. Angela was nominated multiple times in the Team Care and Support category in the Thank You Awards 2021, and she was the Silver Award Winner. That was a really strong category as you might imagine, and all the nominations were really powerful. However, I was totally struck by what was written about Angela by so many of her colleagues in the nominations and wanted to recognise her additionally for exceptional care and support of her colleagues.

Appreciation of WHH staff from patients, family, visitors and colleagues

I have also specifically recognised the work of the following colleagues:

- Dr Alex Gomez, Consultant Geriatrician, Integrated Medicine & Community
- Anna Upham, Sister – PIU, Digestive Diseases
- Pamela Jacobs, Clinical Nurse Specialist – PIU, Digestive Diseases
- Lynda Sibert, Waiting List Clerk, Digestive Diseases
- Dr Anne Robinson, Deputy Medical Director
- Jacqueline Graham, Medical Secretary, Women's & Children's Health
- Georgia Berry-Price, Student Nurse - Ward B1, Integrated Medicine & Community
- Hellan Owens, HCA - Ward B12, Integrated Medicine & Community
- Dr Eshita Hasan & Team, Associate Medical Director, Women's & Children's Health
- Jill Nuckley, Ward Manager – CAU, Urgent & Emergency Care
- Louise Foley, Cancer Nurse Specialist, Digestive Diseases
- Mr Mark Tighe & Team, Digestive Diseases
- Jeanette Jones, Ward Clerk, Women's & Children's Health
- Lesley McKay & Team, Infection Control Team, Corporate Nursing
- Tom Poulter, Chief Information Officer
- Dan Moore, Chief Operating Officer
- Rachael Browning, Associate Chief Nurse, Corporate Nursing
- Valerie Fidler, Assistant Practitioner – Physiotherapy,Clinical Support Services
- Anita Wainwright, Non-Executive Director
- Rachel Lamb & Team, Matron, Urgent & Emergency Care
- Mr Rajiv Sanger & Team, Consultant Orthopaedic Surgeon, Surgical Specialities
- Angela Chiweshe, Staff Nurse, Urgent & Emergency Care
- Kelly Johnson & Team, Ward A2, Urgent & Emergency Care
- Pearl Arnold, Sister, Urgent & Emergency Care
- Jennie Myler, Executive Assistant, Trust Executives
- Loretta Lowe, Sister – ITU, Medical Care

2.13 Signed under Seal

Since the last Trust Board meeting, the following has been signed under seal by the Chairman and myself:

New MRI Scanner and construction

3) MEETINGS ATTENDED/ATTENDING

The following is a summary of key external stakeholder meetings I have attended in December 2021 and January 2022 since the last Trust Board Meeting (meetings generally taking place via Zoom or MS Teams). It is not intended to be an exhaustive list.

- NHSE/I COVID-19 System Leadership (Monthly)
- NHSE/I COVID-19 NW Hospital Cell Gold
- C&M Integrated Care System Transitional Oversight Board
- C&M Provider Collaboration CEO Group (Bi-weekly)
- C&M Acute And Specialist Trust (CMAST) Provider Collaboration CEO Group (Monthly)
- C&M Medical Directors Clinical Prioritisation & Mutual Aid meeting (Weekly)
- C&M and NW Critical Care Network Gold Command Calls (Twice Weekly)
- Steve Broomhead, Chief Executive, Warrington Borough Council
- David Parr, Chief Executive, Halton Borough Council
- Dr Andy Davies, Clinical Chief Officer, NHS Warrington and Halton CCG
- C&M Hospital Cell (Weekly)
- Warrington Wider System Sustainability Group (Monthly)
- Warrington System Pressures Meeting (Weekly, then Daily)
- Clinical Research Network North West Coast Health Research Alighnment

4) RECOMMENDATIONS

The Board is asked to note the content of this report.

Appendix 1: Chief Executive Dashboard - Month 9 (December 2021)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Quality of Care

Indicator	Target	Actual
Incidents over 40 days	0 open	0 (29 open over 20 days)
Sepsis	90%	71% | 64% | 65% | 68%
Duty of Candour	100%	100%
Inpatient Falls (YTD)	Less than 612 (for the year)	416
VTE	95%	95.3%
Pressure Ulcers (YTD)	Less than 65 (for the year)	62
Medication Reconciliation (24 hrs)	80%	61.00%
Staffing Average Fill Rates	90%	Above 84.0%
Care Hours Per Patient Day (CHPPD)	7.9	7.7
NICE Compliance	90%	88.26%
Friends & Family Test (IP/Day Case)	95%	97%
Friends & Family Test (ED & UTC)	87%	75%
Complaints over 6 months	0	0
Continuity of Carer	51%	78.90%
Healthcare Infections - MRSA	0	0
Healthcare Infections - CDI	Less than 44 for the year	31
Healthcare Infections - E. coli	Less than 81 for the year	53
COVID-19 nosocomial – 8-14 Days (In Month) 15 Days +	N/A	15 13
Mixed Sex Accommodation Breaches	0	0

Operational Performance

Indicator	Target	Actual
Diagnostic 6 Weeks	99%	77.50%
RTT 18 Weeks	92%	70.25%
RTT 52 Weeks	0	1,005
A&E 4 Hour Wait	95%	68.92%
A&E 12 Hour Wait	0	24 patients
Cancer 14 Days	93%	78.29%
Breast Symptomatic 14 days	93%	36.76%
Cancer 28 Day Faster Diagnostic Standard	75%	76.47%
Cancer 31 Days First Treatment	96%	98.48%
Cancer 31 Day Surgery	94%	100%
Cancer 31 Day Drug	98%	100%
Cancer 62 Days Urgent	85%	73.47%
Cancer 62 Days Screening	90%	90.91%
Ambulance Handovers 30-60 mins	0	91
Ambulance Handovers 60+ mins	0	30
Discharge Summaries 24 hours	95%	81.60%
Discharge Summaries 7 days	0	394
Cancelled Operations – nonclinical	Less than 2%	0.11%
Cancelled Operations – nonclinical not rebooked 28 days	0	5
Urgent Operations Cancelled for a 2nd time	0	0
Fracture Clinic – 72 Hours	95%	38.51%
Super Stranded Patients	Trajectory	132

People

Workforce

Indicator	Target	Actual
Sickness Absence	4.2%	7.38%
Return to Work	85%	55.70%
Recruitment Time to Hire	65 days or less	73 days
Vacancy Rates	9% or less	8.93%
Turnover	Less than 13%	15.71%
Retention	85%	82.48%
Core/Mandatory Training	Trajectory	84.67%
Role Based Training	Trajectory	86.86%
Safeguarding Training	Trajectory	68.00%
Workforce Carrying Out a Qualification	2.3%	3.59%
Payspend (month)	£19.37m (Plan)	£19.40m
Bank/Agency Reliance	Less than 9%	15.59%
PDR Compliances	Trajectory	62.70%

Sustainability

Finance

Indicator	Plan	Actual
Income & Expenditure	Breakeven	£1.4m deficit
Capital	£11.4m	£5.3m spend
Cash	£10.1m	£42.97m balance
Better Practice Payment Code	95%	94% cumulative
CIP In Year	£1.85m	£1.9m savings
CIP Forecast	£4.9m	£1.7m recurrent saving

Strategy

Strategy

- Warrington Town Deal – Full Business Case approved by Government for new £3.1m health and wellbeing hub in town centre.
- Establishment of formal Integrated Care Systems and Partnerships, including new statutory body in Cheshire and Merseyside – deadline extended from April 2022 to July 2022.
- New breast unit opened at CSTM. Further public consultation planned for Spring on proposed consolidation of breast screening services in Warrington to increase capacity, reduce waits and improve patient experience.
- Expression of Interest for national funding for new hospitals in Warrington and Halton submitted and prioritised by Cheshire and Merseyside. Awaiting response from NHS England.
- Work on new ED plaza commenced.

Report to the Board of Directors

AGENDA REFERENCE:	**BM/22/01/06**	
SUBJECT:	**COVID-19 Performance Summary and Situation Report**	
DATE OF MEETING:	26th January 2022	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	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. #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. #1126 Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily Executive Summary which includes data outlining the key information pertinent to the command and control of the pandemic. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where available. This report is part of the continuing development and understanding of demand, capacity and outcomes and will determine future strategic planning. Data up to 21st January 2022 is included.	

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

RECOMMENDATION:	The Trust Board is asked to: 1. Note the contents of this report.	
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 THE BOARD OF DIRECTORS

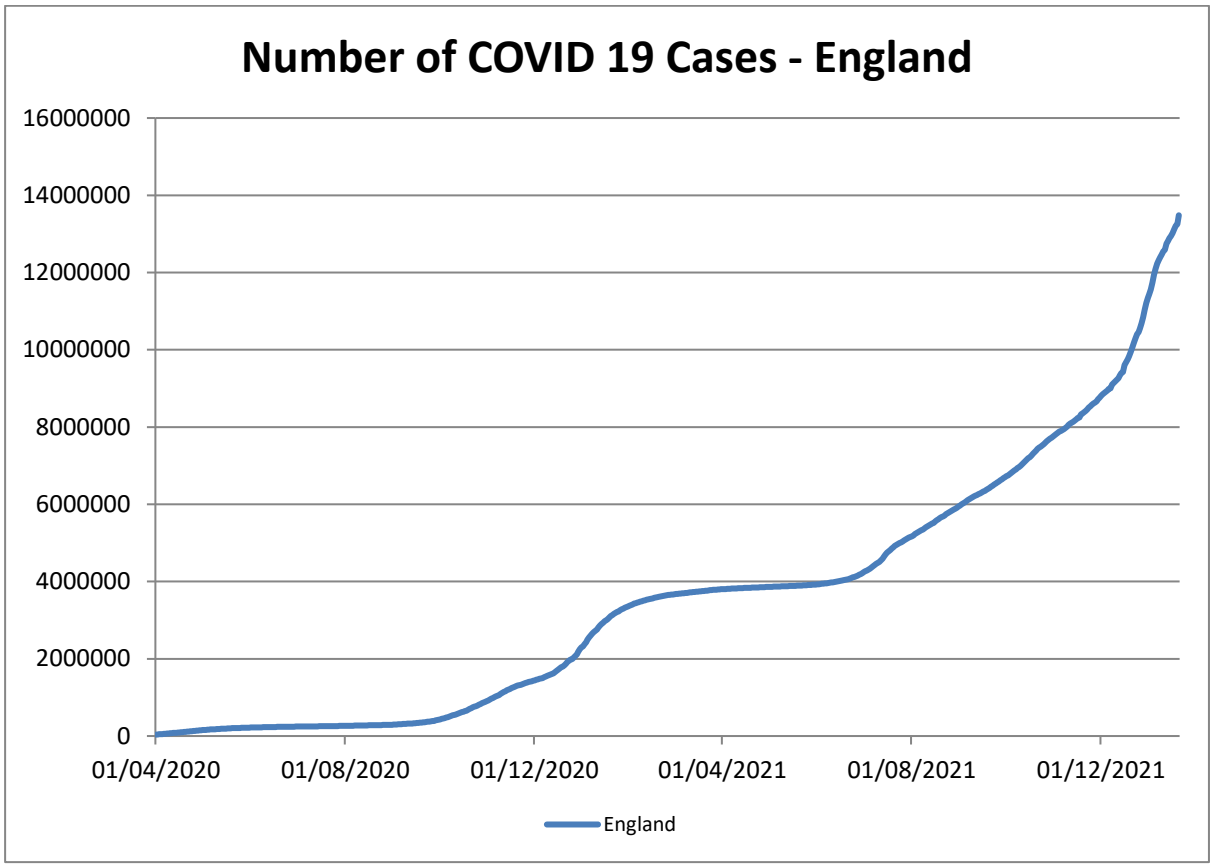
SUBJECT	COVID-19 Performance Summary and Situation Report	**AGENDA REF:**	BM/22/01/06

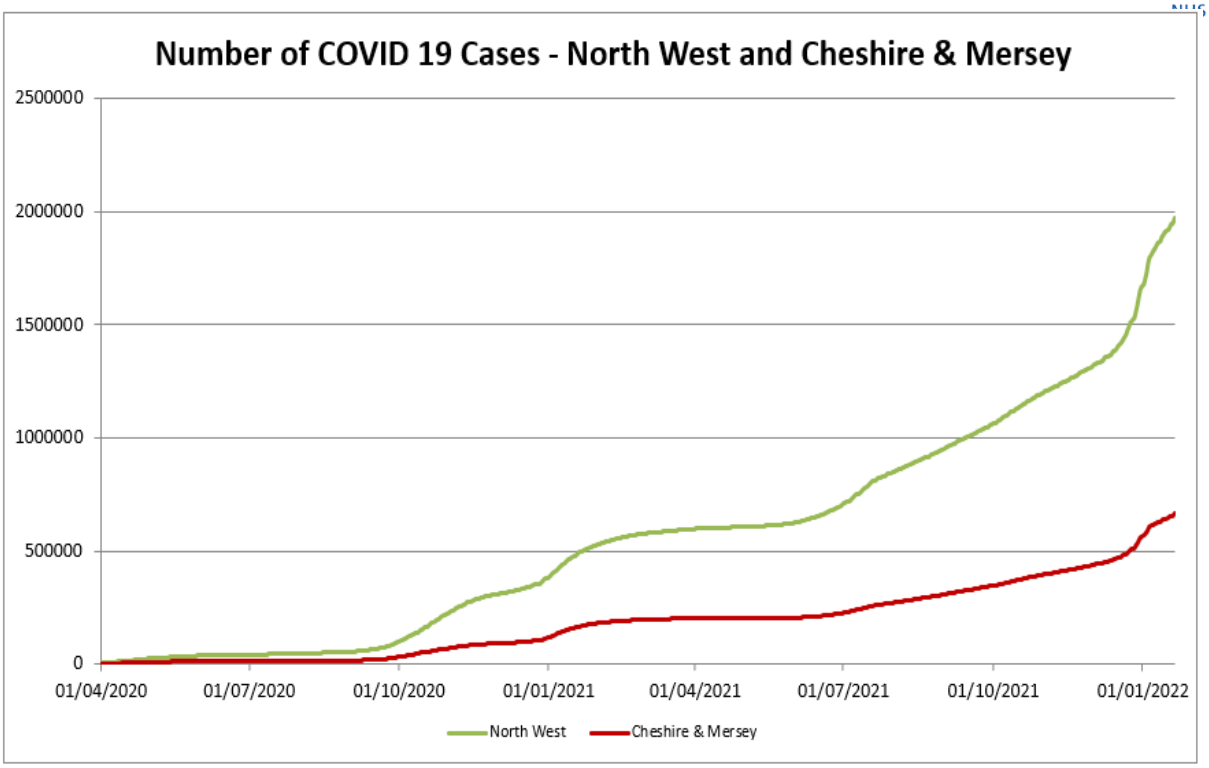
1. BACKGROUND/CONTEXT

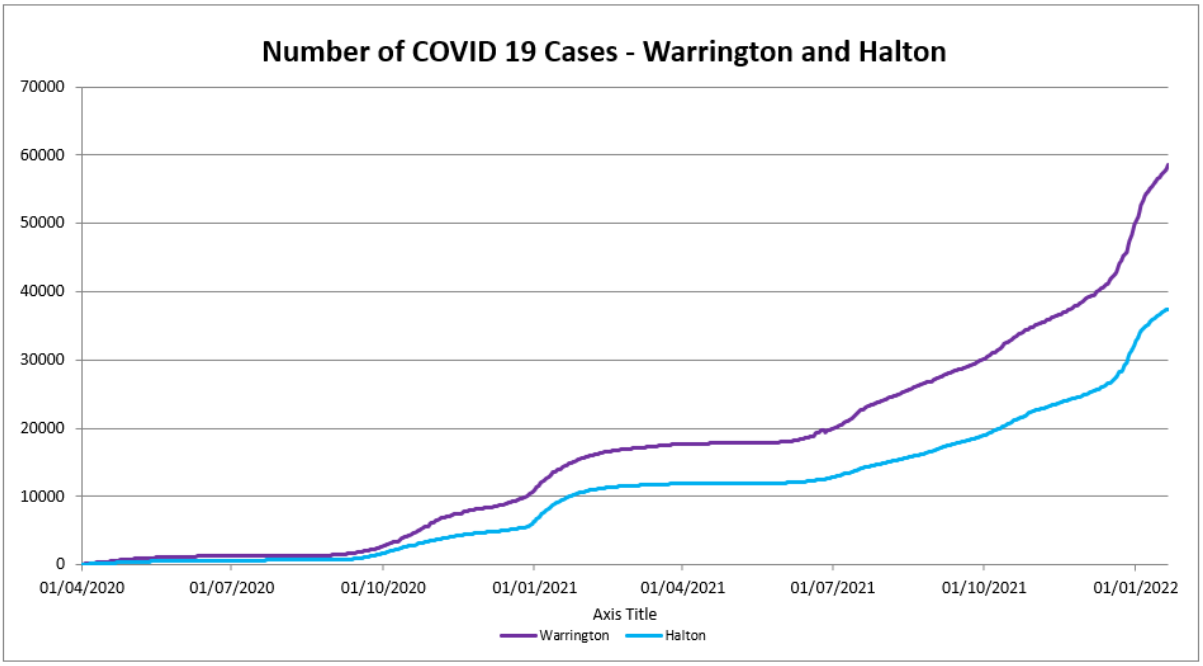
The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily Executive Summary which includes data outlining the key information pertinent to the command and control of the pandemic. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where available. This report is part of the continuing development and understanding of demand, capacity and outcomes and will determine future strategic planning. Data up to 21st January 2022 is included.

2. KEY ELEMENTS

2.1 Number of Reported Cases



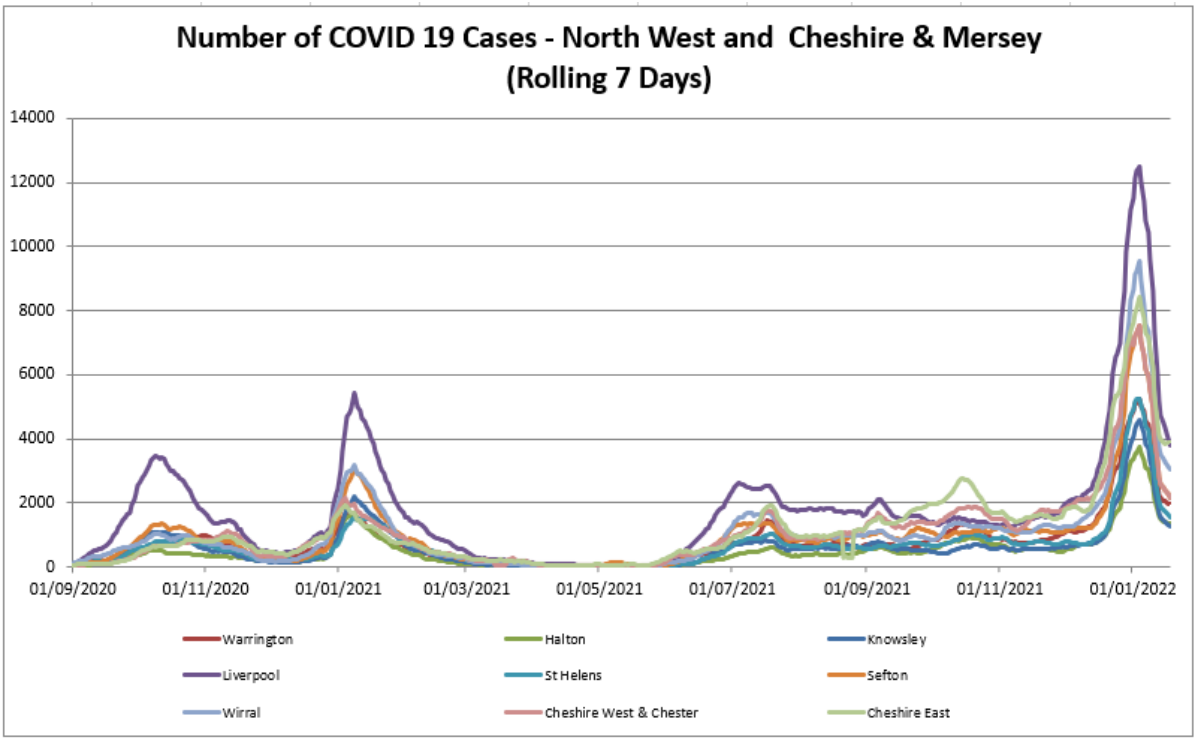


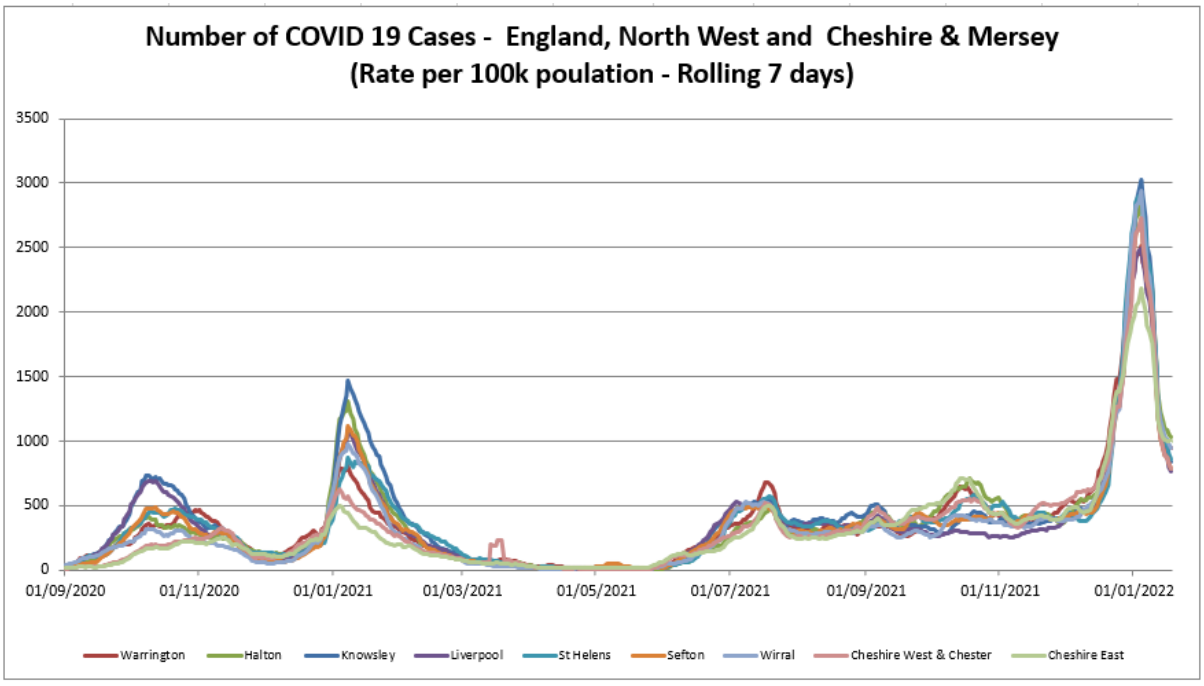


Narrative: As of 21/01/2022, there were 58,537 cases of confirmed COVID-19 reported in Warrington and 37,428 cases reported in Halton. The Trend is in line with the England, Cheshire & Mersey and the North West positions.

Source: https://coronavirus.data.gov.uk/

2.2 Infection Rates in the Community (per 100k population – Rolling 7 days)

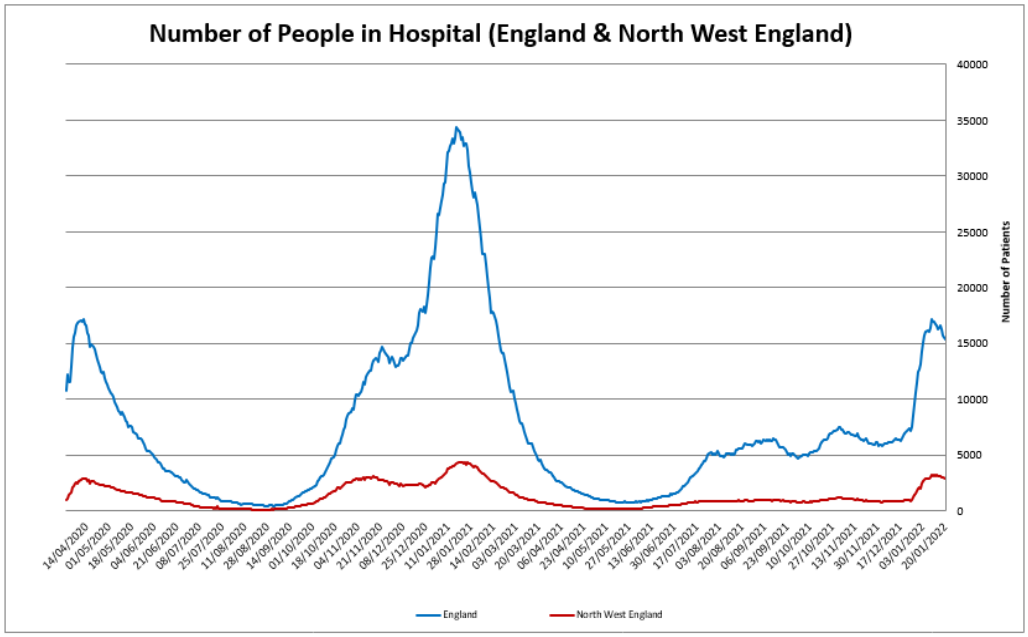


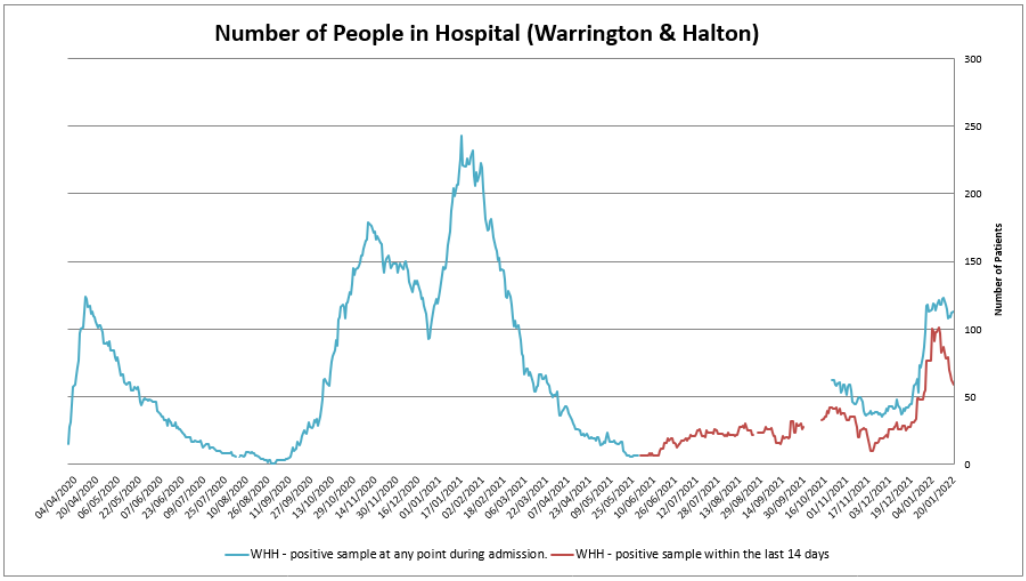


Narrative: The graphs show the infection count and rates per 100k population over a rolling 7 day period. This is a more accurate comparison than total number of cases due to the differences in population. The data shows the latest "Omicron" peak came in early January 2022 with the highest number of infections than at any other point of the pandemic. As at 18/01/2022, (the latest data period for this indicator) Warrington had 946 cases per 100k population and Halton had 1,037 cases per 100k population which is higher than the Northwest position (921 cases/100k population) and the England position (974 cases/100k population).

Source: https://coronavirus.data.gov.uk/

2.3 Number of People in Hospital



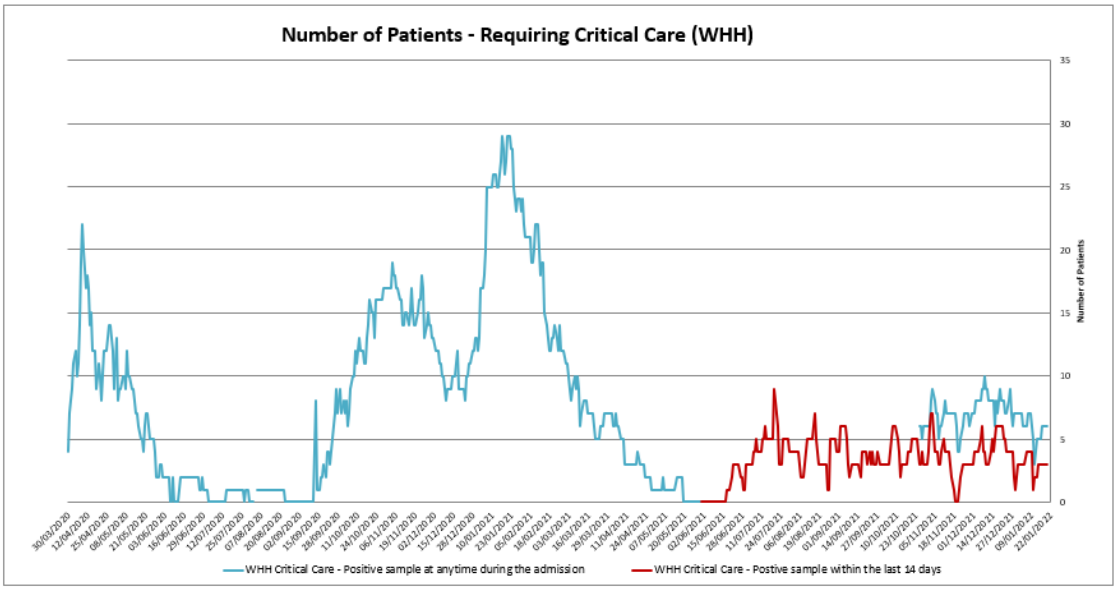


Narrative: As 20/01/2022, there were 59 inpatients being treated by the Trust with confirmed COVID-19 (with a positive COVID-19 sample within the last 14 days) and 115 patients (with a positive COVID-19 test at any point during admission). The peak of the 3rd wave was on 18/01/2021 with 243 inpatients receiving treatment (with a positive COVID-19 sample at any point during admission). The peak of the 4th wave (so far) was on 17/01/2022 with 117 inpatients receiving treatment (with a positive COVID-19 sample at any point during admission).

Source:https://www.gov.uk/government/collections/slides-and-datasets-to-accompany-coronavirus-press-conferences (England & North West) and Trust Data (Warrington & Halton).

Please note: For Wave 1, 2 and 3 up to 31st May 2021, the data included patients with a positive COVID-19 sample at any point during their inpatient episode. For Wave 4 from 1st June 2021, the data includes patients with a positive COVID-19 sample during the last 14 days, in line with national guidance.

2.4 Number of Patients Requiring Critical Care

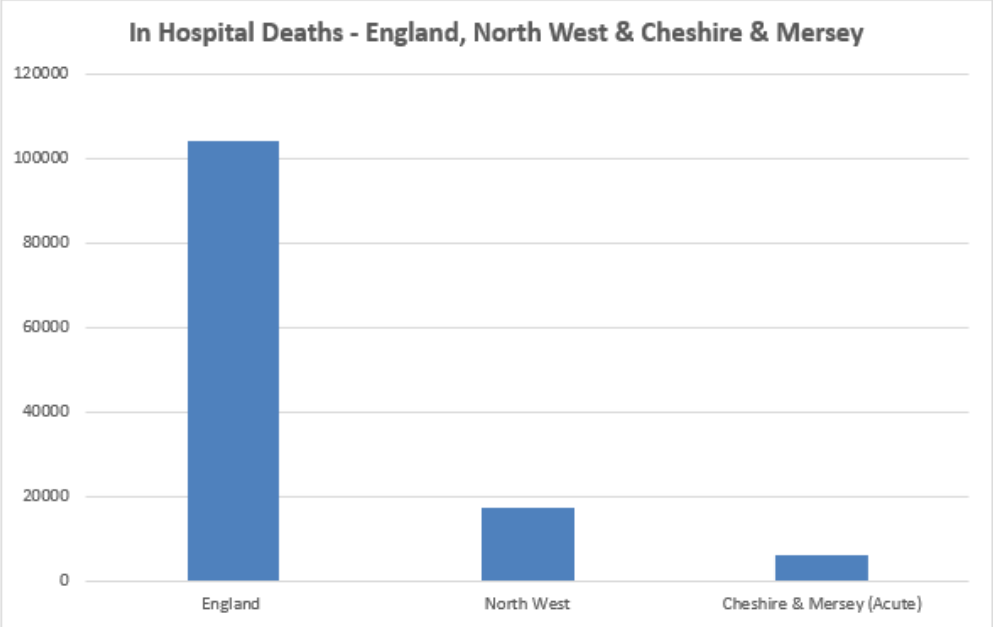


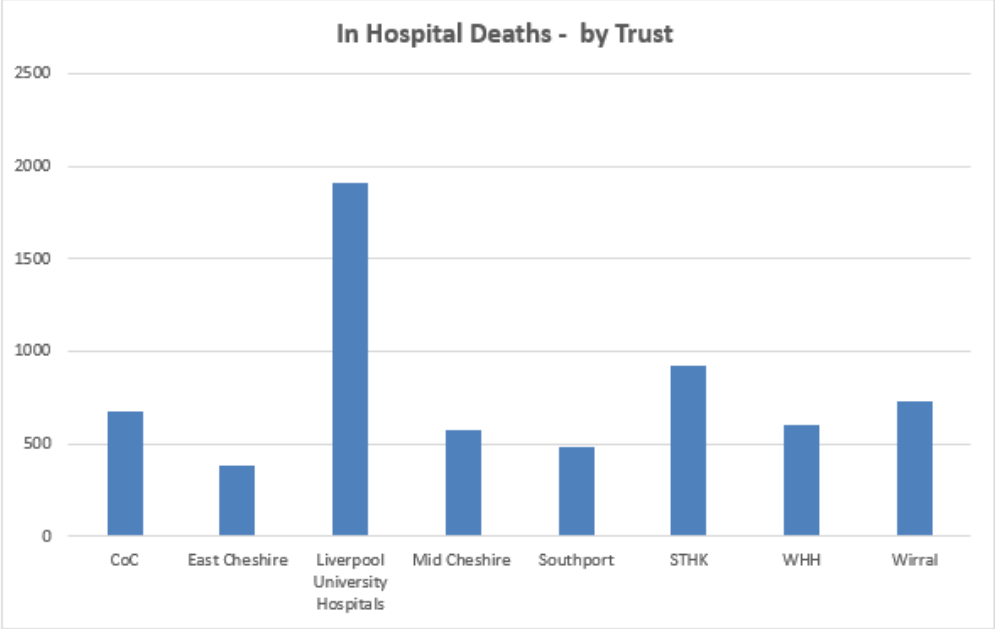
Narrative: As of 20/01/2022, there are 3 inpatients with confirmed COVID-19 (positive sample within the last 14 days) requiring critical care and 6 patients (positive sample at any point during admission).

Source: Trust Data (Warrington & Halton).

Please note: For Wave 1, 2 and 3 up to 31st May 2021, the data included patients with a positive COVID-19 sample at any point during their inpatient episode. For Wave 4 from 1st June 2021, the data includes patients with a positive COVID-19 sample during the last 14 days, in line with national guidance.

2.5.1 Number of In-Hospital Deaths





Narrative: As of 20/01/2021, the Trust had reported 603 deaths of inpatients with confirmed COVID-19. The trend is in line with the North West and Cheshire & Mersey positions.

Notes: There is a time lag between the date that the death was reported and actual date of death for national data.

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/ and Trust Data.

2.5.2 Crude Mortality

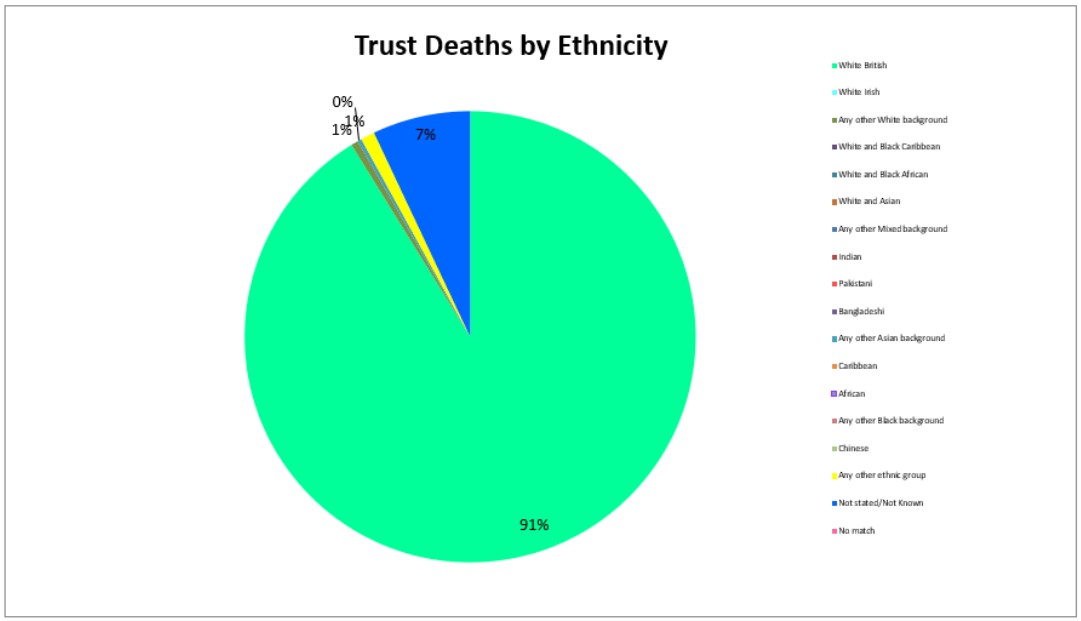
	2020	2021
December (All Deaths)	107	113
December (Non-COVID)	52	96
December (COVID)	55	17
% COVID Deaths (of all deaths)	51.4%	15.0%
Discharges	4243	4842
Crude Mortality (deaths divided by deaths+discharges)	2.5%	2.3%

	Wave 1 Apr-Aug 2020	Wave 2 Sept-Dec 2020	Wave 3 Jan 2021 - May 2021	Wave 4 June 2021 - Present
All Deaths	405	402	478	628
Non-COVID	272	227	293	532
COVID	133	175	185	96
% COVID Deaths (of all deaths)	32.8%	43.5%	38.7%	15.3%
Discharges	19326	17241	23507	37707
Crude Mortality (deaths divided by deaths+discharges)	2.1%	2.3%	2.0%	1.7%
Crude Mortality COVID-19 (COVID-19 deaths divided by COVID-19 deaths+ COVID-19 discharges)	25.2%	20.3%	16.9%	10.1%

Narrative: Crude mortality in December 2021 was 2.3% compared with 2.5% in December 2020. Crude mortality was 2.1% in wave 1 and 2.3% in wave 2 and 2.0% in wave 3 and 1.7% in wave 4 (to date) with Crude mortality for COVID-19 patients 25.2% in wave 1, 20.3% in wave 2, 16.9% in wave 3 and 10.1% in wave 4 (to date).

Source: Trust Data.

2.5.3 Number of In Hospital Deaths (Ethnicity)

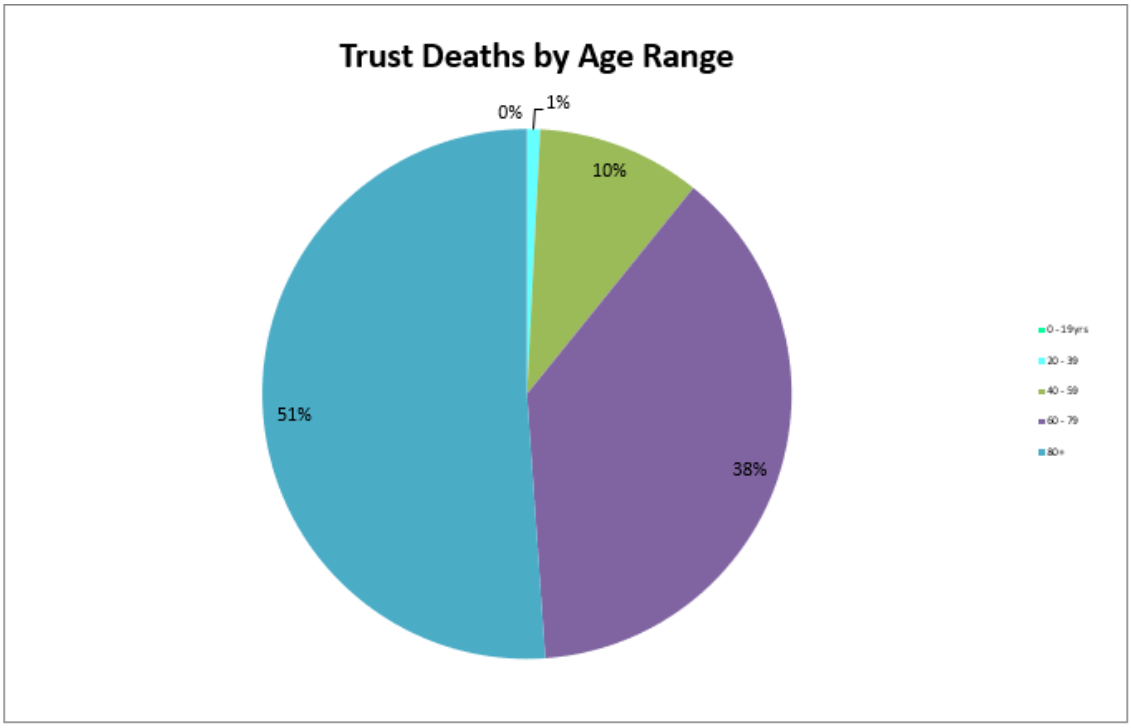


Narrative: As of 20/01/2022, 91% of reported deaths were patients who identified as "White British", with 7% patients' ethnicity "Not Stated/Not Known", 1% patients' ethnicity stated as "Any Other Ethnic Group", <1% patients stated as "Asian" or "Asian British", <1% Indian and <1% patient identified as "White Any Other Background". The proportion of White British patient deaths is greater than the national position, however this is as expected when comparing the population of Warrington (96.00% White British) & Halton (98.00% White British).

Notes: National data for COVID-19 deaths by ethnicity was not available at the time of writing, having previously been made available on the NHSE website.

Source:https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/ (England, North West, Cheshire & Mersey) and Trust Data (Warrington & Halton)

2.5.4 Number of In Hospital Deaths (Age Range)

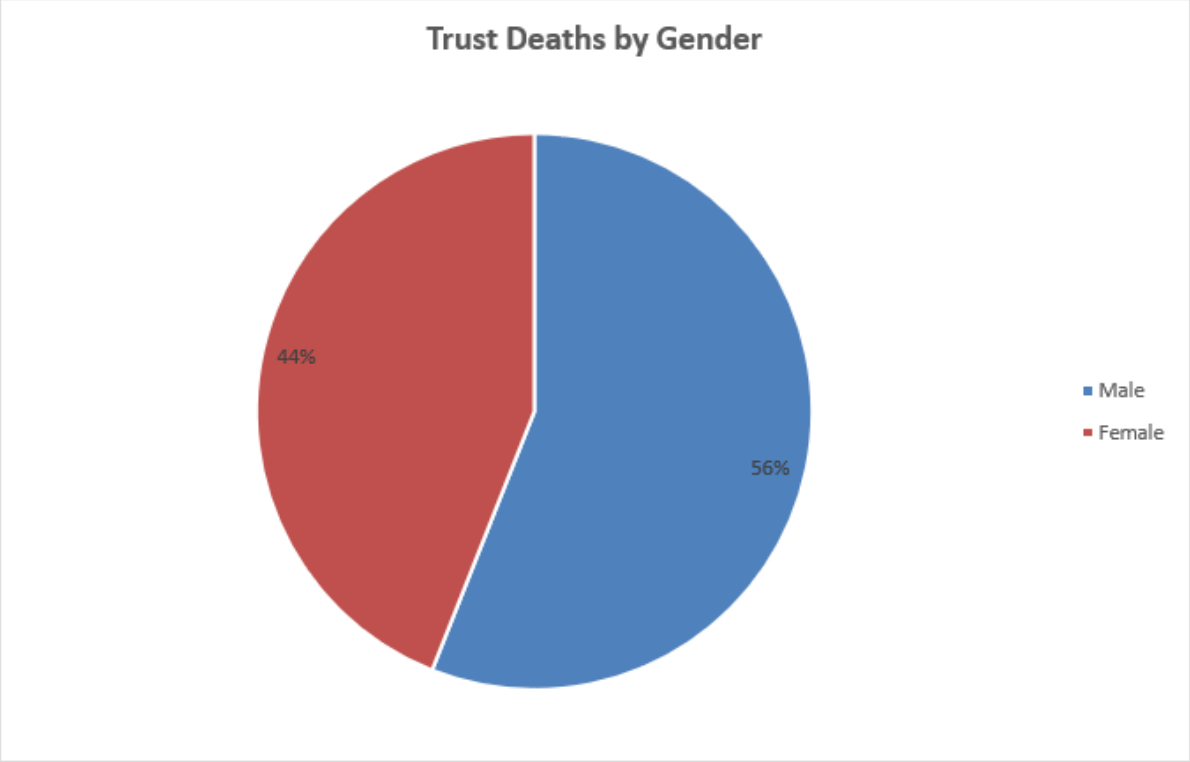


Narrative: As at 20/01/2022, 89.00% of COVID-19 related deaths were inpatients over the age of 60, which is line with the national position. The average age of death was 77.2 years.

Notes: Data utilised is for the date each death was reported, not the date that the death occurred and therefore there is a 3-5 day time lag for national data.

Source:https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/ (England, North West, Cheshire & Mersey) and Trust Data (Warrington & Halton)

2.5.5 Number of In Hospital Deaths (Gender)

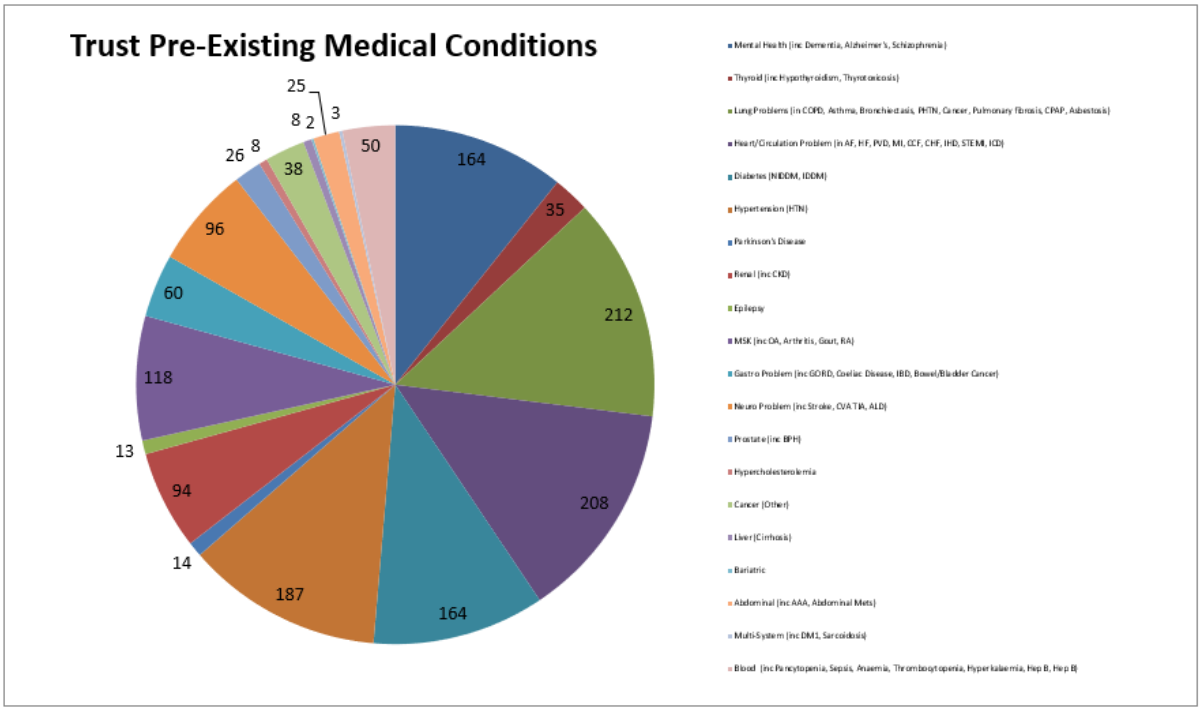


Narrative: As at 20/01/2022, 56% of COVID-19 deaths were male patients and 44% of deaths were female patients.

Notes: National data for COVID-19 deaths by gender was not available at the time of writing, having previously been made available on the NHSE website.

Source:https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/ (England, North West, Cheshire & Mersey) and Trust Data (Warrington & Halton)

2.5.6 In Hospital Deaths - Pre-Existing Medical Conditions



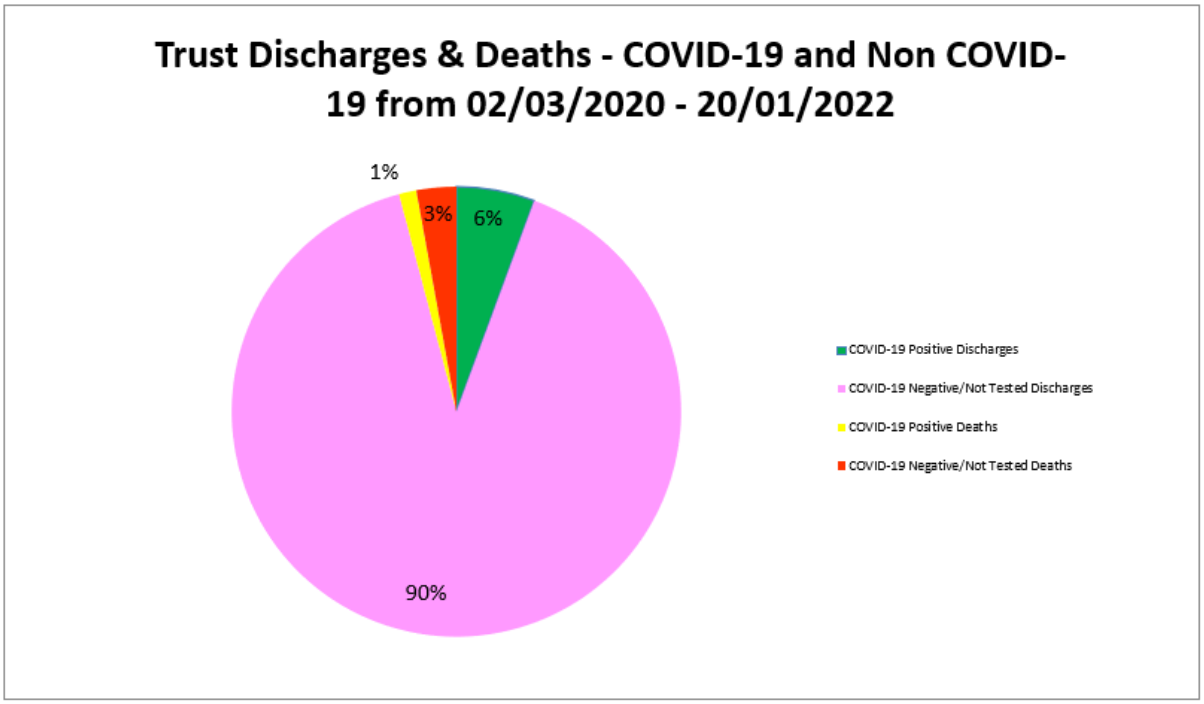
Narrative: As at 20/01/2022, 87% of inpatients who have died with a confirmed COVID-19 positive sample had a pre-existing medical condition recorded. The most common of these were Heart and Lung conditions and Diabetes.

Notes: The majority of patients had more than one pre-existing medical condition, therefore are counted multiple times in the data.

This data was obtained from a review of free text fields in Lorenzo which is not coded data, therefore there maybe some omissions.

Source: Trust Data (Warrington & Halton)

2.6 Trust Outcomes

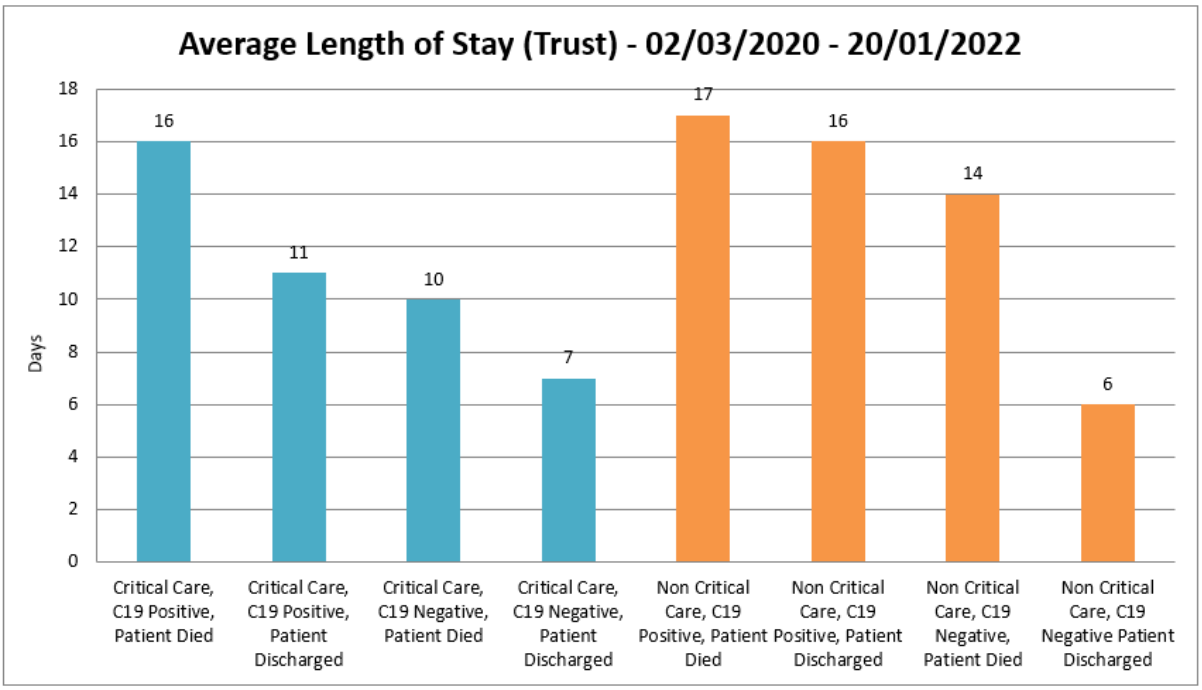


Narrative:

- Between 02/03/2020 – 20/01/2022, the Trust treated 47,785 inpatients (any patient with at least 1-night stay).
- 3,296 (6.89%) inpatients had tested positive for COVID-19.
- 95.88% of all patients were discharged from hospital (COVID-19 and Non COVID-19).
- There was a total of 1,967 inpatients (all causes) who have died; this represents 4.11% of all inpatients.
- 603 inpatient deaths were related to COVID-19 which represented 1.26% of all inpatients and 18.29% of inpatients with COVID-19.
- 121 patients who have died and who had tested positive for COVID-19 were admitted from a care home, 3.67% of all COVID-19 positive inpatients and 20.06% of inpatients who have died with a positive COVID-19 sample.

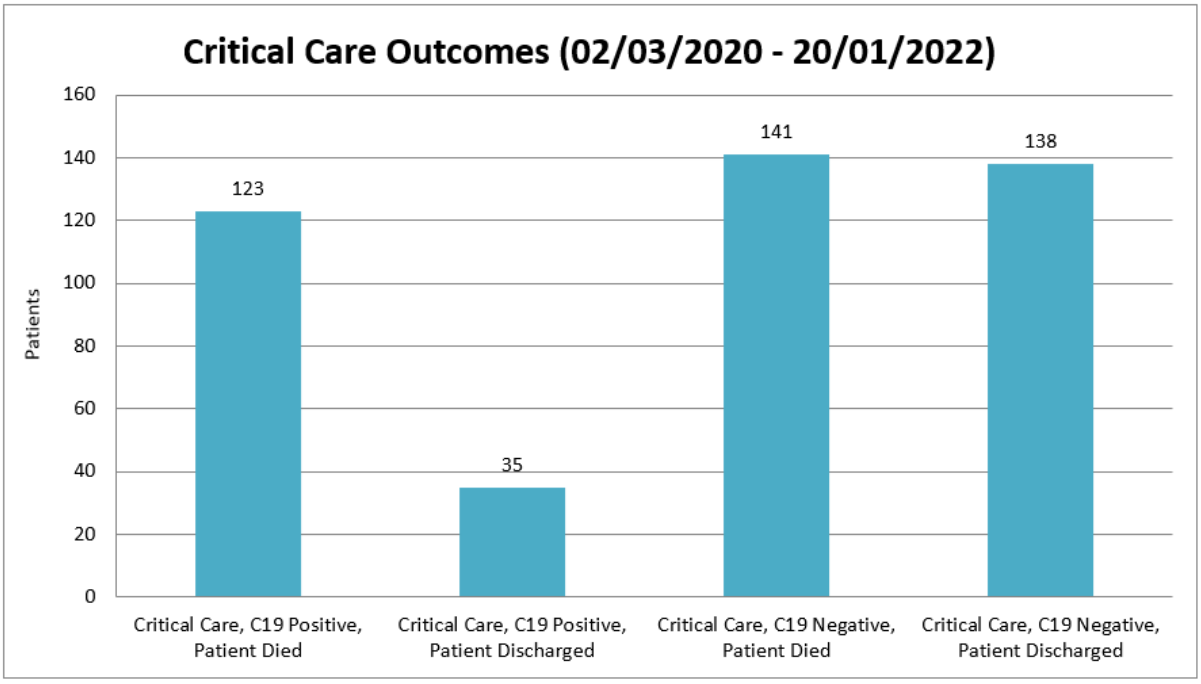
Source: Trust Data

2.6.1 Average Length of Stay



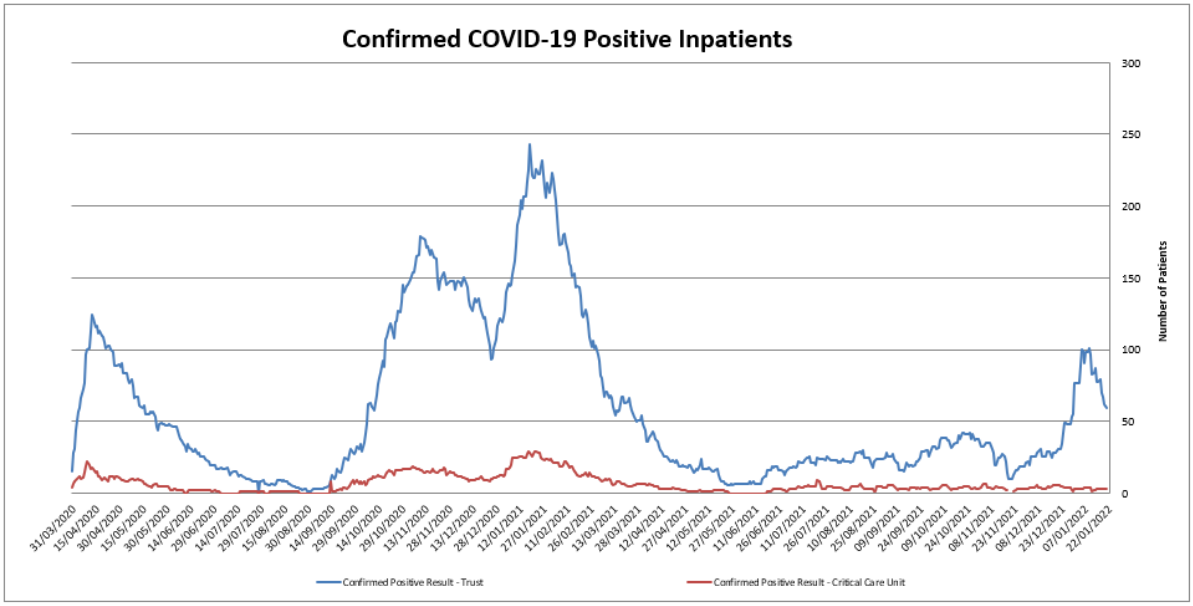
Narrative: From 02/03/2020 – 20/01/2022, the average length of stay for patients who had tested positive for COVID-19 was 15 days in critical care and 16 days in non-critical care.
Source: Trust Data

2.6.2 Critical Care Outcomes



Narrative: From 02/03/2020 – 20/01/2022, there were 264 critical care inpatient deaths (123 COVID-19, 141 non-COVID-19) and 173 critical care inpatient discharges (35 COVID-19, 138 non-COVID-19).
Source: Trust Data

2.7 Confirmed Positive COVID-19 Patients



Narrative: As of 20/01/2022, there were 59 patients who have had a COVID-19 positive test within the last 14 days with 3 patients in critical care.

2.8 Nosocomial Infection

Nosocomial infections are defined as:

- Length of Stay at the Time of Positive COVID Sample 0-2 Days – Community Acquired
- Length of Stay at the Time of Positive COVID Sample 3-7 Days – Hospital Onset Indeterminable Hospital Associated
- Length of Stay at the Time of Positive COVID Sample 8-14 Days – Hospital Onset Probable Hospital Acquired
- Length of Stay at the Time of Positive COVID Sample 15 Days+ – Hospital Onset Definite Hospital Acquired

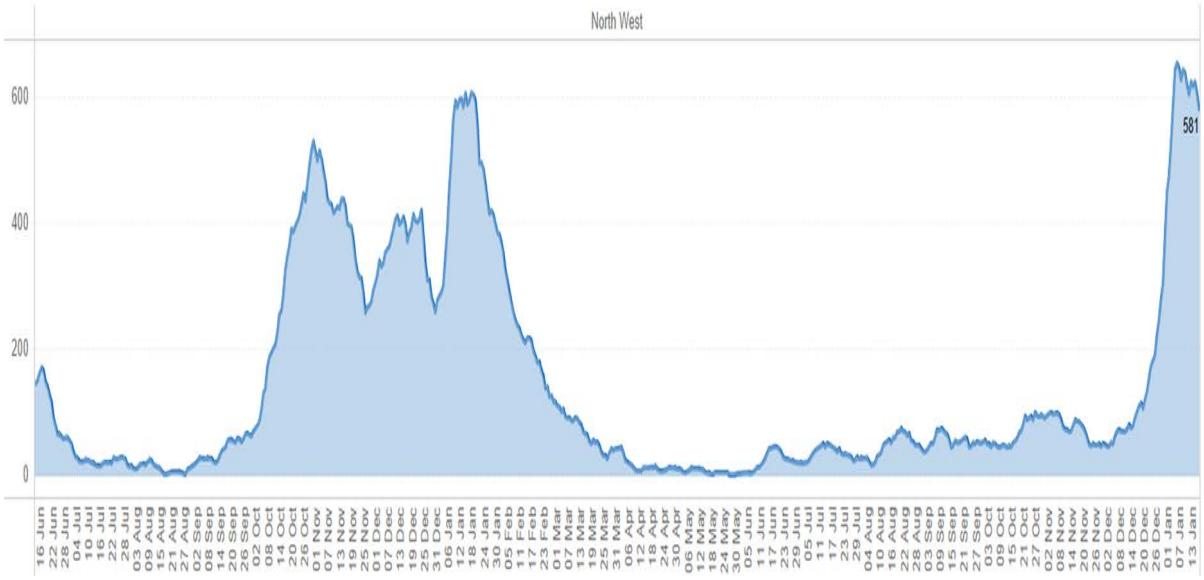
Cheshire & Mersey Benchmarking for Cumulative Nosocomial Infection Rates w/e 16th January 2022

Cumulative Total Since Recording started until latest data available	Sum of Total Nosocomial Cases	Sum of Total Number of COVID-19 Inpatients	Cumulative % Rate
Cheshire And Merseyside STP	**4781**	**32392**	**14.70%**
Countess of Chester Hospitals	497	2786	**17.80%**
Warrington & Halton Hospitals	444	3250	**13.70%**
Liverpool University Hospitals	1271	9843	**12.90%**
Southport And Ormskirk	322	2543	**12.70%**
Mid Cheshire Hospitals	535	2792	**19.20%**
Wirral University Hospitals	376	3237	**11.60%**
East Cheshire Hospital	337	1835	**18.40%**
St Helens And Knowsley Teaching Hospitals	338	4017	**8.40%**

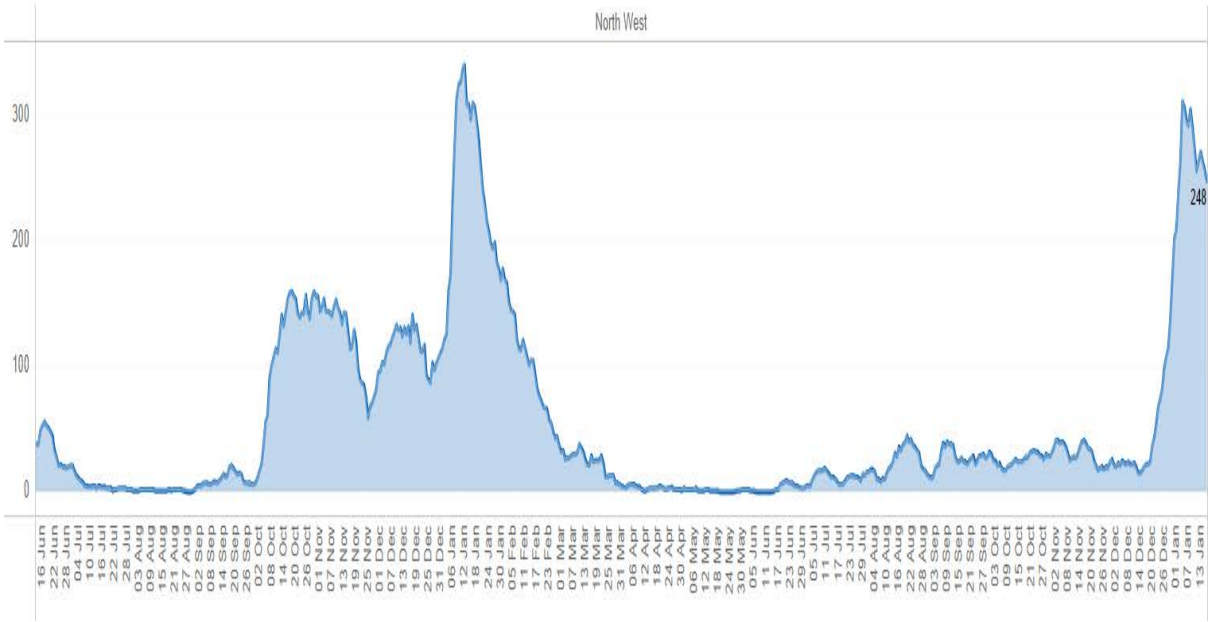
Narrative: The Trust is performing in line with peer Trust and in line with Cheshire & Mersey nosocomial rates of 13.70%.

North-West

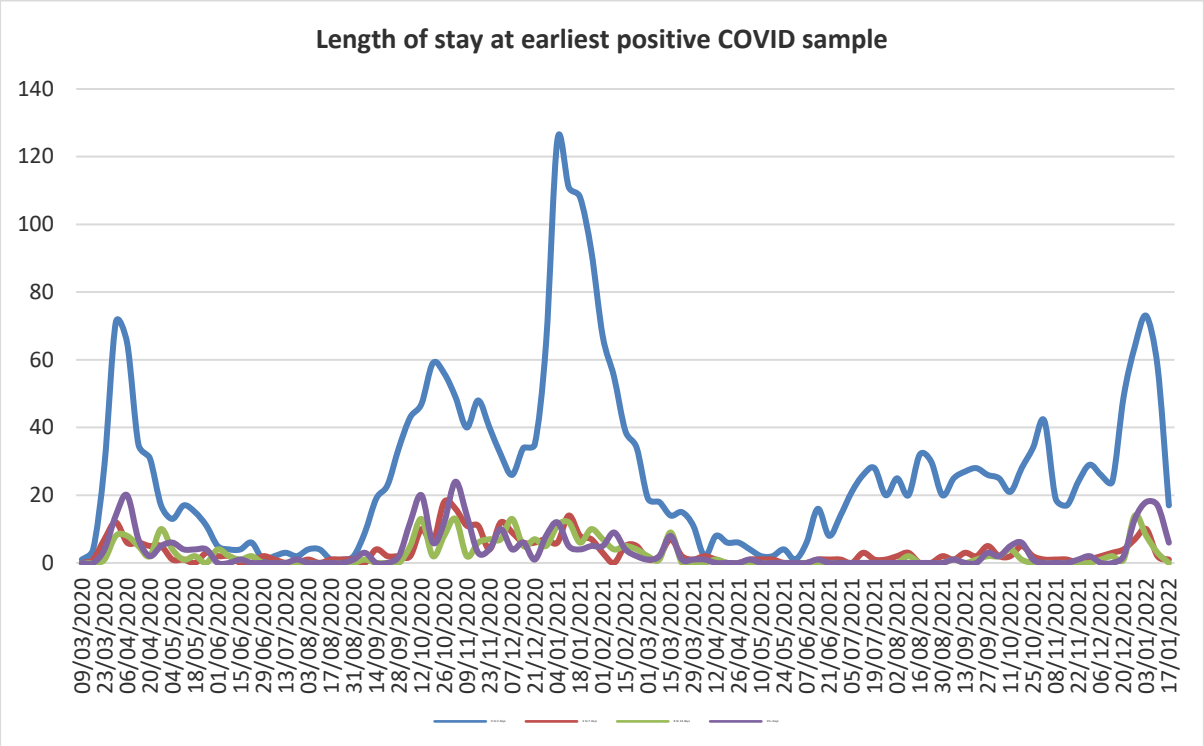
NW



Cheshire & Merseyside



Trust


Length of stay at earliest positive COVID sample
140
120
100
80
60
40
20
0
09/03/2020
23/03/2020
06/04/2020
20/04/2020
04/05/2020
18/05/2020
01/06/2020
15/06/2020
29/06/2020
13/07/2020
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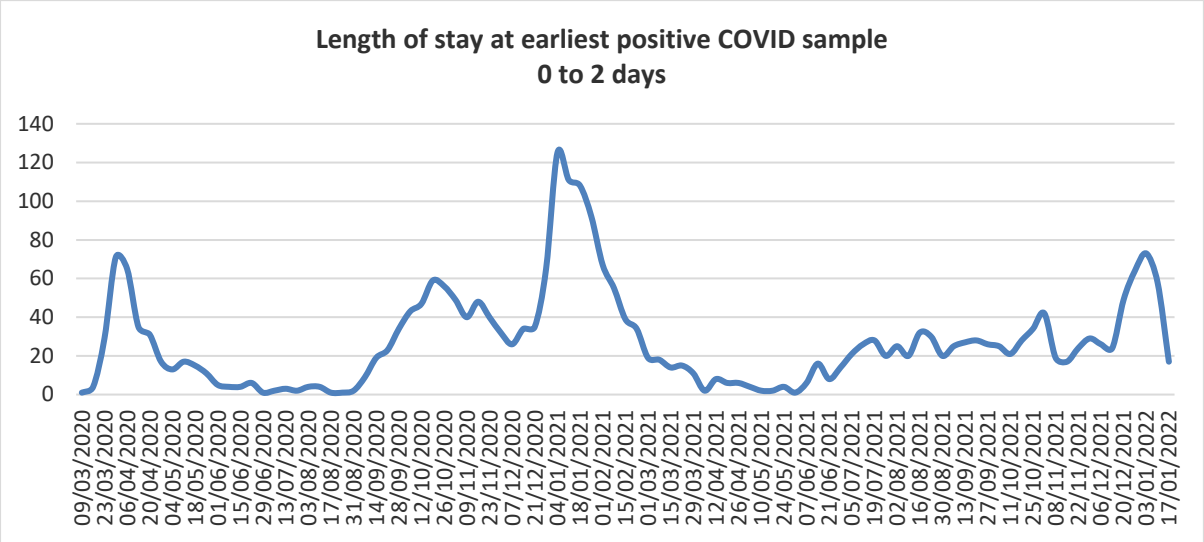
17/01/2022


Length of stay at earliest positive COVID sample
0 to 2 days
140
120
100
80
60
40
20
0
09/03/2020
23/03/2020
06/04/2020
20/04/2020
04/05/2020
18/05/2020
01/06/2020
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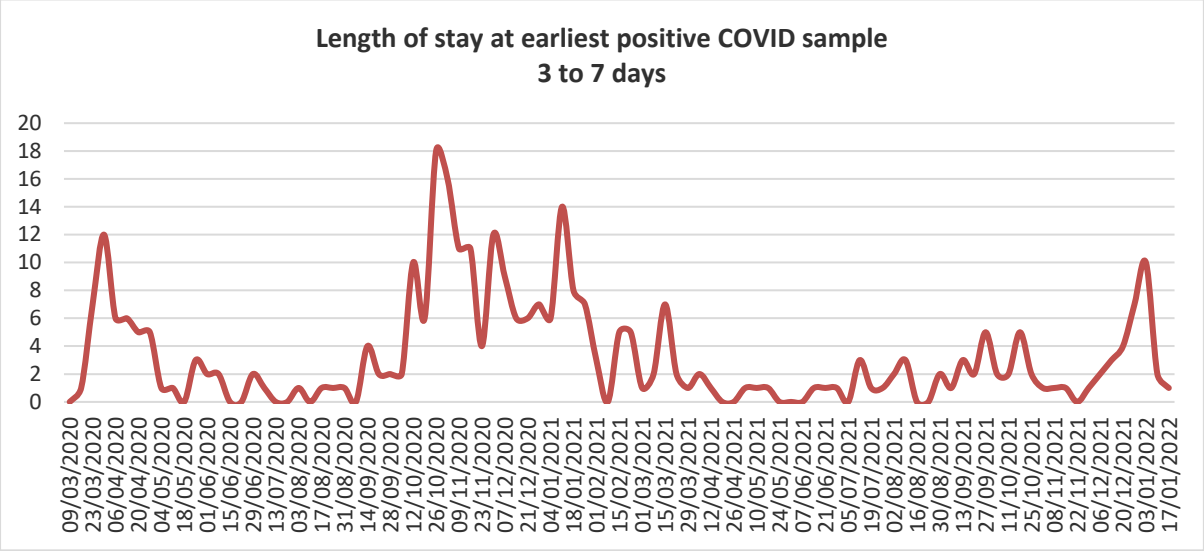
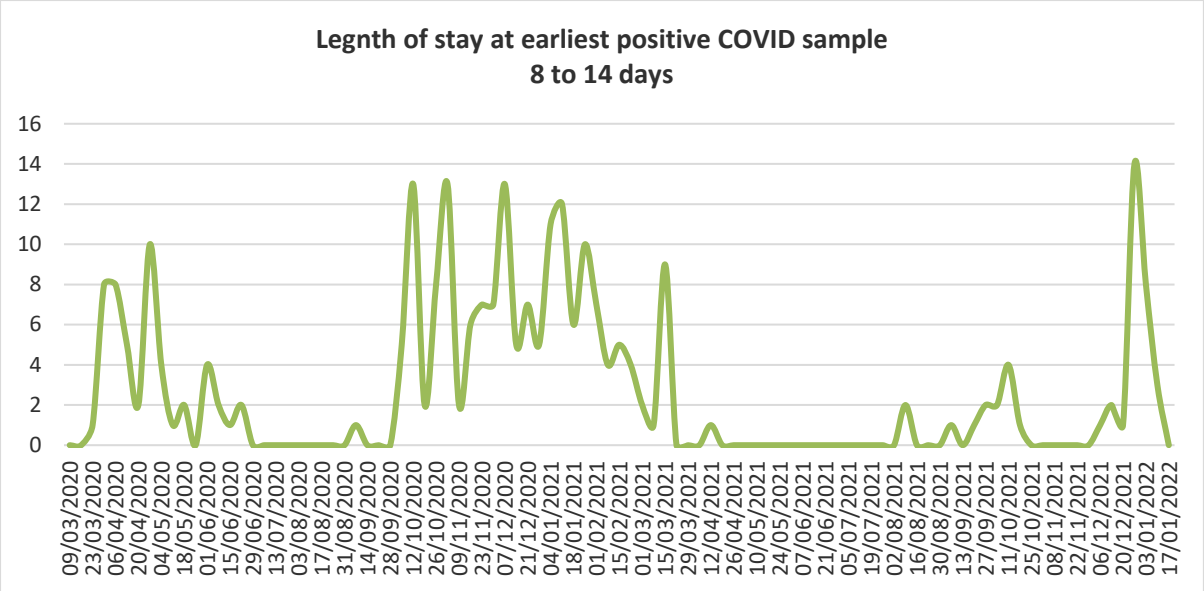
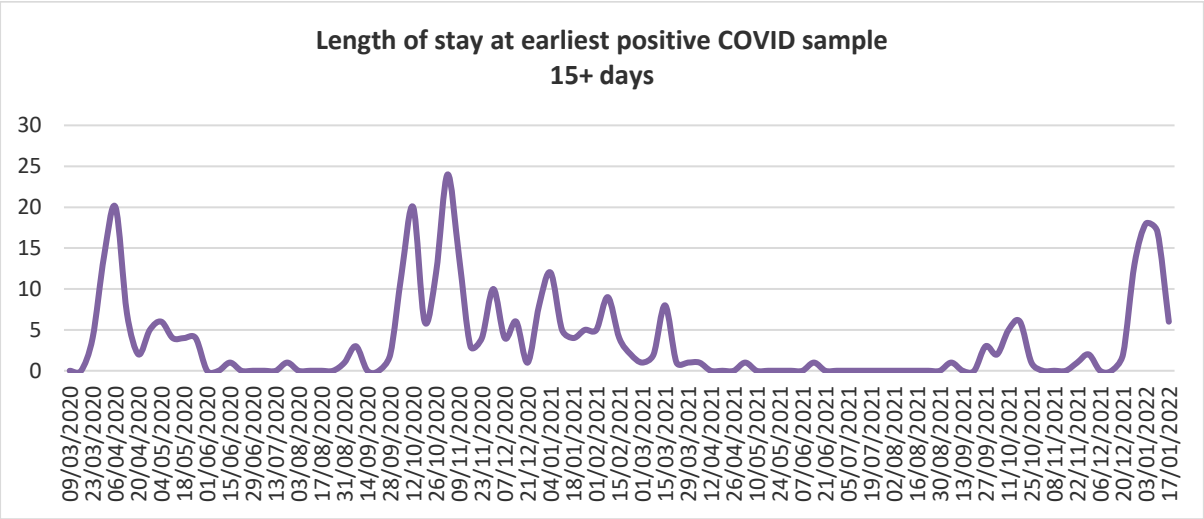




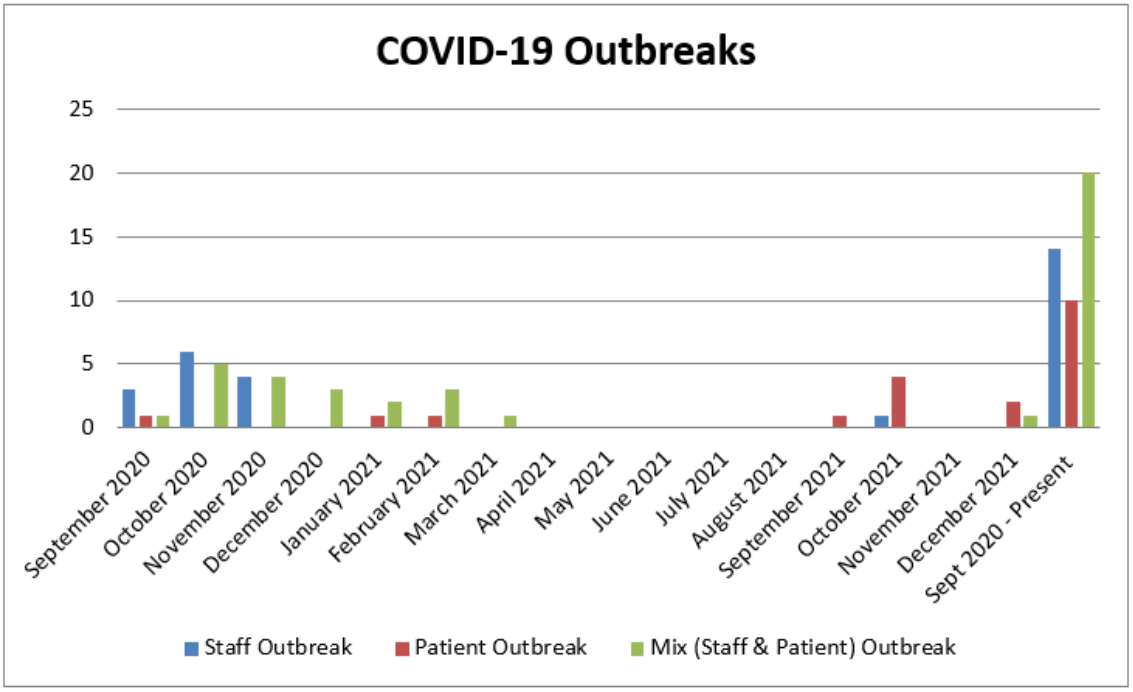


Narrative: The graphs show that the majority of the positive tests come within 2 days of admission or between 3-7 days of admission which suggest these infections were probably picked up in the community and brought into hospital.

Source: Trust Data

2.9 Outbreaks

An outbreak of COVID-19 is defined as two or more people experiencing a similar illness that are linked in time and or place. Where there are endemic rates of a specific infection it can also be considered to be where there is a greater than expected incidence of infection compared to the background rate for the infection. For the purposes of hospital onset COVID-19 infection, the definition of an outbreak is for two or more cases to occur within the same ward environment within 14 days.



Narrative: In December 2021, there was 0 staff outbreaks and 2 patient outbreaks and 1 mixed staff and patient outbreak at the Trust. As at 20/01/2022, the Trust is managing 10 outbreaks.
Source: Trust Data

3. CONCLUSION

The Trust continues to respond to developments as the situation changes.

4. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/07**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	26th January 2022	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Andrea McGee - Chief Finance Officer and Deputy Chief Executive Dan Moore - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1215 Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic. #1272 Failure to provide enough beds caused by the requirement to adhere to social distancing guidelines. #1273 Failure to provide timely patient discharge caused by system-wide COVID-19 pressures. #1275 Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission. #1289 Failure to deliver planned elective procedures caused by the Trust's decision to pause some elective procedures in order to ensure safe staffing and critical care capacity during the COVID-19 pandemic. #115 Failure to provide adequate staffing levels in some specialities and wards caused by the inability to fill vacancies and staff sickness. #134 Financial Sustainability a) Failure to sustain financial viability caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has 78 IPR indicators which have been RAG rated in December as follows: Red: 34 (from 30 in November) Amber: 11 (from 9 in November) Green: 28 (from 33 in November) Not RAG Rated: 5 (from 4 in November) December includes 2 additional indicators approved by the Trust Board in November 2021.	

	As a result of the COVID-19 pandemic, the Trust has not met the RTT 18 week, RTT 52 week, Diagnostics 6-week, Cancer 2 Week, Breast Symptomatic 2 week or Cancer 62-day urgent standards. A&E and Ambulance Handover performance remains challenging with increased attendances. There were 24 patients waiting over 12 hours in A&E in December. Sepsis screening and anti-biotics administration within the one hour timeframe remains a key focus. A focussed improvement plan is in place with oversight from the Deputy Chief Nurse for Patient Safety and Clinical Education. The month 9 position is £1.4m deficit which is in line with plan. The Trust has submitted a breakeven plan for H2 and for the full year. There are several risks in the forecast position and the Trust ability to breakeven, including Elective Recovery Fund, Cost Improvement Programme and the H2 planning gap of £2.9m. Capital programme slippage has increased and plans are required to mitigate the risk of on underspend. The Trust continues to actively engage with the ICS to support the 2021/22 position.

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

RECOMMENDATION:	The Trust Board is asked to: 1. Note the changes to the Capital programme approved by Finance and Sustainability Committee as per the agreed delegated authority in December Board. 2. Note the contents of this report.

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)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/22/01/06

1. BACKGROUND/CONTEXT

The RAG ratings for all 78 IPR indicators from January 2021 to December 2021 are set out in **Appendix 1.** The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the Trust Board with assurance in relation to the delivery of all Key Performance Indicators (KPIs) across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

In month, there has been a movement in the RAG ratings as outlined in **Table 1**:

Table 1: RAG Rating Movement

	November	December
Red	30	34
Amber	9	11
Green	33	28
Not RAG Rated	4	5
Total:	76	78

Due to the validation and review timescales for Cancer, the RAG ratings on the dashboard for these indicators are based on November's validated position.

Descriptions of each KPI are available in **Appendix 3**. Statistical Process Control (SPC) charts are included on the IPR dashboard; **Appendix 4** contains further information on these charts.

Quality

Quality KPIs

There are 5 Quality indicators rated Red in December, the same number as in November.

The 5 indicators rated Red in November, which have remained rated Red in December are as follows:

- Sepsis % Screening for Emergency Patients within 1 hour – the Trust achieved 71.00% in December, a deterioration from 79.00% in November, against a target of 90.00%.
- Sepsis % Screening for Inpatients – the Trust achieved 64.00% in December, an improvement from 59.00% in November, against a target of 90.00%.

- Sepsis % Emergency Patients Administered Antibiotics Within 1 Hour – the Trust achieved 65.00% in December, a deterioration from 79.00% in November, against a target of 90.00%.
- Sepsis % Inpatients Administered Antibiotics Within 1 Hour – the Trust achieved 68.00% in December, a deterioration from 82.00% in November, against a target of 90.00%.
- Friends and Family Test (ED) – the Trust achieved 75.00% in December, an improvement from 73.00% in November, against a target of 87.00%.

There is 1 indicator which has moved from Green to Amber in month as follows:

- NICE Compliance – the Trust achieved 88.26% in December, a deterioration from 91.37% in November, against a target of 90.00%.

Access and Performance

Access and Performance KPIs

There are 18 Access and Performance indicators rated Red in December, an increase from 17 in November. Performance against Access & Performance indicators has been significantly impacted by the COVID-19 pandemic and recovery plans are in place to address this performance.

The 17 indicators which were rated Red in November and remain rated Red in December are as follows:

- Diagnostic 6 Week Target – the Trust achieved 77.50% in December, a deterioration from 78.41% in November, against a target of 99.00%.
- Referral to Treatment Open Pathways – the Trust achieved 70.25% in December, a deterioration from 72.83% in November, against a target of 92.00%.
- Referral to Treatment 52+ Week Waiting – there were 1,005 patients waiting over 52 weeks in December, an improvement from 1,011 patients in November, against a target of 0. RTT and Diagnostic performance is as a result of the reduction in the elective programme, suspension of services and the associated backlog during the initial phases of the pandemic. The Trust has robust recovery plans in place with clinical prioritisation.
- A&E Waiting Times 4-hour National Target – the Trust achieved 68.92% (excluding Widnes Walk ins) in December, a deterioration from November's position of 70.38%, against a target of 95.00%.
- A&E Waiting Time Trajectory – the Trust did not achieve the trajectory of 85.00% in month.
- A&E 12 Hour Breaches – the Trust recorded 24 12 hour breaches in December, a deterioration from 16 breaches in November, against a target of 0.
- Cancer 14 Days - the Trust achieved 78.29% in November, a deterioration from 92.54% in October, against a target of 93.00%.
- Cancer Breast Symptoms - the Trust achieved 36.76% in November, a deterioration from 86.11% in October, against a target of 93.00%.
- Cancer 62 Days Urgent - the Trust achieved 73.47% in November, an improvement from 52.44% in October, against a target of 85.00%.

- Ambulance Handovers 30 – 60 minutes – there were 91 patients who experienced a delayed handover in December, the same number as in November against a target of 0.
- Ambulance Handovers 60 minutes plus - there were 30 patients who experienced a delayed handover in December, an improvement from 45 patients in November against a target of 0.
- Discharge Summaries % sent within 24 hours – the Trust achieved 81.60% in December, a deterioration from 83.20% in November, against a target of 95.00%.
- Discharge Summaries NOT sent within 7 days (to achieve the 95.00% standard) – there were 394 discharge summaries not sent within 7 days to achieve the 95.00% standard in December, a deterioration from 374 discharge summaries not sent in November.
- Cancelled Operation for non-clinical reasons (not rebooked within 28 days) – there were 5 cancelled operations in December, a deterioration from 3 in November, against a target of 0.
- Super Stranded Patients – there were 132 super stranded patients at the end of December, an improvement from 141 patients at the end of November, against a trajectory of 95 patients.
- COVID-19 Recovery (Inpatient & Daycase) – the Trust achieved 93.44% of inpatient procedures and 88.21% of daycase procedures in December 2021/22 in comparison with activity in the same period in 2019/20, against a target of 95.00%.
- COVID-19 Recovery (Diagnostics) – the average performance across all diagnostic modalities was 85.95% in December 2021/22 in comparison with activity in the same period in 2019/20, against a target of 95.00%.

There is 1 new IPR indicator in month which has been RAG rated Red as follows:

- Fracture Clinic – the Trust achieved 38.51% of patients seen within 72 hours in the fracture clinic in December, an improvement from 17.21% in November, against a target of 95.00%.

PEOPLE

Workforce KPIs

There are 8 Workforce indicators rated Red in December, an increase from 5 in November.

The 5 indicators which were rated Red in November and remain rated Red in December are as follows:

- Sickness Absence – the Trust's sickness absence was 7.38% in December, a deterioration from 7.06% in November, against a target of less than 4.20%.
- Return to Work Compliance – interview compliance was 55.70% in December, a deterioration from 68.52% in November, against a target of 85.00%.
- Turnover – the Trust's turnover was 15.71% in December, a deterioration from 15.39% in November, against a target of less than 13.00%
- Bank/Agency Reliance – the Trust's reliance was 15.59% in December, a deterioration from 13.71% in November, against a target of less than 9.00%.

- Agency Shifts Compliant with the Cap – 21.44% of agency shifts were compliant with the cap in December, a deterioration from 36.32% in November, against a target of 49.00%.

There is 1 indicator which has moved from Green to Amber in month as follows:

- Use of the Apprenticeship Levy – the Trust utlised 69.00% of the levy in December, a deterioration from 100% of the levy in November, against a target of 85.00%.

There are 3 indicators which have moved from Green to Red in month as follows:

- Agency Rate Card Compliance – 31.22% of agency shifts were compliant with the rate card in December, a deterioration from 65.71% in November, against a target of 60.00%.
- Monthly Pay Spend – monthly Trust pay spend was £29k above budget in December.
- PDR Compliance – the Trust achieved 62.70% in December, an improvement from 62.18% in November. However, the trajectory for December was 69.00%.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 3 Finance & Sustainability indicators rated Red in December:

- Capital Programme – the actual spend year to date is £5.3m which is £6.1m below the planned spend of £11.4m.
- Agency Spending – the year to date spend of £9.3m is £2.4m above the plan of £6.9m.
- Cost savings schemes (recurrent) - compared to plan, the recurrent forecast is £1.7m against a plan of £4.9m. Further work to increase identification of CIP schemes is underway across the Trust.

The Income and Activity Statement for Month 9 is attached in **Appendix 5**.

The Trust submitted a finance plan for H2 in November detailing a breakeven position. This included risk of £2.9m linked to the Cheshire and Merseyside system gap of c£50m and ERF of £0.7m which is dependent on system achievement. The Trust continues to work with the ICS to understand the gap work is progressing to review CIP, Elective Recovery Fund (ERF), and balance sheets across the system.

The 2022/23 priorities and operational planning guidance has been released. However, the Finance guidance remains in draft, the Trust is awaiting further updates to support budget setting.

Table 2 details the estimated RTT performance against target for December 2021.

Table 2: estimated RTT performance against activity for December 2021

Activity	Target	Actual
Non admitted RTT	89%	90%
Admitted RTT	89%	91%
Total	**89%**	**90%**

The Trust is estimated to meet the planned activity submitted for December and the ERF minimum threshold of 89.00%, however funding is dependent on system performance. For H2, the Cheshire and Mersey Hospital Cell is responsible for collating weekly information from Trusts and CCGs to enable estimations of any potential ERF funding available.

Cash

At month 9 there is a cash balance of £42.9m this relates to:

- Additional income received in the sum of £10.3m year to date for COVID top up.
- SLA income received in advance of £2.7m.
- Additional income received in the sum of £2.1m year to date for the recovery of VAT.
- A shortfall in the payment of capital creditors of £8.8m due to the delay to the start of schemes.

The Trust needs to ringfence funds to support the OBC for a new Electronic Patient Care Management System (EPCMS) of c£13m.

Capital Programme

The Capital Programme of £19.6m for 2021/22 was approved at the start of the year. There was an increase of £0.1m in month 7 for Department of Health and Social Care (DHSC) COVID-19 donated assets. This is funded by donated income and is excluded from the Trusts capital limit. There was an increase of £0.7m in month 9 for Public Dividend Capital (PDC) schemes, increasing the total to £20.36m (as per NHSE/I return). The Trust has signalled that the ED Plaza scheme will not be completed within this financial year. Therefore, it is planned that the programme will underspend by £2.8m this year. This underspend will be utlised within the Cheshire & Mersey system and will be included within the Trust's 2022/23 capital programme.

Table 3: Capital Expenditure as at 31 December 2021

Capital	Annual Plan	Original Plan to Date	Revised Plan to Date	Expenditure to Date	Variance: Against Rev. Plan
	£000	£000	£000	£000	£000
Trust Funded	18,770	11,476	10,535	5,158	5,378
PDC Funded:					
Cardiac Catheterisation Suite	650	410	650	0	650
Ultrasound	105	105	105	0	105
MRI Patient Monitor	45	45	45	45	0
Total Approved Capital Programme (as per NHSE/I Return)	**19,570**	**12,036**	**11,335**	**5,203**	**6,132**
Patient Flow (Tif)	260	0	0	0	0
Network Switches	249	0	0	0	0
Clinical Treatment Room (Halton) Upgrade	143	0	0	0	0
NW Imaging Academy Radiology	37	0	0	0	0
PDC Funded: Sub Total	**689**	**0**	**0**	**0**	**0**
Equipment Donated by DHSC	100	132	100	100	0
Total Forecast Capital Investment	**20,359**	**12,168**	**11,435**	**5,303**	**6,133**

Table 4 provides a high-level summary by category.

Table 4: Capital Expenditure by category as at 31 December 2021

Capital	Annual Plan	Original Plan to Date	Revised Plan to Date	Expenditure to Date	Variance: Against Rev. Plan
	£000	£000	£000	£000	£000
Estates	15,610	9,250	8,914	4,469	4,446
IM&T	2,689	1,415	1,121	816	305
Medical Equipment	2,335	1,102	1,400	274	1,126
Contingency	-275	401	0	0	0
VAT refunds prior year	0	0	0	-256	256
Total Planned Capital Investment	**20,359**	**12,168**	**11,435**	**5,303**	**6,133**

Underspends in Estates schemes include slippages on the Shopping City, Paediatrics and Urology schemes. The ED Plaza underspend is currently estimated to be £2.8m and has been added to the 2022/23 capital programme. The Breast unit is complete, however the Trust is awaiting final sign off and the scheme has an underspend of £0.3m. All other Estates schemes are on track. IT schemes are behind the revised plan due to schemes starting later than planned due to recruitment. Medical equipment schemes are behind plan due to the

timescales of procuring equipment for the Cardiac Catherisation suite taking longer than expected, however it is anticipated this will be completed by 31 March 2022.

Table 5 shows the balance of contingency as at month 9 (£0.16m) and the capital changes in month 10 which bring the total to £0.46m.

Table 5: Balance of contingency fund as at 19th January 2022 and changes.

Detail	£000s	£000s
Contingency Balance start of month 9		**159**
Additional Funds Approved at December Board		
Fluoroscopy Inc Turnkey	-54	
REVISED Contingency Position as at month 9		**105**
Changes approved by Finance & Sustainability Committee on 19th January 2022		
Return to Contingency:		
Replace Obsolete Nurse Call Alarms Ph1 (unable to complete)	50	
CT Room Halton Upgrade (external funding secured)	90	
Essential power installation - Halton Pharmacy (no longer required)	9	
Backlog - Croft Wing Electrical (unable to complete)	26	
Backlog - Catering Department remove or replace roof lantern (unable to complete)	30	
Warrington and Halton Gas Meter Replacement (underspend)	100	
Induction Bay (Now part of 2022/23 scheme)	20	
Finance & Comm Development Refurb (VAT)	7	
Thelwall House Lift (VAT)	31	
OPTUS (Ophthalmology machine) integration costs	-8	
Contingency as at 19th January 2022		**460**

Weekly meetings led by the Chief Operating Officer are scheduled to review progress of all major schemes.

Appendix 6 contains the updated capital programme.

The Trust Board is asked to:

- **Note the changes to the Capital programme approved by Finance and Sustainability Committee as per the agreed delegated authority in December Board.**

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The KPI's that are underperforming are managed in line with the Trust's Performance Assurance Framework.

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

- Finance and Sustainability Committee
- Audit Committee
- Quality & Assurance Committee
- Strategic People Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the changes to the Capital programme approved by Finance and Sustainability Committee as per the agreed delegated authority in December Board.
2. Note the contents of this report.

Key

Improvement in Performance	↕
Deterioration in Performance	↕
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating January 2021 – December 2021

KPI	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
QUALITY												
Incidents (over 40 days old)	↔	↑	↑	↔	↔	↔	↔	↓	↑	↔	↔	↔
Duty of Candour	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Healthcare Acquired Infections - MSRA	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Healthcare Acquired Infections – Cdiff	↓	↑	↓	↔	↓	↑	↓	↑	↓	↑	↓	↓
Healthcare Acquired Infections – Gram Neg	↑	↕	↓	↓	↑	↓	↑	↓	↑	↕	↓	↓
Healthcare Acquired Infections – COVID-19 Hospital Onset & Outbreaks												
VTE Assessment	↓	↓	↑	↑	↑	↑	↑	↑	↑	↑	↓	↓
Total Inpatient Falls & Harm Levels	↓	↑	↓	↑	↓	↑	↓	↑	↑	↑	↓	↓
Pressure Ulcers	↓	↑	↓	↑	↔	↓	↓	↑	↓	↑	↑	↓
Medication Safety (24 Hours)	↑	↓	↑	↓	↑	↑	↓	↓	↓	↓	↑	↓
Staffing – Average Fill Rate	↑	↑	↓	↑	↑	↑	↓	↓	↑	↓	↓	↓
Staffing – Care Hours Per Patient Day	↑	↑	↑	↓	↑	↓	↓	↑	↑	↓	↓	↑
Mortality ratio - HSMR												
Mortality ratio - SHMI												
NICE Compliance	↑	↑	↓	↑	↑	↑	↑	↓	↑	↓	↓	↓
Complaints	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Friends & Family – Inpatients & Day cases	↔	↓	↔	↑	↔	↓	↔	↔	↔	↓	↑	↓
Friends & Family – ED and UCC	↑	↓	↓	↓	↓	↔	↓	↓	↑	↓	↑	↑
Mixed Sex Accommodation Breaches (Non ITU Breaches Only)					↔	↔	↔	↔	↔	↔	↔	↔
Continuity of Carer	↓	↑	↑	↓	↑	↓	↑	↓	↓	↑	↓	↑
Sepsis - % screening for all emergency within 1 hour.					↑	↓	↑	↑	↓	↑	↑	↓
Sepsis - % screening for all inpatients within 1 hour.					↑	↓	↓	↓	↑	↕	↓	↕
Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis.					↓	↓	↑	↑	↑	↕	↑	↓
Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis.					↓	↓	↑	↓	↑	↓	↑	↓
Ward Moves between 10:00pm and 06:00am												

Key

Improvement in Performance	
Deterioration in Performance	
Static Performance	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating January 2021 – December 2021

KPI	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
ACCESS & PERFORMANCE												
Diagnostic Waiting Times 6 Weeks												
RTT - Open Pathways												
RTT – Number of Patients Waiting 52+ Weeks												
A&E Waiting Times – National Target												
A&E Waiting Times – STP Trajectory												
A&E Waiting Times – Over 12 Hours												
Cancer 14 Days*												
Breast Symptoms 14 Days*												
Cancer 28 Day Faster Diagnostic*												
Cancer 31 Days First Treatment*												
Cancer 31 Days Subsequent Surgery*												
Cancer 31 Days Subsequent Drug*												
Cancer 62 Days Urgent*												
Cancer 62 Days Screening*												
Ambulance Handovers 30 to <60 minutes												
Ambulance Handovers at 60 minutes or more												
Discharge Summaries - % sent within 24hrs												
Discharge Summaries – Number NOT sent within 7 days												
Cancelled Operations on the day for a non-clinical reasons												
Cancelled Operations– Not offered a date for readmission within 28 days												
Urgent Operations – Cancelled for a 2nd time												
Super Stranded Patients												
COVID-19 Recovery Elective Activity												
COVID-19 Recovery Diagnostic Activity												
COVID-19 Recovery Outpatient Activity												
% Outpatient Appointments delivered remotely												
% of Patients seen in the fracture clinic within 72 hours												

Key

Improvement in Performance	
Deterioration in Performance	
Static Performance	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating January 2021 – December 2021

KPI	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
WORKFORCE												
Sickness Absence												
Return to Work												
Recruitment												
Vacancy Rates												
Retention												
Turnover												
Bank & Agency Reliance												
Agency Shifts Compliant with the Cap												
Agency Rate Card Compliance												
Monthly Pay Spend (Contracted & Non-Contracted)												
Core/Mandatory Training												
Role Specific Training												
Safeguarding Training												
% Use of Apprenticeship Levy												
% Workforce carrying out an Apprenticeship Qualification												
PDR												

Key

Improvement in Performance	↕
Deterioration in Performance	↕
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating January 2021 – December 2021

KPI	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
FINANCE												
Trust Financial Position	↓	↑	↑	↑	↓	↑	↑	↑	↔	↓	↑	↓
System Financial Position	-	-	-	-	-	-	-	-	-	-	-	-
Cash Balance	↓	↑	↑	↑	↓	↑	↑	↑	↑	↑	↑	↓
Capital Programme	↑	↓	↑	↑	↓	↓	↓	↓	↓	↓	↓	↓
Better Payment Practice Code	↔	↑	↔	↑	↔	↓	↔	↔	↔	↔	↔	↔
Use of Resources Rating	-	-	-	-	-	-	-	-	-	-	-	-
Agency Spending (Monthly)	↓	↓	↓	↑	↑	↑	↓	↓	↓	↑	↓	↓
Cost Improvement Programme – Performance to date				-	-	-						
Cost Improvement Programme – Plans in Progress (In Year)	-	-	-	-	-	-						
Cost Improvement Programme – Plans in Progress (Recurrent)	-	-	-	-	-	-						

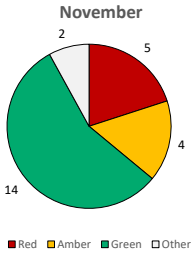
*RAG rating is based on previous month's validated position for these indicators.

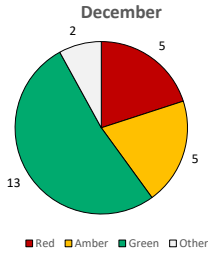
Integrated Dashboard - December 2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

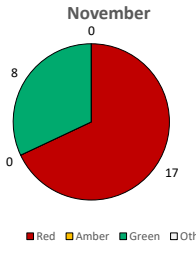
Appendix 2

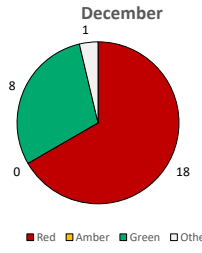
Quality Improvement



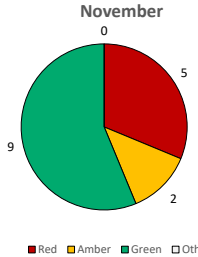


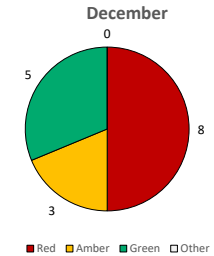
Access & Performance



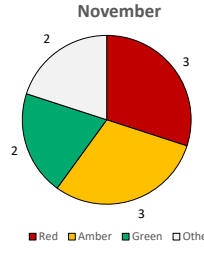


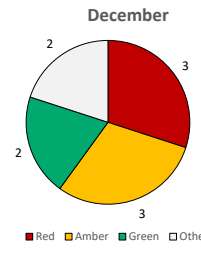
Workforce





Finance





Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

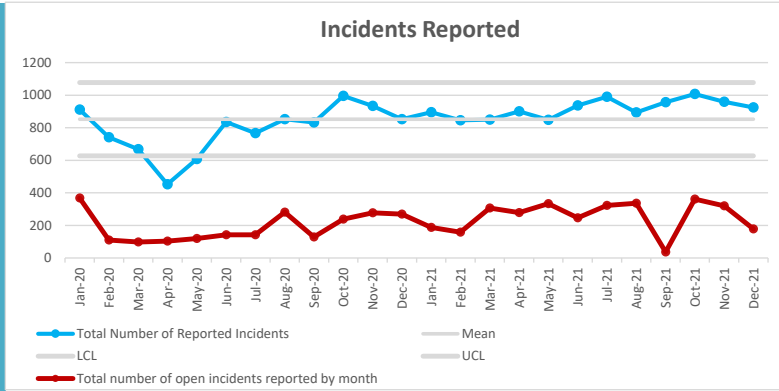
Patient Safety

SOF CQC

Incidents

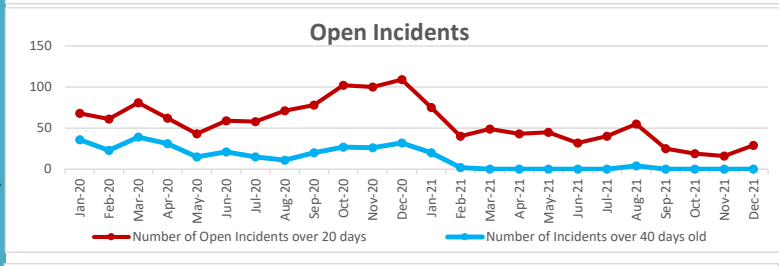
Red: Open incidents outside 40 day timeframe
Amber: Open incidents between 20 - 40 days old.
Green: Open incident within timeframe of 20 days.

There were 0 incidents over 40 days old.



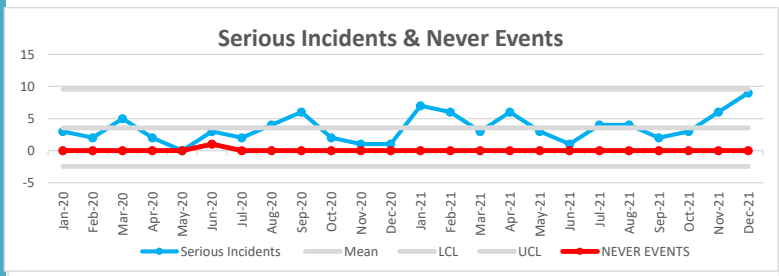
Incident reporting remains stable - within expected range.

The Report to Improve Campaign continues with close weekly monitoring of incident reporting Trust wide, CBU and speciality specific. This is overseen by the Associate Director of Governance and Patient Safety Manager. A governance dashboard is provided to the Executive Team weekly.



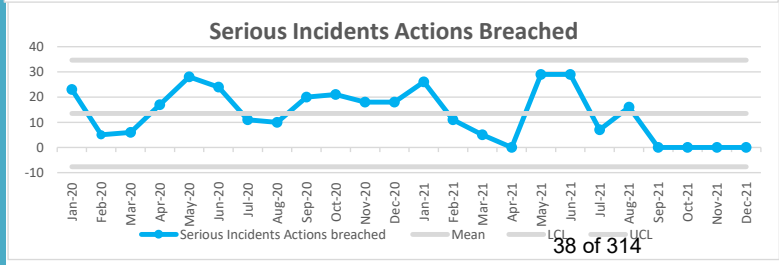
There are 0 overdue 40-day incidents.

Plans are in place to work towards a position of 0 incidents over 20 days old and to maintain the current position of 0 incidents over 40 days. The Patient Safety Manager meets with the CBU's weekly with timely escalation to the Associate Director of Governance as required.



There were 9 serious incidents reported in December 2021. 2 of these incidents were community acquired pressure ulcers and 1 incident was a patient fall (automatically SI reportable). No specific themes identified.

To ensure lessons are learnt across the organisation, findings are shared via the Trust Safety Brief, speciality and CBU Governance meetings. Learning is also shared in the format of newsletters. This is triangulated with learning following inquests. Themes are monitored weekly by the Governance Team with escalation to the Director of Governance. Specific governance sessions have commenced to support medical trainees. This will be provided for nursing teams also.



There were 0 breached serious incident actions in December 2021.

A breached actions position is now provided to the Director of Governance with weekly appropriate escalation to the CBU leads.

Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

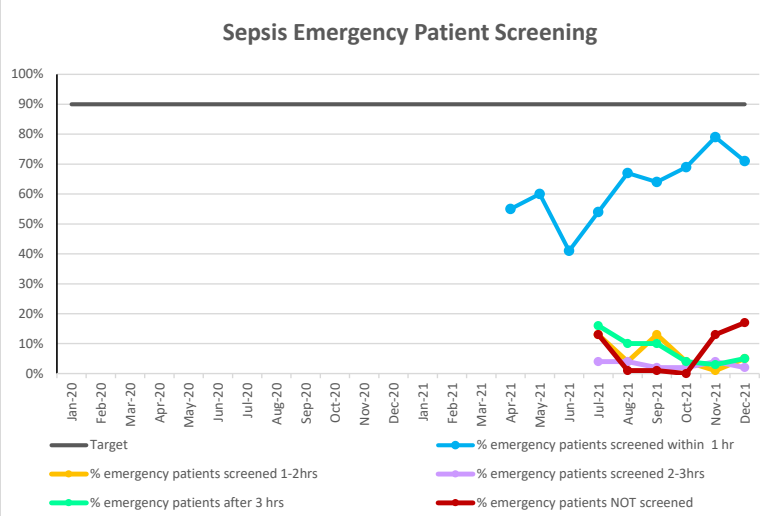
Quality Improvement - Trust Position

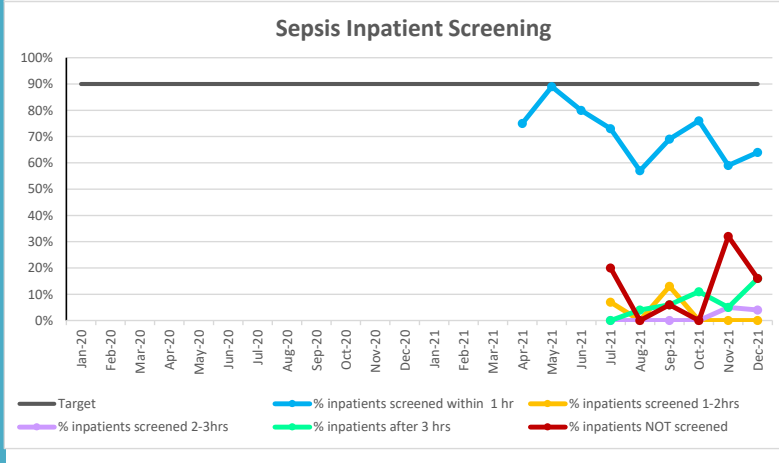
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Sepsis - % screening for all emergency patients.
Red: Below 90%
Green: 90% or Above

Sepsis - % screening for all inpatients
Red: Below 90%
Green: 90% or Above

The Trust achieved:
- **71.00% Sepsis screening for all emergency patients with suspected sepsis within 1 hour.**
- **64.00% screening for all inpatients with suspected sepsis within 1 hour.**



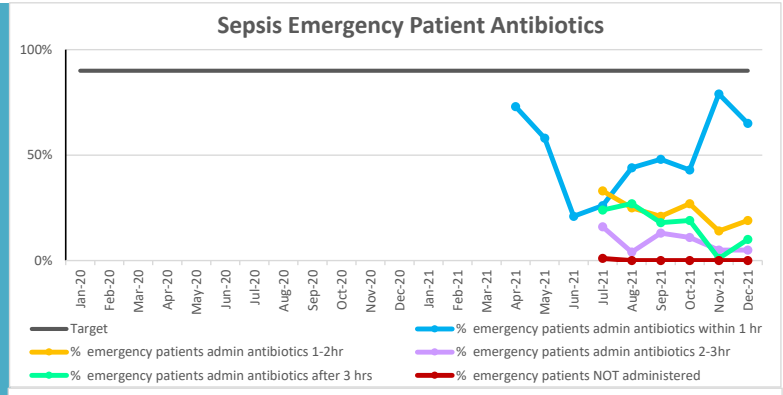
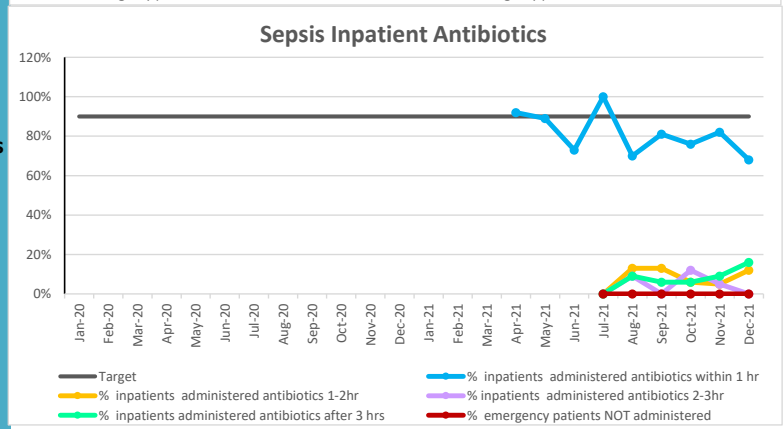
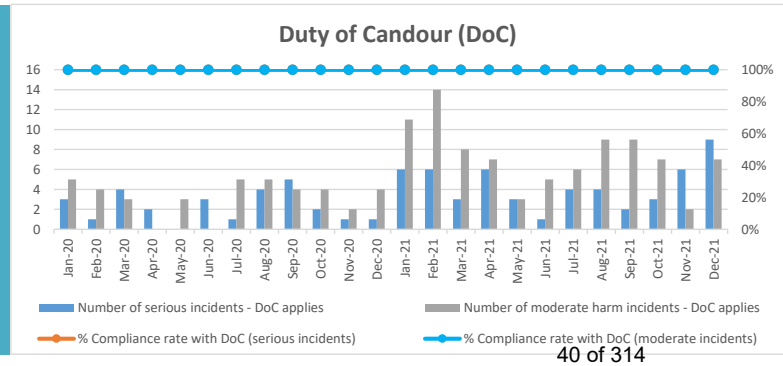


The sepsis bleep continues to be utilised to ensure prompt clinician reviews for patients who are suspected to have sepsis. The ED senior nursing team have developed a sepsis pathway step-by-step guide which has been disseminated to NHS Professionals and relevant agencies to make clear the expectations regarding completion of the sepsis pathway in ED.

The Task and Finish Group meetings continue to monitor progress against the Trust wide Sepsis Action Plan. Work between the sepsis leads, Patient Safety and the Data Warehouse team continues to identify inpatients who are treated for sepsis to ensure the inpatient audit is representative. The E-outcome data system is checked 3 times a week for early warning scores >5, and these patients are investigated to ensure sepsis completeness. Sepsis awareness training remains a priority and an updated training video is being disseminated Trust-wide along with extra training sessions held over MS Teams. The sepsis improvement plan is due to commence this month with the Patient Safety Nurses, sepsis leads and the QI Team working collaboratively to improve sepsis management across inpatient wards. This will report into the Task & Finish Group.

Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

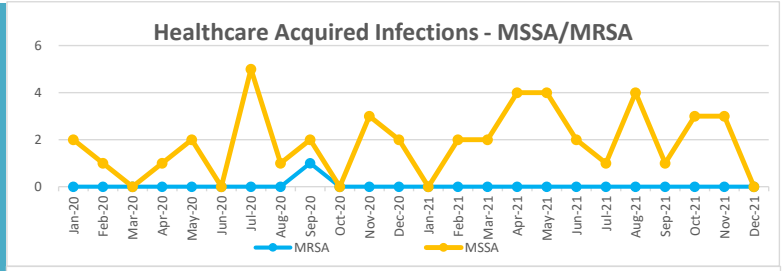
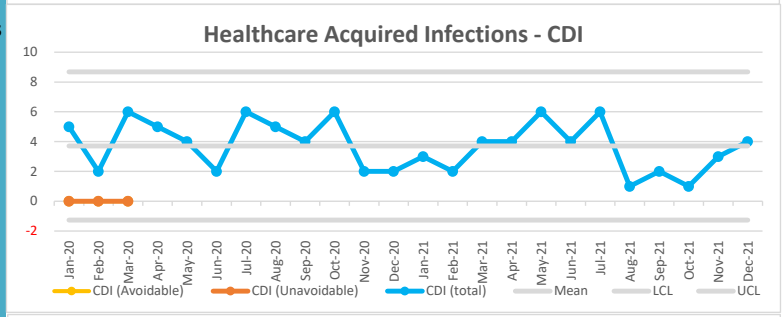
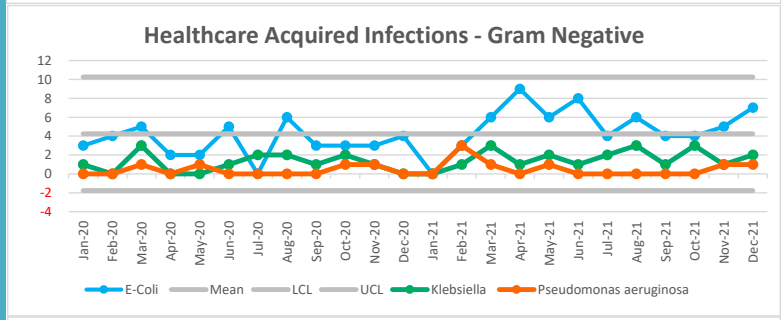
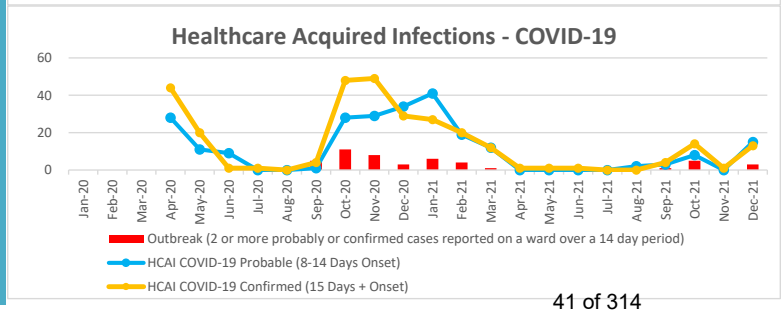
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag sepsis **Red: Below 90%** **Green: 90% or Above**	**The Trust achieved:** **• 65.00% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** **• 68.00% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.**	 	**Pre-made IV Piperacillin/Tazobactam is now available in ED which has reduced the amount of time required to reconstitute these antibiotics. The Patient Safety Nursing Team have attended Medical Handover meetings to reinforce the use of the Sepsis 6 Pathway.**	**The Task and Finish Group meetings continue to monitor progress against the Trust wide Sepsis Action Plan. Work between the sepsis leads, Patient Safety and the Data Warehouse team continues to identify inpatients who are treated for sepsis to ensure the inpatient audit is representative. The E-outcome data system is checked 3 times a week for early warning scores >5, and these patients are investigated to ensure sepsis completeness. Sepsis awareness training remains a priority and an updated training video is being disseminated Trust-wide along with extra training sessions held over MS Teams. The sepsis improvement plan is due to commence this month with the Patient Safety Nurses, sepsis leads and the QI Team working collaboratively to improve sepsis management across inpatient wards. This will report into the Task & Finish Group.**
Duty of Candour **Red: <100%** **Green: 100%**	CQC **The Trust achieved 100% for Duty of Candour in month.**		**There is no variance, the Trust remains 100% compliant.**	**Weekly scrutiny and monitoring is in place by the Patient Safety Manager and a Duty of Candour Policy has been ratified.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

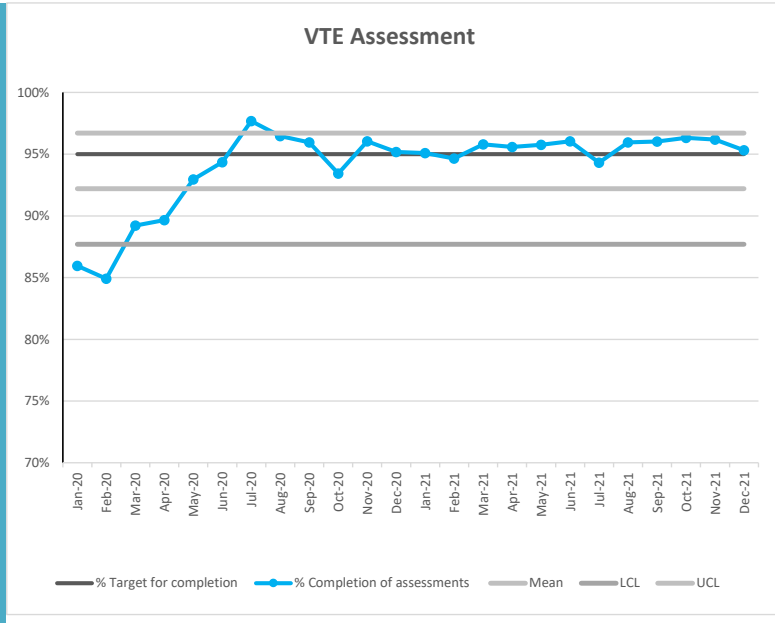
Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Healthcare Acquired Infections MRSA Red: 1 or more Green: 0 Healthcare Acquired Infections C-Difficile Red: 44+ per annum Green: Less than 44 per annum Healthcare Acquired Infections - Gram Negative E-Coli Red: 81+ per annum Green: Less than 81 per annum Pseudomonas aeruginosa Green: 4 or Less Klebsillea Green: 23 or Less Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	CQC SOF S **December cases:** **CDI – 4 cases - 31 Cases YTD: 2 cases under trajectory and 3 other cases considered unavoidable by CCG review panel** **E-Coli – 7 cases - 53 cases YTD: 7 cases under trajectory** **Klebsiella – 2 cases - 16 cases YTD: 1 case under trajectory** **MRSA - nil cases and 15 months since last reported case** **MSSA – 0 cases - 22 cases YTD no threshold set** **Pseudomonas aeruginosa - 1 case - 3 cases YTD and on trajectory** **Covid-19: 13 day 8-14 probable healthcare associated cases and 22 15+ days cases definite healthcare associated** **3 Covid-19 outbreaks reported in December** RR1275	   	**The change in the apportionment standard has increased the number of GNBSI (Gram Negative Bloodstream Infection) cases apportioned to the Trust.** **The continuing global COVID-19 pandemic with high local prevalence per 100,000 / 7 day rate.**	**Action plans are in place for the prevention of all HCAIs. The GNBSI reduction Group is established with 8 wards engaged in phase 1. Focus areas include hydration, continence management, care of urethral catheters, hand hygiene and UTI detection and management. The Catheter Passport has been launched at a series of meetings across the Trust.** **Learning for COVID-19 RCA investigations has been shared at QAC, Medical Cabinet and CBU level with drill down to individual wards. Action plans are in place to address findings including missed screening, length of stay, multiple ward moves, environmental hygiene, IPC training compliance and PPE compliance. Robust processes are in place for COVID-19 admission, day 3 and day 5 testing with Infection Prevention and Control (IPC) guidance on isolation and Personal Protective Equipment (PPE).**

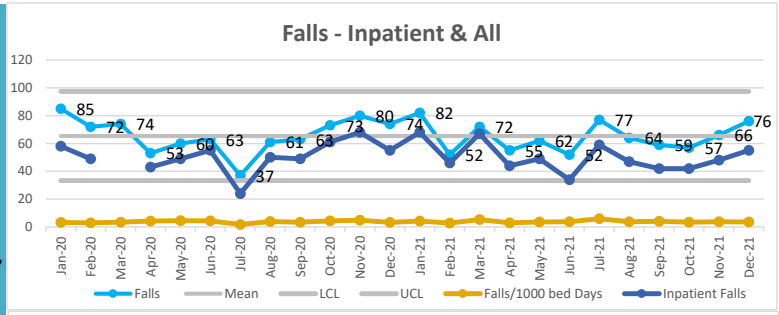
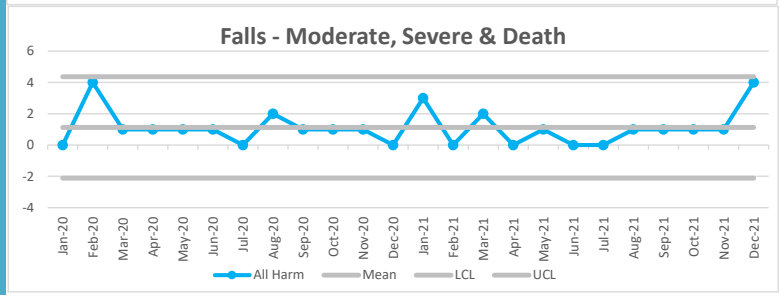
Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
VTE Assessment Red: <95% Green: 95% or above based on previous months' figures due to timescales for validation of data	SOF S The Trust achieved 95.83% for VTE assessments in YTD 2021/22 from April - December 2021.		1. The Trust achieved 95.31% for VTE risk assessments in December 2021 and this data is obtained directly from pivots of VTE risk assessment compliance report. 2. The quality standard has been achieved consistently above the target for VTE compliance data > 95% since April this year apart from July data at 94.64%. 3. However, if the guidance on the national VTE data collection is to be changed to within 14 hours compliance of VTE RA, there is still a gap to reach >95% compliance as YTD for all assessments done within 14 hours is at 88.68%.	Current systems in place to improve VTE compliance: User friendly format and the ease of VTE risk assessment form incorporated into CDC forms on clerking/PTWR/WR proforma is partly the driver for this improvement. Future proactive approach/plan to improve VTE compliance within 14 hours of admission: 1. To continue to raise the awareness of mandatory VTE RA through communications sent out to all doctors/nursing staff through daily safety huddle. 2. To engage with CBU specific data to improve overall VTE risk assessment compliance by provision of quarterly data in future. 3. To continue to promote the consistent use of ward round CDC forms to improve VTE compliance.

Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

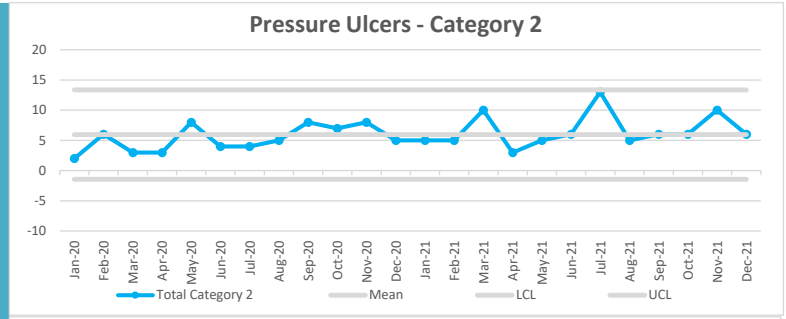
Quality Improvement - Trust Position

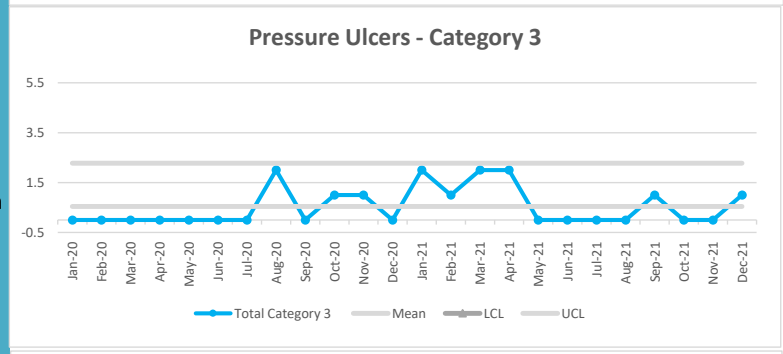
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Total number of Inpatient Falls & harm levels Red: <10% decrease from 19/20 Amber: 10-19% decrease from 19/20 Green 20% or more decrease from 19/20	76 total falls were reported, 55 of those were inpatient falls, 4 fall resulted in moderate harm.	 	The number of low/no harm falls remains within normal variation. Rapid incident reviews took place to highlight lessons learned from the fall with moderate harm.	The Trust falls audit will be reaudited in January which will include a review of bed rail usage. Weekly falls meetings continue to reinforce preventative measures to address immediate issues. Electronic forms are completed for each fall discussed to audit and highlight themes. The Trust Wide Safety Brief highlights falls awareness and learning, in addition a daily spreadsheet is completed to highlight and track harms.

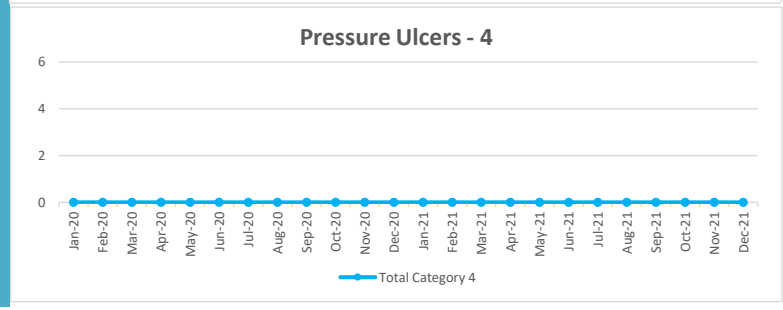
Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Pressure Ulcers Based on 65 in 2019/20 Red: 4% reduction or below Amber: 5%-9% reduction Green: 10% reduction or above.	There were 6 hospital acquired category 2 pressure ulcers and 1 category 3 pressure ulcer in December 2021.	Two of the category 2 pressure ulcers in December were a direct consequence of proning a patient with COVID-19. Prolonged length of time on trolleys in the Emergency Department has also been identified as a factor.	New pressure reducing trolley toppers are now in use in the Emergency Department to reduce skin damage. The Quality Improvement Programme to support the prevention of pressure ulcers has launched the change package to spread and sustain improvements. Mattress champions have been identified and awareness sessions held twice weekly throughout December. Face to face general pressure ulcer prevention and specific device training has recommenced.







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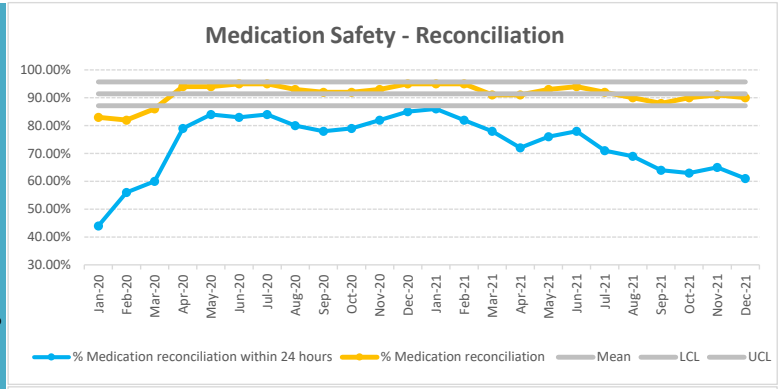
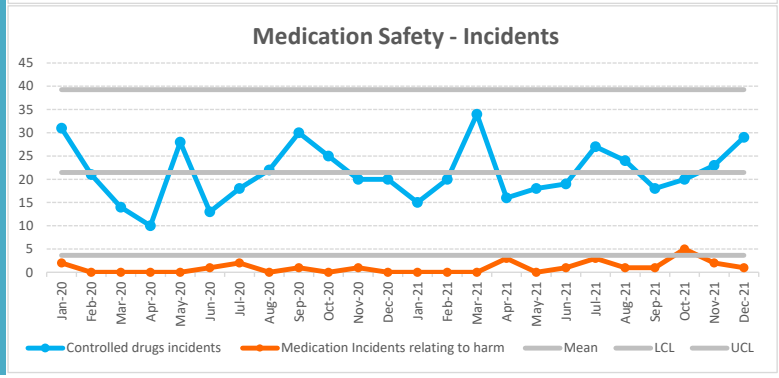
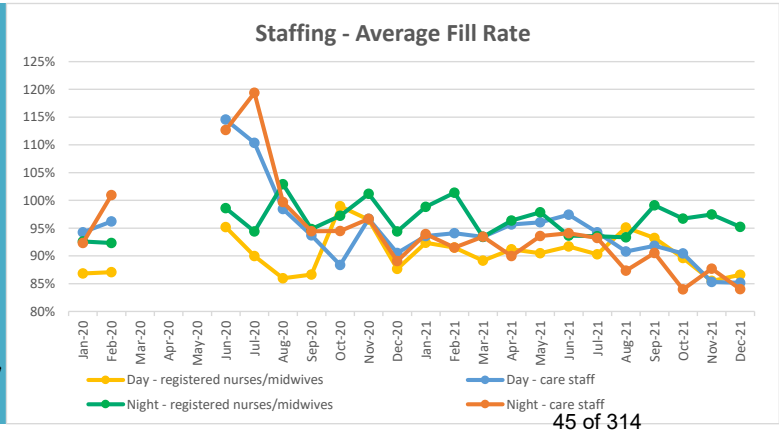
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Medication Safety Reconciliation within 24 hours Red: below 60% Amber: 60% - 79% Green: 80% or above	S The Trust achieved 61.00% for medicines reconciliation within 24 hours and 90.00% for overall medicines reconciliation. There were 29 controlled drug incidents.	 	Medicines reconciliation is below 80.00% within 24 hours (61.00%) and is achieving 90.00% across the inpatient stay. This is due to vacancy level within junior pharmacist and ward-based technician services. Incidents reported relating to controlled medicines have increased. The majority are due to errors made in documentation.	Recruitment is ongoing to fill existing gaps in the technician team. Remaining vacancies have been skill mixed and the recruitment process commenced, to deliver a robust, sustainable clinical service as a result of review of the Pharmacy establishment. Improvements need to be made in use of controlled drug registers at ward level. The Patient Safety Nurses will continue to support this agenda.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	In December 2021, the average staffing fill rates were: Day (Nurses/Midwife) 86.61% Day (Care Staff) 85.16% Night (Nurses/Midwife) 95.24% Night (Care Staff) 84.02% RR1108 RR115		12 of the 23 wards reported staffing levels over 90.00% in December 2021. Additional beds in use across the Trust and increased staff absence due to COVID-19 related reasons remains a driver for variation.	Staffing is reviewed twice daily by the senior nursing team and acuity and activity are monitored to ensure safe patient care at all times. All wards have senior nurse oversight by a matron and lead nurse. The recruitment of 96 international nurses along with full recruitment to health care assistant vacancies ensures consistent fill rates.

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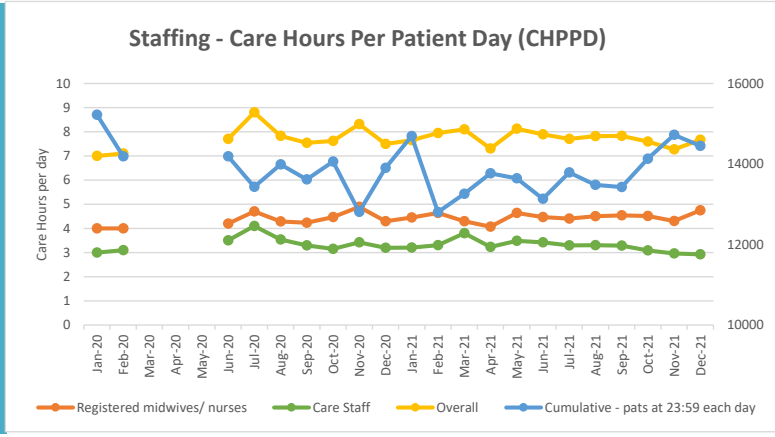
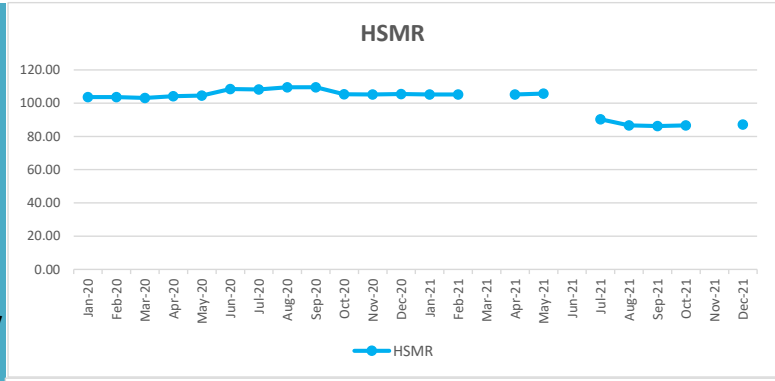
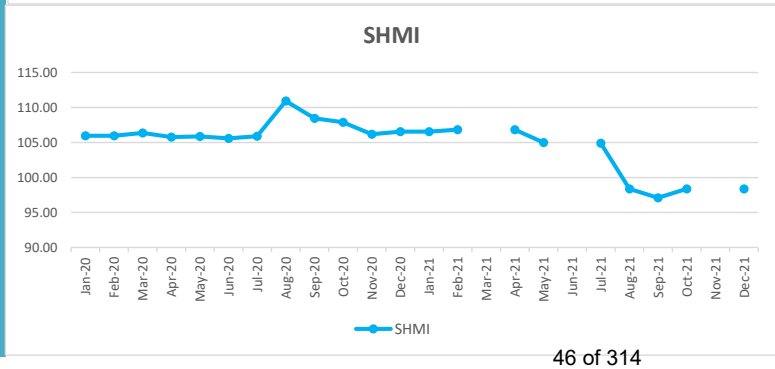
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Staffing - Care Hours Per Patient Day (CHPPD) Red: Below 6.0 Amber: 6.0 - 7.8 Green: 7.9 or More	RR115 RR1108 In December 2021, the average CHPPD were: Nurse/Midwife: 4.7 hours Care Staff: 2.9 hours Overall: 7.7 hours		An increase is noted in CHPPD for December. This is due to increased availability due to limited annual leave over the Christmas period.	Ward staffing levels continue to be systematically reviewed, which includes planned versus actual staffing levels and overall staffing plans are on track. A Trust wide SOP in place to support the return of COVID-19 exposed staff following risk assessment. Recruitment is ongoing for RNs & HCAs to minimise vacancies and reduce reliance on temporary staff.
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	CQC SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 87.11. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 98.36.	 	No variation. HSMR and SHMI remain within expected range.	Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning.

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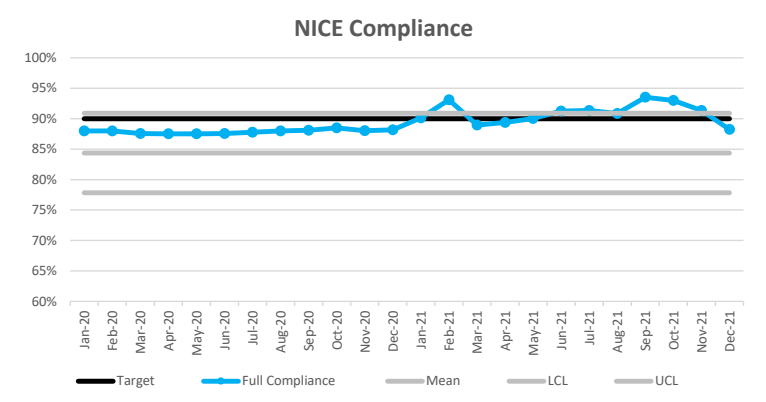
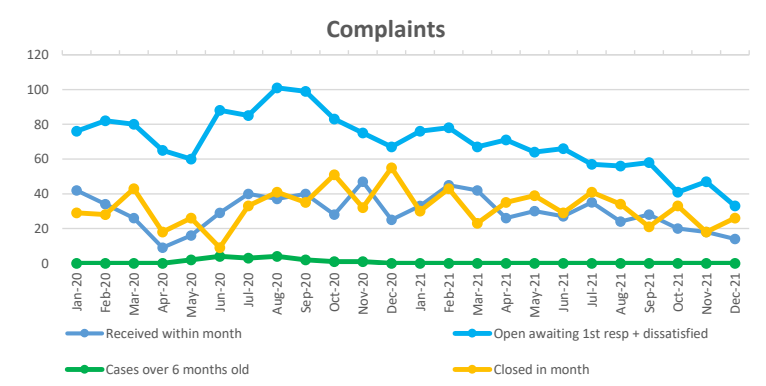
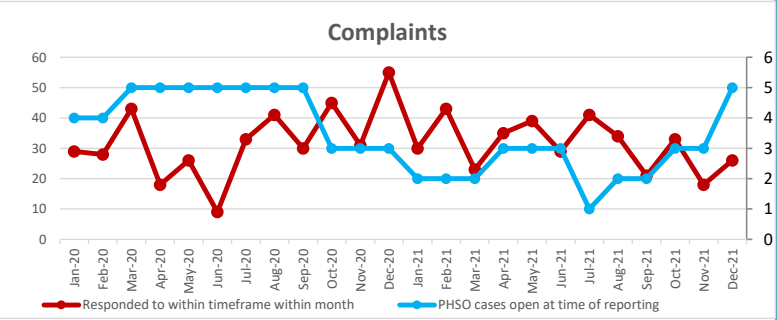
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
NICE Compliance Red: Below 75% Amber: 75% to 89% Green: 90% or Above	The Trust achieved 88.26% in month.		The Trust has decreased in compliance against the trust's target of achieving over 90%. 21 pieces of guidance have been published that require a review, due to a gap in staffing these have not been completed and due to organisational pressures.	Staffing has now been recruited to and the 21 outstanding pieces of guidance will be completed as a priority week commencing 17th January 2022. A large portion of new guidance relates to Technical Appraisal and the Associate Director of Governance has arranged to meet with the leads to get these completed by 14th January 2022.
Patient Experience				
Complaints Red: Complaints over 6 months old/69% or less responded to within the timeframe Amber: No complaints over 6 months old, 70% - 89% responded to within the timeframe Green: No backlog, 90% responded to within the timeframe.	In December 2021, 14 new complaints were received to the Trust which was a decrease of 4 from the previous month. There was 2 dissatisfied responses received, which has decreased by 2 when compared to the previous month.	 	The Trust continues its performance in the timeliness of responding to complaints. There continue to be no complaints over 6 months old, and all complaints are currently within date. The number of complaints open is 33.	Work on a complaints toolkit and training package has begun, to give staff information on addressing a complaint and writing a detailed response. Head of Complaints to link in with CBUs, to understand what support the different areas need.

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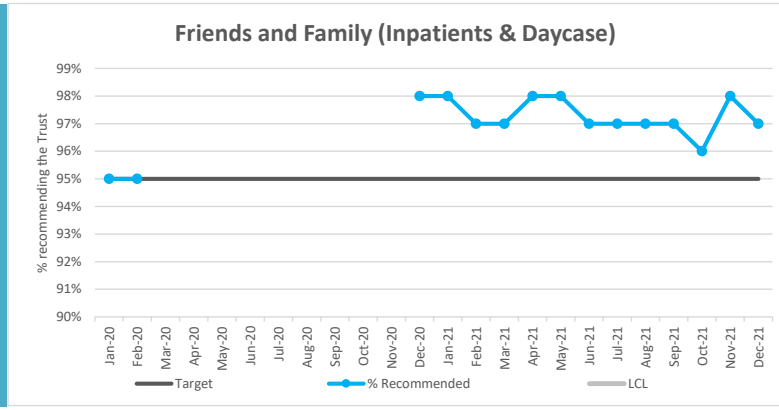
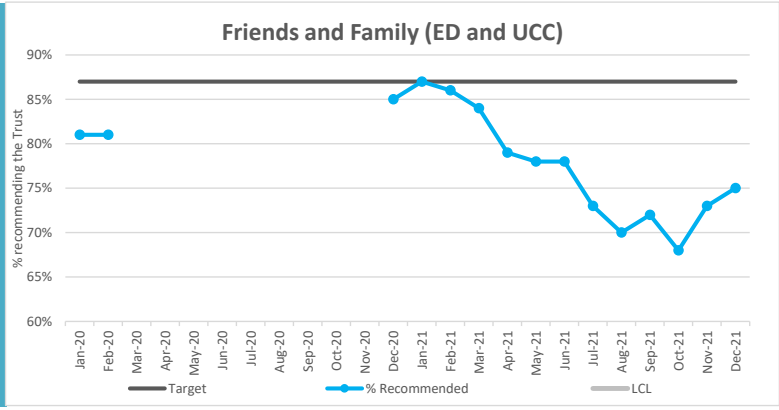
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	CQC S The Trust achieved 97.00% in month.		The Trust achieved 97.00% recommendation rate in December 2021.	The Trust continues to receive high positivity rates through the FFT responses. Any variation is addressed locally and monitored through the Patient Experience Sub Committee.
Friends and Family (ED and UCC) Red: Less than 87% Green: 87% or more	CQC S The Trust achieved 75.00% in month.		The Trust achieved 75.00% positive feedback in friends and family test results in December 2021. This is a 2.00% increase to the previous month of November 2021 where the positive recommendation rate was 73.00%	An Emergency Department response group has been developed to improve flow and patient experience within the Emergency Department and subsequent in-patient stay across the organisation. Emergency Department staff ensure clear communication with patients to explain any delays.

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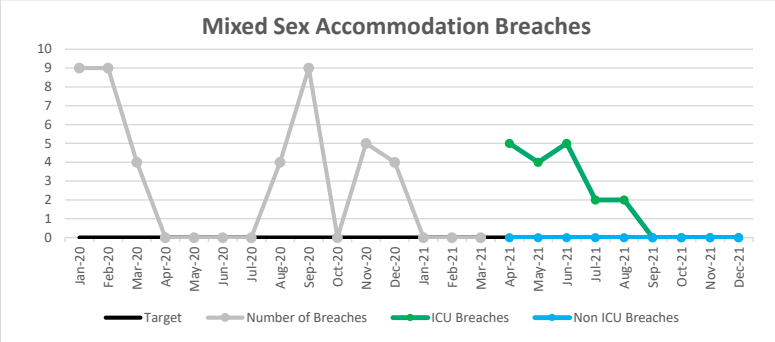
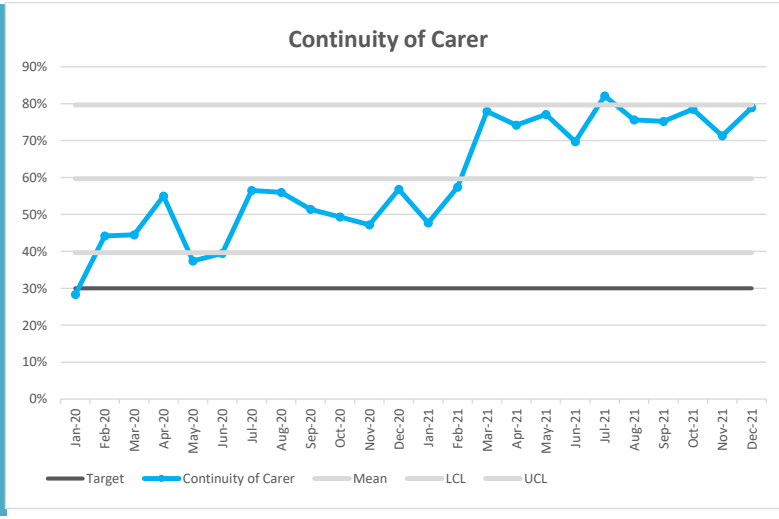
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Mixed Sex Accommodation Breaches (Non ITU Only) Red: 1 or more Green: Zero	There were 0 mixed sex accommodation incidents during December 2021.		There were 0 mixed sex accommodation breaches reported in December 2021 in the Intensive Care Unit. There were zero breaches within any other ward area.	Patients are cohorted within the Intensive Care Unit, to minimise breaches. Patients who are due to step down from the Intensive Care Unit are tracked and prioritised in the regular patient flow meetings. Any delays are escalated via silver command.
Continuity of Carer Green: 51% or Above Amber: 35% - 50% Red: below 35%	In December 2021, 100% of Warrington & Halton women are booked onto such a pathway, if 'out of area' bookings are included the figure is 78.9% as we cannot provide the postnatal aspect of the pathway. SOF		The Trust achieved 78.9% onto a CoC pathway (including intrapartum care) in December 2021. This figure varies month on month as it is impacted by the number of women who are "out of are" being booked for care at WHH.	New care models have been developed by the CBU to enable the Trust to deliver 100% against the continuity of carer standard for in-area women. WHH continues to work towards ensuring women booked on a pathway receive continuity across the pathway. Updated national guidance was published in October 2021 in relation to Continuity of Carer and a revised action plan is being prepared to reflect the new recommendations.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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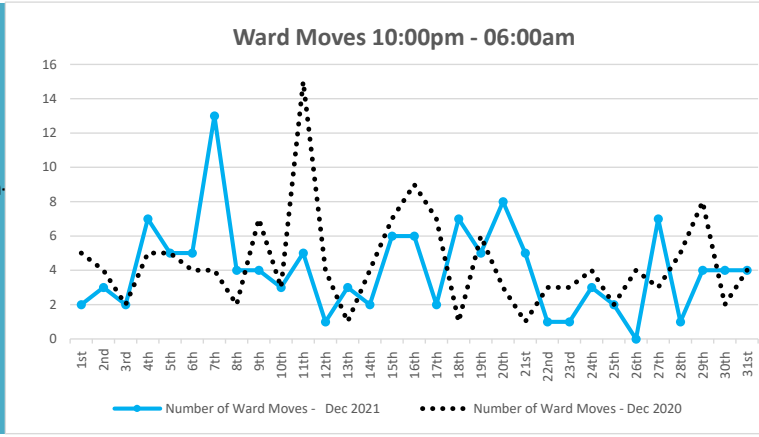
Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Ward Moves between 10:00pm and 06:00am	There was a total of 125 ward moves between 10pm-6am in December 2021 compared to 133 in December 2020.		The reason for the reduction on ward moves after 10pm for this reporting period compared to last year is as a result of the out of hours patient flow and senior manager on call minimising non-essential clinical patient moves.	Increased focus on the reduction of non-essential clinical patient moves at night is part of the improvement workstreams in relation to patient flow.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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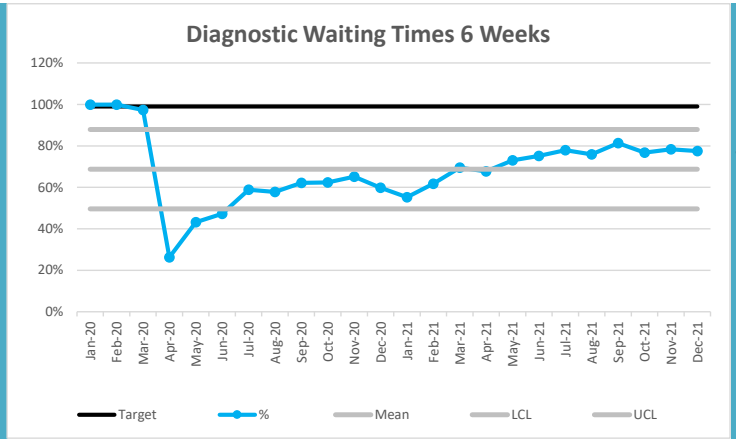
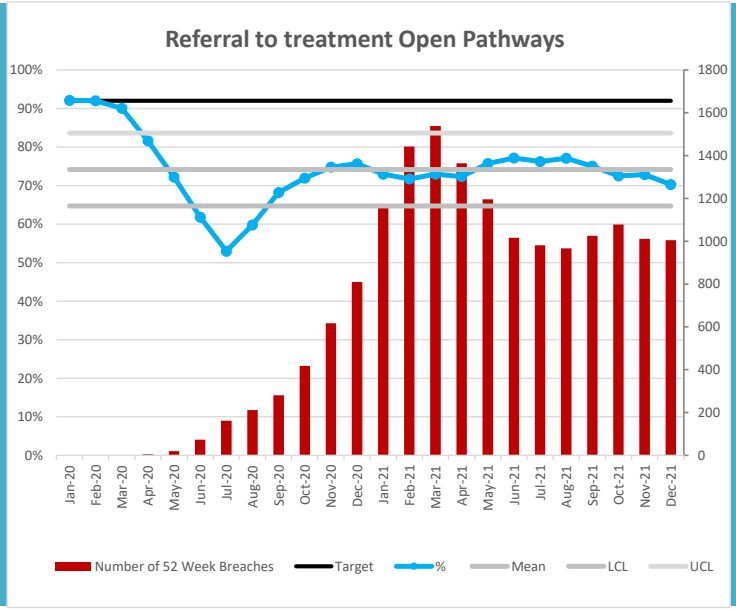
Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above SOF CQC The Trust achieved 77.50% in month. RR1215 RR1125		The diagnostic standard was not achieved in December 2021, this was due to the impact of the COVID-19 pandemic. The position continues to be manged in line with the recovery trajectory.	A recovery plan has now been agreed and patients are being clinically prioritised accordingly in line with national guidance. The recovery plan is demonstrating that the actions agreed are delivering recovery with fewer breaches recorded as services are brought back online. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although there has been good progress in radiological modalities, challenges remain in Endoscopy, Cardiorespiratory, Cystoscopy and CT.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or above **RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red** SOF CQC The Trust achieved 70.25% in month. There were 1005, 52 week breaches in December 2021. RR1215 RR1125		RTT performance and 52 week wait performance in December was compliant against the Trust H2 plan for this month. Progress has been impacted by Wave 5.	Recovery of the elective programme is taking place with: • Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients. • Elective capacity has been restored at the Halton Elective Centre and Captain Sir Tom Moore Centre. • The Trust continues to utilise Independent Sector Capacity. • Restoration and recovery plans for 2021/22 have been drawn up in line with H1 and H2 Operational Planning Guidance.

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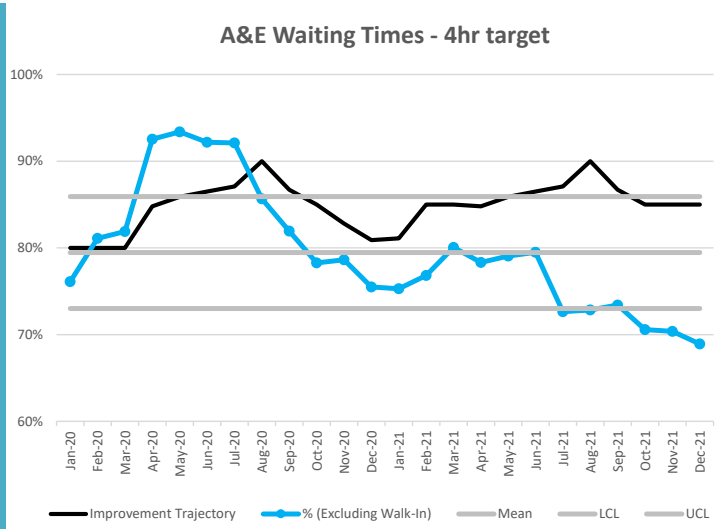
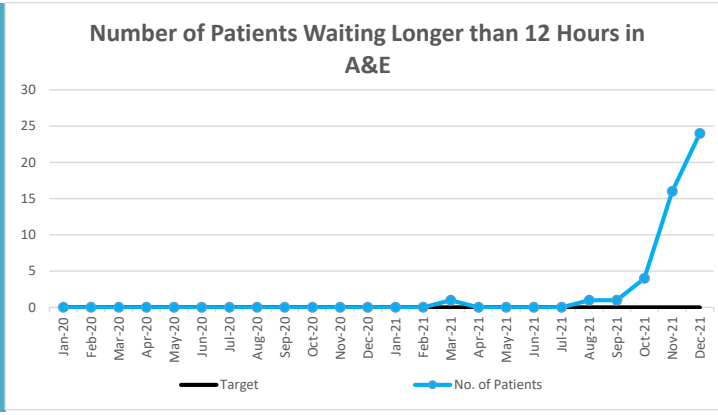
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Four Hour Standard - National Target Red: Less than 95% Green: 95% or Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory	CQC The Trust achieved 68.92% excluding widnes walk ins in month. RR224		There was a further decrease in Type 1 performance attributable to continuing high attends at A&E, a trend continuing to be seen across Cheshire & Merseyside. Bed occupancy at the Trust has continued to be >90% over this period with an increase number patients with a LoS >21, impacting flow and 4 hour performance. Additionally Wave 5 negatively impacted performance.	• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity to support flow. • An ED recovery group has been established to support demand management and deflection from site. • Additional beds remain open on the Halton site to support bed capacity and flow. • The Trust has started the Same Day Emergency Care Capital build, due for completion by April 2022. • The Trust implemented a successful 'Home for Christmas' campaign on the 8th December to create bed capacity to support urgent care and create capacity for COVID-19 positive patients.
The number of patients who has experienced a wait in A&E longer than 12 hours from the decision to admit. Green = 0 Red = > 0	There was 24 patients waiting longer than 12 hours in A&E in month.		There has been a continued deterioration in 12 hour performance in December which is in line with the growing pressures in this period. This Trend is also in line with the trend seen nationally and regionally. The Trust continues to perform well when compared to other Trusts against this standard. The key themes for the breaches are the continuing high urgent care attends and high occupancy restricting flow through A&E.	The Trust will continue to monitor and manage compliance around the 12 hour standard.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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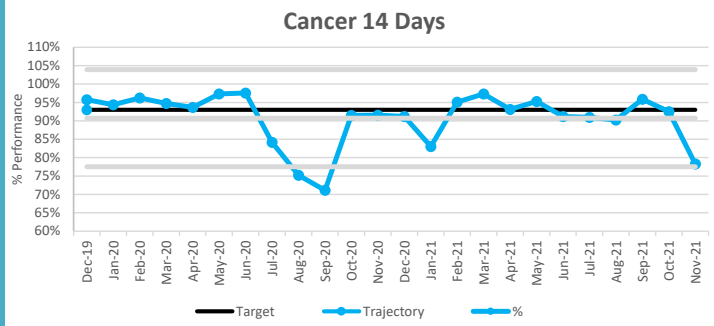
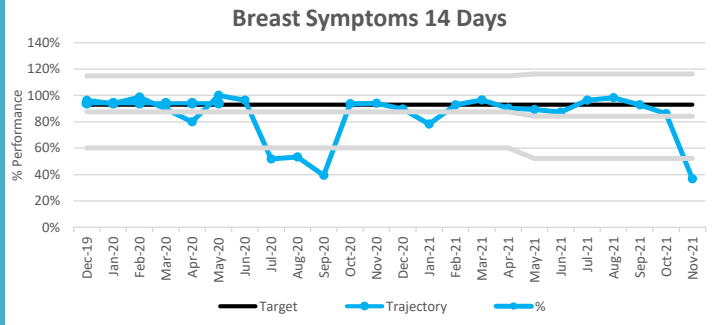
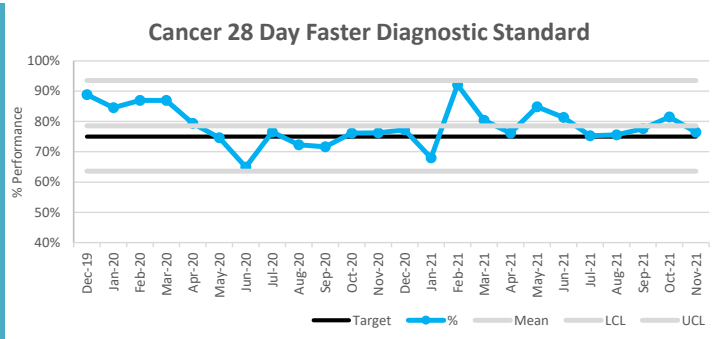
Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 14 Days Red: Less than 93% Green: 93% or above SOF CQC **The Trust achieved 78.29% in November 2021.** RR1125		**The deterioration in performance is attributable to the increase in referrals to the Breast service following a high profile in the media and Breast Cancer awareness month in October. This impact has been a sustained increase in referrals above demand. Capacity was further restricted in November as a result of Locum Consultant leave and senior medical staff isolating for COVID-19.**	**The Trust will continue to review capacity with clinical service restoration plans to support ongoing compliance against this standard.** **Performance against this standard is monitored via the Performance Review Group (PRG), the KPI sub-committee and the Clinical Services Recovery Oversight Group (CSOG).** **Targeted capacity and demand work has been initiated for the Breast service. The service is expected to fully recover by January/February 2022.**
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above SOF CQC **The Trust achieved 36.76% in November 2021.** RR1125			
28 Day Faster Cancer Diagnosis Standard Red: Less than 75% Green: 75% or above SOF **The Trust achieved 76.47% in November 2021.**		**The Trust achieved the standard in November 2021.**	**The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG) and KPI Sub-Committee.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

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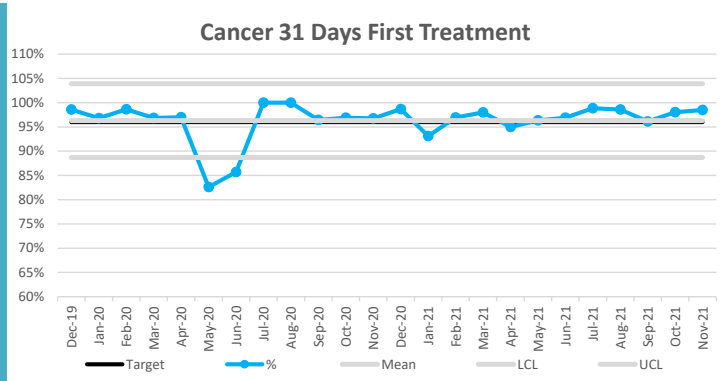
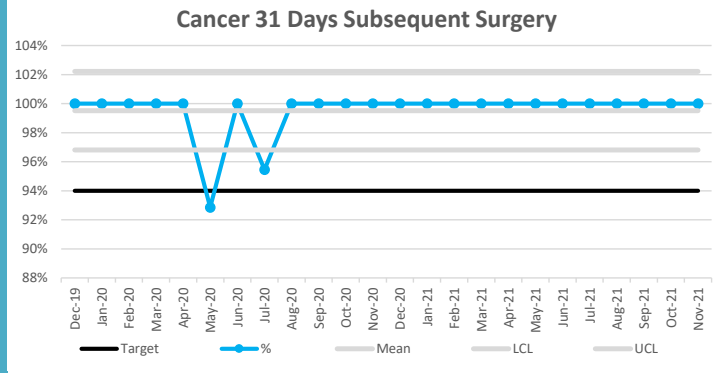
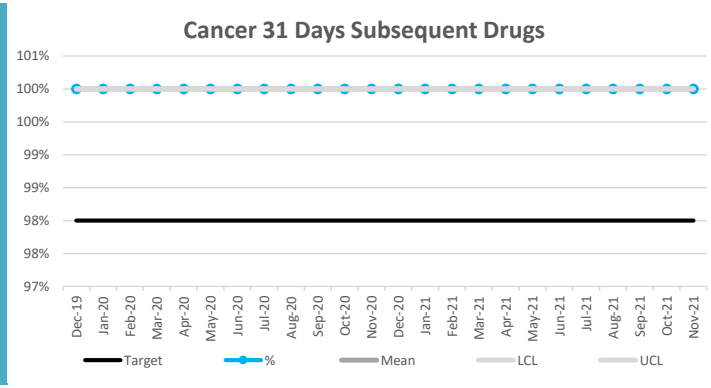
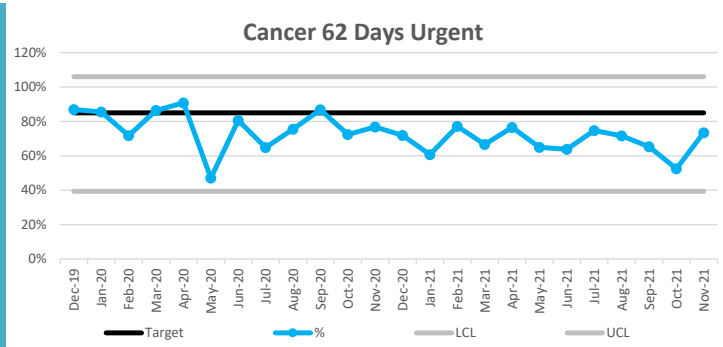
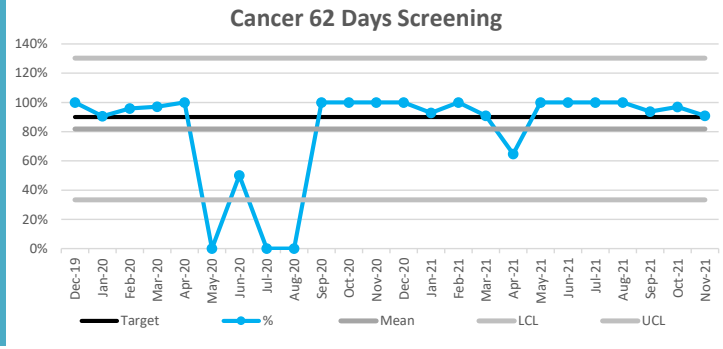
Care Quality Commission CQC

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	SOF CQC The Trust achieved 98.48% in November 2021. RR1125		The 31 day cancer target was achieved in November 2021. Good compliance against this standard continues to be tracked.	There remains a risk for performance due to the impact of the pandemic. Capacity is being reviewed in line with clinical service restoration plans.
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	SOF CQC The Trust achieved 100% in November 2021. RR1125			
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	SOF CQC The Trust achieved 100% in November 2021. RR1125		The Trust achieved 100% in November 2021.	Maintain compliance against the 31 day subsequent treatment (drug) standard.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register RR116
System Oversight Framework SOF
Care Quality Commission CQC

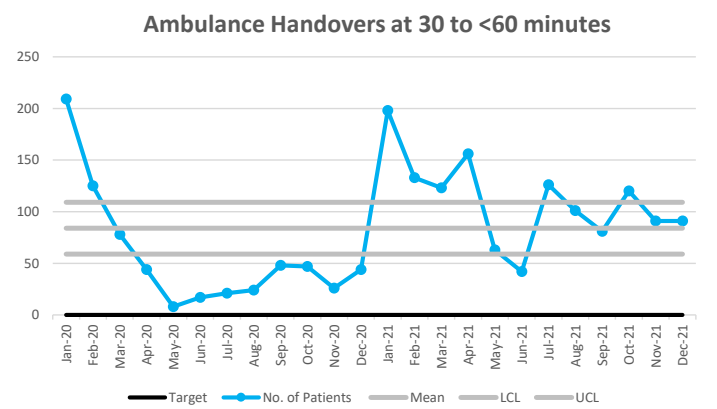
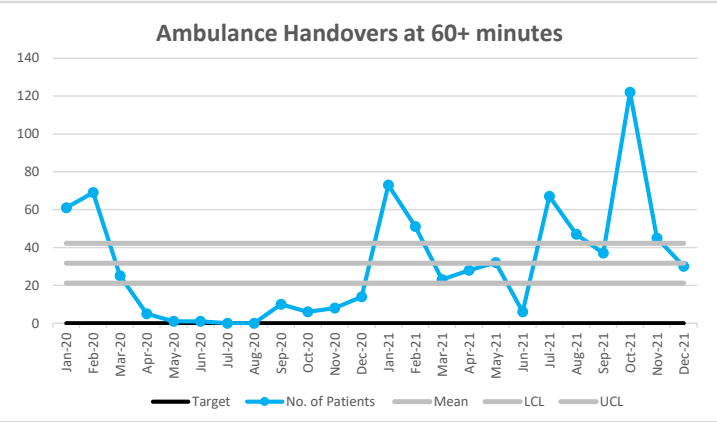
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	SOF CQC The Trust achieved 73.47% in November 2021. RR1125		The 62 day urgent target was not achieved in November 2021 at 73.47%. The Trust is meeting the Cheshire & Merseyside Cancer Alliance agreed trajectories for improvement. The Trust has achieved the 62 day screening standard.	There remains a risk for performance due to the impact of the pandemic.
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	SOF CQC The Trust achieved 90.91% in November 2021. RR1125			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register RR116
System Oversight Framework SOF
Care Quality Commission CQC

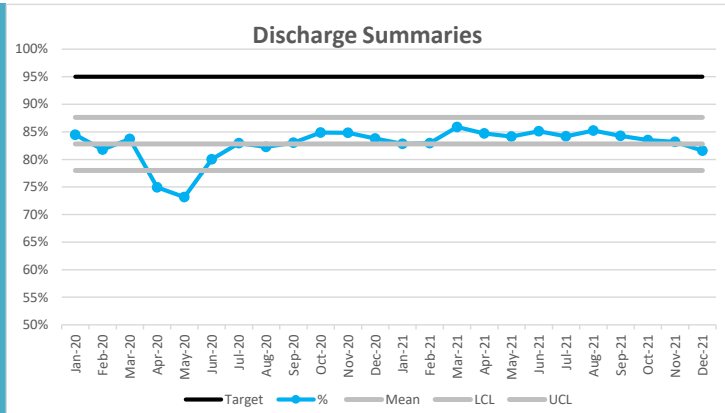
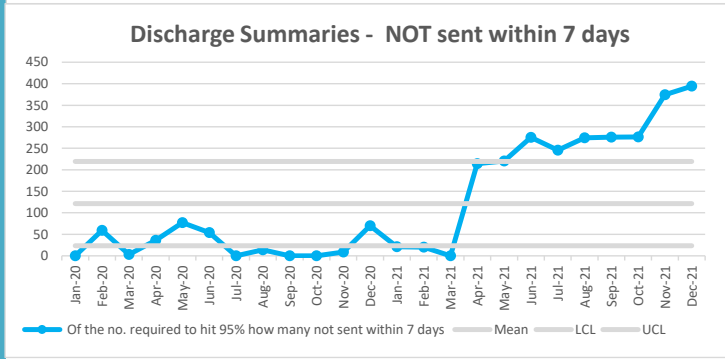
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Ambulance Handovers 30 to <60 minutes **Red: More than 0** **Green: 0**	SOF **There were 91 patients who experienced a delay in Ambulance Handovers between 30 to 60 minutes in month.**		**Handover performance has improved following the improvement collaborative with the North West Ambulance Service (NWAS).**	**In May 2021, the Trust began a service improvement collaborative with NWAS to improve ambulance handover waiting times. The Trust will continue to work in partnership with the NWAS to identify and implement improvements.**
Ambulance Handovers at 60 minutes or more **Red: More than 0** **Green: 0**	SOF **There were 30 patients who experienced a delay in Ambulance Handovers over 60 minutes in month.**			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register RR116
System Oversight Framework SOF
Care Quality Commission CQC

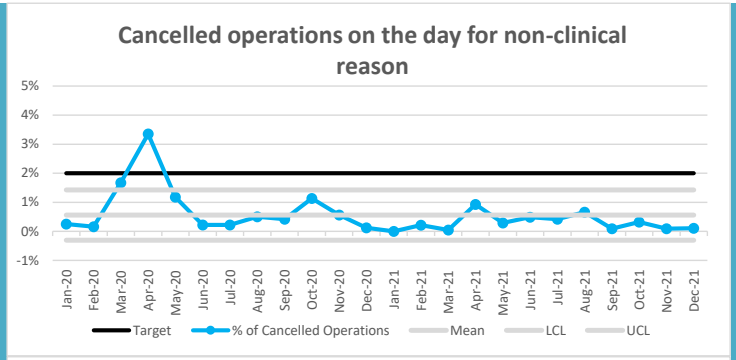
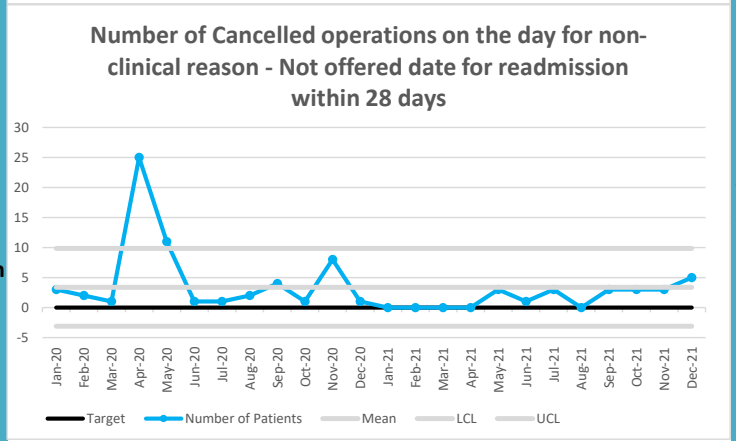
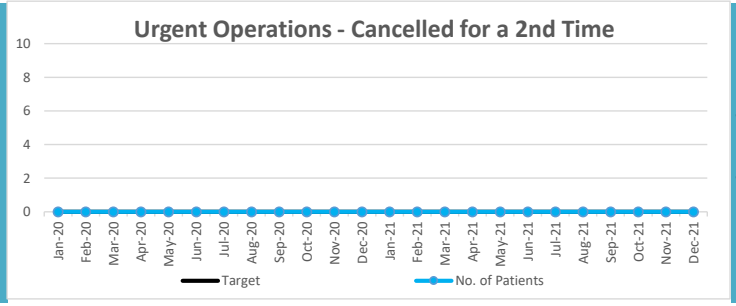
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	The Trust achieved 81.60% in month.		Performance of discharge summaries within 24 hours has been maintained despite Wave 5 challenges.	The Performance Review Group (PRG) continues to monitor this standard to support improvements.
Discharge Summaries - Number NOT sent within 7 days Red: Above 0 Green: 0	There were 394 discharge summaries not sent within 7 days required to meet the 95.00% threshold.		Challenges remain for compliance against the 7 day standard. The is attributable to the implementation of the new process. Although this had been identified, progress in resolving this issue has been impacted by the staffing challenges as a result of Wave 5. Further work will be undertaken in Q4 to resolve this.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register RR116
System Oversight Framework SOF
Care Quality Commission CQC

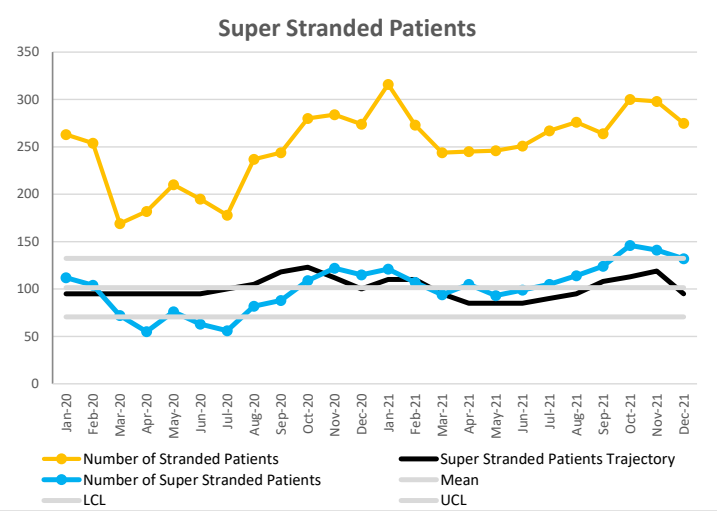
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancelled Operations on the day for a non-clinical reason Red: > 2% Green: < 2%	CQC 0.11% of operations were cancelled on the day for non clinical reasons in month.		Compliance against this standard remains below the monitored threshold of 2.00% (positive).	Recovery of elective activity continues to be monitored via the Clinical Services Recovery Oversight Group (CSOG).
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	There was 5 cancelled operations on the day for non clinical reasons in month, where the patient was not re-booked in within 28 days.		The deterioration in December is attributable to the festive period and the growing impact of Wave 5 in the month.	
Urgent Operations - Cancelled for a 2nd Time Green = 0 Red = > 0	There were 0 urgent operations cancelled for a second time in month.		This is an additional standard to enhance monitoring of cancelled operations. The Trust continues to maintain this standard.	Maintain the standard that no urgent operations are cancelled for a second time.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register RR116
System Oversight Framework SOF
Care Quality Commission CQC

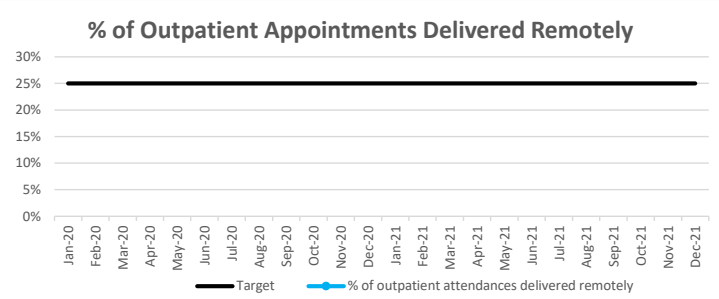
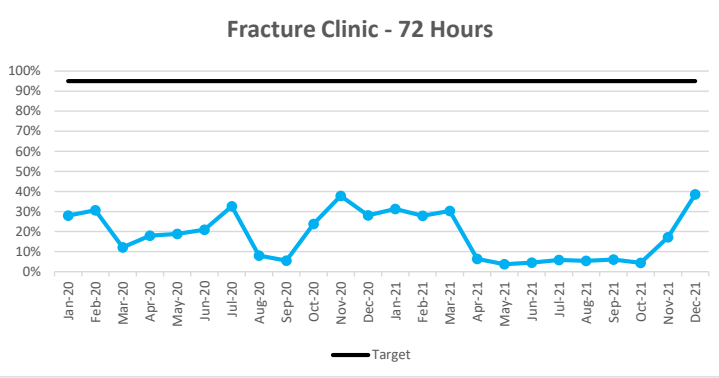
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Super Stranded Patients Green: Meeting Trajectory Red: Missing Trajectory	There were 275 stranded and 132 super stranded patients at the end of December 2021.		The number of Super Stranded patients to increase to a level not seen since 2017/18. The modest decrease in December is attributable to the Home for Christmas Campaign that ran between the 8th -24th December in preparation for the Festive Bank Holidays.	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available throughout the pandemic. The Trust has introduced "Where's best next" Length of Stay meetings on a daily basis to support timely discharge.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register RR116
System Oversight Framework SOF
Care Quality Commission CQC

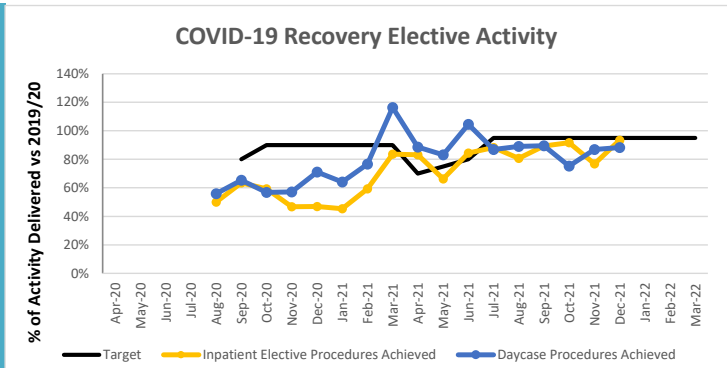
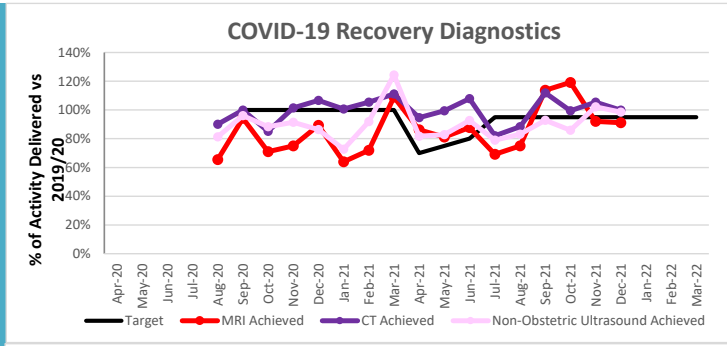
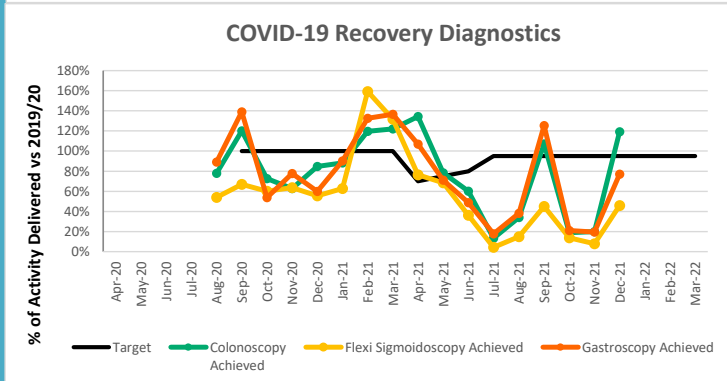
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Outpatient Activity Delivered Remotely Green = 25% Red = Less than 25%	This indicator is under development.		This indicator is under development.	
Patients seen in the Fracture Clinic within 72 hours Green: 95% Red: Less than 95%	38.51% of patients were seen in the Fracture Clinic within 72 hours in month.		In line with the action plan, the Fracture clinic service has improved performance but continues to track below compliance. The service remains on track to achieve this indicator in Q4.	The action plan will continue to be monitored within the Planned Care Group.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

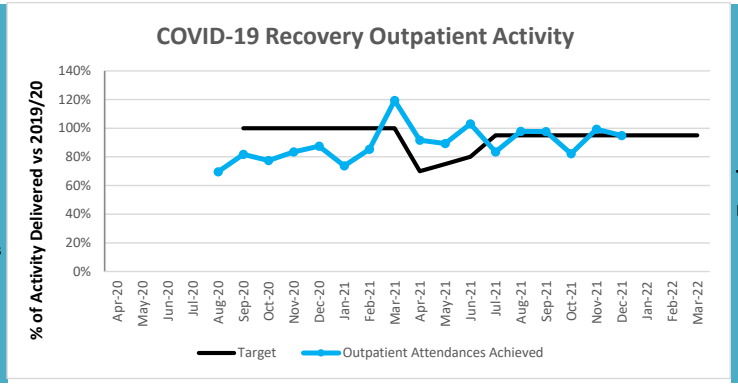
Key:
Risk Register RR116
System Oversight Framework SOF
Care Quality Commission CQC

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
COVID-19 Recovery Elective Activity RED = Below Elective Recovery Target Green = Elective Recovery Target % activity is against activity in the same month in 2019/20 **In December 2021, the Trust achieved the following % of activity against December 2019. This included 88.21% of Daycase Procedures and 93.44% of Inpatient Elective Procedures.** SOF RR1125		**The Trust did meet the aggregated elective activity recovery trajectories for December 2021 in line with the H2 plan.**	**The Trust monitors progress weekly via PRG and Clinical Services Oversight Group (CSOG)and will progress measures to switch services back on at the earliest opportunity based on the impact of COVID-19.**
COVID-19 Recovery Diagnostic Activity RED = Below Elective Recovery Target Green = Elective Recovery Target % activity is against activity in the same month in 2019/20 SOF RR1125 **In December 2021, the Trust achieved the following % of activity against December 2019. This included:** **91.12% of MRI** **99.83% of CT** **98.57% of Non-Obstetric Ultrasound** **45.93% of Flexi Sigmoidoscopy** **119.20% of Colonoscopy** **77.02% Gastroscopy**	 	**The Trust did not meet the diagnostic activity recovery trajectories for December 2021. Colonoscopy, Flexi Sig and Gastroscopy have started to show an improvement. Cardiorespiratory, particularly Echo and Ultrasound remain the most challenged areas.**	**The Trust continues to restore clinical services in line with the national operating guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register RR116
System Oversight Framework SOF
Care Quality Commission CQC

Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
COVID-19 Outpatient Activity **RED = Below Elective Recovery Target** **Green = Elective Recovery Target** **% activity is against activity in the same month in 2019/20**	**In December 2021, the Trust achieved 95.00% of Outpatient activity against December 2019.** **Please note: M1-6 (H1) Outpatient, Daycase & Elective Activity has been provided in relation to ERF achievement. From Month 7 (H2) ERF is not determined by % of activity against 2019/20 and is therefore not adjusted against plan.** SOF RR1125		**The Trust met the Outpatient activity recovery trajectories for December 2021.**	**The Trust continues to restore clinical services in line with the national operating guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
System Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR200)

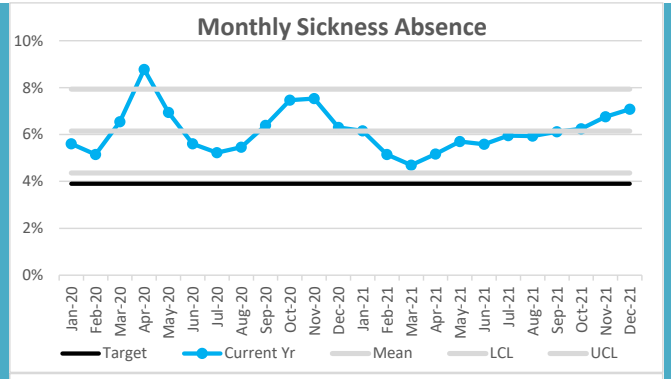
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

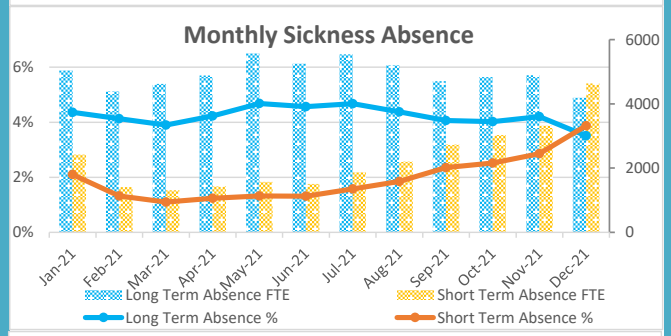
UoR SOF S RR200 RR1134 RR1108

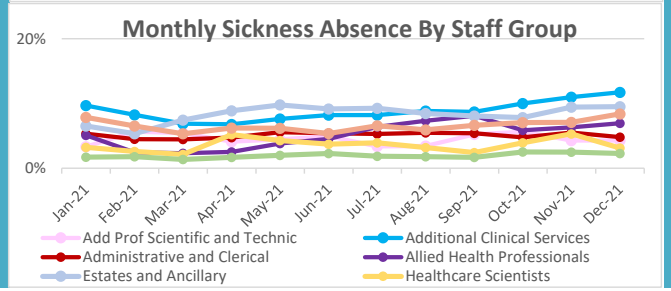
Sickness Absence

Red: Above 4.5%
Amber: 4.2% to 4.5%
Green: Below 4.2%

The Trust's sickness absence rate was 7.38% in month.







Sickness absence is 7.38% in December 2021.

Short term absence is 3.87% and 3.51% relates to long term absence.

Sickness absence in December 2020 was 6.60%.

Anxiety, Stress and Depression is the highest reason for sickness absence, followed by Chest and Respiratory problem.

The Trust continues to work in partnership with NHSE/I to explore and implement the findings of the NW Deep Dive into Sickness Absence. Findings from this Deep Dive are currently being mapped into an organisational workplan to support Attendance across the organisation that will be monitored via the WHH Supporting Attendance Task and Finish Group.
Following robust benchmarking against best practice and consultation with Staff Side and Management colleagues, a revised and refreshed Supporting Attendance Policy has been drafted and is due to be ratified in January 2022.
A project has been started to plan the launch of the new Supporting Attendance Policy, and working in partnership with Nursing colleagues, seeking to identify a pilot area for focused work to commence in late January 2022. Learning from this pilot will seek to reduce sickness absence within the pilot area and recommendations to be available in April 2022, will inform organisational approach within 22/23.
The HR Business Partner Team are providing ongoing support to operational managers in managing sickness absence. This includes advisory support in relation to policy and attendance at welfare, and sickness stage meetings/hearings.
KPI's continue to be monitored through Operational People Committee, where operational colleagues are required to provide assurance on key metrics (incl. Sickness Absence), provide plans for improving KPI's as required and sharing best practice.

<u>Preventing Absence</u>
Preventative measures continue to be implemented including Occupational Health and Wellbeing interventions, the COVID-19 Booster and Flu Vaccination Campaigns and asymptomatic staff testing.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

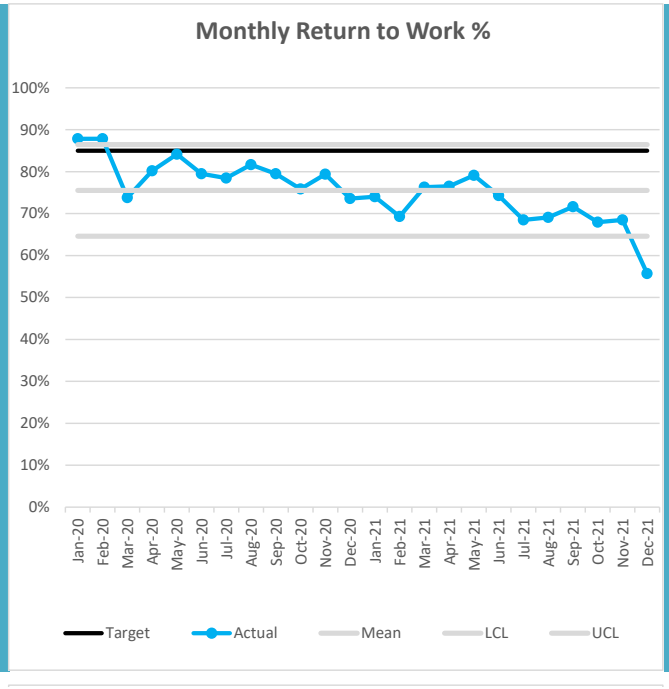
Key:
System Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR200)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Return to Work

Red: Below 75%
Amber: 75% to 85%
Green: Above 85%

The Trust's return to work compliance was 55.70% in month.



Return to work interview compliance is 55.70% in December 2021.

Its worth noting that previous months RTW compliance has increased, as managers input historic RTWs that occurred, but were not recorded on the system.

As part of continued work with NHSE/I RTW documentation from best practice organisations has been sourced and meetings have been held with two organisations to understand their success factors. Learning from this has been implemented in a review and reframing of return to work process and documentation and will be launched as part of the revised attendance policy due to be ratified in January 2022.

Following the successful implementation of bespoke manager training in pilot areas, the reframed approach to RTW interviews will be included in the WHH Management and Leadership Development Programme from April 2022. Access to this training will be provided on an ad hoc basis from January 2022.

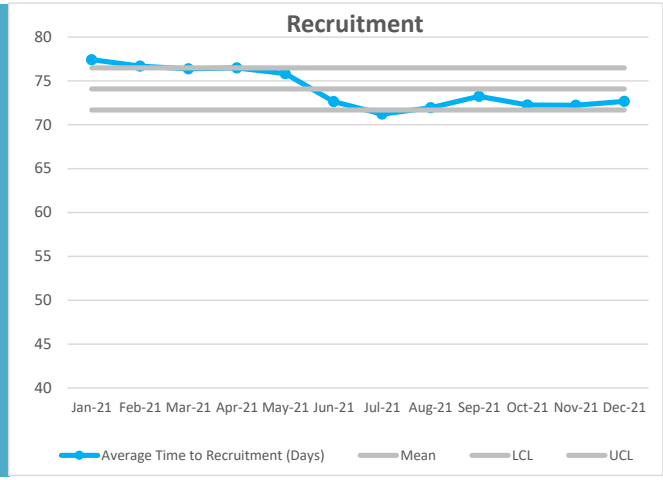
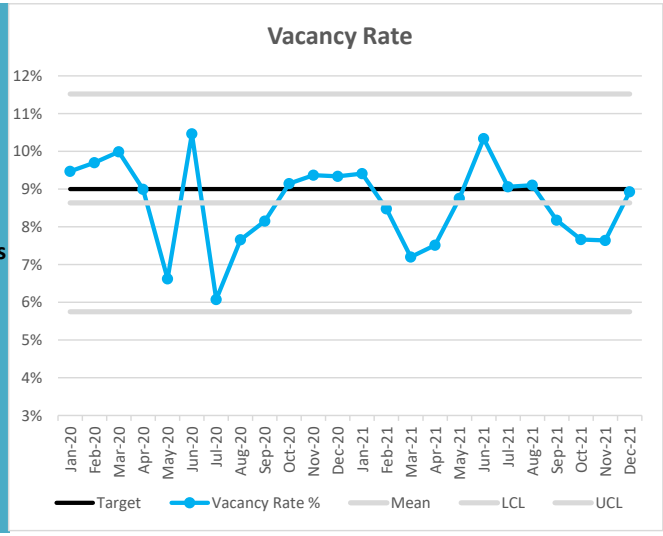
The Operational People Committee continues to request plans/trajectories to demonstrate improving compliance for each CBU and shares best practice as available.

In addition, the Workforce Systems teams are arranging monthly drop-in sessions (an expansion to what is currently delivered), part of this offer is will include RTW data input demo in both ESR and E-Rostering.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
System Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR200)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or below			
The average number of working days to recruit is 73 days, based on the last 12 months average.		**Recruitment time to hire for December 2021 is 73 working days.**	**The Recruitment team continue to refine communications and engagement with recruiting managers to manage expectations and also proactively consider recruitment timelines aligned to best practice. In addition, the team are actively developing an inclusive recruitment approach which will have a positive impact on attraction of candidates, supporting reduction in time to hire and potential retention within the organisation.**
Vacancy Rates Red: 11% or Above Amber: 11% to 9% Green: 9% or Below			
UoR **The Trust vacancy rate was 8.93% in month.**		**The vacancy rate is below the 9.00% threshold, at 8.93% in December 2021 (positive).**	**The reduction in the Trusts vacancy rate is due to the successful recruitment of international nurses and the HCA recruitment drive.** **Trust Headcount continues to be the highest on record. This is due to an increase in the number of new starters and a reduction of leavers.** **The Trust has started to implement an Inclusive Recruitment action plan, following a review, in partnership with the organisation's Staff Networks which will maximise the attraction offer by actively promoting the organisation's rewards and benefits aligned to the "All About You" branding. In addition, the team are looking at additional accessible supporting information on NHS Jobs to support candidates and also other platforms such as LinkedIn.** **It is anticipated that the development of NHS Jobs 3 will enable further options to support candidate experience.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
System Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR200)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

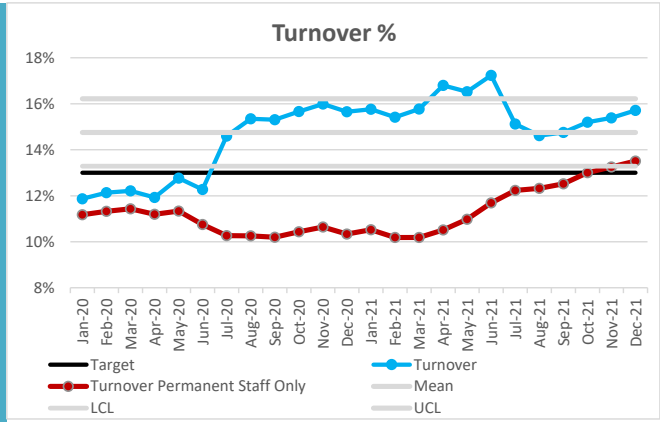
Turnover

Red: Above 15%
Amber: 13% to 15%
Green: Below 13%

CQC UoR

Turnover in December 2021 and is above target at 15.71%. Turnover of Permanent staff is 13.51%

S SOF



For permanent staff only, the Trust is performing at 0.51% above Trust Target Turnover.

Work-life balance continues to be the number one reason people leave WHH. The Trust is part-way through an NHSE/I Flex for Future programme to look at flexible working in its entirety across the organisation. The organisation have established an Agile Working Task and Finish Group which will work collaboratively to implement any recommendations from the Flex for Future programme and will also outline the strategic approach to Agile Working within the organisation. The group have met to confirm the Terms of Reference and the priorities for the group in the interim.
The organisation's reward and benefit scheme has been reviewed and benchmarked against regional and national colleagues. A new health and wellbeing framework has been published by NHSE/I and the organisation will be reviewing the offer aligned to this new framework to identify any areas for improvements to support our staff within the workplace.
A range of work is on-going as part of the WHH People Strategy and the NHS People Plan support retention of staff, including:

- **Total of 162 bespoke OD offers in 2021 with 181 sessions with a total of 247.5 learning hours delivered.**
- **34 sessions as part of the "how am I developed" suite of offers (coaching/PDR etc) with a total of 192 learning hours undertaken for these sessions.**
- **Ongoing self-compassion in work programme, 96 members of staff have taken up this offer.**
- **Compassionate leadership workshops planned for February and March.**
- **The Career development programme pilot is complete and now available on ESR.**
- **Ongoing staff engagement and Mental Health and Wellbeing interventions.**
- **Partnership working to provide additional mental and physical fitness support.**
- **Identification and implementation of a Talent Management framework for WHH, which will be Scope for Growth the NHSE/I Talent management approach.**

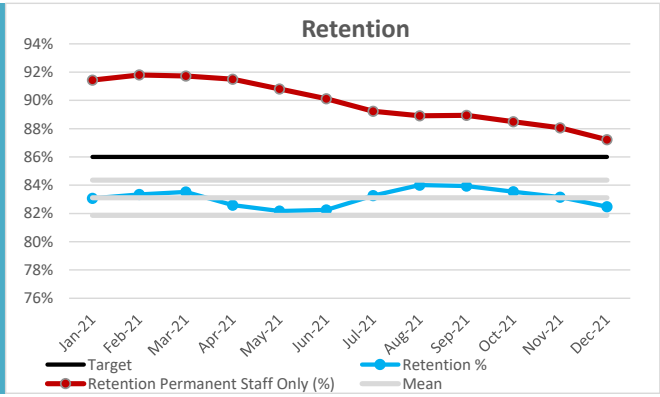
A Staff Facilities Task and Finish Group has been established with priorities identified for the short, medium and long term to enhance Staff facilities within the organisation aligned to national recommendations.

Retention

Red: Below 80%
Amber: 80% to 85%
Green: Above 86%

UoR

Retention in December 2021 and is just below Trust target at 82.48%. Retention of Permanent staff is 87.22%



Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
System Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR200)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

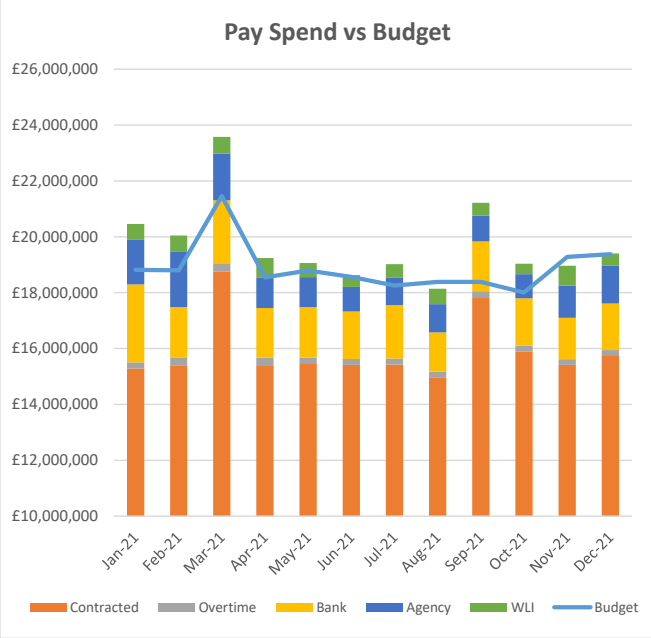
Pay

Red: Greater than Budget

Green: Less than Budget

UoR

Total pay spend in December 2021 was £19.40m against a budget of £19.37m.



Total pay spend in December 2021 was £19.40m against a budget of £19.37m.

The total pay spend is broken down into the following elements:
- **£15.73m Contracted Pay (i.e. substantive staff)**
- **£1.67m Bank Pay**
- **£1.35m Agency Pay**
- **£0.44m Waiting List Initiative (WLI) Pay**
- **£0.21m Overtime Pay**

As a reminder the additional controls and challenge around pay spend have been identified, to support a reduction in premium pay:
- **ECF process for non-clinical vacancies approval**
- **ECF process for bank and agency temporary staffing pay spend approval.**

A new medical bank rate card has been implemented and currently developing a sign-off process for escalations. A new weekly escalation panel is in place to review all medical bank rate escalations.

In addition, through the Finance and Sustainability committee, compliance against our processes and rate cards continues to be monitored.

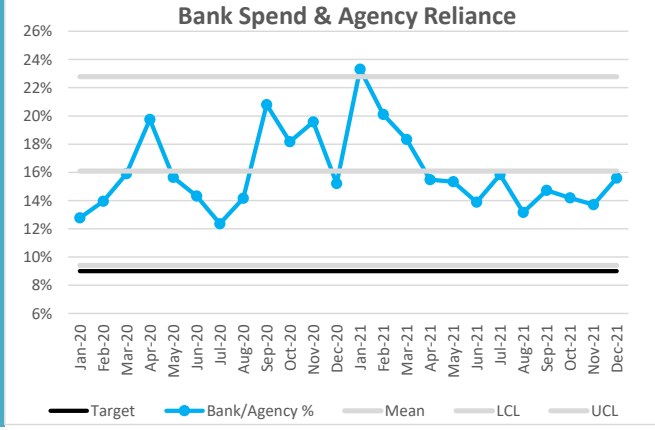
Following a MIAA WLI Audit in November 2021, the Trust is currently awaiting the final report in order to implement any recommendations.

Bank and Agency Reliance

Red: 11% or Above
Amber: 11% to 9%
Green: 9% or Below

UoR

Bank and Agency Reliance was 15.59% in month. SPC - Bank/Agency reliance is within common cause (expected) variation.



Bank and Agency reliance peaked at 23.3% in January 2021 and there has been a continued reduction since. In December 2021, reliance is 15.59%.

Processes are in place to ensure appropriate usage of temporary staffing through the ECF process and/or NHSP booking platform with the links to the roster system.

Within the last 12 months, Bank and Agency reliance peaked at 23.30% however the graph illustrates a sustained reduction in Bank and Agency Reliance.

With the introduction of the new medical bank rate card, Care Groups are required to identify long term recruitment plans for rate escalations as part of a new process.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
System Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR200)

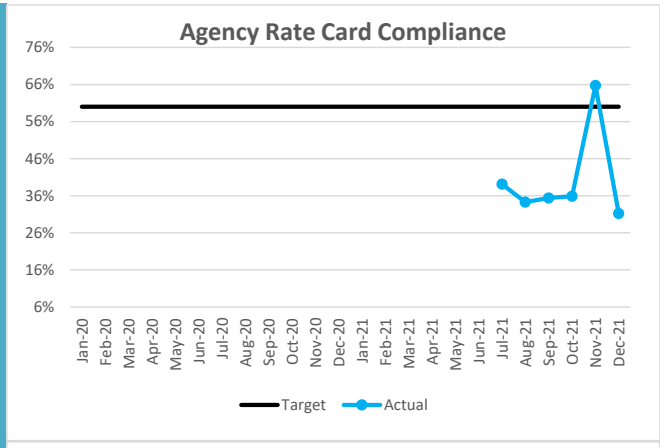
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Agency Rate Card Compliance

Red: below 50%
Amber: 50-59%
Green: 60% or above

UoR

Agency Rate Card Compliance was 31.22% in month.

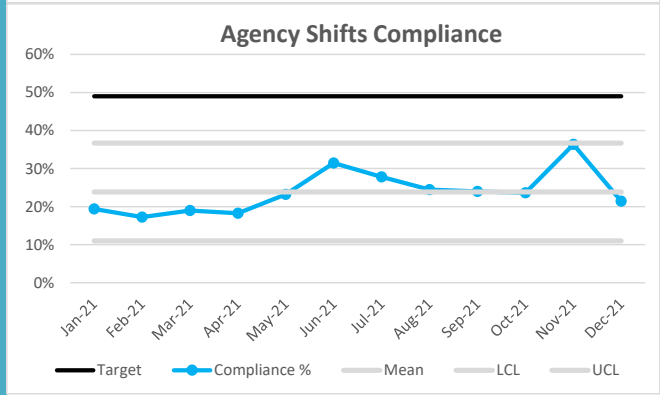


Agency Shifts Compliant with the Cap

Red: below 49%
Green: above 49%

UoR

21.44% of shifts were compliant with the NHSI Price Cap.
SPC - There is evidence of special cause variation within Agency Shift Compliance.



Compliance with the NHSEI cap was 21.44%. In December 2021, non-compliance was highest amongst the following staff groups:

- **Medical and Dental**
- **Nursing and Midwifery**
- **AHPs**

Compliance with the Cheshire and Merseyside rate card was 31.22% in December 2021 which is a reduction from the previous month.

The central bank and agency team continue to support Care Groups in relation to the booking of medical and dental staff in order to negotiate rates in line with the Cheshire and Mersey Rate Card and the NHSI Price Cap compliance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
System Oversight Framework (SOF) | Use of Resources Assessment (UoR) | Risk Register (RR200) | Care Quality Commission (CQC) | Trust Strategy (S)

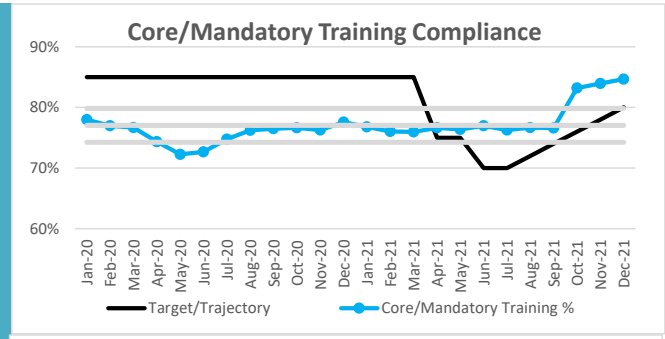
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Core/Mandatory Training

Red: Below Trajectory
Green: Trajectory

CQC

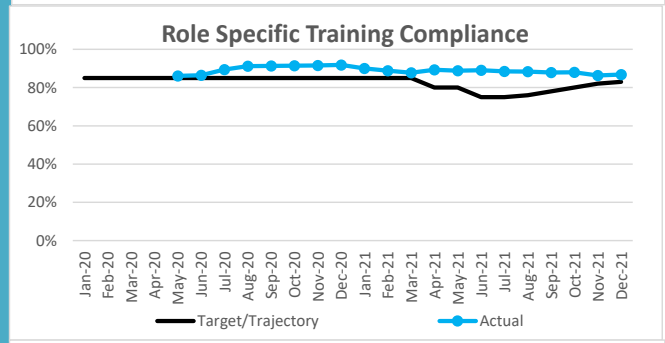
Core/Mandatory training compliance was 84.67% in month.



Role Specific Training

Red: Below Trajectory
Green: Trajectory

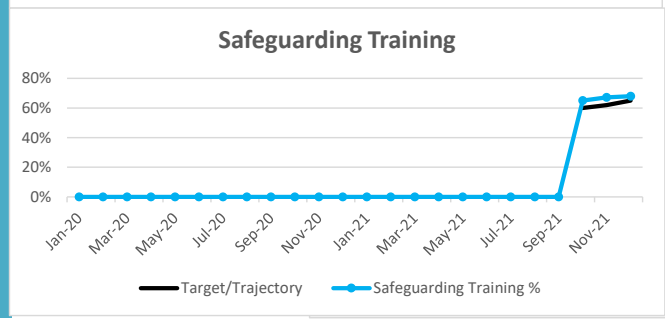
Role Specific Training compliance was 86.86% in month.



Safeguarding Training

Red: Below Trajectory
Green: Trajectory

Safeguarding Training compliance was 67.97% in month.



In December 2021 Mandatory Training compliance was 84.67%, this now excludes Safeguarding Training (Children's and Adults); Safeguarding compliance is 67.97%, and Role Specific Training compliance was 86.86%.

Currently Mandatory Training, Safeguarding Training and Role Specific Training are above their agreed trajectories (positive).

The Mandatory Training compliance is now split by Mandatory, Safeguarding and Role Specific Training.

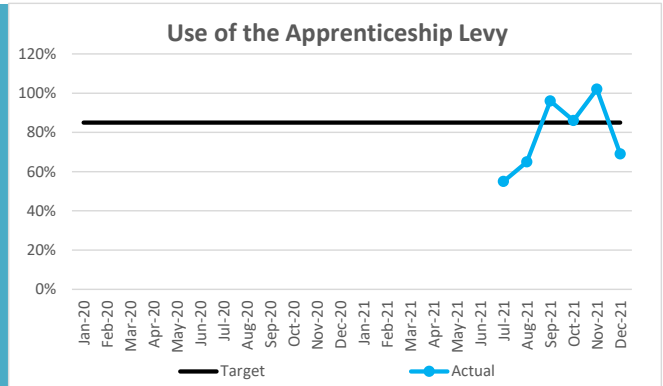
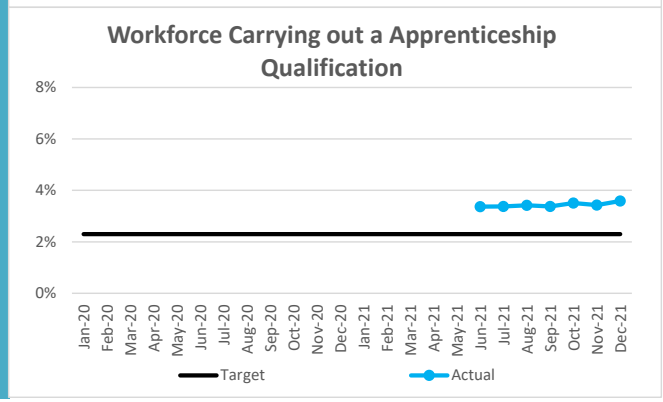
The CBUs and Subject Matter Experts have been supported to develop trajectories to improve compliance, these are monitored through workforce governance structure.

The organisation continues to support staff to access training safely with virtual offers where possible.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

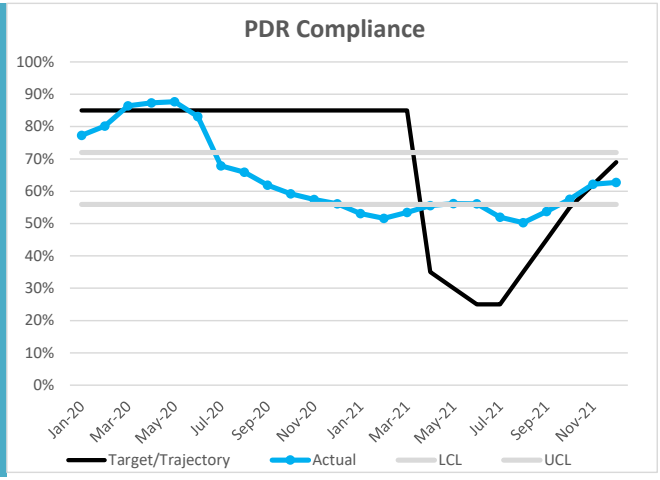
Key:
System Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR200)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Use of Apprenticeship Levy Red: below 50% Amber: 50-84% Green: 85% or above **Use of the Apprenticeship Levy was 69.00% in month.**		**Utilisation of the apprenticeship levy is 69.00% in December 2021, below target in month. 3.59% of staff are carrying out a qualification, which is above target (positive)**	**Use of the apprenticeship levy continues to be challenged for new recruitment episodes and the uptake of formal training.**
Workforce carrying out an Apprenticeship Qualification Red: below 1.5% Amber: 1.5% - 2.2% Green: 2.3% or above **The percentage of the workforce carrying out a qualification was 3.59% in month.**			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

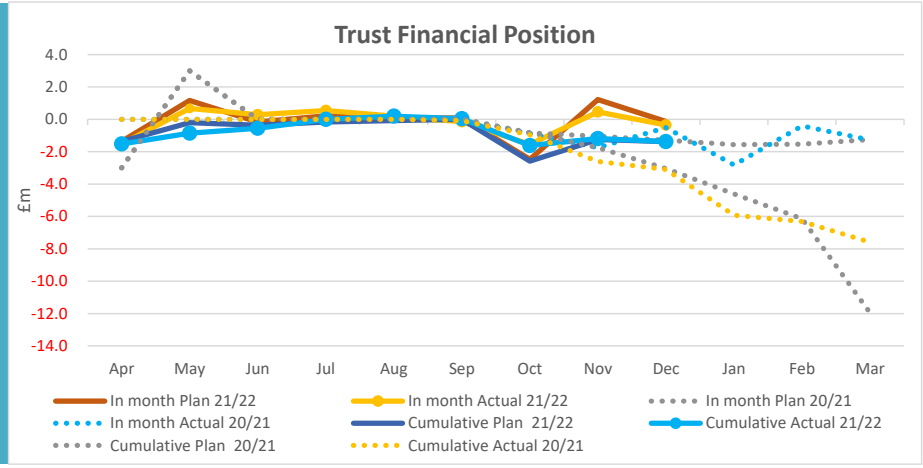
Key:
System Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR200)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
PDR Red: Below Trajectory Green: Trajectory	S CQC **PDR compliance was 62.70% in month.**		**In December PDR compliance was 62.70%.** **Currently PDR rates are below the trajectories.**	**An improvement trajectory to return to above target compliance has been in place since July 2021.** **The CBUs have been and continue to be supported to develop trajectories to improve compliance, including use of the Wellbeing Check In conversation where appropriate. These are monitored through the Workforce governance structure.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
System Oversight Framework (SOF) | Use of Resources Assessment (UoR) | Risk Register (RR116) | Care Quality Commission (CQC) | Trust Strategy (S)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
The Trust has recorded a deficit position of £1.4m as at 31 December.		For the period ending 31 December 2021, the Trust has recorded a deficit of £1.4m. The position includes an overspend on COVID-19 partly offset with underspends in other areas of the organisation.	The Trust is applying national guidance as this emerges in relation to financial planning for H2.

Trust Financial Position

Red: Deficit Position
Amber: Actual on or better than planned but still in deficit
Green: Surplus Position

RR134

System Financial Position

Red: Deficit Position
Amber: Actual on or better than planned but still in deficit
Green: Surplus

Warrington & Halton System reporting is currently on hold.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
System Oversight Framework (SOF) | Care Quality Commission (CQC) | Use of Resources Assessment (UoR) | Trust Strategy (S) | Risk Register (RR116)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

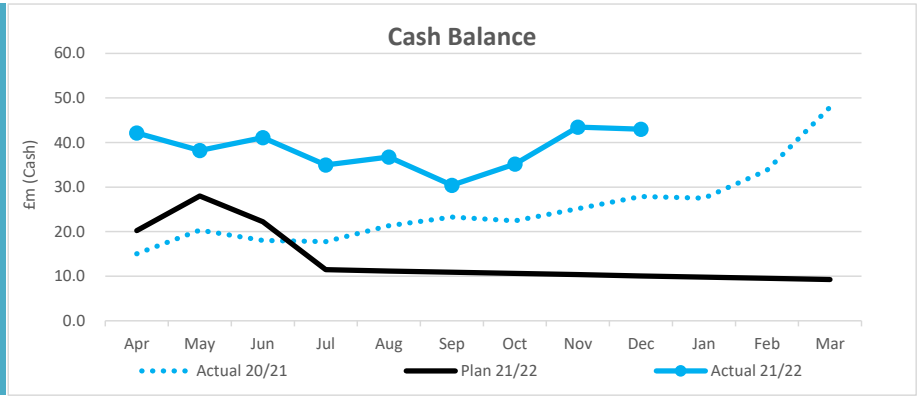
Cash Balance

Red: Less than 90% or below minimum cash balance per NHSI
Amber: Between 90% and 100% of planned cash balance
Green: On or better

UoR

The current cash balance is £42.97m.

RR134



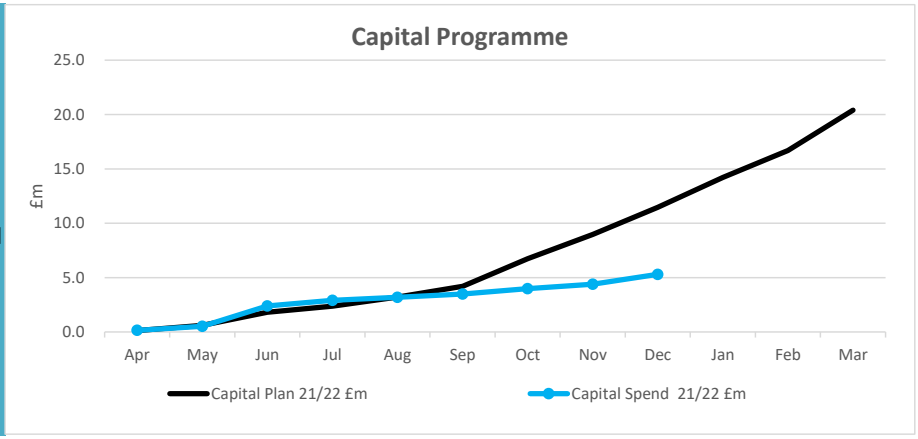
The current cash balance is £42.97m. Of this, £13m needs to be ringfenced to support the procurement of the Electronic Patient Care Management System (EPCMS).

Capital Programme

Red: Off plan <80% - >110%
Amber: Off plan 80-90% or 101 - 110%
Green: On plan 90%-100%

UoR

The actual capital spend in month 9 was £0.9m. There are £9m committed orders on the system.

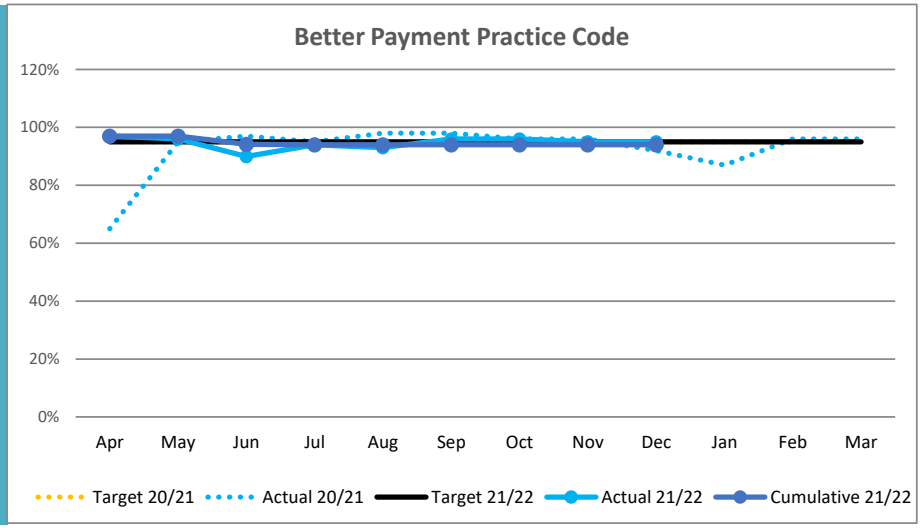


The capital plan is £20.4m. Of this it is now forecast that £2.8m of the ED plaza scheme will not be completed until next year. The actual spend year to date is £5.3m which is £6.1m below the planned spend of £11.4m. Weekly monitoring is overseen by the Chief Operating Officer is in place to support delivery to plan.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
System Oversight Framework (SOF) | Use of Resources Assessment (UoR) | Risk Register (RR116) | Care Quality Commission (CQC) | Trust Strategy (S)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR **In month, the Trust has paid 95.00% of suppliers within 30 days.**		**Cumulative performance is 94.00% which is below the national target of 95.00%.**	**Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments.**

Better Payment Practice Code

Red: Cumulative performance below 85%
Amber: Cumulative performance between 85% and 95%
Green: Cumulative performance 95% or better

UoR

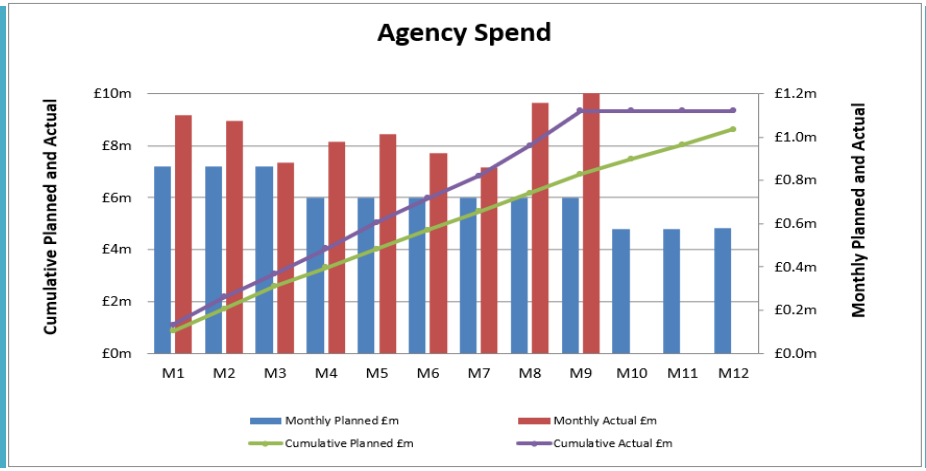
The Use of Resources Rating is not currently being reported. The Trust is awaiting further guidance from NHSE/I.

Use of Resources Rating
Red: Use of Resource Rating 4
Amber: Use of Resource Rating 3
Green: Use of Resource Rating 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
System Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR116)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR **The actual agency spend in month is £1.3m.**		**The year to date spend of £9.3m is £2.4m above the plan the year to date plan of £6.9m. £2.0m of year to date expenditure relates to COVID-19.**	**The Trust continues to monitor and report the use and spend on agency as well as the use of efficient models to reduce costs.**

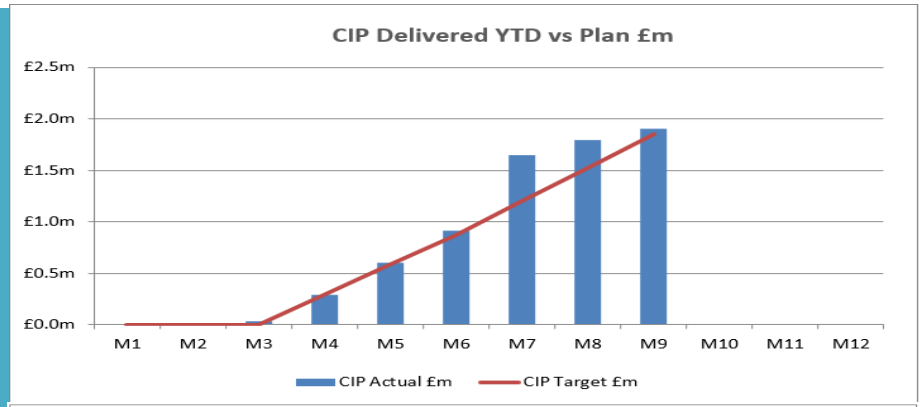
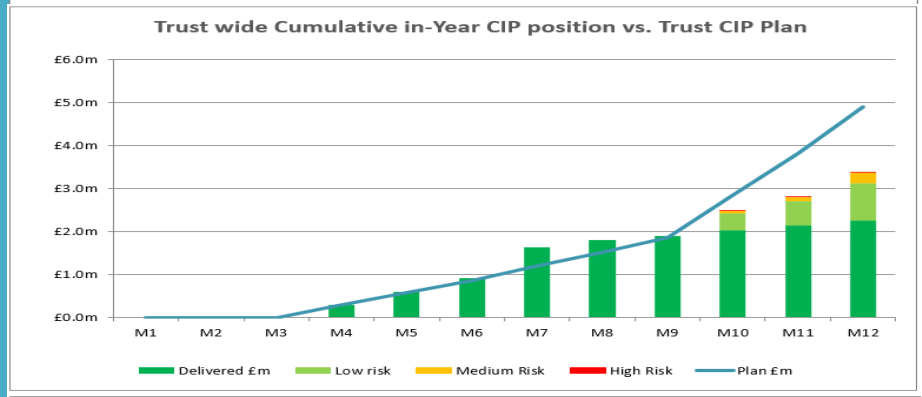
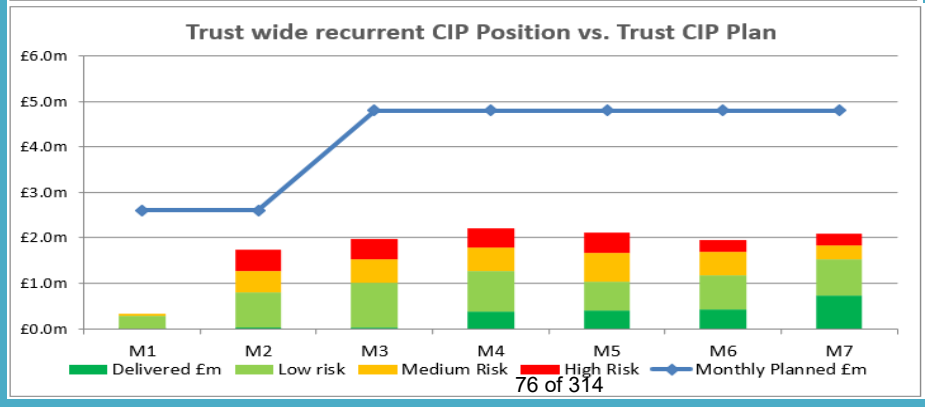
Agency Spending

Red: More than 105% of ceiling
Amber: Over 100% but below 105% of ceiling
Green: Equal to or less than agency ceiling.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
System Oversight Framework (SOF) | Use of Resources Assessment (UoR) | Risk Register (RR116) | Care Quality Commission (CQC) | Trust Strategy (S)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR **The year to date savings are £1.9m**		**The year to date savings are £1.9m against a plan of £1.85m.**	**CIP progress is reviewed on a weekly and monthly basis. Where possible, the Trust seeks to accelerate schemes and is reviewing additional areas to support further cost reductions.**
UoR **The current forecast based on recurrent schemes identified is £1.7m, against a plan of £4.9m.**		**There was no CIP target in Q1 2021/22. The Trust has a target of £4.9m for the year and schemes are being developed with CBU and Corporate Services to deliver the CIP. There is risk going into Q4 as £1.5m of schemes are yet to be identified.**	**To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT is being used. Further work to increase identification of CIP schemes continues across the Trust.**
UoR			

Cost Improvement Programme - In year performance to date
Red: 0-70% Plan delivered YTD
Amber: 70-90% Plan delivered YTD
Green: >90% Plan delivered YTD

Cost Improvement Programme - Plans in Progress - In Year
Red: Forecast is less than 50% of annual target
Amber: Forecast is between 50% and 90% of the annual target
Green: Forecast is more than 90% of the annual target

Cost Improvement Programme - Plans in Progress - Recurrent
Red: Forecast is less than 50% of annual target
Amber: Forecast is between 50% and 90% of the annual target
Green: Forecast is more than 90% of the annual target

Appendix 3 – Trust IPR Indicator Overview

Indicator	Detail
Quality	
Incidents	Number of Serious Incidents and Never Events reported by the Trust. Number of Serious Incident actions breached. Number of open incidents is the total number of incidents that we have awaiting review.
Duty of Candour	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days. Duty of Candour must be completed within 10 working days.
Healthcare Acquired Infections (MRSA, CDI and Gram Negative)	Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to meticillin are termed meticillin susceptible Staphylococcus aureus (MSSA). MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. Clostridium difficule (c-diff) due to lapses in care; agreed threshold is <=44 cases per year. Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections. A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2024.
Healthcare Acquired Infections COVID-19 Hospital Onset and Outbreaks	Measurement of COVID-19 infections onset between 8-14 days and 15+ days of admission. Measurement of outbreaks on wards (2 or more probably or confirmed cases reported on a ward over a 14 day period).
VTE Assessment	Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month.
Total Falls & Harm Levels	Total number of falls per month and their relevant harm levels. This indicator shows total number of falls which occur in the hospital (including staff and public falls) and total number of inpatients falls
Pressure Ulcers	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.
Medication Safety	Overview of the current position in relation to medication, to include; medication reconciliation (overall and within 24 hours of admission), controlled drugs incidents and medication incidents relating to harm.
Staffing Average Fill Levels	Percentage of planned verses actual for registered and non-registered staff by day and night. Target of >90%. The data produced excludes CCU, ITU and Paediatrics.
Care Hours Per Patient Day (CHPPD)	Staffing Care Hours per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
HSMR Mortality Ratio	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.
SHMI Mortality Ratio	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following

	hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
NICE Compliance	The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world.
Complaints	Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe.
Friends and Family Test (Inpatient & Day Cases)	Percentage of Inpatients and day case patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?
Friends and Family (ED and UCC)	Percentage of AED (Accident and Emergency Department) patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?
Continuity of Carer	Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives. This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience.
Sepsis	To strengthen oversight of sepsis management in regard to treatment and screening all patients should be screened within 1 hour and if necessary administered anti-biotics within 1 hour. The target is 90%.
Ward Moves Between 10pm and 6am	Root Cause Analysis findings in relation to serious incidents has shown that patients who are transferred at night are more susceptible to a longer length of stay. It is also best practice not to move patients between 10:00pm and 06:00am unless there is a clear clinical need as research shows restful sleep aids recovery.
Access & Performance	
Diagnostic Waiting Times – 6 weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks.
RTT Open Pathways and 52 week waits	Percentage of incomplete pathways waiting within 18 weeks. The national target is 92%.
Four hour A&E Target and STP Trajectory	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95%
A&E Waiting Times Over 12 Hours (Decision to Admit to Admission)	The number of patients who has experienced a wait in A&E longer than 12 hours from the decision to admit the patient to the patient being admitted as an inpatient to hospital.
Cancer 14 Days	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%.

Breast Symptoms – 14 Days	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%.
Cancer – 28 Day Faster Diagnostic Standard	All patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis. The national target is 75%.
Cancer 31 Days - First Treatment	All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%.
Cancer 31 Days - Subsequent Surgery	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%.
Cancer 31 Days - Subsequent Drug	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%.
Cancer 62 Days - Urgent	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory.
Cancer 62 Days – Screening	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%.
Ambulance Handovers 30 – 60 minutes	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system).
Ambulance Handovers – more than 60 minutes	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system).
Discharge Summaries – Sent within 24 hours	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patient's discharge. This metric relates to Inpatient Discharges only.
Discharge Summaries – Not sent within 7 days	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patient's discharge.
Cancelled operations on the day for non-clinical reasons	% of operations cancelled on the day or after admission for non-clinical reasons.
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
Urgent Operations – Cancelled for a 2nd Time	Number of urgent operations which have been cancelled for a 2nd time.
Super Stranded Patients	Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.
COVID-19 Recovery Elective Activity	% of Elective Activity (Inpatients & Day Cases) against the same period in 2019/20, monitored as part of 2021/22 Operational Planning Guidance.
COVID-19 Recovery Diagnostics	% of Diagnostic Activity against the same period in 2019/20, monitored as part of 2021/22 Operational Planning Guidance.
COVID-19 Recovery Outpatients	% of Outpatient Activity against the same period in 2019/20 monitored as part of 2021/22 Operational Planning Guidance.

Fracture Clinic	The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.
% Outpatient Attendances Delivered Remotely	Part of the transformation of outpatient care, this indicator will monitor the % of outpatient appointments delivered remotely via telephone or video consultation.
Workforce	
Sickness Absence	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and peer average.
Return to Work	A review of the completed monthly return to work interviews.
Recruitment	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks.
Vacancy Rates	% of Trust vacancies against whole time equivalent.
Retention	Staff retention rate % over the last 12 months.
Turnover	A review of the turnover percentage over the last 12 months.
Bank & Agency Reliance	The Trust reliance on bank/agency staff against the peer average.
Agency Shifts Compliant with the Price Cap	% of agency shifts compliant with the Trust cap against peer average.
Agency Rate Card Compliance	% of agency shifts which comply with the Cheshire & Mersey rate card.
Pay Spend – Contracted and Non-Contracted	A review of Contracted and Non-Contacted pay against budget.
Core/Mandatory Training	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation.
Role Specific Training	A summary of role specific training compliance.
Safeguarding Training	A summary of safeguarding training compliance.
Use of Apprenticeship Levy	% of the apprenticeship levy being utilised.
Workforce carrying out an Apprenticeship Qualification	% of the workforce carrying out an apprenticeship qualification.
Performance & Development Review (PDR)	A summary of the PDR compliance rate.
Finance	
Trust Financial Position	The Trust operating surplus or deficit compared to plan.
System Financial Position	The system operating surplus or deficit compared to plan.
Cash Balance	The cash balance at month end compared to plan (excluding cash relating to the hosting of the Sustainability and Transformation Partnership).
Capital Programme	Capital expenditure compared to plan (The capital plan has been increased to £10.2m as a result of additional funding from the Department of Health, Health Education England for equipment and building enhancements).
Better Payment Practice Code	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
Use of Resources Rating	Use of Resources Rating compared to plan.
Agency Spending	Agency spend compared to agency ceiling.
Cost Improvement Programme – In Year Performance	Cost savings schemes deliver Year to Date (YTD) compared to plan.

Cost Improvement Programme – Plans in Progress (In Year)	Cost savings schemes in-year compared to plan.
Cost Improvement Programme – Plans in Progress (Recurrent)	Cost savings schemes recurrent compared to plan.

Appendix 4 - Statistical Process Control

What is SPC?

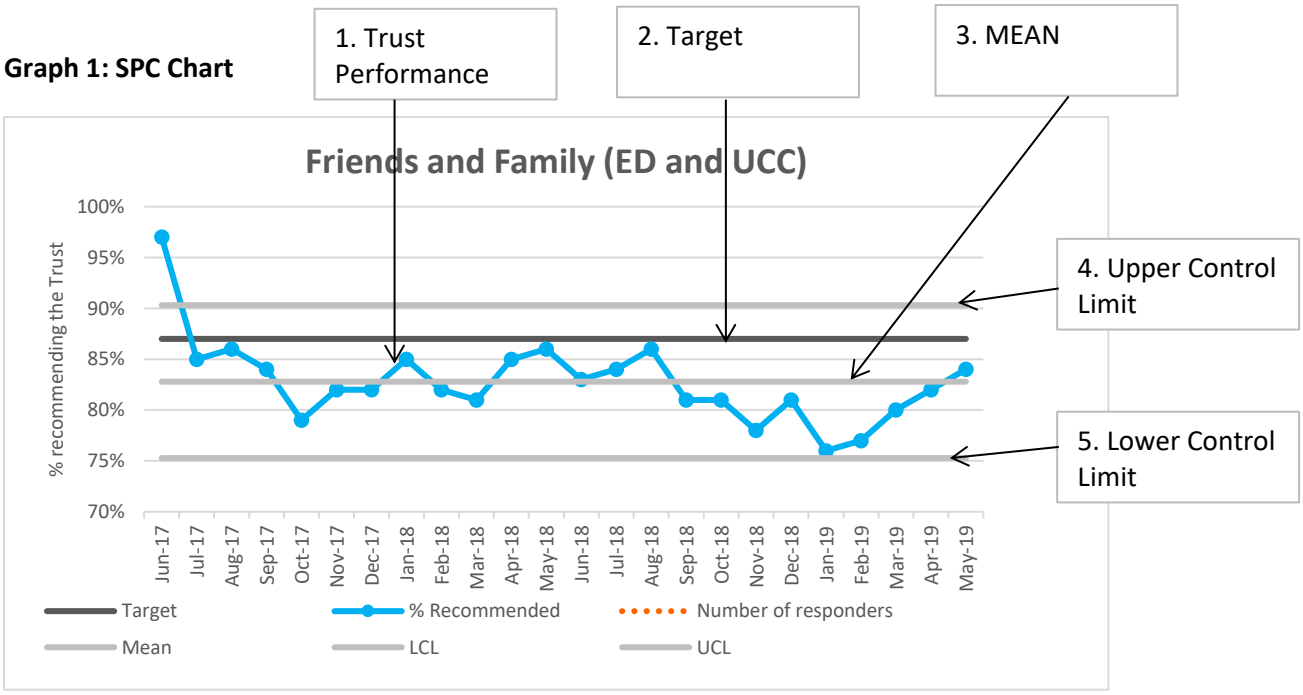
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes and both common cause (normal) and special cause (unexpected) variation.

SPC Charts

In addition to the process/metric being measured, SPC charts on the IPR have 3 additional lines.

- Mean – is the average of all the data points on the graph. This is used a basis for determining statistically significant trend or pattern.
- Upper Control Limit – the upper limit that any data point should statistically reach within expected variation. If any one datapoint breaches this line, this is what is known as special cause variation.
- Lower Control Limit – the lower limit than any data point should statistically reach within expected variation. If any one datapoint breaches this line, this is what is known as special cause variation.

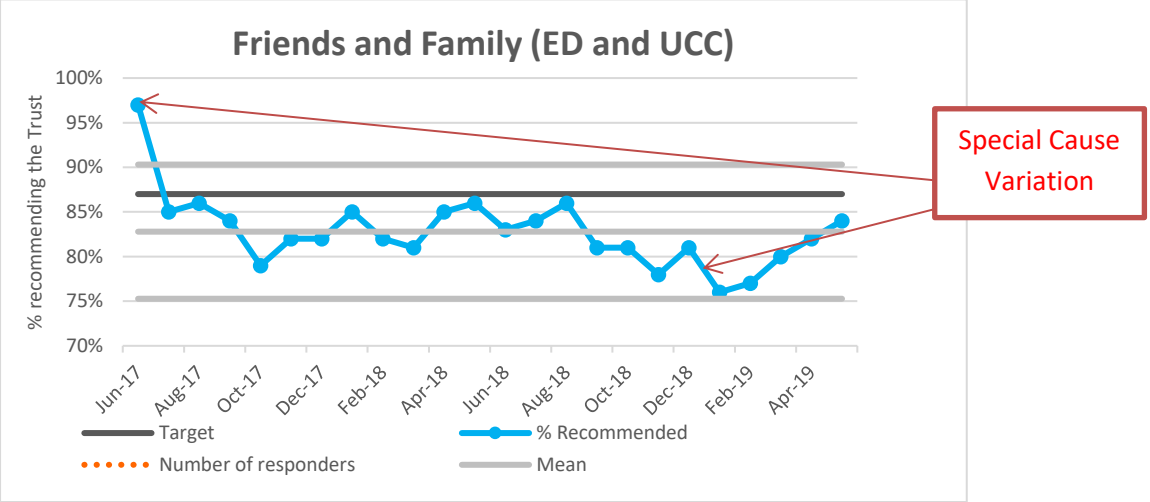
Graph 1: SPC Chart



Interpreting a SPC Chart

There are 3 main rules to interpreting a SPC chart, if one of these rules is broken, there special cause variation present and this means the process is not in control and requires investigation. Please note that breaching the rules does not necessarily mean the process needs to be changed immediately, but it does need to be investigated to understand the reasons for the variation.

1. All data points should be within the upper and lower control limits.
2. No more than 6 consecutive data points are above or below the mean line.
3. There are more than 5 consecutive points either increasing or decreasing.



In the example above, there are two instances of special cause variation; in June 2017 the data point was outside of the upper control limit. Between September 2018 and April 2019, the data points all fall below the mean line.

For high targets (e.g. above 90%) if the upper control limit is below the target, it's unlikely the Trust will achieve the target using the current process.

For low targets (e.g. below 10%) if the lower control total is above the target, it's unlikely the Trust will achieve the target using the current process.

For the purposes of the Trust IPR, the RAG ratings (Red, Amber, Green) will be maintained to understand the Trusts current performance against the outlined targets. SPC should be considered side by side with the RAG rating as it's possible for a process to be within control but not meeting the target.

Appendix 5

Income Statement, Activity Summary and Use of Resources Ratings as at 31st December 2021

Income Statement	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income						
NHS Clinical Income						
Elective Spells	2,543	2,680	138	23,006	20,988	-2,018
Elective Excess Bed Days	13	16	3	116	72	-44
Non Elective Spells	5,334	5,306	-28	53,219	51,632	-1,587
Non Elective Bed Days	179	238	59	1,609	1,373	-236
Non Elective Excess Bed Days	152	245	93	1,348	863	-485
Outpatient Attendances	3,147	3,236	89	28,472	29,092	619
Accident & Emergency Attendances	1,431	1,301	-130	12,722	14,199	1,477
Other Activity	3,497	7,615	4,119	52,221	57,983	5,762
COVID Top up Income (Liverpool CCG)	8,322	4,288	-4,034	42,474	43,610	1,135
Sub total	**24,617**	**24,925**	**308**	**215,188**	**219,812**	**4,624**
Non NHS Clinical Income						
Private Patients	0	2	2	0	225	225
Non NHS Overseas Patients	2	0	-2	23	8	-14
Other non protected	81	73	-8	727	516	-211
Sub total	**82**	**75**	**-7**	**750**	**749**	**0**
Other Operating Income						
Training & Education	683	844	161	6,143	6,304	161
Donations and Grants	0	-32	-32	0	100	100
Miscellaneous Income	1,430	1,320	-111	10,846	11,073	227
Sub total	**2,113**	**2,131**	**18**	**16,988**	**17,476**	**488**
Total Operating Income	**26,812**	**27,131**	**319**	**232,926**	**238,038**	**5,112**
Operating Expenses						
Employee Benefit Expenses	-19,376	-19,195	182	-167,595	-170,660	-3,065
Drugs	-1,558	-1,680	-122	-11,976	-13,962	-1,985
Clinical Supplies and Services	-1,929	-2,393	-464	-16,830	-17,126	-296
Non Clinical Supplies	-2,919	-2,968	-50	-26,357	-27,281	-925
Depreciation and Amortisation	-836	-931	-95	-7,993	-6,950	1,044
Net Impairments (DEL)	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0
Total Operating Expenses	**-26,619**	**-27,167**	**-548**	**-230,752**	**-235,978**	**-5,227**
Operating Surplus / (Deficit)	**194**	**-35**	**-229**	**2,174**	**2,059**	**-115**
Non Operating Income and Expenses						
Profit / (Loss) on disposal of assets (Excl COVID DHSC)	0	26	26	0	66	66
Loss on disposal of COVID Assets to DHSC	0	0	0	0	-149	-149
Interest Income	0	0	0	0	0	0
Interest Expenses	0	0	0	0	0	0
PDC Dividends	-341	-396	-55	-3,703	-3,563	140
Total Non Operating Income and Expenses	**-341**	**-370**	**-30**	**-3,703**	**-3,646**	**57**
Surplus / (Deficit) - as per Accounts	**-147**	**-406**	**-259**	**-1,529**	**-1,587**	**-58**
Adjustments to Financial Performance						
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0	0	0
Less Donations & Grants Income	0	32	32	0	-100	-100
Remove loss recognised on return of COVID assets to DHSC	0	0	0	0	149	149
Add Depreciation on Donated & Granted Assets	19	19	0	152	166	14
Total Adjustments to Financial Performance	**19**	**51**	**32**	**152**	**215**	**64**
Adjusted Surplus / (Deficit) as per NHSI Return	**-128**	**-355**	**-226**	**-1,377**	**-1,371**	**6**

Activity Summary	Planned	Actual	Variance	Planned	Actual	Variance
Elective Spells	265	2,120	1,855	21,233	20,628	-605
Elective Excess Bed Days	47	0	-47	425	241	-184
Non Elective Spells	2,486	2,481	-5	24,735	22,956	-1,779
Non Elective Bed Days	498	318	-180	4,483	3,826	-657
Non Elective Excess Bed Days	562	7	-555	4,985	3,189	-1,796
Outpatient Attendances (PBR Only)	34,789	33,404	-1,385	290,328	334,065	43,737
Accident & Emergency Attendances	10,542	9,276	-1,266	90,653	92,779	2,126

Appendix 6

PERIOD ENDING 31 DECEMBER 2021

Scheme Name	Approved Programme 2021/22 £000	Budget Amendments Mths 1-8 2021/22 £000	Budget Adjustments in Mth 09 2021/22 £000	PDC Adjustments in Mth 09 2021/22 £000	Total Revised Budget 2021/22 £000
ESTATES					
Estates Underspends	0				**0**
Essential power installation - Halton Pharmacy	9		(9)		**0**
Substation B at Warrington Replace 2no. Air Circuit Breakers and 1no. HV Ring Main Unit	200	(200)			**0**
Fire - Relocate and replace medical gas AVSU's to clinical wards	20				**20**
Backlog - Croft Wing Electrical remedial works following fixed electrical testing of clinical areas	30		(26)		**4**
Backlog - Provide safe surface temperatures of radiators in patient clinical areas	10				**10**
Backlog - North Lodge Basement Electrical Installation Replacement	225				**225**
Backlog - Fire install of fire dampers 2nd phase	100	(100)			**0**
Backlog - Catering Department remove or replace roof lantern	30		(30)		**0**
Fire - Replacement of obsolete 5000 series fire alarm panels and end of line devices	600	(100)			**500**
Estates Capital Staffing for Design Team Works	177	28			**205**
Fire - Halton 30 minute Fire Compartmentation (Phase 2)	150	578			**728**
Appleton Wing Circulation Areas Fire Doors	200	(200)			**0**
Warrington and Halton Gas Meter Replacement	141		(100)		**41**
Backlog - All areas fixed installation wiring testing	100	(100)			**0**
6 Facet survey annual update	55				**55**
Backlog - Water Safety Compliance	1				**1**
Backlog - Annual Asbestos Management & Remedial	30				**30**
Backlog - HV (High Voltage) Maintenance annual	40				**40**
CMTC Replacement Emergency Lighting	150	(78)			**72**
Induction Bay	22		(20)		**2**
ED Plaza (Figure shown in full as per NHSE/I return however it is agreed £2.8m is brokered into 2022/23)	0	6,303			**6,303**
Paeds (Childrens Outpatients)	700	149			**849**
ICU/B18	1,000	(184)			**816**
Shopping City	380	465			**845**
Warrington Town Hub	100				**100**
Sub A Statix Fire Protection	50				**50**
Backlog - Flooring Replacement Works	150				**150**
Urology	0	884			**884**
Other	441	(441)			**0**
ANC Clinic Doors	0	10			**10**
Breast Unit Relocation	1,200				**1,200**
MRI Estates	908				**908**
Modular Building	258	30			**288**
Finance & Comm Development Refurb	42	(35)	(7)		**0**
Appleton Wing Roofing	43				**43**
Thelwall House Lift	31		(31)		**0**
Governance Flooring	33				**33**
Halton Endo Ventilation	0	81			**81**
North Lodge Basement Fire Compartment	0	6			**6**
Pharmacy Fire Doors	0				**0**
Water Tanks	0	3			**3**
Kendrick Wing Fire	0	22			**22**
Warr Hospital Site Appraisal	0	14			**14**
Mortuary	0	8			**8**
Lab Air Con - Ha	0	8			**8**
Nurse Call System -ANDU	0	25			**25**
Emergency Generator Repair - Nightingale	0	24			**24**
Damper Power Supply - Burtonwood	0	9			**9**
Backlog - Water Safety Compliance	50				**50**
New Hospital Project	0	96			**96**
Clinical Skills Conservatory Corridor	0	30			**30**
Electrical Infrastructure	0	200			**200**
Backlog - Replace Obsolete Nurse Call Systems Ph 1		50	(50)		**0**
CT Room Ha Upgrade - Now Externally Funded		90	(90)	143	**143**
MaxilloFacial 3rd Surgery		60			**60**
Decontamination Shelter		21			**21**
Main Kitchen Boiler		9			**9**
Histopathology AFOS Downdraft tables		7			**7**
Orthopedic Doors		11			**11**

Appendix 6

NW Imaging Academy Radiology Estates - External Funding			0	29	**29**
Estates Total	**7,676**	**7,783**	**-363**	**172**	**15,268**
IM&T					
IT Underspends	0				**0**
IT Staffing	316				**316**
New Maternity system integration to Lorenzo	132				**132**
New Maternity system	100				**100**
005 Cisco Refresh (Phase 1)	192				**192**
006 Comms Cabinets (Phase 2) x 2 (one each site)	90				**90**
007 IP Telephony	65				**65**
012 UPS - Main Server Room at Warrington	190				**190**
013 Data Warehouse Infrastructure Refresh	85				**85**
014 Device Replacement (Tech Refresh)	55	0			**55**
EPMA 1-4	24				**24**
Health & Wellbeing Workplace	13	(13)			**0**
Phase 2 Structure - Digital Project Management and Benefits Management resource	165				**165**
Lorenzo Theatres Licences	218				**218**
Chief Nurse Information Post	31				**31**
Electronic Patient Record Procurement	243				**243**
SAN	240				**240**
IT Other	0	2			**2**
Audiology Auditbase	0	1			**1**
Lease 4000	0				**0**
008 Network Switch Expansion	23				**23**
NW Imaging Academy Radiology IT - External Funding			0	8	**8**
Digital Maternity Fund - External Funding			0		**0**
Patient Flow - Tif Funding			0	260	**260**
Network Switches - External Funding			0	249	**249**
Information Technology Total	**2,182**	**-10**	**0**	**517**	**2,689**
MEDICAL EQUIPMENT					
Medical Underspends	0				**0**
Call Alarms for Anaesthetic & Recovery Rooms Halton	90	23			**113**
Cardiac Catheterisation Suite	800	(150)			**650**
Radiology - Fluoroscopy Room	300		54		**354**
Breast Relocation Equipment	216	(216)			**0**
MRI Patient Monitor	58				**58**
ECG Machines	27				**27**
CTG Machines	41				**41**
Radiology Ultrasound Transducer	2				**2**
Paediatric Resusitaire	11				**11**
Blood Bank Fridge	0	2			**2**
Pharmacy Fridge	0	6			**6**
Radiology Detector	0	38			**38**
Osmosis x 1 & Dialysis Machine x 2	0	0			**0**
Image Intensifier		80			**80**
Ultrasound Machine		105			**105**
Ophthalmic Microscope		126			**126**
Operating Tables		61			**61**
Dexa Scanner Turnkey		125			**125**
Heidelberg Anterion		60			**60**
Tazocin Fridge - 65547		12			**12**
Microtome and Slide Writers - Pathology		51			**51**
Resuscitaires for Birth Suite		57			**57**
Shoulder Table		14			**14**
DHSC Donated Equipment		132	(32)		**100**
Urology Equipment		200			**200**
Video Laryngoscope		13			**13**
MRI Coil		8			**8**
Medical Equipment Total	**1,545**	**747**	**22**	**0**	**2,314**
Total Trust Funded Capital	**11,403**	**8,520**	**-341**	**689**	**20,271**
CONTINGENCY					
Prior Year Adjustments (VAT Rebates)	0				**0**
Reserves Contingency	1,304	(1,304)			**0**
Contingency	963	(789)	309		**483**
Accruals to be netted off from peer review		(395)			**(395)**
Contingency Total	**2,267**	(2,488)	309	0	**88**
Grand Total	**13,670**	**6,032**	**-32**	**689**	**20,359**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/07 a i**	
SUBJECT:	**Safe Staffing Assurance Report – October and November 2021**	
DATE OF MEETING:	26th January 2022	
AUTHOR(S):	Ellis Clarke, Lead Nurse for Nurse Staffing & Workforce Improvement	
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)***	#115 Failure to provide adequate staffing levels in some specialities and wards.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper details ward staffing data for the months of October and November 2021. Ward staffing data continues to be systematically reviewed to ensure the wards and departments are safe. Mitigation was provided and associated actions put in place when a ward was below 90% of planned staffing levels. Registered nurse and midwife sickness absence in the month of October was recorded at 6.16%. Sickness data in November details a decrease to 6.08%. In the months of October and November, it was noted that 12 of the 21 wards were above the 90% target during the day. 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 was 7.6 and 7.3 in November, with a year to date rate 7.7. This maintains a level of improvement over the last 6 months. This report provides assurance that the Trust is safely staffed and staffing is monitored as appropriate. The report does not cover the analysis of spend and staffing cost.	

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

RECOMMENDATION:	Trust Board asked to receive the contents of this report as discussed and received at the Strategic People Committee.	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Strategic People Committee**
	Agenda Ref.	SPC/22/01/02
	Date of meeting	19th January 2022

	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	Safe Staffing Assurance Report – October and November 2021	AGENDA REF:	BM/21/

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report – October and November 2021.

The purpose of this report is to provide assurance with regard to the nursing and midwifery ward staffing levels during the months of October and November 2021. The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 and in their recommendations in 2018, that Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability.

This paper provides assurance that any shortfalls on each shift are reviewed and addressed, with actions to ensure safe staffing levels are provided and reviewed at the daily staffing meeting. It is well documented that nurse staffing levels make a difference to patient outcomes (mortality and adverse events, including levels of harm), patient experience, quality of care and the efficiency of care delivery.

2. KEY ELEMENTS

All Trusts are required to submit staffing data to NHS England via the Unify Safe Staffing return and provide assurance to the Board of Directors via the Chief Nurse and Deputy Chief Executive.

During the months of October and November 2021 ward staffing data continued to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels.

The safer staffing data consists of the 'actual' numbers of hours worked by registered nursing and health care support staff on a shift by shift basis, measured against the numbers of 'planned' hours to calculate a monthly fill rate for nights and days by each ward. A monthly fill rate of 90% and over is considered acceptable nationally and within the Trust and when fill rates are below 90% the ward staffing is reviewed at the daily staffing meeting taking into account acuity and activity and where necessary staff are moved from other areas to support.

Care Hours Per Patient Day (CHPPD)

The senior nursing team currently collects and reports CHPPD data on a monthly basis. CHPPD is the total time spent on direct patient care based on the number of occupied beds at midnight. The October and November 2021 Trust wide staffing data was analysed and cross-referenced, with ward level data for validation by the Deputy Chief Nurse and Lead Nurses.

Table 1 illustrates the monthly CHPPD data. In the month of October CHPPD was recorded at 7.6 and November recorded at 7.3 with a 2021/22 YTD figure of 7.7.

The monthly CHPPD will continue to be monitored via the Trust monthly Safer Staffing Report.

Table 1 – CHPPD Data 2020/21

Finyear	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2021/22	Apr	13769	4.4	3.3	7.7
	May	13645	4.6	3.5	8.1
	Jun	13134	4.5	3.4	7.9
	Jul	13964	4.4	3.3	7.6
	Aug	13479	4.7	3.3	8.0
	Sep	13428	4.5	3.3	7.8
	Oct	14131	4.5	3.1	7.6
	Nov	14726	4.3	3.0	7.3
2021/22 Total		110276	4.5	3.3	7.7

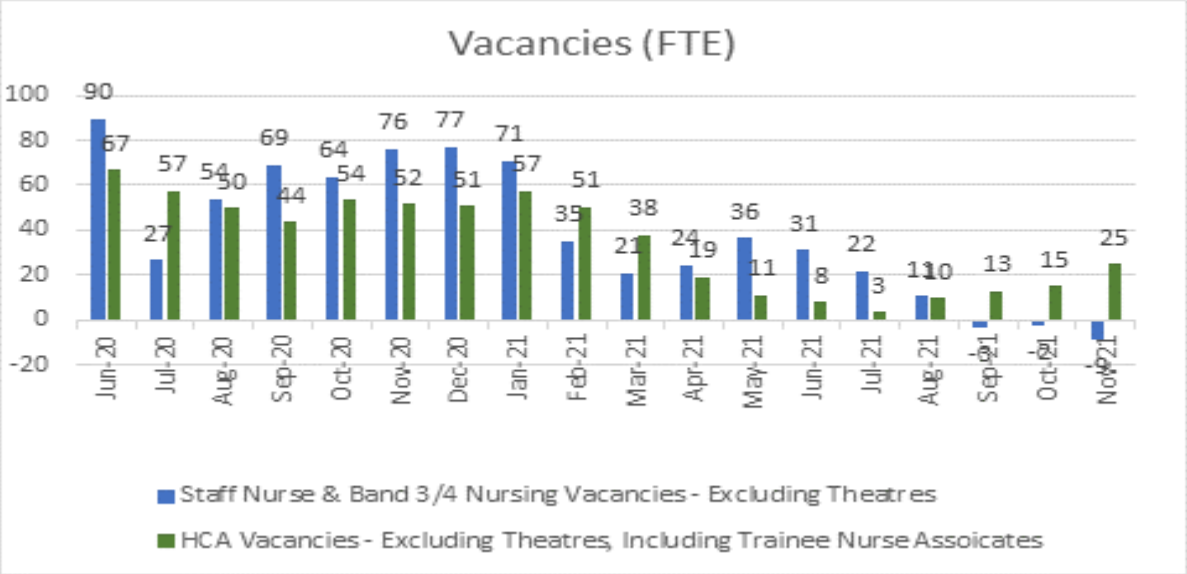
Key Messages

In the month of October and November, it was noted that 12 of the 21 wards were above the 90% target during the day. In order to ensure safe staffing levels, mitigation and responsive plans were implemented daily to ensure that the safe delivery of patient care. Staffing is reviewed twice daily by the senior nursing team and staff are moved based on acuity and activity to ensure safe patient care at all times.

Maternity (ward C23) was 81% in October which was lower than previous months. In November though C23 reported 78% planned versus actual. Ward C23 use their responsive staffing plans in the unit to move staff to support if acuity requires additional staffing.

Vacancy Summary

In October 2021 the Trust had 1- registered nurse and 15 health care assistant vacancies at WHH, which required reliance on temporary staffing to ensure safe staffing levels on the wards. In November vacancy levels were -9 registered nurse and 25 health care assistant vacancies.



Recruitment and retention continue to be priorities for the senior nursing team. Whilst it is important to recognise the achievement of full establishment of registered nurses, the Trust has escalated capacity in ICU, on wards K25 and B3, as well 24 hour nursing coverage of areas in ED as a result of winter pressure during the pandemic.

There will be revised ward budgets in unplanned care in December, so the vacancy figure will change.

Recruiting to HCA vacancies has previously been a challenge. However, the Trust received funding from NHSI to enhance HCA recruitment and pastoral support in the clinical areas. There are 25 vacancies in November, recruitment to these posts is in progress. This is in part due to recognition of the increased number of beds in the IMC CBU. Recruitment has recommenced using the model successful during the accelerated programme in March 2021. WHH has been awarded funding to support further accelerated recruitment and pastoral support to retain staff in post.

Following the success of October's recruitment day for ED staff, a second day is planned for the end of January. This time as well as ED, there will be recruitment for the Acute Respiratory Unit on B18 as well as stands for Maternity and AHPs

WHH is taking part in the recruitment of refugee nurses from the Middle East. The Trust has committed to take on 5 nurses who are expected to go to ICU, B18, A9 and a surgical ward.

Escalation Beds and Costs

In the months of October and November 2021 ward B3 has been open for medically fit patients, the ward is managed by the Unplanned Care Group. Staff are moved from other wards and augmented by temporary staff.

In October K25 was opened as a winter escalation ward. This ward on the Warrington site will mirror the service at Halton on B3 and will be staffed in the same way. A ward manager has been recruited on an interim basis; he is supported by staff relocated from other wards augmented by temporary staff from NHS Professionals.

Off Framework Agency Usage

The Trust continues to manage its bed occupancy and staffing in a responsive and planned way. The use of off framework agency nurses has been minimised. In response to surges in critical care it has been necessary to employ off framework staff who have the required ICU experience. Strict controls are in place and authorisation from the Chief Nurse/DCEO is required. All usage is tracked by the e-rostering team.

Sickness Absence – October & November 2021

Registered nurse and midwife sickness absence in the month of October was recorded at 6.16% showing a slight increase from the August/September report which was recorded at 5.83%. Sickness data in November details a decrease to 6.08%. The cost of bank/agency cover of qualified nursing sickness (at usual bank/agency fill rates) is £240,374 in October and £271,376 for November as detailed in the tables 4 and 5 below.

Table 4 - Registered nurse and midwifery sickness cover – October 2021

	Oct-21
Contracted Nursing WTE (Band 5 to 7)	989.44
% Sickness	6.16%
WTE Equivalent of Sickness	60.95
NHSP Fill Rate	76%
WTE Covered by Temporary Staffing	46.32
Cost at Average NHSP Rates	***249,374***

Table 5 - Registered nurse and midwifery sickness cover – November 2021

	Nov-21
Contracted Nursing WTE (Band 5 to 7)	994.11
% Sickness	6.08%
WTE Equivalent of Sickness	60.44
NHSP Fill Rate	83%
WTE Covered by Temporary Staffing	50.41
Cost at Average NHSP Rates	***271,376***

Staffing levels are reviewed daily to determine the additional staffing required ensuring patient safety as part of the daily operational staffing plans.

Maternity Staffing

- Maternity staffing levels is challenged by increased and unprecedented absence of midwifery workforce due to COVID19 and the Omicron variant.
- Due to the everchanging fluidity and acuity of maternity and neonatal services we do have a set established number of staff who are required to maintain safe care however a reduction in staff may not necessarily lead to maternity or neonatal services being diverted. Maternity services are escalated in accordance with the Cheshire and Mersey Escalation and Divert Policy (2021)
- Staffing is reviewed daily as a minimum and reported locally and regionally at the Cheshire and Mersey Gold command meeting. The Region is under extreme pressure re maternity and neonatal capacity. Where possible each maternity provider within Cheshire and Mersey will offer mutual aid to prevent units going in to divert. This also reduces the likelihood of women being diverted out of region.
- Due to the current staffing pressures within community services the Home Birth Service was suspended on 4th January and is being reviewed weekly.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Following the decision to raise the level of emergency preparedness in the NHS to 4, the Trust has been updating the nurse staffing plans. WHH has seen a significant increase in sickness absence in December and January due to the Omicron variant.

Action: Nurse staffing plan for impact of Omicron variant of COVID-19 – Responsible officer – Deputy Chief Nurse, Ali Kennah and Lead Nurse for Nurse Staffing, Ellis Clarke.

4. RECOMMENDATIONS

The Trust Board is asked to note the content of the report previously discussed at the Strategic People Committee

Appendix 1

Monthly Safe Staffing Data – October 2021																			
		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1782.5	1575.5	1426.0	1357.0	88%	95%	1426.0	1391.5	1426.0	1092.5	98%	77%	1017	2.9	2.4	0.1	0.0	5.4
DD	Ward A5 G	1069.5	851.0	1069.5	977.5	80%	91%	713.0	713.0	1069.5	885.5	100%	83%	620	2.5	3.0	0.3	0.0	5.9
DD	Ward A5 E	690.0	690.0	690.0	689.0	100%	100%	713.0	713.0	690.0	310.5	100%	45%	234	6.0	4.3	0.0	0.0	10.3
MSK	Ward A6	1782.5	1644.5	1782.5	1449.0	92%	81%	1069.5	1207.5	1782.5	1460.5	113%	82%	1049	2.7	2.8	0.0	0.0	5.5
MSK	CMTC	1069.5	1357.0	713.0	862.5	127%	121%	713.0	713.0	713.0	414.0	100%	58%	340	6.1	3.8	0.0	0.0	9.8
W&C	C20	1069.5	834.8	816.0	1094.0	78%	134%	716.5	716.5	0.0	0.0	100%	NA	169	9.2	6.5	0.0	0.0	15.7
W&C	Ward C23	1380.0	1115.5	690.0	552.0	81%	80%	690.0	517.5	690.0	575.0	75%	83%	550	3.0	2.0	0.0	0.0	5.0
W&C	Birth Suite	2139.0	1989.5	356.5	253.0	93%	71%	2139.0	1955.0	356.5	276.0	91%	77%	302	13.1	1.8	0.0	0.0	14.8
W&C	The Nest	356.5	379.5	356.5	230.0	106%	65%	356.5	345.0	356.5	218.5	97%	61%	9	80.5	49.8	0.0	0.0	130.3
W&C	Ward B11	3063.2	2717.5	1042.5	950.0	89%	91%	1608.8	1681.6	322.4	312.9	105%	97%	379	11.6	3.3	0.6	0.4	16.0
W&C	NNU	1782.5	1363.5	356.5	161.0	76%	45%	1782.5	1173.0	356.5	322.0	66%	90%	380	6.7	1.3	0.0	0.0	7.9
UEC	Ward A1	2293.8	2252.4	2175.2	1921.7	98%	88%	1652.5	1615.8	1324.4	1007.2	98%	76%	853	4.5	3.4	0.0	0.0	8.0
UEC	Ward A2	1710.5	1450.0	1906.7	1511.3	85%	79%	1004.0	1039.9	996.3	755.7	104%	76%	800	3.1	2.8	0.0	0.0	5.9
UEC	ED	6250.4	6964.0	3196.7	2192.4	111%	69%	4505.3	5405.0	1891.7	1804.6	120%	95%						
MC	ACCU	2495.5	2243.0	1069.5	989.0	90%	92%	1782.5	1752.0	1069.5	1046.5	98%	98%	825	4.8	2.5	0.0	0.0	7.3
MC	ICU	4991.0	4858.8	1069.5	1023.5	97%	96%	4991.0	5301.5	713.0	828.0	106%	116%	569	17.9	3.3	0.0	0.0	21.1
MC	Ward A7	2403.5	1903.5	1426.0	1432.5	79%	100%	2024.0	1982.0	1368.5	1124.0	98%	82%	888	4.4	2.9	0.0	0.0	7.3
IM&C	Ward C21	1345.5	966.0	1426.0	1333.5	72%	94%	989.0	847.5	1345.5	1096.0	86%	81%	751	2.4	3.2	0.0	0.0	5.7
IM&C	Ward B14	1069.5	1058.0	1840.0	1533.0	99%	83%	713.0	713.0	1426.0	1242.0	100%	87%	744	2.4	3.7	0.0	0.0	6.1
IM&C	Ward B12	1069.5	1032.0	2495.5	2209.0	96%	89%	713.0	713.0	2012.5	1817.0	100%	90%	630	2.8	6.4	0.0	0.1	9.4
IM&C	Ward B19	1782.5	1387.5	1782.5	1426.0	78%	80%	1426.0	1127.0	1150.0	1196.0	79%	104%	984	2.6	2.7	0.0	0.0	5.2
IM&C	Ward A8	1546.0	1415.0	1525.7	1477.6	92%	97%	1426.0	1394.0	1066.2	990.0	98%	93%	1018	2.8	2.4	0.0	0.0	5.2
IM&C	Ward A9	1782.5	1571.5	1782.5	1713.5	88%	96%	1426.0	1472.0	1782.5	1518.0	103%	85%	1020	3.0	3.2	0.0	0.0	6.2
	Total	44924.9	41619.9	30994.68	27337.98	93%	88%	34580.06	34489.3	23908.91	20292.4	100%	85%	14131	4.5	3.1	0.0	0.0	7.7
		= above 100%			= above 90%			= above 80%			= below 80%								

We are WHH & We are PROUD to make a difference

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 2
October 2021 - Mitigating Actions

	MITIGATING ACTIONS
Ward A4	Vacancy - band 6 0.19 band 5 0.19 band 2 1.46 Sickness rate - short term 2.26% long term 8.41% Managed in line with policy. Action taken - Use of agency and NHSP to fill gaps . WM filling shortfalls in gaps also. Regular meetings with NHSP.
Ward A5 Gastro	Vacancy - nil Sickness rate -short term 5.32% long term 5.02% Action taken - Use of agency and NHSP to fill gaps . WM filling shortfalls in gaps also. Regular meetings with NHSP.
Ward A5 Elective	Vacancy - band 6 1.0 wte recruited to vacancy band 5 0.38wte band 2 2.33wte Sickness rate - short term 5.927% long term 4.33% Action taken - Use of agency and NHSP to fill gaps . WM filling shortfalls in gaps also. Regular meetings with NHSP.
Ward A6	Vacancy: band 2 = 3 WTE vacancies awaiting start dates and 2 WTE awaiting recruitment approval Sickness rate - 2.76% ST and 7.95 % Lt Action taken - recruitment for vacant posts, sickness abscence policy followed for all staff, occupational health referrals completed and advice sought from HR for complex cases
CMTC	Vacancy - band 3 housekeeper recruited to awaiting start date, ward clerk out to advert Sickness rate - 4.30% ST and 1.13 % Lt Action taken - recruitment for vacant posts, sickness abscence policy followed for all staff, occupational health referrals completed and advice sought from HR for complex cases
C20	Vacancy - 0 Sickness rate - 11.16% Action taken - OH & Wellbeing support in place in line with Trust Attendance Policy
Ward C23	Vacancy - 5.56% Sickness rate - 12. Action taken - Sickness manages through HR/OH. Recruitment to vacancies in progress
Birth Suite	Vacancy - 3.06% Sickness rate - 1.92WTE Action taken - managed with HR/OH
The Nest	Vacancy - 0% Sickness rate - 8.53% Action taken - LTS resumes to duty Nov 2021.
Ward B11	Vacancy - 2.4 WTE Band 5 Sickness rate -Mat leave 2 wte band 2 bamd 6, 2 wte LTS, Action taken - managed in line with Trust Policy
NNU	Vacancy - 1x Band 7 vacancy Sickness rate - 2x LTS Action taken - Managed in line with Trust attendance policy
Ward A1	Vacancy - 10.75% (sept) Band 6 x2.56 / Band 2 x 2.31 Ongoing Recruitment Sickness rate - 13.15% managed in line with policy Action taken - Ward Manager filling any staffing shortfalls, all shifts pushed out to NHSP. Twice daily staffing meetings. Staffing concerns escalated timely
Ward A2	Vacancy - Fully Established Sickness rate - 7.26% Managed in line with policy Action taken - Ward Manager filling any staffing shortfalls, all shifts pushed out to NHSP. Twice daily staffing meetings. Staffing concerns escalated timely
ED	Vacancy - 10.35% (Sept) Ongoing recruitment Sickness rate - 6.94% Managed in line with policy Action taken - Ward Manager/ Matrons filling any staffing shortfalls, all shifts pushed out to NHSP. Twice daily staffing meetings. Staffing concerns escalated timely.
ACCU	Vacancy - Band 6 - 0.76, band 5 - 0.88, band- 2 2.6 Sickness rate - 0.34% ST/ 2.28% LT = 2.62% Action taken - Recruitment in place to fill vacancies, Sickness managed in line with policy, shortfalls filled with NHSP and ward manager
ICU	Vacancy - 2.86% Sickness rate - 6.86% Action taken - Recent recruitment completed for RN's, HCA recruitment in progress. Well Being support and checks in place
Ward A7	Vacancy - Band 6 - 0.4, Band 5 - 11.26, Band 2 - 8.18 Sickness rate - No figures available Action taken - All sickness managed in line with policy, recruitment in progress to fill newly created posts from business case
Ward C21	Vacancy - Band 5 0 Band 2 0 Sickness rate - Action taken - sickness being managed as per policy
Ward B14	Vacancy - band 5 0 Band 2 2.0 wte Sickness rate -4.48% Action taken - sickness managed in line wih policy recuritment on going
Ward B12	Vacancy - Band 5 0 Sickness rate - 3.90% Action taken - sickness managed in line with policy and supported with OH and HR
Ward B19	Vacancy - Band 5 & band 2 2.0 wte Sickness rate - Action taken - sickness managed as per policy with HR & OH support
Ward A8	Vacancy - Band 2 2.0 wte Sickness rate - 11.68% Action taken - Recuritment ongoing CSWD in place to support vacancies sickness being managed as per policy with HR &OT support as required
Ward A9	Vacancy - band 5 4.0wte Sickness rate - 5.93% band 6 LTS maternity leave 2.0 wte Band 2 Action taken - sickness managed as per policy with HR and OH support

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 3

Monthly Safe Staffing Data – Nov 21

		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1725.00	1477.25	1380.00	1345.50	86%	98%	1380.00	1334.00	1380.00	1184.50	97%	86%	980	2.9	2.6	0.1	0.0	5.5
DD	Ward A5 G	885.50	874.00	1035.00	954.50	99%	92%	690.00	701.50	1035.00	862.50	102%	83%	600	2.6	3.0	0.3	0.1	6.1
DD	Ward A5 E	667.00	720.00	667.00	504.00	108%	76%	690.00	690.00	345.00	345.00	100%	100%	200	7.1	3.8	0.0	0.0	10.9
MSK	Ward A6	1725.00	1564.00	1725.00	1529.50	91%	89%	1035.00	1219.00	1725.00	1403.00	118%	81%	1020	2.7	2.9	0.1	0.0	5.8
MSK	CMTC	1035.00	1149.50	1035.00	793.50	111%	77%	690.00	690.00	690.00	424.00	100%	61%	576	3.2	2.1	0.0	0.0	5.3
W&C	C20	1027.50	878.50	862.00	665.50	85%	77%	691.00	714.00	23.00	23.00	103%	100%	205	7.8	3.4	0.0	0.0	11.1
W&C	Ward C23	1380.00	1076.50	690.00	598.00	78%	87%	690.00	540.50	690.00	632.50	78%	92%	576	2.8	2.1	0.0	0.0	4.9
W&C	Birth Suite	2139.00	1955.00	345.00	207.00	91%	60%	2139.00	2012.50	345.00	310.00	94%	90%	342	11.6	1.5	0.0	0.0	13.1
W&C	The Nest	690.00	425.50	345.00	276.00	62%	80%	690.00	368.00	345.00	253.00	53%	73%	13	61.0	40.7	0.0	0.0	101.7
W&C	Ward B11	2932.50	2621.00	959.50	750.50	89%	78%	1542.80	1516.20	312.00	312.00	98%	100%	406	10.2	2.6	0.9	0.6	14.2
W&C	NNU	1725.00	1219.50	345.00	178.50	71%	52%	1725.00	1104.00	345.00	299.00	64%	87%	311	7.5	1.5	0.0	0.0	9.0
UEC	Ward A1	2219.00	2456.22	2104.00	2066.02	111%	98%	1641.97	1607.72	1273.97	855.27	98%	67%	900	4.5	3.2	0.0	0.0	7.8
UEC	Ward A2	1655.00	1439.67	1854.00	1511.25	87%	82%	971.60	934.12	955.00	879.98	96%	92%	859	2.8	2.8	0.0	0.0	5.5
UEC	ED	6356.00	7192.07	2825.15	1800.17	113%	64%	4392.68	5557.37	1859.67	1866.53	127%	100%						
MC	ACCU	2415.00	2209.03	1030.50	945.50	91%	92%	1710.50	1654.00	1035.00	1036.00	97%	100%	780	5.0	2.5	0.0	0.0	7.5
MC	ICU	4991.00	4858.75	1069.50	839.50	97%	78%	4991.00	5301.50	713.00	839.50	106%	118%	569	17.9	3.0	0.0	0.0	20.8
MC	B18	2325.00	1600.00	1425.00	1386.50	69%	97%	1958.00	1933.00	1034.50	1062.50	99%	103%	701	5.0	3.5	0.0	0.0	8.5
IM&C	Ward A7	1725.00	1432.50	1725.00	1375.50	83%	80%	1380.00	1483.50	1380.00	1253.50	108%	91%	1020	2.9	2.6	0.0	0.0	5.6
IM&C	Ward C21	1214.67	1114.17	1079.25	838.50	92%	78%	690.00	798.25	691.00	520.50	116%	75%	596	3.2	2.3	0.0	0.0	5.5
IM&C	Ward B14	1035.00	1046.50	1725.00	1517.00	101%	88%	690.00	701.50	1035.00	1288.00	102%	124%	720	2.4	3.9	0.0	0.0	6.3
IM&C	Ward B12	1069.50	1023.50	2415.00	1934.50	96%	80%	690.00	690.00	1725.00	1817.00	100%	105%	630	2.7	6.0	0.0	0.1	9.0
IM&C	Ward B19	1380.00	942.00	1380.00	1304.50	68%	95%	1035.00	897.00	1380.00	1035.00	87%	75%	720	2.6	3.2	0.0	0.0	5.8
IM&C	Ward A8	1725.00	1445.00	1725.00	1282.50	84%	74%	1380.00	1345.50	1380.00	1368.50	98%	99%	1020	2.7	2.6	0.0	0.0	5.3
IM&C	Ward A9	1725.00	164.35	1725.00	1629.00	10%	94%	1380.00	1472.00	1725.00	1265.00	107%	73%	982	1.7	2.9	0.0	0.0	4.6
	Total	45766.67	40884.50	31470.90	26232.93	89%	83%	34873.55	35265.15	23422.13	21135.78	101%	90%	14726	4.3	3.0	0.0	0.0	7.4
		= above 100%			= above 90%			= above 80%			= below 80%								

Appendix 4
November 2021 - Mitigating Actions

Ward A4	Vacancy - band 6 0.19 band 5 0 band 2 0.46 Sickness rate - short term 3.7% long term 7.6% Managed in line with policy. Action taken - Use of agency and NHSP to fill gaps . WM filling shortfalls in gaps also. Regular meetings with NHSP. Awaiting uplift in staffing for night to increase to 4 rn and 4 hca from 3 rn and 3 hca
Ward A5 G	Vacancy - band 5 2.0wte Sickness rate -short term 11.81% long term 8.36% Action taken - Use of agency and NHSP to fill gaps . WM filling shortfalls in gaps also. Regular meetings with NHSP.
Ward A5 E	Vacancy - recruited to vacancy band 5 0.38wte band 2 2.33wte. Sickness rate - short term 1.4% long term 4.33% Action taken - Use of agency and NHSP to fill gaps . WM filling shortfalls in gaps also. Regular meetings with NHSP.
Ward A6	Vacancy - 6.49% Sickness rate - ST 3.70% LT 3.02% Action taken - Use of agnecy staff to cover vacancies. Sickness managed through policy/stages
CMTC	Vacancy - HK 1.00 wte started in post Ward clerk and HCA 1.00 appointed Sickness rate - ST 6.03% LT 0.53% Action taken - Sickness managed through policy/stages
C20	Vacancy - 0 Sickness rate - 10.87% Action taken - OH & Wellbeing support in place in line with Trust Attendance Policy
Ward C23	Vacancy - 0% Sickness rate - 10.85% Action taken - Sickness managed in line with HR/OHWB.
Birth Suite	Vacancy - 2.66% Sickness rate - 8.0% Action taken - Sickness managed in line with HR/OHWB. Vacancies recruited to 3.11.21
The Nest	Vacancy - 0% Sickness rate - 10.0% Action taken - Managed in line with guidance
Ward B11	Vacancy - 4 WTE Band 5 Sickness rate - 1 Band 2 WTE/1 Band 5 WTE Maternity Leave 1 band 2 WTE 1 Band 6 WTE HDU 60 day's. Action taken - Band 5 posts out to NHS Jobs. Sickness mananaged in line with trust attendance policy Band 5 WTE resumed 01/12/2021
NNU	1 X band 7 vacancy - hold on recruiting to this post following unsuccessful recruitment - establishment to be assessed. 2 x long term sick management as per policy
Ward A1	Vacancy - 9.90% in November. Band 6 x 2.15 / Band 2 x 3.31 Sickness rate - 8.24%. Action taken - WM and Matron supporting gaps in staffing. NHSP and agency usage also.
Ward A2	Vacancy - Fully established Sickness rate - 7.46% Action taken - WM and Matron supporting gaps in staffing. NHSP and agency usage also.
ED	Vacancy - 11.70% band 6 x 2.15/ Band 5 x2.37 / Band 2 x4.11 Sickness rate - 14% Action taken - Department manager and Matron supporting gaps in staffing. NHSP and agency usage also.
ACCU	Vacancy - 2.46wte B6, 1.56wte B5, 2.75wte B2 Sickness rate - Total 10.5% Action taken - 1.0wte B6 starts Jan 22, 1.92wte B6 a/w start date. 1.0wte B5 IN starts Jan 22. Advert for B5 posts ready to go out. 1.0wte B2 a/w start date.
ICU	Vacancy - 1.64% Sickness rate - 3.85% Action taken - Recent recruitment completed for RN's, & HCA's. Well Being support and checks in place
B18 ARU	Vacancy - Band 5 vacancies and band 2 vacancies- recruitment in progress Sickness rate - 7.66% Action taken - sickness being managed as per policy with HR &OT support as required
Ward A7	Vacancy - Band 2 2.0 wte Sickness rate - 11.68% Action taken - Recuritment ongoing CSWD in place to support vacancies sickness being managed as per policy with HR &OT support as required
Ward C21	Vacancy - 15.15% Sickness rate - 11.91% Action taken - Sickness managed with OH support and recruitment supported by workforce improvement
Ward B14	Vacancy - no trained vacancies HCA x1 Sickness rate - 3.27% Action taken - sickness being manged as policy with support of HR & OH recuritment ongoing with HCA
Ward B12	Vacancy - no vacanies at Band 5 band 2 x 2.0wte Sickness rate - 8.57% Action taken - Recuritment ongoing for HCA's sickness managed as per policy with support from HR & OH
Ward B19	Vacancy - Band 6 1.0 x2 Sickness rate - 9.47% shielding HCA x2 Action taken - Recuritment ongoing sickness managed as policy and discussions with HR re staff shielding with support of OH
Ward A8	Vacancy - no vacancies band 6 on maternity leave Sickness rate - 13.24% Action taken - recuriting for acting band 6 sickness managed as per policy with OH & Hr support
Ward A9	Vacancy - band 6 vacancy band 5 x1 awaiting start date Sickness rate - 9.87% band 6 LTS Action taken - recuritment on going awaiting start date for RNA January Sickness being managed as per policy with support from HR & OH

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/07(b)**	
SUBJECT:	Safe Staffing response to current Omicron wave	
DATE OF MEETING:	26 January 2022	
AUTHOR(S):	Ali Kennah, Deputy Chief Nurse, Patient Safety and Clinical Education	
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 delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	
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. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#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):***	The escalation of COVID-19, predominately driven by the Omicron variant has placed significant pressure on the NHS, in particular the impact on staffing and absences. This paper considers the nursing, midwifery, HCA and AHP staff response plans. To ensure the fundamentals of care are provided to patients at WHH, the following resilience processes are in place: • Extension of current NHSP incentive scheme until end of February 2022 • ED response staff plan to support surge • Extension of current Incentive scheme for final year nursing students until end of February 2022 • Creation of a Staffing Hub • Matron as site bleep holder • Helping Hands scheme • Reintroduction of Volunteers into appropriate clinical areas Due to the increased absence of nursing, midwifery and AHP staff and the associated risk, an amendment of Trust Board Assurance Framework (BAF) risk ID 115 from a score of 20 to 25 has been agreed. Following the NHSE/I publication in November 2021 of A key actions document; Winter Preparedness: Nursing and Midwifery staffing, a benchmark exercise against the staffing assurance framework within the document was completed which demonstrates good assurance and is included within this paper.	

	A review of current staffing levels for in patient areas has been completed by the Chief Nurse, Deputy Chief Nurse and Associate Chief Nurses and minimum staffing levels assessed in order to provide the fundamentals of care which are included in this paper. A review of harm, complaints and PALS contacts for December has been completed has been completed and demonstrates the following: • Reduction in complaints received related to nursing care • Increase in moderate harms and in patient falls reported compared to November with correlation to decreased staffing • Slightl reduction in Datix incident reporting			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	It is recommended that the Trust Board members note the contents of this paper			
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	Safe staffing response to current Omicron wave	AGENDA REF:	BM/22/01/07(b)ii

1. BACKGROUND/CONTEXT

The escalation of COVID-19, which is predominately driven by the Omicron variant has placed significant pressure on the NHS, in particular the impact of increased nursing, midwifery, HCA and AHP staff absence and sickness because of high community transmission.

In response to the daily changing availability of nursing, midwifery, HCA and AHP resource, escalation plans have been put in place with a focus on mitigating emerging risks and trends. Plans are monitored at least twice daily to ensure that staffing levels are in place to provide fundamentals of care. To support this the following are in place:

- Extension of current NHSP incentive scheme for registered nurses and HCA's until end of February 2022
- ED response staff plan to support surge
- Helping hands scheme
- Mobilisation of Volunteers
- Extension of current Incentive scheme for final year nursing students until end of February 2022
- Staffing Hub
- Matron as site bleep holder
- Amendment of Trust Board Assurance Framework (BAF) risk ID 115 from a score of 20 to 25

Guidance from the 'Winter 2021 preparedness: Nursing and midwifery safer staffing Assurance Framework' (Appendix 1) has been considered when implementing the above plans and continues to be a source of reference in our continued preparedness.

The Chief Nurse / Deputy Chief Executive has written to all nursing, midwifery and AHP staff on the 22nd December 2021 (Appendix 2) to highlight the current challenges and the requirement for non-ward based clinical staff to support inpatient areas to ensure safe levels of care are provided at all times this letter and request was in addition to the plans in place above.

A further email communication was sent to all non-ward based nursing, midwifery, AHP and HCA's from the Chief Nurse/Deputy Chief Executive on 7th January 2022 (Appendix 3) to reinforce the ongoing staffing challenges and the level of commitment required from all health care professionals to continue to support the safety of in patients

This paper will provide the reviewed minimum staffing levels, the arrangements for Chief Nurse oversight, daily escalation triggers of green, amber and red status and review the harm profile and its relationship to staffing levels for December 2021

2. KEY ELEMENTS

Ward Staffing Review

A review of all in patient wards has been undertaken by the Associate Chief Nurses overseen by the Deputy Chief Nurse, Patient Safety and Clinical Education to determine the lowest numbers of nursing/HCA's required to deliver fundamentals of care to patients. It must be acknowledged that the minimum numbers in **Fig.1** are not in line with national recommendations for safe staffing levels and are assessed at the level of staff deemed enough to provide the most basic of care. For example, supporting with nutrition, personal hygiene, physiological observations and administration of medicines will be carried out although they may not be as timely as the expected standard. Enhanced care requirements, pressure relief and mobilisation will be compromised when wards are operating on minimum numbers, as minimum staffing levels are consistent with continuing red staffing status

Maternity services have an existing agreed escalation plan in place for staffing in line with the Cheshire and Mersey Escalation plan which is reviewed daily during the system Gold Command call.

Minimum Staffing Numbers per Ward – these are the very minimum staffing levels assessed to provide basic nursing care. These are not minimum staffing levels aligned with acuity and dependency assessments.

Fig.1

Ward	Specialty	CBU	Staffing							
			Current				Minimum			
			Day		Night		Day		Night	
			RN	HCA	RN	HCA	RN	HCA	RN	HCA
AMU	Ac Med	UEC	6	6	5	4	4	3	4	3
A2	Ac Med	UEC	4	4	3	3	2	3	2	3
ACCU Wd	Cardiac	MC	3	3	2	3	2	2	2	2
HCCU HC	Cardiac	MC	4	1	3	1	2	-	2	-
B18	Resp	MC	7	4	6	4	5	2	5	2
C21	Medical	MC	3	4	3	3	2	2	2	2
ICU	Crit Care	MC	14	3	14	2				
A7	Medical	IMC	5	5	4	4	3	3	3	3
A8	Medical	IMC	5	5	4	4	3	3	3	3
A9	Medical	IMC	5	5	4	4	3	3	3	3
B12 FMN	Dementia	IMC	3	7	2	5	2	4	2	3
B14	Medical	IMC	3	5	2	3	2	3	2	2
B19	Medical	IMC	3	3	2	3	2	3	2	2
K25	Medical	IMC	3	3	2	3	2	2	2	2
A4	Surgical	DD	5	5	4	4	3	4	3	3
A5E	Surgical	DD	2	2	2	2	2	1	2	1
A5G	Gastro	DD	3	3	2	3	2	2	2	2
B4	Surgical	DD	4	3	Closed		2	2	2	2
PACU	Crit Care	DD	2	0	2		1	0	1	0
A6	MSK	MSK	5	5	3	5	3	4	3	3

CSTM	MSK	MSK	3	3	2	2	2	2	2	1
B3	Medical	MSK	4	4	3	4	2	3	2	3
C20	Gynae	W&C	3	2	2	0	2	1	2	0
Paeds	Paed	W&C	7	2	5	1	5	2	4	1
NNU	NNU	W&C	4	1	4	1	3	1	3	1

* ICU staffing numbers determined by Critical Care Network- staffing numbers reported daily

Mitigation in place

The nursing team will aim to ensure the following will be in place:

- 1 WHH RN and other registered healthcare professional for wards minimum standard staffing is 2 RN's
- 2 WHH RN's and other registered healthcare professionals for wards minimum standard 3 RN's or above
- 4 WHH RN's and other registered healthcare professionals for assessment areas

Other registered healthcare professionals will need to be able to:

- Be a second checker for medications
- Be able to undertake and recognise abnormal clinical observations
- Be able to undertake any risk assessments and recognise triggers for abnormality

Registered nurses wherever possible should be working at the top of their clinical competence, skills training can be provided for staff who require updates in the following:

- Cannulation - Venepuncture
- Assessment skills
- Prescribing skills
- PGD usage
- Catheter care
- AIMS skills/PGDs

Where bay/team nursing cannot be achieved, the wards will revert to task allocation as follows:

- Staff allocated to administer medications
- Staff allocated to undertake observations (EWS) - Staff allocated to provide hygiene care
- Staff allocated to undertake intentional rounding
- Staff allocated to undertake skincare assessments/positional changes
- Staff to undertake wound care interventions
- Staff allocated to provide nutrition and hydration

The achievement/non achievement of minimum staffing levels will be recorded daily via the senior nurse staffing meeting and escalated to the Deputy Chief Nurse, Patient Safety and Clinical Education, who will inform the Chief Nurse of current levels of patient safety and associated plan. Out of hours this will be determined by the matron or night nurse practitioner and escalated to the executive on call through the SMOC.

During December minimum staffing levels were recorded on 141 ooccasions acoss 18 wards. 58 of those were at night and the area where minimum levels were recorded the most was NNU on 86 occassions. A review of harms (minor falls and pressure ulcers) against this data was completed and 5 (approximately 10%) of minor harm falls occurred in areas where minimum staffing was recorded. Detail for moderate harms related to staffing is highlighted in section 3 of this paper.

Registered Nurse/Midwife current vacancies

Data shows there are currently 99 vacancies in total for registered nurses and midwives at WHH, this is further compounded by staff yet to be included in this figure as they are part of the business case process:

- 7 RNS Ward C21 (draft business case not yet been approved but on tracker)

Staffing Assurance Framework

A national key actions document, Winter 2021 preparedness: Nursing and midwifery safer staffing, was published in November 2021 to support safer nursing and midwifery staffing as the winter period approaches. The actions contained within the document build on the previous guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance. The document summarises and signposts to existing resources, tools, and templates in support of nursing and midwifery workforce planning, preparation, and board assurance.
A benchmark exercise was completed looking at existing and newly introduced processes at WHH using the staffing assurance framework contained in the document (Appendix 4). The outcome of the exercise demonstrates good assurance against the planning, review and escalation of staffing levels across the Trust during and out of times of surge, with only 1 point rated as amber and the remaining points green. A piece of work is underway to complete the Quality Impact Assessments for changes in the function of wards B18, B19, A7 and A8 which will complete the amber action before the end of January 2022.

Staffing Hub

Non- ward based nurses, AHP's, midwives and HCA's have been requested to commit to working in in patient areas to support the provision of care to support the minimum staffing requirements. A 'Staffing Hub' has been set up as a platform to facilitate this support. The purpose of the COVID-19 Staffing Hub is to oversee and administrate the safe and effective redeployment of non-ward based nursing, midwifery, HCA and AHP staff into front line services in line with their risk assessment. This will be achieved in a demand led model adjacent to the daily staffing meetings.

The daily staffing meeting has been brought forward to 08.30 each day Monday-Friday to allow the senior team to request support from the staffing hub. The staff redeployed from the staffing hub will support the mitigation in place associated with the review of minimum staffing levels.

Matron as site bleep holder

From 10th January 2022 the site bleep usually held by a ward manager daily will be given to the matron during the working week Monday to Friday, this will increase the availability of the ward managers on this rota to work within their clinical areas. Ward managers will continue to provide site cover across the weekend to support senior presence in the Trust out of hours.

Emergency Department Staffing Response Plan

A rota commenced in December 2021 to ensure staff are available to quickly respond to surge in ED particularly in relation to supporting patients who are sadly placed on the corridor in term of surge., The staff to support this rota have been identified from non ward based nurses and HCA's and AHP's. The rota is in place until the end of January and will continue through February 2022. The ED staffing response plan is at no extra cost to the Trust as uses existing non ward based nursing staff and AHP's to schedule time to work in ED.

NHSP Incentive Scheme

A paper presented to the Trust Executive 7th December outlined the details and cost of the scheme, a recent review of shift request and fill rates demonstrates the scheme as having a positive impact to date. An extension of the incentive scheme until the end of February 2022 has been approved by the Trust Executive Team on 13th January. Costs of the extended scheme are detailed in Appendix 5.

The incentive scheme has proved positive during January in accordance with the update below (data as of 12th January 2022):

- N&M & AHP staff groups bank fill volume has increased by 3,883 compared to December
- Decrease of 8,135 agency hours – reduction in 62 agency staff at present
- Reduction of 53 off framework agency shifts
- 27 new starters joined NHSP since the start of the incentive on 27th December to date compared to a total of 34 for December
- 26 Additional staff in the pipeline to join NHSP this month

Pay Incentive Scheme for 3rd Year Nursing Students

A pay enhancement scheme to incentivise bank shift fill was introduced on 16th December 2022 to further support safe staffing over the Christmas period and is planned to continue until the end of January. A total of 17 final year student nurses have joined NHSP and 7 have completed 61 shifts to date. An extension of this incentive scheme until the end of February 2022 has been approved by the Trust Executive Team on 13th January, associated costs are outlined in Appendix 5.

Helping Hands Scheme

A scheme to support the wards with staff from non clinical corporate services was introduced in December 2021, training for volunteers is available, this scheme needs to be reinforced to ensure full utilisation as to date there has been no access of this service within the Trust.

Reintroduction of volunteers

A proposal to reintroduce volunteers to clinical areas was presented and approved at the Trust Executive meeting on 11th January 2022, the volunteers will support ward areas with non clinical duties.

3. Harm review December 2021

A review of harms, complaints, incident reporting and PALS contacts was completed for December 2021 to understand if Covid -19 related staffing challenges had negatively impacted on the Trust harm dashboard.

- Formal complaints reduced in December from 17 to 10, 5 of those related directly to nursing care compared to 6 in November 2021.
- PALS contacts slightly decreased with 42 compared to 41 in November 2021, however those directly related to patient care increased from 19, to 23.
- An increase in total moderate harms was noted with 17 recorded against 9 in November 2021
- An increase in total major harm was noted with 4 reported against 1 in November
- A catastrophic harm was also recorded in December
- An increase in falls was noted with 54 recorded compared to 48 in November, 3 falls were recorded as moderate harm compared to no moderate harm falls noted in November 2021
- Datix incident reporting reduced slightly in December to 924 from 955 in November

A review of the staffing levels at the time of the moderate harm falls occurring confirms the areas where 2 of the harms occurred both recorded red RAG status for health care assistants on those shifts. A review of other moderate and catastrophic harms in relation to staffing levels shows no correlation.

4. Triggers for escalation of staffing and patient safety

The Trust agreed RAG rating processes for wards is outlined below, associated actions and escalation are outlined in the Staffing Escalation Plan (Appendix 6)

GREEN	Optimum staffing levels as agreed
AMBER	Safe staffing Levels any wards less than agreed numbers, reviewed and plan in place. 4 or more amber wards will activate overall amber status
RED	All wards reviewed, Step 3 of the staffing escalation activated . Shifts escalated to temporary staffing cascade. 3 or more red wards will activate overall red status

As a result of the significant challenges with staff absences the rag rating is changing rapidly, the 3 times daily staffing meetings continually review staff availability to provide safe cover. **However, consideration of stepping down services to support staff availability must be evaluated in any 24 hour period if staffing is recorded as 2 consecutive shifts at red status, having exhausted all other staffing mitigation plans.** This will be escalated through to the Chief Nurse/Executive on call via the Deputy Chief Nurses.

5. Recommendations

Trust Board members are asked to note the contents of this paper.

Appendix One – Staffing Assurance Framework

Classification: Official

Publication approval reference: PAR1068

Key actions

Winter 2021 preparedness: Nursing and midwifery safer staffing

12 November 2021, Version 1

Trust board members are collectively responsible for workforce planning, practice and safeguards. The following actions focus on preparedness, decision making and escalation processes to support safer nursing and midwifery staffing as the winter period approaches. They build on the previous guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance. The document summarises and signposts to existing resources, tools, and templates in support of nursing and midwifery workforce planning, preparation, and board assurance.

Planning

- When planning the nursing and midwifery workforce, boards should ensure that system wide and local learning from previous staffing deployments in Covid-19 pandemic continue to be incorporated into staffing escalation plans.
- Work with providers of temporary workforce to be clear about anticipated requirements during activity peaks and consider steps such as block booking for hard to fill areas.
- Executive directors of nursing should ensure that all forecast staffing plans are reviewed weekly or more frequently as required by the operating context and changing circumstances.
- Changes in estate function or staffing configuration should be subject to a quality impact assessment with final sign-off by the executive director of nursing and countersigned by the medical director as joint quality lead.

- Redeployment should be voluntary where possible and individual risk assessments must be undertaken with staff prior to any redeployment.

Decision making and escalation

- Even during challenging times, executive directors of nursing should be mindful of the fundamental principles set out in the NQB Safe Sustainable and Productive staffing guidance and Developing Workforce Safeguards guidance.

- When implementing escalation plans, decisions regarding skill mix and nurse ratios should be taken in conjunction with an assessment of patient acuity and dependency, professional judgement and the environment of care.

- In preparation for periods of increased demand, organisations should ensure that staffing plans are reviewed and signed off by the executive director of nursing, with staffing decisions including redeployment and daily deployment of staff led by the senior clinical leadership teams.

- Staffing risk assessments should be undertaken on a shift by shift basis and concerns and issues escalated in a timely manner via clearly established routes. Unresolved issues should be escalated in line with provider governance processes. A system wide discussion and focus should be taken to reach solutions wherever appropriate.

- Escalation mechanisms and governance processes should be clear to all staff and the board should seek assurance that effective escalation occurs and that issues are addressed and recorded.

- Staff should be supported to discuss and raise concerns regarding staffing and their ability to safely care for patients. The board must seek assurance that there are clear mechanisms in place for staff to raise concerns and that these are acknowledged and mitigated where possible.

- Clinical leaders should take a multi-professional and skills-based approach to staffing and ensure each clinical area is supervised by a senior clinical leader.

Staff training and wellbeing

- Supporting the workforce is paramount; boards should seek assurance that there are well-publicised and accessible resources in place for staff.

- Staff wellbeing should be embedded at every level. For example, team-based check-ins, wellbeing support hubs and wobble rooms.

Key actions

- Professional nurse/midwife Advocates (PNA/PMAs) who are trained to provide confidential restorative clinical supervision and support nurses in clinical practice, should be readily available.

- Boards should ensure that local leaders are supporting staff wellbeing, which in turn will support the delivery of high standards of patient care.

Indemnity and regulation

- NHS Resolution has confirmed additional indemnity arrangements that cover healthcare workers who are supporting the COVID-19 response, including those who have been asked to undertake duties outside of their usual role.

- It is recognised that at times staff might need to act outside their normal role or places of work/scope of practice. A risk-based approach should be used to mitigate emerging risks using available resources effectively and responsibly.

- The Nursing and Midwifery Council (NMC) and the four chief nursing officers in the UK have written to all registrants reminding all of the importance of working in partnership with people receiving care and their fellow professionals; and of using professional judgement to assess risk, informed by the values and principles set out in NMC professional standards. This remains as important as it ever was. Trust boards must be assured that wherever possible these standards are met.

Governance and assurance

- There must be a clear and effective line of sight from point of care delivery to board, in relation to nursing and midwifery staffing decisions and challenges.

- To help boards understand the quality impact of decisions that have been taken around staffing, boards should be provided with triangulated information linking staffing with wider intelligence, through regular reporting. For example incidents, complaints and NICE red flags.

- Boards should have reviewed their risk appetite in relation to quality and workforce risks and be clear on the tolerances the board is willing to accept, understanding that not all risks can be fully mitigated. This should be clearly communicated to the organisation.

- Boards should seek assurance that plans are in place to ensure safe nursing and midwifery staffing over the winter period and that these plans are connected to the wider system staffing planning, resourcing and mutual aid.

Key actions

- The Care Quality Commission (CQC) recognises that services are facing tremendous challenges as result of the pandemic – and that the nursing workforce is experiencing these pressures particularly acutely. This includes decisions around nursing, midwifery and care staffing capacity and capability. CQC expects boards to make staffing decisions with a focus on mitigating emerging risks and trends using available resources effectively and responsibly, in line with national guidance – and that where staffing shortages are identified, use of temporary solutions including a multidisciplinary approach to manage immediate risks should be implemented.

- Where necessary, CQC and regional NHS England and NHS Improvement teams should be made aware of any fundamental concerns arising from significant and sustained staffing challenges.

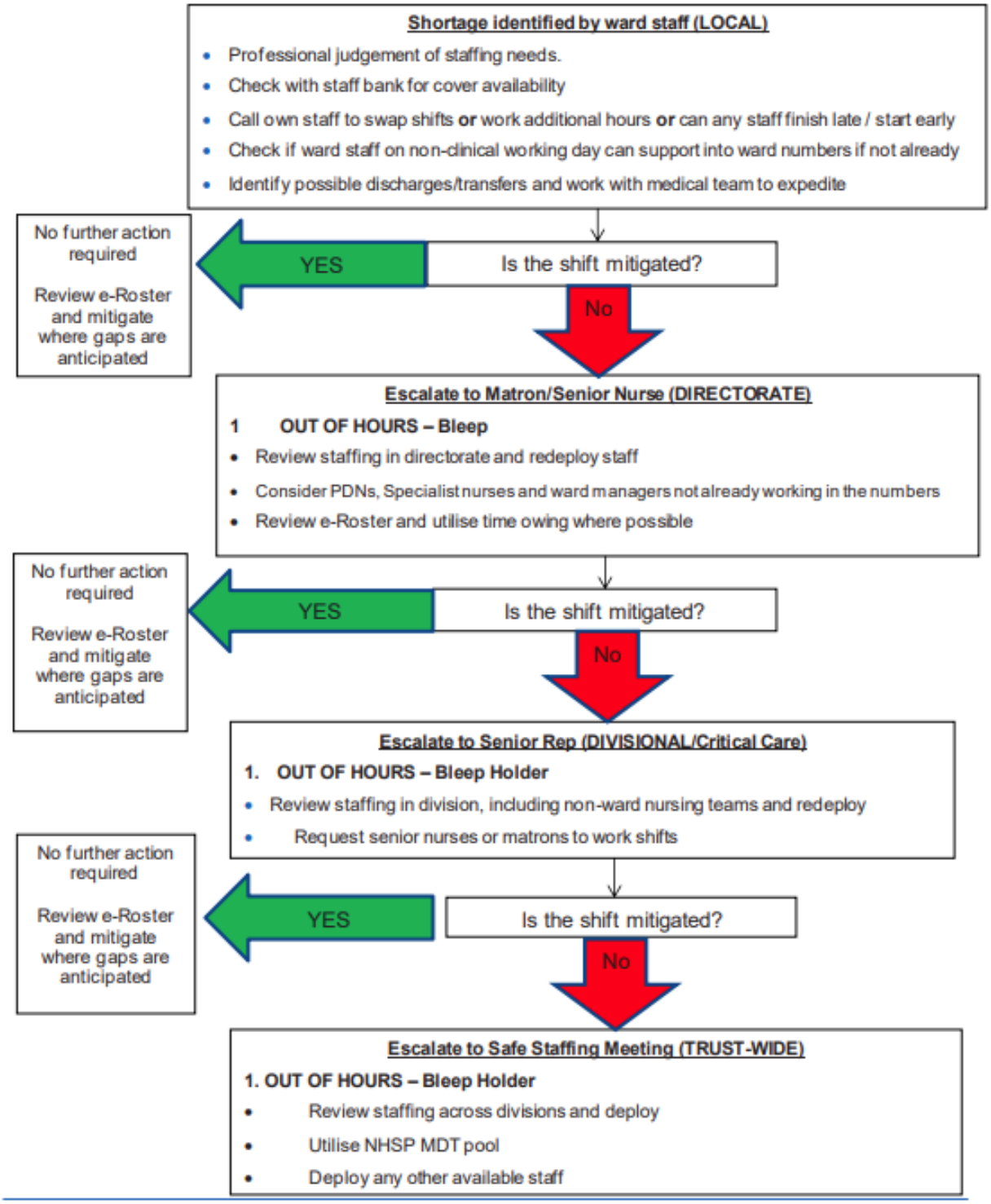
Useful links:

Alongside the formal guidance that has previously been issued in this area, a collection of additional resources has been collated for use by providers. These resources are attached as appendices and/or via the following links:

Planning • NHS England and NHS Improvement: Advice on acute sector workforce models during COVID-19 • NHS England – Respiratory syncytial virus 2021 preparedness: Children's safer nurse staffing framework for inpatient care in acute hospitals • NHS England – Nursing and midwifery e-rostering: a good practice guide • Safe midwifery staffing for maternity settings	**Staff training and wellbeing** • NHSX: Digital staff passport • NHS People: Support and wellbeing resources • NHS Horizons: Caring for NHS people • NHS Employers: Risk assessments for staff	**Decision making and escalation** • Appendix 1: Decision and escalation framework tool • Appendix 2: Quality impact assessment • Appendix 3: Staffing escalation (SBAR) • Appendix 7: EPRR escalation and alerting
Governance and assurance • Appendix 4: Risk appetite statement • Appendix 5: Assurance Framework • Appendix 6: Safe staffing Governance framework • NQB Safe Sustainable and Productive staffing guidance • Developing Workforce Safeguards • Care Quality Commission	**Indemnity and regulation** • NHS Resolution Clinical Negligence Scheme for Coronavirus (CNSC)	**Additional resources** • Report template - NHSI website (england.nhs.uk)

Appendix 1: Decision tool and escalation framework

Flow chart for resolution of staff shortages, to support nurse(s) in charge and matrons on a shift-by-shift basis.



Appendix 2: Example quality impact assessment

Follow this link to view (FutureNHS account required):
https://future.nhs.uk/BeneficialChangesCOVID19/view?objectId=93995109

Appendix 3: Example staffing SBAR Tool

Staffing communication tool using situation, background, assessment, recommendation (SBAR) principles to ensure critical staffing issues are received and actioned.

Staffing Escalation SBAR

SITUATION:

Ward:

Date, Shift and Band that require covering:

Number of beds:

Acuity and dependency score:

Describe your concern, include Safety/Quality concern:

BACKGROUND:

Current problem:

Reason for problem on shift:

How long has the shift been out to the Hospital Nurse Bank:

How long has the shift been out to Framework Agency:

ASSESSMENT:

My assessment of the situation is:

Current concern:

Describe actions have been taken to solve the current problem:

RECOMMENDATION:

Based on my assessment I request that you approve:

Things to consider:

Explain what you need:

Appendix 4: Example risk appetite statement

For boards and senior leaders outlining the pressures on the service and any potential changes in the level of accepted risk.

Category (highest impact of the risk)	Proposed Risk appetite statement	Risk appetite	Risk score
Clinical innovation	We have a HIGH risk appetite for clinical innovation that does not compromise quality of care	HIGH	8-12
Commercial	We have a HIGH risk appetite aimed at increasing the impact of services. The high risk appetite allows the Trust to explore opportunities to deliver existing and new services into new markets	HIGH	8-12
Compliance / regulatory	We have a LOW risk appetite for risks which may compromise compliance with statutory duties and regulatory requirements	LOW	1-3
Environment	We are committed to providing patient care in a safe environment; however we have a MEDIUM risk appetite for risks related to the Trust estate and infrastructure except where they adversely impact on patient safety and regulatory compliance.	MEDIUM	4-6
Financial / value for money	We have a HIGH risk appetite for financial / value for money risks which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards	HIGH	8-12
Systems and Partnerships	We have a HIGH risk appetite for system working and partnerships which will benefit our local population	HIGH	8-12
Reputation	We have a HIGH risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the Trust	HIGH	8-12
Quality – effectiveness	We have a LOW risk appetite for risks that may compromise the delivery of outcomes for our patients	LOW	1-3
Quality - experience	We have a MEDIUM risk appetite for risks to patient experience if this is required to achieve patient safety and quality improvements	MEDIUM	4-6
Quality - safety	Patient safety is paramount to the Trust and as such it we have a LOW appetite for risks which may compromise patient safety	LOW	1-3
Technology	We have a HIGH risk appetite for the adoption and spread of new technologies whilst ensuring quality for our service users	HIGH	8-12
Workforce	We have a MEDIUM appetite for risks to workforce. This medium appetite allows scope to implement initiatives that support transformational change whilst ensuring it remains a safe place to work	MEDIUM	4-6

Appendix 5: Assurance framework – nursing and midwifery staffing

For quality (or other board level) committees and board members to support discussion and challenge surrounding the active staffing challenges faced and the potential impact this may have on patients.

Ref	Details	Controls	Assurance (positive and Negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
	Guidance notes	*Outline the current controls (controls are actions that mitigate risk include policies, practice, process and technologies)*	*Detail both the current positive and negative assurance position to give a balanced view of the current position* *Assurance is evidence that the control is effective – or conversely is evidence that a control is ineffective / there are still gaps* *Recurrent forms of assurance are audit results, key performance indicators, written reports, intelligence and insight.* *Effective Assurance should be a triangulated picture of the evidence (staff shortages, sickness absence,pt outcomes, complaints, harm reviews)*	*What is the remaining risk score (using the trusts existing risk systems and matrix)* *Are these risks recorded on the risk register?*	*Where there are identified gaps in either control or assurance, outline the additional action to be undertaken to mitigate the risk. Where the organisation is unable to mitigate fully, this should be escalated to the LRF/region/ national teams and outlined in the following column*	*Provide oversight to the board what the current significant gaps are* *Outline those risks that are currently not fully mitigated /needing external oversight and support*	*Due to the likely prevailing nature of these risks, outlines through what operational channels and how are these active risk being monitored (e.g daily silver meetings via safe staffing heatmap)*
	1. **Staffing Escalation / Surge and Super Surge Plans**						

1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e intensive care) or as per the NQB safe staffing guidance						
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.						
1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee						
1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD						
2.0	**Operational delivery**						
2.1	There are clear processes for review and escalation of an immediate						

	shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze.						
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained.						
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs.						
2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients being handed over.						

2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.						
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individuals scope of practice.						
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on patient care.						
2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care.						
2.9	The trust has robust mechanisms for understanding the current staffing						

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	levels and its potential impact on patient care. These mechanisms take into account both those staff who are absent from clinical duties due to required self Isolation, shielding, and those that are off sick. Leaders and board members therefore have a holistic understanding of those staff not able to work clinically not just pure sickness absence.						
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this intelligence.						
3.0 Daily Governance via EPRR route (when/if required)							
3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver						

	and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings.						
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).						
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.						
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.						
4.0	**Board oversight and Assurance (BAU structures)**						
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short and						

	medium term solutions to mitigate the risks.						
4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process.						
4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges.						
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making.						
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur delivering care through staffing in extremis.						

4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.						
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process.						
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.e risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)						
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework						

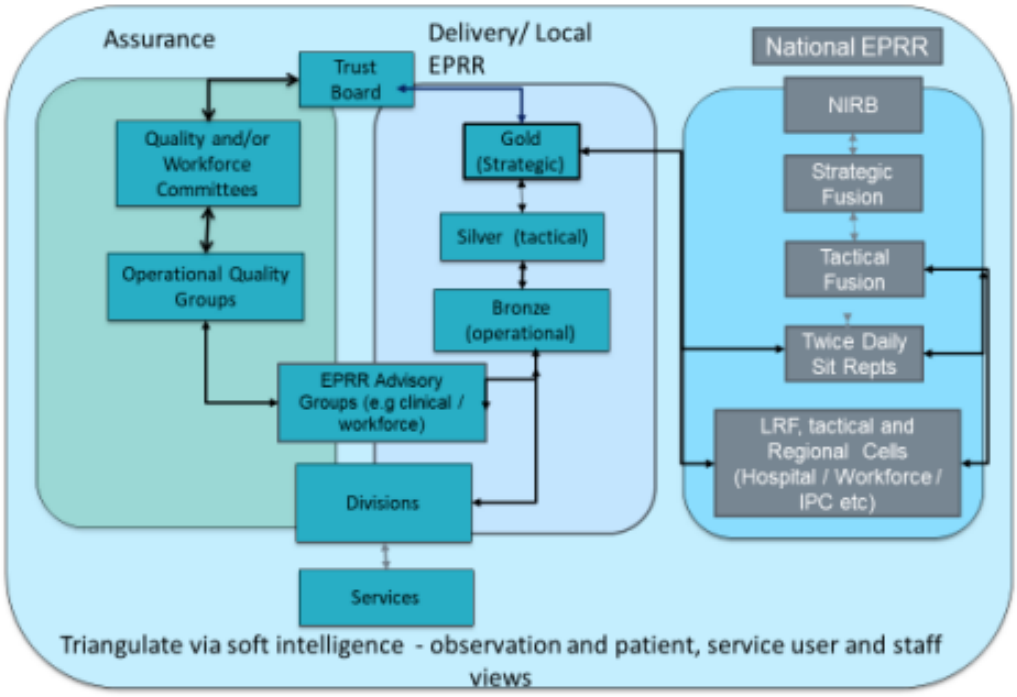
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus						
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges						

Appendix 6: Example safe staffing governance framework

The flowchart below is a general illustrative example. It outlines the two arms of a provider governance framework (assurance and delivery) and further indicates the relationships with the national emergency preparedness, resilience and response (EPRR) structures.

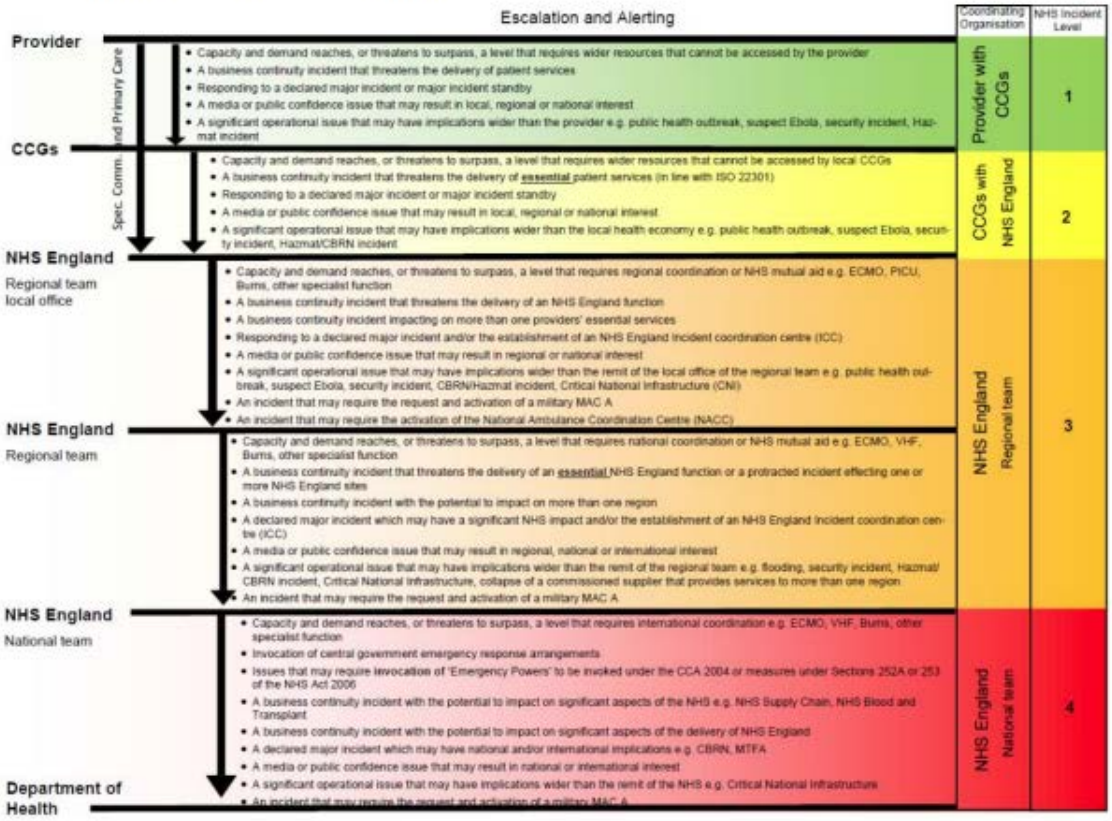
Providers must ensure that non-executive members of the board have clear sight of the significant or sustained operational issues and challenges that are being discussed in the day-to-day delivery of care during these challenging times.

This should be through their existing board assurance routes (ie quality committee, strategic workforce and organisational development committee to the board), to allow the non-executive directors to adequately fulfil their duties of holding the executive director members to account so that quality care is maintained.



Appendix 7: EPRR escalation and alerting

Extracted from NHS England EPRR Framework



Appendix Two – Letter From Chief Nurse and Deputy Chief Executive

Kimberley Salmon-Jamieson
Chief Nurse
Director of Infection Prevention & Control
Executive Director for Midwifery and AHP's
Executive Office
Kendrick Wing
Warrington Hospital WA5 1QG

22nd December 2021

Letter to all AHP professions, midwifery, nursing and support staff

Dear Colleague,

I am writing to you all to highlight the key issues we are facing as a result of the ongoing pandemic. Firstly, I would like to say how amazing you all are and how well we have come together as one team during the surge waves of the pandemic from March 2020 to now. It is truly inspirational and I thank everyone for all that you are doing around the clock to care for our patients and each other.

As you all know, the new Omicron variant of COVID-19 is a faster spreading strain and you may be aware from the national news that a large number of staff across the NHS have been affected and are having to isolate to keep others safe. At WHH we are seeing some impact from this and have recently introduced a new Standard Operating Procedure to support our staff to get back to work safely. This document describes and outlines the process for allowing fully vaccinated staff and students, who are identified as a contact of a positive COVID-19 case, to return to work subject to the safeguards put in place. You can access the document via the link below. Staff may be able to return before their 10-day isolation period following undertaking LFD tests and your manager and senior nursing, midwifery and AHP team leads will be aware of this.
the hub/PP/Policies/SOP Staff Self Isolation Approach v20 Approved.pdf.

Over the next few weeks, we will no doubt experience levels of absence that will be challenging and we are currently planning to ensure we have the right amount of clinical staff to look after our patients safely. We will, where possible, be stepping down some services for at least the first two weeks in January to allow for more staff to be made available to support areas where we are experiencing higher numbers of absences. This will include Outpatient Clinics and some elective surgery. Further information is to follow this week on this.

As a result of the staffing challenges, you may be asked to help in areas that you do not normally work in just as we did in the first wave of the COVID-19 pandemic. This may apply to both ward based and non-ward based staff such as specialist nurses, therapists who would normally be in clinics that may have been paused, and other nursing staff who hold a Registered Nurse (RN) qualification and work in support areas or Corporate Services. Staff who are unfamiliar with the ward or department area of work may be asked to carry out basic care and clinical duties so that no member of staff feels out of their clinical comfort zone. We understand this can be daunting and will always ensure any additional training needed will be made available, please speak to your line manager if this is the case.

I would like to thank you once again for how professionally you have previously responded to these requests without hesitation, I am so proud of our workforce coming together in the way we have.

Chairman: Steve McGuirk CBE DL Chief Executive: Simon Constable FRCP
Warrington and Halton Teaching Hospitals NHS Foundation Trust,
Headquarters Kendrick Wing, Lowely Lane, Warrington WA5 1QG www.whh.nhs.uk
Email: Kimberley.salmon-jamieson@nhs.net Tel: 01925 662298 Executive Assistant: Donna Hargreaves

In addition, we are working closely with NHS Professionals (NHSP) to ensure that our bank recruitment processes are timely and efficient. If you do need to register, please contact: Charlotte Saunders at Charlotte.Saunders@NHSProfessionalsnhs.uk.

In addition, If you have any friends who are retired nurses, AHP's or midwives and you think they would like to come and support the Trust during these extremely difficult times please ask them to get in touch with Ellis Clarke, Workforce Lead Nurse on 01925 662290 Ext: 2290 email: ellis.clarke@nhs.net

Staff wellbeing is so very important to us at WHH, at this time more than ever we understand staff want to spend some time with families and loved ones and it is really important to have that time to rest and recharge the batteries.

There is lots of support available at the Trust, please access the support services if you need to: https://extranet.whh.nhs.uk/workspaces/all-about-you/how-am-i-supported/supporting-you-mental-health-and-burnout

These are unprecedented times and I thank every member of staff for all you are doing to support our patients and each other. We will continue to get through this together. Please do ensure you and your teams connect with the support that is available if you do require this. 'Thank you' never does seem quite enough but I will end with on this one more time, THANK YOU. We are also thinking about our colleagues that are currently isolating and off sick we are wishing them well and sending them all our best wishes.

Please don't hesitate to contact me or any member of the senior team below if you require further information, advice or sign posting. Take care, stay safe and thank you.

- Kimberley Salmon-Jamieson, Chief Nurse 07788300584 — Kimberley.salmon-jamieson@nhs.net
- John Goodenough, Deputy Chief Nurse — jgoodenough@nhs.net, 07500785689
- Ali Kennah, Deputy Chief Nurse — Alison.kennah@nhs.net, 07587159822
- Michelle Smith, Lead AHP/Head of Therapy Services — michelle.smith@nhs.net, 01925 662392
- Catherine Owens, Director of Midwifery — Catherine.owens@nhs.net, 07385491742
- Layla Alani, Deputy Director of Governance — Layla.alani3@nhs.net, 07999993241

Kind regards,

Kimberley

Kimberley Salmon-Jamieson
Chief Nurse & Deputy Chief Executive
Director of Infection Prevention & Control
Executive Director for Midwifery and Allied Health Professionals

#YourNHSNeedsYou

Chairman: Steve McGuirk CBE DL Chief Executive: Simon Constable FRCP
Warrington and Halton Teaching Hospitals NHS Foundation Trust,
Headquarters Kendrick Wing, Lovely Lane, Warrington WA5 1QG www.whh.nhs.uk
Email: Kimberley.salmon-jamieson@nhs.net Tel: 01925 662298 Executive Assistant: Donna Hargreaves

Appendix Three – Updated Staffing Hub Communications

Email sent on behalf of Kimberley Salmon-Jamieson

Dear Colleague

As you are aware from recent communications the new Omicron variant is having a significant impact on our staffing levels across the whole organisation. Prior to Christmas I wrote to you all to explain how we are doing all we can to support our colleagues across the organisation while we continue to provide safe, quality care for our patients. A copy of the letter is attached. Due to the significant challenges with staff absences that we are currently experiencing across nursing, midwifery, HCA, and AHP staff groups we are requesting that all non-ward based nursing, HCA and AHP colleagues to commit to working within in a clinical area supporting patients and colleagues.

In response to this, a new COVID-19 Staffing Hub will be established in the Kendrick Wing Meeting Room on the Warrington site on 7th January 2022 to enable our non-ward based nursing, HCA, Midwifery and AHP staff to check what support is required across the organisation This will mean that you will be asked to commit to working in a different area in accordance with your clinical capabilities in order to support patients and your colleagues. We recognise that this request may be daunting to some of you and we will do all we can to support you. We will ensure that you feel safe and are aligned to an area based on your individual risk assessment, and within your clinical comfort zone. Different ways of working are happening across the NHS at present and in response to this the Nursing and Midwifery Council (NMC) and the four chief nursing officers in the UK have written to all registrants reminding all of the importance of working in partnership with people receiving care and their fellow professionals; and of using professional judgement to assess risk, informed by the values and principles set out in NMC professional standards. In addition, NHS Resolution has confirmed additional indemnity arrangements that cover healthcare workers who are supporting the COVID-19 response, including those who have been asked to undertake duties outside of their usual role.

From **Friday 7th January 2022**, we are asking **all non-ward based nursing, HCA and AHP staff** to review their pattern of work and follow one of the below options:

1. **Specialist Nurse/AHP:** Attend the Kendrick Wing Meeting Room (entrance facing the Appleton Service Corridor) between 8:30am and 10am Monday to Friday to discuss ward-based support that is required on a daily basis
   OR;
2. **Specialist Nurse/AHP:** Email whh.covid19hub@nhs.net at the beginning of each week with the days and hours that you can provide support for across the week.
3. **Department Staff Only:** Your line manager may ask that you support ward-based clinical colleagues at times during your pre-rostered shift.

Following each option you will be asked to support a clinical area by a member of the COVID-19 Staffing Hub. This support will vary from a couple of hours, morning, afternoon or a full shift. For our nursing colleagues, there will be an opportunity to offer extra shifts via NHSP and for our AHP colleagues this will be in the form of additional hours. Please discuss this with your line manager for more information.

We are working closely with NHS Professionals (NHSP) to ensure that our bank recruitment processes are timely and efficient. If you do need to register, please contact Charlotte Saunders at Charlotte.Saunders@NHSProfessionalsnhs.uk or Ellis Clarke, Lead Nurse for Workforce on 01925 662290 or email Ellis.Clarke@nhs.net

If you are unsure if this guidance applies to yourself please contact your manager or CBU Matron, Lead Nurse or Lead AHP.

Thank you for your support during this uncertain time, we value everything that you are doing to support one another and most importantly to support our patients.

Kind regards,
Kimberley

Kimberley Salmon-Jamieson
Chief Nurse (Nursing, Midwifery & AHP)
Deputy Chief Executive

Mobile: 07788 300584 **Email:** kimberley.salmon-jamieson@nhs.net
PA: Donna Hargreaves **Direct Dial:** 01925 662298 **email:** donna.hargreaves4@nhs.net
Twitter: @Kimberley_S_J

Appendix Four – Staffing Assurance Framework

Ref	Details	Assurance (Positive & Negative
1.	**Staffing Escalation/Surge and Super Surge Plans**	
1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e intensive care) or as per the NQB safe staffing guidance	The Trust Staffing Escalation process is in place. Minimum staffing levels have been confirmed across inpatient wards Escalation of staffing levels to CN/ Senior Manager on Call/Executive on Call For staff being temporarily redeployed to support staffing absences, all necessary training will be recorded via the Trust Staffing Hub. ICU staffing levels are reported daily and assessed against network requirements
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.	Yes
1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee	Staffing Escalation plan to be presented at JNCC meeting on 21st February 2022
1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD	All changes to ward functions are considered widely either through the Trust business case process or/and with Executive oversight through reconfiguration papers via the Trust governance process/Executive Meetings. A piece of work is underway to complete QIA documents for areas of recent change
2.	**Operational Delivery**	
2.1	There are clear processes for review and escalation of an immediate shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze.	Trust Staffing Escalation process in place with good assurance provided through audit All senior nurses including matrons/lead nurses/associate chief nurses/deputy chief nurse are involved in the daily safe staffing assessment. Out of hours the senior nursing teams on site complete a review and record the RAG status. 3 times daily staffing reviewed and reported

2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained.	Staffing rotas are signed off 6 weeks ahead, 7-day staffing plans and daily updates. Weekend planning in place Staffing plans are updated 3 times per day, all moves documented on gold command template.
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs.	Nurse in charge will escalate any concerns regarding staff competence via matron, nurse to nurse handover process in place.
2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients being handed over.	Staff aware of escalation process including the use of red flags on Safe Care system when staffing related safety issues are identified.
2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.	The Trust has an Induction Policy applicable to agency staff inclusive of locum staff. Trust local induction documentation is in use and compliance is reported as part of the workforce dashboard reported through the Trust Strategic People Committee (SPC).
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individuals scope of practice.	Escalation of concerns is completed via the shift leader and local matron.
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on patient care.	Raising Concerns Policy. Datix reporting system.
2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care.	The Trust has a robust health and wellbeing offer in place which has been equality impact assessed aligned to the needs of the workforce during all phases of the pandemic. A bespoke mental wellbeing hub has been invested in to support the mental wellbeing needs of the workforce with the addition of two on-site counsellors. To support physical health a range of mechanisms have been implemented to enable the workforce to access discounted gym memberships and leisure facilities and are working in partnership with Rugby League Cares to further develop a bespoke physical activity offer for WHH.

		Supporting the physical side of things, the staff engagement and wellbeing team actively promote the national physical activity offers and public health approaches such as the "Healthy You" campaign. In addition, the organisation undertook a baseline assessment against the national Health and Wellbeing Framework and the Greater Manchester Health and Wellbeing Framework to develop interventions on the basis of the findings from this exercise which has been reported through the organisation's Wellbeing Guardian and also Strategic People Committee. The impact of the mental and physical wellbeing offer within the organisation is measured through the Integrated Performance Report and also reported via the Strategic People Committee Governance route. The Wellbeing Guardian, a requirement from the NHS People Plan and appointed by the Board receives assurance through a monthly meeting with the People Directorate to understand impact of interventions from the organisational offer.
2.9	The trust has robust mechanisms for understanding the current staffing levels and its potential impact on patient care. These mechanisms take into account both those staff who are absent from clinical duties due to required self Isolation, shielding, and those that are off sick. Leaders and board members therefore have a holistic understanding of those staff not able to work clinically not just pure sickness absence.	Safe staffing levels and red flag system of escalating concerns in place. Bi-monthly staffing paper is presented to both the Trust Board and SPC. Escalation to SEOG and Executive on call structures in place and Tactical Meetings. Fill rates and Care Hours per Patient Day are recorded. Staff no longer considered as shielding, however Trust has Monitoring Staff Absence Dashboard in place through business intelligence to provide oversight. Staff deemed previously as Clinical Extremely Vulnerable are tracked through the CBU's with associate nurse oversight and HWWB support to return to work.
2.10	Staff are encouraged to report incidents in line with the normal trust processes.	Datix reporting related to staffing is reviewed and reported through the Trust bi-monthly staffing report. The red flag escalation system on Safe Care is reviewed daily during the staffing meetings.

	Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this intelligence.	Feedback is sought from a number of various sources such as the senior manager on call, night nurse practitioner, site lead and matron out of hours and learning is applied to future staffing plans.
3.	**Daily Governance via Emergency Preparedness Resilience and Response (EPRR) Route (when/if required)**	
3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings.	The Trust Workforce Review Group meets monthly with oversight on workforce plans, the Trust holds twice weekly Tactical meetings whereby the multidisciplinary attendees can escalate workforce concerns. The daily staffing meeting outcomes are held on the Trust gold command system
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).	Daily and weekly forecasts are discussed at daily staffing meetings. Weekend planning in relation to staffing is presented through the Trust Tactical Weekend Handover meeting.
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.	Bi-monthly reports to Trust Board are overseen by the Trust Chief Nurse, Deputy Chief Executive Escalation to senior nursing system leads via CN/Dep CEO. Daily System Meeting and speciality 'Gold Meetings' for Maternity also can consider workforce issues. All EPRR staffing escalation notification is adhered to and presented through the Trust Tactical meeting.
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.	Safe Care system provides this information.
4.	**Board Oversight and Assurance (BAU structures)**	
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short and medium term solutions to mitigate the risks.	A Bi-monthly staffing report is presented to SPC and Trust Board.

4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process.	Triangulation of staffing and harm is included in the staffing reports to SPC and Trust Board.
4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges.	The number of Covid related Nosocomial outbreaks are included on the Trust Integrated Performance Dashboard (IPR). Covid staffing challenges are discussed at daily staffing meeting, via the Trust Tactical meeting and escalated to the Trust Executives when necessary. A deep dive exercise is underway to triangulate Covid-19 staffing absences against harm, this will be reported via the Trust Quality Committee.
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making	Datix and red flags escalation concerns are reported via the Bi-monthly staffing report to SPC and Trust Board.
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur delivering care through staffing in extremis	The deep dive exercise will provide the Quality Committee with assurance of safe decision making. The 6 monthly staffing report is presented to Quality Assurance Committee.
4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.	The Quality Assurance Committee receives a staffing report every 6 months. A deep dive exercise is underway to provide detail of staffing absences triangulated against harm during the recent Covid-19 Omicron variant wave.
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process.	The Board receive the bi-monthly staffing report which details challenges and mitigation. The Board Assurance Framework (BAF) includes a staffing risk which is detailed in the Trust Board reports.
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic	The risk appetite related to staffing has been considered and amended with an increased risk rating applied to staffing risk ID. 115 on the BAF. There is no consideration for a revised risk appetite related to quality at present.

	The risk appetite is embedded and is lived by local leaders and the Board (i.e risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)	Daily system meetings are held for Cheshire and Mersey where staffing risks are discussed in relation to the ability to provide services across the system.
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework	The BAF contains risk ID 115 which is directly related to staffing and details current challenges.
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus	The BAF is received by the Trust Board as a standing agenda item any significant risks are included in the BAF.
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges	The Trust Board is assured via the Trust governance process that where necessary escalation to NHSE/I or CQC is required.

Appendix Five – Cost of Extending Pay Incentive Scheme

Cost of Extending NHSP Pay Incentive Schemes

The approximate cost of extending the NHSP Pay Incentive Scheme for registered nurses and HCA's is outlined below, these costs are based on the forecasted costs for January. It is worth noting that other acute Trusts across Cheshire and Mersey have extended their pay incentive schemes.

Cost of Extending NHSP Incentive Scheme for Registered Nurses and HCA's

		Cost of Incentive
Unqualified	BO (Bank only)	£14,250
Unqualified	MPH (Multi post holder- own staff)	£16,750
Associate Nurses	BO	£350
Associate Nurses	MPH	£1,750
Qualified	BO	£9,000
Qualified	MPH	£64,000
	Total	**£106,100.00**

The table below outlines the cost of extending the 3rd year student nurse pay incentive based on the forecast for January and shift fill in January 2022 to date.

Cost of Temporary Student Nurse Placements in to HCSW Positions

	Student Nurses	Hours per week	Weeks	*Hourly Cost	Total Cost
	20	23	4	£16.86	£31,022
			Total Cost		**£31,022**

Appendix Six – Nurse Staffing Escalation Flow Chart

Escalation – Safe Staffing Across Adult Wards & Departments

STEP 1

- 1 nurse below budgeted establishment on shift
- **Day shift** – Each qualified nurse has no more than 8 patients.
- **Night shift** – minimum of 2 RN's per shift, each RN to have no more than 10 patients
- Are there any patients that require 1:1 (Enhanced Care) and you are unable to allocate a nurse to care for them?
- You have concerns about providing safe care for patients with the current level of staffing?

IF YOU HAVE ANSWERED 'YES' TO ANY OF THESE QUESTIONS

- Review duty roster in relation to staff on annual leave, study leave, swapping shifts, supervisory status of the Ward Co-ordinator or Ward Manager
- Submit a request for temporary staffing via NHSP and agency cascade..
- Review ward acuity in regards to safety.and if appropriate raise a Red Flag on SafeCare system

UNABLE TO ESTABLISH SAFE STAFFING LEVELS - ESCALATE TO STEP

STEP 2

In hours – 08.00h to 17.00h (Matron / Lead Nurse).

- Lead Nurse / Matron to liaise within the CBU to see if other wards can send staff
- If no bank workers available authorise the use of trained agency staff.
- If not resolved escalate to Lead Nurse / Head of Midwifery /Deputy Chief Nurse.

Out of Office Hours (Escalate to Night Practitioner / Site Manager / On-call Manager)

- Night Practitioner / Site Manager / On-Call Manager to liaise with other wards / departments to identify staff who can be moved between wards, departments and Divisions.
- Authorisation for agency use is required from the Site Manager / On-Call Manager.
- If still unable to provide cover escalate to Director On-Call.

UNABLE TO ESTABLISH SAFE STAFFING LEVELS - ESCALATE TO STEP

STEP 3

Lead Nurse for daily staffing/Deputy Chief Nurse/Head of Midwifery.

- At 9am meeting review Trust-wide allocation of staff and liaise with peers to action staff movement between wards and departments.
- Consider further actions for reducing in-house training (except Mandatory Training) requirements to allow for the redeployment of staff.
- Consider allocation of Nurse Specialists and other non-ward based nurses to provide ward cover.
- Consider movement of patients/ case mix/ dependency within the unit to safely manage the patients within the available skill mix.
- Consider planning staff and patient movement for forthcoming shifts, across the Trust.
- Escalate to CBU managers and Deputy Chief Operating Officer (DCOO)

If n the Deputy Chief Nurse will inform the Chief Nurse with a view to moving patients across the Tr ary closure of a bed for less than 4 hours.

Out of Hours – Night Nurse Practitioner/Site Manager/Matron/On call Manager

- Review and ensure actions from earlier escalation are in place.
- Contact "On Call" Manager to review the need to redirect admissions and the possibility of closing beds, assessing the anticipated duration of closure

At no time will beds be closed without prior consultation with the Chief Nurse and Director of Operations (in hours) and the Director on-call (out of hours)

Document all actions on the staffing template report and complete a Datix form if indicated.
MATERNITY LOCATIONS – Please refer to local Policy.

Escalation for Safer Nursing & Midwifery Staffing - For Immediate Action

For the attention of: nurses; midwives and healthcare support workers

For local action by: ward managers; ward sisters; nurses; midwives and healthcare support workers, including multidisciplinary allied professional visiting the ward.

NB. You must cascade this information to all staff at every handover for a period of seven days and keep for reference within the ward / department information folder.

Situation and Background:

- The Trust has a duty to ensure that all wards and departments are staffed with the appropriate number and mix of midwives and allied health professionals.
- This escalation provides guidance to the nursing and midwifery staff with a process for addressing and escalating concerns when short term staffing shortfalls occur.
- This escalation provides guidance to ensure a standardised approach for escalation within divisions once a staffing shortfall is identified.
- Nursing and midwifery staffing levels have been set within the Trust using nationally recognised methodologies and the Trust is committed to ensuring that there are the right number of staff and skill mix to care for our patients safely and to effectively utilise our workforce through efficient resource allocation.

Actions required:

- All nurses, midwives and healthcare support workers to familiarise themselves with the department staffing guideline, temporary staffing guideline and E-rostering policy.
- Display chart “Escalation – safe staffing across wards and departments” in a prominent location ensuring clear visibility for all staff.

For more information please contact:
Ellis Clarke, Lead Nurse for Staffing and Workforce Improvement/John Goodenough, Deputy Chief Nurse

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/01/07 b	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	26 January 2022

Date of Meeting	7th December 2021
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/21/12/ 297	**Hot Topic – ED & Quality Review**	The Committee received a presentation regarding the number of complaints, PALS incidents, risks and claims within ED over the last 2 years. • There have been 6 moderate harm incidents since April 2021 – no specific themes. The majority of incidents were low/no harm. • One of the complaint themes highlighted was wrong diagnosis, a deep dive is currently being undertaken to identify whether these are incidents or complaints. • Currently there are 21 risks for ED open on the risk register and actions are being taken to address this. • Ambulatory and respiratory 1 are struggling with capacity issues, 2 hourly meetings are in place to monitor the position. • Complaints have reduced in ED Department, and this is due to improved processes with the team, supported by the complaints team in Governance. The report did not include 12-hour breaches however, these come to Execs daily and an update will be provided to the next QAC in January 2022.	**The Committee discussed the presentation and received moderate assurance. It was agreed that a further update in relation to 12-hour breaches would be received at the next meeting.**	**January QAC**

QAC/21/12/298	**Deep Dive Review – 72 Hour Fracture Clinical Review**	The Committee received a report centred on the Trauma & Orthopaedics team delivering the BOAST Guideline, particularly noted: • Since 2017, T&O have seen an increase in attendance, however there was a dip in 2020/21 due to Covid. • At the end of October there was 3927 patients referred to clinic and this has resulted in a downward trend in number of patients being seen within 72 hours. A deep dive has taken place and the actions taken to improve compliance are below • The backlog has been cleared with no harms identified • Fracture clinic dashboard has been created • Closer working with ED • Standardisation of clinic names • Validation of planned follow ups • Hot Clinics introduced. Virtual Fracture Clinics are being planned and pilot is to take place in December 2021, and planned launch is January 2022. The Committee was assured that a clear action plan is in place.	**The Committee noted the report and received moderate assurance.**	**N/A**
QAC/21/12/299	**ED Response Group update**	The Committee received a presentation and overview from the ED Response Group. Of particular note was: • An education and training plan is in place to upskill staff based at Warrington in minor illness. • Cross site working with Halton Urgent Care Centre has commenced. • GP has been placed in minor injuries.	**The Committee discussed the presentation and received good assurance and agreed that a further update should be received at January QAC.**	**January QAC**

		• Criteria have been agreed for patients presenting with minor illnesses to be streamed to minor illness for assessment. • Senior doctor in place at Triage, working collaboratively with Acute Medicine Consultant to identify patients who do not need a bed and could be seen in hot clinics and improve patient flow. The number of DTA's has decreased. Has had a very positive impact on ED. • ED Plaza work has commenced, plan to open in 2022. Update in terms of data to be given in January QAC		
QAC/21/12/ 301	**Navajo Chartermark – submission for approval.**	The Committee received a report which provided details on the Navajo Chartermark and submission for approval. The presentation provided an overview of the key areas relating to the Navajo Chartermark submission and explained the background, application process, key findings and actions taken.	**The Committee discussed and supported the Navajo Chartermark application.**	**N/A**
QAC/21/12/ 303	**Maternity Update/ Maternity Safety Champion Bi-monthly report**	The Committee received an update regarding Maternity services. • Moving to Outstanding actions progressing: 112 actions and 57% are completed. • 100% of Warrington women booked onto CoC pathway • Currently recruiting for 3 posts and are moving forward with the Halton Community Midwifery Service – feedback has been very positive. **Maternity & Neonatal Safety Champions Guideline** • The Committee approved the guidance. **Maternity SI Monthly Report** • In October 2021 there were 92 incidents, 84 no harm, 6 low harm and 2 moderate harm. • Top 5 themes were: PPH, Inadequate documentation, new-born blood tests, nursing and midwifery staff, delay in treatment.	**The Committee discussed the reports and received good assurance.**	**Trust board – January 2022 (Maternity & Neonatal Safety Champions Guideline).**

		Assurance given that whilst incidents reported were high, this reflects a positive and transparent reporting culture, with the aim being high reporting and no harm.		
QAC/21/12/304	**Antimicrobial Point Prevalence Audit 6 month report**	The Committee received a presentation outlining the update and key areas to note for Antimicrobial Audit. • Compliance in November 2021 has not managed to exceed the 90% compliance threshold however there has not been a sustained downward trend which is reassuring. • A business case has been submitted to recruit more staff and money has been identified to fund this, it is expected that once this is in place, more frequent and in-depth auditing in areas of concern can happen. This will provide further feedback and a higher level of assurance to the board. An update is to be included in the high-level briefing for future meetings from PSCESC.	**The Committee discussed the presentation and received good assurance.**	**PSCESC TBC**
QAC/21/12/305	**Sepsis – high level update on screening – deteriorating patients**	The Committee received a report with an update on Sepsis screening. • Improved compliance with screening and administration of antibiotics for patients in ED with a suspected diagnosis of sepsis. • 11% of inpatients were given antibiotics over 3 hours after prescribed however all patients have been review and no harm has been found. • It was agreed that a deep dive on inpatient sepsis would be appropriate.	**The Committee discussed the report and received moderate assurance.**	

The Committee also received and discussed:

- **QAC/21/12/300** - Moving to Outstanding Action Plan Update.
- **QAC/21/12/302 –** Key Discussion points from Clinical Recovery Oversight Committee (CROC)

The Committee received and noted the following

- **QAC/21/12/307 –** Quality Dashboard Briefing and Dashboard
- **QAC/21/12/308 –** Dementia Strategy Q2 report
- **QAC/21/12/309 –** Safeguarding Bi-Annual report
- **QAC/21/12/310 –** Learning from Experience Q2 report

- **QAC/21/12/311 –** Clinical Audit Q2 Report
- **QAC/21/12/312 –** Quality Priorities Q2 Report
- **QAC/21/12/313 –** Quality Impact Assessment Report for CIP Plans

The Committee received the High-Level Briefing Reports from the following Sub Committees:

- **QAC/21/12/314 –** Patient Safety and Clinical Effectiveness Sub Committee 30.11.2021
- **QAC/21/12/315 –** Safeguarding Sub Committee 17.11.2021
- **QAC/21/12/316 –** Patient Experience Sub Committee 09.11.2021
- **QAC/21/12/317 –** Complaints Quality Assurance Sub Committee 13.10.2021
- **QAC/21/12/318 –** Patient Equality, Diversity and Inclusion Sub Committee 16.11.2021

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/01/07 b ii	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	26 January 2022

Date of Meeting	11 January 2022
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/22/01/ 04	**Hot Topic – 12 Hour Breaches – Themes and Trends**	The Committee received a presentation regarding an update on 12-hour breaches and particularly noted: • Since August there have been 67 recorded breaches. However, none resulted in any harm to patients. • From December to date there has been a further 23 recorded. • For 66 out of 67 breaches, there had been no bed capacity and the remaining one attributed to a delay in transfer. • On average there were between 125-137 super stranded patients, this week had reported 150. • Early escalation to senior managers and the Executive Team has continued to take place and updated policies and processes continue to be ratified to provide clarity on oversight, identifying the importance of the relationship between governance and clinical teams. • A significant challenge is the complexity of patient placement during unprecedented times. • Assurance given that 12-hour breaches would continue to be tracked and scrutinised, identifying themes and trends.	**The Committee discussed the presentation and received moderate assurance.**	**QAC Ongoing**

QAC/22/01/ 07	**Deep Dive Review/ Service Review – Implementation of the Medical Examiner**	The Committee received a presentation centred on the background and implementation of the Medical Examiner (ME) programme and noted in particular: • Over the last 7 months, the ME service has reviewed almost 100% of deaths within the Trust. • Moving forward the service would include reviewing deaths within the community and close working with GP practices. • Feedback on the ME service, particularly from the coroner was very positive. • To move forward into the community, it is important that a review and plan is looked at in terms of governance oversight, and reporting updates into the organisation. • The next step for the service would be to report into Datix, which would help with learning. To have clarity at an early stage it would be helpful to understand what the process will be in terms of the ME reviewing community deaths. Therefore, it was agreed: • A report to be presented at PSCESC in February and reported to QAC via a high-level briefing report which describes the current process and links with Governance that the ME service has in place. • A report detailing what the future service within the community would like to be brought to QAC in June.	**The Committee discussed the report and received good assurance.**	**QAC 1 February 2022** **QAC 7 June 2022**
QAC/22/01/ 08	**Strategic Risk Register/ BAF**	The Committee received an update regarding the Strategic Risk Register and BAF, and was asked to support the below changes: • Escalate risk #1579 – in relation to the transfer of care of patients with major trauma • Amend the description of risk #1331 It was noted that:	**The Committee noted the report, received good assurance, and approved the proposals.**	

		• Risk #1134 regarding increased absences still had significant issues and therefore will be reviewed. • Risk #1275 relating to Nosocomial infection is also going to be reviewed considering the Omicron variant.		
QAC/22/01/ 11	**Maternity Update/ Maternity Safety Champion Bi-monthly report**	The Committee received an update regarding Maternity services of note: • During November there were 80 incidents, 77 no/negligible harm and 3 minor harms. There was 1 RCA, 1 SI and 1 perinatal mortality report. • Audit findings highlighted the need to improve PPH management which has now been addressed through audit meetings and the Safety Champions Newsletter. • Discussions were taking place to find solutions to Wi-Fi issues for community midwives to improve documentation. • Regarding reportable ward closures, 4 incidents had been reported and the maternity unit had been put on divert. A further update will be given at the next meeting. • Regarding communication issues with staff, 4 incidents had been reported in isolation. It was agreed that the Perinatal Quality Surveillance report was to be presented at February meeting. **Safety Champion Bi- Monthly report** • Regarding Ockenden, there was nearly 68% compliance which was high in comparison to other organisations.	**The Committee discussed the reports and received good assurance.**	**QAC 1 February 2022**
QAC/22/01/ 12	**Inpatient Survey**	The Committee received a report regarding the findings from the Inpatient Survey which had a specific focus on food and nutrition, discharge, and noise at night, particularly noted: • 1250 patients surveyed, of which 42% has responded, an increase of 2% from last year.	**The Committee discussed the presentation and received moderate assurance.**	**QAC 1 March 2022**

		• Overall, the results averaged within the 60% range. • The focus going forward for the Patient Experience Committee would include waiting for a bed, operational pressures, hospital food, and communication after an operation (clinical staff). It was agreed that a report will be brought to QAC including a deep dive on improvement/areas of decline.		
QAC/22/01/12	**Quality Dashboard**	The Committee received an update regarding the Quality Dashboard and particularly noted: • High numbers of Sepsis patients – a deep dive will therefore be brought to the next meeting. • The position around medication administration had been escalated and performance has not dramatically improved at 65%. A business case is in its final stages which will support the improvement of this.	**The Committee discussed the report and received moderate assurance.**	**February QAC**

The Committee also received and discussed:

- **QAC/22/01/06**- Moving to Outstanding Action Plan Update.
- **QAC 22/01/09** – Cycle of Business

The Committee received and noted the following

- **QAC/22/01/14 –** Fit Testing Compliance Bi-Monthly Report

The Committee received the High-Level Briefing Reports from the following Sub Committees:

- **QAC/22/01/16–** Patient Safety and Clinical Effectiveness Sub Committee 30.11.2021
- **QAC/22/01/20 –** Health and Safety Sub Committee
- **QAC/22/01/21 –** Palliative Care & End of Life Steering Group – 14.10.2021
- **QAC/22/01/22 –** Risk Review Group
- **QAC/22/01/23 –** Quality Academy
- **QAC/22/01/25 –** IG and Corporate Records Sub Committee
- **QAC/22/01/26 –** High Levels of Enquiries

The Committee did not receive the following reports/ briefings due to operational pressures.

- **QAC/22/01/05 –** ED response Group Update **Deferred due to operational pressures.**
- **QAC/22/01/11 –** Clinical Recovery Oversight Committee – Key Discussion Points **– No report as meeting stepped down**
- **QAC/22/01/15 – Infection Prevention and Control BAF Bi- Monthly Report – not presented due to operational pressures, will still be presented at Board**
- **QAC/22/01/17 –** Infection Control Sub Committee – **meeting stepped down due to operational pressures**
- **QAC/22/01/18–** Safeguarding Sub Committee **meeting stepped down due to operational pressures**
- **QAC/22/01/19 –** Patient Experience Sub Committee - **meeting stepped down due to operational pressures**
- **QAC/22/01/24 –** Patient Equality, Diversity and Inclusion Sub Committee – **meeting stepped down due to operational pressures**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/01/11 (e)		TRUST BOARD OF DIRECTORS	DATE OF MEETING	26 January 2022

Date of Meeting	19 January 2022
Name of Meeting + Chair	Strategic People Committee
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
SPC/21/11/9	**Local Induction Temporary Medical Staff**	**Local Induction Temporary Medical Staff** **Deputy Medical Director**	**Information** Local Induction compliance increased to 72% following data cleanse Continued review of incidents related to locum doctors ongoing via SPC	**March 2022**
SPC/22/01/04	**People Strategy**	**People Strategy** **Chief People Officer** Updated People Strategy 2022 – 2025. Presented for ratification	**Decision** The new People Strategy presented for ratification in line with Warrington and Halton Teaching Hospitals NHS Foundation Trust strategic aim for our workforce … ***To be the best place to work with a diverse and engaged workforce that is fit for now and the future.*** Four new strategic People pillars: • Looking After Our WHH People • Innovating the Way we Work	

			• Growing our WHH Workforce for the Future • Belonging in WHH Request for inclusion of the Top 3 key priorities from the four strategic pillars within the People Strategy to be included. Revised draft to be sent to chair of committee and NED of Committee prior to Chairs Action to ratify. **Agreed** to take Chairs Actions to approve the strategy and send to board within SPC Chairs Log for assurance. Decision to be confirmed in March 2022 SPC Matters Arising.	**March 2022**
SPC/22/01/05	**Workforce Annual KPI Review and Refresh**	**Workforce Annual KPI Review and Refresh** **Deputy Chief People Officer (CR)** This paper outlines recommendations for updates to existing IPR indicators which are relevant to the remit of the Strategic People Committee (SPC)	**Decision** The Strategic People Committee (SPC) is asked to support the updates to the existing KPIs outlined in this paper. **Agreed:** To approve the amendments to existing People KPIs within the IPR and the removal of the following 2 KPI's: • C&M Agency Rate Card comparison • National Agency Rate Card comparison Both KPI's are also reported to Finance & Sustainability Committee. Both refer to rates that have not been aligned to national uplifts to pay rates. C&M Agency Rate Card has not been used by other Trusts since quarter one (2020) and there is no intention to refresh this work by C&M HCP / ICS at this point.	**Complete**
SPC/22/01/06	**Policies and Procedures Report**	**Policies and Procedures Report, Deputy Chief People Officer** (LH) The document sets out the review of a number of HR and OD policies, for approval.	**Decision** • Employment Break Policy (Formerly Career Break Policy) • Protection of Pay Policy The above two policies have been reviewed, developed and approved within the Policies and Procedures group and received by the Joint Negotiating and Consultative Committee (JNCC) and Operational People Committee (OPC) on the 13th January 2022.	

			Action: Both policies were presented to SPC and approved for ratification. • Supporting Attendance Policy (Formerly Attendance Management Policy) SPC was informed that a late request was received at 5pm on 18 January 2022 by staff side colleagues seeking to delay approval of the Supporting Attendance Policy by SPC to enable a more comprehensive review by all union representatives. They did not provide any information on any specific concerns, issues and proposals with the draft policy so a request was made by DCPO (LH) for this to be provided in writing and SPC were therefore asked to note the current draft and the intention to hold an extraordinary JNCC w/c 24th January 2022. Request from SPC to link the Supporting Attendance to the People Strategy given the positive cultural change outlined in both. **Agreed:** Chairs Actions to approve the Supporting Attendance policy for ratification, following the extraordinary JNCC and any agreed amendments confirmed, unless the changes are substantial which would result in the policy being tabled in March 2022 SPC.	**March 2022**
SPC/22/01/07	**BAF & Risk Register** - **Staff**	**BAF & Risk Register,** **Trust Secretary** Workforce risks on the Board Assurance Framework (BAF) and Corporate Risk Register (CRR)	**Decision** Proposal to add a new risk related to the amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to introduce the COVID vaccination as a condition of redeployment (VCOD) that will come into force on the 1 April 2022. The risk description proposed for this risk was questioned by members however the rating of 20 considered appropriate. JC agreed to work with Executive members to review the risk description in readiness for Trust Board ratification.	

			Agreed: To approve for onward ratification by Trust Board a new risk rated at 20 related to VCOD No risks deescalated. Discussion around the current risk rating for Risk 1207 related to workplace risk assessments for all staff and whether this was appropriate given the actions and listed gaps. It was noted that during Wave 5 of COVID-19 risk assessments were being used to safely deploy staff and therefore this would be reviewed for the next SPC.	**January 2022**
SPC/22/01/08	**Chief People Officer Report**	**Chief People Officer Report, Chief People Officer** The Chief People Officer updated the Committee on: • COVID-19 Workforce Risk Assessments • Self-Isolation SOPs • Annual Staff Survey • Wellbeing Update • ED&I • Occupational Health • HR&OD Flip Book	**Assurance** **COVID-19 Workforce Risk Assessments** – maintained high compliance levels; for assurance reports of any outstanding self-assessment and risk-assessments are provided to managers daily 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. **Self-Isolation SOP** – In response the continuing staff pressures within the care system, national guidance is constantly being updated to support organisations to enable early return to work for staff testing positive or who have been identified as a contact of a positive COVID-19 case, subject to the safeguards put in place. **Annual Staff Survey Update -** The annual staff survey took place between October and November 2021 with an overall response rate of 40.2% which is an increase in comparison with 2020 which was 36%. 1,744 members of staff participated and had their say in the 2021 staff survey which was an increase of 252 individuals. **Wellbeing Update** • Wellbeing of the NHS Pledge	**Complete**

			• Cultural Toolkit – Health and Wellbeing • Work Well Wednesday • Schwartz Rounds **Equality, Diversity, and Inclusion** - The update confirmed the Trust has submitted the Navajo application for the charter mark. The Trust have been offered a place on the Disability Confident Pilot, run jointly by Indeed and the Shaw Trust. The Trust is already Level 2 Disability Confident and are looking to use the pilot to become Level 3, a Disability Confident Leader in the local community. **Occupational Health** - throughout the Christmas and New Year period, the Occupational Health and Wellbeing Service have continued to provide high quality and responsive Covid support to staff and services across the organisation. **Flip Book** - In December 2021, Cheshire and Merseyside ICS published a 'People Professions Recognition Flip Book' to acknowledge the work undertaken by the staff working in People Services who have all played, and continue to play, an incredibly important role. **Vaccination as a Condition of Deployment** Report noted and link to Hot Topic agenda item.	
SPC/22/01/09	**Hot Topic - Vaccination as a Condition of Deployment**	**Vaccination as a Condition of Deployment** **Deputy Chief People Officer** (CR) This presentation provides an overview of the approach to Vaccination as a Condition of Deployment (VCOD)	**Assurance** The VCOD Hot Topic outlined the WHH approach to Vaccination as a Condition of Deployment which is being used to encourage uptake and understand/manage the potential impact of these regulations. SPC noted the dynamic nature of the approach to VCOD due to the details provided in Guidance Phase Two published on 14th January 2022 , including the ongoing decisions to be taken by Executive	

			Team including confirmation of roles in and out of scope to ensure consistency within the Trust; the emerging risks related to staff deciding to not be vaccinated and the extensive work to support staff who have concerns. **Agreed:** SPC to received further update at SPC noting that this is the end of March 2022	**March 2022**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/01/07 d i		TRUST BOARD OF DIRECTORS	DATE OF MEETING	26 January 2022

Date of Meeting	**22 December 2021**
Name of Meeting + Chair	**Finance and Sustainability Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
FSC/21/12/205	Additional oversight of Capital Expenditure (Schemes above £500k)	The Committee considered and reviewed the report noting: - • £19.7m capital plan (inclusive of donated assets) • £4.4m spend to date at month 8 against a rephased plan of £9m, underspend mainly due to ED Plaza, Paediatrics, Urology and Cardiac Catheterisation Suite • There is an underspend of £2.8m on ED Plaza, which is not to be spent until the next financial year. Recommended that this be brokered to support Cheshire and Mersey ICS and seek Capital Resource Limit Cover for the completion of the scheme next year • Schemes over £0.5m were reviewed, specifically the ED Plaza and the Urology Investigations Unit • No issues identified as a result of COVID-19 at this stage, this will remain under review	The Committee **noted** the update	FSC January 2022
FSC/21/12/206	Waiting List Initiatives Audit Report	The Committee considered and reviewed the report noting: -	The Committee **noted** the update	FSC January 2022

		• Normally audit reports are considered at Audit Committee, however given the potential financial implications this has also been brought to FSC and will be taken to Trust Board • The audit opinion is limited assurance given the number of recommendations • The audit focussed on the speciality of ENT and covered the application of the current SOP, pay rates and authorisation • The five recommendations (four high and one medium) were presented. • It was highlighted that detailed management responses were included in the report to provide operational context • Agenda item to be included on FSC going forward to review ongoing progress		Trust Board 26 January 2022
FSC/21/12/207	Monthly Finance report	The Committee considered the report and capital proposals. Key points to note included: • £1m deficit, better than planned position by £0.2m • RTT 93%, higher than target set, not included in the financial position as payment is contingent on the rest of the CM system • Breakeven plan submitted which includes risk, £2.9m gap phased across Q4 and still to be bridged • ERF is at risk due to COVID-19 which could impact on elective activity • Noted the change in the capital contingency as a result of approved emergency capital of £21k and supported use of net £15k of capital contingency • Supported brokerage of ED Plaza underspend by £2.8m • Supported the request for delegated authority for the remainder of the financial year	The Committee **noted** the update and **supported** use of net £15k of capital contingency. The Committee **supported** the brokerage of the £2.8m slippage of the ED Plaza. The Committee also **supported** the request to Trust Board that any changes to the capital plan be delegated to FSC for the remainder of the	FSC January 2022 Capital to be approved at Board December 21

			financial year to support delivery of the programme.	
FSC/21/12/208	Electronic Patient Care Management System (EPCMS) OBC	The Committee considered and reviewed the report noting: - • Three key areas being 1. Cash reserves to be utilised rather than PDC funding 2. Further work on cash releasing benefits has been undertaken 3. Revenue shortfall to be addressed in FBC stage through engagement with suppliers and pursuing national funding where available • Risks highlighted around closure of K25 and ICS support • Requires support from ICS when governance arrangements are formally established, acknowledging this is a challenge at present as systems are formed • Supported to be taken to Trust Board for review with a positive recommendation	The Committee **noted** the update and **supported** for review at Trust Board	Trust Board 22 December 2021
FSC/21/12/209	Business Cases a) Diagnostic Recovery b) B3 c) K25 d) 18 Beds e) Replacement of Fluoroscopy kit	The Committee considered and reviewed the business cases noting: - • **a) Diagnostic Recovery** • Request for non-recurrent funding of £2.1m for additional diagnostic capacity until the end of the financial year • £1.1m funding received therefore a balance of £1m requested • Request for non-recurrent funding of £0.1m to support the delivery of Echocardiogram recovery by agency staff • Request for recurrent funding of £0.1m to recruit an additional 1.83WTE Band 7 substantive staff to support continued delivery of Echocardiogram activity • Supported for review at Trust Board • **b) B3** • Request for non-recurrent funding of £1.2m in order to continue to operate B3 in Halton • £0.2m funding received therefore a balance of £1m requested • Supported for review at Trust Board	The Committee **noted** the update and **supported** the business cases for review at Trust Board. K25 **supported** with the caveat of exploring pushing forward the final date of hire agreement which would be difficult during the winter period, acknowledging the additional cost.	Trust Board 22 December 2021

		• **c) K25** • Request for funding of £2.8m per annum to enter into a 3-year hire agreement alongside maintaining the current staffing establishment to retain ward K25 • Risk highlighted that three years may not be sufficient given the timing of the end of the hire agreement, decommissioning could be at the time of the highest need • Supported for review at Trust Board with the caveat of exploring pushing forward the final date of hire agreement acknowledging the additional cost • **d) 18 Beds** • Request for recurrent funding of £0.7m, which is held in reserves, for the provision of an additional 18 beds across the Trust • Supported for review at Trust Board • **e) Replacement of Fluoroscopy kit** • Verbal presentation with paperwork to follow • The kit allows clinicians to undertake live imaging rather than a still image • £300k is currently ringfenced in the current year capital plan however £354k is the current estimate therefore £54k additional capital funding requested • Order needs to be placed by the end of the calendar year to be delivered by 31 March 2022 • Installation and turnkey can only take place post year end • £254k to be spent in current financial year (underspend of £46k which will increase contingency) • £100k to be spent in 2022/23, to be ringfenced in next year's capital programme • Supported for review at Trust Board subject to receiving paperwork in the first week in January	Replacement of Fluoroscopy kit **supported** subject to receiving paperwork in Extraordinary Trust Board meeting 22 December 2021.	
FSC/21/11/210	Corporate Performance Report	Given time constraints, the presenter was asked to take the paper as read and highlight any key items. Report noted as read noting:-	The Committee **noted** the updates	FSC January 2022

		• Nothing to report by exception		
FSC/21/11/211	Pay Assurance Report	Given time constraints, the presenter was asked to take the paper as read and highlight any key items. Report noted as read noting:- • Nothing to report by exception • Increasing demands on workforce, likely to be reflected in next month's report	The Committee **noted** the update.	FSC January 2022
FSC/21/12/212	Risk Register	Given time constraints, the presenter was asked to take the paper as read and highlight any key items. Report noted as read noting:- • Nothing to report by exception • There are no new risks or changes to the current risks	The Committee **noted** the update	FSC January 2022
FSC/21/12/213	Digital Services Board Report	Given time constraints, the presenter was asked to take the paper as read and highlight any key items. Report noted as read noting:- • The last meeting was stood down due to operational pressures • Cyber alert has been received which will also be reported to Trust Board	The Committee **noted** the update.	Report to Extraordinary Trust Board 22 December 2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/01/07 d ii		TRUST BOARD OF DIRECTORS	DATE OF MEETING	19 January 2022

Date of Meeting	**19 January 2022**
Name of Meeting + Chair	**Finance and Sustainability Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
FSC/22/01/05	Capital Plan – stocktake/deep dive outcomes	The Committee considered and reviewed the capital update, noting: - • Schemes over £0.5m were reviewed, specifically the breast relocation, Children's and Urology, shopping city and ED plaza schemes	The Committee **noted** the update.	FSC February 2022
FSC/22/01/09	2022/23 Capital Plan	The Committee considered and reviewed the capital plan for 2022/23, noting: - • Timescales and process undertaken • IFRS16 update • Planned capital • Risks and mitigations • Potential underspends and possible bring forward from 2022/23		FSC February 2022
FSC/22/01/06	Waiting list initiative update	The Committee considered the verbal update noting:- • actions on track,		FSC February 2022

		• being monitored through WLI Group and the Executive Team Meeting and • considering next years audit plan and WLI pay rates in the future		
FSC/22/01/07	Monthly Finance report	The Committee considered the report and capital proposals. Key points to note included: • Deficit position £1.4m which is on plan • Noting increase in COVID-19 expenditure • Unidentified CIP of £1.5m for remainder of the year • The Trust and system are reporting a forecast breakeven position, noting the ongoing risks of the system gap, unidentified CIP and ERF income • Approval of the change in the capital contingency	The Committee **noted** the update.	FSC February 2022
FSC/22/01/08	Warrington Town Deal	The Committee considered the report and was asked to support (subject to confirmation of final costs) the preferred option of the project team to enter into partnership with a third party supplier to deliver the next stages of the Warrington Health & Wellbeing Hub project.	The Committee **noted** the report, there are elements to the proposal that still need to be finalised & are worthy of further consideration at Board	Board January 2022
		Matters to note for assurance		
FSC/22/01/10	Corporate Performance Report	The Committee considered and reviewed the report noting: - • Cancer for November achieved the 31 day target but not the 62 day however the Trust was slightly over the interval trajectory, • Didn't achieve 2 week cancer target – linked to Breast due to increase in referrals and COVID-19 sickness within the team • Ambulance turnaround continues to perform well	The Committee **noted** the report	FSC February 2022

FSC/22/01/11	Pay Assurance Report	The Committee considered and reviewed the report noting: - • Rate card is not being used by C&M therefore suggesting recommendation to remove the graph from the table • On target with interface scheme of patchwork and plus us rota master system • VCOD reference to bank & agency will need to be compliant	The Committee **noted** the update.	FSC February 2022
FSC/22/01/12	Monthly CIP	The Committee considered and reviewed the monthly CIP noting: - • On plan at the end 31 December with £1.9m delivered • Greater CIP challenge in H2 with the current risk of £1.5m	The Committee **noted** the CIP report	FSC February 2022
FSC/22/01/13	COVID-19	The Committee noted the quarterly COVID-19 update, noting: - • An increase in expenditure compared to last month • Agreed to receive this report on a quarterly basis rather than monthly subject to expenditure continuing to reduce	The Committee **noted** the update and agreed to change in reporting frequency	FSC April 2022
FSC/22/01/14	Lastest NHS guidance, consultations and budget setting	The Committee considered and reviewed the capital update, noting: - • Clarified 10 priorities however not all details are yet available • The draft timetable	The Committee **noted** the update.	FSC February 2022
FSC/22/01/15	Digital Services Board Report	The Committee considered and reviewed the report noting: - • The assurance levels in the report • Items for escalating included cyber alert and maternity system • EPR slides reviewed including o ICS currently unable to support the submission due to CDEL limits o Current status of procurement process continue until preferred bidder stage and o then produce a preferred suppliers OBC rather than average costs. o It is believed we can then go back to ICS and consider current external funding opportunities at that time	The Committee **noted** the update and supported the EPR slides to be presented to Board.	Board January 2022

FSC/22/01/16	Costing Report	The Committee carried the report forward to the February meeting	The Committee **agreed to carry forward to February meeting**.	FSC February 22
FSC/22/01/17	Risk Register	The Committee noted the report noting: - • There are no new risks or changes to the current risks	The Committee **noted** the update	FSC February 2022

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/01/07 e	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	26 January 2022

Date of Meeting	18 November 2021
Name of Meeting & Chair	Audit Committee, Chaired by Michael O' Connor
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
AC/21/11/75	**Changes/update to BAF**	The Committee particularly noted the following since the last meeting: Two new risks had been added to the BAF: • Risks #1331 and #1125 There have been no amendments to the ratings of any risks and no risks have been de-escalated from the BAF since the last meeting. The number of risks currently on the BAF were discussed and felt to be appropriate.	**The Committee discussed the report and received good assurance**	**Audit Committee 17 February 2022**
AC/21/11/76	**Progress Report on Internal Audit Follow-Up actions**	The Committee received a report providing details of Internal Audit Reports with any outstanding management actions. The Committee particularly noted: • At 30th September there were 21 audits with 2 overdue management actions.	**The Committee discussed and approved the report and received moderate assurance.**	**Audit Committee 17 February 2022**

		The following requests for extensions to partially completed actions were agreed: • Extra Duties Payment Review – low risk - extension from the original deadline of 31 August 2021 to 30 November 2021. • Change Management – medium risk - extension from the original deadline of 30 September 2021 to 31 December 2021.		
AC/21/11/78	**Internal Audit Progress Report**	The Committee received a report providing an update in respect of the assurances, key issues and progress against the internal Audit Plan for 2020/21. 2 reports issued: • Data Quality Review – substantial assurance • CPR Decision making – moderate assurance The Committee received an update of 2021-22 audit plans. • MIAA to set their fee increase for 2021-22 at 1.7%. • The planned Agenda for Change increments review for this year was to consider Pay Step Progression which has been paused nationally, therefore it was proposed to be replaced by the Waiting List initiative review. This change would result in an increased Internal Audit plan from 230 days to 241 days. • The fee for 2021/22 would be £78,286. The Committee agreed to the proposal that the Agenda for Change Increments review is replaced by the Waiting List Initiative review.	**The Committee reviewed and discussed the report and assurances provided. Moderate assurance was received.**	**Audit Committee 17 February 2022**
AC/21/11/82	**Review of Quotation & Tender Waivers July 2021-30 September 2021**	The Committee received the report and noted: • Formal training is currently being delivered, focusing initially on the Clinical Business Units and Divisions with the highest number of retrospective waivers that commenced end of July 2021.	**The Committee noted and discussed the report and received moderate assurance**	**Audit Committee 17 February 2022**

		• Letters are now to be sent to repeat offenders.		

Other items included on the agenda were:

AC/21/11/74 – Update from Chairs – FSC, SPC, QAC, CFC and CROC
AC 21/11/77 – Internal Audit Progress Report on Follow-Up actions
AC/21/11/79 – Report and Updates from External Audit
AC 21/11/80 – Counter Fraud Progress Report
AC 21/11/81 – Review Losses & Special Payments period 1 July 2021 to 30 September 2021
AC/21/11/83 – Review of Trust Registers
AC/21/11/84 – Update of SORD and SFI's
AC/21/11/85 – Freedom to Speak Up Policy update
AC/21/11/86 - Review other reports and policies as appropriate, eg changes to standing orders, FTSU, Treasury Management Policy
AC/21/11/87 – Audit Committee Annual Committee Effectiveness Survey

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/08**	
SUBJECT:	**Moving to Outstanding and Red Flags Bi-Monthly Report**	
DATE OF MEETING:	26 January 2022	
AUTHOR(S):	Layla Alani, Director of 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 delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	

	#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 and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#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. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#1579** Failure to transfer patients with major trauma, PPCI and Vascular to specialist units, caused by unprecedented demands on the North West Ambulance Service, resulting in a delay for identified or accepted specialist high risk cases. **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident. **#1331** Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	Moving to Outstanding Steering Group continues to focus on: • The 'Red Flags' report, linked to CQC's Insight Report • Oversight of CQC enquiries (12 received October 21 to date) • Oversight of the mock inspection programme • Progress updates on: o Medicines Improvement Group o Progress towards ACSA accreditation

	o Progress towards JAG accreditation renewal o Appraisal and Mandatory training compliance o Communications o Use of Resources This paper provides high-level updates across each of these areas. Some meetings have been stood down and mock inspections paused due to capacity operationally and within the compliance team.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors are asked to note the contents of this paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/22/01/06		
	Date of meeting	11 January 2022		
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Moving to Outstanding and Red Flags Bi-Monthly Report	AGENDA REF:	BM/22/01/08

1. BACKGROUND/CONTEXT

Moving to Outstanding Steering Group continues to focus on:

- The 'Red Flags' report, linked to CQC's Insight Report
- Oversight of CQC enquiries (12 received October 21 to date)
- Oversight of the mock inspection programme
- Progress updates on:
-
    - Medicines Improvement Group
    - Progress towards ACSA accreditation
    - Progress towards JAG accreditation renewal
    - Appraisal and Mandatory training compliance
    - Communications
    - Use of Resources

This paper provides high-level updates across each of these areas.

2. KEY ELEMENTS

2.1 Red flags report

The Red Flags report presented at the Moving to Outstanding Steering Group in November 2021, noted that:

- The CQC had not released a revised Insight report. This meant the CQC's data for the 72 indicators reported in September 2021 had not been updated.
- In the absence of the revised Insight report, the Trust's teams have continued to focus on all indicators that are declining or below the national average. These indicators are monitored through the Red Flags report. In November 2021 there were 28 indicators in total outstanding.
- A summary overview of all indicators is below in Appendix 1. Key points are:
    - 35.7% of indicators (10/28) are improving, compared to 43% (12/28) in October 2021. Further detail is included at 2.1.1 below in relation to the performance of indicators.
    - 64.3% of indicators (18/28) are declining, which is a slight deterioration, from 57% (16/18) in October 2021. Further details are provided at 2.1.1 below.
    - 14.3% (4/28) of the declining indicators are above or in line with the national average. These are ratio of ward managers to staff, immediate managers, team working and ambulance turnaround times.

2.1.1 Performance of indicators

Trust-wide

- Trust-wide the number of indicators showing improvement performance has increased from 3/11 to 5/11 (18% improvement when compared to September 2021). The improved indicators related to sickness absence.
- The Trust is actively monitoring 3/6 indicators showing declining performance, noting they remain above the national average when benchmarked.
- The remaining indicators (GMC Enhanced Monitoring; Whistleblowing; and Turnover of Nursing and Midwifery Staff) have plans in place to address them, which are monitored across all Executive agendas.

Urgent and Emergency Care

- There was deterioration in 3 of the 6 indicators for Urgent and Emergency Care.
- The deterioration related to operational pressures and the challenges across the hospital with flow. Operational performance is being supported by the Patient Flow Programme with oversight provided at the Clinical Services Oversight and Performance Review Group.
- The ED steering group continue to meet and trial initiative recognised by the CQC as good practice. Work also continues with system partners to improve discharges for super-stranded patients.

Medicine

- Performance remained unaltered in relation to the indicators showing improvement (3/5) and those declining (2/5).
- The 2 declining indicators relate to mortality. Assurance can be offered that action plans are in place to address the two mortality indicators.

Surgery

- There was an improvement in one indicator (RTT completed admitted pathways), resulting in 2/3 indicators demonstrating improvements.
- The declining indicator relates to historic data (2019) for surgery no longer performed at the Trust. This is being monitored to ensure it is removed from the Trust's dataset by the CQC.

Cancer

- There has been a decline in the performance against the 2 week wait standard due to an increase in breast service referrals. The breaches are being managed with an expected recovery in January 2022.
- Performance against agreed trajectories for the 62+ day and 104+ are being consistently met and are monitored via the Clinical Services Oversight Group and the Performance Review Group.

Outpatients

- The two indicators for Outpatients deteriorated, but still demonstrated performance above the national average when benchmarked.

- Performance was impacted by staff sickness and annual leave.
- Assurance can be offered that performance has subsequently improved. Oversight of these indicators is provided at the Clinical Services Oversight Group and Performance Review Group.

There are plans in place to monitor CQC red flags across all executive agendas.

2.2 CQC Enquiries

From 21 October 2021 the Trust has received 12 new CQC enquiries. All enquiries are linked to internal incident investigations. The Director of Governance oversees responses to these enquiries and there are no concerns to escalate to this Committee.

2.3 Oversight of the mock inspection programme

- At the November Moving to Outstanding Steering Group the Maternity team provided an update of the actions agreed following their mock inspection.
- The on-site part of the Urgent and Emergency Care inspection has been completed. Due to unforeseen absence, the triumvirate interview has been rescheduled. An initial compliance action plan will be implemented followed by a moving to outstanding action plan. These action plans will be monitored through the CBU governance process and the Moving to Outstanding Steering Group.
- The unannounced mock inspection for outpatients has been completed. An initial compliance action plan will be implemented followed by a moving to outstanding action plan. These action plans will be monitored through the CBU governance process and the Moving to Outstanding Steering Group. Further inspections are scheduled/ proposed throughout Q4 2021/22.
- Mock inspections have been intermittently paused due to operational pressures and staff absence.

2.4 Medicines Improvement Group

Assurance was provided that the Medicines Improvement Group continue to meet and address relevant areas including:

- Omitted Medicines
- Controlled Drugs
- Medicines Storage

There are no concerns to escalate to this Committee.

2.5 Accreditations

Progress towards ACSA accreditation

- A final accreditation on-site visit is scheduled for 22 March 2022.
- Actions are currently on-track for this visit.

2.6 Progress towards JAG accreditation renewal

- The JAG visit is scheduled for 10th and 11th February 2022.
- Actions are currently on-track for this visit.

2.7 Appraisal and Mandatory Training Compliance

At the meeting trajectories for Mandatory training, Role Specific Training and PDR were provided. Assurance can be offered that good progress is being made across the trust for both Adult and Children Safeguarding. SMEs and CBUs continue to be supported to develop trajectories to improve compliance and this is being reported monthly through the Operational People Committee. Further work is scheduled in relation to appraisals, which are currently behind trajectory (planned: 62% vs actual: 55.9% (November 2021)).

2.7 Communications

The Director of Communications and Engagement provided a progress updated across the three key elements required under the CQC Responsive and Well Led domains that are being addressed jointly by the Patient Experience and Communications & Engagement teams:

- The production of patient information
- Compliance with the accessible information standard
- The engagement, participation and involvement of service users, wider stakeholders and our community in the development of our services.

A progress update was provided on the five key workstreams:

- The production of patient information (PINFO)
- Compliance with the accessible information standard
- Patient and Public Participation and Involvement (PPP&I)
- Communications and Engagement
- Freedom of Information Act Information requests (FOI)

There are no concerns to escalate to this Committee.

2.8 Updates on Use of Resources

Use of Resources assessments remain suspended whilst the CQC and NHSI/E develop a revised framework. Internal work continues to be completed whilst further information relating to these frameworks is awaited. There are no concerns to escalate to this Committee.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

A monthly update will be provided by the Director of Governance to the Moving to Outstanding Steering Group Meeting. This will then report to the Quality Assurance Committee and Trust Board accordingly.

4. ASSURANCE COMMITTEE

This paper will continue to be provided on a bi-monthly basis to the Quality Assurance Committee.

5. RECOMMENDATIONS

The Board of Directors are asked to note the contents of this paper.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/09**	
SUBJECT:	**Use of Resource Assessment (UoRA) Update – Q3 2021/22**	
DATE OF MEETING:	26th January 2022	
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 delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1273 Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. #1289 Failure to deliver planned elective procedures caused by the Trust's decision to pause some elective procedures in order to ensure safe staffing and critical care capacity during the COVID-19 pandemic, resulting in potential delays to treatment and possible subsequent risk of clinical harm #115 Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. #134 Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. #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):*	The Trust continues to progress improvement in its Use of Resources both internally and in collaboration with system wide partners, however COVID-19 has impacted progress. This paper outlines the current status of the Use of Resources Dashboard, however it should be noted that a number of the indicators have not been updated on the Model Hospital.	

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

RECOMMENDATION:	The Board of Directors is asked to: 1. Note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	

	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO THE BOARD OF DIRECTORS

SUBJECT	Use of Resource Assessment (UoRA) Update – Q3 2021/22	AGENDA REF:	BM/22/01/09

1. BACKGROUND/CONTEXT

The Use of Resource Assessment (UoRA) is designed to improve understanding of how effectively and efficiently the Trust uses its resources. The UoRA is based on 5 key lines of enquiry (KLOEs) these are; clinical services, people, clinical support services, corporate services and finance. The UoRA workstream has prepared narrative for each KLOE and has developed a dashboard. This forms the basis from which to review and improve each KLOE indicator.

UoRA data is from the Model Hospital and has been benchmarked against peer and national median groups. The RAG rating is based on the Trust's position against the national median on the model hospital. The peer median group is based on NHSI's peer finder tool.

2. KEY ELEMENTS

This paper presents the update for Quarter 3 2021/22. Progress has been impacted by the COVID-19 pandemic. Performance against each UoRA KLOE is set out in **Appendix 1**, the full detail for each KLOE indicator can be found in **Appendix 2**.

The following movements have taken place on the UoRA Dashboard since Quarter 2:

- Pre-Procedure Non Elective Bed Days – The Trust has moved from Green to Red for this indicator as the Trust is slightly worse the national median.
- HR Costs per £100m income – The Trust has moved from Red to Green for this indicator as costs per £100m income are below the national median based on the 2020/21 national corporate benchmarking exercise.

National Corporate Benchmarking

The Trust has received the National Corporate Benchmarking report and is reviewing the data to understand areas of variation and improvement. Once this work is complete, this will be shared with the Trust Board and any actions resulting from the review, will be incorporated within the UoRA work plan.

3. RECOMMENDATIONS

The Board of Directors is asked to:

1. Note the contents of this report.

Andrea McGee
Chief Finance Officer and Deputy Chief Executive
14th January 2022

Appendix 1 – Benchmarking Performance against the National Median

KLOE Indicator	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22
KLOE 1 - Clinical														
Pre-Procedure Elective Bed Days	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22
Pre-Procedure Non-Elective Bed Days	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22	Q2 20221/22
Emergency Readmission (30 Days)	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22
Did Not Attend (DNA) Rate	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22
KLOE 2 - People														
Staff Retention Rate	June 2018	September 2018	December 2018	December 2018	December 2018	December 2018	March 2020	March 2020	June 2020	Sept 2020	December 2020	March 2021	March 2021	September 2021
Sickness Absence Rate	May 2018	August 2018	November 2018	November 2018	June 2019	October 2019	March 2020	March 2020	June 2020	Sept 2020	January 2021	March 2021	June 2021	September 2021
KLOE 3 – Clinical Support Services														
Top 10 Medicines - Percentage Delivery of Savings	March 2018	March 2018	March 2018	March 2018	September 2019	November 2019	March 2020	March 2020	August 2020	November 2020	February 2021	May 2021	July 2021	July 2021
Pathology - Overall Costs Per Test	Q4 2017/18	Q4 2017/18	Q2 2018/19	Q2 2018/19	Q4 2018/19	Q2 2019/20	Q3 2019/20	Q3 2019/20	Q3 2019/20	Q1 2020/21	Q3 2020/21	Q4 2020/21	Q4 2020/21	Q2 2021/22
Radiology Cost Per Report	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	2020/21	2020/21
KLOE 4 – Corporate Services														
Finance Costs per £100m Turnover	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2020/21
Human Resource Costs per £100m Turnover	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2020/21

Procurement Process Efficiency and Price Performance Score Clinics	Q4 2016/17	Q4 2017/18	Q3 2018/19	Q3 2018/19	Q4 2018/19	Q4 2018/19	Q4 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q2 2019/20	Q2 2019/20	Q2 2019/20	Q2 2019/20
Estates Costs Per m2	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2019/20	2019/20	2020/21	2020/21

KLOE 5 - Finance														
Capital Services Capacity*														
Liquidity (Days)*														
Income & Expenditure Margin*														
Agency Spend - Cap Value*														
Distance from Financial Plan*														

*the model hospital does not benchmark these indicators against the national median and therefore there is no RAG rating available.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

Green on the Model Hospital (Better than the National Median)
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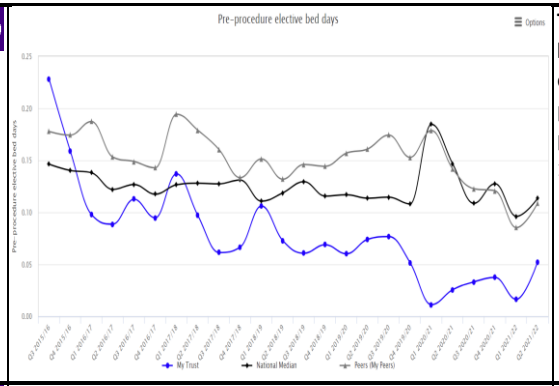
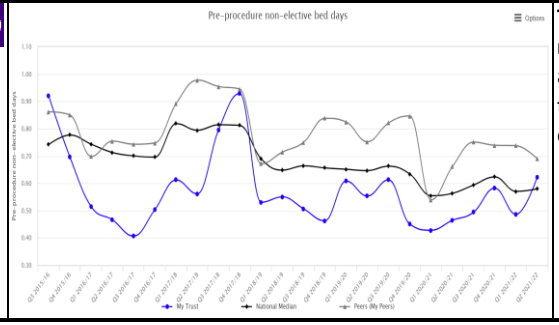
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q3 2021/22

Action/ Recommendation | **Benchmarking/Progress** | **Trend** | **Narrative - Warranted/Unwarranted & Justifiable**

KLOE 1: Clinical/Operational

KLOE Operational Lead: Zoe Harris

Pre Procedure Elective Bed Days - The number of bed days between the elective admission date and the date that the procedure taken place.	**National Median: 0.10 days** **Peer Median: 0.11 days** **Best Quartile: 0.06 days** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2021/22** **Target: Maintain** **0.05 days** **3/9 Peer Group** **1 (Best)**		**The Trust is performing in the best quartile for this metric and is performing better than the national and peer medians.** The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme supported the reduction in theatre cancellations and in improving productivity and efficiency. The position has been sustained throughout the COVID-19 pandemic and continues to be monitored.
Pre Procedure Non Elective Bed Days - The number of bed days between an emergency admission date and the date the procedure taken place.	**National Median: 0.57 days** **Peer Median: 0.69 days** **Best Quartile: 0.40 days** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2021/22** **Target: National Median** **0.62 days** **04/09 Peer Group** **3 (2nd Worse)**		**The Trust is performing worse than the national median but better than the peer median**. The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme supported the reduction in theatre cancellations and in improving productivity and efficiency. The position continues to be monitored.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

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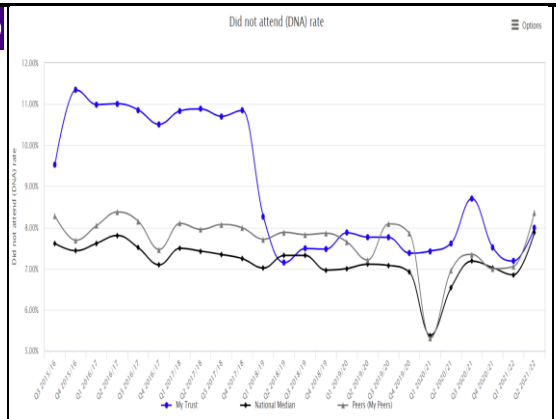
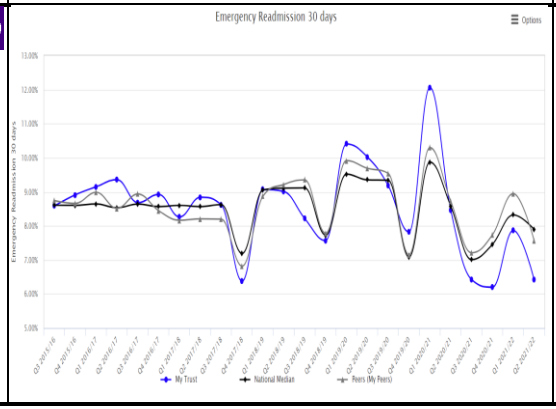
Use of Resources Assessment Dashboard - Q3 2021/22

Action/ Recommendation	Benchmarking/Progress		Trend	Narrative - Warranted/Unwarranted & Justifiable
Did Not Attend Rate - Rate of patients not attending their outpatient appointment	**National Median: 7.88%** **Peer Median: 8.63%** **Best Quartile: 6.43%** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2021/22** **Target: National Median** **7.99%** **04/09 Peer Group** **3 (2nd Worse)**		**The Trust is performing slightly worse than the national median but is performing better than the peer median.** The Trust has utlised several initiatives to support improvement in the DNA rate. This has proved challenging during the COVID-19 pandemic and the Trust continues to see seasonal variation and variances between specialties. The Trust has established the Outpatient Recovery Improvement Group incorporating 5 workstreams; Risk Stratification, Workforce, Performance & KPIs, Operational and Access Policy. DNA performance is monitored through the Performance & KPI workstream. The Access policy and the DNA policy have been reviewed and individual CBUs are monitoring frequent DNAs to ensure that these patients are clinically reviewed for potential discharge. Patient Initiated Follow Ups (PIFU) are also being used and will reduce DNAs.
Emergency Readmission Rates (30 Days) - This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay. Admissions for cancer and obstetrics are excluded as they may be part of the patient's care plan.	**National Median: 7.89%** **Peer Median: 7.57%** **Best Quartile: 6.42%** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2021/22** **Target: Maintain** **6.42%** **2/09 Peer Group** **1 (Best)**		**The Trust is performing better than national and peer medians and is in the best quartile for this metric.** Every effort is made when discharging a patient to ensure that the discharge is appropriate. Readmissions are reviewed by the clinical directors to understand any inappropriate discharges and to ensure lessons are learned. The Trust is fully engaged with GIRFT (Getting It Right First Time) and continues to use intelligence to make improvements in efficiencies and the quality of services.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

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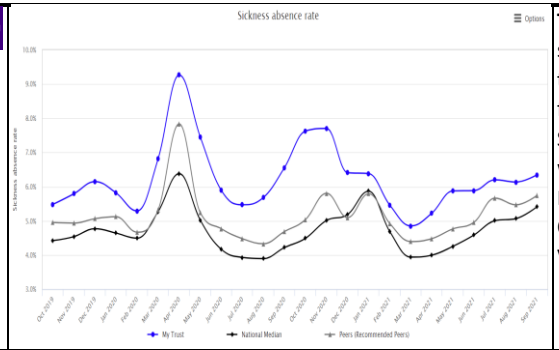
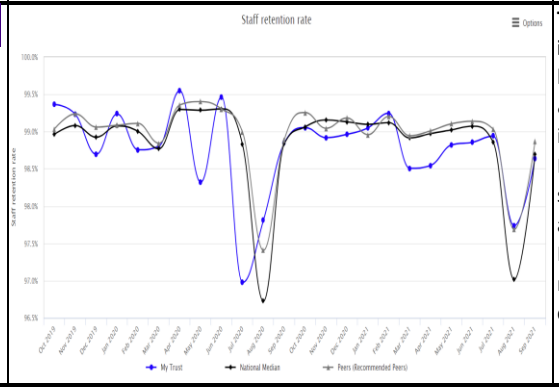
Use of Resources Assessment Dashboard - Q3 2021/22

Action/ Recommendation | **Benchmarking/Progress** | **Trend** | **Narrative - Warranted/Unwarranted & Justifiable**

KLOE 2: People

KLOE Operational Lead: Carl Roberts

Staff Sickness - Percentage of staff FTE sick days.	**National Median: 5.4%** **September 2021** **Peer Median: 5.7%** **Target: 4.2%** **Best Quartile: 4.6%** **WHH Position:** **6.30%** **Ranking:** **7/11 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: Trust Board, SPC** **Source: HSCIC - NHS Digital iView Stability Index**		**The Trust is performing worse than the national and peer medians.** Following a successful NHSE/I bid, an improvement project has commenced. Engagement with the Trust's Supporting Absence Task and Finish Group is positive with nominations for attendees across the care groups and specialities. Supporting the attendance policy development is progressing with discussions held with NHSEI, our legal partners and staff side representatives. Preventative measures continue to be implemented including; Occupational Health and Wellbeing interventions, COVID-19 Booster Campaign, Flu Vaccination Campaign and Asymptomatic staff testing.
Staff Retention Rate - The percentage of staff that remained stable over 12 months period.	**National Median: 98.7%** **September 2021** **Peer Median: 98.9%** **Target: National Median** **Best Quartile: 89.2%** **WHH Position:** **98.60%** **Ranking:** **9/11 Peer Group** **Quartile:** **3 (2nd Worse)** **Monitoring: SPC** **Source: HSCIC - NHS Digital iView Stability Index**		**The Trust is performing worse than the national and peer median, however there is less than 0.3% difference.** The Trust's reward and benefit scheme has been benchmarked with regional and national colleagues via NHS Employers and Health & Wellbeing leads across Cheshire & Mersey. Improvements which have been identified include; the Trusts approach to Long Service Awards and You Made a Difference (YMAD) monthly awards and Values Badge nominations. Reward schemes have been refreshed and are to be relaunched following Executive approval. In relation physical activity, the Trust is developing a dedicated section in the Trusts new winter wellbeing booklet "Looking After Your Health and Wellbeing" which is currently being distributed.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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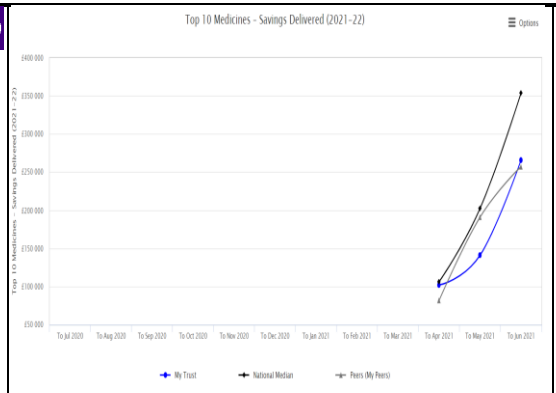
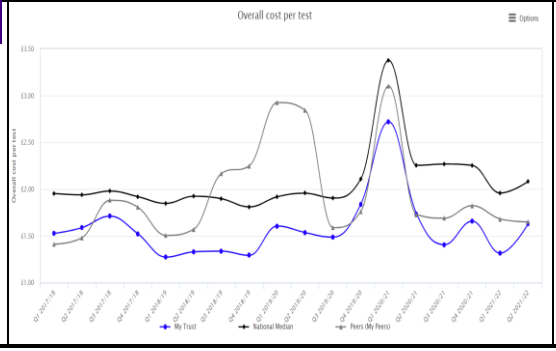
Use of Resources Assessment Dashboard - Q3 2021/22

Action/ Recommendation | **Benchmarking/Progress** | **Trend** | **Narrative - Warranted/Unwarranted & Justifiable**

KLOE 3: Clinical Support

KLOE Operational Lead: Diane Matthew
KLOE Operational Lead: Neil Gaskell
KLOE Operational Lead: Mark Jones

Top 10 Medicines - Percentage Delivery of Savings (Pharmacy)	**Benchmark: £125k** July 2021 **Peer Median: £356k** **Target: Benchmark** **Best Quartile: N/A** **WHH Position:** **£311k** **Ranking:** **Quartile:** **N/A** **Monitoring: Medicines Governance Committee** **Source: Rx-Info Define© (processed by Model Hospital)**		**The Trust is performing better than the national benchmark.** The Trust is exceeding the national benchmark and has achieved savings of £311k as of July 2021 (this is the latest available information on the Model Hospital). Medicines optimisation remains a prioritised workstream. Processes continue to be aligned between the Trust, CCGs/ICS and the Pan Mersey Area Prescribing Committee. Collaboration is ongoing to ensure opportunities for further improvements are identified. WHH is engaged in a ICS level medicines optimisation workstream which will look to collaborate on medicines efficiencies across the network.
Pathology - Cost Per Test - The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items.	**National Median: £2.08** Q2 2021/22 **Peer Median: £1.65** **Target: Maintain** **Best Quartile: N/A** **WHH Position:** **£1.63** **Ranking:** **1/4 Peer Group** **Quartile:** **1 (Best)** **Monitoring: Pathology Business Meeting** **Source: NHSI Q Pathology Data Collection 21/22**		**The Trust is performing better than the national and peer medians.** Overall the Trust's pathology service is efficient with the use of streamlined processes, technology and procurement opportunities. The Trust continues to perform well with regards to overall cost per test during the recovery period following the COVID-19 pandemic.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

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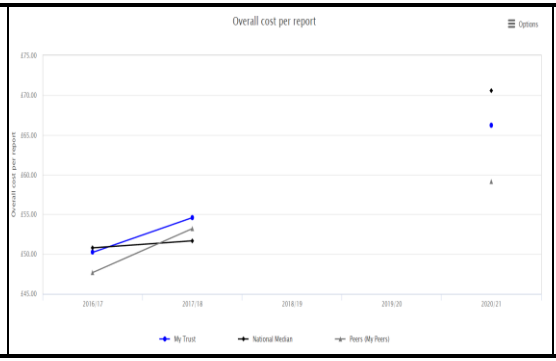
Use of Resources Assessment Dashboard - Q3 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Imaging - Cost Per Report - Total cost of reporting one image, irrespective of modality	**National Median: £70.59** **2020/21** **Peer Median: £59.10** **Target: Maintain** **Best Quartile: £55.93** **WHH Position:** **£66.19** **Ranking:** **8/10 Peer Group** **Quartile:** **2 (2nd Best)** **Monitoring:** **Source: NHS Imaging Productivity Data Collection (Annual)**		**The Trust Imaging Cost Per Report is better than the national median.** The Trust has invested significantly in diagnostic equipment which has enabled the Trust to reduce its outsourcing of radiology including vascular.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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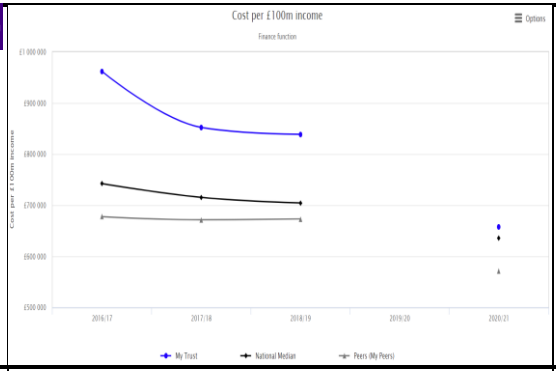
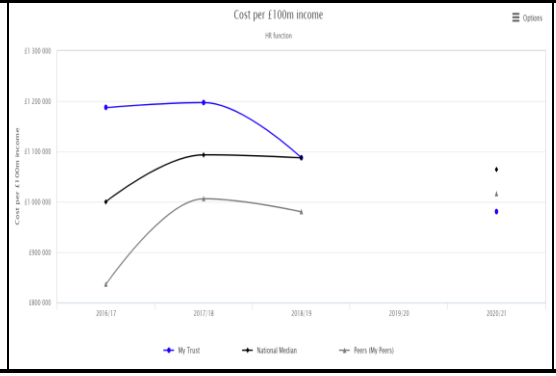
Use of Resources Assessment Dashboard - Q3 2021/22

Action/ Recommendation | **Benchmarking/Progress** | **Trend** | **Narrative - Warranted/Unwarranted & Justifiable**

KLOE 4: Corporate Services

Finance — KLOE Operational Lead: Jane Hurst
Procurement — KLOE Operational Lead: Alison Parker
HR & OD — KLOE Operational Lead: Carl Roberts
Estates & Facilities — KLOE Operational Lead: Ian Wright

Finance Costs per £100m Income - Total finance cost divided by trust turnover multiplied by a £100m	**National Median: £636k** **Peer Median: £579k** **Best Quartile: £541k** **WHH Position: £658k** **Ranking: 7/9 Peer Group** **Quartile: 3 (2nd Worse)** **Monitoring: FSC** **Source: Trust consolidated annual accounts and NHSI improvement 18/19 data collection template**	**2020/21** **Target: Benchmark**		**The Trusts Finance costs per £100m income are higher than the national and peer medians based on national benchmarking data from 2020/21**. The Trust has improved from £838k to £658k cost per £100m income which is £22k worse than the national median and £77k worse than the peer median. The Trust is reviewing the benchmarking data to understand the areas of variation and areas of improvement. A review by sub-function is being undertaken. An issue which requires further investigation is the cost of Finance specific IT systems.
Human Resource Costs per £100m Income - HR is made up of a number of sub compartments taken into consideration when considering total HR costs per £100m turnover.	**National Median: £1.06m** **Peer Median: £1.02m** **Best Quartile: £888k** **WHH Position: £980k** **Ranking: 5/11 Peer Group** **Quartile: 2nd Best** **Monitoring: SPC** **Source: Trust consolidated annual accounts and NHSI improvement 18/19 data collection template**	**2020/21** **Target: Benchmark**		**The Trusts HR costs per £100m income are lower than the national and peer medians based on national benchmarking data for 2020/21 which is positive.** The Trust is reviewing the benchmarking data to understand the areas of variation and areas of improvement. Early indications show that the Trust has a higher cost per £100m income for the following sub-functions; Non Clinical Occupational Health, Workforce Information, Education, Organisational Development and HR systems. The Trust is performing better than the national median for the following sub-functions: Core HR, Occupational Health, Clinical Occupational Health, Recruitment, Temporary Staffing, Medical Staffing and Rostering. Further work to understand the data in detail will now take place.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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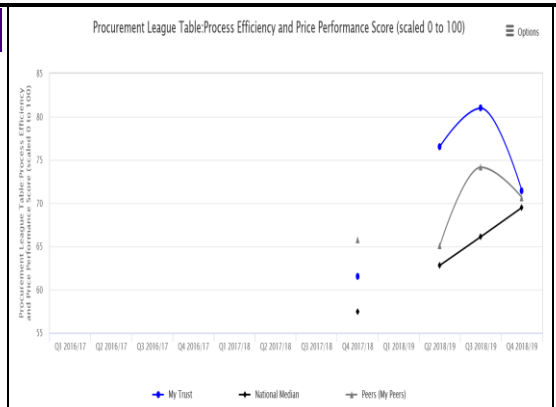
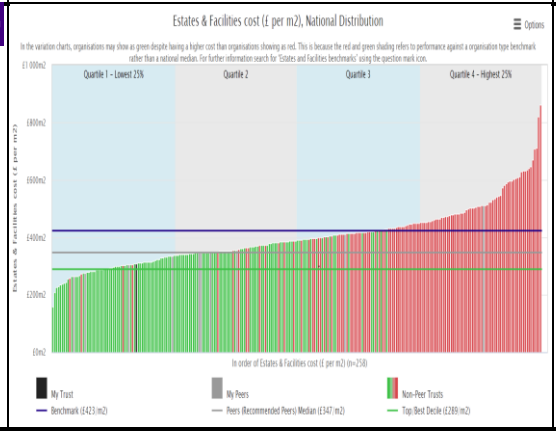
Use of Resources Assessment Dashboard - Q3 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Procurement Process Efficiency and Price Performance Score - This measure provides an overall view of how efficient and how effective an NHS Provider is in it's procurement process and price performance, respectively, when compared to other NHS providers.	**National Median: 56** **Q2 2019/20** **Peer Median: 44.7** **Target: 72** **Best Quartile: 72** **WHH Position:** **61** **Ranking:** **4/11 Peer Group** **Quartile:** **3 (2nd Best)** **Source: Purchase Price Index and Benchmark (PPIB) tool**		**The Trust is performing better the national and peer median for the Procurement Process Score.** Pre COVID-19 the Trust was engaged to move to Edge for Health, SBS has suspended new clients with no date for resuming. Edge for Health supports the streaming of processes between suppliers and Trusts, providing a single point to compare suppliers and prices. The Trust will engage with Edge for Health once SBS is accepting new clients. This will further improve the Electronic Transfer of Order and Invoices metric and therefore contribute to the Procurement League Table ranked position. The procurement metrics have been reviewed and the Trust has submitted data.
Estates & Facilities Costs (£ per m2) - The total estates and facilities running costs is the total cost of running the estate in an NHS trust including, staff and overhead costs. In-house and out-sourced costs, including PFI costs, will be included.	**Benchmark: £423** **2020/21** **Peer Median: £347** **Target: Maintain** **Best Quartile: £321** **WHH Position:** **£308** **Ranking:** **4/11 Peer Group** **Quartile:** **1 (Best)** **Monitoring: Estates and Facilities Operational Group** **Source: ERIC 2018-19 Total Estates and Facilities Running Costs**		**The Trust Estates and Facilities costs are better than the national Benchmark.** The Trust has invested year on year to reduce backlog maintenance. The Trust had the opportunity in 2020/21 to significantly invest in backlog maintenance. The Trust has received the outcome of the ERIC return, once this is uploaded to the model hospital, the Trust will be able to look at where it benchmarks against the peer and national medians for all indicators, however early indications show that the Trust continues to perform well in overall Estates & Facilities costs.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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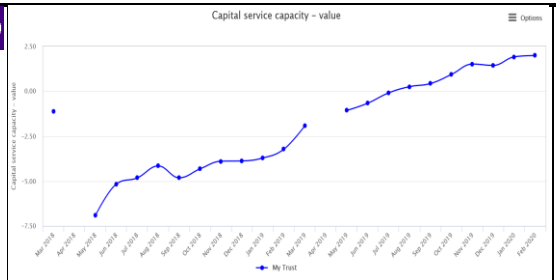
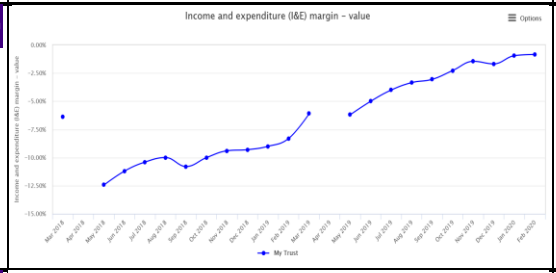
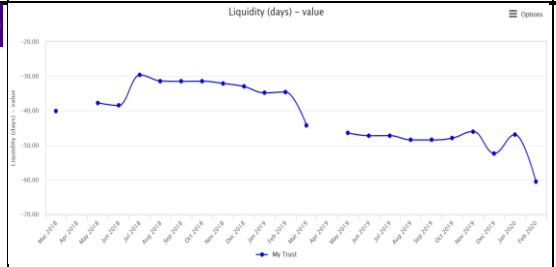
Use of Resources Assessment Dashboard - Q3 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable

KLOE 5: Finance

KLOE Operational Lead: Jane Hurst

Capital Services Capacity - The degree to which the provider's generated income covers its financial obligations	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 1.99 (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		Use of Resource (Finance) reporting has been suspended since March 2020. As of M9, the Trust's Capital service capacity is 2.50 which means the Trust is able to cover its financial obligations. It is expected to remain the same until the end of 2021/22.
Income & Expenditure Margin - The income and expenditure surplus or deficit, divided by total revenue.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital -0.85% (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		As at M9, the Trust's I&E Margin is -0.67% which means the Trust is currently operating in a small deficit.
Liquidity (Days) - Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital -66.53 (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		The Trust liquidity days are 20.43 as of M9 2021/22. This is positive and means that the Trust can promptly pay suppliers. As at M9, the cumulative Trust performance against the Better Practice Payment Code was 94%.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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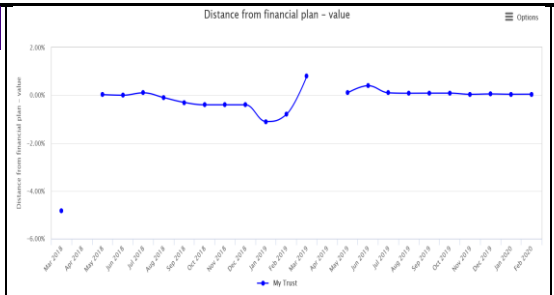
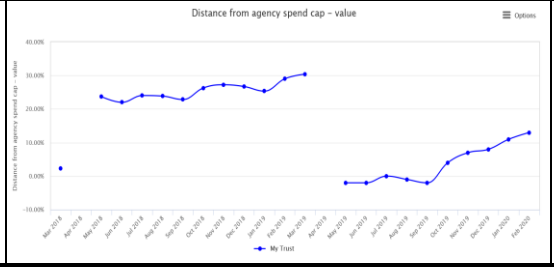
Green on the Model Hospital (Better than the National Median)
Red on the Model Hospital (Worse than the National Median)
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q3 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Distance from Financial Plan - Year-to-date actual I&E margin in comparison to year-to-date plan I&E margin. I&E margin calculated on a control total basis. Measure is in percentage points.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 0.04% (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		As at month 9 the Trust is on plan. In year the ongoing COVID-19 costs and increase in drug costs have been offset by slippage on schemes and underspends on some budget lines. The challenges for the remainder of the year and the Trusts ability to breakeven include; CIP, ERF, the current COVID-19 wave and the gap identified of £2.9m when the breakeven plan was set for H2.
Agency Spend - Cap Value - The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 13.00% (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		There is no agency cap for 2021/22, however the Trust continues to closely monitor agency spending for both business as usual and COVID-19 requirements. The agency costs are £9.3m as at month 9, which is £2.4m above plan.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q3 2021/22

KLOE/Area	Action Lead(s)	Action Plan
Clinical/ Operational - Operational Efficiency	**Zoe Harris**	• Progression of collaboration opportunities through mutual aid/SLAs to maximise use of assets e.g. Walton Centre Pain service and support recovery. • Virtual Enhanced Care – review and re-design of processes to improve patient care/experience. Expansion of the use of virtual clinics. All CBUs are creating SOPs where appropriate. • Patient Transport Services – review and reprocurement of patient transport services including capacity/demand management to improve patient flow. • ED plaza development - phase 1 (ED Ambulatory Assessment Service) to be delivered in 2021/22. Building work is now underway. • COVID-19 Recovery – recovery programme for the Trust to achieve the elective activity and outpatients. • DNA - Patient Initiated follow up is live in T&O, Cardiology, Ophthalmology, Gastroenterology and Gynaecology. Other specialties are being scoped.
People - Sickness	**Carl Roberts**	**Sickness:** •Establishment of an Absence Task and Finish Group which first met in December 2021 with a continued focus on employee Health and Wellbeing. The working group is expected to meet for the next 6 to 12 months. • Focus on interventions for staff living in Halton and Warrington, working with local community partners. • The HR Business Partner Team is providing ongoing support to operational managers in managing sickness absence. This includes advisory support in relation to policy and attendance, welfare, and sickness stage meetings/hearings. • Review 'Supported Early Return' pilot and roll out Trust wide. • Undertake a full and thorough review of the Attendance Management Policy. The Trust has secured funding from NHSE/I for a project to launch the Absence Policy as a pilot. The project lead has commenced in post and the project has commenced. • Preventative measures continue to be implemented including Occupational Health and Wellbeing interventions, the COVID-19 Booster and Flu Vaccination Campaigns and asymptomatic staff testing. • The team will be working with the Christie NHS Foundation Trust to understand their Return to Work processes. Alongside this review, the HR team continues to support CBUs through bespoke Return to Work training, which has had a positive impact on Return to work compliance. This training will be incorporated into the new line manager training to be launched in Q4 2021/22.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q3 2021/22

KLOE/Area	Action Lead(s)	Action Plan
People - Retention	**Carl Roberts**	**Retention:** • A line manager development programme is being implemented - in progress, a task and finish group has been set up to share proposed development programme and will seek feedback. Implementation of a career development programme pilot with staff networks, to be rolled out Trust wide in Q4 2021/22. • Launch of a kindness, civility and respect campaign commenced on 15th November 2021 with Anti Bullying week. • Working with NHSE/I "Flex for the Future" programme to look at how we can improve both agile and flexible working throughout the organisation. • Supporting 40 of the Trusts leaders through the Compassionate Leadership Development Programme. • Team development offers includes; bringing teams back together, leadership offers, and leadership circles. Identification and implementation of a Talent Management framework for WHH, which will be "Scope for Growth" the NHSE/I Talent management approach. • A staff facilities task and finish group has been established to review the current staff facilities based national recommendations and to develop a strategic plan to improve. Plans to meet for the next 6 months, or until the actions are complete if before.
People - Staff Costs per WAU	**Carl Roberts**	**Staff Costs per WAU:** • The workforce review group Terms of Reference will be reviewed to include the assessment of high vacancies/high temporary staffing spend and will develop action plans to address. • Expansion of the International Recruitment Programme to cover Medics, AHPs, Operating Department Practitioners - no further opportunities have been identified at this time. • Analysis of the established medical model and the proposed effective establishment within the context of RCP Safe Medical Staffing guidance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q3 2021/22

KLOE/Area	Action Lead(s)	Action Plan
Clinical Support - Pharmacy	Diane Matthew	**Savings on Medicines:** Further action and focus on Homecare services and Biosimilar switching. **Job Planning:** Undertake internal review of job plans within pharmacy establishment. **GP Connect:** Implementation of GP connect, enabling the Trust to see a list of medications prescribed by the GP which links into the Trust EPR, reducing the risk of selection errors when prescribing medication in hospital which also improves safety. Anticipated implementation by Q4 2021/22. **TCAM:** Transfer of medication prescription details to a patients nominated community pharmacy to inform of discharge prescription details. **ePMA 1 & 2:** The Trust continues to implement ePMA with the last speciality (Neonatal) to be scoped by the end of 2021/22. **ePMA Part 3:** Dose Range Checking - Testing and planning of rollout anticipated by the end of Q1 2022/23. **ePMA: Part 4:** Integration with JAC system (Stock Control) upgrade released in Q2 2021/22 and progression of testing is underway, there has been some delays in the Trust gaining access to the test system around integration. Therefore it is anticipated that the testing will be completed by Q1 2022/23. **Missed Dose Report:** Use of the report is in the process of being embedded at ward level. **Clinical Research Network:** Halton Clinical Trials Unit is functioning and the recruitment of pharmacy posts is in progress. • Review of the potential to utilise a pharmacy robot on the Halton site to improve efficiencies, specifically at weekends and out of hours. This has been included on the draft capital programme for 2022/23. • The Trust continues to monitor for and implement changes in the use of COVID-19 medicines as commissioning policies evolve.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q3 2021/22

KLOE/Area	Action Lead(s)	Action Plan
Clinical Support - Radiology	Mark Jones	**Radiology Efficiencies:** • The Trust has installed a new MRI machine which will mean the Trust is able to repatriate cardiac MRI and reduce the use of outsourced mobile MRI from March 2022. • Cheshire & Mersey ICS is carrying out a review of how data is recorded and reported across the network to ensure like for like comparisons. This has been paused due to COVID-19.
Clinical Support - Pathology	Neil Gaskell	**Pathology Network:** The Trust continues to work with the Pathology Network and specifically with STHK around the future of pathology services across Cheshire & Mersey. A number of options are being explored. A second review of the PID (WHH & STHK) has taken place and the Trust is awaiting a response. A number of risks have been identified around Finance, Logistics and Operations. Further detail has been requested from the Network to understand how these risks can be mitigated. Process mapping of the current service is underway. A post has been created to support the collaborative work between STHK and WHH with a longer term strategy across C&M. **Digital Pathology:** The Pathology Network has funded the implementation of a digital pathology solution that allows the scanning and visualisation of microscopic tissue slides for diagnosis. The solution works similarly to tried and tested PACS technology. The network is looking at using the Trust system (Molis) for Cellular Pathology as it is more digitally mature than other LIMS in C&M. A second version of the bid has been submitted by the network and the outcome is awaited. **Pathology Efficiency & Quality:** • The Trust will pilot the phlebotomy and transfusion application, this will improve patient safety by taking the sample at bedside using the electronic identification system which matches the patient request to the wrist band reducing the risk of taking the wrong blood from the wrong patient and therefore issuing the wrong results. Future options around efficiencies relating to the Phlebotomy application will be explored. The phlebotomy application is being utilised in Outpatients, further work is taking place. This will be followed by Halton, Community services and Wards. • The Pathology Team will carry out a review of cost per test and benchmark against the actual costs in Q4 2021/22. • The Trust has engaged with suppliers and Halton CCG to electronically book patient appointments for Phlebotomy which will reduce paper and improve patient experience and referrals. A project manager has been assigned with monthly project meetings in place. This is part of the Trust's Digital Operational Group's agenda. The Trust has received some funding to take this project forward. • E-Task management system – the Trust utilises its e task management system out of hours to inform acute clinical areas of critical abnormal pathology results. This utilises an interfaces between the Trust pathology systems and e-task management providing real-time alerts which improves efficiency and patient safety. Currently this is only used in Acute services out of hours, however future options to expand in other areas (excluding A&E and Maternity). • The pathology is exploring opportunities to provide pathology services to third sector and private organisations in order to generate additional income.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q3 2021/22

KLOE/Area	Action Lead(s)	Action Plan
Corporate - Estates	**Ian Wright**	**Strategic Cost Reduction:** • Explore and develop further collaboration opportunities (impacted by COVID-19). • Review of Facilities Management Contracts at C&M Level (Energy, Linen, Post and Decontamination). A plan has been developed for a collaborative approach across C&M as current contracts expire. There are opportunities to tender collaboratively to reduce costs. • Progression/Expansion of agile working to reduce floor space (this has been accelerated by COVID-19, however due to social distancing requirements, the ability to remove desks has been affected). **Energy Saving Schemes:** • Internal replacement of emergency lighting to improve efficiency is an ongoing programme within capital developments. The tender for this is ongoing. • Proposal for electric car charging points - a contract has been awarded, to commence in January 2022. • Capital spend on projects that will reduce critical infrastructure risk and long term estates maintenance costs. **Collaboration & Sustainability:** • Monitoring of critical infrastructure risk and how this has had an impact on estates maintenance costs. • Development and publication of the Trust's Green Plan - approved by the Strategy & Sustainability Sub-Committee. The draft plan has been submitted to the Finance & Sustainability Committee and will be presented to the Trust Board Q4 2021/22. • The Trust has commissioned a deep dive review in the CHP contract to ensure the Trust is gaining value of money and expert advice - the Estates team will review the report and progress recommendations. • Establishment of a furniture swap in order to reduce expenditure on new furniture, anticipated in Q4 2021/22.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q3 2021/22

KLOE/Area	Action Lead(s)	Action Plan
Corporate - Procurement	**Alison Parker**	**Procurement Efficiency** • Development of a high-level ICS Procurement Plan to deliver actions with the Procurement Target Operating Model (PTOM) steering group. The Trust is part of a C&M Metrics Group which collectively agreed on the submission at C&M Level (monthly). In the future it is anticipated that actions will be developed to improve at ICS level depending on performance across the metric, further clarity is required. Progress is measured against 34 point action plan. • The ICS has invested in a single data analytics platform, all NHS provider organisations are in the process of submitting data. The Data analytics group will interpret the data and develop a work plan as a ICS. • Re-engage with SBS regarding the implementation of Edge for Health. This has been placed on hold by SBS, the Trust is awaiting next steps. • Re-engage on the development of a strategy for the Category Tower 10 (Food) to deliver potential savings of c£0.8m. This has commenced. The Trust is awaiting a strategy from the supplier. The Trust is currently analysing the data. • The Trust has re-engaged with Supply Chain Co-ordination Limited (SCCL) to develop a C&M wide strategy for the delivery of savings from the category towers which was presented to the C&M procurement committee in September 2021. Additional development is required, this has been escalated. • Re-commence data analytics regarding the Spend Comparison Service, a plan has been developed. • Six Monthly Basis - Every six months the top 500 purchased products based on the total spend of the Trust (% Variance for Top 500 Product Metric) will be run comparing the data to the; lowest floor price, C&M Trusts, NHSE/I Peer Group. This will serve two purposes; support the delivery of savings and support work required in line with model hospital requirements. Saving opportunities will reviewed on a monthly basis focusing on those with the highest opportunity until all 500 opportunities have been exhausted. This exercise will then be repeated. • Catalogue Benchmarking - The Trust has 309 catalogues in place covering 42,471 product lines. Catalogue Benchmarking to be undertaken on a rolling monthly basis comparing our catalogue prices to those prices paid across the NHS.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q3 2021/22

KLOE/Area	Action Lead(s)	Action Plan
Finance	**Jane Hurst**	**Financial Planning, Sustainability & Controls:** • The Trust will continue to monitor and assess emerging guidance to ensure compliance. Financial performance is closely monitored and variation from plan is addressed in a timely manner. • Continue to monitor COVID-19 schemes due to cease along with monitoring any new schemes due to current COVID-19 wave. • Continued scrutiny and governance on capital schemes over £0.5m. • The Trust is working with the system to deliver a breakeven position in 2021/22 and to understand the gap left by reduced income, gap in pay award and risk to access ERF in H2. • Delivery of CIP in 2021/22 and monitoring of Quality Impact Assessments. • Delivery of £20.4m Capital Programme in 2021/22. This has been adjusted to reflect the £2.8m ED plaza brokerage to the system to support Cheshire & Mersey capital plans. • Quarterly monitoring of benefits realisation of investments. • Increase scrutiny and governance over retrospective waivers. • Action plan to achieve level 3 Future Focused Finance accreditation. • Ringfenced cash to support the EPCMS (Electronic Patient Care Management System)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/10**	
SUBJECT:	**Vaccination as a Condition of Deployment (VCOD)**	
DATE OF MEETING:	26 January 2022	
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 delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	√ √
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**Proposed New Risk #1125** presented to Trust Board forapproval 26 January 2022: *Failure to prevent staff shortages within certain professional groups and / or CBUs caused by individual decision making associated with the amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, introducing the COVID vaccination as a condition of deployment (VCOD) resulting in staffing gaps, a reduction in service provision and risks associated with risk 115 concerning staffing levels.*	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Department of Health and Social Care, on 9 November 2021, proposed amendments to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to introduce the COVID Vaccination as a Condition of Deployment (VCOD), these proposals have since been approved as part of a parliamentary passage on 6 January 2022 and will come into force on the 1 April 2022. This report provides an overview of the Planning and Preparation undertaken in advance of the 6 January 2022 parlimentary approval and the ongoing work to implement the regulations as set out in: Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers Version 1, 14 January 2022 Phase 2: VCOD Implementation Guidance for employers in healthcare in England	

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

RECOMMENDATION:	Trust Board are asked: ▪ To note the new legislation approved by Parliament on 6 January 2022 which amended the Health and Sopvcial Care Axct 2008 (Regulsated Activites) Regulations 2014 ▪ To note the actions taken to plan and prepare in advance of 6 January 2022 as set out in Guiance 1

	▪ To note the requirements for all NHS England Trusts to Implement VCOD as set out in Guidance 2 and the requirement to conduct processes aligned to the 3 step process.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee
	Agenda Ref.	SPC/22/01/09
	Date of meeting	19 January 2022
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Vaccination as a Condition of Deployment (VCOD)	AGENDA REF:	BM/22/01/11

1. BACKGROUND/CONTEXT

The Department of Health and Social Care, on 9 November 2021, proposed amendments to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to introduce the COVID Vaccination as a Condition of Deployment (VCOD), these proposals have since been approved as part of a parliamentary passage on 6 January 2022 and will come into force on the 1 April 2022.

Regulation objectives:
Making COVID-19 vaccination a condition of deployment in health and adult social care settings (domiciliary care and other CQC-regulated settings) is intended to:

- Protect all those who use health and care services, a large number of whom are vulnerable, as well as the wider community.
- Protect workers themselves by increasing vaccination rates.
- Help reduce COVID-19 related sickness absences.

What this means, is that for Warrington and Halton Teaching Hospitals (a registered body with the Care Quality Commission - CQC) to employ or otherwise engage with a person in a role in scope of the regulations, the person will be required to provide evidence that they have been fully vaccinated against COVID-19 by 1 April 2022.

Individuals who are considered to be in scope of the regulations must be undertaking **CQC regulated activities** and are **required to work in areas which are utilised for the provision of CQC regulated activity which may result in incidental face to face contact with patients.**

The requirements apply to CQC-regulated activities whether they are publicly or privately funded. They will also apply where a regulated activity is delivered through agency workers, volunteers, locums, students or trainees, or contracted to another provider. Compliance will be monitored and enforced by CQC.

Roles with direct patient care responsibilities and those who have social and incidental contact with patients within the patient care setting (Ward, Clinic area, Patient waiting area etc.) will fall within scope. ***Patient contact in corridors or cafés alone does not constitute incidental contact with patients within the patient care setting.***

Currently fully vaccinated is defined as two doses of the COVID vaccine and therefore does not include the booster.

Unvaccinated individuals will need to have had their first dose of an approved COVID-19 vaccine by 3 February 2022, in order to have received their second dose by the 31 March 2022 deadline to continue in employment from 1 April 2022.

The requirement will **not apply** to those who:

- Are medically exempt. Medical Exemptions can only be sought using the following link- www.gov.uk/guidance/covid-19-medical-exemptions-proving-you-are-unable-to-get-vaccinated
- Are under the age of 18
- Are pregnant and have a temporary exemption which will be valid until they are 16 weeks post birth
- Are working in roles not in scope of the VCOD regulations.

Please note, it's been confirmed individuals are not exempt on the grounds of religion or beliefs, although they may wish to request a specific COVID vaccine.

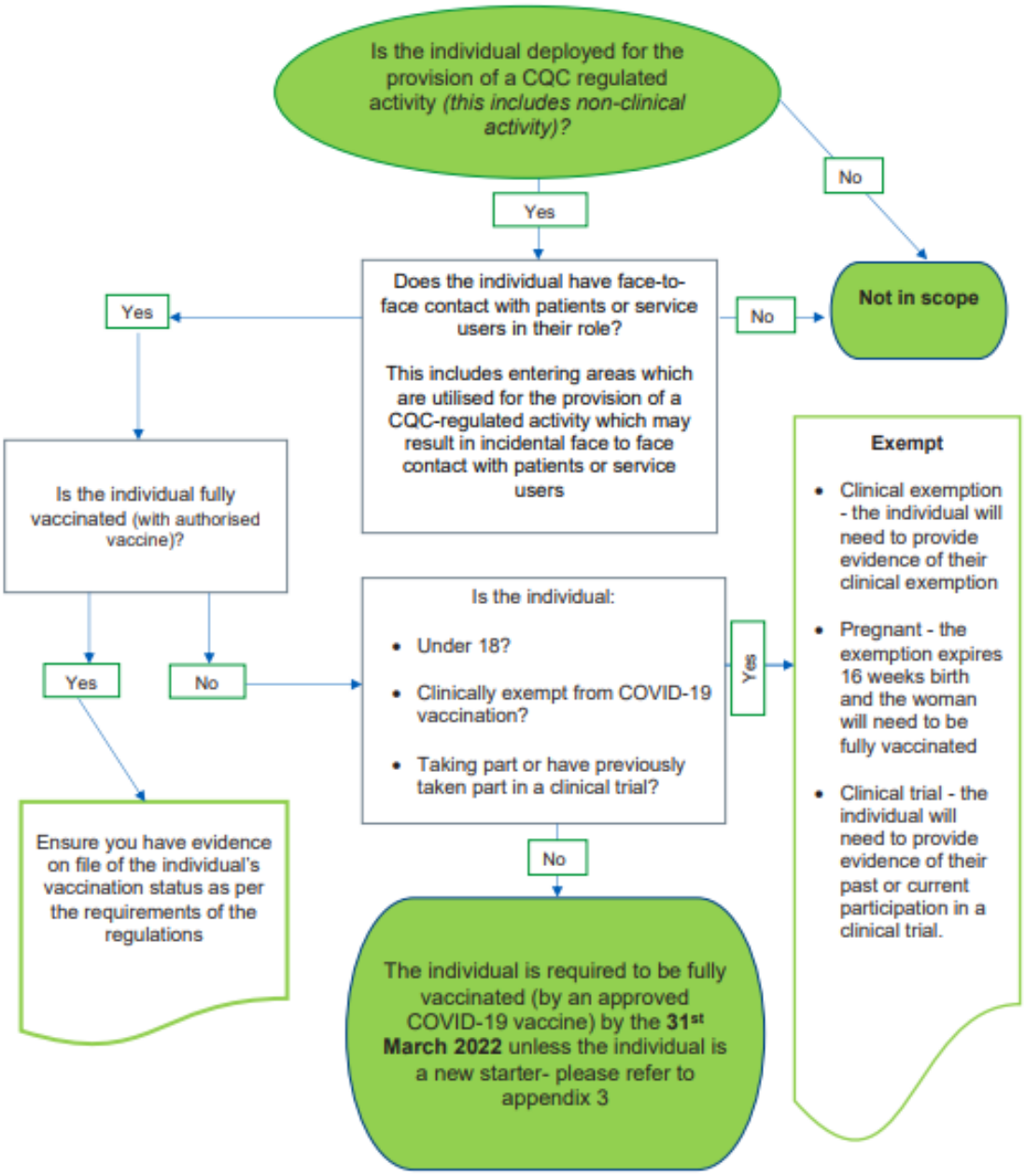
VCOD Regulations are currently only applicable to NHS England, however NHS Wales and NHS Scotland have committed to making it a condition of new employment.

2. KEY ELEMENTS

Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers
6 December 2021 Version 1
Phase 1: Planning and Preparation Guidance for employers in healthcare in England (Appendix 1)

Employers in partnership with local staff side representatives were guided to act immediately to:

- Review and assess which roles are likely to fall within the scope of the new regulations.
- Review and update privacy notices (please refer to data information section in this guidance).
- Actively support uptake of vaccination via communication and engagement. Evidence has shown that sensitive 1:1 conversations approached holistically, with empathy and respect, are the best way to convert vaccine hesitancy to vaccine uptake.
- Understand and document 'in scope' workers vaccination and exemption status. Ensuring systems are in place to keep this under review.
- Agree arrangements with suppliers of temporary, agency or bank workers, education institutions who provide students and any other partners who supply workers or volunteers who will be required to evidence vaccination to continue to be deployed into relevant settings.
- Start to identify options for potential redeployment to non-face-to-face roles, however, avoid taking formal action in regard to redeploying workers or reallocating duties until the regulations have received parliamentary approval. There will be a 12-week grace period from when the regulations are made to when the regulations come into force which will give workers time to decide to get vaccinated.
- Proactively plan and identify potential workforce reconfigurations and redesign, ahead of 1 April 2022, to support staff wellbeing and avoid disruption to services.



Actions Taken:

- Meeting with Staff Side Chair to provide detail of the Phase 1 Guidance and confirm process for agreeing roles in scope and roles out of scope
- Provision of list of unvaccinated staff shared via email on 10 January 2022 to specific Line Mangers including WHH eForm for completion to be submised eipt by Occupational Health to OH (Submission of Medical Exception)
- Drop In Sessions for Line Managers commenced w/c 10 January 2022
- VCOD extranet set up and promoted

Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers Version 1
14 January 2022

Phase 2: VCOD Implementation Guidance for employers in healthcare in England (Appendix 2)

- **6 January 2022** – this is when the 12-week grace period between the regulations being made and coming into force, commences. This period is intended to give providers and workers time to prepare and meet the new regulatory requirements. Communication and engagement with staff, supportive in nature, should have commenced with workers before this date, to respond to vaccine hesitancy and drive vaccination uptake.

- **3 February 2022** - the last date for workers in scope of the regulations to get their first dose of an authorised vaccine (unless exempt) so they can be fully vaccinated with a complete course of doses of an authorised vaccine (as listed in guidance on the approved COVID-19 vaccines and countries and territories with approved proof of vaccination) by 1 April 2022. Under current vaccination guidance, eight weeks are required between the first and second vaccine dose.

- **1st April 2022** regulations come into force.

Monitoring

The regulations will form part of the fundamental CQC standards for health and wider social care and as such the following question is added to the Provider Information Return (PIR) and built it into their monitoring approach '*How are you assured that those you employ and deploy within your service are vaccinated in line with government requirements?'*

Enforcement

When the new requirements under the regulations come into force 1 April 2022, CQC will use their existing assessment approach and enforcement policy to assess compliance within the services they regulate.

Any enforcement activity which is generated as a result of non-compliance with the regulations will be undertaken on a proportionate basis and based on the CQC's assessment of the impact on quality of care and people's welfare and safety. They will also consider

individual circumstances when assessments are carried out and when a decision is to be made to take further action for potential breaches of the regulations.

It is recommended that employers conduct a provider assessment on roles deemed out of scope, but which carry some uncertainty. The rationale for the decision of the role being deemed out of scope, the context and mitigations put in place if applicable, must be recorded.

Establishing vaccination status

There are a number of ways in which vaccination status can be obtained:

- Staff can be asked directly about their vaccination status.
- Organisations that have undertaken their own vaccination delivery programme can look up which staff have received vaccinations.
- Central databases that record vaccination data from the national vaccination programme can be used and integrated with staff records.

The legal basis for obtaining and using vaccination status information

Data protection law provides that it is lawful to 'process' (use) 'special category data' (i.e. health data, including information about vaccination status) where:

- it is necessary for employment purposes.
- in is in the 'substantial public interest', including to comply with legal obligations.
- it is necessary for the management of healthcare services; and/or
- it is necessary for public health purposes.

Collective Consultation and Redundancy

It is important to note this is not a redundancy exercise under section 188 of the Trade Union and Labour Relations (Consolidation) Act 1992 (TULRCA). There is no diminishment or cessation of work of a particular kind. Employers will not be concerned with finding "suitable alternative employment" and there will be no redundancy entitlements, including payments, whether statutory or contractual, triggered by this process. The redeployment or dismissal of workers is determined by the introduction of the regulations and an individual's decision to remain unvaccinated. Whilst organisations are encouraged to explore redeployment, the general principles which apply in a redundancy exercise are **not applicable.**

All NHS Organisations are required to follow a 3 step process

Step one: Engagement with unions

Employers should engage and work in collaboration with their trade union or staff side representatives, as to the formal measures being taken in respect of redeployment processes and potential dismissals of staff due to VCOD.

Actions Taken:

- Meeting with Staffside Chair held with Deputy Chief People Officer
- 19 January 2022 - Deputy Chief People Officer and Senior HR Management Team attended MS Teams meeting hosted by Staff Side Chair with staff side representatives to go through Guidance Two and respond to any questions, issues or concerns.
- Q&A Sessions for Staff commenced 18 January 2022 hosted by Chief Executive
- Q&A Sessions for specific staff groups (Nursing & Midwifery; Additional Clinical Services, and Allied Health Professionals) commenced 19 January 2022 by Chief Nurse & Deputy Chief Executive
- Frequently Asked Questions available on VCOD extranet site – updated after each Manager Drop In session and Q&A sessions
- Links to further national guidance to help inform decisions about the COVID vaccine available on the VCOD extranet site

Step two: Formal Review Process

It is recommended that within the grace period (from the 6 January 2022) a formal review process with staff who decline to disclose their vaccine status, for whom vaccination status cannot be ascertained, or who are unwilling to participate in the COVID-19 vaccination programme (and are not medically exempt) should take place, in which the consequences of remaining unvaccinated are clearly explained. This formal review process can be undertaken by way of meetings (whether in person or virtually), by written correspondence or a combination of these methods of communication, as appropriate in the particular case. The formal review process should include clarification of the dates by which the requirements must be complied with, and what steps will be taken for those who remain unvaccinated by those dates.

Alternative options potentially available to the individual, such as any possible adjustments to their current role, restrictions to duties or redeployment opportunities available, should also be explored with the individual, noted in writing and timescales confirmed.

The individual should be asked to make suggestions on potential adjustments to their current role and due consideration given to any such suggestions. During this formal review process, line managers will need to advise staff that if the above options cannot be facilitated, a possible outcome is that the individual may be dismissed from their employment with their last day of employment being 31 March 2022 (or after depending on contractual notice period) if they remain unvaccinated or have not disclosed their vaccination status.

Staff may be given the opportunity to be accompanied to any meeting which takes place during the formal review process by a trade union representative or work-based colleague. Where staff are away from work, for example on maternity leave, sabbatical, or long-term sick leave, employers should make appropriate arrangements in good time to avoid lack of

knowledge of the requirement and potential outcomes of non-compliance being a barrier to returning to work on time.

Action Taken:

- Letter sent on 18 January 2022 to all staff considered in scope and who are currently unvaccinated to provide details of the new regulations, details of Q&A Sessions, process for securing a Medical exception if appropriate and the potential outcome of dismissal if they remain unvaccinated after 1 April 2022 – sent to home addrtess and NHS Net email account.
- Additional Vaccination Clinic capacity confirmed (in advance of 3 February – 1st dose deadline)

Step three: Formal Meeting

From 4 February 2022, staff who remain unvaccinated (excluding those who are exempt) should be invited to a formal meeting chaired by an appropriate manager, in which they are notified that a potential outcome of the meeting may be dismissal. Meetings may take place in person or virtually.

It should be noted that employers can issue staff with contractual notice of dismissal whilst they explore redeployment options, and thus notice periods and the search for alternative roles can run concurrently. Every effort should be made to redeploy staff within their notice period up to and including their last date of service.

Formal processes leading to the termination of employment, including issuing notice of dismissal, should not commence before the 6th January 2022 and notice should not expire before 31 March 2022.

Action Taken:

- Draft SOP for VCOD Redeployment Process for Executive approval w/c 24 January 2022
- Draft Schedule for Formal Meetings for Executive approval w/c 24 January 2022
    - To consider and approve by Executives, release of:
        - Trade Union representatives to accompany individuals to Formal meetings being reviewed - Facilties Time. Not to impact on schedule of meetings / introduce any delays in the process
        - Release of Manager for Formal Meetings
        - Release of HR representatives to support meetings

Equality Act 2010
In the consideration and exercise of formal processes for the purposes of the regulations, employers have a duty to ensure that they have due regard to the Equality Act 2010. Employers will need to ensure (not an exhaustive list):

- Formal processes avoid unlawful discrimination; for instance, for staff with a disability it may be necessary to make reasonable adjustments to any formal process followed.
- Formal processes should advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
- That due regard is given to the impact of decisions on those people with one or more protected characteristics, which are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, marriage and civil partnerships, and sexual orientation.
- Redeployment processes which may include multiple cases of potential redeployment for a variety of reasons concurrently, are conducted in an equitable fashion.
- Where multiple cases of redeployment are being considered including for reasons other than unvaccinated status, organisations should take into account the enhanced statutory rights of disabled people and pregnant women.

Reconfiguration of roles
Employers will need to consider whether it is reasonable, practicable or appropriate to reallocate patient/service user facing duties amongst existing teams to enable an individual to continue working in their current role whilst remaining unvaccinated.

An evaluation of the impact of amending an individual's duties will need to include consideration of the potential impact on resources, other staff within the service, the wider organisation and service provisions. ***Patient pathways, care and experience must not be compromised.***

The reconfiguration of an individual's role should be effective from 1 April 2022 in accordance with the date the regulations come into force.

Redeployment for the purposes of VCOD
It is unlikely that most organisations' local policies and procedures will apply to redeployment due to unvaccinated status. Whilst there may be similarities in approach to existing redeployment policies and procedures, employers will need to be cautious about extending said policies (e.g. the application of redeployment as a result of organisational change) to those under the scope of VCOD redeployment and thus setting a precedent.

Pay Protection

- Where redeployment is undertaken for the purpose of the VCOD framework, individuals in scope of the regulations are not eligible for pay protection of their basic salary or additional earnings (e.g. on-call payments, unsociable hours enhancements, high cost area supplement) should they obtain employment at a lower band/grade to the one currently held, with different working arrangement;

- Staff who are temporarily redeployed at the discretion of the organisation due to not being fully vaccinated for good reason until shortly after 1 April 2022 or due to being pregnant may be eligible for pay protection (inclusive of enhancements) in accordance with local pay protection arrangements.

Termination of employment for the purposes of VCOD
Employers will need to consider the termination of employment of staff whose roles are in scope of the regulations and who refuse to be vaccinated in-line with the mandated timescales (excluding staff who are exempt) or decline to disclose their vaccination status.

Any such termination should be undertaken lawfully, which requires that there be a proper reason for the dismissal and that a fair and reasonable procedure is followed.

Employers should consider an individual's reasons for declining to be vaccinated and examine options short of dismissal, where appropriate. However, if it's not feasible to implement alternative solutions, staff will be taken through a formal process to dismissal.

Notice of Dismissal
Notice of dismissal should not be issued before 4 February 2022 and should not expire before 31 March 2022.

Staff should not be pre-emptively issued with notice of dismissal at any point prior to the date by which they are required to have received their first vaccination, given that they may still wish to change their mind and seek to be vaccinated.

Where individuals are serving a notice period which extends beyond 1 April 2022, they will need to be redeployed or removed from patient-facing roles whilst they await termination of employment. If redeployment is not available individuals should be placed on leave from 1 April 2022 until termination takes effect.

Payment in lieu of notice (PILON) can only be applied in accordance with contractual arrangements or written particulars of employment.

Service contingency plans
During the grace period, as part of the implementation of the requirements, organisations should identify the potential for workforce capacity pressures, (alongside existing pressures e.g. due to staff absences), and the potential impact on service provision, and plan mitigating actions to ensure effective arrangements are in place to continue to deliver appropriate care to patients and service users. Business as usual escalation routes apply for service disruption. Commissioners and systems should be informed of likely or actual service disruptions, which they can escalate to NHS England and NHS Improvement regional teams as needed.

Organisational support for staff
It is recognised that formal processes may be difficult and challenging for staff especially with regards to mental health, and as such, employers should provide staff with access to local

staff support services such as occupational health, employee advisory services, psychological services, chaplaincy, and spiritual care.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Application of the regulations in order to implement from 1 April 2022

4. ASSURANCE COMMITTEE

Strategic People Committee:
Hot Topic 19 January 2022

5. RECOMMENDATIONS

Trust Board are asked:

- To note the new legislation approved by Parliament on 6 January 2022 which amended the Health and Sopvcial Care Axct 2008 (Regulsated Activites) Regulations 2014
- To note the actions taken to plan and prepare in advance of 6 January 2022 as set out in Guiance 1
- To note the requirements for all NHS England Trusts to Implement VCOD as set out in Guidance 2 and the requirement to conduct processes aligned to the 3 step process.

6. APPENDICES

Appendix 1 –
Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers
6 December 2021 Version 1
Phase 1: Planning and Preparation Guidance for employers in healthcare in England

Appendix 2 –
Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers Version 1
14 January 2022
Phase 2: VCOD Implementation Guidance for employers in healthcare in England

Classification: Official

Publication approval reference: C1470

Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers

6 December 2021 Version 1

Phase 1: Planning and Preparation

Guidance for employers in healthcare in England

Contents

Introduction

Regulations

The Department of Health and Social Care, on 9 November 2021, laid regulations which amend the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (“the 2014 Regulations”), to provide that the registered person can only employ or otherwise engage a person in respect of a CQC regulated activity, if the person provides evidence that they have been vaccinated with a complete course of an authorised vaccine against COVID-19 or, if otherwise vaccinated against coronavirus is also within a specified time period, vaccinated with a single dose of an authorised vaccine, subject to specific exemptions.

These regulations will sit alongside the already existing regulations which require registered persons of all Care Quality Commission (CQC) registered care homes (which provide accommodation together with nursing or personal care) to ensure that a person does not enter the indoor premises unless they have been vaccinated (subject to certain exemptions) which came into force on 11 November 2021.

These regulations will apply equally across the public (NHS) and independent health sector, and will require workers aged 18 and over, who have direct, face to face contact with service users to provide evidence that they have received a complete course of a Medicines and Healthcare products Regulatory Agency (MHRA) approved COVID-19 vaccine, subject to limited exceptions, by no later than 1 April 2022. This will include front-line workers, as well as non-clinical workers not directly involved in patient care but who nevertheless may have direct, face to-face contact with patients, such as receptionists, ward clerks, porters and cleaners.

These regulations will protect vulnerable people and individual workers in health and social care settings, including hospitals, GP practices, dentists, community services and where care is delivered in a person’s home. The requirements will apply to CQC-regulated activities whether they are publicly or privately funded. They will also apply where a regulated activity is delivered through agency workers, volunteers, locums, students or trainees, or contracted to another provider. Compliance will be monitored and enforced by CQC.

Registered person

Any person (individual, partnership or organisation) who provides regulated activity in England registered with the CQC[1].

The use of the term ‘employer’ in this document refers to the registered person. Further information regarding CQC registration can be found on the CQC website for further information.

CQC regulated activity

CQC monitor and regulate services that provide health and social care.

Examples of the types of activities CQC regulates includes:[2]:

- personal care
- accommodation for persons who require nursing or personal care
- accommodation for persons who require treatment for substance misuse
- treatment of disease, disorder or injury
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- surgical procedures
- diagnostic and screening procedures
- management of supply of blood and blood-derived products
- transport services, triage and medical advice provided remotely
- maternity and midwifery services
- termination of pregnancies
- services in slimming clinics
- nursing care
- family planning services.

[1] What is registration? | Care Quality Commission (cqc.org.uk)

[2] https://www.cqc.org.uk/sites/default/files/20151230_100001_Scope_of_registration_guidance_updated_March_2015_01.pdf

Children's services, clinics, community-based services for people with learning disabilities and substance misuse, hospices, health and justice secure settings[3] are also types of services regulated by the CQC. A full list of activities and services can be accessed on the CQC's website at: www.cqc.org.uk/what-we-do/services-we-regulate/services-we-regulate

CQC activity

It is our expectation that the registered person would keep a record of vaccinations as part of their staff employment or occupational health records.

When registering with CQC and if inspected, the registered provider will need to be able to demonstrate that:

- They have systems in place to ensure that they can comply with the requirements of the regulations and that they can monitor compliance.
- There is a record to confirm that satisfactory evidence has been provided. This record must be kept securely by the registered person in compliance with the UKGDPR and the Data Protection Act 2018.
- They have systems in place to review whether they need further evidence in relation to vaccination or exemption status of the people they employ or otherwise engage for the purposes of the provision of the regulated activity, carry out those reviews and secure such further evidence.
- There is appropriate information and access to advice/guidance about vaccines and the requirements of the regulations available to all workers, and that individuals receive support in connection with the vaccine.
- Workers are provided with the appropriate support to access vaccination.

The purpose of this guidance

The regulations were laid in Parliament on 9 November 2021 and **subject to parliamentary passage will come into force on the 1 April 2022.** If the regulations are approved, unvaccinated individuals will need to have had their first dose of an approved COVID-19 vaccine by 3 February 2022 (this date is subject to change), in order to have received their second dose by the 31 March 2022 deadline.

[3] https://www.cqc.org.uk/guidance-providers/criminal-justice-system/health-care-criminal-justice-system

NHS England and Improvement (NHSEI) has engaged with the Social Partnership Forum (SPF), NHS Employers and Department of Health and Social Care (DHSC) to develop this guidance to support service providers in preparing and planning for the regulations.

Guidance will be produced in two phases and will be reviewed and updated accordingly. The focus of this ‘phase one’ guidance is to:

i. support compliance with the regulations,
ii. maximise vaccination rates,
iii. minimise the impact of the regulations on the NHS workforce capacity,
iv. provide a consistent approach in the planning and preparation for the regulations, with minimal operational differences between organisations, and
v. support employers ensuring the best protection for vulnerable patients and staff in healthcare settings.

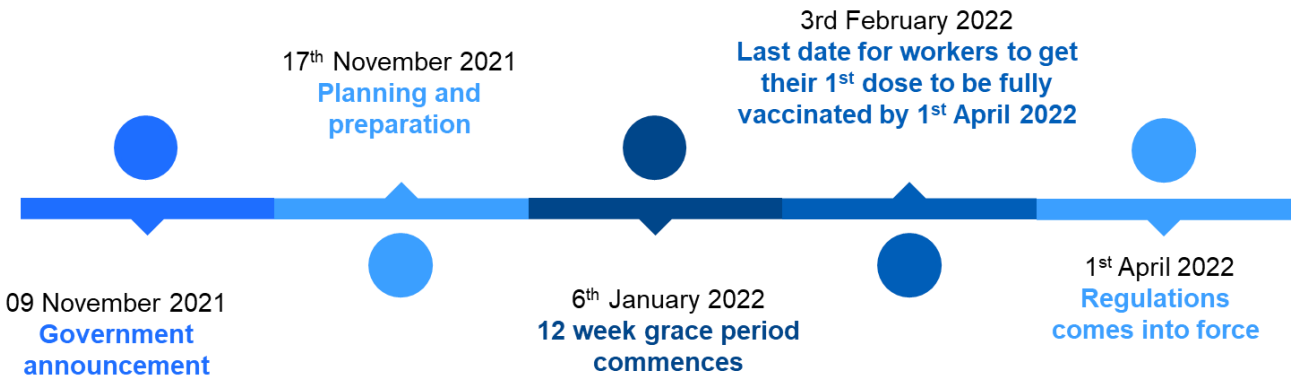
Phase two of the guidance will focus on the safe transition of services and will cover the formal steps that should be considered when implementing the regulations.

Who this guidance is aimed at?

This guidance is aimed at NHS Trusts and Integrated Care Systems (ICS), however, the purpose of this guidance and principles set out can generally be applied to other NHS organisations such as primary care services. It is noted that as independent employers, primary care providers may wish to seek individual legal advice.

Overview

Key actions and indicative timeline (subject to parliamentary passage – dates below may change)



Regulation objectives:

Making COVID-19 vaccination a condition of deployment in health and adult social care settings (domiciliary care and other CQC-regulated settings) is intended to:

- Protect all those who use health and care services, a large number of whom are vulnerable, as well as the wider community.
- Protect workers themselves by increasing vaccination rates.
- Help reduce COVID-19 related sickness absences.

When do employers need to act on these changes?

The regulations are expected to come into force on 1 April 2022, subject to the passage of the regulations through Parliament. In advance of this date, the government approach will include a 12-week grace period from when the regulations are made to when the regulations come into force. This period is intended to give providers and workers the time to meet the new regulatory requirements. Under current vaccination guidance[4], eight weeks are required between the first and second vaccine dose.

[4] Most vulnerable offered second dose of COVID-19 vaccine earlier to help protect against variants GOV.UK(www.gov.uk); and: C1254-covid-19-vaccination-programme-faqs-on-second-dose-v2.pdf (england.nhs.uk)

Employers in partnership with local staff side representatives need to act now to:

- Review and assess which roles are likely to fall within the scope of the new regulations.
- Review and update privacy notices (please refer to data information section in this guidance).
- Actively support uptake of vaccination via communication and engagement. Evidence has shown that sensitive 1:1 conversations approached holistically, with empathy and respect, are the best way to convert vaccine hesitancy to vaccine uptake.
- Understand and document 'in scope' workers vaccination and exemption status. Ensuring systems are in place to keep this under review.
- Agree arrangements with suppliers of temporary, agency or bank workers, education institutions who provide students and any other partners who supply workers or volunteers who will be required to evidence vaccination to continue to be deployed into relevant settings.
- Start to identify options for potential redeployment to non-face-to-face roles, however, avoid taking formal action in regard to redeploying workers or reallocating duties until the regulations have received parliamentary approval. There will be a 12-week grace period from when the regulations are made to when the regulations come into force which will give workers time to decide to get vaccinated.
- Proactively plan and identify potential workforce reconfigurations and redesign, ahead of 1 April 2022, to support staff wellbeing and avoid disruption to services.

It is recommended that formal redeployment of workers should not commence until the regulation has been approved by Parliament which is expected on 6 January 2022 (this date is subject to change).

Who is in scope of the regulation?

Workers who have face-to-face contact with patients and/or service users and who are deployed as part of CQC regulated activity[5]

The regulations apply to health and social care workers who are deployed in respect of a CQC regulated activity, who have direct, face-to-face contact with service users. This include individuals working in non-clinical ancillary roles who enter areas which are utilised for the provision of a CQC-regulated activity as part of their role and who may have social contact with patients, but not directly involved in patient care (e.g. receptionists, ward clerks, porters, and cleaners), regardless of contracted hours or working arrangements. All honorary, voluntary, locum, bank and agency workers, independent contractors, students/trainees over 18, and any other temporary workers are also in scope[6].

The requirements would not apply to those employed, or otherwise engaged, in the provision of a CQC regulated activity if they do not have direct face to face contact with patients and/or services users/patients. For example, those providing care remotely, such as through triage or telephone consultations or those in managerial roles working on sites separate from patient areas would not have direct face to face contact and so registered persons could continue to deploy them in those roles as usual. People on long term absence from work, such as maternity, shared parental leave or sickness absence, would not be in scope unless and until they return to having any face to face contact (which would include on one off visits such as Keeping in Touch (KIT) days).

A person may be deployed in the provision of the regulated activity despite not having been vaccinated if that person:

- Is under the age of 18
- Is clinically exempt
- Is exempt due to a short-term medical condition (which is an option that some pregnant women may choose to take; for pregnant women the exemption expires 16 weeks post-partum and so will allow them to become fully vaccinated after birth)

5 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1032170/making-vaccination-a-condition-of-deployment-in-health-and-wider-social-care-settings-equality-impact-assessment.pdf

6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1032203/making-vaccination-a-condition-of-deployment-in-the-health-and-wider-social-care-sector-government-response.pdf

- Has taken part or is currently taking part in a clinical trial for a COVID-19 vaccine

Refer to appendix 1 ‘Workers Required to be Vaccinated as a Condition of Deployment – Flow Chart’, if help is required in determining if a worker is in scope of the regulations.

Students and trainees

The registered person is required to demonstrate that they have systems and processes in place to evidence and monitor that all students and trainees (over 18) on placement within a healthcare setting, who have face-to-face contact with patients and/or service users and who are deployed, as part of CQC regulated activity, are fully vaccinated against COVID-19.

Students and trainees who opt not to have the vaccination but are not exempt from the regulations, should be directed to their educational provider to discuss the impact this will have on their progression through their programme.

Organisations should ensure that students and trainees are included is all communication and engagement plans to drive up vaccination uptake. Where possible, this should include any targeted campaign, webinar, supportive 1:1 conversations, and disseminating vaccine education and information material on the facts around vaccination.

Contractors, suppliers and bank and agency workers

The registered person is required to demonstrate that they have systems and processes in place to evidence and monitor that all independent contractors, agency or bank staff who have face-to-face contact with patients and/or service users and who are deployed, as part of CQC regulated activity, are fully vaccinated against COVID-19.

If applicable, employers should work with independent suppliers of staff to agree and plan any steps and update contractors to ensure the employer can comply with the requirements of the regulations.

Primary care and independent sector

The new regulations also apply to those working in specific primary care settings (general practice and dentistry) and the independent sector. In most cases the principles set out in this guidance document can be applied to workers in these settings, however, primary care providers may wish to seek individual HR and legal advice to take into account variations in local contractual terms and conditions.

Partnership working within and across primary care networks and ICSs are also encouraged to share resources and expert knowledge. We will engage further with primary care representatives to consider any specific guidance needs for this sector.

How can workers evidence that they are fully vaccinated?

Recognised evidence of COVID-19 vaccination

- The NHS COVID pass, or equivalent from NHS Scotland, NHS Wales or the Department of Health in Northern Ireland; or
- The EU Digital COVID Certificate; or
- The Centers for Disease Control and Prevention vaccination card; or
- A certificate in English, French or Spanish issued by the competent health authority which contains:
  a) the individuals full name
  b) the individuals date of birth
  c) the name and manufacturer of the vaccine that the individual received
  d) the date that the individual received each dose of the vaccine
  e) details of either the identity of the issuer of the certificate or the country of vaccination, or both.

NHS appointment cards cannot be used as proof of vaccination status.

Vaccinated abroad

Individuals who are vaccinated abroad will be required to provide evidence of their vaccination status and, where necessary, have a top-up dose with a UK authorised vaccine consistent with the UK Health Security Agency (UKHSA) guidance on vaccines. To avoid doubt, mixed doses (that is, where different vaccines have been administered to complete the dose schedule) will be accepted for the purposes of the vaccination requirements.

Clinical exemptions

Some individuals may have grounds not to have the vaccine for clinical reasons. Anyone who is unable to get vaccinated for clinical reasons will have to use the NHS COVID Pass to show their exemption status.[7]

The domestic NHS COVID Pass will look and work in the same way for people with clinical exemptions as it will for people who are fully vaccinated. The pass will not show that a worker has a clinical exemption. Workers will receive a confirmation letter which they should

[7] https://www.gov.uk/guidance/covid-19-medical-exemptions-proving-you-are-unable-to-get-vaccinated

keep for their records and use to prove that their unable to get vaccinated. The letter will explain that the individual is medically unable to get vaccinated, the pass does not.

Registered persons can continue to use workers for whom vaccination is not clinically appropriate, however, managers should take steps with regards to ensuring the health and safety of both the individual, other workers, patients and visitors. Managers will be required to update existing risk assessments to ascertain the potential risk of COVID-19 spread caused by unvaccinated (but exempt) workers and to identify the level of risk of exposure to the individual, other workers, patients and visitors. As a result of this assessment, managers may be required to put in place other 'measures' and reasonable adjustments to help reduce the risk, which may include reviewing current personal protective equipment (PPE) use, regular lateral flow testing, remote working, sufficiently ventilated workplaces, cleaning regimes and hand hygiene etc.

Pregnancy and Fertility

The Joint Committee on Vaccination and Immunisation (JCVI) has advised that pregnant women should be offered COVID-19 vaccines and that pregnant women should discuss the risks and benefits of vaccination with their healthcare professional, including the latest evidence on safety and which vaccines they should receive[8]. Women trying to become pregnant do not need to avoid pregnancy after vaccination and there is no evidence to suggest that COVID-19 vaccines will affect fertility.[9]

While the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives (RCM) and the UK Tetralogy Service recommend the COVID-19 vaccination for pregnant and breastfeeding women, pregnant women are eligible to request short-term medical exemptions from vaccination.

For pregnant women, the exemption expires 16 weeks after giving birth. This will allow them to become fully vaccinated after birth. A MATB1 certificate can be used to provide evidence of exemption status[10].

For further guidance regarding supporting pregnant women in the workplace, please refer to Coronavirus (COVID-19): advice for pregnant employees - GOV.UK (www.gov.uk) and COVID-19 vaccines, pregnancy and breastfeeding (rcog.org.uk)

[8] JCVI issues new advice on COVID-19 vaccination for pregnant women - GOV.UK (www.gov.uk)
[9] COVID-19 vaccines, pregnancy and breastfeeding (rcog.org.uk)

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1032203/making-vaccination-a-condition-of-deployment-in-the-health-and-wider-social-care-sector-government-response.pdf

Occupational Health and risk assessments

It is imperative that employers refer individuals who are exempt from having the COVID-19 vaccine, who may be clinically exempt, and pregnant women to Occupational Health for advice and recommendations including locally commissioned occupational health services for primary care providers.

Primary care organisations should contact their local commissioner if they require details of their local OH supplier.

Risk assessments will need to be reviewed and repeated as necessary in line with changes to individual circumstances, emerging evidence and/or national advice, to ensure the mitigation of workplace risk, identification of reasonable steps to be taken and additional support required.

Exemption from COVID-19 vaccination due to participation in clinical trial

In line with clinical advice, those who are taking part or have previously taken part in a clinical trial for a COVID-19 vaccine will be exempt from the requirement.

The registered provider will need to evidence that workers are exempt from having the completed course of an approved COVID-19 vaccination due to participation in a clinical trial.

The worker should provide the registered persons with confirmation in writing, from the organiser of the clinical trial, evidencing that the clinical trial they are participating in / has participated in is:

- For a vaccine against coronavirus; and
- Is regulated by one of the regulatory bodies included in annex B of the code of practice included in the ‘Making vaccination a condition of deployment in health and wider social care sector. Government response to public consultation’ document

Is the COVID-19 booster included in the regulations?

At present, the regulations do not require evidence of boosters, but employers are strongly advised to provide supportive advice to workers to encourage uptake of the booster vaccine if eligible.

Is the Flu vaccination a condition of deployment?

At present, it is not proposed that flu vaccination requirements will be introduced as a regulation, however, the government will keep this under review following this winter and ahead of winter 2022/23.

Phase 1: Planning and preparation

A. Planning

Workforce planning

It is noted that this section on workforce planning is primarily applicable to NHS Trusts and ICS's however the information included can also be considered by primary care organisations.

In all NHS organisations it is the responsibility of the registered manager to implement the regulations, however, employers should, where possible, form a cross-functional team (for example, including HR, Heads of Clinical Services, Information Governance leads and Staff Side representatives) to drive planning and related action. Employers should consider a partnership approach to the application of the new regulations within their Integrated Care Systems (ICS) in an effort to share resources, expert knowledge, provide support and widen opportunities for the redeployment of unvaccinated staff into non face-to-face roles/projects if possible.

Employers are advised to proactively plan their approach to compliance with the regulations in partnership with staff side representatives, commencing with the identification of the staff groups in scope and a review of staff vaccination data. Local data should confirm the numbers of staff in scope, staff vaccination status and inform options for action, key messaging and the resources required.

Employers should start to investigate how certain roles could be redesigned to enable the re-allocation or restriction of duties (taking into consideration the impact upon other staff and services) and opportunities for staff to potentially be redeployed.

Employers should plan redeployment processes and parameters and put in place a proposed timetable and consistent processes for staff engagement on redeployment and next steps. Where possible this should be undertaken within the planning phase, to support staff wellbeing and minimise the potential for service disruption once the regulations come into effect.

Action plan

We recommend that an action plan is drawn up as soon as possible to include the following:

- Initiatives to increase local vaccine uptake taking into consideration the needs of groups where there are low vaccination levels. Resources available for engaging and communicating with staff to increase vaccination uptake can be found here
- Build in support and training time for the managers responsible for working through the process.
- Note the deadlines for individuals to receive their first vaccination is 3 February and second vaccination is 31 March 2022.
- Allow sufficient time for the relevant processes to be implemented and/or concluded by 1 April 2022 deadline, including exploring all options with those who are not exempt and have indicated that they will not be fully vaccinated by the deadline date.
- A specific COVID-19 vaccination policy / procedure.
- Review and assess which roles are likely to be in scope (appendix 1).

As part of the action plan, subject to the timescales / deadlines mentioned above and subject to the passage of the regulations through Parliament, we recommend the following, for individuals directly employed:

- Ask workers to confirm their vaccination status / intentions in writing and set deadlines. All declarations confirming a full completed course of the COVID-19 vaccine will need to be evidenced as per the information in the overview section of this guidance.
- Engage in supportive conversations with colleagues who are indicating that they may not get vaccinated at the earliest opportunity. Encourage vaccine take up and talk honestly about the impact of their decision on their role and, if relevant, the limitations of redeployment into non face-to-face roles/projects.
- Have a meeting with those who refuse or are exempt to confirm evidence required, assess risk and discuss next steps.
- If workers have been vaccinated or are exempt from the vaccine, obtain evidence.
- If it is unlikely that the worker will be fully vaccinated by 1 April 2022 (and no exemption applies), undertake a formal process with the individual in line with internal

policy if applicable ensuring that the individual is aware of the possible implications of their failure to be vaccinated by 1 April 2022.

Engagement with unions

It is best practice for employers to engage with unions and/or staff representatives to collaboratively agree a supportive approach to encourage workers to be vaccinated, agree processes to inform staff, discuss concerns and to consider practical and operational issues. Employers should refer to local partnership agreements and where relevant, consider seeking their own independent legal advice if necessary.

In addition, employers should schedule regular discussions with their Freedom to Speak up Guardian(s) and local staff Equality, Diversity and Inclusion (EDI) networks to support dialogue with staff, identify barriers to participation in the COVID-19 vaccination programme and to address staff concerns.

Adopting a vaccination policy/procedure

Developing (or updating) a policy on COVID-19 vaccination in partnership with staff side representatives, allows employers to outline the organisation's stance on vaccination and explain the role and expectations of managers, HR and employees.

The policy might cover matters such as:

- The benefits of vaccination and how employees can contribute to wider public health by protecting themselves and other employees and wider community by being vaccinated.
- Whether staff over 18 are entitled to time off work (with or without pay) to be vaccinated or obtain evidence of medical exemption.
- Any arrangements relating to leave if staff experience side effects from vaccination. For example, it may be preferable to avoid a large number of staff being vaccinated on a single day.
- How an individual’s vaccination status can be evidenced.
- How data about vaccination or exemption will be processed.
- How any formal policies will apply to staff who cannot comply with the requirement.
- How vaccination requirements of new recruits and agency staff will be addressed.

- Any equality issues that arise from complying with the regulations (see section on Equality Act 2010).

Equality Impact Assessments

DHSC has completed an Equality Impact Assessment (EIA) on the potential impact of the policy on people with protected characteristics. The analysis can be found here.

Local EIAs should be completed to consider and understand the likely impact of the regulations on staff with protected characteristics. Employers will need to have due regard to the potential risks and challenges of decisions and actions associated with making vaccinations a condition of employment.

Working in partnership with Equality, Diversity and Inclusion (EDI) colleagues, local EDI staff network leads may be able to provide specialist advice on the potential impact and mitigations associated with staff groups and guidance on targeted approaches with groups in which vaccination uptake is low.

Data considerations

Vaccination status is 'health' information and would be regarded by many as confidential. It is also 'special category' data for the purposes of data protection legislation (the UK GDPR), which means that it must be used fairly, lawfully, supported by good reasons, and in compliance with other specific obligations under data protection law.

Employers will need to comply with requirements of data protection law, for instance updating privacy notices explaining to individuals how their data is being used, ensuring that the data is kept securely, and that access is controlled. In the circumstances, it would also be prudent for employers to undertake a data protection impact assessment (DPIA). Please refer to ICO Guidance and local Information Governance policies.

Employers must not use the data for purposes other than checking vaccination status for the purpose of the regulations, nor store the data for any longer than is necessary to fulfil that purpose.

We recommend that employers take the following points into account when collating vaccination data:

1. Employers should be clear with workers about how details of whether or not they have had the vaccine will be used. Staff privacy notices should be updated to include such information.

2. Work with staff side representatives and other stakeholder groups to ensure that staff understand what data is being proposed and why.

3. Involve the employer's data protection officer and, where applicable, the Caldicott Guardian.

4. Ensure that if data about vaccine status is shared, it only goes to those who 'need to know it'. Consider also other documenting policy issues such as what employees should be told about how the data will be used, how the organisation will handle the data, what technical and organisational arrangements in place to secure storage and limit access.

5. Consider for how long vaccination data will be retained, in line with data protection law, and update any data retention schedules covering staff data.

6. Have a policy and documented "risks versus benefits" assessment which demonstrate how decision making is justified.

Recruitment

We recommend that employers should include a provision about vaccination and clinical exemption into recruitment processes, offer letters and contracts for new employees. When recruiting staff and workers whose roles are likely to involve Care Quality Commission (CQC) regulated activities and face to face contact with patients and/or service users, it will be lawful to ask candidates about their vaccination status.

New starters

The proposed amendment of the Code of Practice on Infection Prevention and Control and its associated guidance detail that those newly joining the workforce will also need to be vaccinated in order to be deployed by a CQC registered person. The registered person must only deploy those who have had their first dose of vaccination, with a second dose within 10 weeks. This approach is intended to help balance the requirements of the policy with workforce pressures in health and care services.

The effect of the regulations for different staff based on the date that they are first employed or engaged for the purposes of the regulated activity is described in detail, in appendix 3 'New Starters'.

B. Preparation

Driving vaccination uptake

The Health and Safety at Work Act 1974 obliges employers to take reasonable steps to reduce any workplace risks; this duty gives employers justification for encouraging their employees to be vaccinated to protect themselves and everyone else at the workplace. COVID-19 is also a reportable disease under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (known as RIDDOR) which strengthens employers' encouragement that employees should agree to vaccination.

Whilst many staff, volunteers, students, and bank/agency and temporary workers, have welcomed the opportunity to be vaccinated against COVID-19, there are still individuals who are reluctant or hesitant to have the vaccine. Whether to be vaccinated or not is a personal decision based on many factors and it is important to bear in mind that in most cases a decision not to have the vaccination is not a disciplinary or conduct issue. The reasons could be many and varied, including individuals who can't have the vaccine (for example, on medical grounds), those who can have the vaccine but do not wish to do so (for example, on religious or spiritual grounds) and those who can have it but have concerns and are uncertain (for example, due to a mistrust of vaccinations generally).

Employers should refer to previous COVID-19 vaccination communications and engagement campaigns which remain a vital tool in promoting and encouraging vaccinations amongst their workforce. Employers are urged to review key messaging to ensure it is clear, complete, and accurate, and it aligns with current circumstances.

Employers should commence with:

- Liaising with staff side colleagues and EDI networks for support in encouraging workers to receive the vaccine.
- Showing support for vaccination from senior leadership.
- Ensuring line managers responsible for working through the process are aware of the organisational policy and approach and are supported throughout.
- Running an awareness campaign, drawing on NHS information and directing people to trusted sources of information.
- Disseminating vaccine education and information material on the facts around vaccination. Offer employees consistent, accessible and factual safety data which promotes the genuine achievement of science in producing an effective vaccine.

- Further increase engagement with targeted communities where uptake is the lowest, including extensive work with BAME and faith networks to encourage healthcare workers to receive the vaccine.

- Making it as simple and convenient as possible for people to receive the vaccine and to make the most of walk-ins, pop-ups, and other delivery models, such as hospital hubs, vaccinations centres and local vaccination services.

- Holding webinars and Q&A sessions with COVID-19 experts and community leaders, especially inviting doctors or public health experts who reflect the race/ethnicity or cultural identity of the workforce. This can be done as a system wide approach to efficiently share resources.

- Holding 1:1 conversations for all unvaccinated NHS staff with their line manager, with clear guidance on how to do this. This was associated with an increase in vaccine uptake by 10% in phase 1.

It is recommended that a system wide, panel of diverse experts who can provide specialist advice regarding vaccinations, is assembled to provide accessible advice to workers who still have queries or questions.

Targeted information is available from NHSEI to tackle misconceptions around vaccinations. For example, we are engaging with clinicians, BAME networks and faith leaders through our advisory groups to ensure we provide appropriate support across the workforce; and have created videos with experts around fertility and pregnancy to reassure staff of the safety and importance of being vaccinated against COVID-19.

Supportive 1:1 conversations

We know that one-to-one conversations have been the most effective way to support colleagues to make an informed choice, often leading to vaccination uptake. Therefore, we ask organisations to ask line managers to have supportive one-to-one conversations with unvaccinated staff to identify reasons for vaccine hesitancy and provide information that will support them to make an informed decision about the vaccine.

To ensure conversations are focused on support, compassion, understanding and encouragement, we recommend employers coach and train managers as to how to conduct the conversations. This can help to ensure consistent messaging and best practice approach in addition to mitigating against individuals feeling that the conversation with them had not been handled correctly or that they were being ‘forced’ to have the vaccination.

Conversations should include:

- Ensuring the individual is aware of the regulations and advising them of the impact of the regulations on their role.
- Discussing any individual circumstances that may currently be stopping them from getting the COVID-19 vaccination with understanding and compassion.
- If the individual advises that they are medically exempt, please signpost them to obtaining evidence of clinical exemption.
- Addressing concerns and vaccine hesitancy.
- Providing details of access to expert clinical advice from clinicians locally wherever possible.
- Signposting the employee to support services (including health and wellbeing and occupational health) and COVID-19 vaccination information resources from NHS England and the Department of Health and Social Care.
- Encouraging the employee to have further conversations with their own GP or trusted healthcare professional if they have any further questions around vaccination.

A detailed record of informal conversations should be maintained.

Resources to assist with 1:1 conversations can be found here.

Redeployment

Employers should consider the possibility of redeployment for staff in scope of the regulations and who remain unvaccinated on 1 April 2022. It is noted that the possibility of preserving security of employment applies only to those employed under a contract of employment with that employer and not to other workers who are in scope of the regulations. A national redeployment framework designed in partnership with staff side colleagues will be developed and shared in due course. Employers can refer to internal redeployment policies but should be mindful of the extension of such policies in these exceptional circumstances.

If alternative solutions such as the amendment, reallocation or restriction to staff duties and responsibilities are not applicable for staff in scope of the regulations who are directly engaged on a substantive contract and who choose not to participate in the COVID-19 vaccination programme, it is recommended that employers start to consider potential redeployment opportunities locally and across the ICS.

It is acknowledged that opportunities for redeployment may be challenging for smaller organisations, including many primary care providers.

The approach to the redeployment agreed in partnership with staff side, should be guided by a set of best practice principles to ensure a fair and transparent process in addition to local policies, including consideration of the following:

- Vaccination period extended – subject to the outcome of a risk assessment, staff may be redeployed on a temporary basis where possible if the first dose of the vaccine has been received and the second dose is scheduled after 1 April 2022 (while individuals will be afforded some protection against COVID-19 from 3 or 4 weeks after their first vaccine dose, they must not be permitted by the employer to work in roles that require face-to-face contact with patients or service users until they receive their 2nd dose).

- Staff who are temporarily redeployed during the extended vaccination period may be eligible for pay protection in accordance with an organisation's protection arrangements.

- Whether potential suitable alternative roles should be ring-fenced with consideration given to other staff who may be subject to redeployment for a reason unrelated to the regulations.

- Clear guidance should be in place regarding the redeployment process and how staff will be assessed as suitable for a role (focus on assessing transferable skills from the point of what staff can do as opposed to what they can't).

- A selection framework may be agreed for similar roles to ensure consistency of approach.

- If there are several potentially suitable redeployees, some form of competitive assessment will need to take place and should be made clear in advance and applied consistently.

- Consideration of equality principles in accordance with usual recruitment approach.

- Written feedback provided to the employee if they are not a suitable match for a vacancy, detailing clear justification as to why the redeployee has been unsuccessful. This feedback can support future job searches.

- Whether a trial period will be offered for staff who are permanently redeployed to alternative roles.

- The extent to which training, and development will be available to support permanent redeployment if applicable.

Permanent redeployment of employees will potentially impact upon their pay and pension. For clinical staff moving to a non-clinical role maintaining their professional registration will also be impacted. Staff are encouraged to seek advice from the NHS Business Services Authority (NHSBSA) and their professional governing body.

If local redeployment is exhausted, managers should consider wider redeployment within other Trusts, local authority and ICS.

Health and wellbeing support

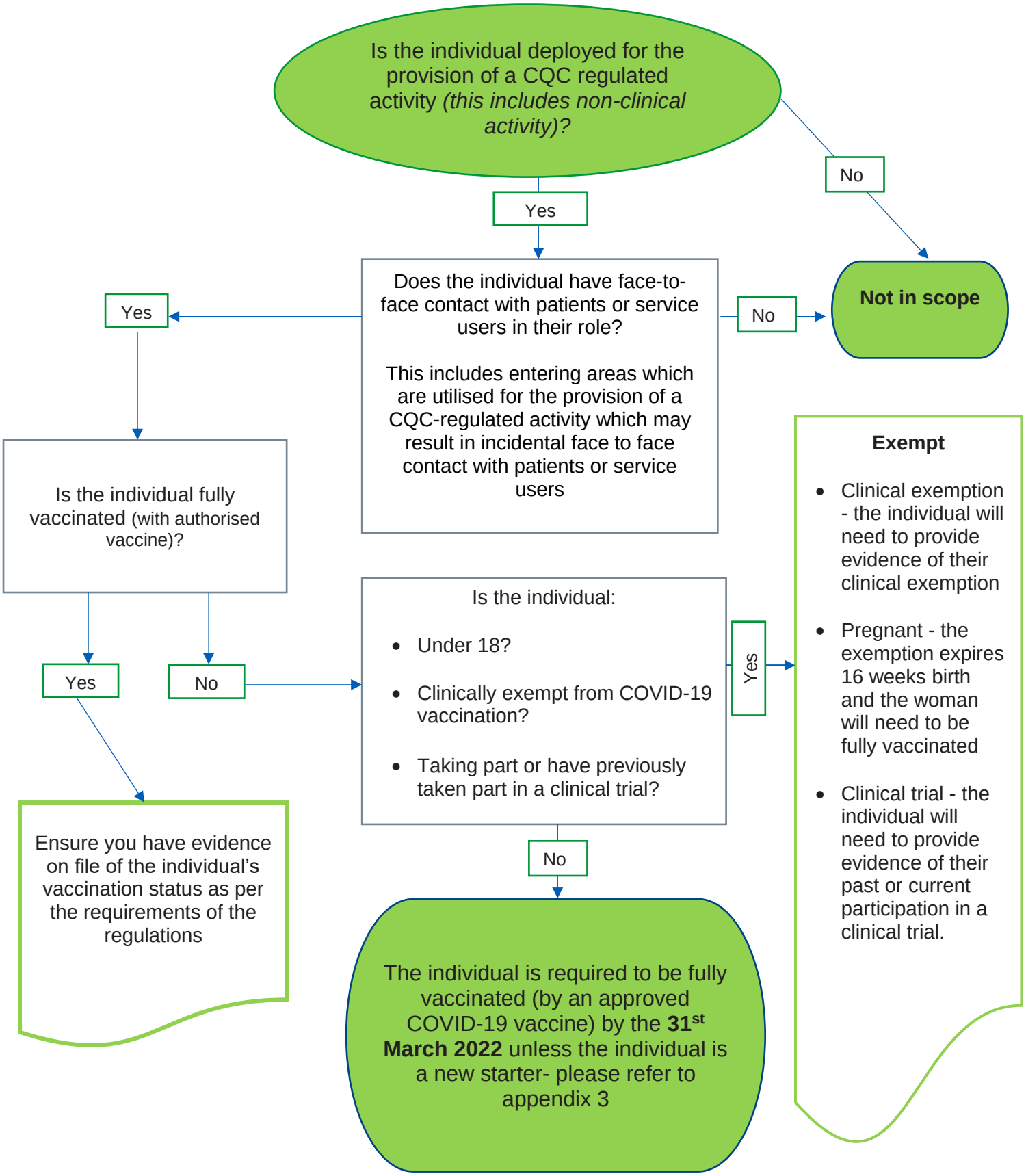
In addition to signposting individuals to internal health, wellbeing and psychological support, NHSEI has put in place a comprehensive package of wellbeing support for health and social care workers which is available to all primary, secondary and tertiary care organisations. The support package includes:

- a dedicated health and care staff support service including confidential support via phone and text message
- free access to a range of mental health apps
- a range of counselling and talking therapies
- online resources, guidance, and webinars

Resources

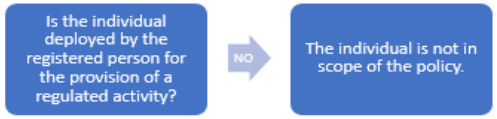
- COVID-19 vaccination: guide for employers - GOV.UK (www.gov.uk)
- Bridging-the-uptake-Gap-BABAC-Toolkit-210622.pdf (england.nhs.uk)
- NHS England and NHS Improvement London » COVID-19 vaccine communication materials
- COVID-19 vaccination: guide for adults - GOV.UK (www.gov.uk)
- COVID-19 vaccination: easy-read leaflets - GOV.UK (www.gov.uk)
- Coronavirus » Primary care guidance (england.nhs.uk)
- Coronavirus infection and pregnancy (rcog.org.uk)
- https://www.nhs.uk/conditions/coronavirus-covid-19/coronavirus-vaccination/health-conditions/

Appendix 1: Workers required to be vaccinated as a condition of deployment for healthcare workers



Appendix 2: VCOD Flowchart Scenarios

Scenario 1: Electrician (tradesperson) visits a hospital ward to fix some loose cabling

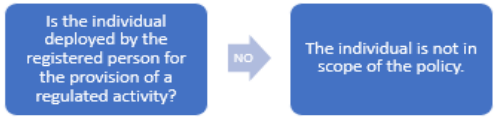


The tradesperson is not deployed for the provision of a CQC-regulated activity.

**maintenance workers in the hospital estates and facilities team are in scope of the policy as their role is part of the provision of a CQC-regulated activity. Additionally they are likely to have social contact with patients in clinical areas.

1

Scenario 2: Café worker who serves food and drink to both staff and patients

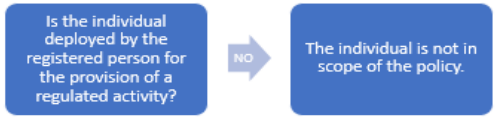


Although this worker is likely to have direct face-to-face contact with patients, they are not deployed by the registered person for the provision of a regulated activity and as such the worker is out of scope.

**Please note that canteen or catering staff who are involved in providing food to patients or service users, particularly in inpatient or residential settings, are in scope as their roles facilitate the delivery of CQC-regulated activities.

2

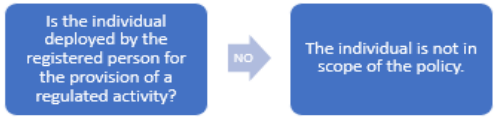
Scenario 3: Volunteer in a hospital shop located within an ante-natal clinic



While the volunteer may have social contact with patients within the clinic, they are not deployed by the registered person for the provision of a regulated activity and as such are not in scope of the policy.

3

Scenario 4: Pharmacist in an outpatient pharmacy service, which is outsourced to an independent provider

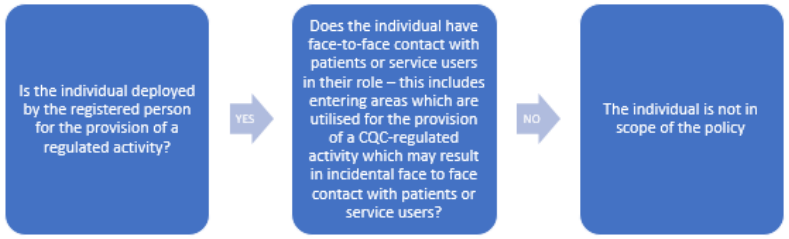


The pharmacy is regulated by the General Pharmaceutical Council and, as an outpatient pharmacy, is not part of the CQC-regulated activity in the hospital. Since the patient may take their prescription to any pharmacy, this service should be considered as a community pharmacy and out of scope of the policy.

**Please note that workers in inpatient pharmacy services are considered within scope as their roles facilitate CQC-regulated activity in the hospital.

4

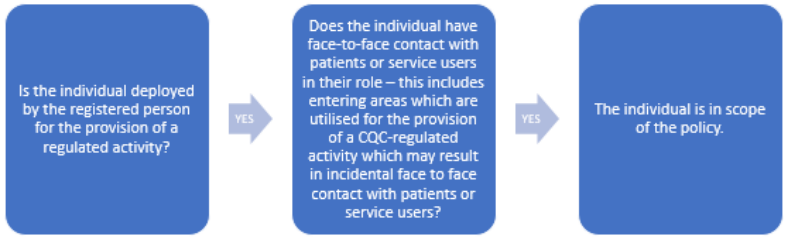
Scenario 5: NHS 111 call handler answers and resolves query from patients



This worker does not have direct face-to-face contact with patients. As such, the worker is not in scope of the policy.

5

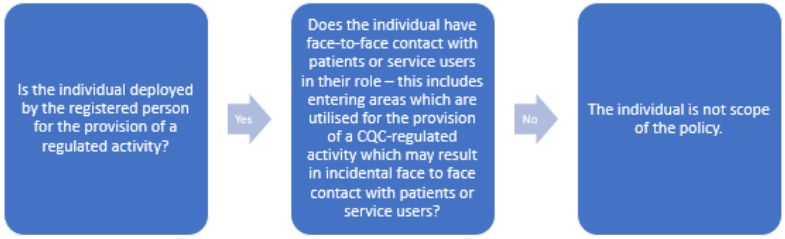
Scenario 6: Service Manager whose office is located on a clinical floor in a hospital



While non-clinical, this worker manages a service providing a CQC-regulated activity. As part of their role, they have face-to-face contact with patients/service users. This worker is therefore in scope of the policy.

6

Scenario 7: Finance Manager based in a hospital but not located in or near a clinical area



While non-clinical, this worker is deployed by the registered person for the provision of regulated activity, however they do not have direct face-to-face contact with patients, and as such the worker is out of scope.

* If the worker's office is based in or near a clinical area and they are likely to have contact with patients and service users (including incidental contact), they will be in scope of the policy.

7

Appendix 3: New starters

[Making vaccination a condition of deployment in the health and wider social care sector: government response (publishing.service.gov.uk)]

The following has been extracted from the proposed addition to the code of practice – criterion 10 which is subject to the passage of the regulations through Parliament.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The effect of the regulations for different staff based on the date that they are first employed or engaged for the purposes of the regulated activity is described below:

1. **Individual is employed or engaged for the purposes of a regulated activity for the first-time during grace period (i.e. between the date the regulation is made and the date on which regulation 4 comes into force)**
   The employer must ensure that individual is not employed or otherwise engaged for the purposes of a regulated activity after the (the date on which regulation comes into force) unless the individual has provided the employer with evidence that either:

a) the individual meets one of the conditions described above (in paragraph 1); or
b) the individual has been vaccinated with one dose of an authorised vaccine. After a period of 10 weeks from the date that the first dose was administered, the employer will need to ensure that the individual has provided evidence that individual then meets one of the conditions described in paragraph 1.

2. **The individual is employed or otherwise engaged for the purposes of a regulated activity for the first time on or after (the date on which reg 4 comes into force).**
   The employer must ensure that individual is not employed or otherwise engaged for the purposes of a regulated activity unless individual has provided the employer with evidence that either:

c) The individual meets one of the conditions described in paragraph 1
d) the individual has been vaccinated with one dose of an authorised vaccine at least 21 days before the first day of deployment. After a period of 10 weeks from the date that the first dose was administered, the registered provider will need to ensure that individual has provided evidence that individual then meets one of the conditions described in paragraph 1.

Appendix 4: Key recommended actions checklist

Planning	
Establish the roles that are in scope of the regulations.	☐
Identify vaccination status of workers in scope of the regulations and ensure there are clear methods of recording and reporting (including exemptions).	☐
Review staff vaccination data and identify areas of low uptake e.g. in diverse groups or service areas, to help plan targeted communication and engagement actions	☐
Update staff privacy notices and consider how long vaccination data will be retained, in line with data protection law. Update any data retention schedules covering staff data.	☐
Engagement with staff side, speak up guardian and staff Equality, Diversity and Inclusion networks	☐
Complete Equality Impact Assessment (EIA)	☐
Draft action plan – noting key dates for action	☐
Amend/draft vaccination policy and procedure	☐
Form a cross-functional team inclusive of organisational representatives, to drive planning	☐
Plan organisation wide communication and engagement utilising subject expert leaders within the organisation community and across integrated care systems	☐
Engage with contractors, suppliers, bank and agencies	☐
Freeze vacancies that may be suitable alternative employment for redeployment	☐
Consider how roles can be reconfigured to enable the reallocation or restrictions of duties	☐
Amend adverts, offers letter and contract templates to reflect regulation	☐
Preparation	

Disseminate vaccination education and information material	☐
Communicate practical information regarding how workers can get their vaccination	☐
Hold staff meetings, webinars and targeted conversations to enable individuals to discuss any queries or concerns they may have. Engage subject experts	☐
Hold supportive 1:1 conversation with staff to address barriers and vaccination hesitancy	☐
Record vaccination status updates (including staff who are exempt from the COVID-19 vaccination) and evidence	☐
Consider if duties can be reallocated and redeployment opportunities	☐
Ensure staff and workers are aware of and have access to health and wellbeing Support	☐

Classification: Official

Publication approval reference: C1545

Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers

Version 1, 14 January 2022

Phase 2: VCOD Implementation

Guidance for employers in healthcare in England

Contents

Introduction

On 6 January 2022, the Government made new legislation[1], approved by Parliament, which amended the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the 2014 Regulations"). This extends the scope of mandatory vaccination requirements for staff beyond registered care homes to health and wider social care settings in England.

The regulations provide that the registered person can only deploy or otherwise engage a person for the purposes of the provision of a CQC-regulated activity, in which they have direct, face to face contact with patients and service users, if the person provides evidence that they have been vaccinated with a complete course of a Medicines and Healthcare products Regulatory Agency (MHRA) approved COVID-19 vaccine. This is subject to specific exemptions and conditions.

The vaccination as a condition of deployment (VCOD) requirements include front-line workers, as well as non-clinical workers not directly involved in patient care but who may have face to face contact with patients, including ancillary staff such as porters, cleaners or receptionists.

The VCOD regulations allow a grace period for compliance and the requirement will come into force on **1 April 2022.**

For the purposes of this guidance the VCOD regulations will be referred to as 'the regulations'.

Registered Person

The registered person within this guidance refers to the person (individual, partnership, or organisation) registered with the CQC as being responsible for the delivery and quality of a service providing CQC regulated activity in England.

The purpose of this guidance

This guidance is supplementary to phase one guidance which focused on planning and preparing for the regulations to be approved.

NHS England and Improvement (NHSEI) has engaged with the Social Partnership Forum (SPF), NHS Employers, the Department of Health and Social Care (DHSC) and Care Quality

[1] The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) (No. 2) Regulations 2022 (legislation.gov.uk)

Commission (CQC), to develop this guidance to support service providers with implementing and complying with the VCOD Regulations and conducting formal processes for staff who will be unvaccinated on 1 April 2022.

Who this guidance is aimed at?

This guidance is aimed at NHS Trusts and Foundation Trusts, Integrated Care Systems (ICS), Community Interest Companies (CICs), and all organisations registered with CQC for the purposes of providing health care. The guidance and principles set out can also generally be applied to other organisations providing NHS-commissioned services, such as primary care services and to the independent sector.

The approaches to formal processes detailed in this guidance may vary from organisation to organisation, depending on the facts and circumstances in each case, and as such, it is recommended that organisations seek their own legal advice on such matters.

Key messages in phase one guidance:

- The responsibility of the registered person is to only employ or otherwise engage a person for the provision of a CQC regulated activity who has face to face contact with patients or service users, if it is evidenced that they have been vaccinated with a complete course of an authorised vaccine against COVID-19, or that the individual satisfies one of the regulations' specific exemptions and conditions.

- The regulations will protect vulnerable people and individual workers in health and social care settings, and they apply in all such settings including hospitals, GP practices, dentist surgeries, within community services and where care is delivered in a person's home.

- The regulations will apply where a regulated activity is delivered through substantive, seconded or fixed-term staff, bank and agency workers, contractors, volunteers, locums, honorary contract-holders, students or trainees, or any other type of worker involved in the provision of a CQC regulated activity and who has direct, face to face contact with patients or service-users.

- The requirement will not apply to those who:
  - Are under the age of 18
  - Are medically exempt
  - Have participated in a clinical trial for a COVID-19 vaccine

- Are pregnant and have a temporary exemption which will be valid until they are 16 weeks post birth
- Are not in scope of the VCOD regulations. Should help be required with determining if a worker is in/out of scope of the regulations, please refer to the *Workers required to be vaccinated as a condition of deployment* flowchart in guidance phase one, appendix 1

- Employers are advised to proactively plan their approach to compliance with the regulations in partnership with staff-side representatives, commencing with the identification and assessment of roles in scope of the regulations and a review of staff vaccination data.

- Employers will need to have processes in place to document in scope workers' vaccination and exemption status and ensure on-going monitoring.

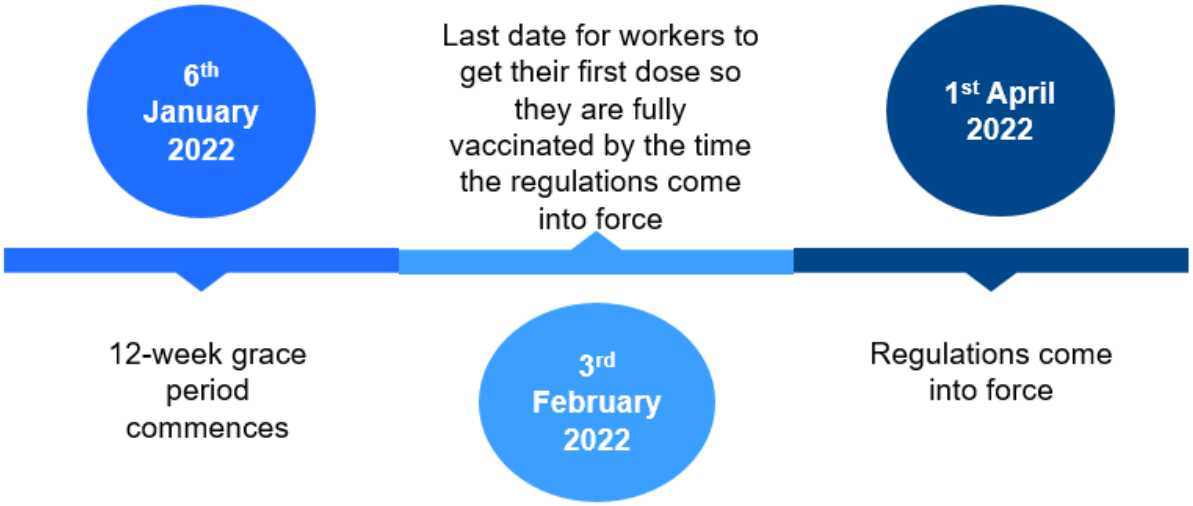
- Employers will need to take action with providers/sub-contractors/agencies regarding third-party workers, to review commercial contracts. The registered person will need to ensure that clear governance and systems are in place to confirm in scope roles and that the registered person is provided with evidence that no third-party workers are provided in breach of the regulations.

- Organisations should actively support vaccination uptake via communication and engagement with staff. Disseminating vaccine information, conducting supportive one-to-one conversations, and engaging with clinical and community experts will help to convert vaccine hesitancy to vaccine uptake.

- Working in partnership arrangements within Integrated Care Systems (ICSs) can help to share resources, support, and widen opportunities for redeployment of unvaccinated staff who are not exempt from the regulations e.g., ICSs can support primary care providers in identifying any opportunities for redeployment within the wider health care service.

- Workforce planning should include the consideration of reconfiguration of roles and services, where it is reasonable to do so, to mitigate against the potential impact of the regulations with regards to staffing levels.

Key implementation dates



- **6th January 2022** – this is when the 12-week grace period between the regulations being made and coming into force, commences. This period is intended to give providers and workers time to prepare and meet the new regulatory requirements. Communication and engagement with staff, supportive in nature, should have commenced with workers before this date, to respond to vaccine hesitancy and drive vaccination uptake.

- **3rd February 2022** - the last date for workers in scope of the regulations to get their first dose of an authorised vaccine (unless exempt) so they can be fully vaccinated with a complete course of doses of an authorised vaccine (as listed in guidance on the approved COVID-19 vaccines and countries and territories with approved proof of vaccination) by 1 April 2022. Under current vaccination guidance, eight weeks are required between the first and second vaccine dose.

- **1st April 2022** regulations come into force.

CQC monitoring and inspection approach

The Phase One guidance detailed CQC's expectations of the registered persons (registered managers, registered providers) in regard to compliance with the regulations. In summary, the registered person will need to be able to demonstrate and provide assurances that they have systems, processes and robust governance in place to monitor vaccination and COVID-19 status (including exemption status) of the people they employ or otherwise engage for the purposes of the provision of the regulated activity. Any evidence collected and recorded (personal data), must be handled in accordance with UK GDPR.

The registered person should also be able to evidence that workers are provided with appropriate information about the vaccines and the regulations in addition to staff being supported to access the vaccine.

CQC has published a statement on their website outlining their approach to VCOD.

Monitoring

The regulations will form part of the fundamental CQC standards for health and wider social care and as such the following question is added to the Provider Information Return (PIR) and built it into their monitoring approach *'How are you assured that those you employ and deploy within your service are vaccinated in line with government requirements?*[2]

Enforcement

When the new requirements under the regulations come into force 1 April 2022, CQC will use their existing assessment approach and enforcement policy to assess compliance within the services they regulate. Any enforcement activity which is generated as a result of non-compliance with the regulations will be undertaken on a proportionate basis and based on the CQC's assessment of the impact on quality of care and people's welfare and safety. They will also consider individual circumstances when assessments are carried out and when a decision is to be made to take further action for potential breaches of the regulations.

It is recommended that employers conduct a provider assessment on roles deemed out of scope, but which carry some uncertainty. The rationale for the decision of the role being deemed out of scope, the context and mitigations put in place if applicable, must be recorded. Further information on CQC's enforcement policy is available.

[2] Statement on COVID-19 vaccination of people working/deployed in care homes: the role of the Care Quality Commission | Care Quality Commission (cqc.org.uk)

Data access and use

NHS providers will be legally required to be able to demonstrate the COVID-19 vaccination status of their staff, and therefore will need to collect, store, and use information about this. The Government's guidance states that NHS organisations are required to review and retain proof of staff and volunteer members' COVID-19 vaccine status. Managers of NHS providers therefore need to know whether or not individuals have been vaccinated, both to plan for their workforce and service delivery in the context of the new legal obligation, and to be able to demonstrate compliance with it on an ongoing basis.

Establishing vaccination status

There are a number of ways in which vaccination status can be obtained:

- Staff can be asked directly about their vaccination status.
- Organisations that have undertaken their own vaccination delivery programme can look up which staff have received vaccinations.
- Central databases that record vaccination data from the national vaccination programme can be used and integrated with staff records.

In order to reduce burdens on organisations and staff, a small number of designated members of staff in organisations (e.g. designated individuals in HR & OD teams) can be given access data about staff which has been recorded on the NHS England National Immunisation System (NIMS) database and linked to the NHS Electronic Staff Record (ESR) number. To be clear, the only clinical information that will be made available to NHS organisations from the national immunisation database is an individual's COVID-19 vaccination status. By getting this information from NHS England's immunisation database individuals will not need to provide evidence of their vaccination status, making it easier for both them and their managers.

The legal basis for obtaining and using vaccination status information

Data protection law provides that it is lawful to 'process' (use) 'special category data' (i.e. health data, including information about vaccination status) where:

- it is necessary for employment purposes.
- in is in the 'substantial public interest', including to comply with legal obligations.
- it is necessary for the management of healthcare services; and/or
- it is necessary for public health purposes.

The Control of Patient Information (COPI) notices[3] issued by the Secretary of State for Health and Social Care under the Health Service (Control of Patient Information) Regulations 2002, provides a legal basis for NHS England to disclose this information to health and care organisations, and NHS organisations are required under the COPI notice to process what would otherwise be confidential patient information for 'COVID-19 purposes'. This includes:

- *"monitoring and managing the response to COVID-19 by health and social care bodies and the government including providing […] information about capacity, medicines, equipment, supplies, services and the workforce within the health services and adult social care services*
- *delivering services to patients, clinicians, the health services and adult social care services workforce and the public about and in connection with COVID-19, including the provision of information, fit notes and the provision of healthcare and adult social care services."*

Further information is available on the legal framework which supports access to the vaccination data: COPI notice - frequently asked questions.

The COPI Notice therefore provides a legal basis for NHS organisations to use what would otherwise be confidential patient information to support the pandemic response. Organisations need to know the vaccination status of individual members of staff who have direct face to face contact with patients and service users in order to protect patients and the workforce. A record should be kept of all data processed under the COPI notice.

Information governance

Organisations should also:

- Complete a data protection impact assessment describing how they plan to use staff vaccination status information, including privacy risks that might arise from this.
- Have an 'appropriate policy document' in place describing how the processing of staff information complies with data protection law.
- Limit who has access to information about staff vaccination status, to only those that 'need to know' as part of their role, and ensure that those that have access to this information are aware of its confidential and sensitive nature and handle it appropriately;

[3] https://www.gov.uk/government/publications/coronavirus-covid-19-notification-of-data-controllers-to-share-information/coronavirus-covid-19-notice-under-regulation-34-of-the-health-service-control-of-patient-information-regulations-2002-general--2 . Equivalent notices have been given to NHS England and Improvement and NHS Digital.

- Make information available to staff describing how vaccination information is used ('fair processing' information).

Communication and engagement

Collective Consultation

Employers have responsibilities under section 188 of the Trade Union and Labour Relations (Consolidation) Act 1992 (TULRCA) to collectively consult with staff being made redundant. NHSEI and the Department for Health and Social Care have considered the issue and do not believe that any dismissals arising because a worker is unvaccinated should engage section 188 requiring collective consultation. However, this is ultimately a decision for each organisation to take independently and based on its individual circumstances.

It is important to note this is not a redundancy exercise. In the context of the regulations, there is no diminishment or cessation of work of a particular kind. Employers will not be concerned with finding "suitable alternative employment" and there will be no redundancy entitlements, including payments, whether statutory or contractual, triggered by this process. The redeployment or dismissal of workers is determined by the introduction of the regulations and an individual's decision to remain unvaccinated.

Whilst organisations are encouraged to explore redeployment, the general principles which apply in a redundancy exercise are not applicable here, and it is important that managers are aware of this.

In any event, organisations will wish to work in close collaboration with their local staff side representatives as far as possible to develop agreed approaches to issues such as redeployment, potential dismissal of staff and related processes due to VCOD.

It is also recommended that engagement with health and safety representatives should take place with regard to the potential impact the regulations will have on workforce health and safety e.g. the implementation of the regulations, changes to risk assessments and changes to working arrangements.

Communication with the workforce

Organisations, should have already engaged with their workforce about the regulations, primarily:

- the vaccination requirement.
- the need for people over 18 providing work or services to evidence vaccination or medical exemption.
- how the organisation is supporting workers to be vaccinated.
- addressing vaccine hesitancy and concerns.
- the potential consequences of not meeting the requirement on time.

Organisations are reminded to communicate with staff who are under the age of 18 on 1 April 2022 but will turn 18 later. This is because the requirement to be vaccinated or medically exempt will immediately apply when a staff member reaches the age of 18.

Formal processes

Formal processes outlined in this section apply only to those employed under a contract of employment with an employer (and not to other workers who are in scope of the regulations e.g. contactors, agency workers and volunteers), who are not fully vaccinated (excluding individuals who are exempt from the regulations as per pages 11 – 12, in phase one guidance).

Where an exemption applies, individuals may remain working in their current patient/service user-facing role if it is safe to do so and it is recommended that their risk assessments are reviewed to consider whether additional measures are required to mitigate against potential risks and provide additional support if necessary.

Staff should be provided with a reasonable opportunity to be vaccinated or obtain evidence they are exempt before any formal action is taken. In some circumstances, employers may need be flexible with regard to when formal processes commence as a reasonable adjustment.

Step one: engagement with unions

Employers should engage and work in collaboration with their trade union or staff side representatives, as to the formal measures being taken in respect of redeployment processes and potential dismissals of staff due to VCOD.

Step two: formal review process

It is recommended that within the grace period (from the 6 January 2022) a formal review process with staff who decline to disclose their vaccine status, for whom vaccination status cannot be ascertained, or who are unwilling to participate in the COVID-19 vaccination programme (and are not medically exempt) should take place, in which the consequences of remaining unvaccinated are clearly explained. This formal review process can be undertaken by way of meetings (whether in person or virtually), by written correspondence or a combination of these methods of communication, as appropriate in the particular case. The formal review process should include clarification of the dates by which the requirements must be complied with, and what steps will be taken for those who remain unvaccinated by those dates.

Alternative options potentially available to the individual, such as any possible adjustments to their current role, restrictions to duties or redeployment opportunities available, should also be explored with the individual, noted in writing and timescales confirmed. The individual

should be asked to make suggestions on potential adjustments to their current role and due consideration given to any such suggestions.

During this formal review process, line managers will need to advise staff that if the above options cannot be facilitated, a possible outcome is that the individual may be dismissed from their employment with their last day of employment being 31 March 2022 (or after depending on contractual notice period) if they remain unvaccinated or have not disclosed their vaccination status.

Staff may be given the opportunity to be accompanied to any meeting which takes place during the formal review process by a trade union representative or work-based colleague.

Where staff are away from work, for example on maternity leave, sabbatical, or long-term sick leave, employers should make appropriate arrangements in good time to avoid lack of knowledge of the requirement and potential outcomes of non-compliance being a barrier to returning to work on time.

Step three: formal meeting

From 4 February 2022, staff who remain unvaccinated (excluding those who are exempt) should be invited to a formal meeting chaired by an appropriate manager, in which they are notified that a potential outcome of the meeting may be dismissal. Meetings may take place in person or virtually.

Any dismissal will be on the grounds of contravention of a statutory restriction i.e. the regulations. Please refer to section 3 *Termination of employment*, for further information regarding dismissal processes due to the regulations.

It should be noted that employers can issue staff with contractual notice of dismissal whilst they explore redeployment options, and thus **notice periods and the search for alternative roles can run concurrently**. Every effort should be made to redeploy staff within their notice period up to and including their last date of service.

Formal processes leading to the termination of employment, including issuing notice of dismissal, should not commence before the 6th January 2022 and notice should not expire before 31 March 2022.

Equality Act 2010

In the consideration and exercise of formal processes for the purposes of the regulations, employers have a duty to ensure that they have due regard to the Equality Act 2010. Employers will need to ensure (not an exhaustive list):

- Formal processes avoid unlawful discrimination; for instance, for staff with a disability it may be necessary to make reasonable adjustments to any formal process followed.

- Formal processes should advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

- That due regard is given to the impact of decisions on those people with one or more protected characteristics, which are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, marriage and civil partnerships, and sexual orientation.

- Redeployment processes which may include multiple cases of potential redeployment for a variety of reasons concurrently, are conducted in an equitable fashion.

- Where multiple cases of redeployment are being considered including for reasons other than unvaccinated status, organisations should take into account the enhanced statutory rights of disabled people and pregnant women.

Please refer to DHSC's Making vaccination a condition of deployment in health and wider social care settings - Equality Impact Assessment for further guidance with regard to the regulations equality analysis, in respect of people with protected characteristics.

Reconfiguration of roles

Employers will need to consider whether it is reasonable, practicable or appropriate to reallocate patient/service user facing duties amongst existing teams to enable an individual to continue working in their current role whilst remaining unvaccinated. An evaluation of the impact of amending an individual's duties will need to include consideration of the potential impact on resources, other staff within the service, the wider organisation and service provisions. **Patient pathways, care and experience must not be compromised**.

Employers should also be mindful to act consistently in conducting these evaluations to ensure fairness in approach and equality of opportunity.

Risk assessments will need to be reviewed and updated in line with changes to individual circumstances, to ensure the mitigation of workplace risk, identification of reasonable steps to be taken for health and safety purposes, so far as is reasonably practicable, and to establish if the individual requires additional support.

The reconfiguration of an individual's role should be effective from 1 April 2022 in accordance with the date the regulations come into force.

Redeployment for the purposes of VCOD

The approach to the redeployment of staff for the purposes of VCOD should be guided by the principles outlined in this section, which the Social Partnership Forum (SPF) has contributed to. This will ensure a fair, transparent, and efficient process with regard to the exploration of possible alternative employment.

It is unlikely that most organisations' local policies and procedures will apply to redeployment due to unvaccinated status. Whilst there may be similarities in approach to existing redeployment policies and procedures, employers will need to be cautious about extending said policies (e.g. the application of redeployment as a result of organisational change) to those under the scope of VCOD redeployment and thus setting a precedent.

The principles set out below provide a framework for organisations to follow as a standalone process.

Organisations should proactively identify roles not in scope of the regulations and if possible and if it doesn't compromise patient care and services, pause external recruitment processes to allow for internal redeployment. The earlier the exploration of redeployment options can take place, the better informed the individual can be as to whether the process is likely to deliver a beneficial outcome and in turn has any bearing on their decision whether to be vaccinated.

It is acknowledged that for many providers, redeployment of staff for the purposes of VCOD may not be feasible or practical.

Temporary redeployment

As noted in phase one guidance, scientific advice is that pregnant women can be vaccinated against COVID-19[4]. However, a short-term medical exemption from the COVID-19 vaccination is an option that pregnant woman may choose to take (pregnant woman can apply for an exemption or use a MATB1 certificate as an alternative). The exemption expires 16 weeks after giving birth. This will allow them to become fully vaccinated after birth. Whilst the short term exemption means that pregnant women can continue to be deployed in their role, temporary redeployment may be considered and mutually agreed upon following the

[4] https://www.gov.uk/government/publications/safety-of-covid-19-vaccines-when-given-in-pregnancy/the-safety-of-covid-19-vaccines-when-given-in-pregnancy

outcome of applicable risk assessments (COVID-19 risk assessment, pregnancy and expectant mothers risk assessment) or on the advice of occupational health.

Permanent Redeployment

Responsibility of the employer

- To ensure all recruitment and selection processes are carried out in accordance with local policies and procedures, best practice, and employment legislation.
- To work in partnership with other organisations within Integrated Care Systems (ICS) to explore the potential for wider redeployment opportunities across all service providers.
- Whilst this is not a redundancy scenario and therefore an organisation's local policies on suitable alternative employment and "slotting-in" will not apply to redeployment due to unvaccinated status, organisations may consider suitable slotting in opportunities where appropriate.
- Employers should provide individuals with easy access to job vacancies. This can include sharing vacancies lists.
- Whilst there is no guarantee that staff will obtain redeployment opportunities, employers must be committed to providing support and redeployment assistance to staff.
- To ensure staff who require VCOD redeployment are not provided with preferential treatment over other staff in organisational redeployment 'pools' and who might have a legal entitlement to redeployment.

Responsibility of manager

- Ensure there will be no unreasonable delays in commencing redeployment processes as an alternative to dismissal, for unvaccinated staff.
- Make reasonable efforts to support staff through the redeployment process inclusive of the continuation of one-to-one conversations, signposting staff to information, occupational health and/or specialist expert advice to address vaccine hesitancy.
- Proactively identify potential redeployment opportunities.

- Wherever practicable and reasonable, support staff who are successful in obtaining alternative employment through their transition period to the new role via access to training and development or other forms of support.

- To keep communication open and transparent throughout with staff and their representatives, where applicable.

Responsibility of employee

- Proactively engage in supportive conversations and consider the advice and information from specialist experts regarding vaccinations.

- Communicate changes in their vaccination status to their line manager without delay.

- To proactively search for and identify redeployment opportunities as an alternative to dismissal, keeping their line manager up to date on their progress.

- Engage with and participate in redeployment processes.

- Create either a CV or a recruitment profile, detailing skills, knowledge and competency and the types of role for which they wish to be considered.

- To recognise that redeployment opportunities may change current working arrangements inclusive of hours, pay and place of work, and impact upon professional registration if applicable.

- Should an individual decide not to apply for, or take up an offer of, a role identified as a permanent redeployment option, they will notify their line manager without delay, setting out their reasons for their decision.

Recruitment and selection

- Whilst organisations should look for redeployment opportunities, it must be noted that unvaccinated staff should not be given priority to vacancies over staff who are legally entitled to additional protection due to maternity leave or disability, or to ‘slotting in’ under a contractual organisational change policy;

- Staff will need to create either a CV or a recruitment profile, detailing their skills, knowledge and competency and the types of roles for which they wish to be considered.

- There should be clear agreed processes as to how staff will access vacancies i.e. via a regular circulated list of existing vacancies, for which they are free to apply, or by providing access to vacancies via organisational recruitment systems.

- Suitable vacancies i.e. those that do not fall within scope of the regulations, will not be opened to staff within the wider internal workforce who do not require redeployment due to VCOD (excluding staff who require redeployment due to organisational change, ill health, pregnancy/maternity or any other legal entitlement) or to applications externally, until it is established that no unvaccinated staff member is appointable;

- Redeployment opportunities will be achieved by staff applying for a role(s) unless an organisation considers that the use of “slotting-in” is appropriate in circumstances.

- The application of equality principles will be included in all recruitment and selection processes in accordance with the principles that underpin improving recruitment and career progression for all staff.

- Decisions in relation to alternative employment opportunities should be made objectively and without prejudice. A decision not to appoint must be justifiable and based on evidence which will withstand objective scrutiny and may include that the individual is not the best candidate for the role and/or that the individual does not meet the identified essential criteria required for the role and would be unlikely to be able to do so following reasonable training and support. The validity of recruitment decisions can be tested as part of any future dismissal process including consultation with the individual up to the effective date of termination and any appeal which follows.

<u>Outcome</u>

- A record of the reasons for the decisions made following a recruitment process should be kept, detailing clear justification as to why the individual has been successful/unsuccessful at obtaining the role.

- Individuals should be provided with the opportunity for feedback if they are unsuccessful at obtaining an alternative role to help with future interviews and assessments.

- Should an individual decline an offer of permanent employment following a recruitment process, they must notify their line manager, setting out their reasons for their decision. They will continue to be considered for redeployment up to and including their last date of service.

All changes to an individual's role/duties should be documented and expressly agreed with the individual. The impact of changes to working arrangements, banding, contractual hours, enhancements etc., on a staff member pay should be explained and followed up in writing.

The commencement date of all redeployments to new roles is 1 April 2022 in accordance with the date the regulations come into force. This date can be brought forward if mutually agreed with the employee.

Pay Protection

- Where redeployment is undertaken for the purpose of the VCOD framework, individuals in scope of the regulations are not eligible for pay protection of their basic salary or additional earnings (e.g. on-call payments, unsociable hours enhancements, high cost area supplement) should they obtain employment at a lower band/grade to the one currently held, with different working arrangement;

- Staff who are temporarily redeployed at the discretion of the organisation due to not being fully vaccinated for good reason until shortly after 1 April 2022 or due to being pregnant may be eligible for pay protection (inclusive of enhancements) in accordance with local pay protection arrangements.

Redeployment support for staff

- It is recommended that individuals be provided with the opportunity to informally discuss identified alternative roles with relevant parties (e.g. their line manager or the recruiting manager).

- The following measures will be considered by an organisation:

    - access to support services such as interview skills workshops.

- signposting to staff psychological, health and wellbeing services.
- reasonable paid time off to attend interviews.

Termination of employment for the purposes of VCOD

Employers will need to consider the termination of employment of staff whose roles are in scope of the regulations and who refuse to be vaccinated in-line with the mandated timescales (excluding staff who are exempt) or decline to disclose their vaccination status. Any such termination should be undertaken lawfully, which requires that there be a proper reason for the dismissal and that a fair and reasonable procedure is followed.

Employers should consider an individual's reasons for declining to be vaccinated and examine options short of dismissal, where appropriate. However, if it's not feasible to implement alternative solutions, staff will be taken through a formal process to dismissal.

As previously detailed, the fair reason for dismissal will be on the grounds of a contravention of statutory restriction or in the alternative, "some other substantial reason" (SOSR). SOSR could apply where, for example, an individual refuses to confirm their vaccination status and it cannot be established from existing records. It is unlikely that employers will have any existing policy in place for the management of dismissals on this basis and accordingly, employers will wish to be clear about the process they will apply in order to ensure fairness and consistency across the organisation.

Organisations should follow a fair and reasonable dismissal process to provide protection against unfair dismissal claims and such a process should include the following steps:

- Inviting the individual to an initial meeting to discuss the regulations and their vaccination status which could be either in person or virtual.
- One-to-one supportive conversations, discussing concerns, providing vaccination information materials and access to specialist experts.
- Consideration of the extent to which the regulations affect the individual's ability to carry out their job i.e. it is a legal requirement of the individual's role.
- Consideration of any possible adjustment to the individual's role.
- Consideration of alternative roles.

- Invitation to a meeting (either is person or virtually) warning the individual that the outcome may be dismissal if they do not evidence, they are vaccinated or exempt within specified timescales.

- A meeting (either in person or virtually) at which the individual can be accompanied by a trade union representative or work-based colleague. The Chair of the meeting should assess whether adequate consideration of alternatives, such as adjustment or redeployment, has been given and whether, in light of those matters, employment should be terminated.

- Dismissal on notice (in accordance with contractual arrangements) to terminate not before 31 March 2022.

- Providing the individual with a right of appeal against dismissal.

It is recognised that some employers may have significant numbers of unvaccinated staff who cannot be redeployed, and accordingly, processes may need to be adjusted to enable them to take place within the required timescales. In all cases, processes should ensure that individuals' representations can properly be taken into account and that overall, they are fair and reasonable in the circumstances.

In all cases, robust documentation of actions taken to date inclusive of a summary of discussions held, formal letters to the individual and redeployment efforts, should be maintained to support the assessment of the reasonableness of the employer's decision to dismiss. The validity of recruitment decisions can be tested as part of any future dismissal process.

Notice of Dismissal

Notice of dismissal should not be issued before 4 February 2022 and should not expire before 31 March 2022. Staff should not be pre-emptively issued with notice of dismissal at any point prior to the date by which they are required to have received their first vaccination, given that they may still wish to change their mind and seek to be vaccinated.

Where individuals are serving a notice period which extends beyond 1 April 2022, they will need to be redeployed or removed from patient-facing roles whilst they await termination of employment. If redeployment is not available individuals should be placed on leave from 1 April 2022 until termination takes effect.

Payment in lieu of notice (PILON) can only be applied in accordance with contractual arrangements or written particulars of employment.

Service contingency plans

During the grace period, as part of the implementation of the requirements, organisations should identify the potential for workforce capacity pressures, (alongside existing pressures e.g. due to staff absences), and the potential impact on service provision, and plan mitigating actions to ensure effective arrangements are in place to continue to deliver appropriate care to patients and service users.

Business as usual escalation routes apply for service disruption. Commissioners and systems should be informed of likely or actual service disruptions, which they can escalate to NHS England and NHS Improvement regional teams as needed.

Organisations must notify CQC (via email or using the on-line form) if they identify that they are unable to continue delivering activity safely[5]. Notification should take place if the registered provider has concerns that any event will prevent, or appears to the service provider to be likely to threaten to prevent, the service provider's ability to continue to carry on the regulated activity safely, or in accordance with the registration requirements, including an insufficient number of suitably qualified, skilled and experienced persons being employed for the purposes of carrying on the regulated activity.

Employers should continuously assess the impact of the regulations on recruitment and retention activity, patient care, staff health and wellbeing and their public sector equality duty.

Organisational support for staff

It is recognised that formal processes may be difficult and challenging for staff especially with regards to mental health, and as such, employers should provide staff with access to local staff support services such as occupational health, employee advisory services, psychological services, chaplaincy, and spiritual care.

NHS England provides a range of support resources available to staff which can be found here.

[5] Events that stop a service running safely and properly – notification form | Care Quality Commission (cqc.org.uk)

Resources

The Advisory, Conciliation and Arbitration Service (ACAS) has produced a range of guidance. This should be useful for employers when considering good employment practice as part of implementing vaccination as a condition of deployment.

- Getting the coronavirus vaccine for work
- Advice on dismissals
- Disciplinary and grievance procedures
- Dealing with a problem raised by an employee
- Tailored support for your workplace
- Informing and consulting employees
- Notice periods
- Pay during the notice period
- Discrimination, bullying, and harassment
- Reasonable adjustments
- Hiring someone

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/01/11**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	26th January 2022	
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):***	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. Since the last meeting: • One new risk has been added to the BAF and there is a proposal to add a further risk; • It is proposed to increase the rating of one risk. • The description of one risk on the BAF have been amended and there is a proposal to update the title of one further risk; • No risks have been de-escalated from the BAF since the last meeting. Notable updates to existing risks are also included in the paper.	

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

RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC 22/01/08
	Date of meeting	11.01.2022
	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	Board Assurance Framework and Strategic Risk Register report	AGENDA REF:	BM/22/01/12

1. BACKGROUND/CONTEXT

This is an update of strategic risks on the Trust Strategic Risk Register. 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 latest Board Assurance Framework (BAF) is included as Appendix 1.

2. KEY ELEMENTS

2.1 New Risks

Since the last meeting, and following approval at the Quality Assurance Committee on 11th January 2022, one new risk has been added to the BAF. It was agreed to escalate risk **#1579** (detailed below) at a rating of 16.

ID	Risk description	Rating (current)	Rating (Proposed)	Risk Register	Executive Lead	Monitoring Committee
1579	Failure to transfer patients with major trauma, PPCI and Vascular to specialist units, caused by unprecedented demands on the North West Ambulance Service, resulting in a delay for identified or accepted specialist high risk cases.	16	16	BAF	Dan Moore	Quality Assurance Committee

Furthermore, and following support from the Strategic People Committee on 19th January 2022, it is proposed to add a new risk **#1590** (detailed below) at a rating of 20. This proposal is as a result of an amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to introduce the COVID vaccination as a condition of deployment (VCOD) that will come into force on the 1 April 2022.

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
1590	Failure to prevent staff shortages within certain professional groups and / or CBUs caused by individual decision making associated with the amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, introducing the COVID vaccination as a condition of deployment (VCOD) resulting in staffing gaps, a reduction in service provision and risks associated with risk 115 concerning staffing levels.	20	20	BAF	Michelle Cloney	Strategic People Committee

2.2 Amendment to Risk Ratings

Following the amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to introduce the COVID vaccination as a condition of deployment (VCOD) that will come into force on the 1 April 2022, it is proposed to increase the rating of risk **#115** (detailed below) from **20** to **25**

ID	Risk description	Rating (current)	Rating (Proposed)	Risk Register	Executive Lead	Monitoring Committee
115	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	20	25	BAF	Kimberley Salmon-Jamieson	Quality Assurance Committee

2.3 Amendments to descriptions

Following discussion and subsequent approval at the Quality Assurance Committee on 11th January 2022, it was agreed that the description of risk **#1331** should be amended as follows to provide greater clarity and be reflective of the current circumstances:

Previous: *Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.*

Current: *Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by increased restoration and recovery activity and the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.*

Furthermore, it is proposed to revise the description of risk **#1233** as described below to better reflect the current circumstances.

Current: *Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base.*

Proposed: *FAILURE TO review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed CAUSED BY Combined Assessment Unit (CAU) frequently being bedded with inpatients due to overcrowding in the ED and an excess demand for inpatient beds RESULTING IN a lack of surgical assessment bed capacity, poor patient experience, delays in treating surgical patients and increased admissions to the surgical bed base.*

2.4 De-escalation of Risks

Since the last meeting no risks have been de-escalated.

2.5 Existing Risks - Updates

Detailed below are the updates that have been made to the risks since the last meeting.

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
224	Failure to meet the emergency access standard, caused by system demands and pressures. Resulting in potential risks to the quality of care and patient safety, staff health and wellbeing, Trust reputation, financial impact and below expected Patient experience.	• Additional Senior Manager on call support at weekends • Successful bid for c£618k to support urgent care pressure in H2 • ECIST is supporting effective deployment of the national discharge policy • ED Plaza due for completion in May 2022 • Command & Control initiative in place since 8th December 2022 and ongoing to support pathway 0 and pathway 1 discharges. This is creating necessary capacity to support wave 5. This is in line with national guidance. • w/c 3rd January 2022 Ward B4 at Halton converted to provide additional G&A capacity (additional 27 beds) and flow in ED • To support capacity for Wave 5, elective activity moved to CSTM Halton facility to protect elective programme	No impact on risk rating
1215	Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm	• 500-700 additional domiciliary care hours to be released from w/c 6th December 2021 to support reducing long length of stay and super stranded patients • To support capacity for Wave 5, elective activity moved to CSTM Halton facility to protect elective programme • Phase 2 ED Plaza commenced in October 2021. And due for completion in May 2022	No impact on risk rating
1273	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.	• 500-700 additional domiciliary care hours to be released from w/c 6th December 2021 to support reducing long length of stay and super stranded patients • Command & Control initiative in place since 8th December 2022 and ongoing to support pathway 0 and pathway 1	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		discharges. This is creating necessary capacity to support wave 5. This is in line with national guidance. • w/c 10th January 2022, the Trust is supporting system designation of the Lilycross facility as being able to receive COVID positive patients. This is supporting wave 5 bed capacity.	
1272	Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 meters apart, resulting in reduced capacity to admit patients and a potential subsequent major incident.	• At times of extreme escalation extra beds on ward K25 and CAU	No impact on risk rating
1275	Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks	• Programme of OH screening for employees in place for symptomatic and asymptomatic employees with household contact. • Revised guidance in place for respiratory and non-respiratory pathway • Testing amended to included Influenza A&B & RSV. Agreed patient flow pathways based on results of screening. • Mask station not present at all entrances • Cleanliness score (on small number of ward items) sit just below 95% • Increased transmission rate of the Omicron variant	No impact on risk rating
1289	Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm	• Additional ultrasound contract awarded to start in January 2022 • Successful bid of c£3m to support elective recovery in H2 • All priority/urgent cancer P1 and P2 elective plans have been maintained through wave 5 • To support capacity for Wave 5, elective activity moved to CSTM Halton facility to protect elective programme	No impact on risk rating
115	Failure to provide adequate staffing levels in some specialities and wards, caused by inability to fill vacancies, sickness, resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	• Rolling advert for B5 Nurses paused for 3 months whilst international nurses are placed – recommenced November 2021 • Developing WHH recruitment campaign – 1st open day in October 2021 to be followed in January 2022 • Trust has intensified the HCA recruitment and achieved 0 vacancies by April 21. NHSI funding support received to achieve this aim. Weekly monitoring on progress and reporting to NHSI in place. Work now ongoing for pastoral support of new recruits to improve turnover rate in this group.	Proposed to increase rating from 20 to 25

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• The Trust will be placing 95 International Nurses by Dec 21. • In November 21 we have 0 wte band 5 vacancies. • Recruitment campaign for ED staffing is active, open day 28th October will be followed up in January • There are currently 28 Health Care Assistant vacancies within the Trust. All vacancies are being recruited into during January supported by HR, Education and Workforce Improvement Lead. • International nurses have all been placed (95 in total) on wards. • Increased incidence of COVID-19 Omicron variant is leading to increased staff absence. Plans are in place to reduce activity to ensure staff are available from elective areas to support affected areas. • Incentives have been offered to staff able to work increased hours via NHSP • 13.91% nursing turnover • Incentives have been offered to staff able to work increased hours via NHSP – Extended to the end of February 2022 • Minimum ward staffing numbers assessment completed • Significant staffing absences from Dec 2021 due to the increased transmission rate of the Omicron variant.	
134	Risk: Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	• Governance process in place to ensure all additional costs are being approved and monitored – re-introduced for Wave 2 & Wave 3. Further re-introduction in January 2022 related to the latest COVID-19 surge. • ERF Funding is not guaranteed and is non-recurrent & subject to system performance and achievement of five gateways. H2 ERF of £0.7m at risk due to planned activity stepped down across the region • Current unidentified CIP is £1.5m in 2021/22 • Inability to manage winter/COVID-19 costs could impact on the ability to breakeven in H2. This risk is enhanced due to current surge. • High Level planning guidance sent on 24th December 2021; however, the detail has not yet been provided. • Availability of social care to support the current super stranded position (currently c25% of bed base)	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
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	• Enhanced Occupational Health Service to support the Christmas period and weekend to deal with the spike caused by the Omicron variant. • New Supporting Attendance Policy to go live from February 2022 policy is currently in final stages of ratification process. • Supported by funding from NHSI there has been a big push to fill our HCA vacancies, we are currently reporting 28.95 FTE vacancies (31/11/2021). • In Nov 2021 overall vacancy rate has continued to reduce to 7.65% compared to a peak in Jun 2020 of 10.5%. • Therefore, as vacancies and sickness absence reduced it is expected our bank and agency reliance reduce and within Nov 2021 reliance on bank and agency staff increased slightly to 13.45% compared to a peak of 23.3% in Jan 2021 • Mandated vaccination of NHS staff – following introduction of new legislation on 6th January 2022 the Trust is currently following phase 1 guidance in relation to Vaccination as a condition of deployment (VCOD). **Gaps** • Potential gaps within services brought by introduction of VCOD.	No impact on risk rating
1125	Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance	• Discussed at the NED led Clinical Recovery Oversight Committee (CROC) • Discussed at the Clinical Services Oversight Group (CSOG) • Constitutional Standard Performance reporting to the Finance & Sustainability Committee (F&SC) • Executive attendance at the weekly Elective Restoration meeting for Cheshire & Merseyside. Linked with the ICS Governance Structure • H2 planning linked to restoration & recovery agreed with NHSE/I	No impact on risk rating
1207	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	Trust compliance as at 7th January 2022 • Have you offered a Risk Assessment to all staff? - Yes • What % of all your staff have you Risk Assessed? – 96.12% • What % of risk assessment have been completed for staff who are known to be	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	"at risk", with mitigating steps agreed where necessary? – 95.32% • What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary? – 93.58% The new Workforce Cell is meeting from 12.01.2021 and will continue to hold managers to account regarding compliance with Risk Assessments. **<u>Gaps</u>** At 10th January 2022: • 91 staff members yet to complete self-assessment (reduced from 231 in September 2021, demonstrating the impact of the letter) • 0 Management Risk Assessments (required when an individual identifies as having a COVID Vulnerability) have been outstanding since at least Jun 2021 • 86 Management Risk Assessments are outstanding between Jul 2021 and Dec 2021	
1233	Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base.	Assurance: • CAU assessment capacity and availability considered on a thrice daily basis in bed meetings • CAU assessment capacity status considered at twice weekly Tactical Board • Regular CAU steering group meetings will continue to review effectiveness of controls Controls • Ensuring CAU assessment capacity is preserved or reinstated is a standing priority at bed meetings and Tactical Board • Other escalation areas bedded before escalation to bed CAU • A surgical ambulatory nurse co-ordinator supports surgical emergency admission patient flow • New ways of surgical working implemented 17/1/22 to mitigate risk by pulling patients requiring operative intervention directly to theatres from the ED and CAU to avoid delays to surgery caused by a lack of beds	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• Completion of the ED plaza will negate this risk as the dedicated assessment areas in the ED plaza cannot be bedded and as such surgical assessment capacity will be preserved Gaps in Controls • An admission avoidance clinic is set up but cannot be utilised effectively as no alternative assessment area is available to bring patients back to when CAU is bedded. • During periods of excess bed demand CAU is very likely to be a bedded area limiting the availability for the surgeons to review any admission avoidance patients. • Surgeons may struggle to find assessment areas in ED to treat patients • Any delay in the ED Plaza program will delay the resolution of this risk	
125	Failure to provide a safe, secure, fit for purpose hospitals and environment caused by the age and condition of the WHH estate and limited availble resource resulting in a risk to meeting compliance targets, staff and patient safety, increased backlog costs, increased critical infrastructure risk and increased revenue and capital spend.	• Capital plan to improve kitchen and catering facilities being worked up to be included financial year 2022/23	No impact on risk rating
1108	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	• 1:1 care rate currently @ c98% • Daily review of staffing, report to Cheshire and Mersey Gold Command weekly to identify hot spots and request mutual aid. • COVID Omicron Variant staffing plan being developed to activate additional staffing if required. Cheshire and Mersey • Escalation and Divert Policy embedded in organisation.	No impact on risk rating
145	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services	• Breast Centre of Excellence opened to consolidate breast screening in Warrington but to commence in April 2022 • Consistent Trust representation within Cheshire & Merseyside ICS to support transition to ICS. WHH CEO appointed as Head for Clinical Pathways within C&M. • Trust representation on newley established place based Boards within	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	both Warrington & Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected. • Sefl assessments of both Warrington & Halton hospitals place based governance development indicate that Halton is 'emerging' (stage 2 of 4) and Warrington is establishes (stage 3 of 4). • There is a requirement to further develp as places to ensure both boroughs can benefit from potential future autonomy.	
1331	Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by increased restoration and recovery activity and the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.	Challenges presented with COVID-19 saw an increased capacity demand, patient acuity and the need for isolation capacity for infection prevention and control reasons which resulted in the use of theatres as that was the only area that had the correct standards of Electrical & Gas supplies to support critical care patients outside of the critical care unit What we did: • Increased Critical Care operational capacity to 20 beds within the unit. • Additional staffing facilitated via NHSP to support 20 bedded operational capacity of the critical care unit • Installed 5 additional isolation cubicles within ICU making a total of 7 isolation rooms. (DOH HBN 04 02 regulations state that Critical Care should have 20% isolation capacity, Warrington Critical Care unit now has a 35% capacity based on 20 bedded foot print) • Purchased additional Monitoring, pumps and ventilators to support increase in capacity and acuity and demand. • Refurbishment of B18 with an additional 14 enhanced care beds with the appropriate Electrical & Gas supplies to support o 4 Isolation cubicles equipped to care for up to level 3 patients • 10 enhanced care beds to care for up to level 2 patients • A review of the impact of wave 5 is currently providing assurance that action taken to date are working to maintain a safe level of capacity for priorities 1,2 & 3 patients. However, the capacity level is still being impacted by staffing levels.	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
1290	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices, technology products and services, clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.	• The subgroup continues to meet quarterly to monitor national changes, including the current logistical challenges associated with EU exit.	No impact on risk rating

3 RECOMMENDATIONS

The Board is asked to discuss and approve the changes and updates to the Board Assurance Framework.

Board Assurance Framework

Board Assurance Framework

The Board Assurance Framework (BAF) focusses on the key strategic risks i.e. those that may affect the achievement of the Trust's Strategic Objectives

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	Daniel Moore	Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience.	1	25 (5x5)	8 (2x4)	TBC	Clinical Recovery Oversight Committee
1215	Daniel Moore	Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm	1	25 (5x5)	6 (3x2)	TBC	Quality Assurance Committee
1273	Daniel Moore	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.	1	25 (5x5)	5 (5x1)	TBC	Quality Assurance Committee
1272	Kimberley Salmon-Jamieson	Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident.	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
1275	Kimberley Salmon-Jamieson	Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
1289	Daniel Moore	Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
115	Kimberley Salmon-Jamieson	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	1	20 (5x4)	12 (4x3)	TBC	Quality Assurance Committee
134	Andrea McGee	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b)	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee

Board Assurance Framework

		Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.					
1134	Michelle Cloney	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee
1114	Paul Fitzsimmons	FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	1	20 (5x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1125	Daniel Moore	Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance	1	20 (5x4)	8 (2x4)	TBC	Clinical Recovery Oversight Committee
1079	Kimberley Salmon-Jamieson	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.	1	20(4x5)	2 (1x2)	TBC	Quality Assurance Committee
1207	Michelle Cloney	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. The two staged approach to risk assessments means that this will be caused by either employees not completing the self-risk assessment in a timely manner or managers not acting upon the information provided and completing a	2	16 (4x4)	8 (2x4)	TBC	Strategic People Committee

Board Assurance Framework

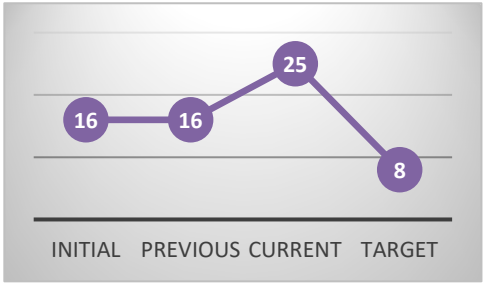
		management risk assessment, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.					
1372	Paul Fitzsimmons	FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case	3	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1597	Daniel Moore	Failure to transfer patients with major trauma, PPCI and Vascular to specialist units, caused by unprecedented demands on the North West Ambulance Service, resulting in a delay for identified or accepted specialist high risk cases.	1	16 (4x4)	8 (2x4)	TBC	Quality Assurance Committee
1233	Paul Fitzsimmons	Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base.	1	16 (4x4)	6 (2x3)	TBC	Quality Assurance Committee
125	Daniel Moore	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.	1	16 (4x4)	4 (4x1)	TBC	Executive Management Team
1108	Kimberley Salmon-Jamieson	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team	1	16 (4x4)	4 (4x1)	TBC	Quality Assurance Committee
145	Simon Constable	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient	3	15 (3x5)	8 (4x2)	TBC	Executive Management Team

Board Assurance Framework

		population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.					
1274	Kimberley Salmon-Jamieson	Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.	1	15 (3x5)	5 (5x1)	TBC	Quality Assurance Committee
1331	Daniel Moore	Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by increased restoration and recovery activity and the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.	1	15 (5x3)	5 (5x1)	TBC	Quality Assurance Committee
1290	Andrea McGee	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.	3	12 (3x4)	4 (1x4)	TBC	Finance & Sustainability Committee

Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.
Strategic Objective 2: We will… Be the best place to work with a diverse and engaged workforce that is fit for now and the future
Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.

Board Assurance Framework

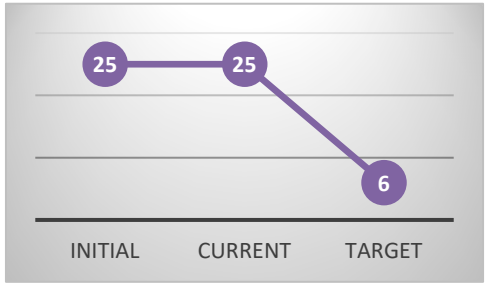
Risk ID:	224	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience.			**Initial:**	16(4x4)
				Current:	25(5x5)
				Target:	8 (2 x 4)
Assurance Details:	•Regular Trust Wide Capacity meetings led by the Senior Site Manager for the day •Systemwide relationships including social care, community, mental health and CCGs •Discharge Lounge/Patient Flow Team/Silver Command •ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing •Controller •Private Ambulance Transport to complement patient providers out of hours •FAU/Hub operational from June 2018 - Now operating 5 days per week. •Discharge Lounge opened 26th November 2018 •Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance. •System actions agreed supporting the Winter Plan •Further development of Rapid Response to avoid admission •Increase IMC provided by the system such as the opening of the Lilycross site •Increase IMC at home •Regular monitored at the Mid Mersey A&E Board •Trust is working with ECIST on a number of Long Length of Stay & Flow improvement projects •ECIST is supporting effective deployment of the national discharge policy •Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. •The Trust participates at the system & regional UEC improvement meeting on each Wednesday •Redeveloped ED 'at a glance' dashboard •Trust implemented NHS 111 first successfully in August 2020 allowing for directly bookable ED appointments •Board approval of capital plan to build new £5m purpose built acute Medical Ambulatory Care area aka ED Plaza •Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings •Integrated discharge Team now in place •Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients •ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised. •Respiratory Ambulatory Care Facility agreed by CCG •Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved •Collaborative working with Orthopaedics in management ok MSK Minor injuries via Minor's Stream •Reinstated CAU 24/7 •Upgrade to Minor's resulting in Oxygen points in all cubicles •Non-Elective flow activity now above 2019/20 activity levels for type 1 & 3 •Operation Re-set undertaken at the end of May 2021 to support flow and discharge •ED Response Group established in August 2021, clinically led by Dr Vondy to review internal ED processes. •Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly. •Monthly Focus on Flow weeks scheduled every month until July 2022 • Additional Senior Manager on call support a weekends • Successful bid for c£618k to support urgent care pressure in H2				

Board Assurance Framework

	ED Plaza due for completion in May 2022 Command & Control initiative in place since 8th December 2022 and ongoing to support pathway 0 and pathway 1 discharges. This is creating necessary capacity to support wave 5. This is in line with national guidance. w/c 3rd January 2022 Ward B4 at Halton converted to provide additional G&A capacity (additional 27 beds) and flow in ED To support capacity for Wave 5, elective activity moved to CSTM Halton facility to protect elective programme	
Assurance Gaps:	•Staffing pressure created as a direct result of COVID-19 Global pandemic. •Confirmed exponential growth in types 1 & 3 as a result of population nedd and lack of access to Primary Care	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12 hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Silver Command and SMOC (out of hours) and Executive on Call.	Field-Delaney, Sheila	31/03/2022	
ED Response Group	Executive recommend the formation of Supportive forum for ED to support current issues highlighted during May2021 operation reset.	ED Response Group Formed and TOR agreed and lead assigned	Vondy, Dr Anna	31/03/2022	
DATIX Reporting for Patients Waiting for a Bed	Staff are encouraged to report near misses of patients who have been waiting for a bed for a long period of time.	Review the DATIX and carry out rapid incident reviews.	Field-Delaney, Sheila	31/03/2022	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG	Field-Delaney, Sheila	31/03/2022	

Board Assurance Framework

Risk ID:	1215	**Executive Lead:**	Dan Moore	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to deliver the capacity required caused by the on-going COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm			**Initial:** 25 (5x5) **Current:** 25 (5x5) **Target:** 6 (3x2)
Assurance Details:	• H2 Planning Guidance submission – October 2021 • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery • Operational planning to be monitored by Gold Command on a daily basis, by Cheshire & Merseyside elective restoration meeting weekly and the Clinical Recovery Oversight Committee (CROC) & Clinical Services Oversight Group (CSOG). This relates to elective surgical activity. • 2021/22 Operational Planning Guidance received in April 2021 outlining planning requirement for the first 6 months. • Elective Recovery Plan Business Case under development to support waiting list recovery for outpatients, cancer and electives in H2 • To support capacity for Wave 5, elective activity moved to CSTM Halton facility to protect elective programme Radiology • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Department has been supported by the Trust through £380K recurrent funding to recruit additional staff. Advert out 11th June 2020. Recruiting 4 Radiographers, 2 Sonographers, 2 Healthcare Assistants. • Additional staff will support additional capacity through extended working days across all scanners – currently unable to achieve this due to Covid-19 demands. • Additional CT capacity (15 exams per week) will be provided mid-July 2020 via use of mobile CT scanner supported by the National Imaging Team Covid-19 Response initiative. (this has been extended to mid-September 2021) • MR business case supported to provide a mobile MR van until October 2021 until the new static MR capacity commences. • All outstanding requests are clinically reviewed by Senior Consultant Radiologists as per local SOP. Exams are deferred in line with clinical priority. Cancer and Urgent patients are being imaged as per pre-Covid-19 as per national guidance. • Those deferred patients are sent a letter informing of delay, and to contact their Doctor if any concern. The referrer of delayed patients are also sent a letter informing of delay, but this referrer letter includes a direct telephone number to the Senior Radiology Consultants, and also an email address should there be a concern with delaying. Any exams that are highlighted from referrers as not suitable for delay are appointed on the next available appointment. • This delay process has been discussed via Medical Cabinet and agreed as most appropriate process. • This clinical review and delay process is ongoing daily. • Improvement against all modalities for numbers waiting more than 6 weeks noted in April performance. • CT Business case approved to increase CT capacity and support expediting recovery. Unplanned care • The emergency department has been reconfigured to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics in line with Royal College of Emergency Medicine (RCEM) guidance. • Minor injuries is provided in an area in close proximity but separate to the main emergency department. This has provided an opportunity to use the old minors department as Majors 2 to support management of surge demand and avoidance of corridor care. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • In patient capacity is reviewed with the patient flow and CBU teams daily to ensure that there is adequate capacity for all patient groups to be admitted.			

Board Assurance Framework

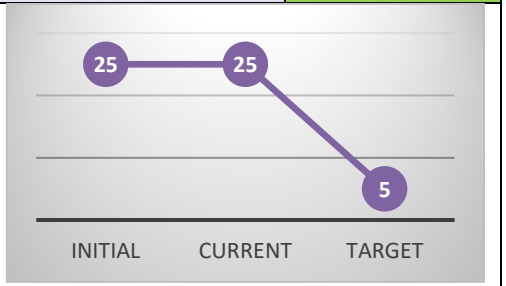
	• ITU business continuity plans have been agreed to escalate critical care as and when required. • Clinic templates have been revised to ensure social distancing measures are in place and patients are not brought to a face to face appointment unless clinically indicated. Virtual appointments are in place (telephone and video) for use where this is clinically appropriate. • Suspected cancer, cancer and clinically urgent patients are allocated out patients and diagnostic appointments as a priority. • Waiting lists are reviewed through the performance review group weekly – outpatients and diagnostics. • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • NHS 111 First pilot went live on 8th September 2020 to reduce attendances to the emergency department and to support the planning of activity in a more streamlined way to reduce overcrowding and risk of nosocomial infection. • Business Case for ED Plaza Scheme approved in 2021/22 Capital Plan • Reconfiguration of Paediatric ED completed and operational • Phase 2 ED Plaza commenced in October 2021. And due for completion in May 2022 • Deployment of Bioquell Pods in ICU live and operational Planned Care • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery. • All elective patients have been clinically reviewed and categorised in line with national guidance. • Suspected cancer, cancer and clinically urgent patients are treated as a priority. • Theatre capacity has been reviewed and additional capacity is now available with the de-escalation of the theatre PODs • The Halton site is being developed as a covid secure site and will be run as an Elective Centre. • Elective Surgery Standard Operating Procedure (SOP) in place • Capacity identified and being utilised at spire Healthcare • Clinical Services Oversight Group (CSOG) established • Clinical Recovery Oversight Committee (CROC) established • Clean/green pathways have been developed for those priority 2 patients (cancer & urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward 5 on the Warrington site. This pathway is set to commence w/c 8th February and replaces the B18 pathway. • A separate pathway has been developed for Emergency surgery and future plans and bed base has been agreed as part of the ward reconfiguration process. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Workforce plans are continually reviewed to ensure that all wards and teams are staffed safely. • Waiting lists are reviewed through the performance review group weekly • Weekly theatre scheduling to ensure listing of patients in line with national guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021 • Continued use of the independent sector (Spire Cheshire) under new contract in 2021/22 with support from the CCG. • Participation in national clinical validation exercise commenced in November 2020 to support and inform patient waiting time status and support safe management of waiting lists.	
Assurance Gaps:	Radiology 1. Harm may be caused due to the incompleteness of clinical information on a referral. This may also be compounded by the referrer incorrectly entering the wrong priority code on the referral. • It is thought that the letter to the referrer will highlight the exam has been delayed and that the provision of a direct link to the Radiology Consultant team by phone/email will allow these cases to be expedited where appropriate. 2. Harm may be caused by the delay of a routine examination where there is an unlikley serious pathological finding present.	

Board Assurance Framework

	• This risk is present in all routine exmas as the waiting time for routine diagnostic imaging is up to 6 weeks as per national targets. This risk is hightened due to Covid-19 and the reduced capacity at present. It is thought the letter to the patient advising to contact their Doctor with any concern will reduce this risk. Unplanned care 1. Estates work is required to complete the segregation of paediatric patients in the emergency department. • This is being progressed with the support of the estates and capital planning team. 2. Expansion of the emergency department is required to ensure any increase in demand can be accomodated in line with RCEM guidance 3. Referrals do not include adequate information to triage and prioritise patietns appropriately • Regular meetings and communication with the CCG and GP's to inform them with recovery progress within the organisation and to highlight/address any identified problems 4. Reduction in face to face primary care appointments having a negative impact on increased attendances. 5. Capacity challenge with social workers to keep on top of demand and necessary patient assessments. 6. Estates work required to increase general ICU Capacity & ICU cubicle capacity e.g. Installation of Bioquell cubicles Planned Care 1. Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility. • This is being progressed with the support of the estates and capital planning team. 2. Waiting list do not include adequate information to triage and prioritise patients appropriately • Regular meetings and communication with the waiting list and scheduling teams and inform them of recovery plans and to highlight/address any identified problems 3. New framework for ISP will not include all specialties currently being undertaken. This will increase waiting list pressure for those specialties on this site.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Install of Bioquell Cubicles	Install of Bioquell Cubicles	Complete Installation	Sharon Kilkenny	28/02/2021	Installation in ICU Complete Jan 2021
Build ED Plaza	Completion of ED Plaza building works	Complete Building work	Sharon Kilkenny	31/05/2022	

Board Assurance Framework

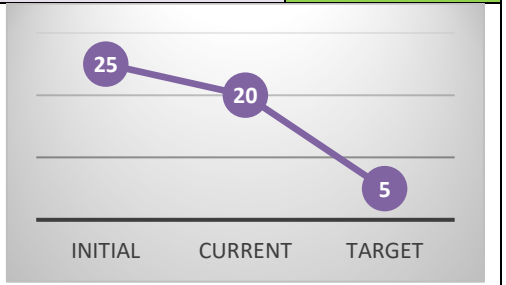
Risk ID:	1273	**Executive Lead:**	Moore, Daniel	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.			**Initial:** 25 (5x5) **Current:** 25 (5x5) **Target:** 5 (5x1)
Assurance Details:	Integrated Discharge Team comprising of hospital and Local Authority colleagues from Warrington and Halton to develop systems and process of discharge acknowledging difficulties of Covid-19. Daily system pressures meeting that reviews hospital and wider system bed capacity to support safe and timely discharge of patients from hospital to support flows Trust participates in Mid-Mersey Operational Group which supports Out of Hospital Cell discussions in relation to system discharge planning. The number of discharge delays in relation to Super Stranded patients is reported daily in the Executive Summary and reviewed so that Executive Directors can support and escalate pathway delays. 'Where's best next' event initiated in January 2021 with system partners to support safe discharge of patients with long lengths of stay to create capacity through December and January expected winter pressures and support wave 3. Scheme issued by the Government to support indemnity concerns of care homes in relation to caring for COVID-19 patients. It will support the system in the creation of COVID-19 designated setting capacity. New 'Discharge to Assess' process has gone live to reduce the length of stay for a cohort of patients who would otherwise be assessed in hospital can be assessed in a transitional care bed. Progressing the procurement of a new software programme which will be able to accurately track and share system delays with partners. By improving information, it will enable quicker and more effective decisions on discharges. Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly. Monthly Focus on Flow weeks scheduled every month until July 2022 Daily bed meetings organised by the Director of Operations & Performance to provide timely and effective benefits to patient flow Approval of IMC business case which will support a reduction in frailty length of stay and admission avoidance through geriatric input in to the Emergency Department. 500-700 additional domiciliary care hours to be released from w/c 6th December 2021 to support reducing long length of stay and super stranded patients Command & Control initiative in place since 8th December 2022 and ongoing to support pathway 0 and pathway 1 discharges. This is creating necessary capacity to support wave 5. This is in line with national guidance. w/c 10th January 2022, the Trust is supporting system designation of the Lilycross facility as being able to receive COVID positive patients. This is supporting wave 5 bed capacity.			
Assurance Gaps:	Delays in discharge caused by adherence to Covid-19 infection control pathways and the patient's Covid-19 status. Intermediate Care and other community capacity impacted and restricted by Covid-19 e.g. Care Home and other facility closures due to outbreaks. Access to community capacity impacted by Covid-19 as a result of staff sickness Internal staff shortages to help support discharge planning. Restricted as a result of Covid-19 sickness and self-isolation High number of patients in Warrington awaiting social work assessment, causing a delay in discharges from the acute site in to care homes and intermediate care capacity Significantly reduced capacity in the domiciliary care market due to the high number of vacancies. This is causing package of care delays.			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Improve discharge planning skills & knowledge	Undertake educational sessions to improve discharge planning skills & knowledge as part of Focus on Flow sessions	Complete educational sessions	William, Caroline	30/01/2022	

Board Assurance Framework

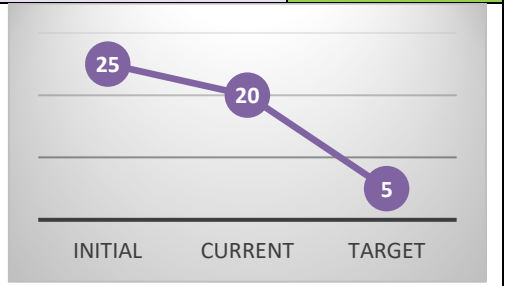
Improve quality and effectiveness of Board Rounds	Undertake educational session to improve quality and effectiveness of Board Rounds to help support reductions in length of saty	Complete educational sessions	Harris, Zoe	30/01/2022	
Review length of stay data	Undertake en-masse review of length of stay data across the Trust to inform new actions and action plan	Complete review	Harris, Zoe	30/11/2021	

Board Assurance Framework

Risk ID:	1272	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 meters apart, resulting in reduced capacity to admit patients and a potential subsequent major incident.			**Initial:** 25 (5x5) **Current:** 20 (4x5) **Target:** 5 (5x1)
Assurance Details:	The Trust has in place a full environmental plan. The Trust has used a risk assessment approach to identify compliance or challenges in meeting the 2-metre requirement. Risk assessments have been completed on each Ward. Clear curtains are in place all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. Collapsible screens in some areas 8 weeks environmental visit rota in place, supported by the Health & Safety Team and senior clinical nursing staff Expected deployment of Bioquell Pods in ED & ICU in March/April 2021 Bioquell Pods now in place in ICU Bioquell Pods now in place in ED. Bioquell Pods now in place in B18			
Assurance Gaps:	Individual Ward risk assessments identify challenges in meeting the 2 metre requirement. In October 2021 and increase in community prevalence noted. Increase in formally declared nosocomial infection At times of extreme escalation extra beds on ward K25 and CAU			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
An environmental inspection plan to be set up to ensure there is monitoring of social distancing.	Clear curtains are in place on all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. Bioquell Pods are now in place in ICU. As the number of COVID positive patients has reduced and the nosocomial outbreaks has also reduced, it was agreed at QAC on the 4th May 2021 to reduced the risk from 25 to 20. The situation needs to be continually monitored and therefore the action will remain open and reviewed each month.	Health and Safety to develop and implement an environmental inspection programme in all clinical areas.	Kennah, Ali	31.03.2022 (Rolling plan)	
All wards and departments to have up to date risk assessments in place.	All wards and departments to have up to date risk assessments in place.	Review risk assessments	Wynn, Helen	30.03.2022	

Board Assurance Framework

Risk ID:	1275	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks			**Initial:** 25 (5x5) **Current:** 20 (4x5) **Target:** 5 (5x1)
Assurance Details:	Restricted site access is in place to reduce the risk of COVID19 transmission. COVID19 incidents are monitored daily. Risk assessments are in place in all Wards/Departments and rest rooms. Mask stations and santiser is in place at all entrances and designated points throughout the Trust. Agile working policy is in place Information technology infrastructure is in place to support remote working. Risk assessment in place to support safe visiting where appropriate. PPE is monitored daily. Providing and maintaining a clean environment that facilitates the prevention and control of infections. Daily communications through TWSB to staff reinforcing social distancing measures Environmental Safety Action plan in place reported by exception to Silver Infection Control Outbreak meetings held with lessons learned shared across the Trust Signage and written information in place to support social distancing practices Retractable screens between beds spaces in ED PPE audits completed weekly on wards PPE & Swabbing Champions identified Clear curtains are in place all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. Process for assurance of 3 and 5 day swabs in place Bioquell Pods now in place in ICU Bioquell Pods now in place in ED Bioquell Pods now in place B18 Trust completed learning from Nosocomial outbreaks sessions. COVID-19 quality metrics in place Cohorting of COVID-19 positive patients recommenced Programme of OH screening for employees in place for symptomatic and asymptomatic employees with housegold contact. Revised guidance in place for respiratory and non-respiratory pathway Testing amended to included Influenza A&B & RSV. Agreed patient flow pathways based on results of screening.			
Assurance Gaps:	Non-compliance with social distancing & PPE Non-adherence to Trust Staff isolation policy Mask station not present at all entrances Cleaniliness score (on small number of ward items) sit just below 95% Increased transmission rate of the Omicron variant			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Health and Safety inspections to include the monitoring of social distancing and ensure hand sanitiser and masks are located at each entrance.	Findings from inspections reported to the Health & Safety Sub-Committee Health and Safety inspections continue on an 8 week programme.	Health and Safety inspections to be carried out.	Kennah, Ali	31.03.2022	

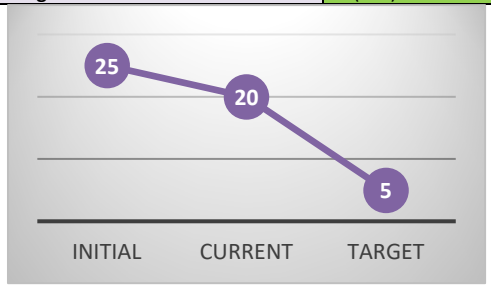
Board Assurance Framework

Design of mask stations to be reviewed	Design of mask stations to be reviewed	Review to be undertaken	Kennah, Ali	31.03.2022	
Review Nurse cleaning roles & responsibilities	Reviewed as part of a Task & Finish Group to implement revised cleanliness standards	Agree roles and reseponsibilities	McGreal, Julie	31.03.2022	

Board Assurance Framework

1289	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm			**Initial:**	25 (5x5)
			Current:	20 (4x5)
			Target:	5 (5x1)

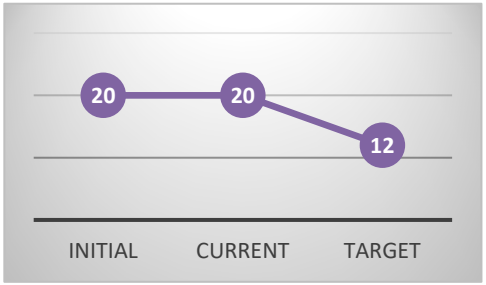
Confirmed continued use of the private sector (Spire Cheshire) in 2021/22. Under new contracting arrangements.
Waiting lists monitored and measured weekly
Post Anaesthetic Care Unit (PACU) remains open and operational
Continue to undertake harm review process and triangulate with waiting list process and Priority 2 patients
Continue to specifically focus on and monitor patients waiting greater than 52 weeks
Continue to ensure urgent cancers are prioritised in line with national guidance
Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site.
Bioquell Pods in ED live and operational
B18 footprint development to support improved Respiratory & Critical response to peaks in the pandemic is underway and set to complete in September 2021.
Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee.
Safe staffing levels reviewed daily. If necessary this may mean a review of clinical services to support the release of staff on a temporary basis.
The re-start of the Warrington site green pathway commenced w/c 8th February in the newly established ward A5 elective footprint. At present this supports cancer and other green pathways on the Warrington site
Clinical Recovery Oversight Committee (CROC) established
Clinical Services Oversight Group (CSOG) established
Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery.
B18 opened in October 2021
Respiratory nursing business case approved to support step down of respiratory patients from ICU to B18 earlier in their care pathway thus creating ICU capacity to support planned care
Additional ultrasound contract awarded to start in January 2022
Successful bid of c£3m to support elective recovery in H2
All priority/urgent cancer P1 and P2 elective plans have been maintained through wave 5
To support capacity for Wave 5, elective activity moved to CSTM Halton facility to protect elective programme



Theatres 3 and 4 currently used for Endoscopy rather than as Theatres until the Endoscopy rooms are completed in October 2021
Limited bed base within A5 elective footprint
Increase in COVID-19 ICU patients as a result of wave 4 (July 2021) impacted on scheduling for patients requiring ICU post op

Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop plan for Ward 18 Footprint to support alternative critical care escalation.	Develop plan for Ward 18 Footprint	Kilkenny, Sharon	28/02/2021	28/02/2021
Complete the B18 development	Complete the B18 development	Kilkenny, Sharon	30/09/2021	13/10/2021

Board Assurance Framework

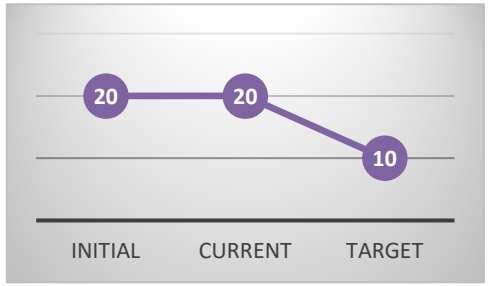
Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.			**Initial:** 20 (5x4) **Current:** 20 (5x4) **Target:** 12 (4x3)
Assurance Details:	• Monthly workforce information produced via workforce dashboard. Information is reviewed and monitored at the Workforce Group Chaired by the Chief Nurse • Robust staffing escalation process across WHH to manage staffing daily – This has become the forum for responsive staff management during the COVID 19 pandemic • Lead Nurse identified daily to co-ordinate staffing supported by a senior nurse rota 7 days a week 8am – 8pm which commenced in April 2020 • 4 hourly update shared as part of Gold Command template • Wards & Departments use E-Roster and Safecare data to support staffing ratios • New models of care currently being implemented in Maternity in line with BR+. Business case being developed as there will be a requirement for a staffing uplift • Recruitment / media plan produced and recruitment campaign ongoing • Rolling advert for RN's continue. Students who were redeployed to the Trust during the COVID 19 pandemic have been offered substantive posts • International Nurse Business Case has been approved for 96 Registered Nurses – all nurses have been recruited and will be in post by December 2021 • National staffing guidance has been utilised to inform new staffing models • Care Hours Per Patient Day (CHPPD) currently 7.6 (Year to date position 7.8) <u>Recruitment Assurances</u> • Rolling advert for B5 Nurses paused for 3 months whilst international nurses are placed – recommenced November 2021 • Developing WHH recruitment campaign – 1st open day in October 2021 to be followed in January 2022 • Career advice events in local schools and colleges • Production of monthly and bi-annual staffing reports received by the Trust Board • Trust has intensified the HCA recruitment and achieved 0 vacancies by April 21. NHSI funding support received to achieve this aim. Weekly monitoring on progress and reporting to NHSI in place. Work now ongoing for pastoral support of new recruits to improve turnover rate in this group. • The Trust will be placing 95 International Nurses by Dec 21. • In November 21 we have 0 wte band 5 vacancies. • Recruitment campaign for ED staffing is active, open day 28th October will be followed up in January HCA • There are currently 28 Health Care Assistant vacancies within the Trust. All vacancies are being recruited into during January supported by HR, Education and Workforce Improvement Lead. <u>Retention Assurances</u> • Workforce Dashboard reporting monthly in relation to leavers • WHH Nursing retention plan to be refreshed for 2022 • Burdett Nursing Trust award winners • Highly commended for nursing retention data provision			

Board Assurance Framework

	• 'Transfer Window' implemented allowing staff to move to other specialties without having to apply for role • Registered Nurse Turnover 11.59% • International nurses have all been placed (95 in total) on wards. COVID-19 Assurances • Implemented a graduated and planned nurse staffing response to the COVID-19 Pandemic. • Revised staffing models for the expansion of critical care capacity, acute and supportive respiratory wards • Strengthened daily staffing meetings chaired by the Associate Chief Nurse for senior oversight • Increased use of temporary staffing through NHSP and off framework agencies – close monitoring arrangements in place • Implementation of NHSP incentive scheme for staff to improve fill rates – update monitored weekly • Increased incidence of COVID-19 Omicron variant is leading to increased staff absence. Plans are in place to reduce activity to ensure staff are available from elective areas to support affected areas. • Incentives have been offered to staff able to work increased hours via NHSP – Extended to the end of February 2022 • Minimum ward staffing numbers assessment completed	
Assurance Gaps:	Increase staffing pressure due to ongoing use of temporary winter wards (B3, B4 & K25) for which there is no funded establishment Recruitment Gaps • 0 RN Vacancies in September 21. ED & B18 are recruiting RNs for increased capacity. Retention Gaps • 13.91% nursing turnover • Significant staffing absences from Dec 2021 due to the increased transmission rate of the Omicron variant.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
WHH to review international nurse recruitment to support registered nurse vacancy fill.	Targeted recruitment campaign	International nurse recruitment programme in place. Develop a business case. Agreement to join GTECH in partnership with WWL. Business case agreed for 30 nurses. Task and finish group established to support the recruitment campaign and welcome nurses to WHH Application for bid to access financial support for the programme.	Browning, Rachel	31/03/2022	

Board Assurance Framework

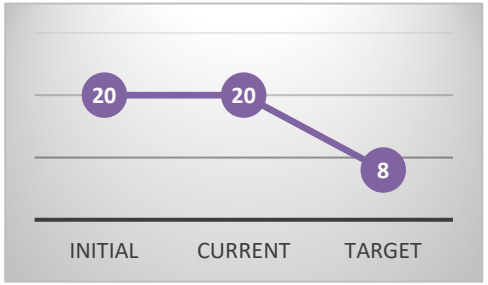
Risk ID:	134	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that future loans will be required which would raise the question if the Trust is a going concern.			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	10 (5x2)
Assurance Details:	•Core financial policies controls in place across the Trust •Revised governance structure within the Trust to enable strengthened accountability •Finance and Sustainability Committee (FSC) established overseeing financial planning •Regular financial monitoring with NHSE/I •Regular review at Executive team meeting and development sessions •Annual plan development process • Achieved 2020/21 Control Total. • Achieved Break Even H1 2021/22 • Unqualified audit opinion (2020/21) •Corporate Trustee Charities Commission Checklist, reporting annually through Board •Monitoring of charitable funds income, assessment of return on investment and controls on overhead ratios via quarterly financial reports •Regular updates to Executive Team, FSC and Trust Board •Financial Resources Group (FRG) and Capital Resources Group that report to FSC • Workshop undertaken with - Exec, CBU, Corporate to review 2021/22 cost pressures • 2021 cost pressures supported by Trust Board. Business cases being developed to secure required levels of funding. There are 9 are in progress, 5 are complete, 2 have been closed as the funding is in budget. These are expected to be completed by 28th February 2022. •Completed MIAA Governance Checklist received by Audit Committee •H1 Expenditure Budgets approved by the Trust Board on 31st March 2021 •Capital Plan approved by Trust Board on 31st March 2021 (£19.75m) •c£34m cash support secured in the form of PDC in March 2021 •Monthly Report to Executive Team Meeting, FRG, and Finance & Sustainability Committee includes review of outstanding MIAA recommendations and actions. The report also highlights the number of retrospective waivers compared to the same period in 2019/20. Detail of CIP progress and actions to work with CBUs using benchmarking data such as Model Hospital and PLICS. •Capital is reported monthly detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. •Phase 3 of the Health Infrastructure Programme (HIP) announced. WHH submitted an Expression of Interest (EOI) in September 2021. WHH assessed & submitted by Cheshire & Merseyside Health & Care Partnership to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&M <u>COVID-19</u> • Governance process in place to ensure all additional costs are being approved and monitored – re-introduced for Wave 2 & Wave 3. Further re-introduction in January 2022 related to the latest COVID-19 surge. • Reporting to NHSE/I • Regular attendance to regional and national conference calls • Circulate latest guidance from MIAA Counter Fraud team				

Board Assurance Framework

	• Ensure governance and processes in place including checks in place for all expenditure in particular procurement, contracts, payroll and HR. • Highlighted the different methods of fraud/ scam in operation to all staff and share it as widely through Trust • Quarterly Report to Exec & F&SC on COVID Pay Costs • Deloitte Audit completed. Positive report received with one overclaim reported (£112k). Final report received by the Finance & Sustainability Committee in July 2021 and presented to the Audit Committee in August 2021 • Participating in exercise to understand run rate for 2020/21 to support funding envelopes for 2021/22 • Executive review of COVID-19 costs completed and supported as part of budget setting. • Clinical Review Oversight Committee (CROC) established to provide oversight and assurance on recovery performance. • Submitted breakeven plan for H1 and H2 • H1 ERF was £3.3m • H2 included ERF of £0.7m	
Assurance Gaps:	• Inability to develop a strategic plan to deliver a break-even position over the next 5 to 10 years • Non-recurrent and unidentified CIP presents a risk to in-year and future year financial position. • Failure to fully comply with emerging national employment litigation resulting in additional pay costs or the trust receiving potential claims. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Risk that capital needs exceed capital funding resources available. • Need to determine the future run rate which is currently uncertain in order to mitigate risks. • Increased threat of fraud during COVID-19 global pandemic • Uncertainty of the Trust allocation from the Cheshire & Merseyside Integrated Care Board • Cheshire & Merseyside system is required to break-even • ERF Funding is not guaranteed and is non-recurrent & subject to system performance and achievement of five gateways. H2 ERF of £0.7m at risk due to planned activity stepped down across the region • Capital slippage poses a risk to next year's programme. Cheshire & Merseyside capital for 2022/23 oversubscribed. • In H2 Cheshire & Merseyside have a £50m gap of which £2.9m sits in the Trust's position. Plans to resolve the gap are yet to be developed. This will impact on the ability to breakeven. • Current unidentified CIP is £1.5m in 2021/22 • Inability to manage winter/COVID-19 costs could impact on the ability to breakeven in H2. This risk is enhanced due to current surge. • High Level planning uidance sent on 24th December 2021; however, the detail has not yet been provided. • Availability of social care to support the current super stranded position (currently c25% of bed base)	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Submit requested Workforce & CIP information to NW Intensive Support Director	Cheshire and Merseyside Health & Care Partnership in receipt of Tier 1 Intensive Support – Information requested by NHSE/I on workforce & CIP	Submit requested Workforce & CIP information to NW Intensive Support Director	Andrea McGee	30/03/2020	Paused
Monitor all COVID-19 requests	COVID-19 Revenue	All covid expenditure to be reported to Execs and only extended following approval (Currently undertaken monthly)	McGee, Andrea	31/03/2022	

Board Assurance Framework

Risk ID:	1134	**Executive Lead:**	Cloney, Michelle	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
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)
Assurance Details:	• The COVID-19 nursing advice line continues to be funded until March 2022 , to provide a range of advice and guidance to the workforce. • The OH call centre continues to be funded until March 2022, which enables 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 (for symptomatic staff) • Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical. • Enhanced Occupational Health Service to support the Christmas period and weekend to deal with the spike caused by the Omicron variant. • An enhanced wellbeing offer continues , linked to learning from Wuhan, Italy and the British Psychological Society. • A specialist extranet page is in place which includes all national wellbeing offers, and links to discounts for our NHS staff during this period of time. • Mental health wellbeing drop in sessions continue across both Warrington and Halton sites, with a specific wellbeing email address created for any enquiries to the wellbeing hub. • Facilitated conversations are available to staff working on COVID-19 wards. • Face to face counselling is available on-site. • Alternative therapies such as relaxation therapy is available. • Additional support put in place for Black, Asian and Minority Ethnic staff including a specific risk assessment • Guidance on risk assessments for various groups of staff has been issued to managers with clear expectation on completion. • Following national guidance, amendments have been made to the pre-employment check process to support speedier recruitment • The Workforce Information Hub has supported the 'real time' reporting of absence, to enable a clear picture of current staffing. • A Temporary Workforce Redeployment Hub was established to support staffing levels by identifying staff who are available for redeployment and match them with demand. This hub increased its capacity as the Trust moved into wave 3 in December 2020. • A deep dive review of all Clincally Extremely Vulnerable Staff was undertaken to ensure that staff were supported back into work and that resource was utilised apporporiately. • Retirement Policy has been temproarily updated to allow a shorter break (24 hours) in service. • All Trust staff were afforded the opporunity to carry over any untaken annual leave from 19/20 providing that they were unnable to take it due to the covid response. • Work to support workforce recovery continues including health, wellbeing, leadership, teams, HR and resourcing with some tailored support being provided to some departments such as ITU and A&E. • Central log in HR Department to capture all clinically extremely vulnerable staff – process in place for on-going updates. A Covid Secure SOP was written to support the safe return of CEV to work or to agree working from home arrangements as appropriate to a completed Risk Assessment signed off by Occupational Health professionals. Covid Secure areas under regular review by Microbiologist via Tactical Group. • Electronic system continues to be available to support the COVID-19 Workforce Risk Assessment Tool in line with Risk Reduction Framework				

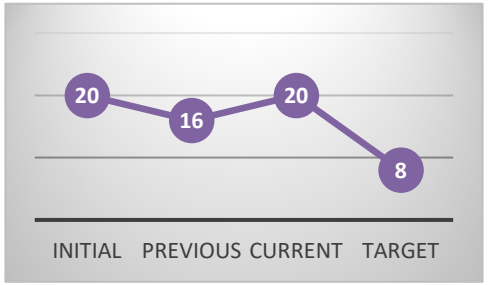
	• Regular reporting on compliance with risk assessment requirements is in place and reported at Tactical on a weekly basis. • Regular training on COVID-19 Workforce Risk Assessment is in place. • A letter was sent out to all staff who have not completed the self-risk assessment in a timely manner, the number of outstanding self-risk assessments reduced by 43%. • Trust continues to be challenged by high sickness absence rates nationally the North West has higher sickness absence rates. Trust has conducted a deep dive into their data and also participated in a NHSE/I deep dive to understand the challenged faced. Improving attendance programme commenced in September 2021 incorporating the data findings and recommendations of both deep dives. • Overall absence rate is 6.36% for Sept 2021 and is therefore reducing. Sept 2020's absence rate was 6.69%. • The Trust has also recently secured funding from NHSI/E to be used to deliver a 4-month project to launch the WHH Supporting Attendance Policy • New Supporting Attendance Policy to go live from February 2022 policy is currently in final stages of ratification process. o Preventative measures continue to be implemented including; ▪ Occupational Health and Wellbeing interventions ▪ COVID Booster Campaign ▪ Flu Vaccination Campaign ▪ Asymptomatic staff testing • The Trust continues to promote the importance of Return to Work interviews to support attendance and bespoke Manager training has been undertaken in pilot areas with high levels of return to work non-compliance. • Extensive communications via Trust Safety Huddle and global emails to promote use of PPE, social distancing and compliance with environmental risk assessments restricting numbers within confined staff areas. • Participation in LAMP testing. Due to low update a comprehensive communication and engagement plan has been deployed in order to increase compliance. The Trust is currently planning to move towards an Asymptomatic Testing approach. • COVID vaccine programme continues with good uptake from across the workforce, with monitoring arrangements in place. • COVID-19 Workforce Recovery Steering Group commenced. • Supported by funding from NHSI there has been a big push to fill our HCA vacancies, we are currently reporting 28.95 FTE vacancies (31/11/2021). • In Nov 2021 overall vacancy rate has continued to reduce to 7.65% compared to a peak in Jun 2020 of 10.5%. • 96 of our 96 international Nurses are now in the country. • Therefore, as vacancies and sickness absence reduced it is expected our bank and agency reliance reduce and within Nov 2021 reliance on bank and agency staff increased slightly to 13.45% compared to a peak of 23.3% in Jan 2021 • In response the continuing staff pressures within the care system, national guidance has been released to support organisations to identify fully vaccinated staff who are identified as a contact of a positive COVID-19 case, to return to work, subject to the safeguards put in place. • The Trust introduced a tool to support the decision-making process. This tool was developed following the published guidance: o Infection prevention and control (IPC) guidance on infection prevention and control for COVID-19 o Sustained community transmission is occurring across the UK and COVID-19: management of staff and exposed patients or residents in health and social care settings • To date implementation of the tool has saved the Trust a total of 1610 days, with 215 staff members having been approved by OH to proceed with the approach.	

Board Assurance Framework

	• Mandated vaccination of NHS staff – following introduction of new legislation on 6th January 2022 the Trust is currently following phase 1 guidance in relation to Vaccination as a condition of deployment (VCOD) there is a separate BAF for VCOD	
Assurance Gaps:	• Staff will receive results and instructions from national Trace and Trace service and will have to self-isolate if the contact is from a household member. • Continued lack of national/regional clarity of the management of long covid in the context of the National agreement. • Potential gaps within services brought by introduction of VCOD.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
VCOD to be added to the Board Assurance Framework for enhanced oversight	Submit proposal for the new risk in relation to VCOD to the Trust Board	Approval from the Trust Board to add VCOD risk to the Board Assurance Framework	Roberts, Carl	26/01/2022	

Board Assurance Framework

Risk ID:	1114	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	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 statatory obligations (e.g. Civil Contigency measures) and subsequent reputational damage.			**Initial:** **Current:** **Target:**	20 (5x4) 20 (5x4) 8 (2x4)
Assurance Details:	**Assurance:** • **Digital Governance Structure** including weekly structured Senior Leadership Team meetings, Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Data Standards Group reporting to the Information Governance and Corporate Records Sub-Committee with escalations to the Quality Assurance Committee and onwards to the Digital Board, which itself submits highlights to the QAC and resource go to FSC. The **Quality Assurance Committee report provides** assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Cyber Essentials Plus/Audit Actions/IG training figures). • **Digital annual IT audit** plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with progress monitored at the Trust Audit Committee. • **Trust benchmarking** activities including Use of Resources reviews (Model Hospital). • ITHealth Assurance Dashboard is live, monthly external penetration testing is now in place using NHS Digital's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. (March 2021) **Controls:** • **Digital Operations Governance** including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard. • Active membership of the **Sustainability Transformation Partnership Cyber Group.** • **Digital Change Management** regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions. • **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training. • **Cyber Training** for the Trust Exec Board • Secured annual capital investment to increase Digital skills and capacity. • Digital Board support for profiling of a 7 Year Capital investment based upon asset replacement cycle and strategic roadmap (to deliver the approved Digital Strategy (January 2020)) • The use of automatic patching software to rollout security updates to devices. • Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links. • 5 servers 2008 R2 unable to install security patches: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system & Winscribe dictation system (all issues resolved). • Office 2010 being used while end of life due to the N365 deployment plan (100% migrated)				

Board Assurance Framework

	• Secondary secure backup at Halton Data Centre	
Assurance Gaps:	**Gaps In Assurance:** • Mostly achieving of mandated compliance with DSPT, incorporating CE+ (to be confirmed post MIAA audit results) **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Outcome of the Phishing exercise by NHS Digital, lack of awareness of staff. Communications have been sent out to staff members regarding phishing. Arranging second test with NHS Digital. • Current performance of Lorenzo and whether migration to the cloud will provide any benefit. • Not been able to fully recruit to the Digital Service restructure in terms of cyber. Majority of post filled by end of Sept 21. Not being able to recruit to post that are planned in Traunch 2 of the paperless care programme • Development of staff behaviours to protect data evidenced via reduced IG incident report levels, impacted training due to Covid-19 pandemic. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Not all Windows Server 2003 server will be migrated to Windows Server 2016 before the N365 agreement starts. (1 out of 77 servers are at risk of not being migrated in time. The system at risk is Medicorr.) • No local device (PC & laptop) based firewalls in use while on site, dependant on the site boundary firewalls • Using generic logins staff usernames and passwords are stored in browser when selecting “remember me” • No dedicated logging tool to pull all key logs together and provide useable alerts. MIAA to review processes and tools (July 21) •Using no longer supported Exchange 2010 email system for mail archive • Using SharePoint 2010 for the Hub •Remote devices bypassing the proxy • Lack of process to check antivirus alerts in console. MIAA to review processes and tools (July 21) • Administrator accounts still have access to the Internet & email, although only used when required (SIRO to approve process). • No controls in place for Bluetooth connectivity. • Active Directory password set not to expire. • No agreed patching schedule for network equipment with the Trust.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Standardised policies and procedures across the C&M STP using the core documentation from standard of ISO 27001 and the DSPT	Standardise policies and procedures across the C&M STP	• MIAA to map the basic standards to form the minimum and gold standard of documentation for Cyber. MIAA and WHHT to create the documentation templates from the mapping: • ISO 27001 (ISMS) • Data Security & Protection Toolkit (DSPT) • Information Security Standard (ISF) • Centre for Internet Security (CIS) • Information Systems Audit and Control Association (ISACA) • National Institute of Standards and Technology (NIST) • Cyber Security Body Of Knowledge (CyBOK)	Deacon, Stephen	28/02/2022	

Board Assurance Framework

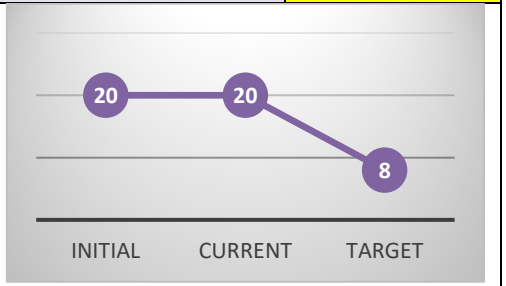
		[Progress has been slow as core members were trying to provide an automated "bot" style document suite. This was too ambitious, and the group decided to scale it down to templates only. MIAA have writing the templates. The workstream are currently reviewing these documents for the 5th review and providing feedback and will be approved by the May C&M STP Cyber Group. Once approved Digital Compliance would rewrite the local documentation and seek approval from the Information Governance and Records Sub Committee.]			
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system). [Delivers: Best Practice]	Migrate all 2003 and 2008 servers to 2016.	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to Windows Server 2016 • Extend Support for Windows Server 2008 until Feb 2022 NB: Windows Server 2003 is out of support; however, Windows Server 2008 is still in support until March 22. [All simple migrations have been completed by IT Services. A report was presented at the October's Digital Board, providing progress made in the decommissioning of Windows 2003/2008 servers, the timetable for decommissioning the remaining servers and the mitigations identified for those servers which are unlikely to be decommissioned before 31st December 2020. The only server at risk is the Medicorr Server. As part of the DSPT requirements we have asked for an update action plan.]	Deacon, Stephen	31/03/2022	
Implementation of the revised staff structure	Implementation of the revised staff structure	Phase 1 Consultation complete. Process to now to get the IT Services staff in place. Contractors are covering the gaps	Deacon, Stephen	31/12/2021	

Board Assurance Framework

Migrate the last 9 endpoints devices to Windows 10	Migrate the last 9 endpoints devices to Windows 10	4 devices migrated with 5 devices left The below endpoint devices can be replaced: 1 x Laptop in Medical Engineering – Unsure why this is still in use. (Deployment contacting ME regarding whether still in use) Endpoint devices more complicated to migrate: 1 x Dexa Scanner computer – This cannot be replaced at the moment, however, a new dexa scanner has been procured, just waiting on delivery and installation (waiting on date). 1 x Ophthalmology Fundus imaging computer – This cannot be upgraded/replaced as the Fundus camera is not Windows 10 compatible. Conversations on going with the department around replacement camera or removing use of the system altogether. 1 x Pathology Cognos client – This is some sort of information reporting system used in Pathology. They have supposedly purchased a replacement, just not implemented it yet (waiting on date) 1 x Cardiology (can be replaced but need to contact the 3rd party)	Waterfield, Tracie	31/03/2021	
Obtain funding for configuring web protection for remote devices	Obtain funding for configuring web protection for remote devices	Obtain quotes (COMPLETE) Obtain funding (COMPLETE) Configuration	Waterfield, Tracie	31/01/2022	
Ongoing recruitment in the ePR Team	Ongoing recruitment in the ePR Team	Ongoing recruitment in the ePR Team	O'Brien, Emma	31/12/2021	
Turn on device firewalls, to help limit a spread of an infected device infected other devices on the internal network	Turn on local device firewalls	Prioritise workload to look at turning on personal firewalls Create a test group Phase turn on / turn on [Meeting set up for 03/09/21]	Deacon, Stephen	28/02/2022	
Agree patching schedule for network equipment with the CCIO and get approval with Event Planning Group	Agree patching schedule for network equipment with the CCIO	Agree patching schedule for network equipment with the CCIO and get approval with Event Planning Group/ Local CBU Groups	Waterfield, Tracie	31/01/2022	

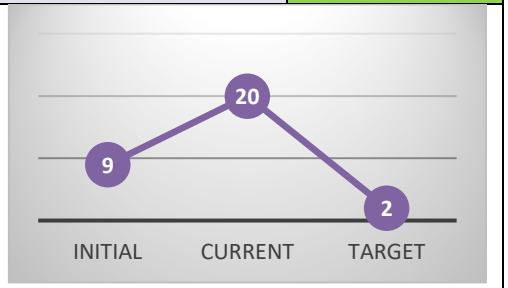
Board Assurance Framework

.2022

Risk ID:	1125	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	8 (2x4)
Assurance Details:	• Following national EPRR guidance for Cancer & RTT • All patient referrals are being prioritised due to clinical need • Rejected referrals are following recognised procedures particularly ensuring all have a clinical review to determine outcome • Moved a high proportion of OPD activity to virtual. • One elective theatre maintained for cancer and clinically urgent cases • Maintaining monthly reporting for each external standard • Discussed at the NED led Clinical Recovery Oversight Committee (CROC) • Discussed at the Clinical Services Oversight Group (CSOG) • Constitutional Standard Performance reporting to the Finance & Sustainability Committee (F&SC) • Executive attendance at the weekly Elective Restoration meeting for Cheshire & Merseyside. Linked with the ICS Governance Structure • H2 planning linked to restoration & recovery agreed with NHSE/I • Restoration & recovery achievement of constitutional standards will be further impacted by wave 5. This will be addressed in the 2022/23 activity plan in line with planning guidance issued on 24th December 2021.				
Assurance Gaps:	Some weekly reporting reduced as per guidance				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

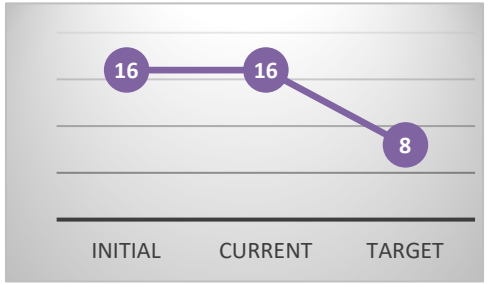
Risk ID:	1079	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.			**Initial:** **Current:** **Target:**	9 (3x3) 20 (4x5) 2 (2x1)
Assurance Details:	CBU Triumvirate attended Executive financial update board to highlight continuing issues with Lorenzo system Chief Nurse, medical director and head of safety and risk aware of system issue Digital IT paper to QAC and PSCE in collaboration with IT director to highlight system failures and inoperability paper based backup systems introduced Additional administration in significantly affected areas. Site visit to MBFT for lessons learnt in improving system Miro meeting with IT manager to look for interim solutions Scoping new systems with procurement Capital funding meeting attended to seek funds to support alternative maternity specific system New mobile phones for community to support hot spotting in areas with no connectivity IT visited community clinics with Lorenzo connectivity issues Support from lead midwife for IT. To ensure data quality, data is cross-checked to ensure that accurate data is submitted to for screening and Payment By Results Quick reference guides have been created for users to improve data quality related to erroneous input Off line version of Lorenzo to assist Community midwives to input real time data and reduce errors Support currently in place is cleansing historical data staff required to cleanse data going forward In order to ensure health visitors are notified, the current system is a paper based crosschecking system which is dependent on individuals pulling data of current pregnancies at 28 weeks gestation and cross checking the Lorenzo system to confirm ongoing pregnancy. Presentation provided by prospective suppliers on 18th December 2020 Decision on supplier expected by 31st January 2021 EPR Strategic Outline Case supported by the Trust Board in December 2020 Temporary fix for CTG archiving agreed and fitted in December 2020 with review in January & February 2021 Following completion of supplier decision making process, implementation due to complete in September 2021 Weekly digital transformation meetings in place to monitor progress. Staff training schedule initiated to ensure all staff can be supported during the implementation phase. Increased training sessions may pose a potential staffing pressure and risk in terms of COVID/Omicron variant status and potential reduction in staffing.				
Assurance Gaps:	Lack of connectivity to ensure that system can operate Lack of data to provide internet hotspot Poor quality lap tops The current digital solution is contributing to poor data quality and its detrimental care quality and activity income effects, poor staff moral and concerns by regulators. Work related stress due to additional hours required to achieve correct level of data inputting leading to sickness absence				

Board Assurance Framework

	Lack of assurance that all women are captured for both operational clinical and financial ends. This leads to uncaptured activity and risk to safety if women are not entered onto the system appropriate due to the above Loss of income due to poor data quality. The cross checking is dependent on time being available for the team to complete this time consuming task. Ineffective use of midwifery time- midwives continuing to report excessive additional effort to correct omissions and inaccuracies, impacting upon carer/woman relationship and data quality, and leading to concerns that the current situation may impact the Trust's aspirations to achieve outstanding status.

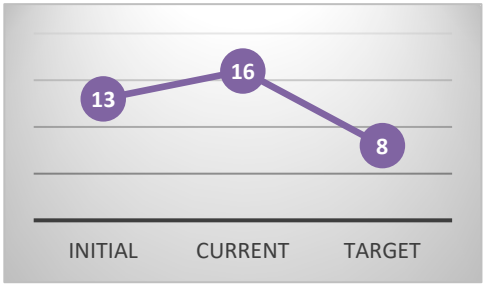
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Implementation of new EPR system	New EPR is fully in use and all training completed	Implementation plan Training of staff on new EPR.	Arya, Dr Rita	30/03/2022	

Board Assurance Framework

Risk ID:	1207	**Executive Lead:**	Michelle Cloney, Chief People Officer	**Rating**	
Strategic Objective:	Strategic Objective 2: We will… Be the best place to work with a diverse and engaged workforce that is fit for now and the future				
Risk Description:	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. The two staged approach to risk assessments means that this will be caused by either employees not completing the self-risk assessment in a timely manner or managers not acting upon the information provided and completing a management risk assessment, 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 (4 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)
Assurance Details:	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. Trust compliance as at 7th January 2022 Have you offered a Risk Assessment to all staff? - **Yes** What % of all your staff have you Risk Assessed? – **96.12%** What % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary? – **95.32%** What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary? – **93.58%** 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. The new Workforce Cell is meeting from 12.01.2021 and will continue to hold managers to account regarding compliance with Risk Assessments.				
Assurance Gaps:	At 10th January 2022: •91 staff members yet to complete self-assessment (reduced from 231 in September 2021, demonstrating the impact of the letter) •0 Management Risk Assessments (required when an individual identifies as having a COVID Vulnerability) have been outstanding since at least Jun 2021 •86 Management Risk Assessments are outstanding between Jul 2021 and Dec 2021				

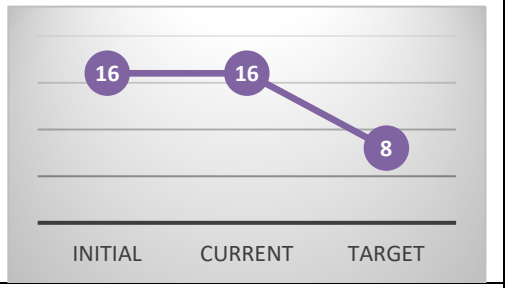
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Further encouragement on the completion of the Self-Risk Assessments to be sent, outlining the formal process that will be followed should the self-risk assessment not be completed	Letter sent requesting the completion of Self-Risk assessments.	• Further communication to staff re the importance of completing Self-Risk Assessments • Completion of Self-Risk assessments	Carl Roberts and Laura Hilton Deputy Chief People Officers	~~30/11/21~~ 31/01/22 The above new deadline is proposed, following the 60% reduction of SRAs following the initial letter	

Board Assurance Framework

Risk ID:	1372	**Executive Lead:**	Paul Fitzsimmons	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case			**Initial:** **Current:** **Target:**	12 (3 x 4) 16 (4 x 4) 8 (2 x 4)
Assurance Details:	Assurance: • Trust Board approved Outline Business Case • EPR Project Board (and escalation/assurance through Digital and Trust Boards) • Regular, documented conference call with NHSE, NHSX and NHSD • Noted support of the Health Care Partnership Digital Board Controls: • Procured a new 5 year Lorenzo contract with an option to break after 3 years • Trust financial modelling includes 3 – 5 year Lorenzo costs • Trust performance Task & Finish group has introduced measures such as auto desktop reboots and Tech Refresh continues to assure all desktops are less than 5 years old • Principle CCIO and Associate CCIOs in post to support the business case production • Tenders received from prospective vendors in preparation for full business case • Extension of ORMIS Theatre Module contract				
Assurance Gaps:	Gaps In Assurance: • Funding has been approved by Board for the initial 3 year period only Gaps In Controls: • Deployment of dedicated Maternity EPR and thus avoidance of the associated risks . Go live date in May 2022				

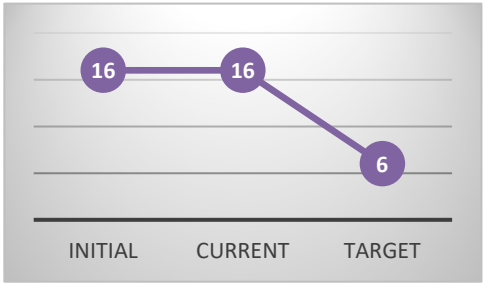
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Maternity go live	Maternity go live	Maternity go live	Deacon, Stephen	30/04/2022	

Board Assurance Framework

Risk ID:	1579	**Executive Lead:**	Daniel Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to transfer patients with major trauma, PPCI and Vascular to specialist units, caused by unprecedented demands on the North West Ambulance Service, resulting in a delay for identified or accepted specialist high risk cases.			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)
Assurance Details:	LHCH PPCI pathways have been adjusted to give guidance for patients not being transferred for more than 120 minutes. UEC are following the escalation process to the ROC/NWAS Control room to discuss patients transfer needs on an individual basis. All SMOC's and Silver Command are aware of the escalation process. With regards to trauma issues, UEC have raised this at the regional network meeting. For assurance a high level paper is presented to Trust Wide Trauma Group and Patient Safety and Clinical Effectiveness Sub Committee.				
Assurance Gaps:	NWAS assess there response times based upon current active and waiting calls when there regional activity is high. However, there is still significant delays.				

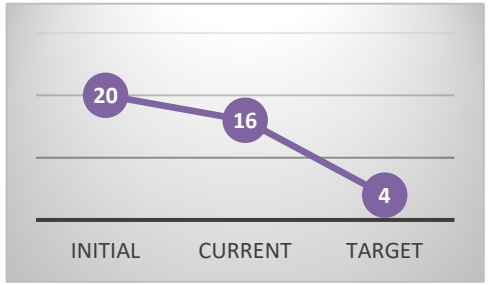
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Risk ID:	1233	**Executive Lead:**	Paul Fitzsimmons	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base.			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	6 (2 x 3)
Assurance Details:	Assurance: • CAU assessment capacity and availability considered on a thrice daily basis in bed meetings • CAU assessment capacity status considered at twice weekly Tactical Board • Regular CAU steering group meetings will continue to review effectiveness of controls Controls • Ensuring CAU assessment capacity is preserved or reinstated is a standing priority at bed meetings and Tactical Board • Other escalation areas bedded before escalation to bed CAU • A surgical ambulatory nurse co-ordinator supports surgical emergency admission patient flow • New ways of surgical working implemented 17/1/22 to mitigate risk by pulling patients requiring operative intervention directly to theatres from the ED and CAU to avoid delays to surgery caused by a lack of beds • Completion of the ED plaza will negate this risk as the dedicated assessment areas in the ED plaza cannot be bedded and as such surgical assessment capacity will be preserved				
Assurance Gaps:	Gaps in Controls • An admission avoidance clinic is set up but cannot be utilised effectively as no alternative assessment area is available to bring patients back to when CAU is bedded. • During periods of excess bed demand CAU is very likely to be a bedded area limiting the availability for the surgeons to review any admission avoidance patients. • Surgeons may struggle to find assessment areas in ED to treat patients • Any delay in the ED Plaza program will delay the resolution of this risk				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Direct pull of patients from ED to Theatre	Effective pull of patients directly from ED to theatre to avoid delays in operative intervention	Systems in place to pull of patients directly from ED to Theatre with direct admission to bedbase from theatres	Doyle, Val	17/01/2022	17/01/2022
Completion of ED plaza	Increased dedicated assessment capacity delivered in ED plaza	Completion of ED plaza	Wright, Ian	01/04/2022	

Board Assurance Framework

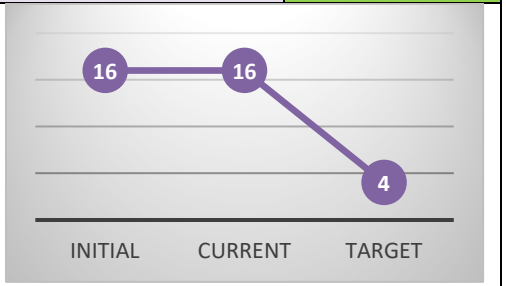
Risk ID:	125	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to provide safe, secure, fit for purpose hospitals and environment caused by the age and condition of the WHH estate and limited available resource resulting in a risk to meeting compliance targets, staff and patient safety, increased backlog costs, increased critical infrastructure risk and increased revenue and capital spend.			**Initial:**	20 (5x4)
				Current:	16 (4x4)
				Target:	4 (4x1)
Assurance Details:	Controls: 2018 C&M H&CP Estates strategy – updated annually Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out Capital Planning Group and associated capital funding allocation process Planned Maintenance Program Reactive maintenance regime Annual asbestos survey - asbestos management survey makes an assessment of the condition of any materials present and determine the likelihood of any fibres being released. Annual PLACE assessments Assurance: External estates compliance audit carried out in November 2019 which has in formed a number of remedial actions to improve compliance across the estate Monthly Estates compliance audit Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers Fire Safety Group – monitors fire safety issues across the trust and provides assurance to Cheshire fire and rescue service on Fire Safety Management PLACE assessment action plan and monitoring - Capital Planning Group – determine how the trust capital is spent Use of resources group – monitors how cost effective and value for money estates and facilities are in relation to a number of national and regional benchmarks New hospitals for Warrington and Halton groups – providing a platform to address the critical infrastructure and backlog risk 20-21 capital programme approved which includes £2.27m to address backlog maintenance Business Case for ED Plaza Scheme approved and due for completion in March in February 2022 Commencement of Phase 2 (although approved) reliant on capital funding in 2021/22 which is now confirmed. Progress will now be made against the scheme with indicative construction completion date of January 2022. Critical Infrastructure Capital Funding to support schemes with critical and high levels of backlog maintenance approved Cancer Alliance funding of £0.5m for endoscopy enabling work at Halton to improve the environment Phase 1 of CT Buildings work complete Additional staff rest areas deployed to support social distancing and reduce staff nosocomial infection during rest and break times during the Covid-19 pandemic. Approved and recruiting for additional Estates Compliance Manager role to support routine compliance and routine small estates works. New MRI build set to be completed in October 2021 New Endoscopy roofing infrastructure at Halton set to be completed in November 2021 Capital schemes to improve paediatric outpatients due for completion in December 2021 Capital schemes to develop a Urology Investigation Unit set to be completed by March 2022 Mortuary refurbishment set to be completed by November 2021				

Board Assurance Framework

	Ward B18 refurbishment completed in October 2021 Moving clinical services out of the Kendrick Wing and new Breast clinic opened at Halton in September 2021 Residual screening service to be opened at Bath Street by March 2022 Capital plan to improve kitchen and catering facilities being worked up to be included financial year 2022/23 Capital project plan for 2022/23 being worked up to upgrade Warrington kitchen facilities.	
Assurance Gaps:	Estates staffing - reduced staffing numbers since 2011 has impacted on ability to carry out elements of essential maintenance – review to be undertaken in 2021 Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome Cost pressures – unfunded elements of maintenance in I&E budget Use of Resources - benchmarking against backlog maintenance and critical infrastructure risk are below national medium Threat to the delivery of capital schemes due to the pandemic e.g. manufacturing delays, additional costs of construction relating to IPC guidelines and the unavailability of an appropriately skilled workforce.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Upgrade Warrington kitchen facilities	Following a review of the kitchen facilities at Warringotn Hospital. An improvement plan in place to progress	Complete upgrade of kitchen facilities	Ian Wright	31/12/2022	

Board Assurance Framework

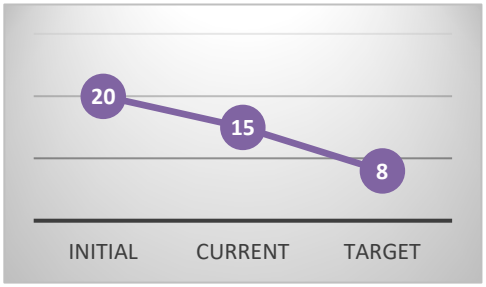
Risk ID:	1108	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.			**Initial:**	16 (4x4)
				Current:	16 (4x4)
				Target:	4 (4x1)
Assurance Details:	Provided listening events and 1:1 meetings for all staff. This has resulted in accumulated feedback to identify key themes to be addressed. Review of all processes. Interim Head of Midwifery in post New CBU manager appointed and in post. Appointment of 9.2 WTE midwives. Daily staff meetings taking place to intensively monitor staffing. NHSP and agency staff are being used to back fill shifts where possible. Nursing staff utilised for C23 when it is not possible for a midwife to fill the post. When short staffed on C23, an extra maternity support worker is asked to work. NICE staffing red flags linked to Safecare implemented at beginning of June 2021 Midwifery management team strengthened – Two matrons in acting posts until end September 2021 All additional 9.2 WTE Midwives in post. Midwives redeployed across the unit as appropriate 1:1 care rate currently @ c98% Birth suite Manager appointed and in post 9th June 2021 Additional 3 Band 7 Birth suite Co-ordinators appointed 1st Feb 2021. Interview for permanent posts 27th June 2021 Birthrate plus full review funded by Local Maternity System to be carried out by 31st Dec 2021 3 X Interim managers extended until 30th June 2021 Board approved 6 recurrent additional band 7 WTE midwife posts and 1.58 band 6 WTE in March 2021 to support the roll out of the Continuity of Carer model – recruitment on going Daily staffing meeting and redeployment of staff to maintain safe staffing levels Birth Rate plus review has been undertaken and awaiting draft report end of October. This will incorporate Halton staffing and acuity in the report. Midwifery Staffing challenges continue and reviewed daily. Cheshire and Mersey Escalation and Divert Policy updated to support internal and external escalation. Weekly LMS gold command staffing meeting to identify staffing hotspots and need for mutual aid. Staffing vacancies appointed awaiting start date. Daily review of staffing, report to Cheshire and Mersey Gold Command weekly to identify hot spots and request mutual aid. COVID Omircon Variant staffing plan being developed to activate additional staffing if required. Cheshire and Mersey Escalation and Divert Policy embedded in organisation.				
Assurance Gaps:	Potential for uncertainty across the services as a result of COVID-19 pandemic Short term sickness 1 matron in maternity - 1 matron has stepped down Covid pressures remain and are exacerbated by the current annual leave absences this is a regional and national concern. Gold command and a daily / weekly sit rep has been created. Transfer of maternity service from Halton to WHH from 1st November 2021 including staff transfer and need to complete local induction which will add to current staffing pressures. Current sick rate IRO 8%				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Continue to review staffing on a regular basis with daily reviews, and monitor vacancy rates closely to ensure prompt recruitment to any midwifery vacancies. Birth rate plus is currently in progress to be completed by the end September.	Actions to monitor staffing	daily reviews	Owens, Catherine	28/02/22	

Board Assurance Framework

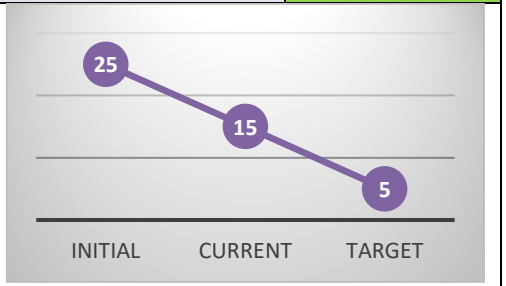
Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.			**Initial:**	20 (5x4)
				Current:	15 (5x3)
				Target:	8 (4x2)
Assurance Details:	The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the C&M Health and Care Partnership plans. The Trust has developed effective clinical networking and integrated partnership arrangements. Some examples include: - The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. - Council and CCG in both Warrington & Halton supportive of development of new hospitals. Agreement with key stakeholders to progress single programme and proceed with OBC development. - Agreement of sustainability contract with Warrington CCG and subsequently Warrington & HaltonSystem Financial Recovery Plan - Regular Strategy updates are provided to the Council of Governors - Clinical strategy wide engagement - Clinical Strategy approved by Trust Board - CBU specialty level strategies complete and incorporated in business plans. - Initial talks held with Elective Care C&M Lead in relation to the suitability of Halton as a potential Elective Care Hub. Opportunity to accelerate elective hub as part of Covid recovery - Trust has met with Cheshire & Merseyside leads for Women's and Children's review to demonstrate strength of local Women's and Children's services and help inform outcomes of regional review. - Breast Centre of Excellence opened to consolidate breast screening in Warrington but to commence in April 2022 - DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. Phase 3 of the HIP announced. WHH submitted an Expression of Interest (EOI) in September 2021 - Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. - Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside. Currently options for further development do not include any option where WHH is a hub. All options proposed include Essential Services Labs (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESLs. Pathology OBC supported by the Trust Board - Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services to commence from summer 2022. - Director of Strategy invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington				

Board Assurance Framework

	- Town Deal plan for Warrington submitted. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £22.1m funding approved for the Town investment plan, including £3.1m for the Health & Wellbeing Hub and £1m for the Health & Social Care Academy. - The Trust is leading the development of the detailed plan for the Health & Wellbeing Hub. - Strategy refresh completed and approved at Trust Board to confirm 2020/21 priorities. - Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. - In February 2021 the Government White Paper, "Integration and Innovation: working together to improve health and social care for all - The Department of Health and Social Care's legislative proposals for a Health and Care Bill" was published. - The Trust Board agreed in March 2021 that a transaction between BCH and WHH is no longer required, given that the White Paper enables an acceleration of place-based integration including all commissioners and providers. - The Trust has been awarded Social Value Award status recognising the contribution to the outcomes of local populations. It is one of only two organisations in Cheshire & Merseyside to receive the award. - £90k funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington - WHH commenced a focussed programme of work on addressing health inequalities, the green agenda and our role as an anchor instiution. Initial work recognised as the exemplary within Cheshire & Merseyside. - Consistent Trust representation within Cheshire & Merseyside ICS to support transition to ICS. WHH CEO appointed as Head for Clinical Pathways within C&M. - Trust representation on newley established place based Boards within both Warrington & Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected.	
Assurance Gaps:	Risk to securing capital funding to progress new hospitals Sefl assessments of both Warrington & Halton hospitals place based governance development indicate that Halton is 'emerging' (stage 2 of 4) and Warrington is establishes (stage 3 of 4). There is a requirement to further develp as places to ensure both boroughs can benefit from potential future autonomy.	

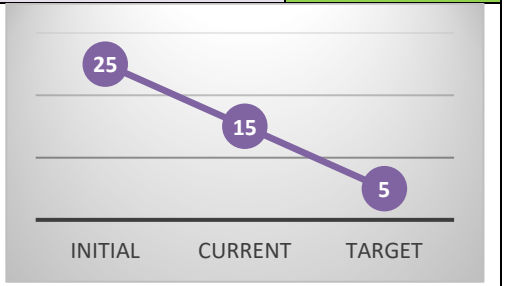
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Progress plans for new hospitals to be best placed to secure funding when available	Develop SOCs and participate in competitive process for HIP funding	Develop SOCs and participate in competitive process for HIP funding	Lucy Gardner	SOCs – April 2020 Expression of Interest due September 2021	SOCs – March 2020
Actively participate in and contribute to the development of integrated care partnerships at PLACE & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Simon Constable	31/03/2022	

Board Assurance Framework

Risk ID:	1274	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.			**Initial:**	25 (5x5)
				Current:	15 (3x5)
				Target:	5 (5x1)
Assurance Details:	Plan in place to carry out Asymptomatic testing of staff. There is a high-level rationale for testing due to the level of community transmission in the North West as well as nosocomial infection rates. Staff are being tested over a ten-day period. All staff to wear face masks in both non-clinical and clinical areas. Use of effective messaging and communication. Risk stratification in place so there is no service level disruption to provision. Staff groups have been split to ensure only 5 members of staff from each service are tested at any one time. Lateral flow self-testing twice weekly in place – 1.8% positivity rate Loop-mediated Isothermal Amplification (LAMP) testing introduced. LAMP testing introduced across the Trust and actions in place to increase uptake Internal review of Clinically Extremely Vulnerable (CEV) completed to expedite return to work and ensure staff safety. Updated guidance in place to support staff return to work Review of CEV staff continue to support returns to work New self-isolation guidelines received, and SOP developed. SOP circulated and effective from 23.08.2021				
Assurance Gaps:	Potential for unsafe staffing levels. Requirement to improve uptake of LAMP testing across the organisation				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Improve compliance with uptake of LAMP testing across the Trust	Campaign to increase awareness	Campaign to increase awareness	Rylett, Louise	31/03/2022 (rolling ongoing actin reviewed eery three months)	

Board Assurance Framework

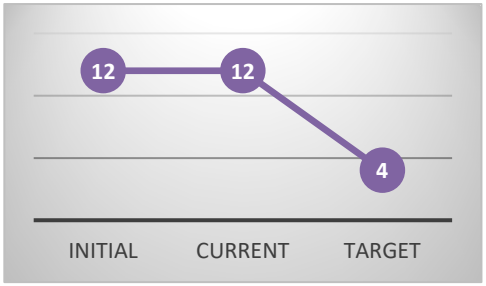
Risk ID:	1331	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by increased restoration and recovery activity and the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.			**Initial:**	25 (5x5)
				Current:	15 (5x3)
				Target:	5 (5x1)
Assurance Details:	•Creation of additional appropriate clinical areas with appropriate clinical staff; •Non-urgent elective procedures stepped down to help support sufficient staffing levels and provide additional clinical areas. •Daily submission of Critcon score to SEOG, Gold Command and the wiser network to optimise the deployment of mutual aid as required. •National 'Call to Arms' to encourage experienced ICU Nurses & Doctors to return to work; - 2 staff joined ICU from external providers •Internal 'Call to Arms' for staff who have previous experience of the ICU setting and communications with Managers to support release - 15 staff identified – worked in Wave 1 and 2 on a part and full time basis depending on availability and release from current role. 86 staff identified in the re deployment process under Category A (category A are staff in the trust with Critical care experience or transferable skill suitable for critical care) •AHP, Proning & Transfer Teams created to support ICU staff •Transfer out of ICU via the Critical Care Network to support decompression; •Mutual aid in place to ensure adequate provision of essential equipment e.g. Non-Invasive Ventilation (NIV) •Incentive scheme in place to help support sufficient staffing levels; •Off framework agency usage to help support sufficient staffing levels; •Nurse buddy system in place; •Opening of B18 in October 2021 & approval of Respiratory Business case supports provision of bed capacity for ICU patients Challenges presented with Covid saw an increased capacity demand, patient acuity and the need for isolation capacity for infection prevention and control reasons which resulted in the use of theatres as that was the only area that had the correct standards of Electrical & Gas supplies to support critical care patients outside of the critical care unit • What we did: o Increased Critical Care operational capacity to 20 beds within the unit. o Additional staffing facilitated via NHSP to support 20 bedded operational capacity of the critical care unit o Installed 5 additional isolation cubicles within ICU making a total of 7 isolation rooms. (DOH HBN 04 02 regulations state that Critical Care should have 20% isolation capacity, Warrington Critical Care unit now has a 35% capacity based on 20 bedded foot print) o Purchased additional Monitoring, pumps and ventilators to support increase in capacity and acuity and demand. o Refurbishment of B18 with an additional 14 enhanced care beds with the appropriate Electrical & Gas supplies to support …. ▪ 4 Isolation cubicles equipped to care for up to level 3 patients ▪ 10 enhanced care beds to care for up to level 2 patients A review of the impact of wave 5 is currently providing assurance that action taken to date are working to maintain a safe level of capacity for priorities 1,2 & 3 patients. However, the capacity level is still being impacted by staffing levels.				
Assurance Gaps:	•Limited estate •Limited O2 flow capacity				

Board Assurance Framework

	•Limited staffing

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Risk ID:	1290	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices, technology products and services, clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.			**Initial:**	12(3x4)
				Current:	12 (3x4)
				Target:	4 (1x4)
Assurance Details:	• The Brexit Sub Group has been stepped up with key leads for the associated work streams (Procurement, Pharmacy, EPRR, Finance, Communications, HR and Information). • The Procurement Department has undertaken a review of all suppliers as part of the national self-assessment exercise which was completed as C&M HCP system. Whilst this piece of work has been completed with no apparent adverse impact the Procurement Department continues to monitor fulfilment of orders to adopt a process of early investigation where supply appears to be disrupted. In addition, the Procurement Department is implementing processes to monitor prices to determine if there has been any financial impact upon exit from the EU. To date there are no significant price increases; for the period January to March 2021 there has been a net price impact of £621. This work will continue for Q1 and Q2 of 2021/22. • The Pharmacy department has contacted the Regional Procurement Pharmacist who has advised that there will be monitoring of medicines purchases and usage centrally to manage medicines continuity. Issues / concerns / actions required will be communicated via regular updates to the Chief Pharmacist network. To date there have been no medicines supply issues linked to the end of the EU transition period, however recent logistical changes have impacted on the way some items are delivered. This has not caused much of an impact on the service and will be monitored through Brexit Subgroup or escalated if there is an impact on business continuity. • Nationally, lessons in supplies and medicines have been captured from the COVID-19 period and there has been assurances made around national supplies of PPE and consumables. • Service level business continuity plans continue to be refreshed. • The majority of Pathology consumable suppliers are being checked by DHSC for supply assurances. Suppliers not on this list have been identified to procurement and are being address through the procurement department. • The Digital department has reviewed all the Trust key IT systems and data flows. To date no issues have been identified which will impact upon data flows. A time limited 'bridging mechanism' has been agreed which will allow personal data to continue to flow as it does now from the EEA whilst EU adequacy decisions for the UK are discussed. A UK data adequacy decision was reached in June 2021 enabling personal health data to continue to flow legally from the EU to the UK. The Information Governance Lead will now only update by exception only. • Assurance letters and communication regarding the EU settlement scheme have been circulated as a reminder about the settlement scheme. An assurance exercise based on the EU settlement scheme was submitted to NHSE in May 2021, indicating no significant risks. The HR and OD team continue to monitor settlement status, impacts on leavers and new starters and the robust recruitment process includes reference to EU settlement status. • Re-instigated the Brexit Sub-Group on 9th September 2020 and the group continues to meet bi-monthly, this will be quarterly from January 2022. • In December 2020 NHSE/I completed an assurance exercise with NHS Trusts to ensure EU Exit SRO and EU Exit Team in place. • Processes developed by UEC and Finance to ensure chargeable patients are managed appropriately. From the Chargeable Patients point of view, there are no risks to financial procedures, patients or staff. Additional processes and a dashboard have been shared for assurance purposes. Additional communications plans continue with clinical teams to ensure the Chargeable Patients SOP is embedded. • Daily SitRep reporting was stepped down on 08/06/21 as per communication from NHSE. • Single point of contact in place for operational response, aligned with the regional Level 3 incident expectations.				

Board Assurance Framework

	• An EU Exit deal was established on 24th December 2020. The impacts of the terms of this deal and the implications on the supply of medicines and consumables are under review nationally and locally. The Brexit Subgroup continues to meet to monitor the implications of the established deal. • The subgroup continues to meet quarterly to monitor national changes, including the current logistical challenges associated with EU exit.	
Assurance Gaps:	Continued national uncertainty on the terms of the EU exit. Trusts being requested not to stockpile supplies. Potential price increases to supplies. Winter pressures, COVID-19 pressures and increase demand on Workforce and UEC.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Reinstate Brexit Sub Group	Reinstate Brexit Sub Group	Reinstate Brexit Sub Group	Andrea McGee	01/02/2021	09/09/2020