We are WHH & We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WHH Board of Directors Meeting Part 1

Wednesday 27 JANUARY 2021
10.00am-11.30am
VIA MS Teams

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Agenda for a meeting of the Board of Directors held in public (Part 1)

Wednesday 27 January 2021 time 10.00am -11.30am

Via MS Teams

Due to the ongoing COVID-19 situation Trust Board Meetings are being held virtually. If you wish to observe any of our public Board meetings, please contact the Foundation Trust Office at the following address: whh.foundation@nhs.net

REF BM/21/01/	ITEM	PRESENTER	PURPOSE	TIME	
BM/21/01/ 01	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	10.00	Verb
BM/21/01/ 02 PAGE 7	Minutes of the previous meeting held on 25 November 2020	Steve McGuirk, Chairman	Decision	10:02	Encl
BM/21/01/ 03 PAGE 18	Actions & Matters Arising	Steve McGuirk, Chairman	Assurance	10:05	Encl
BM/21/01/ 04 PAGE 20	Chief Executive's Report	Simon Constable, Chief Executive	Assurance	10:10	Encl
BM/21/01/ 05	Chairman's Report	Steve McGuirk, Chairman	Information	10:20	Verb
	Quality People Sustainability				
BM/21/01/ 06 PAGE 36	COVID-19 Performance Summary Report and Situation Report – to follow	Simon Constable Chief Executive	To note for assurance	10:25	Enc
BM/21/01/ 07 PAGE 64	Integrated Performance Dashboard and Assurance Committee Reports	All Executive Directors	To note for assurance	10:30	Enc
(a i)	- Quality Dashboard including Monthly Nurse Staffing Report, October & November 2020 PAGE 131	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO			Enc
(b) PAGE 147	- Committee Assurance reportQuality Assurance Committee (1.12.2020 & 12.01.2021)	Margaret Bamforth, Committee Chair			Enc
(c i)	People Dashboard	Michelle Cloney Chief People Officer			Enc
(c ii) PAGE 157	- Committee Assurance report Strategic People Committee (20.01.2021)	Anita Wainwright, Committee Chair			Enc
(d i)	- Sustainability Dashboard	Andrea McGee Chief Finance Officer & Deputy CEO			
(d ii) PAGE 162	- Committee Assurance report Finance and Sustainability Committee (23.12.2020 & 20.01.2021) -	Terry Atherton, Committee Chair			
	Quality				
BM/21/01/ 08 PAGE 169	Nosocomial COVID-19 Infections Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	To note for assurance	10.50	Enc
BM/21/01/ 09 PAGE 192	WHH Maternity Services – Compliance with Ockenden	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	To note for assurance	10.55	Enc

GOVERNANCE

BM/21/01/ 10 PAGE 203	Strategic Risk Register & BAF	John Culshaw Trust Secretary	To note for assurance	11.15	Enc

MATTERS FOR APPROVAL

	ITEM	Lead (s)				
BM/21/01/ 11	Quality Assurance Committee Cycle of Business 2020-21	John Culshaw Trust Secretary	Committee	Quality Assurance Committee	11.20	Enc
			Agenda Ref.	QAC/21/01/08		
			Date of meeting	12.01.2021		
			Summary of Outcome	Approved		
BM/21/01/ 13	Amendment to the Constitution – Appointment of Additional Non-Executive Director *Virtual **Approva**l by Council of Governors 8.01.2021*	John Culshaw Trust Secretary	Committee	Council of Governors		
			Agenda Ref.	VCOG/21/01/001		
			Date of meeting			
			Summary of Outcome	Approved		
BM/21/01/ 14	Amendment to the Constitution – Update to the Governor Code of Conduct *Virtual **Approval** by Council of Governors 8.01.2021*	John Culshaw Trust Secretary	Committee	Council of Governors		
			Agenda Ref.	VCOG/21/01/002		
			Date of meeting			
			Summary of Outcome	Approved		

MATTERS FOR NOTING

	ITEM	Lead (s)				
BM/21/01/ 15	DIPC Q2 report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/21/01/18		
			Date of meeting	12.01.2021		
			Summary of Outcome	Noted		
BM/21/01/ 16	Learning from Experience Q2 report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/20/12/244		
			Date of meeting	01.12.2020		
			Summary of Outcome	Noted		
BM/21/01/ 17	Maternity SI Monthly Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/21/01/10		
			Date of meeting	12.01.2021		
			Summary of Outcome	Supported.		
BM/21/01/ 18	COVID-19 Mortality Review Report	Alex Crowe Executive Medical Director	Committee	Quality Assurance Committee		
			Agenda Ref.	QAC/21/01/04		
			Date of meeting	12.01.2021		
			Summary of Outcome	Noted		
BM/21/01/ 19	Moving to Outstanding (M2O) Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		
			Agenda Ref.	QAC/21/01/05		
			Date of meeting	12.01.2021		
			Summary of Outcome	Noted		
BM/21/01/	Use of Resources Q3 Report	Andrea McGee	Committee	N/A		Enc

20	erence	**Chief Finance Officer & Deputy CEO**	**Agenda Ref.** **Date of meeting** **Summary of Outcome**			
BM/21/01/ 21	**Guardian of Safeworking Q3 Report**	**Alex Crowe Executive Medical Director**	**Committee** **Agenda Ref.** **Date of meeting** **Summary of Outcome**	Strategic People Committee SPC/21/01/10 20.01.2021 Noted		
BM/21/01/ 22	**Digital Update report**	**Phill James Chief Information Officer**		N/A		
BM/21/01/ 23	**Infection Prevention and Control Covid-19 and orthopaedic trauma cases**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**		N/A		
BM/21/01/ 23	**Any Other Business**	**Steve McGuirk, Chairman**		**N/A**	**11.25**	**Ver**
	Date of next meeting: Wednesday 31 March 2021, Trust Conference Room					

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.

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		

DRAFT

Warrington and Halton Teaching Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 25 November 2020
Via MS Teams

Present	
Steve McGuirk (SMcG)	Chairman
Simon Constable (SC)	Chief Executive
Terry Atherton (TA)	Deputy Chair, Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
Alex Crowe (AC)	Executive Medical Director & Chief Clinical Information Officer
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director,
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	
Michelle Cloney (MC)	Chief People Officer
Lucy Gardner (LG)	Director of Strategy
Phillip James (PJ)	Chief Information Officer & Senior Information Risk Officer
Pat McLaren (PMcL)	Director of Communications & Engagement
Daniel Moore (DM)	Acting Chief Operating Officer
John Culshaw (JC)	Trust Secretary
Julie Burke	Secretary to The Trust Board
Observing	N Holding, Lead Governor, J Howe, Public Governor, N Newton Partner Governor Warrington & Vale Royal College members of the public (2)

BM/20/11/ 110	**Staff Story** The Board received a recorded patient story from a member of staff who had suffered a severe brain injury a number of years ago, describing his journey as a patient and his recovery and rehabilitation. As part of their recovery and rehabilitation they joined the Trust early in the year. They described the challenges faced as a person living with a disability during COVID-19 and the significant support received from the Trust and Manager to support their health and wellbeing both physically and mentally. This had improved their confidence in a number of ways, particularly their communication skills by interacting with work colleagues and patients. They had found the culture and environment at the Trust supportive and inclusive. They had received counselling from the Trust Occupational Health Service, supported by their Manager working in a supportive environment, which had been beneficial to them. They encouraged staff to speak out and seek additional support when required. The Board reflected on the positive story which was reflective of the supportive and inclusive culture at the Trust.
BM/20/11/ 111	**Welcome, Apologies & Declarations of Interest** The Chairman welcomed all to the meeting. No declarations made in relation to the agenda.
BM/20/11/ 112	**Minutes of the meeting held 30 September 2020** Page 4. Amendment to the penultimate sentence relating to VTE. With this amendment, the minutes of 30 September 2020 were agreed as an accurate record.

BM/20/11/ 113	**Actions and Matters Arising. Action log and updates noted and recorded.**
BM/20/11/ 114	**Chief Executive's report** The CEO recorded his thanks to Executive colleagues for their tremendous hard work and support during Wave 2 of the pandemic. Wave 2 had affected WHH more profoundly than wave 1 and it had been significantly more challenging to manage from an operational perspective. Colleagues were supporting each other as well as leading their own portfolios. Asymptomatic Testing of Staff – SC again thanked staff for the huge effort to undertake this pilot at short notice which had been successfully delivered. A comprehensive lessons learned document has been produced and this will support next steps including of staff testing which has already now started. Questions were invited. CR referred to the Armed Forces Covenant and in practical terms what this meant for patients who are referred to the Trust to ensure no patient is disadvantaged and pathways are supportive for their need from a patient and staff perspective. KSJ explained an action plan is in place, work progressing from both an employee and patient experience perspective and work continues with CCGs and local stakeholders to support. This is supported and enhanced with the development of a Patient Access Policy detailing on how this cohort of patients is treated. The first Trust Veterans Staff Network had taken place mid-November which will further support this initiative. Following discussion it was proposed that a dedicated session be for Board on the detail behind the Armed Forces Covenant to include perspective from (1) Veteran as a patient (2) Veteran as an employee and (3) relationship with Territorial Army (TA) and other armed services. **The Board noted the report.**
BM/20/11/ 115	**Chairman's Report** The Chair reported since the last Board meeting, internal meetings with Non-Executives (NED) continue with NED Assurance Committee meetings, Board, Council of Governors, Governor Briefing meetings and 1:1 meetings with the Lead Governor. The Governor elections are due to conclude 26 November, a number of Public and staff constituencies currently out for election. The Chair had supported the recent Asymptomatic staff testing pilot and recorded his thanks for the efforts of staff to come together at short notice, overcoming operational and logistical challenges. AMcG concurred, adding that the report in the CEO report had been shared at regional level and neighbouring organisations. External meetings continue with Local Authority CEOs, NW Chairs, local partners and stakeholders. Chairman had Chaired the recent C&M Health & Care Partnership Board, **The Board noted the update**
BM/20/11/ 116	**COVID-19 Performance Summary and Situation Report** The CEO referred to the situation report and Elective Recovery plans. All data is submitted through Emergency Planning Resilience Reporting to NHSE/I and provides headline figures and outcomes data from a regional, national and local perspective. The data informs decisions taken internally to inform strategic and operational decisions and the report shared with NEDs at their weekly meetings to provide assurance and reassurance of plans in

	place. WHH position against England and NW perspective highlighted, the Trust was one of the most challenged Trusts during Wave 1 which has continued in Wave 2 surpassing the peak of the first wave on 26 October 2020. Patients in hospital in Wave 2 higher than the peak in Wave 1 whilst continuing to restart services that had been paused during Wave 1. Responding to SMcG query if a NW 12 month overall summary is anticipated to help understand spike in prevalence in Warrington. SC anticipated that a number of Public Health measures including effect on community prevalence, Trust activity and attendances would formulate any future report. The spike in prevalence could be multi-factorial, including the timing of the different public health measures and when these came into force across different boroughs. Discussion took place on mortality data relating to pre-existing medical conditions to understand impact on individual patients and severity of pre-existing medical conditions and if there is any difference. SC explained data is recorded for this cohort of patients as part of the medical history, which could include various pre-existing conditions as part of co-morbidity conditions, further analysis of data would support understanding of how individual factors may have contributed. AC added some conditions are due to various pre-existing conditions ie hypertension / diabetes, some impact could be due to not having access to primary care services as a result of the pandemic. In relation to early indication of improved outcomes in Wave 2 against Wave 1, AC explained it is too early for this detailed data, but improvement indicated in mortality rate in Wave 1 (26-27%) and in Wave 2 (23%), early indications due to early intervention of treatment and patients not having to be ventilated. • **The Board noted the report.**
BM/20/11/ 117 (a ii)	**IPR Dashboard and IPR Key Issues** The CEO introduced the report, and asked DM to provide an update relating to 4 hour performance constitutional standard and KSJ relating to nurse staffing challenges and mitigations in place. **Performance** 4 hour standard achieved 78.31% against NHSE/I trajectory of 85%, the third month not achieving this standard. DM explained September and October challenging due to increase in community COVID-19 prevalence, constraints in bed base to continue with elective services as part of Phase 3 recovery and increase in through-put in Urgent Care footprint. Activity 91% compared to same period last year, which had dropped to 85% in the last wo weeks. K25 and B3 at Halton had been opened to provide additional capacity. Challenges in Ambulatory Care being bedded to help support admissions. Ambulance handovers – progress in 30 minute handover, not seen as outlier in C&M. Challenges in Urgent Care and patient flow whilst maintaining segregated flows, IPC and social distancing guidance.

	TA reassured the Board that Finance Sustainability Committee (FSC) had discussed performance metrics in detail, data is benchmarked with Peers to ensure Trust is not an outlier which had included keeping ED COVID secure, impact on COVID and Non-COVID patients, significant impact operationally of Super Stranded patients which is in excess of 60 compared to Wave 1. Additional support being sought from Local Authority and partners, which will be supported by campaign to discharge patients home for Christmas, preparedness plans to commence end of November. Challenges related to change in IPC criteria testing regime to safely discharge patients not testing positive within 14 days prior to discharge to care homes which had been raised as nationally.
BM/20/11/ 117 (a i)	**Monthly Safe Staffing Reports, August 2020 + September 2020** The reports were taken as read. All staffing data is submitted via Unify Safe Staffing Return. KSJ explained the daily staffing challenges to ensure that all areas are staffed safely across the Trust and mitigations in place when a Ward falls below 90% of planning staffing levels and the mitigation and staff plan are detailed in the report for further assurance. Staffing numbers s are reviewed a number of times by the Nursing Leadership time during the day to ensure movement of staff in real-time. To mitigate and address any gaps in staffing, agency and locum staff is utilised. Current sickness absence in RNs and HCAs reported at 12-15% including COVID-related absence, and staff requiring to self-isolate. MC added that non-COVID sickness absence levels for Nursing and AHPs last year was 6.24%, compared to 6.54% for November an increase of COVID related absence of 2.5% in month. KSJ explained Incentive scheme had been launched to encourage current staff to take up additional shifts, up to 5 and Bank staff up to 10 shifts, plans in place to extend this scheme which will be taken through the appropriate Trust governance process. Following discussion it was proposed that a dedicated Board session is held to include financial challenges relating (it wasn't around finical challenges) to session is to be held to further update board members about the methodology of nurse staffing and assurances on the way we calculate staffing methods nursing and AHP staffing and outcomes of a deep dive into absence reasons of RNs and HCAs. In relation to AHPs, KSJ reassured that Board that whilst there is no digital system to manage/report staffing levels for AHPs, the same rigorous approach is applied. Nursing vacancies – 100 RNs, 20 some vacancies to be filled as part of International Recruitment this month and early 2021. Successful HCA recruitment event recently, improvement in vacancy rate (54) compared to previous month.
BM/20/11/ 117 (b)	<u>Quality Assurance Committee (QAC) Assurance Report 06.10.2020 + 03.11.2020</u> MB explained the QAC had continued to meet to enable assurance reporting of key areas and to address any areas of concern. Radiology deep dive, high level of assurance relating to complaints and incidents <u>Clinical Harm Review</u> - Delayed treatments prioritised into low/medium/high risk pathways based on "perceived risk". Assurance that Clinical Harm Reviews undertaken on each individual patient delayed on high risk pathway with individual treatment plan, cluster reviews for low/medium risk pathways.

	Urology Deep Dive - Action plan received, further work required, assurance of monitoring at various Sub Committees in the reporting structure. Service Improvement Group in place to progress particular workstreams, Bladder/Prostate Cancer and Prostate pathway, action plan in place, monitored at PSCESC with assurance report to future QAC. For further reassurance, AC added that the action plan is reviewed bi-weekly alongside governance dashboard to align with Risk Register and a weekly working group had also been established. Correction noted in the IPR VTE Assessment October compliance reported at 96.75%. KJS further explained the first Clinical Harm Review Panel had taken place on 24 November 2020 with GP representation on the Clinical Review Pane which will report through the appropriate Committee(s). Further meeting with the Urology Team to progress actions and maintain momentum.
BM/20/11/ 117 (c i)	**Workforce –** MC provided an update on Trust and regional sickness absence - Challenges relating to COVID-19 related workforce response including where staff had been redeployed during Wave 1 and consequences of returning to their own role. - Long and Short term sickness absence highlighted, 31 members of staff currently on Long Term absence (longer than 28 days) mainly Additional Clinical Services (ACS), N&M and Health Care Support Workers, non-COVID related absence, increase in Chest and Respiratory, decline in anxiety and stress absence. ACS absence 8.83%, N&M 6.54% non COVID related absence. - Increase reported in A&C non-COVID related absence, primarily stress and anxiety. Absence rates reported daily to Executives, Wave 1 16%, Wave 2 10% reflecting safe staffing plans and actions implemented across all staff groups to support staff. - MC explained that C&M is an outlier nationally for sickness absence. A review of Trust policies, procedures and practices related to Attendance Management had been undertaken by the Director HR at C&M Health Partnership and this had confirmed that Trusts policies and practices were consistent. It was noted that there was to be an Attendance Management Symposium arranged with NHSE/I and that this would aim to share best practice within the NHS but also include industry experts to improve the regional position and in particularly C&M. - KSJ referred to sickness levels, particularly RNs and HCAs and the need to reinvigorate previous actions plans to address and improve sickness absence levels. - MC acknowledged the current sickness absence as reported in the IPR and provided Trust Board with additional information as a comparison for October 2019 (5.98 %) and 2020 (Non-Covid) (4.67%). MC explained that the difference in policy and practice between Trusts relates to how policies are enacted and operationalised by line managers and the organisational culture within the Trust rather than differences in the policy, triggers or training provision. AW confirmed her agreement that having consistent policies across C&M or the NW is one thing but the culture and application by line managers is key to performance in this area. Following discussion it was proposed that a dedicated session be held with Trust Board on Nurse Staffing by the Chief Nurse. In addition a review of shared learning from the C&M Symposium and implications to improve sickness absence at WHH will be undertaken by the Chief People Officer.
BM/20/11/ 117 (c ii)	Strategic People Committee (SPC) 18.11.2020 AW highlighted the Trust had continued with its Medical Appraisal process the current Pandemic, reflecting culture of the Trust to

	support this cohort of staff, 82% compliance reported for October. Process had been paused by peer organisations.
BM/20/11/ 117 (d)	**Sustainability** – AMcG reported: - Financial reporting regime had changed, October being the first month that the Trust did not receive any reimbursement of COVID-19 top up. - Deficit Plan £10.3m based on R=1, request to revise forecast outturn to improve the plan. £10.3m deficit plan would require cash support in March 2021, with circa £17m at the beginning of the financial year for creditor payments. - £1.1m cost pressure without income and reduction in recovery not included in £10.3m deficit plan. - October deficit plan £0.7m, delivered £0.8m due to a one off income receipt and ability to offset spend due to pause in recovery activity. Particular elements of the Capital Plan and spend year to date were highlighted: - Critical Care bid submitted for £1.7m, £300k related to Neonatal Critical Care, was informed this sum did not include Neonatal after adding to the Capital Programme, reduction in Capital Programme required of £0.3m to £26.0m. - Two red rate schemes - A&E (£4.3m) related to the challenge to deliver in-year due to delay in receipt of funding, ongoing discussions with NHSE/I if any funds can be carried forward. £1m for Paediatrics forecast to be delivered by the end of this financial year. - Critical Care scheme (£1.7m) late approval, equipment to be procured to be agreed and Estate work required. - CSTMB (CMTC) Breast – some delays but scheme will deliver. AMcG highlighted proposed changes to the Capital Programme which had been discussed in detail and supported at the FSC in November. **The Board** - **Noted, reviewed and discussed the report.** - **The Board approved the proposals outlined above and changes to the Capital Plan including contingency and the adjustment of the additional capital funding of £1.7m to £1.4m for Critical Care (excluding Neonatal).** - **The Board approved the additional schemes in the Capital Plan as above.** - **The Board approved the additional capital funding request of £821,000 for the MRI Build discussed earlier in the meeting.** - **Noted the approval of emergency request for a SeraSep analyser for £106k, leaving Contingency Budget at £886k.** - **The Board approved the changes to the contingency budget and reduction in contingency to £437k.**
BM/20/11/ 117 (d i)	Finance & Sustainability Committee (FSC) 21.10.2020 and 18.11.2020 TA highlighted deep dive into Digital risks to October FSC, Interim Medical Establishment Review, with final report conclusions to December FSC. November FSC discussed in detail Phase 3 recovery and impact of Wave 2 which had also been discussed earlier in the meeting.
BM/20/11/ 117 (e)	Audit Committee 19.11.2020. IJ reported assurance of continued reporting of all Assurance Sub Committees. MIAA reviews and recommendations continue to keep assurance work progressing.

BM/20/11/118	**Moving to Outstanding Action Plan (M2O)** The report was taken as read, KSJ highlighted key points to note: - Significant activity since the last Board meeting. 2019 CQC action plan closed down, 2 outstanding actions transferred for continued monitoring at CBU meetings. - CQC 50 point issues log closed down. - Local System Review (Provider Collaborative Review) took place 22 October 2020, led by CQC, KSJ, AC and DM interviewed as part of the process, report awaited and, if required, action plan will be formulated to address any areas highlighted. - Patient First Assessment – KSJ, AC and DM interviewed as part of this assessment to measure safety milestones in Urgent Care against specific KLOEs of safe, responsive and well-led domains. No report to be issued, positive verbal feedback received, assessment could be used in the future by CQC focussing on different services across the Trust. - 6 enquiries received from CQC, including 1 Compliment. - CQC Strategy – formal consultation to take place on the Strategy which is split into 4 pillars, People, Smart, Safe and Improve. - Hospital Food – priority item for CQC, recommendations following recent national review highlighted. The Trust to develop a Food Strategy when National guidance issued. - M20 Workstreams – M2O meetings continue, receiving comprehensive updates, M2O action plan progressing. - MB reassured the Board that training related to the Serious Illness Care Programme which had paused due to Wave 2 will progress and monitored by herself as Chair of the Group. - Discussion took place relating to digital recommendations in the Hospital Food Review to address quality elements, being mindful of advance notice of any associated costs. KSJ reassured the Board this new innovation would form part of Quality Improvement agenda and shared with Executives for support before progressing. - SMcG referred to the progress and good news stories in the report and that a media communication is prepared to highlight the work. He referred to some 'quick win's and proposed that the Board sample patient menu at a future Board meeting. • **The Board discussed, reviewed and supported the CQC action plan and progress.**
BM/20/11/119	**WHH Mission and Values in COVID-19 era** The CEO introduced the report. Extensive engagement exercise over the last few months to refresh the Trust Vision, Objectives and Values in the context of COVID-19 and staff experience. Feedback received from staff included incorporating the words 'inclusive' and 'kindness' to reflect the Trust's culture. Also the Halton site had been renamed to unite the site as one Hospital with two buildings. These proposals had been supported by staff, stakeholders and Governors. • **The Board approved the recommendations and changes to the Trust Mission and Values.**
BM/20/11/120	**Strategic Risk Register and Board Assurance Framework (BAF)** The report was taken as read and JC highlighted the following for the Board to review and consider the following proposals for the BAF since the last meeting and the rationale: - Six risks had been added to the BAF Risks #1272, #1273, #1274, #1275, #1108, #1079. - The rating of three risks had been amended

	- **Risk #134** approved at the Quality Assurance Committee on 6 October 2020 to increase rating from 15 to 20. - Finance and Sustainability Committee had assumed responsibility for monitoring the Digital agenda and supported changes to the ratings of **Risk #1114** from 16 to 20 to increase its current consequence and acknowledge that the achievable target risk also increases from 8 to 15 and - **Risk #1205** rating decreased from 5 to 10. The risk and its scoring reflect an intense and focused multidiscipline piece of work. These amendments had been approved at the Quality Assurance Committee on 3 October 2020. - Amendment to description of Risk #1079 following review and discussion at the Risk Review Group on 7 October 2020 and approval at the Quality Assurance Committee on 3rd November 2020 - The Board considered and supported the proposal to add two additional Risks #1289 and #1290, supported at the Quality Assurance Committee on 3rd November 2020. - No risks have been de-escalated from the BAF since the last meeting. Also included in the report were notable updates to existing risks #1124; #1215; #115; #134; #1207; #125; #1134; #145; #1205, #1114. Discussion took place regarding the narrative description of Risk #1114, SMcG asked for this to be reviewed. Proposal to take amendment to FSC in December for support and QAC in January for approval. Discussion took place relating to Risk #1275 Nosocomial Infection and if the rating was too high. KSJ explained scoring was reached due to the complex operational difficulties this type of infection creates. Not all transmission data themes and evidence available and the risk will be continually reviewed. • **The Board reviewed and noted the BAF and Strategic Risk Register and approved:** - **the addition of 6 risks to the BAF as above;** - **The amendment to rating of three risks as above.** - **The amendment to description of one risk as above** - **Proposal for addition of two additional risks as above**
BM/20/11/121	**Digital Assurance Report** PJ introduced this new report to ensure the Board is fully briefed on Digital agenda, providing assurance in respect of the Digital Programme, DXC relationship, IT services, Digital Analytics Programme, Digital Compliance and Risks, Clinical Safety and Risk Review and Digital Maternity. • Assurance provided relating to Cyber Security standards that protect from attempted breaches to Trust systems which are reported to us by the National Security Centre. • Assurance provided related to delays in elements of the programme of work and mitigations in place, no material impact to Trust financial plans or programme benefits. • Digital Analytics Programme - review and baseline of this programme completed. Robust involvement of stakeholders being implemented in the prioritisation process. TA thanked PJ for the comprehensive report to help the Board understand both quality and financial elements of the digital agenda ensuring Board is sighted on future potential investment requirements which could impact on the Trust financial plans. Discussion took place relating to detailed reporting arrangements of quality and financial elements to QAC and FSC. SMcG proposed Executives to discuss content of the report,

	purpose of the report to the Board to determine the most beneficial way to report digital assurance as the detail is discussed at the relevant assurance committees. • **The Board reviewed and discussed the report and assurance and mitigations provided relating to escalated matters.**
BM/20/11/122	**Legal Considerations of Governance during COVID-19 Pandemic** KSJ introduced the report which described the legal challenges resulting from the COVID-19 Pandemic and the controls in place to address these. The most significant potential risks and actions taken in addition to controls put in place by the Trust to mitigate against these (14 areas) highlighted: - Of the 14 areas, 12 were rated Green - 2 Amber - 1 related to Working Time Directive central monitoring system. Working with HR & OD team, and wider staff to address recommendations. - (2) Delayed Discharge due to challenges of Super Stranded Patients. Care Home Forum established to support delayed discharge, challenges relating to testing/discharge regime for Care Homes as discussed earlier - Recommendations of 2 Amber risks will be reviewed to turn to Green and reported to Quality Assurance Committee. - HSE – requirement for future reporting of Fit Testing results to Quality Assurance Committee and Trust Board as appropriate. SMcG referred to the importance of strong governance processes in all areas identified, particularly in relation to H&S At Work Act to protect colleagues. AMcG asked of any implications for staff and others if some patients refuse to wear PPE. KSJ explained this issue had been discussed at C&M and other regional meetings and an approach is to be considered internally. There was a draft supportive staff proposal in place and which was reviewed by the legal team. The Trust is developing robust and supportive guidance for staff where a patient declines PPE, taking exemptions into consideration. The Trust had not experienced any challenges and staff had been able to support patients. Discussion also took place relating to anticipated COVID vaccine and Trust line to encourage staff to participate as it is not mandated. National guidance will be followed based on regulatory approval of the Vaccine. WHH is a member of the C&M Steering Group with LG as the Executive Lead. From a digital perspective, PJ added that work is progressing to support roll-out, some elements may be out of the Trust's control but assurance provided that appropriate controls will be in place. • **The Board reviewed the report and assurance provided of mitigations and action in place to address the recommendations.**
	MATTERS FOR APPROVAL/RATIFICATION
BM/20/11/123	**Director of Infection Prevention & Control (DIPC) Annual Report** The Board **ratified** the DIPC Annual Report which had been approved at the Quality Assurance Committee on 6 October 2020.

BM/20/11/124	**Workforce Race Equality Standard (WRES)** • The Board **ratified** the WRES which had been approved at the Strategic People Committee on 18 November 2020. **Workforce Disability Equality Standard (WDES)** • The Board **ratified** the WDES which had been approved at the Strategic People Committee on 18 November 2020.
BM/20/11/125	**Quality Assurance Committee (QAC) Terms of Reference** • The Board **ratified** the QAC Terms of Reference which had been supported at the Quality Assurance Committee on 6 October 2020
BM/20/11/126	**Strategic People Committee (SPC) Terms of Reference** • The Board **ratified** the SPC Terms of Reference which had been supported at the Strategic People Committee on 18 November 2020
BM/20/11/127	**Finance & Sustainability Committee (FSC) Terms of Reference** • The Board **ratified** the FSC Terms of Reference which had been supported at the Finance & Sustainability Committee on 23 September 2020.
BM/20/11/129	**GMC Re-validation Annual Report** • The Board **ratified** the GMC Re-validation Annual Report and Statement of Compliance, supported at the Strategic People Committee on 18 November 2020.

	MATTERS FOR NOTING FOR ASSURANCE
BM/20/11/130	**Mortality Review Q2 Report** This report had been reviewed and discussed at the Quality Assurance Committee on 3 November 2020 • **The Board noted the report.**
BM/20/11/131	**Guardian of Safeworking Q1 and Q2 Reports** This report had been reviewed and supported at the Strategic People Committee on 3 18 November 2020. • **The Board noted the report.**
BM/20/11/132	**Engagement Dashboard Q2 Report** This report had been reviewed and supported at the Council of Governors meeting on 12 November 2020. • **The Board noted the report.**
BM/20/11/133	**Use of Resources Q2 Report** The Board reviewed and noted the report. • **The Board noted the report.**
	ADDITIONAL ITEM FOR APPROVAL - Non-Executives left the meeting for this item
BM/20/11/133	**Amendment to the Trust Constitution.** This report had been reviewed and approved at the Council of Governors meeting on 12 November 2020. JC introduced the item, explaining the background and rationale for the proposed amendment which would allow additional terms of office for NEDs of up to three years, following their initial term. Non-Executive Directors may serve for a maximum of 9 years. The proposal to amend the Trust's Constitution had been discussed and supported at the

	Governor Working Party in September and October 2020 and the Governors Remuneration Committee on 28 October 2020 as follows: *Non-Executives are appointed for an initial period of up to three years. Appointments may be renewed at the end of the period of office, subject to the recommendations of the Council of Governors Nomination and Remuneration Committee and approval of the Council of Governors, for a further period up to three years. Non-Executives may serve up to a maximum of 9 years.* In response to query raised by MC relating to ED&I Board representation, SC commented representation would be reviewed as part of the annual review, acknowledging the demographic of Warrington and Halton. • **Voting Members of the Board ratified the amendment to the Trust Constitution (AMcG, DM, SC, AC, KSJ, and supported by non voting members PMcL/LG)**
	Next meeting to be held: Wednesday 27 January 2021

Signed …… Date ……

Chairman ……..

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE	BM/21/01/03	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	27 January 2021

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/20/11/121	25.11.2020	Digital Assurance Report	Purpose of the report to the Board to determine the most beneficial way to report digital assurance to Board as the detail is discussed at the relevant Assurance Committees.	**Chief Information Officer**	**27.01.2021**		To commence 27 January 2021. Report BM/21/01/22	

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/07/57	26.05.2020	Junior Doctor/Trainee Engagement update Trello)	6 mth update presentation.	**Executive Medical Director + CCIO**	**Paused nationally 2020, date TBC**		14.01.2019. Deferred to March 27.03.2019. Deferred to future BTO 29.05.2019. Update to September Board to include results from GMC survey. 06.09.2019. Deferred to November Board due to deferred HEE visit. 18.11.2019. Deferred to January Board due to HEE visit. 13.01.2020 Date of HEE visit still to be confirmed. 9.03.2020 HEE visits cancelled on 3 occasions. HEE visit confirmed for 22.5.2020. Verbal update to May Board	

							27.05.2020 Visit cancelled. HEE visits paused due to COVID, future date to be confirmed 29.07.2020. Visit confirmed for Autumn 2020. 30.09.2020. Virtual HHE GMC assessment anticipated Nov/Dec 2020. 25.11.2020 Notification of potential visit in February 2021.	
BM/20/11/114	25.11.2020		Armed Veterans Action Plan to future Board meeting	**Chief Nurse & Deputy CEO**	**31.01.2021**		To be ciruclated sparately to the Board	
BM/20/11/117ac	25.11.2020	Nurse Staffing challenges	Dedicated session be held with Trust Board on Nurse Staffing by the Chief Nurse.	**Chief Nurse & Deputy CEO**	**28.04.2021**			
BM/20/11/117c	25.11.2020	People IPR - Attendance Management Policy	Review of shared learning from the C&M Symposium Deep Dive of Trust Sickness and Absence to take place	**Chief People Officer**	**27.01.2021** **20.01.2021**		C&M symposium paused due to pandemic Received at the Strategic People Committee on 20.01.2021 and referenced in SPC Committee Assurance Report at agenda reference – BM21/01/07 cii	
BM/20/11/118	25.11.2020	M2O Report – Hospital Food National Review	Board sample of patient menu at a future Board meeting.	**Chief Nurse & Deputy CEO**			On hold due to Pandemic	
BM/20/11/120	25.11.2020	BAF	Risk #1114 – proposal to amend narrative/description to FSC for review and support in December and QAC for approval in January prior to January Board.	**Trust Secretary**				

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

RAG Key

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

We are WHH & We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/04**			
SUBJECT:	**Chief Executive's Briefing**			
DATE OF MEETING:	27th January 2021			
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 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 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/21/01/04

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 25th November 2020, some of which are not covered elsewhere on the agenda for this meeting.

2) KEY ELEMENTS

2.1 Briefings shared with the Board since the last meeting

- Letter from Amanda Pritchard, Chief Executive, NHS Improvement and NHS England Chief Operating Officer & Julian Kelly, NHS Chief Financial Officer in respect of operational priorities for winter.

2.2 Key issues

2.2.1 Current COVID-19 Situation Report

WHH continue to be severely impacted by the third wave of COVID-19 over the last two months, being one of the most affected trusts in Cheshire and Merseyside, the North West and England as a whole. The peak of wave 3 so far (243 inpatients with COVID-19 on 19th January 2021) has significantly exceeded that of wave 1 (124 inpatients with COVID-19 on 13th April 2020) and wave 2 (179 inpatients on 9th November 2020).

We had not fully recovered from wave 2 either, because unlike the nadir of single figures we had over the summer with wave 1, the lowest COVID-19 inpatient burden we have had in wave 2 was 93 patients on Christmas Day.

Once again we have had to 'pause' certain non-urgent services to support staffing in critical services, especially those that are ward based. Critical care capacity has been a particular area for focus and concern, given the fact that our critical care unit has been stretched to accomodate as many as 30 patients by escalating into theatre and recovery areas. That is also without taking into consideration an additional 14 patients receiving CPAP (non-invasive ventilation) on our respiratory ward A7.

We have been working constantly with local partner organisations on patient flow through our hospitals and we are in constant discussion with our regional team and other local NHS trusts on mutual aid (including use of the independent sector). We participate fully in the local Cheshire and Merseyside cell structure, including a daily Gold Command call, which I have been jointly chairing with James Sumner, Chief Executive at Mid-Cheshire Hospitals NHS Foundation Trust.

As at the time of writing, 25th January 2021, we have a total of 227 inpatients with COVID-19. That number was 243 on 19th January 2021. The number of inpatients with negative tests is currently 213, with 42 patients currently awaiting test results.

Since March, we have performed over 55312 COVID-19 tests and 4348 have been positive in total. We have discharged a total of 1358 patients with COVID-19 to continue their recovery at home. Sadly, a total of 383 patients have died in our care.

The latest R number for the North West, updated on Friday 22nd January, is at 0.9 – 1.2; the UK as a whole is at 0.8-1.0.

We are currently using approximately 1500 litres of oxygen per minute (approximately 50% of capacity). In terms of PPE stock, based on estimated current usage, we have plenty of PPE, as well as good testing capacity for both staff and patients. Total staff absence remains at just over 9%.

The overall burden of COVID-19 remains high.

2.2.2 Executive Team Appointment

This month I was delighted to announce that after a competitive selection process that started in December, on 20th January 2021 our Nominations and Remuneration Committee confirmed Dan Moore, as our 'new' Chief Operating Officer with immediate effect. He has obviously been doing the job ever since Chris Evans left the Trust to go to Portsmouth in September, on top of him being our Director of Operations and Performance (Deputy COO) since June 2018.

Dan fulfils a key role as our Accountable Emergency Officer (AEO) in this level 4 national major incident.

2.2.3 WHH COVID-19 Vaccination Programme

We received an initial delivery of the Pfizer-Biontech Covid-19 mRNA vaccine on Tuesday 22nd December 2020. We therefore began administering the initial allocation of vaccines over a three day period until Christmas Eve inclusive, with a plan to vaccinate 1000 people before Christmas. We did this successfully.

We commenced our vaccination hub programme targeting JCVI priority groups 1 and 2 which included inviting patients aged 80 and over who were due to attend outpatient appointments, care home staff from Halton and Warrington local authority areas, then extending to cover all WHH frontline staff at Warrington and Halton hospitals and at our NHS partners.

There has been some concern and frustration that has emerged from the updated national guidance around the timing of the second dose of the COVID-19 vaccination. This was not a unilateral Trust decision. We are part of a national vaccination programme during a national major incident and thus must follow the national protocols. All other vaccination hubs are expected to do the same.

The rationale has been widely publicised, and it remains the subject of much national debate and challenge.

All individuals who have had a first appointment have a second appointment booked in within 12 weeks. To comply with the national directive of 30th December 2020 we had to move approximately 1700 second appointments; this is complete and emails have been sent to all individuals regarding the new appointment dates on the email address supplied by the individual at the time of their initial booking.

Since our initial supply of the Pfizer vaccine we have had no issues with supply and we have been informed that we are able to continue to order supply in line with demand. The supply chain is contingent on the recording of this first dose. It is also clear if any second doses are administered and this is externally monitored.

The vaccination team works incredibly hard to avoid wastage. Not a single dose has been wasted due to scheduling or unutilised capacity. As of the time of writing in total we have had 28 unused doses, the reasons for these are summarised thus: 15 doses due to dropped vials, 8 doses due to contaminated vials, and 5 doses due to the syringe detaching from the needle – a reconstitution issue. This equates to total wastage of 0.4%. When we commenced the programme, published experience from previous vaccination programmes indicated to plan on the basis of 15% wastage; our performance therefore far exceeds national expectations.

We have steadily increased capacity and are now vaccinating 425 people per day, 6 days per week. All slots are filled prior to the start of each day and additional staff are called daily to account for the small number of DNAs. Our capacity and vaccine delivery equates to 2550 vaccines per week. Based on the latest figures received from the regional team this places WHH as administering the highest number of vaccines per week of all the hospital hubs in Cheshire and Merseyside. I anticipate this will increase further in the coming weeks,

On the 4th January the Prime Minister announced that everyone in JCVI priority groups 1-4 should be vaccinated by 15th February 2021. WHH was one of the first cohort of hospital hubs established in North West to administer the Pfizer-BioNtech vaccine to the first four priority groups established by the Joint Committee on Vaccines and Immunisation (JCVI) – that is: those over 70 years old, front line health and social care staff, and the clinically extremely vulnerable (the latter - aside from staff - being the most common group to find themselves in our hospital without being acutely unwell).

We are pleased to have played a significant role in supporting these priority individuals to access the vaccine across the boroughs we serve. As vaccine doses are precious, WHH staff have been invited to nominate a small number of family members/friends that are on this JCVI priority list (1 to 4) to register for appointments to take up any vacant slots ensuring no vaccines were wasted, especially since we had to alter many appointments (1700) with the second dose change. WHH staff saved at least 750 hours of administration time by directly booking appointments on the system for elderly and vulnerable individuals.

This has enabled us to widen access for those in our patient population waiting to be called and support primary care colleagues by administering vaccine to many of their patients - freeing up their precious resources to vaccinate more in the community. This approach to

support our local population has been endorsed by the local Director of Public Health for Warrington, Thara Raj.

To ensure JCVI compliance, all individuals presenting for vaccination are asked for proof of age/photo ID and letter of proof of extreme clinical vulnerability provided by their GP/Consultant. To date, no one has been vaccinated outside of the JCVI priority groups 1 to 4.

We have also started vaccinating with the Oxford/Astra Zeneca vaccine, including vaccinating appropriate inpatients with a 'roving' vaccination team.

Up until 23rd January 2021, 8554 individuals have been vaccinated through the WHH COVID-19 Vaccination Programme. The Programme Priority Group report is attached to this report as Appendix 1.

2.2.4 The Thank You Awards 2020

On 18th December 2020 we held an extra special Thank You Awards.

Following one of the most unusual and difficult years in our history, we made our annual Thank You Awards bigger and more inclusive than ever – despite the fact that it was virtual for the first time.

On Friday 18th December at 7pm, colleagues from across the Trust met via Microsoft Teams for an evening of fun and celebration. As well as videos of all shortlisted nominees showcasing their range of achievements, there was a warm welcome from the Chairman, bingo, and a charity raffle.

Whilst some enjoyed the evening from the comfort of their own home, many teams were still hard at work within the hospitals, tuning in where possible. One thing that brought everyone together, wherever they were, was the 'Proud to be part of Team WHH during COVID-19' badges and cupcakes that were distributed ahead of the event.

We considered it was never more important to celebrate the work of colleagues in all roles within the NHS, and this was reflected in the 207 nominations received for the awards – making it a near impossible task for the judging panel. The 10 categories included Excellence in Patient Care, Star of the Future, and Team of the Year.

The awards were made possible via the WHH Charity and our Charitable Funds Committee, and a grant from NHS Charities Together – a one-off sponsorship to thank each and every one of #TeamWHH for all they have done in this remarkable year.

The full list of winners is:

- Star of the Future – Adam Harrison
- Team Care & Support - Occupational Health & Wellbeing Team
- Inclusion Ally - Suresh Arni Sukumaran
- Innovation & Quality Improvement - The 'Black Box' Team (Dr Mithun Murphy, Dr Mark Forrest, Dr Sagaar Patel and Jo Thomas)

- Leadership Award – Dr Zaman Qazzafi
- Supporting Excellence Award - Clinical Education Team
- Excellence in Patient Care Award - Microbiology & Infection Control Team
- Employee of the Year - Alison Parker
- Team of the Year - Critical Care, Anesthetics & Theatre Team
- Outstanding Contribution of 2020 – Lesley McKay

2.2.5 National Awards and Recognition

In December we also had national recognition for no fewer than three of our teams.

Our team that transformed a simple medical device to help some of the most seriously ill COVID-19 patients won the prestigious national innovation award in the annual London Business School (LBS) Innovation Awards when WHH was named as the inaugural winners of a new 'Innovating in Adversity' category at the LBS Awards ceremony which was held virtually yesterday afternoon.

The mixed team of our doctors, nurses and allied health professionals working across Intensive Care, A7 and our cardiorespiratory team were recognised for the remarkable impact of their innovation. The simple modified CPAP (continuous positive airway pressure) device brought almost instant relief to patients with extreme breathing difficulties admitted with the debilitating effects of COVID-19.

They decided to try to modify the community CPAP devices for high-flow oxygen use. They made a simple change to the mask and added a filter which also allowed oxygen to be supplied via the mask and then tested the devices on themselves, using anaesthetic gas analysis to confirm the levels of oxygen being delivered. Testing on patients in a controlled environment followed and the team were delighted when most patients found their breathing easing and oxygen levels rising. Patients that did not adequately oxygenate after a few hours on the CPAP 'Black Box' were escalated to intensive care for ventilation.

Particular mention should go to Dr Mithun Murthy, respiratory consultant, Dr Saagar Patel, acute medicine and respiratory consultant, Dr Mark Forrest, Clinical Director and critical care consultant, and Jo Thomas, lead physiotherapist who were key in completing this work stream within supportive multidisciplinary respiratory, cardiorespiratory and critical care teams.

This significant development was the focus of a Sky News documentary during the first wave of the pandemic and was also named winner of a London Business School People's Choice Award, following a public vote earlier this year.

London Business School Innovation Award Judge, Charlie Dawson added: "The teeth of the COVID-19 crisis in a regional hospital on its way to being overwhelmed… definitely adversity. The response was practical, smart, fast and described modestly as 'just doing our job'. The results were way beyond such understatement."

Only a couple of hours later our Finance Department (which covers a whole host of services including procurement, clinical coding, contracts, commercial development) was named the

very prestigious HFMA (Healthcare Financial Management Association) Finance Team of the Year because of the work done during 2020 in support of patients and staff.

I know the team were so happy to be shortlisted for the award, and were informed by the panel that we were very fortunate because there were some excellent entries this year.

The award recognises the contribution the finance team has made in the last 12 months for promoting and improving team work, innovation, collaboration, transformation and governance. The judges were impressed with the team work of the finance function and its contribution to the overall goals and objectives of our Trust. There was commendation for support to the provision of PPE, strong governance culture including the 'right way to yes', top shared services metrics, and for our 'be inspired, be inspiring' approach.

Finally, WHH and NHS Professionals (NHSP) won the Best Recruitment Experience Award in the prestigious Nursing Times Workforce Summit Awards for its rapid response COVID-19 recruitment campaign. Mirroring the national picture, we were experiencing significant vacancy rates for nursing roles and healthcare assistants. Recognising the need for support to manage workforce challenges during the COVID pandemic, we set up a responsive staffing recruitment process, enabling staff to be ready for deployment to the clinical frontline within 48 hours.

The initiative was developed in collaboration with NHSP and within ten days a brand-new solution was mobilised, accompanied by a multi-channel marketing campaign and a local call to arms asking student nurses or returners to support the hospitals. The campaign attracted 98 new qualified nurses, 38 new HCAs, 133 student nurses resulting in over 4,000 hours worked by rapid response applicants within general, emergency department, and theatre settings.

We are obviously thrilled and so very proud to have been recognised for the services we provide, which for me perfectly describes the whole-trust approach to how we do things as well as the utter inter-connectedness of all services, clinical and non-clinical.

2.2.6 Opening of The Nest (Midwifery-Led Unit)

On 1st December our Chairman Steve McGuirk and I had the privilege of cutting the ribbon on our new Midwifery-Led Unit, The Nest, on the ground floor of Croft Wing. This has been several years in the thinking, talking and planning and after a £1.5m investment it was scheduled to be open in the spring of 2020.

Less than four hours after the ribbon was cut, the first baby, a boy, was born gently and calmly into the birthing pool to proud new parents.

The Nest is our Midwifery-Led Unit (MLU) and the latest addition to the birth options available to the local women of the Warrington and Halton area, as well as across the northwest. The Nest offers four ensuite birth rooms, each with its own birthing pool and two having outside access to the garden area (which is still under development). The state-of-the-art rooms have been designed to promote active, upright labours in a calm and relaxed environment.

The equipment available reflects the ethos of promoting a normal physiological labour, utilising birthing couches, birthing stools, mats and positioning pillows. Specialist lighting, Bluetooth speakers and projectors allow personalisation of the space to help create a home-from-home feel.

If bright lights, hard surfaces, additional help or equipment is required, then these can all be provided at the flick of a switch.

There is a strong clinical rationale behind creating a calming subdued environment. The key hormone in labour, oxytocin, is a 'feel good' hormone that is released at times of happiness and when lighting is dim. In labour, rising levels of oxytocin cause the uterus to contract. Endorphins are also released during labour; these are the body's natural pain killers. Oxytocin powers the contractions and makes labour more efficient, whilst endorphins can help make labour more 'comfortable'.

We know that the transition into hospital during labour can be stressful and trigger the release of adrenaline. As adrenaline levels rise, these 'good' labour hormones can decrease, causing contractions to slow, or even disappear, disrupting the progress of labour.

A home-like birth unit alongside a traditional 'labour ward' is part of offering women choice.

To date, 42 babies have been born into the world in The Nest since it opened last month.

2.2.7 Opening of PACU at Halton Hospital's Captain Sir Tom Moore Buidling

On 13th January 2021 we opened our Post Anaesthetic Care Unit (PACU) at the Captain Sir Tom Moore (CSTM) Building on our Halton site. Taking just a few months from concept to completion this new four bed facility will allow us to improve the care for patients who are undergoing major surgery and support our strategy to transfer more elective surgery to CSTM and our 'green pathways' by providing the facilities needed to accommodate surgery for higher risk patients.

The PACU is equipped to provide enhanced Level 1.5 care including ECG, pulse oximetry, non-invasive and invasive blood pressure monitoring. There is an arterial blood gas machine, point of care blood glucose and haemoglobin monitoring. There is also access to emergency blood (O negative) and emergency intubation kit and drugs. Each bed has a vital signs monitor linked to a central monitor, volumetric pumps, syringe drivers and the oxygen capacity to support High Flow Nasal Oxygen therapy if required.

This was a 'pop-up' unit on its first opening, brought about the need to keep urgent and cancer surgery going despite the enormous pressures on critical care and Warrington Theatres that built further through January. As such, in just two days of its first opening it enabled four cancer patients (3 colorectal and 1 breast cancer) to go ahead with their surgery that almost certainly we would have struggled to do without further delay.

Potentially we could also share this facility within the CSTM Building with other trusts during the pandemic to support their urgent and cancer work in the spirit of mutual aid across Cheshire and Merseyside.

2.2.8 Home for Christmas Campaign

On Monday 7th December 2020, we launched our Home for Christmas campaign to tackle some of the significant patient flow issues we have experienced over the last few months. This initiative, supported by partner organisations, was to ensure more patients return home or on to their next care setting in time for Christmas. This was even more important this year with the additional the impact of the COVID-19 pandemic and the need to treat patients requiring inpatient care. This means that people who no longer require the care of an acute hospital should be supported to return home or step down into alternative provision in the community.

We know that the longer patients remain in hospital the worse their experience: 35% of 70-year-old patients experience functional decline during hospital admission in comparison with their pre-illness baseline; for people over 90 this increases to 65%; exposure to the risk of healthcare associated infections, now including COVID-19, as well as the emotional strain of a long hospital stay increases with time on both patients and their families.

Our challenge during Home for Christmas was to break the cycle and reset the system so we were in the best shape possible for Christmas and New Year.

Overall an additional 89 patients were able to be 'home for Christmas' because of this campaign.

2.2.9 Special Days/Weeks for professional groups

Since our last Board meeting in November, 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 in equal measure.

It has once again been a busy couple of months, reflecting the depth, breadth and diversity of WHH in terms of healthcare delivery in our communities. These include:

Nursing Support Workers Day – 23rd November 2020
Clinical Audit Awareness Week – 23rd to 27th November 2020
World AIDS Day – 1st December 2020
International Day of Persons with Disabilities – 3rd December 2020

2.2.10 Local political leadership communication

Over the last two months 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. This is extremely important and helpful in the whole system response to the pandemic. I have also continued to be in regular dialogue 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.

2.2.11 Employee Recognition

During the COVID-19 pandemic the WHH employee recognition scheme (*Employee of the Month and Team of the Month)* has been temporarily suspended.

Chief Executive Award (December 2020): Patient Flow Team

The Patient Flow Team have been operating in an extremely challenging patient flow environment thoughout the pandemic, but especially through waves 2 and 3 when bed constraints, segregation and infection control issues are very difficult. This has required absolute diligence and an attention to detail like never before.

Chief Executive Award (December 2020): Complaints Team

This award was made for the extra hard work and success in complaints resolution during the COVID-19 pandemic. Our Complaints Team have worked tirelessly in the background throughout the pandemic to reduce the backlog of open complaints to 60, working around the clinical teams to ensure they are not needlessly diverted away form front-line care, whilst at the same time as not delaying responses to complainants.

Chief Executive Award (December 2020): Linda Henshall and Gemma York

Linda and Gemma have been recognised for all their hard work on the medical rotas which have taken on new layers of complexity during the pandemic as well as short notice changes to increase our capacity for medical cover, especially out-of-hours.

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

The following members of staff have also been recognised:

- Alex Leather, Porter Halton CSTM Theatres
- Vicky Neville, Sister ITU
- Tom Coalbran, RRT Business Manager
- Dr Rita Arya, Associate Clinical Director, Women's & Children's Health
- Graham Marshall, Manager - Microbiology
- Rachel Clint, EPRR Manager
- John Boileau, Head of Strategy & Partnerships
- David Merriman, Ward Manager - Combined Assessment Unit
- Sue Lewis, Ward Manager - Ward A6
- Lesley O'Hara & Team, Nurse Manager -Ophthalmology
- Gail Wilson, Housekeeper - Finance & Procurement
- Paul Coates, Security Officer
- Jan Adamson, Cancer Nurse Specialist - Breast Team
- Rachel Lamb & Team, Matron, Urgent & Emergency Care
- Anais Mason & Team, Ward Manager - Ward A8
- Nemonie Marriott & Team, R&D Manager
- Caroline Martin, Midwife
- Dr Clara Carpenter, ST7 O&G

- Grace Fellows, Student Midwife
- Danielle Hogg, Advanced Radiographer
- Naomi O'Prey, Advanced Radiographer
- Ellie Kerr, Sister B12

3) MEETINGS ATTENDED/ATTENDING

The following is a summary of key external stakeholder meetings I have attended in December 2020 and January 2021 since the last Trust Board Meeting (meetings generally taking place via conference call or MS Teams). It is not intended to be an exhaustive list.

- North West Coast Vaccine Alliance Steering Group (Biweekly, now monthly)
- NHSE/I COVID-19 System Leadership (Weekly)
- Warrington & Halton COVID-19 Health Protection Board (Biweekly)
- C&M CEO Provider Group Calls (Biweekly)
- C&M Medical Directors Clinical Prioritisation & Mutual Aid meeting (Weekly)
- NHS 111 Oversight Group (Monthly)
- Update calls with our local MPs: Andy Carter MP, Charlotte Nichols MP, Derek Twigg MP, Mike Amesbury MP
- 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
- Colin Scales, Chief Executive, Bridgewater Community Health NHSFT
- C&M Hospital Cell (Weekly)
- C&M Gold Command (Daily)
- NW Hospital Cell Gold Command (Twice weekly)

4) RECOMMENDATIONS

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

WHH COVID-19 Vaccination Programme
Priority Group Report
25th January 2021

1 Scope

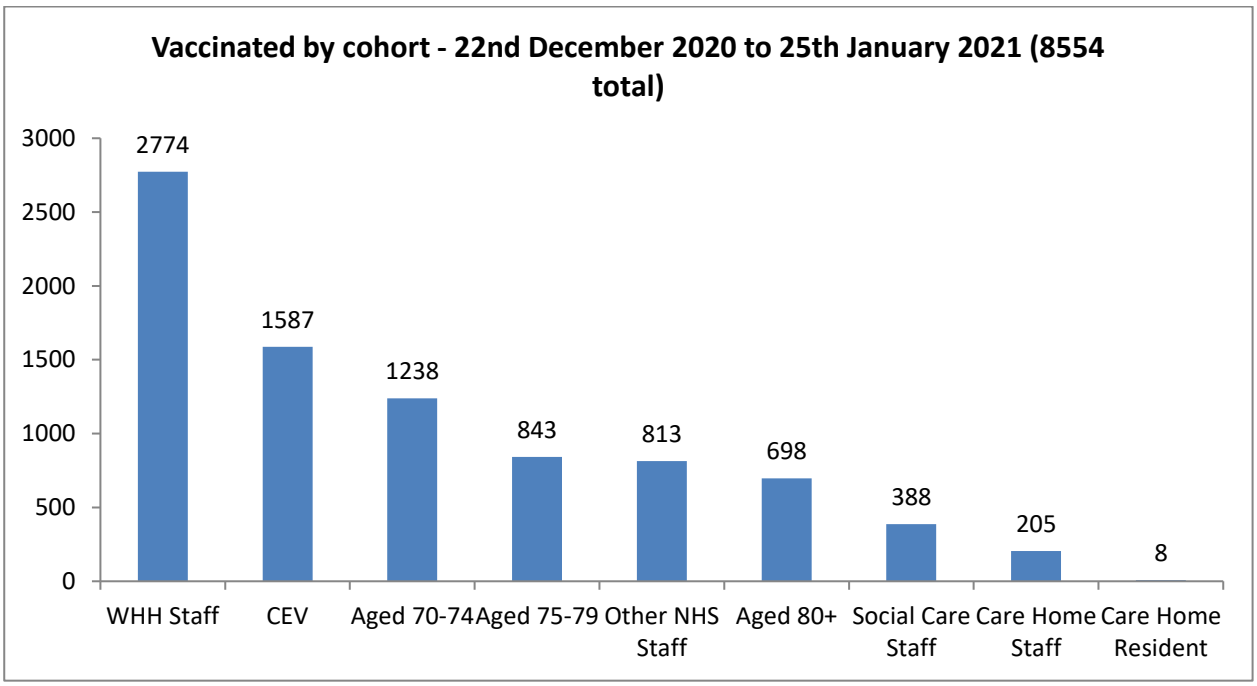
This report covers all 8554 vaccinations confirmed in the National Immunisation Management System (NIMS) carried out at Warrington between 22nd December 2021 and 23rd January 2021. In sections 3 and 4 it includes 113 vaccinations carried out on the morning of 25th January 2021 when the report was run.

2 Priority Groups

Priority	Risk group
1	Residents in a care home for older adults and staff working in care homes for older adults
2	All those 80 years of age and over and frontline health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over and clinically extremely vulnerable individuals (not including pregnant women and those under 16 years of age)
5	All those 65 years of age and over
6	Adults aged 16 to 65 years in an at-risk group (see below)
7	All those 60 years of age and over
8	All those 55 years of age and over
9	All those 50 years of age and over
10	Rest of the population (to be determined)

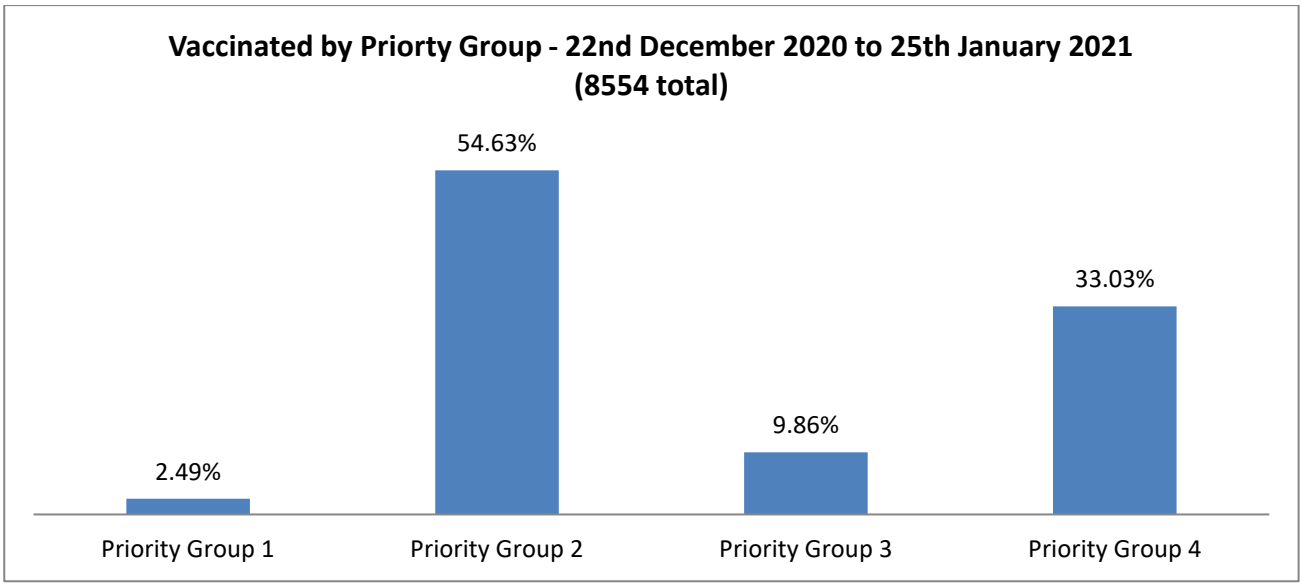
3 Summary of those vaccinated – Cohorts

Group	Priority Group	Number Vaccinated	Number Vaccinated (%)
WHH Staff	2	2774	32.4%
CEV	4	1587	18.6%
Aged 70-74	4	1238	14.5%
Aged 75-79	3	843	9.9%
Other NHS Staff	2	813	9.5%
Aged 80+	2	698	8.2%
Social Care Staff	2	388	4.5%
Care Home Staff	1	205	2.4%
Care Home Resident	1	8	0.1%
Grand Total		**8554**	**100.0%**



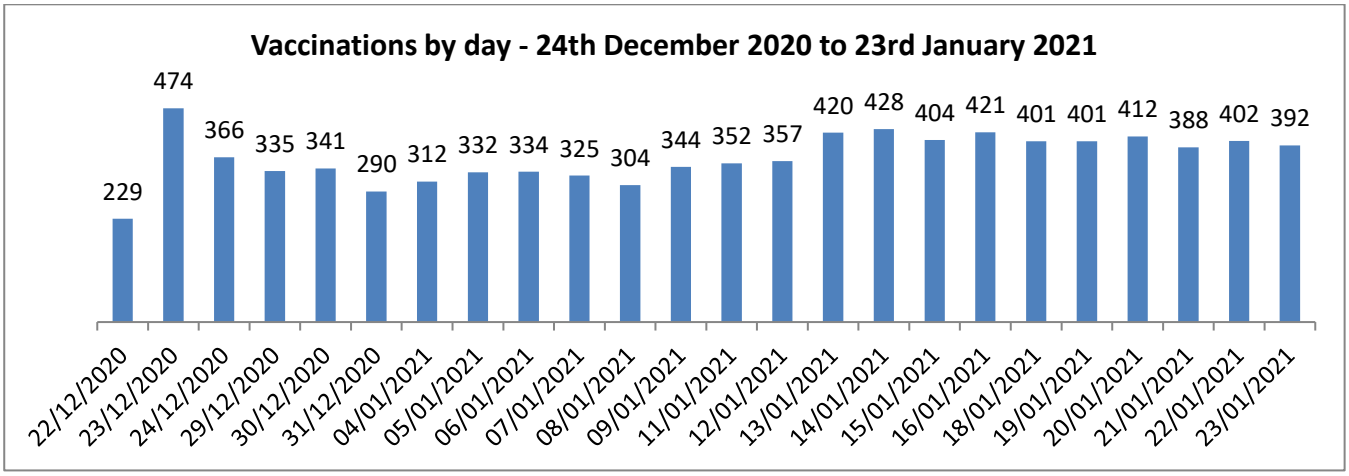
4 Summary of those vaccinated – Priority Groups

Priority Group	Number	Percentage
Priority 1	213	2.49%
Priority 2	4673	54.63%
Priority 3	843	9.86%
Priority 4	2825	33.03%
	8554	**100.00%**



5 Vaccinations by Date

Date	Daily Vaccinations	Cumulative Vaccinations
22/12/2020	229	229
23/12/2020	474	703
24/12/2020	366	1069
29/12/2020	335	1404
30/12/2020	341	1745
31/12/2020	290	2035
04/01/2021	312	2347
05/01/2021	332	2679
06/01/2021	334	3013
07/01/2021	325	3338
08/01/2021	304	3642
09/01/2021	344	3986
11/01/2021	352	4338
12/01/2021	357	4695
13/01/2021	420	5115
14/01/2021	428	5543
15/01/2021	404	5947
16/01/2021	421	6368
18/01/2021	401	6769
19/01/2021	401	7170
20/01/2021	412	7582
21/01/2021	388	7970
22/01/2021	402	8372
23/01/2021	392	8764



We are WHH & We are PROUD to make a difference

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Report to the Board of Directors

AGENDA REFERENCE:	**BM 21/01/06**		
SUBJECT:	**COVID-19 Performance Summary and Situation Report**		
DATE OF MEETING:	27th January 2021		
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 through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x x x	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	1126 – Failure to provide the required levels of oxygen for ventilators caused by system constraints, resulting in a lack of adequate oxygen flow at outlets. 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 Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily COVID-19 Executive Summary which outlines key information pertinent to the command and control of the situation. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where possible. This is the eighth iteration of this report which is part of the continuing development of understanding of demand, capacity and outcomes that will determine future strategic planning. Data up to 23rd January 2021 is included.		
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board 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)***	None			

We are WHH & We are PROUD to make a difference

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS

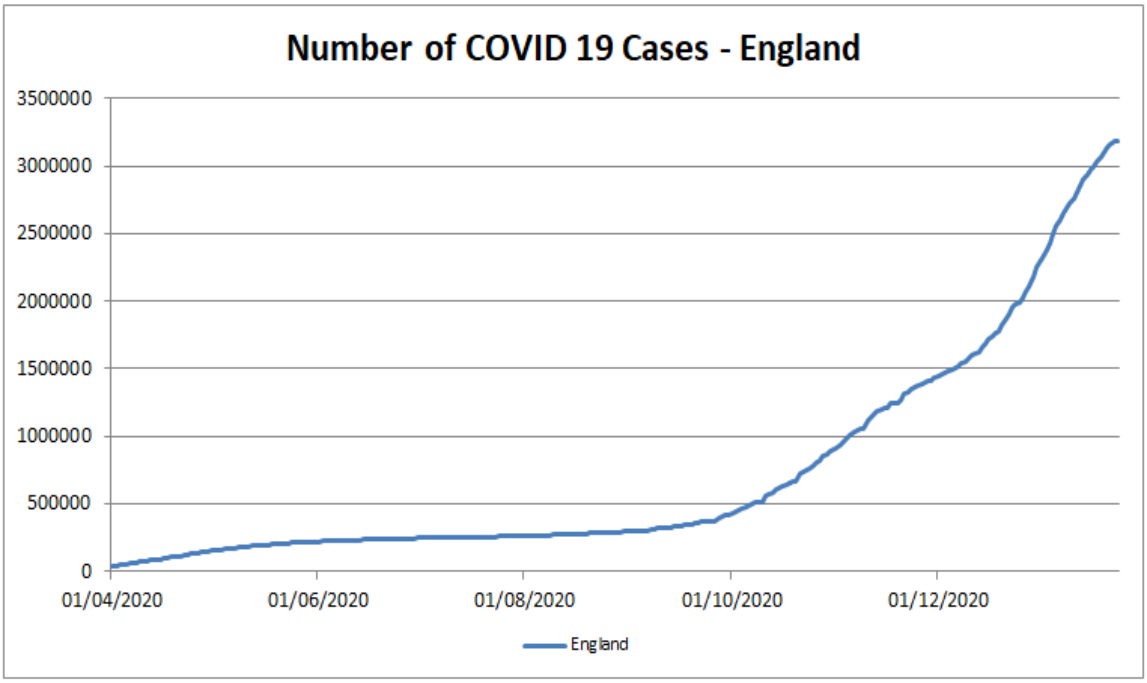
SUBJECT	COVID-19 Performance Summary and Situation Report	**AGENDA REF:**	**BM 21/01/06**

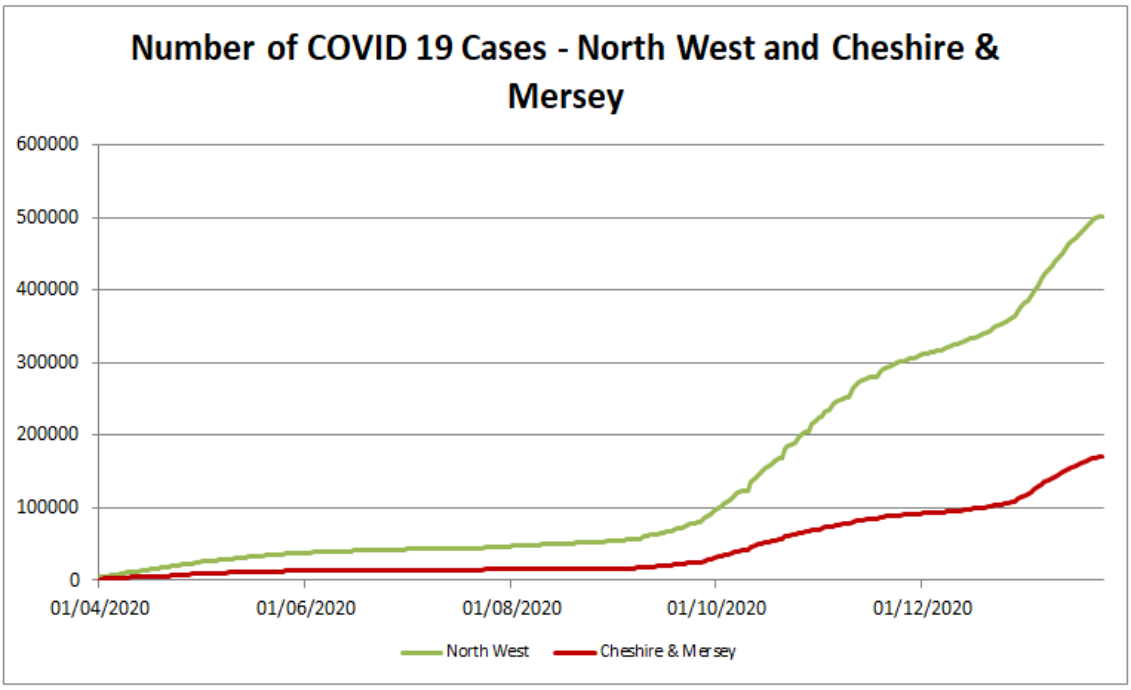
1. BACKGROUND/CONTEXT

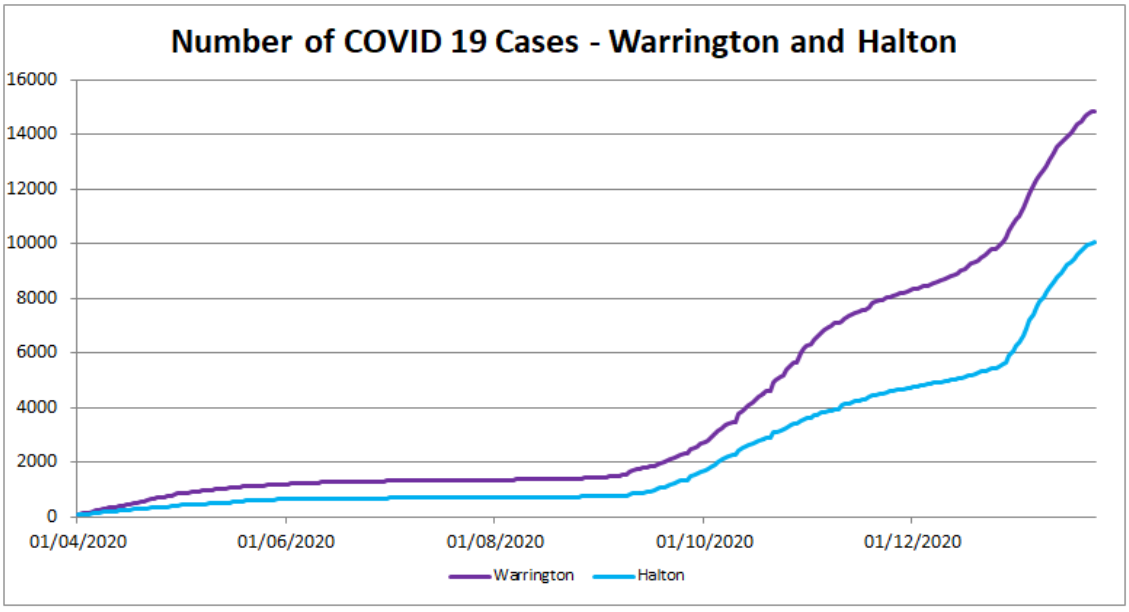
The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily COVID-19 Executive Summary which outlines key information pertinent to the command and control of the situation. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where possible. This is the eighth iteration of this report which is part of the continuing development of understanding of demand, capacity and outcomes that will determine future strategic planning. Data up to 23rd January 2021 is included.

2. KEY ELEMENTS

2.1 Number of Reported Cases



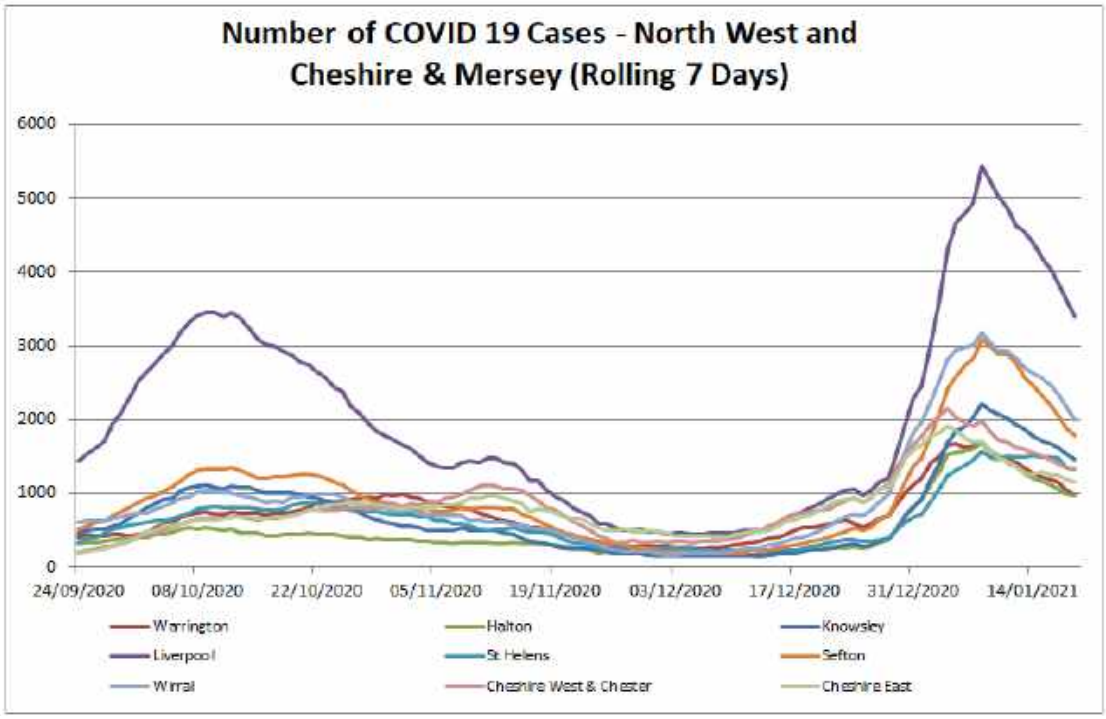


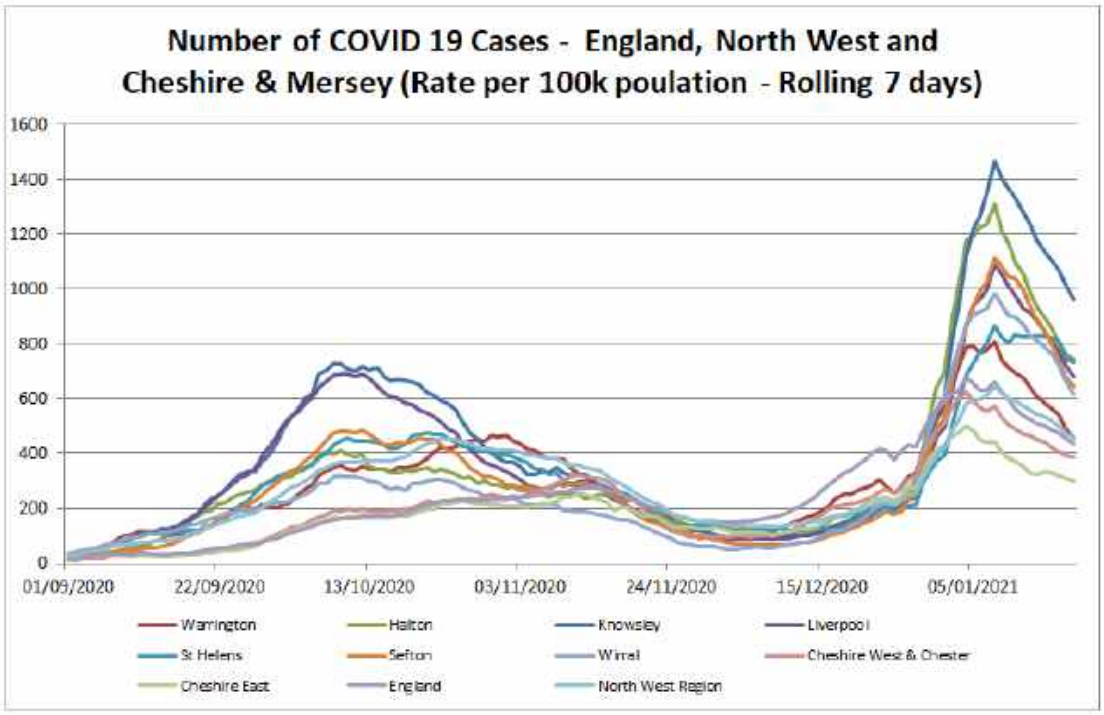


Narrative: As of 23/01/2021, there were 14,869 cases (from 7,865 on 21/11/2020) of confirmed COVID-19 reported in Warrington and 10,043 (from 4,474 on 21/11/2020) cases reported in Halton. The sharp risk which started in October has continued through November & December. The Trend is in line with Cheshire & Mersey and the North West positions, however the increase is greater than the England average.

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

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

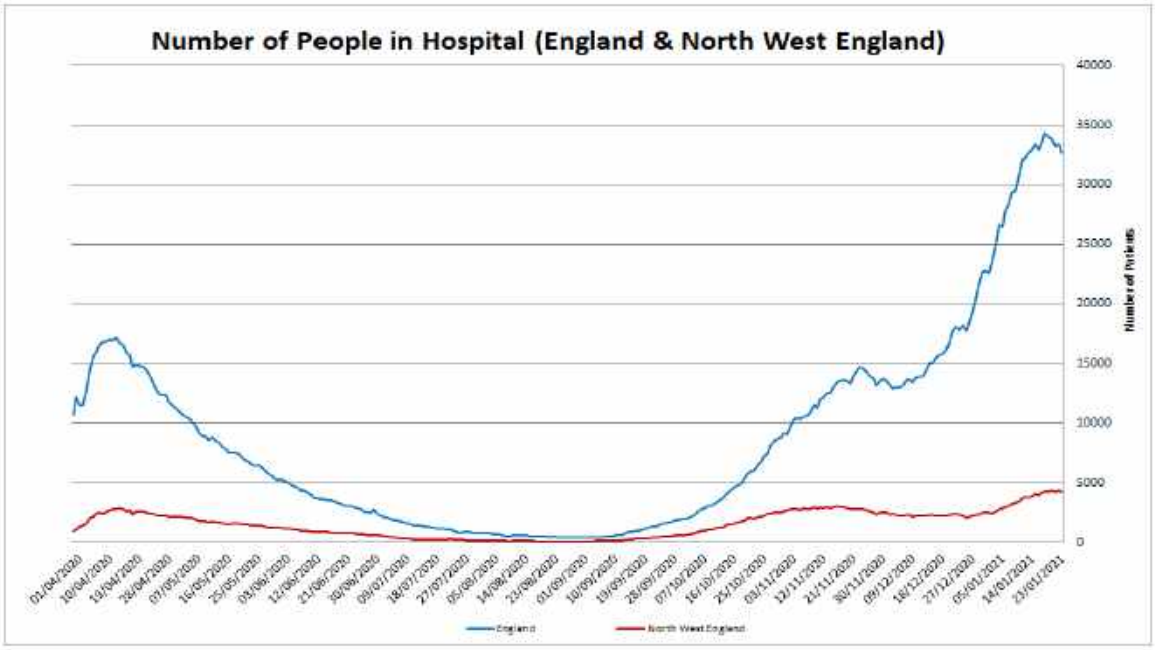


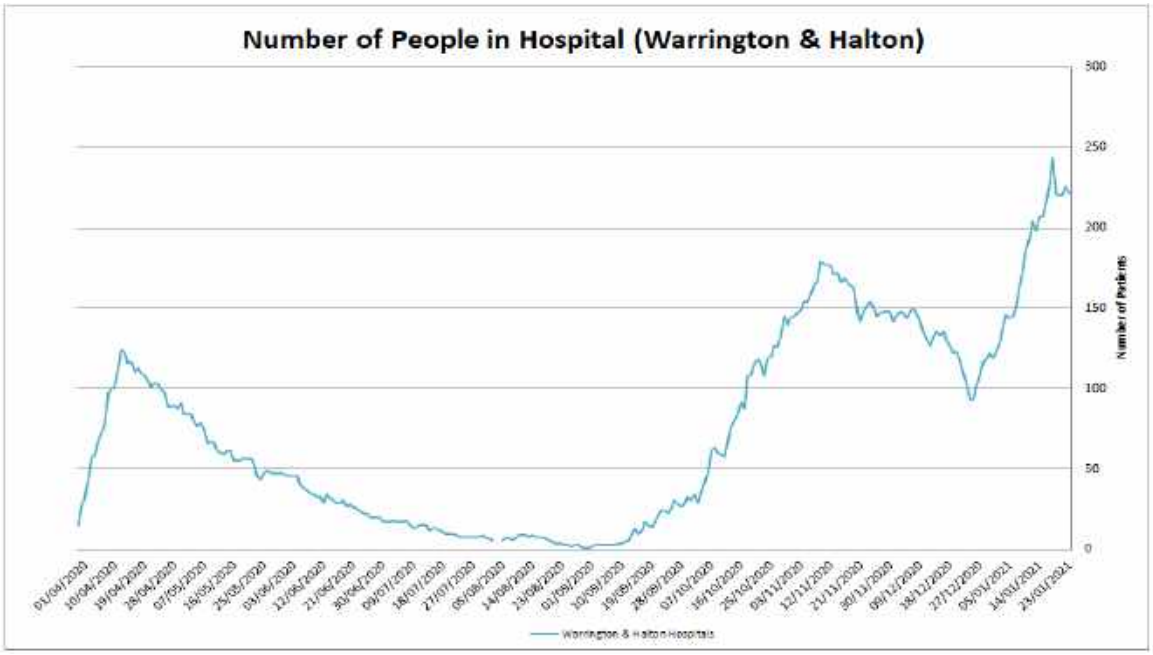


Narrative: The graphs show the infection count and rates per 100k population over a rolling 7 day period. This is a fairer comparison than total number of cases due to the different populations. The data does show signs of a decline in infections over the last full 7 day reporting period. As at 19/01/2021 (the latest data period for this indicator) Warrington had 456 cases per 100k population which is in line with the North West (455 cases/100k population) and England (437 cases/100k population. However, Halton has reported 745 cases per 100k population.

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

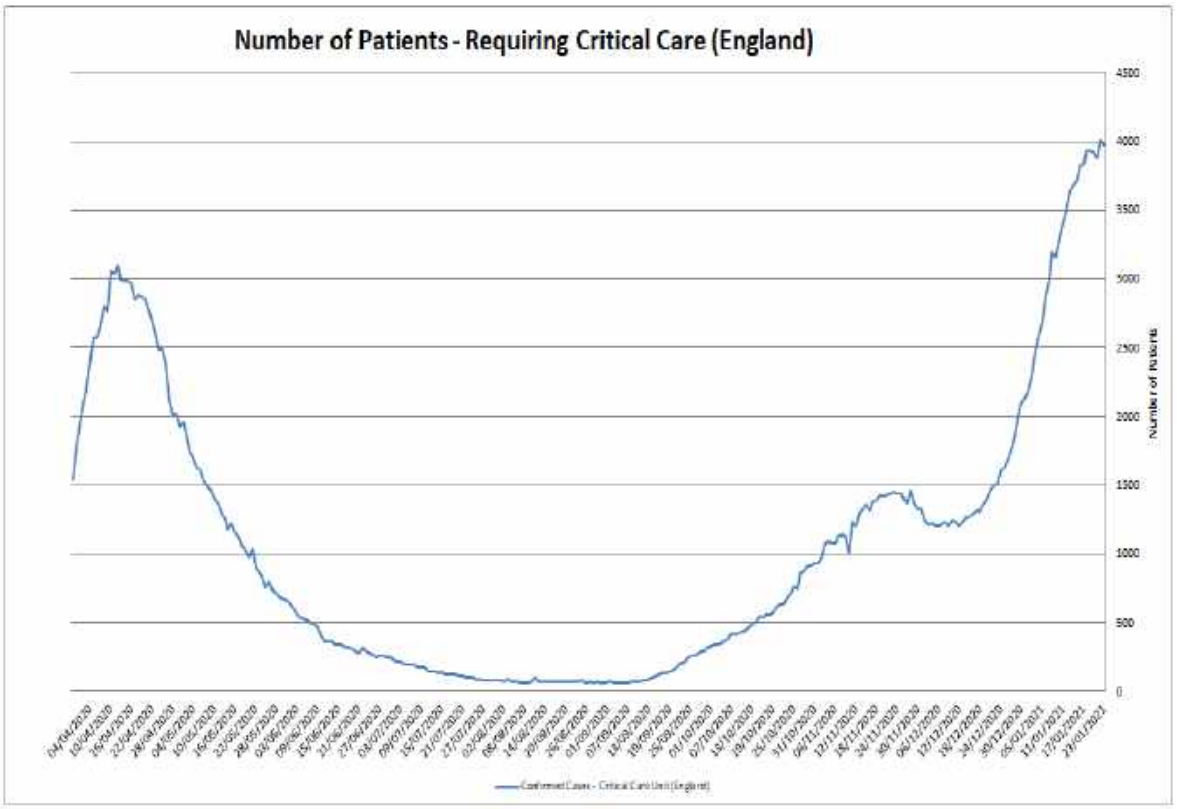
2.3 Number of People in Hospital

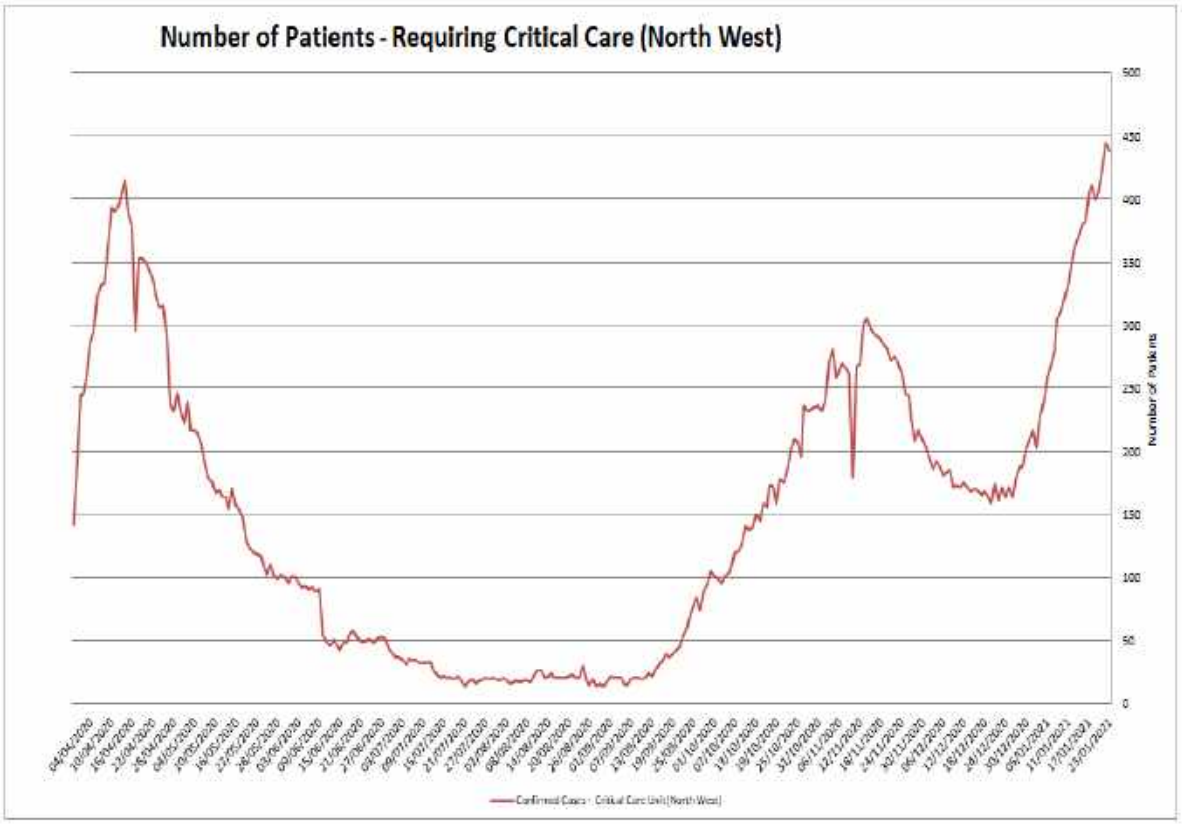


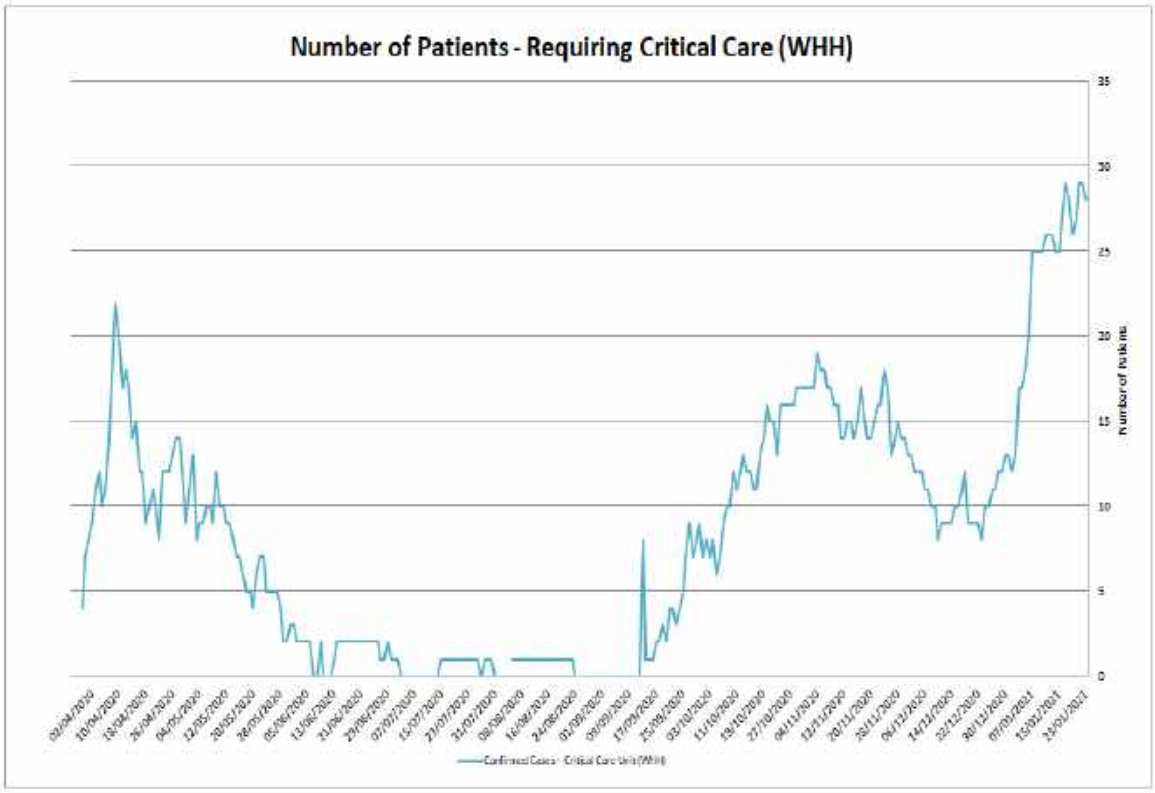


Narrative: As of 23/01/2021, there were 222 inpatients being treated by the Trust with confirmed COVID-19 (from 142 on 21/11/2020). On 26/10/2020, the Trust surpassed the peak of the first wave (124 patients on 12/04/2020), this continued to a peak of 179 patients on 09/11/2020. This second wave peak was exceeded on 10/01/2021 and continued to a peak of 243 patients on 18/01/2021. The positions all show the beginning of a reduction in the number of people in hospital.
Source:https://www.gov.uk/government/collections/slides-and-datasets-to-accompany-coronavirus-press-conferences (England & North West) and Trust Data (Warrington & Halton).

2.4 Number of Patients Requiring Critical Care





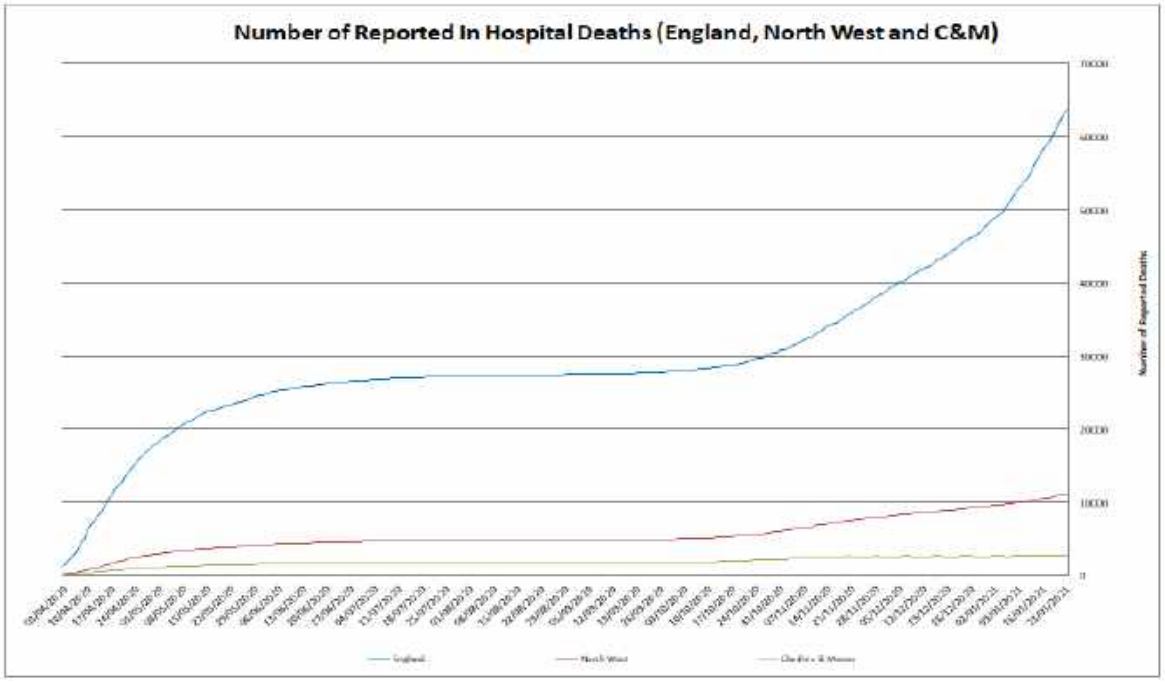


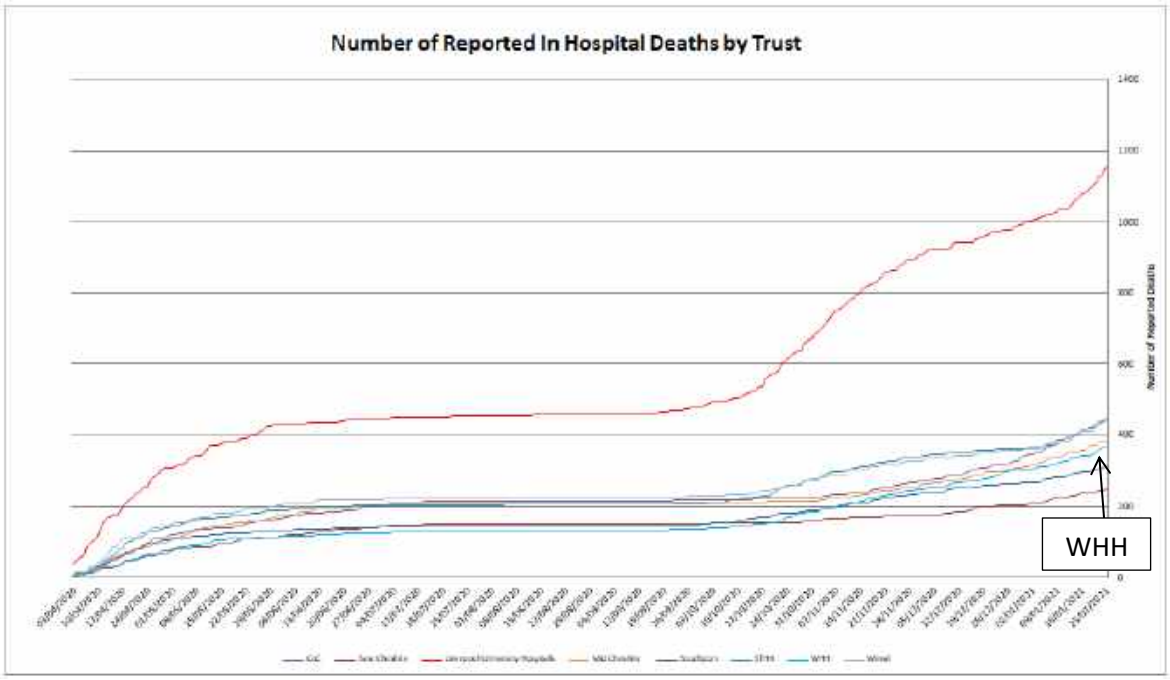
Narrative: As of 23/01/2021, there were 28 inpatients with confirmed COVID-19 and 0 inpatients with suspected COVID-19 in critical care (from 15 confirmed cases and 0 suspected cases on 21/11/2020). The Trust surpassed the peak (22 patients on 09/04/2020) of the first wave of critical care patients on 08/01/2021 with 25 patients. This peaked on 22/01/2021 with 29 patients in critical care.

The non-COVID-19 burden on critical care has been significant and WHH has been one of the most escalated trusts from a critical care perspective in wave 2.

Source: National SITREP data (England & North West) and Trust Data (Warrington & Halton).

2.5.1 Number of In-Hospital Deaths





Narrative: As of 23/01/2021, the Trust had reported 381 deaths of inpatients with confirmed COVID-19 (from 244 on 21/11/2020). The trend is in line with the North West and Cheshire & Mersey positions.

Notes: There is a time lag between the date 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

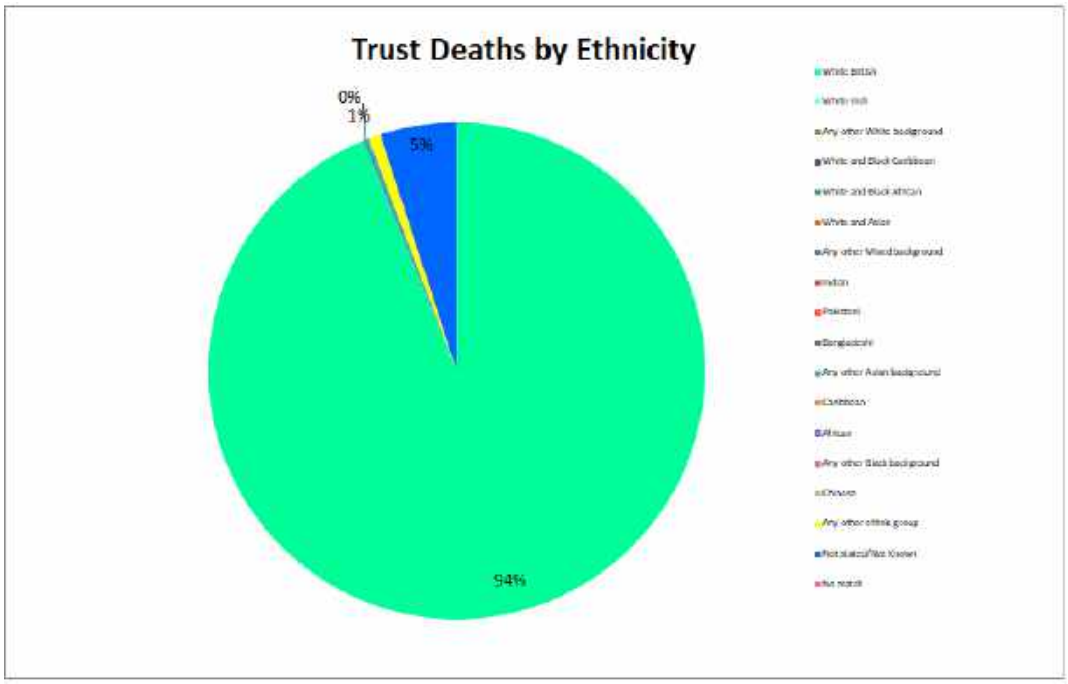
	2019	2020
December (All Deaths)	96	107
December (Non COVID)	96	52
December (COVID)		55
% COVID Deaths (of all deaths)		51.4%
Discharges	6352	4241
Crude Mortality (deaths divided by deaths+discharges)	1.5%	2.5%

	Wave 1 Apr-Aug 2020	Wave 2 Sept-Dec 2020
All Deaths	405	402
Non-COVID	272	228
COVID	133	174
% COVID Deaths (of all deaths)	32.8%	43.3%
Discharges	19328	17242
Crude Mortality (deaths divided by deaths+discharges)	2.1%	2.3%
Crude Mortality COVID-19 (COVID-19 deaths divided by COVID-19 deaths+ COVID-19 discharges)	25.2%	20.1%

Narrative: Crude mortality in December 2020 was 2.5% compared with 1.5% in December 2019. Crude mortality was 2.1% in wave 1 and 2.3% in wave 2 with Crude mortality for COVID-19 patients 25.1% in wave 1 and 20.1% in wave 2.

Source: Trust Data.

2.5.3 Number of In Hospital Deaths (Ethnicity)

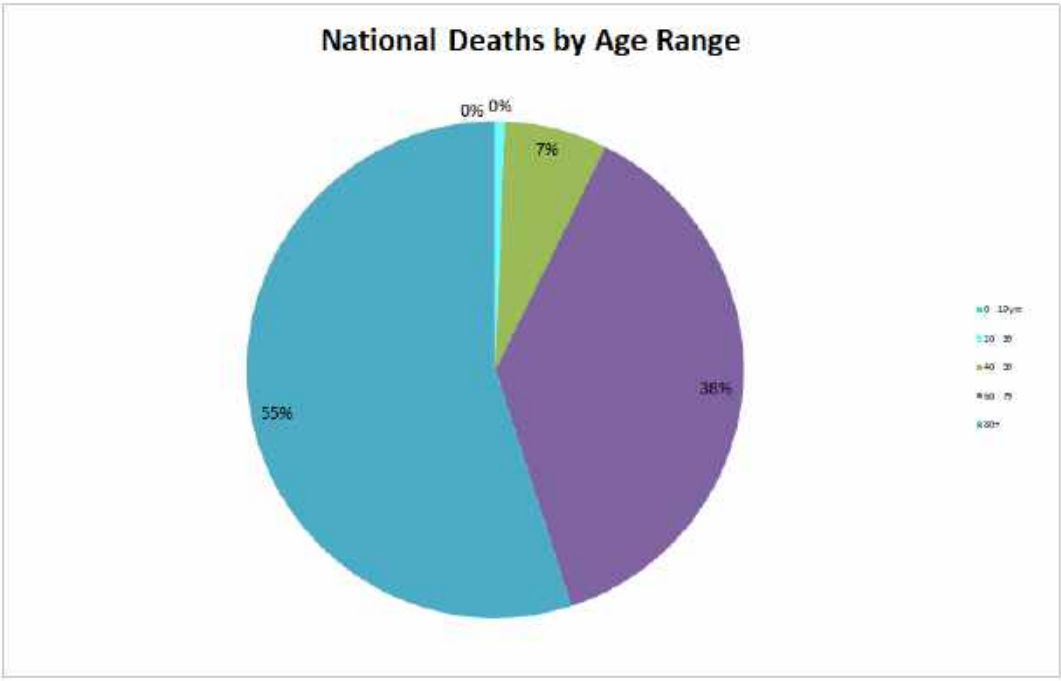


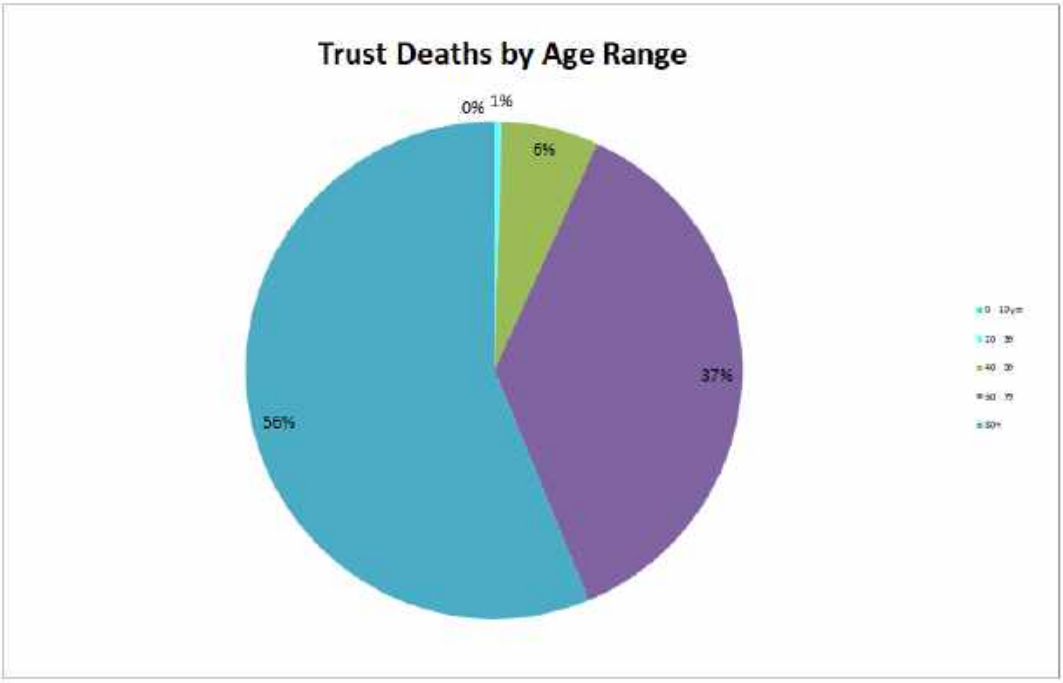
Narrative: As of 23/01/2021, 357 of the 381 reported deaths were patients who identified as "White British", with 19 patients' ethnicity "Not Stated/Not Known", 2 patients' ethnicity stated as "Any Other Ethnic Group", 2 patients stated as "Asian" or "Asian British" and 1 patient identified as "White 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)



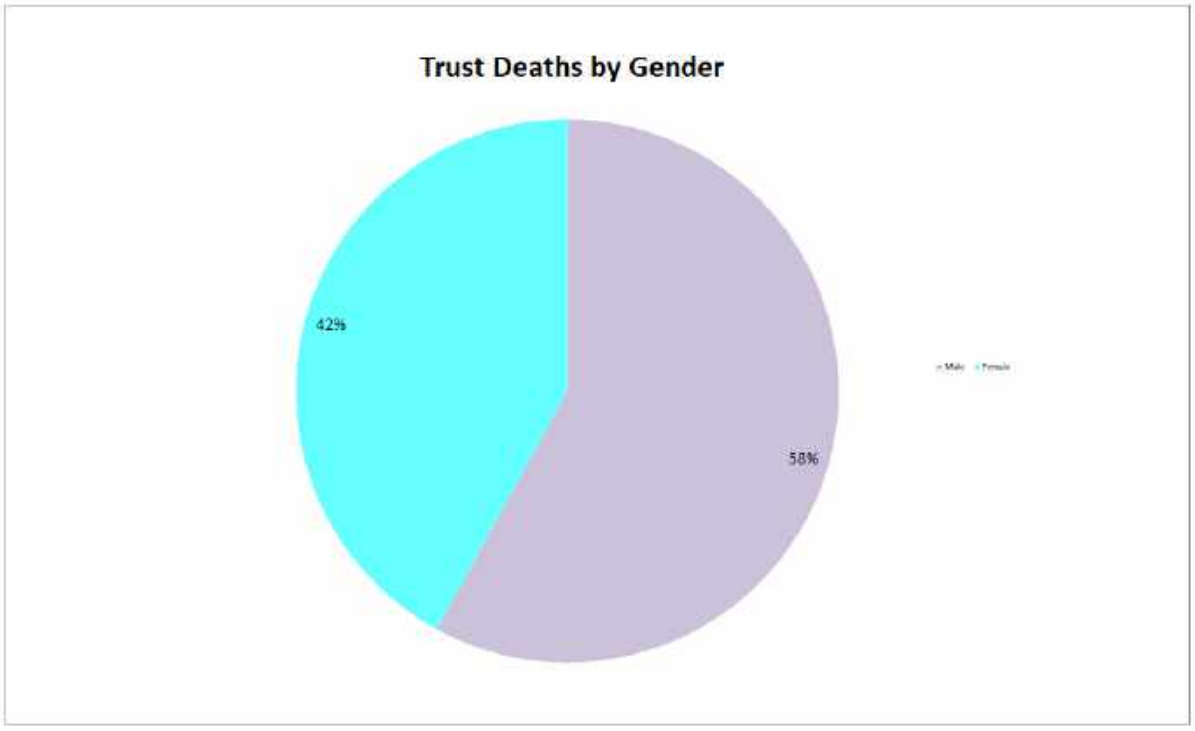


Narrative: As at 23/01/2021, 93.2% of COVID-19 related deaths were inpatients over the age of 60, which is line with the national position. The average age of death was 79 years.

Notes: Data utilised is for the date each death was reported, not the date 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)

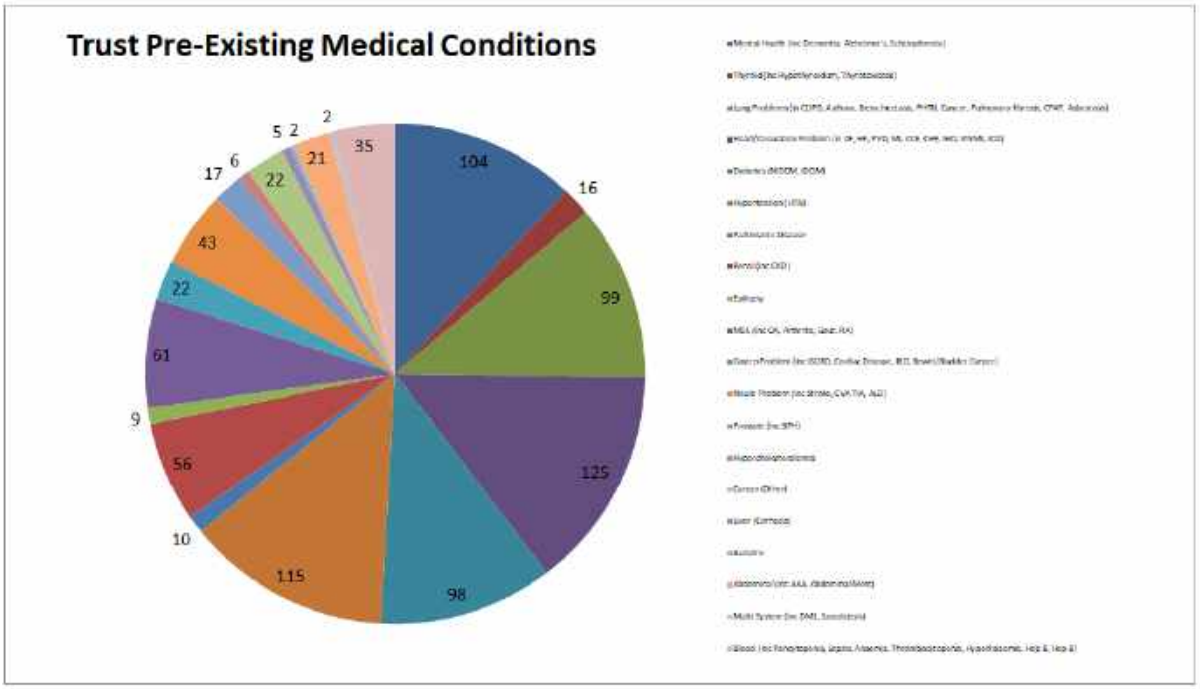


Narrative: As at 23/01/2021, 58.0% of COVID-19 deaths were male patients and 42% of deaths were female patients.

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



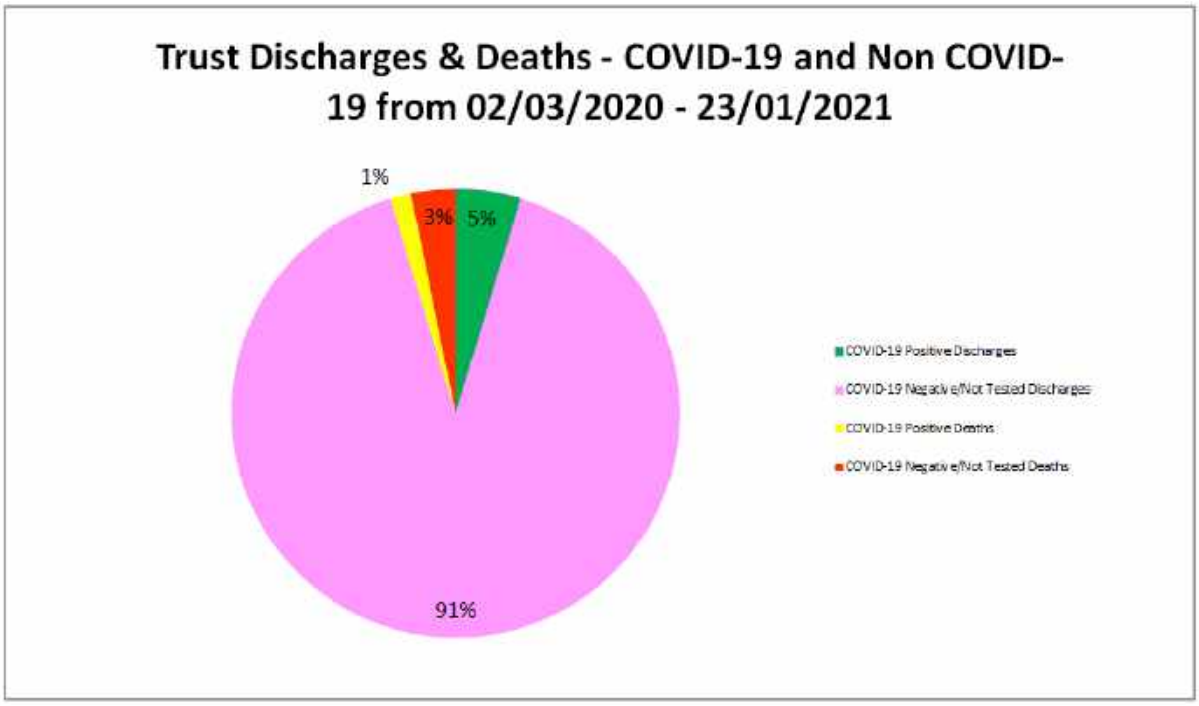
Narrative: As at 23/01/2021, 89.0% of Trust inpatients who have died as a result of COVID-19 had a pre-existing medical condition recorded. The most common of these were Heart and Lung conditions in additional diabetes and organic mental health conditions such as Dementia and Alzheimer's.

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 and is not coded data, therefore there maybe some omissions.

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

2.6 Trust Outcomes

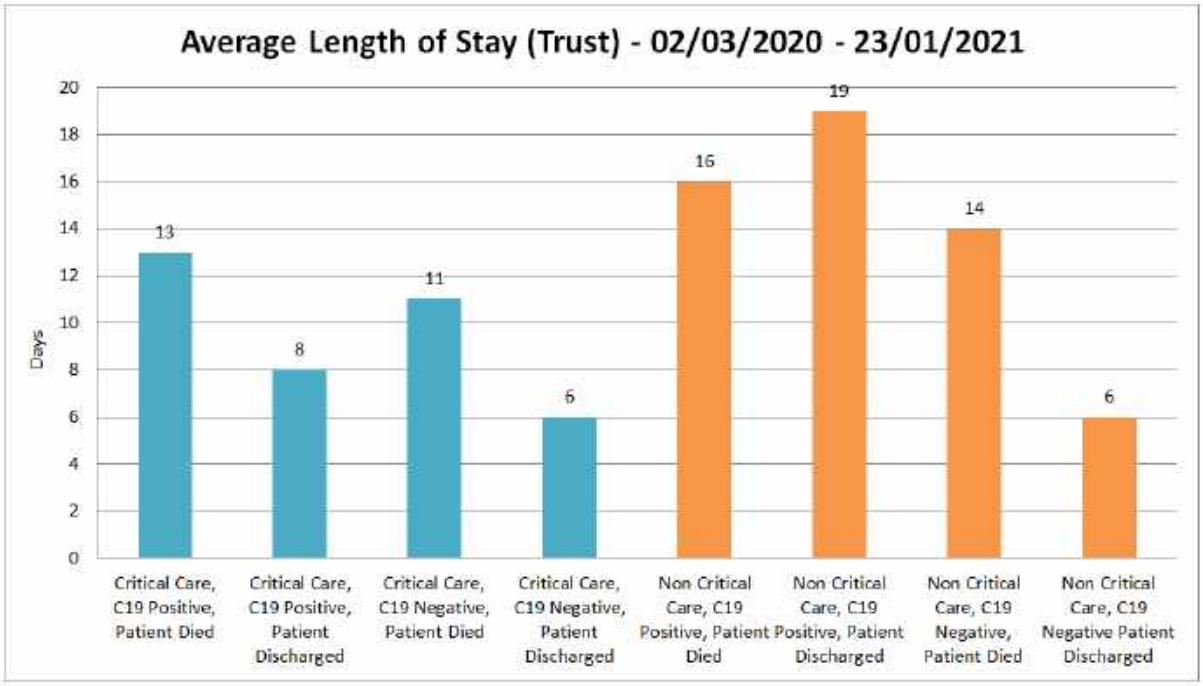


Narrative:

- Between 02/03/2020 – 23/01/2021, the Trust treated 21,500 inpatients (any patient with at least 1 night stay).
- 1,664 (7.74%) inpatients had tested positive for COVID-19.
- 95.41% of all patients were discharged from hospital.
- There were a total of 986 inpatients (all causes) who have died; this represents 4.59% of all inpatients.
- 381 inpatient deaths were related to COVID-19 which represented 1.77% of all inpatients and 38.74% of all inpatients who had tested positive for COVID-19.
- 82 patients who have died and who had tested positive for COVID-19 were admitted from a care home, 4.92% of all COVID-19 positive inpatients.

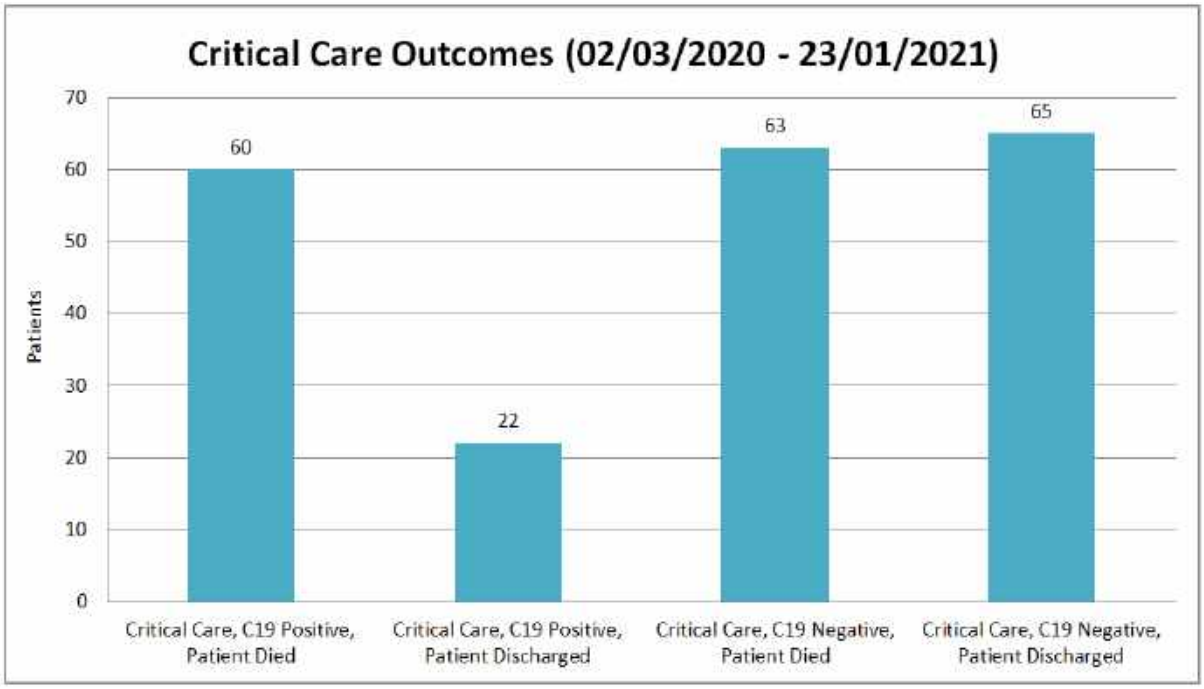
Source: Trust Data

2.6.1 Average Length of Stay



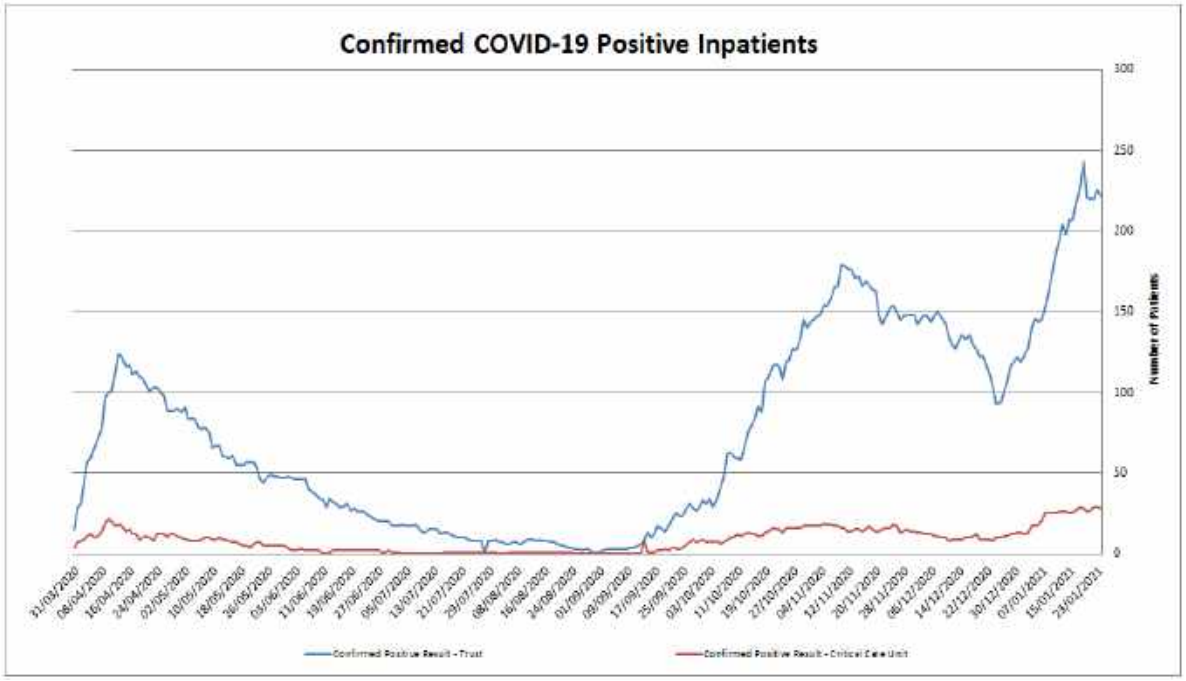
Narrative: From 02/03/2020 - 23/01/2021, the average length of stay for patients who had tested positive for COVID-19 was - 12 days in critical care, 18 days non-critical care.
Source: Trust Data

2.6.2 Critical Care Outcomes



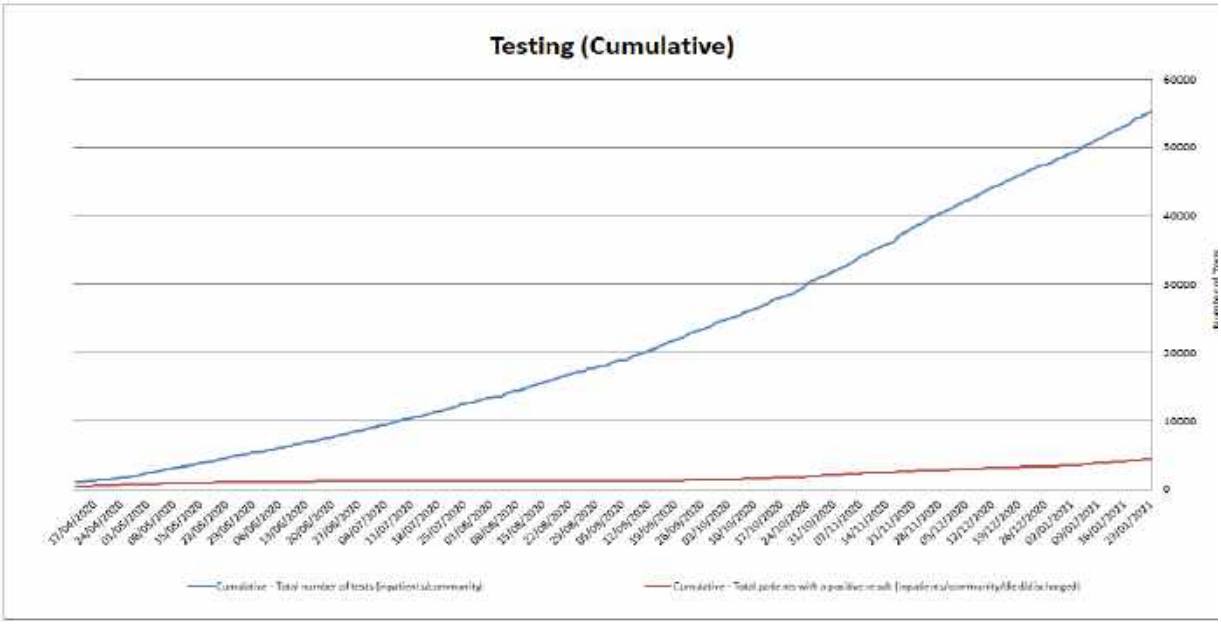
Narrative: From 02/03/2020 – 23/01/2021, there were 123 critical care inpatient deaths (60 COVID-19, 63 Non-COVID-19) and 87 critical care inpatient discharges (22 COVID-19, 65 Non-COVID-19).
Source: Trust Data

2.7 Confirmed Positive COVID-19 Patients



Narrative: As of 23/01/2021, there were 222 confirmed COVID-19 positive inpatients with 28 patients in critical care. The increase is expected given the increase in cases, however there are signs that this has peaked and is reducing in line with the national position.

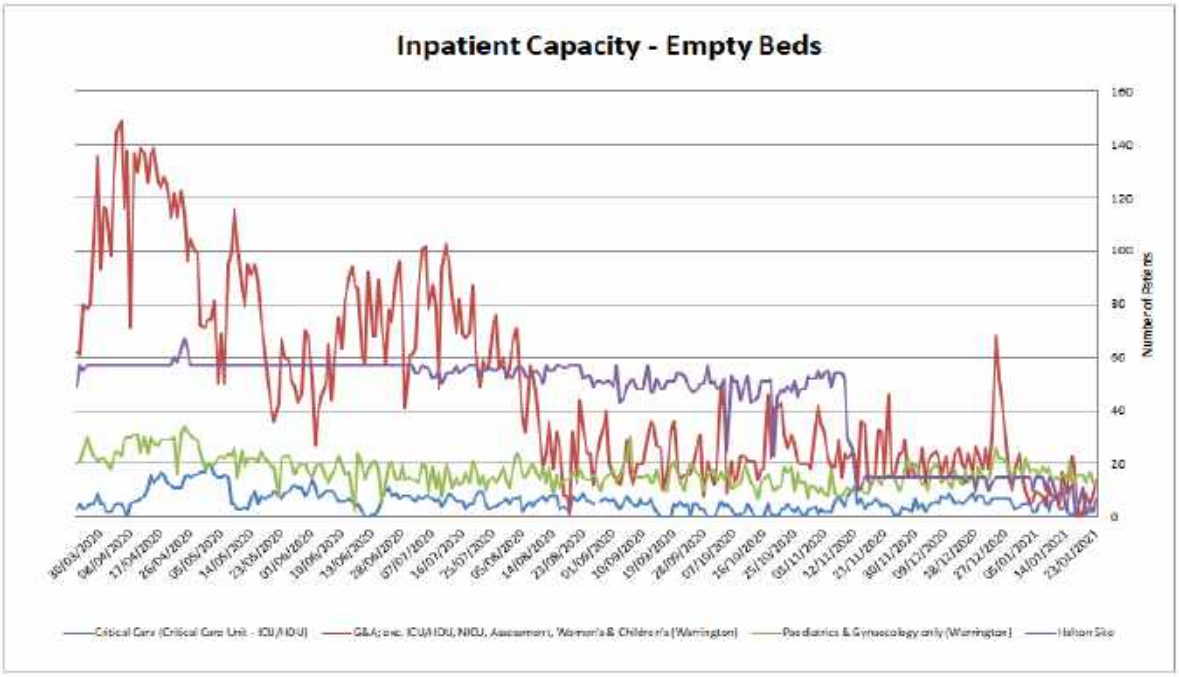
2.8 COVID-19 Testing



Narrative: As of 23/01/2021, 55,110 patients (inpatients & community) have been tested and 5,612 staff tests have been carried out (internally). Of the 55,110 patients tested, 4,329 (7.85%) patients have tested positive.

Source: Trust Data

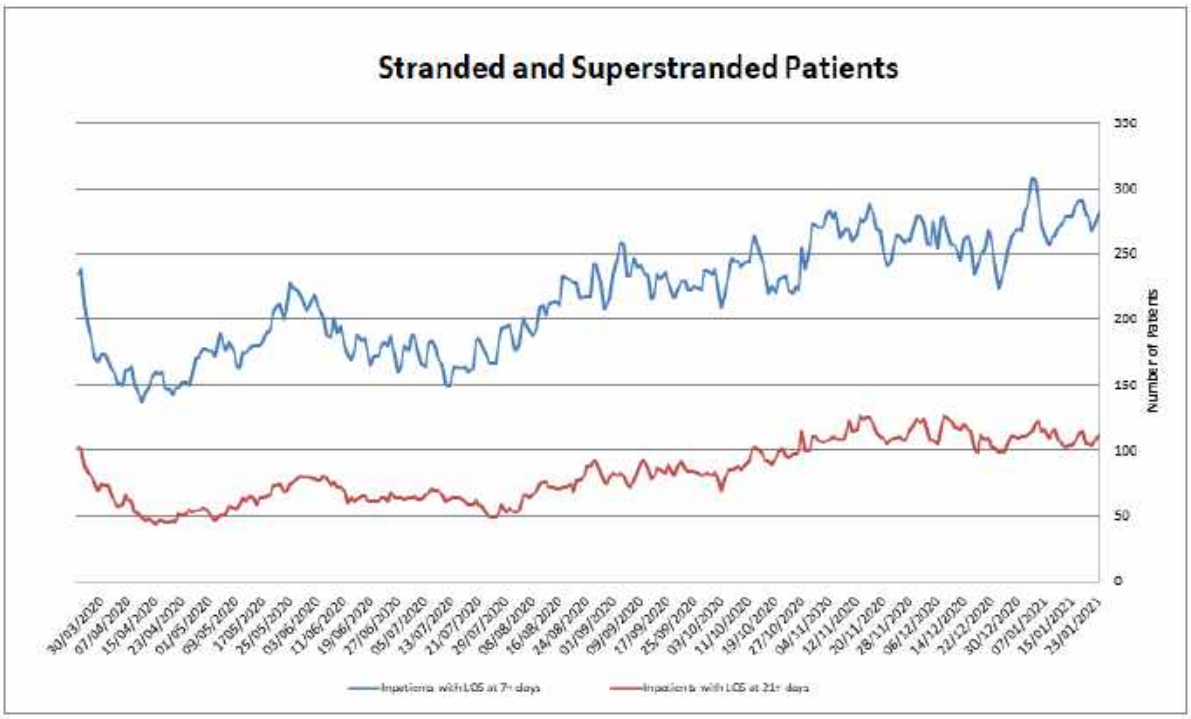
2.9 Capacity/Empty Beds



Narrative: Critical care capasity has been escalated to include Theatre areas and therefore there has been at least 1 bed available.

Source: Trust Data

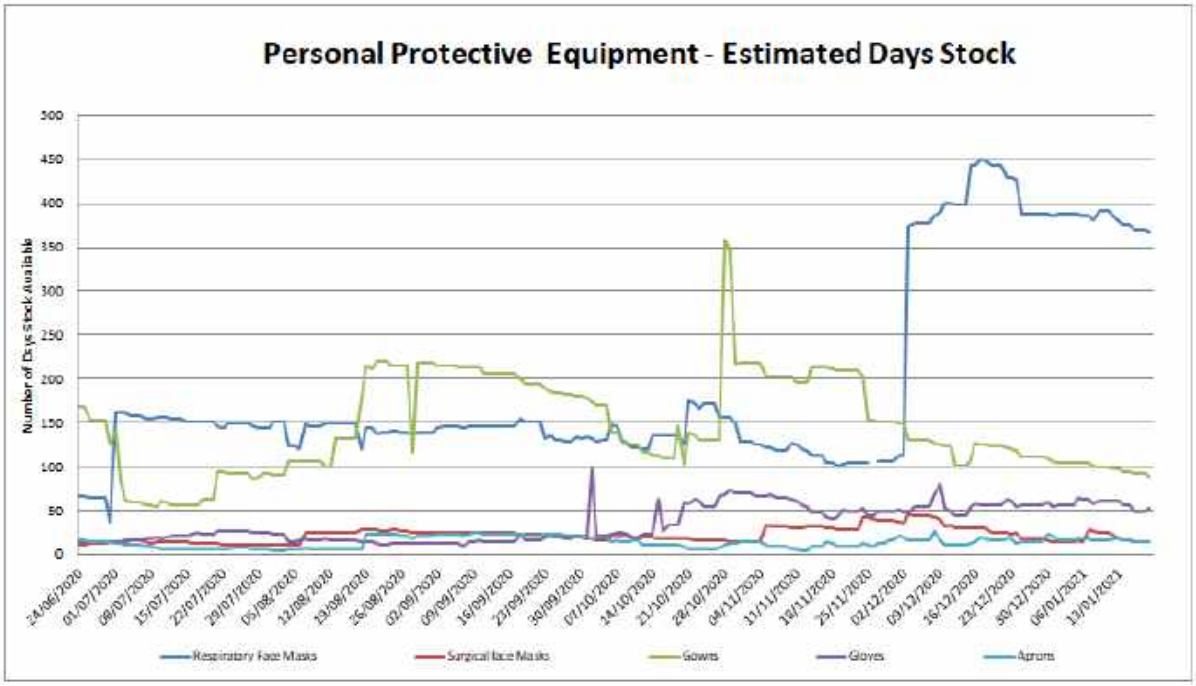
2.10 Stranded/Super Stranded Patients



Narrative: On 23/01/2021, there were 282 Stranded and 112 Super Stranded patients.

Source: Trust Data

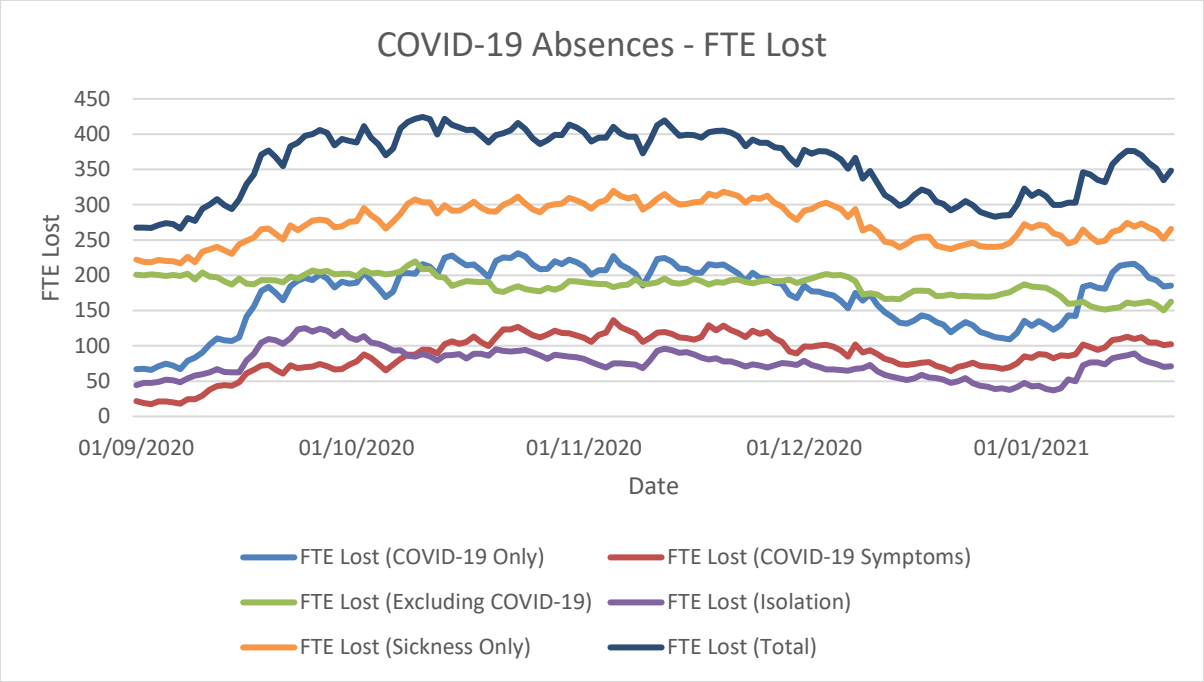
2.11 Personal Protective Equipment (Stock Days)

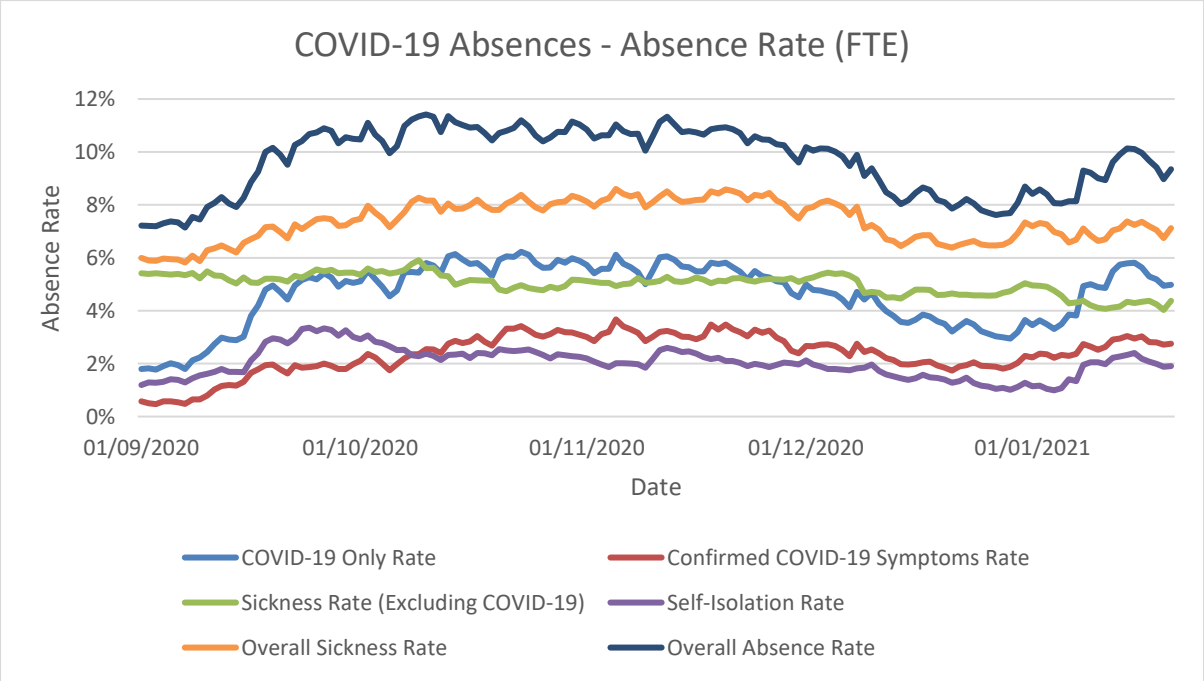


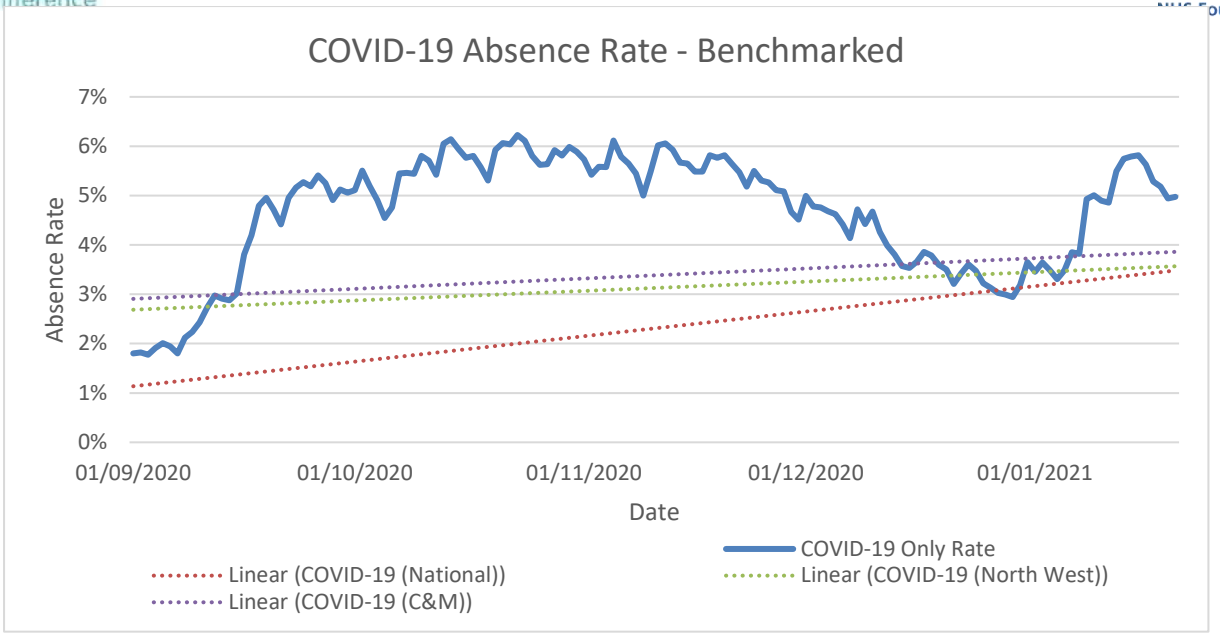
Narrative: The Trust had a minimum stock level of 14 days for all items of PPE as of 23/01/2021.

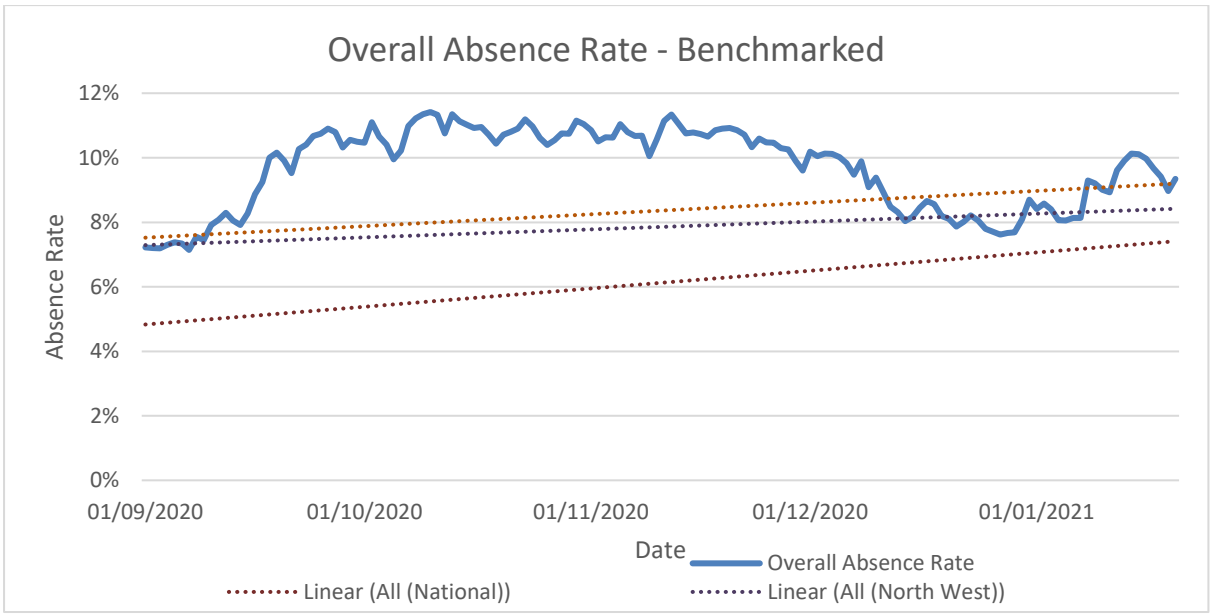
Source: Trust Data

2.12 Staff Sickness







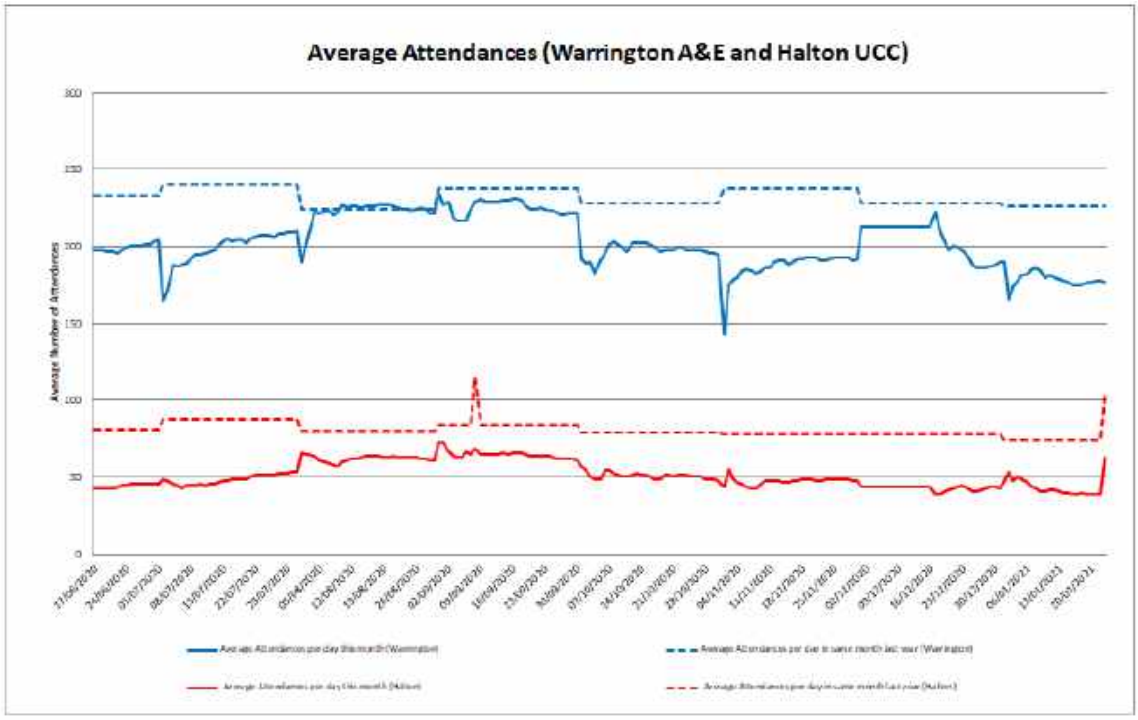


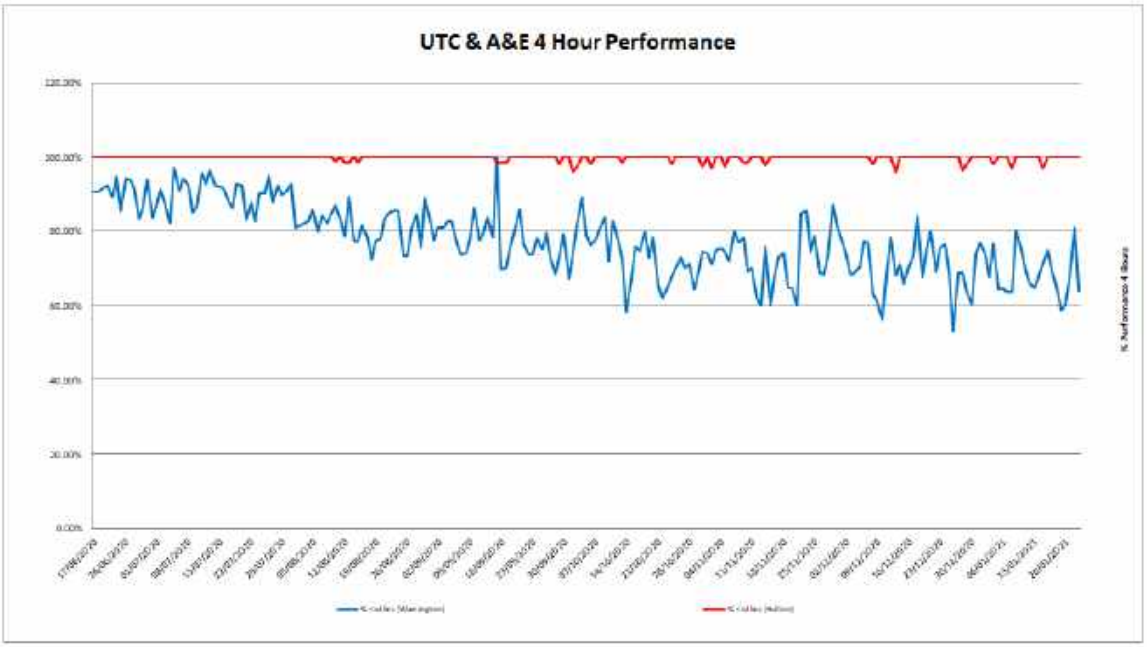
Narrative: Non COVID-19 related sickness absence has reduced to 4.40%. COVID-19 related sickness absence has decreased to 2.70% from 3.50%. There has been a reduction in the number of staff isolating to 71 FTE. Technology is enabling individuals to work from home, where this is the case, they do not count towards the isolation numbers and the Trust continues to support Clinically Extremely Vulnerable staff back into the workplace when Risk Assessments are approved.

Nationally absences are increasing; COVID-19 absence rate (sickness and isolation/shielding) is 3.90%, 3.90% in the North West, 5.0% in C&M and 5.0% for WHH. However the C&M rate includes specialists Trust's which have a lower absence rate, reducing the whole C&M average.

Source: Trust Data

2.13 Urgent Care

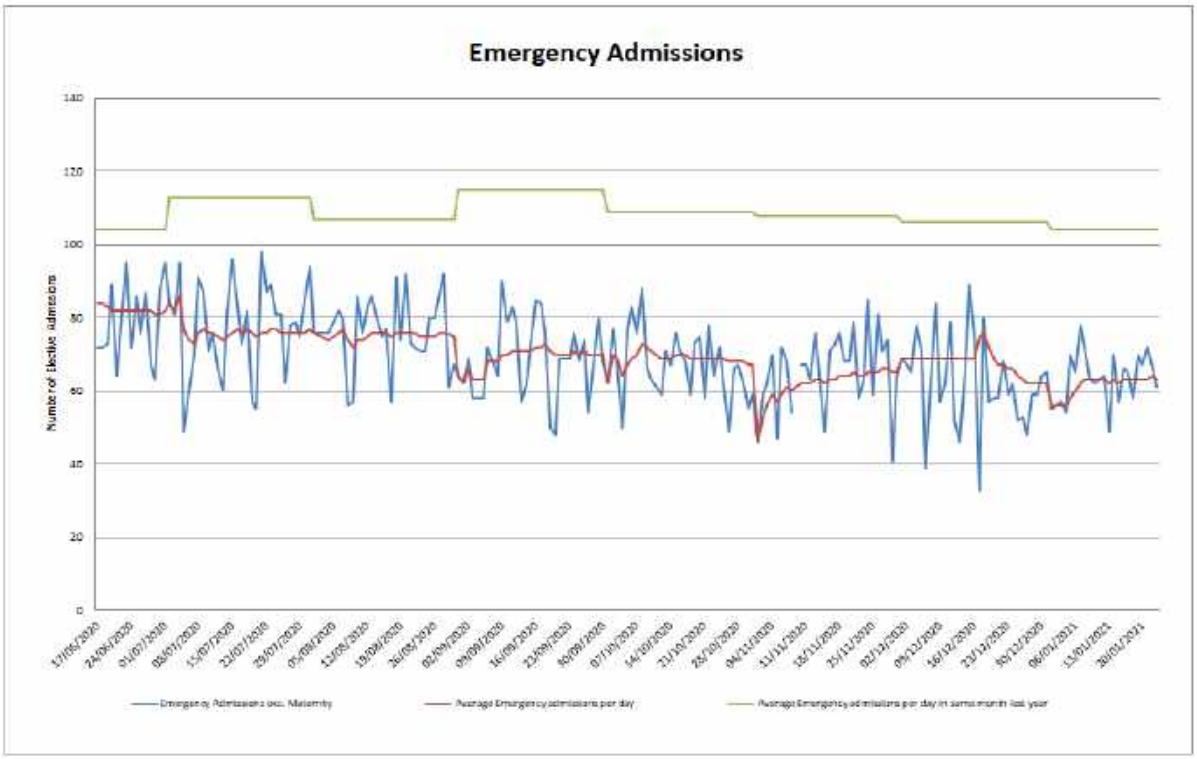




Narrative: Activity in December 2020 in Warrington A&E has averaged 90.00% of activity in December 2019. Activity in December 2020 at the Halton UTC has averaged 55% of activity in December 2019.

Source: Trust Data

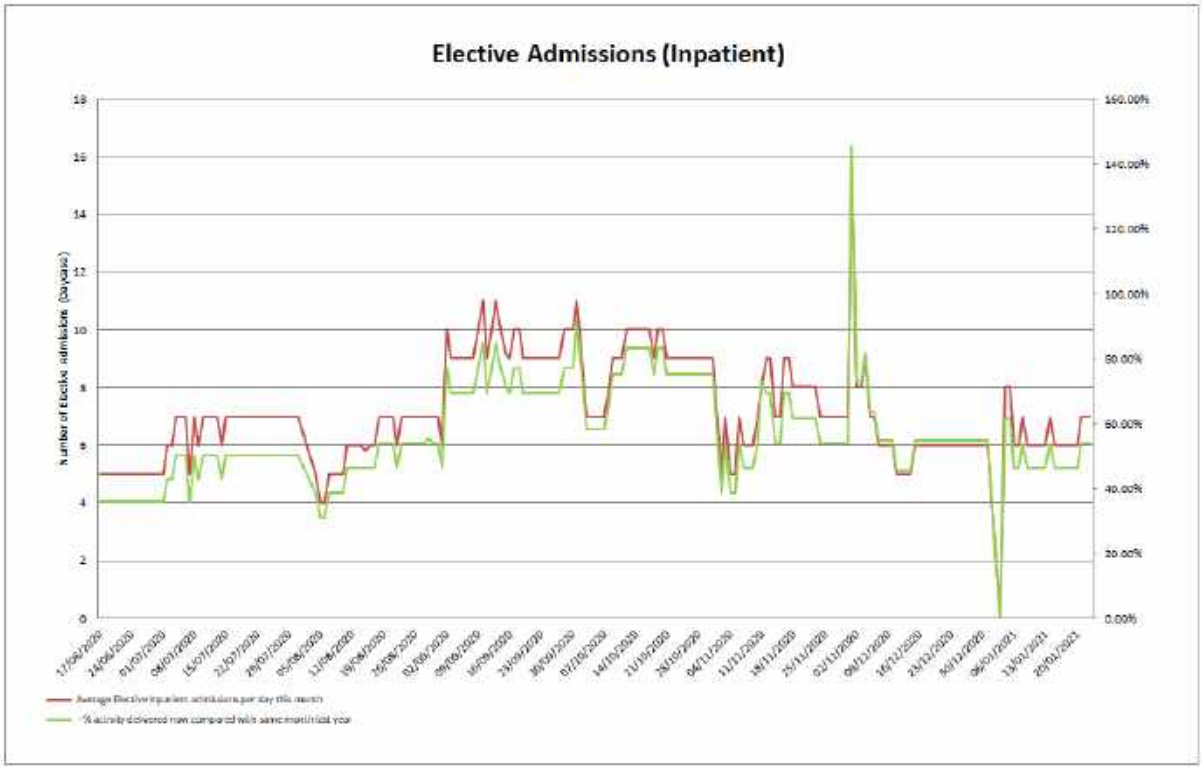
2.14 Emergency Admissions

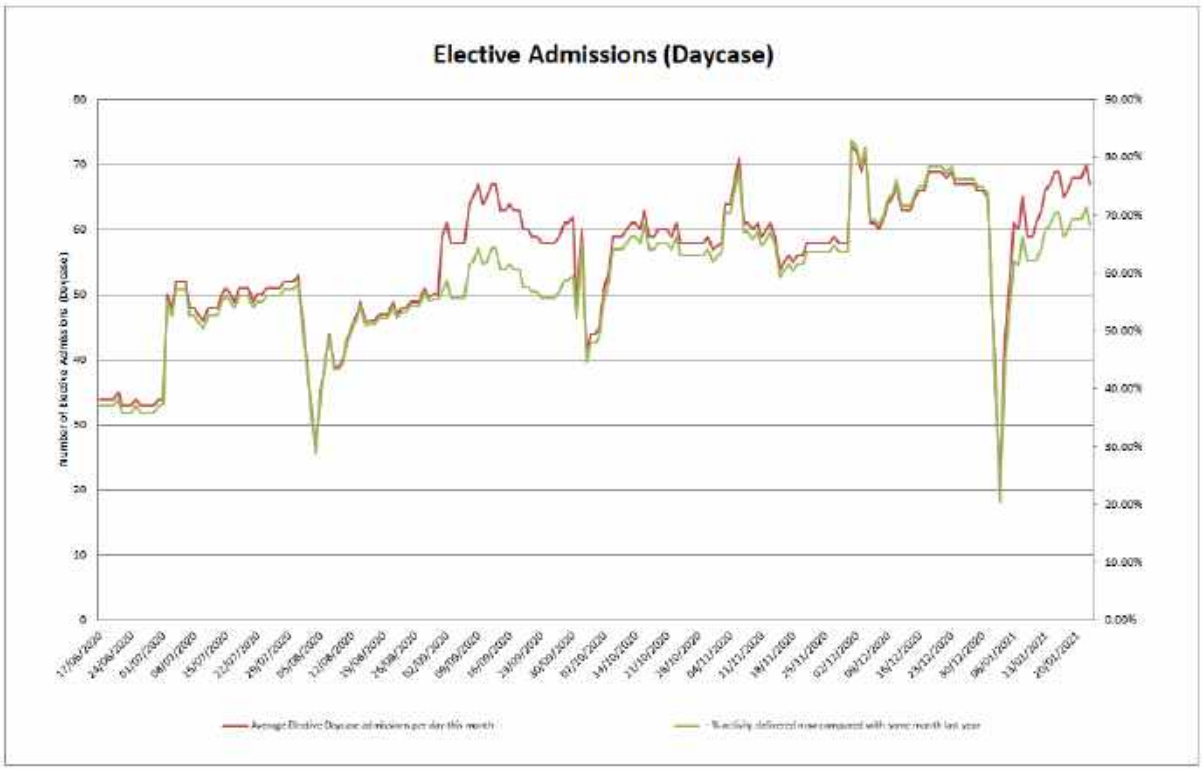


Narrative: The average number of emergency admissions in December 2020 was 64.00% of the average number of emergency admissions in December 2019.

Source: Trust Data

2.15 Elective Admissions



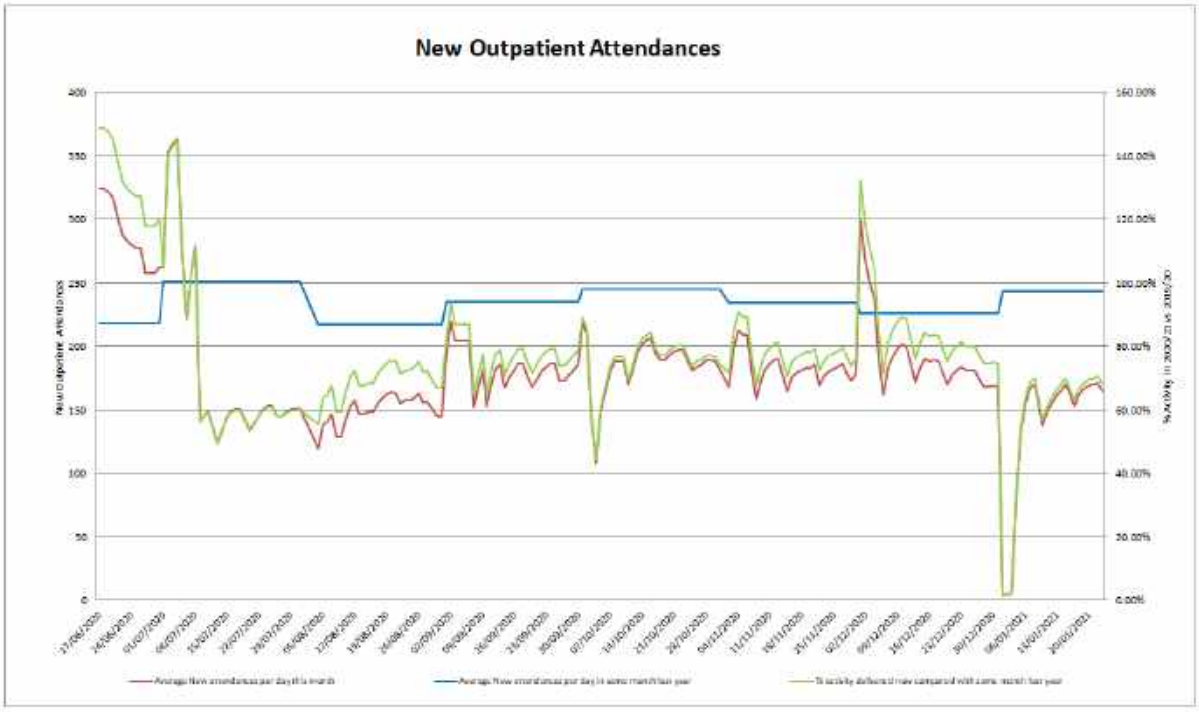


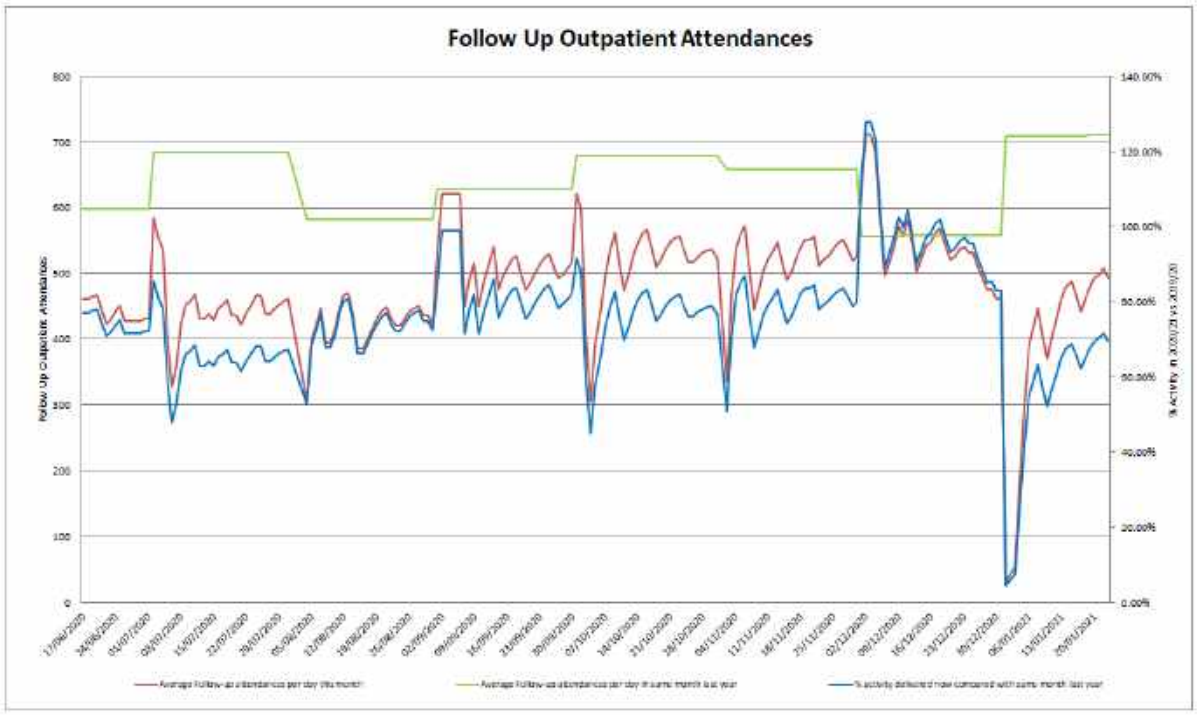
Narrative: The average number of elective inpatient admissions in December 2020 was 59.00% of the average number of elective inpatient admissions in December 2019.

The average number of elective daycase admissions in December 2020 was 75.00% of the average number of elective daycase admissions in December 2019.

Source: Trust Data

2.16 Outpatient Attendances





Narrative: The average number of new outpatient attendances in December 2020 was 85.00% of the average number of new outpatient attendances in December 2019.

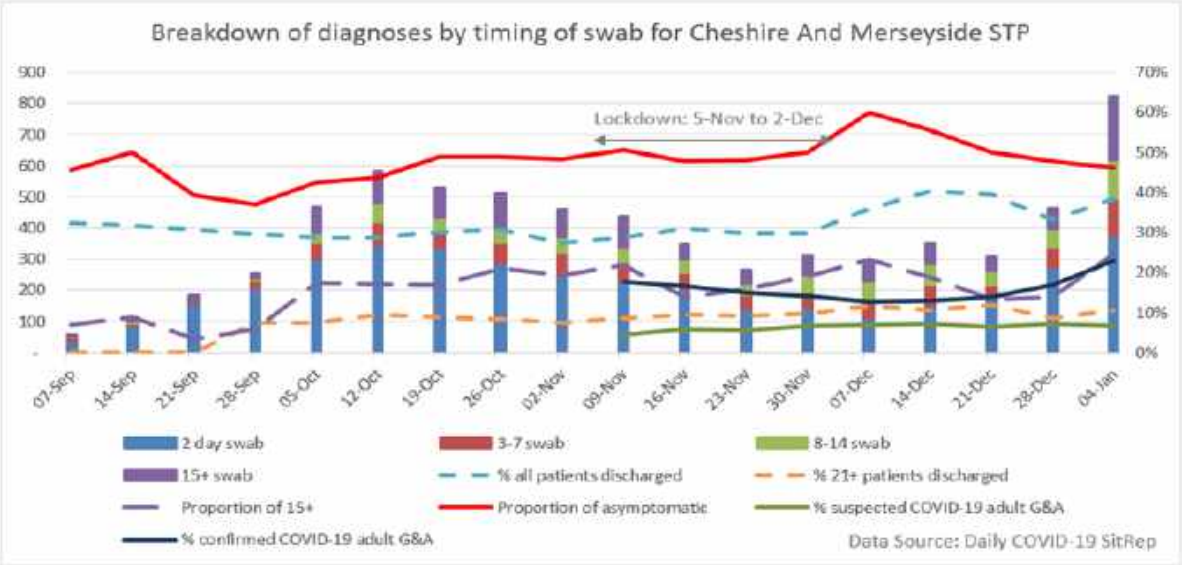
The average number of follow up outpatient attendances in December 2020 was 98.00% of the average number of follow up outpatient attendances in December 2019.

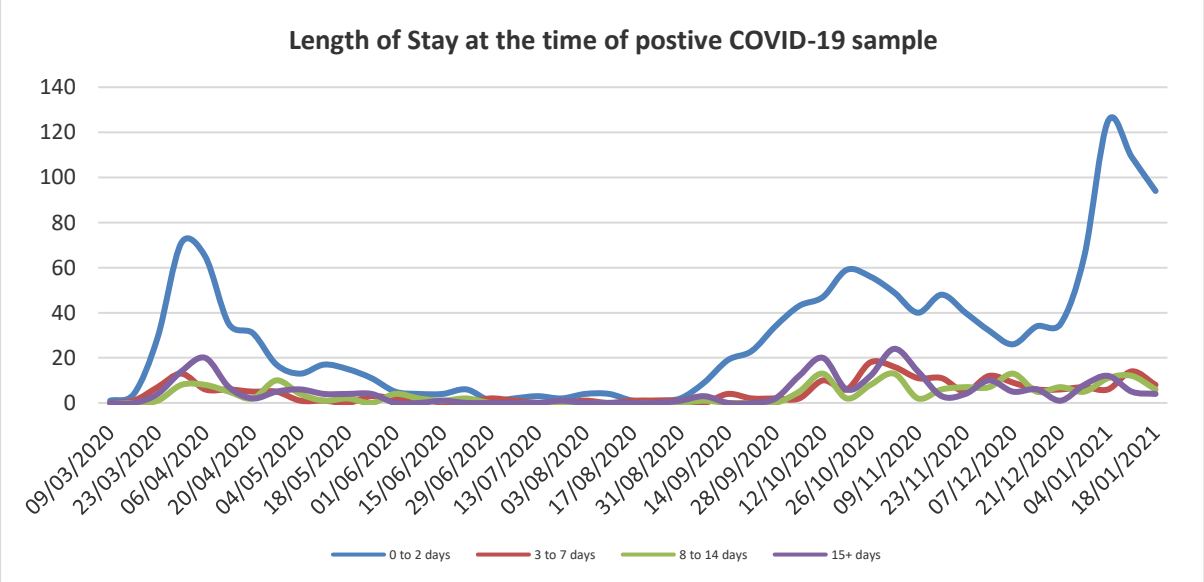
Source: Trust Data

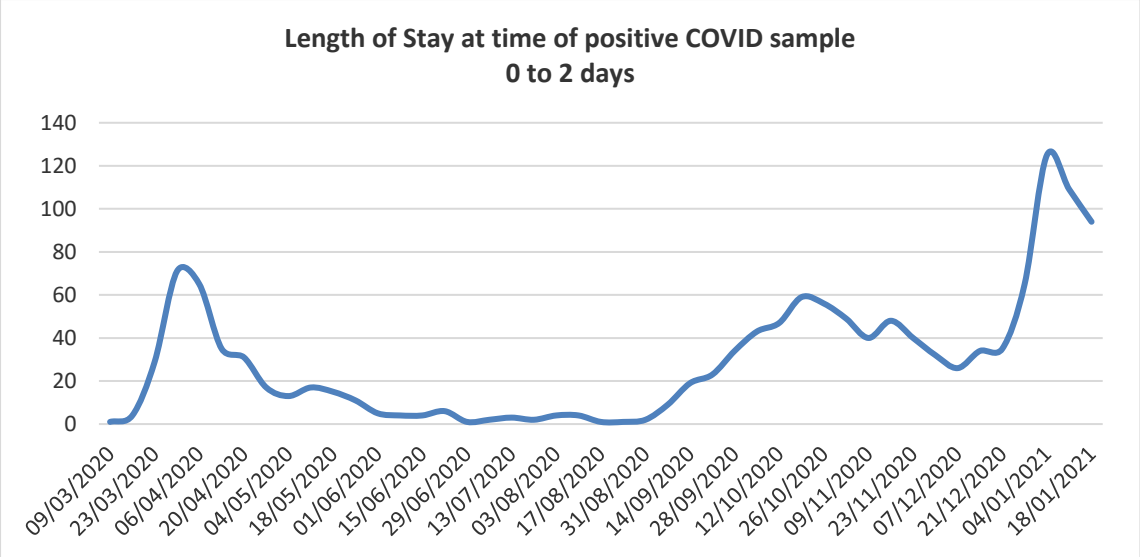
2.17 Nosocomial Infection

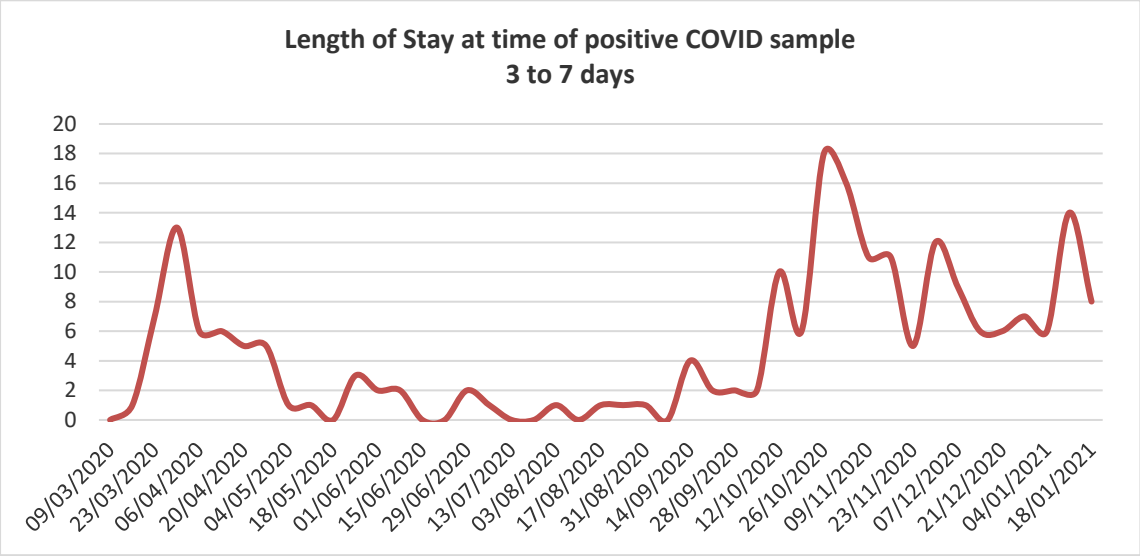
Nosocomial infections are defined as:

- 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






Length of Stay at time of 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
15/06/2020
29/06/2020
13/07/2020
03/08/2020
17/08/2020
31/08/2020
14/09/2020
28/09/2020
12/10/2020
26/10/2020
09/11/2020
23/11/2020
07/12/2020
21/12/2020
04/01/2021
18/01/2021


Length of Stay at time of positive COVID sample
3 to 7 days
20
18
16
14
12
10
8
6
4
2
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
03/08/2020
17/08/2020
31/08/2020
14/09/2020
28/09/2020
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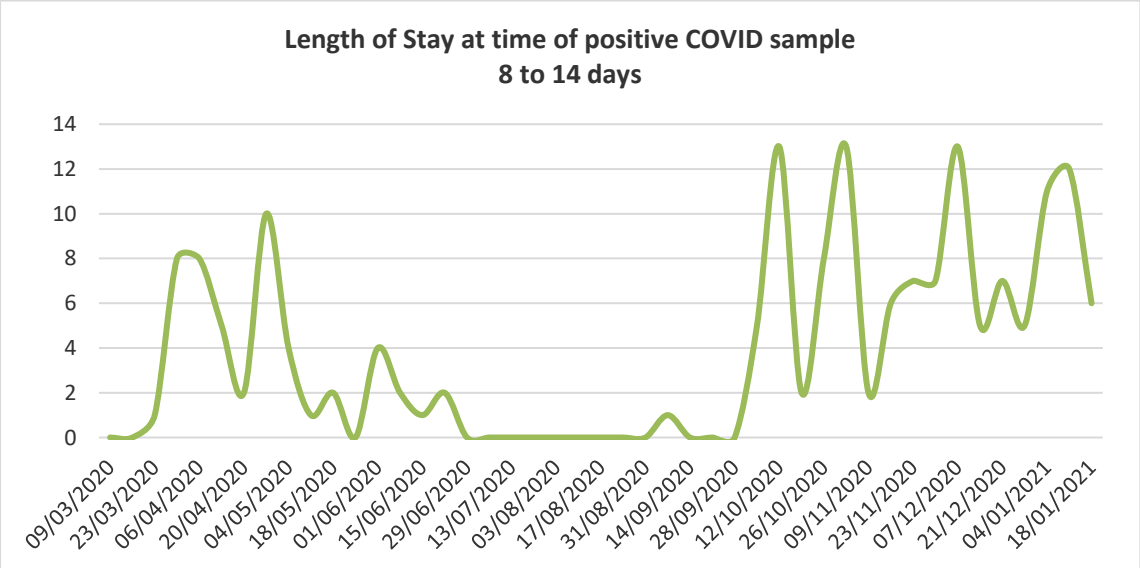
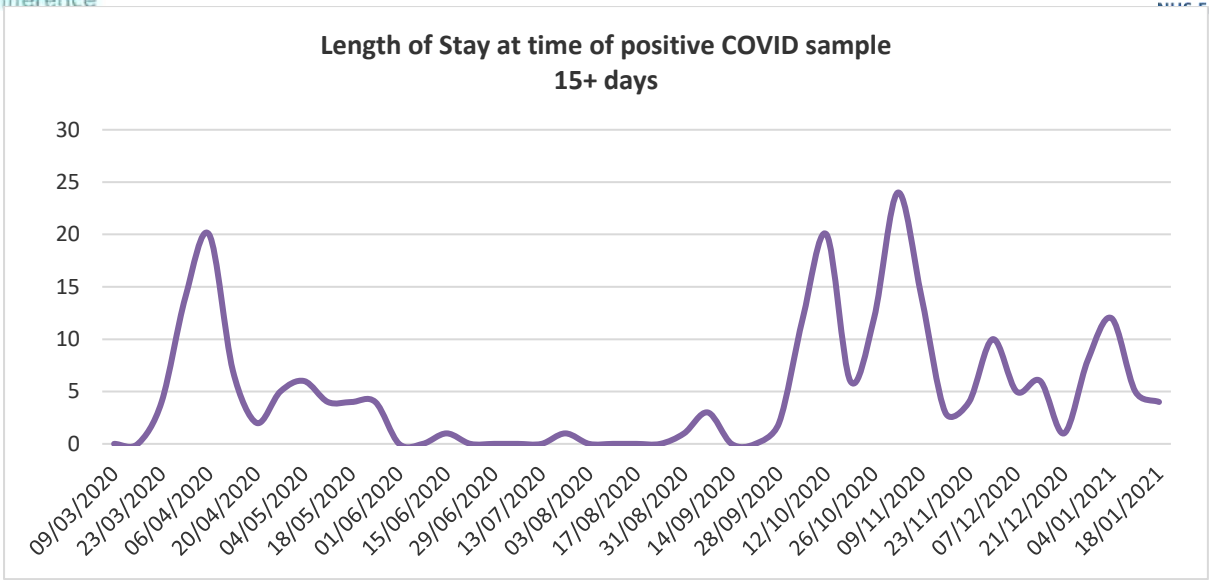
09/11/2020
23/11/2020
07/12/2020
21/12/2020
04/01/2021
18/01/2021


Length of Stay at time of positive COVID sample
8 to 14 days
14
12
10
8
6
4
2
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
03/08/2020
17/08/2020
31/08/2020
14/09/2020
28/09/2020
12/10/2020
26/10/2020
09/11/2020
23/11/2020
07/12/2020
21/12/2020
04/01/2021
18/01/2021



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. However in the last 7 days, 6 infections were detected within 8-14 days which indicates probable hospital onset infection and 4 infections were detected after 15 days which suggests definite hospital onset infection.

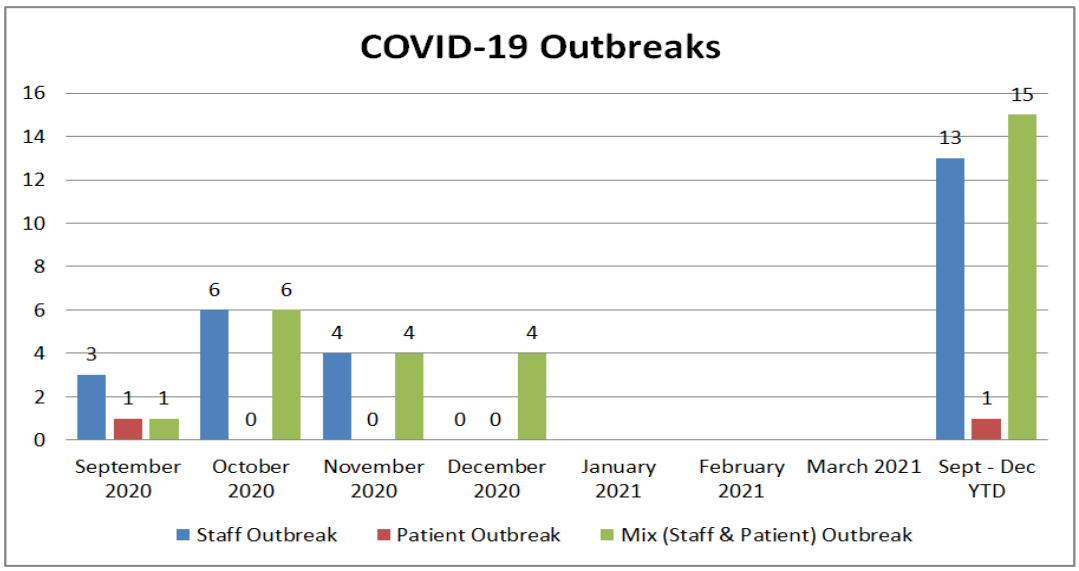
In comparison for w/c 4th January 2021 the proportion of inpatients diagnosed from swabs taken after 15 days was:

- 11% for England
- 17% for the North West
- 25% for Cheshire & Mersey
- 8% for Warrington & Halton Hospitals

Source: Trust Data

2.18 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 2020, there were 4 outbreaks which was a mix of staffing and patient areas.

Source: Trust Data

3. CONCLUSION

The Executive Team will continue to monitor this data and will take immediate action as appropriate where concerns are noted in any area.

4. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/21/01/07	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	27th January 2021	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, 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 through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #224 Failure to meet the emergency access standard.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has 72 IPR indicators which have been RAG rated in December as follows: **Red: 24 (from 30 in November)** **Amber: 9 (from 8 in November)** **Green: 32 (from 27 in November)** **Not RAG Rated: 7 (from 7 in November)** As a result of the COVID-19 pandemic, the Trust has not met the RTT 18 week, RTT 52 week, Diagnostics 6 week, Cancer 14 day or Cancer 62 day urgent standards. Prior to COVID-19, the Trust had consistently met these standards. The Trust has established robust recovery plans in line with phase 3 planning guidance and clinical prioritisation is in place. However due to impact of wave 2, the Trust is not currently meeting the phase 3 plans. The Trust will continue to utilise independent sector support and will engage in system conversations to seek out mutual aid in an effort to address the backlog. The Trust has ensured that processes remain in place to monitor and improve quality during the COVID-19 pandemic. Open Incidents are monitored, with progress tracked weekly via	

	the Trust Meeting of Harm. CBUs continue to be supported to ensure the timely closure of incidents. The Trust continues to monitor and manage Mixed Sex Accommodation Breaches which have all occurred in ICU due to the current pressures. There were no complaints open over 6 months old. For the period ending 31 December 2020 the Trust has recorded a deficit position of £3.1m against a deficit plan of £3.0m. The plan excludes the impact of COVID-19 wave 2. The position variance is £0.1m worse than plan. The forecast outturn is formally a £10.3m deficit. The Trust Board has approved a revised forecast of £13.9m deficit. This revised forecast has been submitted in the month 9 monitoring return. The forecast takes into account the impact of wave 2 COVID-19 costs and is being reviewed to assess the impact of wave 3. The budget will be updated from 1 January 2021 to reflect this forecast. As at 31 December 2020 the cash balance was £27.9m, however the current cashflow forecast shows a cash shortfall of circa £26m in March 2021. This is due to no block payment in March 2021 as two months were paid in April 2020. The upfront payment was utilised to pay creditors of circa £16m at the start of the year in line with national guidance. This along with the forecast deficit is a key driver of the forecast cash position. It has been confirmed that PDC should be available in March 2021 to support the cash position.

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

RECOMMENDATION:	**The Trust Board is asked to:** **1. Note the OCT machine scheme approved as emergency capital by the Chief Finance Officer & Deputy Chief Executive.** **2. Approve the additional capital spend in relation to the MRI adjustments.** **3. Approve the additional capital spend in relation to the X-Ray quotes.** **4. Approve the increase in the capital contingency budget due to the availability of alternative funding streams.** **5. Approve the proposed change in the reporting logic for the Discharge Summary KPI to be implemented from Q1 2021/22.** **6. Note the contents of this report.**

PREVIOUSLY CONSIDERED BY:	**Committee**	Finance & Sustainability (Discharge Summary KPI Change)
	Agenda Ref.	FSC/20/12/170
	Date of meeting	23rd December 2020
	Summary of Outcome	Supported
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/21/01/07

1. BACKGROUND/CONTEXT

The RAG ratings for all 72 IPR indicators from January 2020 to December 2020 are set out in **Appendix 1**. The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the 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	24
Amber	8	9
Green	27	32
Not RAG Rated	7	7
Total:	72	72

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.

The Friends and Family Test indicators for Inpatients/Daycases and Urgent Care were suspended nationally, however this is now reportable from December 2020 and is included in this report.

Due to the impact of COVID-19, 6 indicators cannot be RAG rated in month as the data is not available or not reportable. These are:

Access & Performance

- Ambulance Handovers 30-60 Minutes – data from the North West Ambulance Service was unavailable for December 2020.
- Ambulance Handovers 60 Minutes Plus – data from the North West Ambulance Service was unavailable for December 2020.

Finance

- Use of Resource Rating – UoR rating is not currently reportable. The Trust is awaiting further guidance from NHSE/I.

- CIP x 2 (In Year & Recurrent Plans in Progress) – CIP was suspended nationally during the pandemic. However the Trust is now reporting CIP performance against plan and will recommence the reporting of the in year and recurrent plans in progress indicators in 2021/22.
- System Financial Position – system reporting across the Warrington & Halton system is currently on hold.

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 3 Quality indicators rated Red in December, an improvement from 4 in November.

The 3 indicators rated Red in November, which have remained rated Red in December are as follows:

- Incidents - There were 32 open incidents over 40 days old at the end of December, a deterioration from 26 incidents at the end of November, against a target of 0. Performance has been impacted by the COVID-19 pandemic, as clinical areas have been required to focus on providing direct patient care. All areas continue to be supported by the Governance Department and virtual meetings continue.
- Healthcare Acquired Infections (MRSA) – there was 1 case of MRSA reported in September, therefore this indicator will remain Red for the rest of the year. No MRSA cases were reported in December.
- Mixed Sex Accommodation Breaches – there were 4 breaches in December, an improvement from 5 breaches in November, against a target of 0.

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

- Complaints - There was 0 complaints open over 6 months at the end of December, an improvement from 1 open complaint at the end of November, against a target of 0.

There are 2 indicators which have moved from Green to Amber in month as follows:

- Staffing Average Fill Rate – the Trust achieved 87.68% for registered nurses in the day and 89.07% for care staff at night in December, a deterioration from 96.52% for registered nurses in the day and 96.70% for care staff at night in November. The target for this indicator is 90.00%.
- Care Hours Per Patient Day – the Trust achieved an overall CPPD of 7.5 hours in December, a deterioration from 8.3 hours in November, against a target of 7.9 hours.

Access and Performance

Access and Performance KPIs

There are 12 Access and Performance indicators rated Red in December, decreased from 15 indicators in November. This includes 2 indicators where data was unavailable in December and have therefore not been RAG rated in month. Performance against Access & Performance indicators has been significantly impacted by the COVID-19 pandemic.

The 12 indicators which were rated Red in November and remain rated Red in December are as follows:

- Diagnostic 6 Week Target – the Trust achieved 59.80% in December, a deterioration from 65.17% in November, against a target of 99.00%.
- Referral to Treatment Open Pathways – the Trust achieved 75.43% in December, an improvement from 74.79% in November, against a target of 92.00%.
- Referral to Treatment 52+ Week Waiting – there were 811 patients waiting over 52 weeks in December, a deterioration from 617 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 with clinical prioritisation; however these have been impacted by wave 2.
- A&E Waiting Times 4 hour National Target – the Trust achieved 75.50% (excluding Widnes Walk ins) in December, a deterioration from November's position of 78.62%, against a target of 95.00%.
- A&E Improvement Trajectory – the Trust did not achieve the improvement trajectory of 80.90% in December.
- Cancer 14 Days – the Trust achieved 91.54% in November, an improvement from 91.50% in October, against a target of 93.00%.
- Cancer 62 Days Urgent - the Trust achieved 75.79% in November, an improvement from 72.38% in October, against a target of 85.00%.
- Discharge Summaries % sent within 24 hours – the Trust achieved 85.54% in December, an improvement from 85.52% in November, against a target of 95.00%.
- Super Stranded Patients – there were 115 super stranded patients at the end of December, an improvement from 122 patients at the end of November.
- COVID-19 Recovery Elective Activity – the Trust achieved 46.89% of inpatient elective activity and 70.95% of daycase activity in December, against the target of 90.00% of activity in the same period in 2019/20.
- COVID-19 Recovery Outpatient Activity – the Trust achieved 85.90% of outpatient activity in December, against the target of 100% of activity in the same period in 2019/20.
- COVID-19 Recovery Diagnostic Activity – the Trust achieved 89.30% of MRI Activity, 106.63% of CT Activity, 86.34% of Non-Obstetric Ultrasound Activity, 84.80% of Colonoscopy Activity, 55.56% of Flexi Sigmoidoscopy Activity and 59.94% of Gastroscopy Activity in December, against the target of 100% of activity in the same period in 2019/20.

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

- Cancelled Operations on the Day (for non-clinical reasons, not rebooked within 28 days) – there were 0 patients whose operation was cancelled on the day and not rebooked within 28 days in December. This is an improvement from 8 patients in November, against a target of 0.

The 2 Ambulance Handovers indicators (30-60 Minutes and 60 minutes+) have not been RAG rated in month as the information is unavailable from the North West Ambulance Service. These indicators were both rated Red in November.

PEOPLE

Workforce KPIs

There are 6 Workforce indicators rated Red in December, an improvement from 8 indicators in November.

The 6 indicators which were rated Red in November and remain rated Red December are as follows:

- Sickness Absence – The Trust's sickness absence was 6.27% in December, an improvement from 7.72% in November, against a target of less than 4.20%.
- Return to Work Compliance – interview compliance was 51.90% in December, a deterioration from 64.81% in November, against a target of 85.00%.
- Bank/Agency Reliance – The Trust's reliance was 15.18% in December, an improvement from 18.46% in November, against a target of less than 9.00%.
- Agency Shifts Compliant with the Cap – 24.68% of agency shifts were compliant with the cap in December, a deterioration from 27.10% in November, against a target of 49.00%.
- Agency Rate Card Compliance – 38.00% of agency shifts were compliant with the rate card in December, a deterioration from 40.00% in November, against a target of 60.00%.
- PDR Compliance – The Trust's PDR compliance was 52.68% in December, a deterioration from 55.34% in November, against a target of 85.00%.

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

- Turnover – Trust turnover was 12.85% in December, an improvement from 13.19% in November, against a target of less than 13.00%.

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

- Monthly Pay Spend – the monthly pay spend in December was £18.8m against a budget of £19.1m.

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

- % Use of the Apprenticeship Levy – the Trust's use of the apprenticeship levy was 61.00% in December, an improvement from November's position of 46.00%, against a target of 85.00%.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 3 Finance & Sustainability indicators rated Red in December, the same as November.

The 3 indicators which were rated Red in November and remain rated Red in December are as follows:

- Trust operating surplus / (deficit) – The year to date position is a deficit of £3.1m against a deficit plan of £3.0m. The position includes a retrospective top up of £20.1m to support COVID-19 expenditure and income loss of £26.4m year to date.
- Capital Programme – The actual spend year to date is £6.4m which is £5.5m below the planned spend of £11.9m. However, the Trust has committed orders of £7.6m.
- Agency Spending – The actual spend in December was £1.3m which is £0.6m above plan. Year to date actual expenditure is £10.0m of which £5.3m relates to COVID-19.

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

During December, £2.0m of COVID-19 costs were incurred which is the lowest month recorded. These were offset by underspends on recovery plans and the reduction in elective activity.

Capital Programme

Details of the capital plan including COVID-19 and spend year to date are set out in **Table 2.**

Table 2 - Capital plan and spend year to date

Capital	Annual Plan	Plan To Date	Expenditure to Date*	Variance Year to Date	RAG
	£'000	£'000	£'000	£'000	
Core Programme	8,887	4,618	2,340	2,278	
MRI (PDC)	875	0	0	0	
Non Covid19 Loan Programme (PDC)	4,851	2,516	1,366	1,150	
Critical Infrastructure Risk (CIR) Funding (PDC)	2,410	1,141	272	869	
A&E Plaza (PDC)	4,300	450	54	396	
Phase 1 covid (PDC)	2,802	2,802	2,373	429	
Endo (PDC)	592	148	0	148	
Critical Care (PDC)	1,422	202	0	202	
Total Planned Capital Investment	**26,139**	**11,877**	**6,405**	**5,472**	

In addition to the expenditure, there are also committed orders of £7.6m.

Due to the high value of the capital programme, additional governance and oversight has been put in place. Weekly meetings with the key capital leads have been set up which are chaired by the Chief Nurse and Deputy Chief Executive. Reports from these meetings are provided to the Strategic Executive Oversight Group (SEOG) where deep dives can be requested.

There are 21 schemes which have a budget of £0.25m or more. The overall value of these schemes is £17.2m. In addition, the schemes below £0.25m will continue to be monitored via the Capital Planning Group and will be reviewed in the fortnightly meetings with the key capital leads.

The key risks to the capital programme are A&E Plaza (£3.3m), Breast Services at Captain Sir Thomas Moore (Core Programme £1.1m), and Critical Care (£1.2m). Therefore £5.6m of the programme is at risk. The current information from NHSE/I is that there will be no carry forward available to the next financial year. Of these risks, £4.5m relates to PDC which the Trust would be unable to receive into this year or next. This relates to the A&E Plaza and Critical Care schemes. The unprecedented position in which the Trust is operating has severely impacted the ability to deliver the A&E plaza and Critical Care schemes by 31 March 2021. NHSE/I has been approached to consider how this risk can be managed to support scheme delivery.

In December, the Trust Board approved bringing forward a number of 2021/22 schemes to cover the slippage on Breast to enable completion of the project in 2021/22.

Additional proposed changes to the contingency budget are outlined in **Table 3.**

Table 3: Request for changes to the contingency budget

£000	
318.8	**Contingency budget at 30 November 2020**
- 60.0	OCT machine (approved as an emergency by the Chief Finance Officer & Deputy Chief Executive)
266.8	**Contingency budget after emergency requests**
- 43.0	MRI adjustments
- 4.0	Adjustments to Xray quotes
167.0	Anaesthetic Machine (funding received)
17.0	ENT Scope (funding received)
403.8	**Revised Contingency budget**

The above adjustments increase the capital contingency to £0.4m.

The Trust Board is requested to:

1. Note the OCT machine scheme approved as emergency capital by the Chief Finance Officer & Deputy Chief Executive.
2. Approve the additional capital spend in relation to the MRI adjustments.
3. Approve the additional capital spend in relation to the X-Ray quotes.
4. Approve the increase in the capital contingency budget due to the availability of alternative funding streams.

The Trust capital programme is attached in **Appendix 6**.

Amendment to the Discharge Summary Key Performance Indicator Reporting Logic

As part of a recommendation made by Mersey Internal Audit in relation to the Trust's annual audit programme, the Trust has reviewed the reporting logic for the Discharge Summaries Key Performance Indicator (KPI). In order to improve accuracy of reporting, it is proposed that several services are added to the cohort for which compliance is reported from Lorenzo (the Trust's electronic patient record). The Finance & Sustainability Committee has supported this change which is outlined in detail in **Appendix 7**.

The Trust Board is asked to approve the proposed change in the reporting logic for the Discharge Summary KPI to be implemented from Q1 2021/22.

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
- Trust Operational Board
- Strategic People Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the OCT machine scheme approved as emergency capital by the Chief Finance Officer & Deputy Chief Executive.
2. Approve the additional capital spend in relation to the MRI adjustments.
3. Approve the additional capital spend in relation to the X-Ray quotes.
4. Approve the increase in the capital contingency budget due to the availability of alternative funding streams.
5. Approve the proposed change in the reporting logic for the Discharge Summary KPI to be implemented from Q1 2021/22.
6. 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 2020 – December 2020

	KPI		Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20
	QUALITY													
1	Incidents		↑	↑	↓	↑	↑	↓	↑	↑	↓	↓	↑	↓
2	CAS Alerts		↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
3	Duty of Candour		↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
4	Healthcare Acquired Infections - MSRA		↔	↔	↔	↔	↔	↔	↔	↔	↓	↑	↔	↔
5	Healthcare Acquired Infections – Cdiff		↓	↑	↓	↑	↑	↑	↓	↑	↑	↓	↑	↔
6	Healthcare Acquired Infections – Gram Neg		↓	↓	↓	↑	↔	↓	↑	↓	↑	↓	↑	↑
7	Healthcare Acquired Infections – COVID-19 Hospital Onset & Outbreaks													
8	VTE Assessment		↓	↓	↑	↑	↑	↑	↑	↓	↓	↓	↑	↓
9	Total Inpatient Falls & Harm Levels		↓	↑	↓	↑	↓	↓	↑	↓	↓	↓	↓	↑
10	Pressure Ulcers		↑	↓	↑	↔	↓	↑	↔	↓	↓	↑	↓	↑
11	Medication Safety (24 Hours)		↑	↓	↑	↑	↑	↑	↑	↓	↓	↑	↑	↑
12	Staffing – Average Fill Rate		↓	↓	-	-	-	↑	↓	↓	↑	↑	↑	↓
13	Staffing – Care Hours Per Patient Day		↓	↑	-	-	-	↑	↑	↓	↓	↑	↑	↓
14	Mortality ratio - HSMR													
15	Mortality ratio - SHMI													
16	NICE Compliance		↑	↔	↓	↓	↔	↑	↑	↑	↑	↑	↓	↑
17	Complaints													
18	Friends & Family – Inpatients & Day cases		↓	↔	-	-	-	-	-	-	-	-	-	
19	Friends & Family – ED and UCC		↑	↔	-	-	-	-	-	-	-	-	-	
20	Mixed Sex Accommodation Breaches		↑	↔	↓	↔	↔	↔	↔	↓	↓	↑	↓	↑
21	Continuity of Carer		↓	↑	↑	↑	↓	↑	↑	↓	↓	↓	↑	↑
22	CQC Insight Indicator Composite Score		↓	↓	↓	-	-	-	-	-				

Key

Improvement in Performance	↑
Deterioration in Performance	↓
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating January 2020 – December 2020

	KPI	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20
	ACCESS & PERFORMANCE												
23	Diagnostic Waiting Times 6 Weeks	↑	↑	↓	↓	↑	↑	↑	↓	↑	↑	↑	↓
24	RTT - Open Pathways	↓	↓	↓	↓	↓	↓	↓	↑	↑	↑	↑	↑
25	RTT – Number Of Patients Waiting 52+ Weeks	↔	↔	↔	↓	↓	↓	↓	↓	↓	↓	↓	↓
26	A&E Waiting Times – National Target	↑	↑	↑	↑	↑	↓	↓	↓	↓	↓	↑	↓
27	A&E Waiting Times – STP Trajectory	↑	↑	↑	↑	↑	↓	↓	↓	↓	↓	↑	↓
28	A&E Waiting Times – Over 12 Hours	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
29	Cancer 14 Days				↓	↓	↑	↑	↓	↓	↓	↑	↑
30	Breast Symptoms 14 Days				↓	↓	↑	↓	↓	↑	↓	↑	↑
31	Cancer 28 Day Faster Diagnostic				↓	↓	↓	↓	↑	↓	↓	↑	↑
32	Cancer 31 Days First Treatment*	↓	↓	↑	↓	↑	↓	↑	↑	↔	↓	↑	↓
33	Cancer 31 Days Subsequent Surgery*	↔	↔	↔	↔	↔	↓	↑	↓	↑	↔	↔	↔
34	Cancer 31 Days Subsequent Drug*	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
35	Cancer 62 Days Urgent*	↑	↓	↓	↑	↑	↓	↑	↓	↑	↑	↓	↑
36	Cancer 62 Days Screening*	↑	↓	↑	↑	↑	↓	↑	↓	↔	↑	↔	↔
37	Ambulance Handovers 30 to <60 minutes	↑	↑	↑	↑	↓	↓	↓	↓	↑	↑	↓	
38	Ambulance Handovers at 60 minutes or more	↓	↑	↑	↑	↑	↑	↔	↓	↑	↓	↓	
39	Discharge Summaries - % sent within 24hrs	↑	↓	↑	↓	↓	↑	↑	↓	↑	↑	↑	↑
40	Discharge Summaries – Number NOT sent within 7 days	↔	↓	↑	↓	↓	↑	↑	↓	↑	↔	↔	↔
41	Cancelled Operations on the day for a non-clinical reasons	↑	↑	↓	↓	↑	↑	↔	↓	↑	↓	↑	↑
42	Cancelled Operations– Not offered a date for readmission within 28 days	↓	↑	↑	↓	↑	↑	↔	↓	↓	↑	↓	↑
43	Urgent Operations – Cancelled for a 2nd time	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
44	Super Stranded Patients	↓	↑	↑	↑	↓	↑	↑	↓	↓	↓	↓	↓
45	COVID-19 Recovery Elective Activity												
46	COVID-19 Recovery Diagnostic Activity												
47	COVID-19 Recovery Outpatient Activity												

Key

Improvement in Performance	↕
Deterioration in Performance	↕
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating January 2020 – December 2020

	KPI	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20
	WORKFORCE												
48	**Sickness Absence**	↑	↑	↓	↓	↑	↑	↑	↓	↓	↓	↑	↑
49	**Return to Work**	↑	↓	↓	↓	↑	↓	↓	↓	↓	↓	↓	↓
50	**Recruitment**	↕	↓	↑	↑	↓	↑	↑	↓	↔	↔	↓	↑
51	**Vacancy Rates**	↓	↓	↓	↑	↑	↓	↑	↓	↓	↓	↓	↑
52	**Retention**	↓	↓	↑	↑	↓	↑	↓	↓	↔	↓	↓	↑
53	**Turnover**	↓	↓	↑	↑	↓	↑	↓	↓	↑	↓	↓	↑
54	**Bank & Agency Reliance**	↓	↓	↓	↑	↑	↑	↑	↑	↓	↓	↓	↑
55	**Agency Shifts Compliant with the Cap**	↓	↑	↔	↓	↑	↑	↑	↑	↓	↓	↓	↑
56	**Agency Rate Card Compliance**					↓	↑	↓	↓	↔	↓	↓	↓
57	**Monthly Pay Spend (Contracted & Non-Contracted)**	↓	↑	↓	↑	↑	↕	↑	↓	↓	↑	↓	↑
58	**Core/Mandatory Training**	↑	↕	↑	↑	↓	↓	↑	↑	↓	↑	↓	↑
59	**Role Specific Training**					↓	↑	↑	↑	↑	↓	↑	↑
60	**% Use of Apprenticeship Levy**					↑	↓	↓	↑	↑	↓	↑	↑
61	**% Workforce carrying out an Apprenticeship Qualification**					↑	↓	↓	↑	↓	↑	↑	↑
62	**PDR**	↓	↑	↑	↑	↓	↓	↓	↑	↓	↑	↑	↑

Key

Improvement in Performance	↕
Deterioration in Performance	↕
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating January 2020 – December 2020

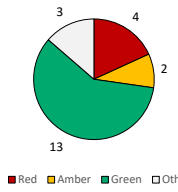
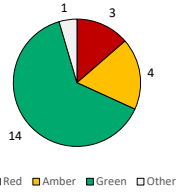
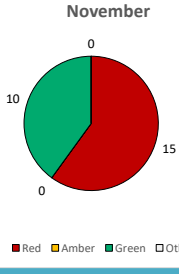
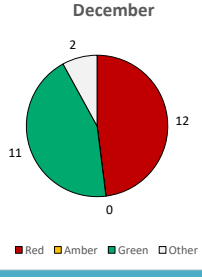
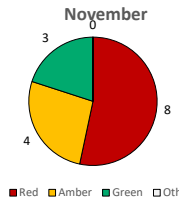
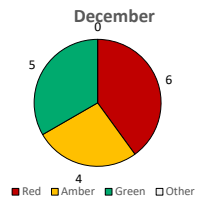
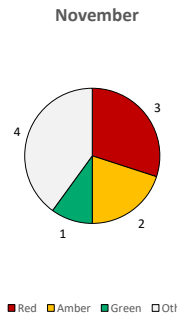
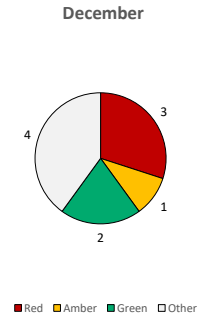
	KPI	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20
	FINANCE												
63	**Trust Financial Position**	↑	↑	↑	↑	↔	↔	↔	↔	↓	↓	↓	↓
64	**System Financial Position**				-	-	-	-	-	-	-	-	-
65	**Cash Balance**	↓	↑	↓	↑	↑	↓	↓	↑	↑	↓	↑	↑
66	**Capital Programme**	↕	↕	↕	↑	↑	↑	↑	↑	↑	↑	↑	↑
67	**Better Payment Practice Code**	↕	↕	↕	↑	↑	↑	↑	↑	↑	↑	↑	↔
68	**Use of Resources Rating**	↔	↔	↔	-	-	-	-	-	-	-	-	-
69	**Agency Spending**				↔	↔	↔	↓	↑	↑	↓	↓	↓
70	**Cost Improvement Programme – Performance to date**	↕	↕	↕	-	-	-	-	-	-	-	↓	↑
71	**Cost Improvement Programme – Plans in Progress (In Year)**	↕	↕	↕	-	-	-	-	-	-	-	-	-
72	**Cost Improvement Programme – Plans in Progress (Recurrent)**	↑	↑	↑	-	-	-	-	-	-	-	-	-

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Integrated Dashboard - December 2020

Appendix 2

			Key Points/Actions
Quality Improvement			There were 270 open incidents that required review and sign off, of which 32 have been open over 40 days. Compliance in relation to Duty of Candour remains 100% in month. There were 2 cases of CDI (under review), 4 cases of E.coli, 0 cases of MRSA, 2 cases of MSSA, 0 cases of Pseudomonas aeruginosa and 0 cases of Klebsiella reported in month. There were 5 category 2 pressure ulcers, 0 category 3 pressure ulcers and 0 category 4 pressure ulcers reported in month. There were 74 falls reported in month, of which 55 were inpatient falls. Medication reconciliation within 24 hours was 85.00% and overall reconciliation was 95.00%. NICE compliance was at 88.17%. There were 4 mixed sex accommodation breaches in month. Care Hours Per Patient Day was at 7.5. Continuity of Carer compliance was 63.20%. There were 0 open complaints over 6 months old.
Access & Performance			Performance against the Access & Performance standards has been significantly impacted by COVID-19. In December, the Trust did not achieve the RTT (75.43%) or the 6 week Diagnostic Standard (59.80%). The Trust did not meet the 4 hour A&E standard (75.50%) or the improvement trajectory in month. The Trust did not meet the Cancer two week wait (91.54%) or Cancer 62 Day Urgent Standard (75.79) in month; however the Trust did achieve all other Cancer Standards. The Trust did not achieve the 24 hour discharge summary standard (85.54%) but did achieve the 7 day standard. There were 0 patients whose operation was cancelled and not rebooked within 28 days. The number of operations cancelled on the day for non-clinical reasons has met the standard (0.37%). The number of Super Stranded patients (115) is worse than the trajectory. The Trust did not meet the COVID-19 Phase 3 recovery plan in month. Data was unavailable from the North West Ambulance Service for Ambulance Handovers in December.
Workforce			In December, the Trust's sickness absence was 6.27%. Return to work compliance was 51.90%. Average recruitment timeframes over the 12 month rolling period are on target at 63 days. Turnover was at 12.85% and Retention was 87.35%. Vacancy rates were 9.30%. Bank and Agency reliance was 15.18%. Core Skills Training was at 84.07% with Role Specific Training at 84.37%. Agency shift compliance against the pay cap was at 24.68% and compliance against the rate card was 38.00%. Pay spend was £18.8m against a budget of £19.1m. PDR compliance was 52.68%. Use of the apprenticeship levy was 61.00% and the % of staff carrying out an apprenticeship qualification was 3.14%.
Finance			The forecast outturn was previously a £10.3m deficit. The Trust Board has approved a revised forecast of £13.9m deficit. This revised forecast has been submitted in the month 9 monitoring return. The forecast takes into account the impact of wave 2 COVID-19 costs and is being reviewed to assess the impact of wave 3. During December, £2.0m of COVID-19 costs were incurred. These were offset by underspends on recovery plans and reduced elective activity. The financial position is a £3.1m deficit against a plan of £3.0m deficit. The actual capital spend year to date is £6.4m which is £5.5m below the planned spend of £11.9m. However, the Trust has committed orders of £7.6m. Year to date agency spend was £10.0m of which £5.3m relates to COVID-19. Better Practice Payment Code was 92.00% in month which is 3.00% below the target of 95.00%, this was due to suppliers providing invalid PO numbers. As at 31 December 2020 the cash balance was £27.9m, however the current cashflow forecast shows a cash shortfall of circa £26m in March 2021. This is due to no block payment in March 2021 as two months were paid in April 2020. The upfront payment was utilised to pay creditors of circa £16m at the start of the year in line with national guidance. This along with the forecast deficit is a key driver of the forecast cash position. It has been confirmed that PDC should be available in March 2021 to support the cash position.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework | Risk Register
Care Quality Commission | Trust Strategy

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)?

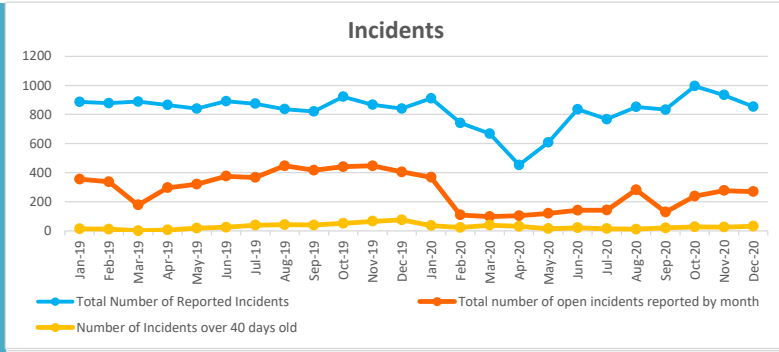
Patient Safety

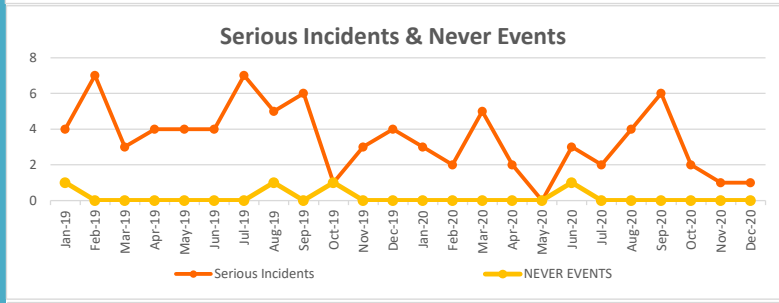
SOF CQC

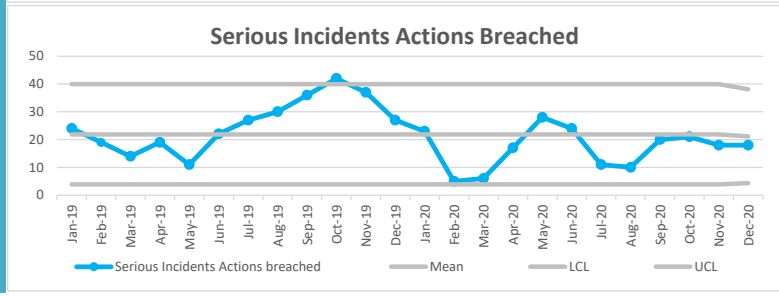
Incidents

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 32 incidents open over 40 days in December 2020 across the 6 CBUs and Clinical Support Services. This is an increase of 23.00% compared to the previous month.







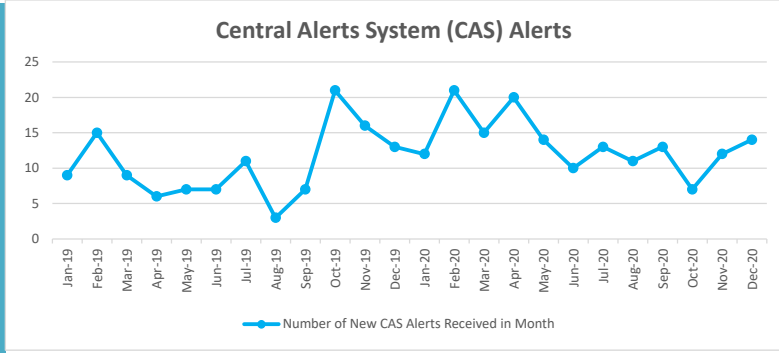
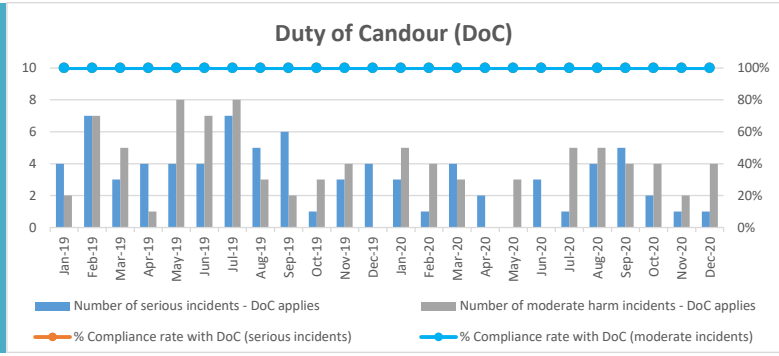
There was 1 serious incident reported in December 2020. This was reported to the weekly meeting of harm. Clinical harm reviews are also being undertaken.

Governance managers will continue to support the CBUs in reviewing and closing incidents with appropriate actions and evidence. This is monitored by the Patient Safety Manager and a weekly report is provided to the Associate Director of Governance and Compliance with escalation as necessary to the Deputy Director of Governance. Weekly oversight of incidents and actions is provided at the meeting of harm.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

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)?
CAS Alerts - Green - All relevant CAS Alerts actioned within timescales Red - Applicable CAS Alert not actioned within the timescale.	CQC There were 14 new CAS Alerts received in month. There were no CAS alert actions which have breached the timescale in month.		The Trust received 14 CAS alerts in month with no breaches of any required actions.	There is ongoing monitoring and oversight at the Health and Safety and Patient Safety and Effectiveness sub-committees to ensure the current position is sustained.
Duty of Candour Red: <100% Green: 100%	CQC The Trust achieved 100% for Duty of Candour in month.		Compliance with Duty of Candour remains in line with Trust policy at 100% compliance.	Training for senior managers and clinicians continues as part of clinical governance training, delivered by the Patient Safety Manager. Weekly scrutiny and monitoring in place by the Patient Safety Manager.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework | Risk Register | Care Quality Commission | Trust Strategy

Quality Improvement - Trust Position

Healthcare Acquired Infections

MRSA
Red: 1 or more
Green: 0

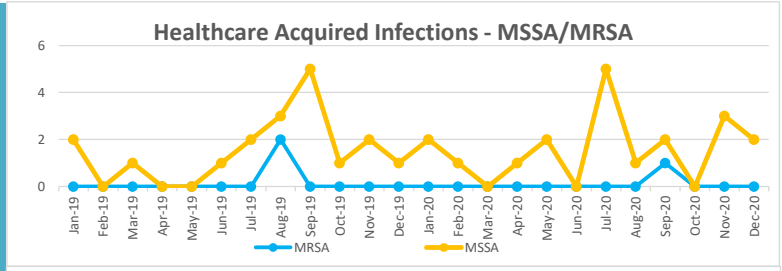
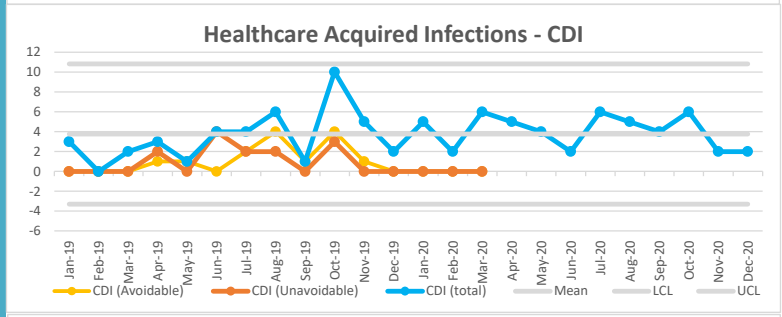
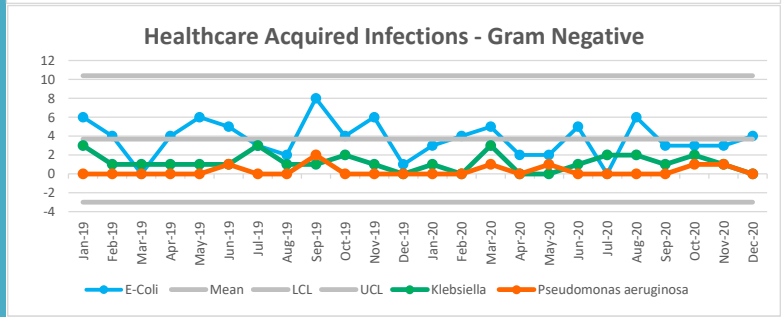
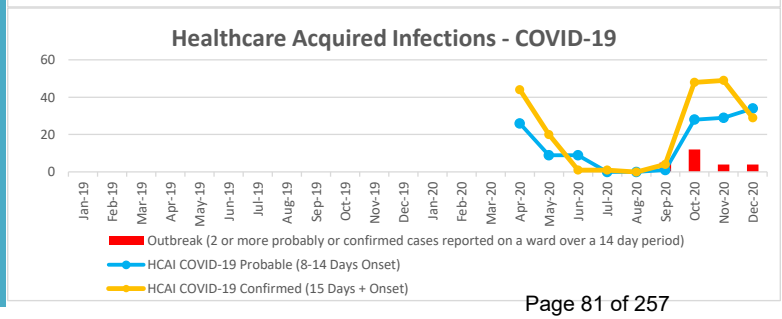
Healthcare Acquired Infections

C-Difficile
Red: 44+ per annum
Green: Less than 44 per annum

Healthcare Acquired Infections - Gram Negative

E-Coli
Red: 47+ per annum
Green: Less than 47 per annum
Pseudomonas aeruginosa & Klebsillea - No Threshold Set

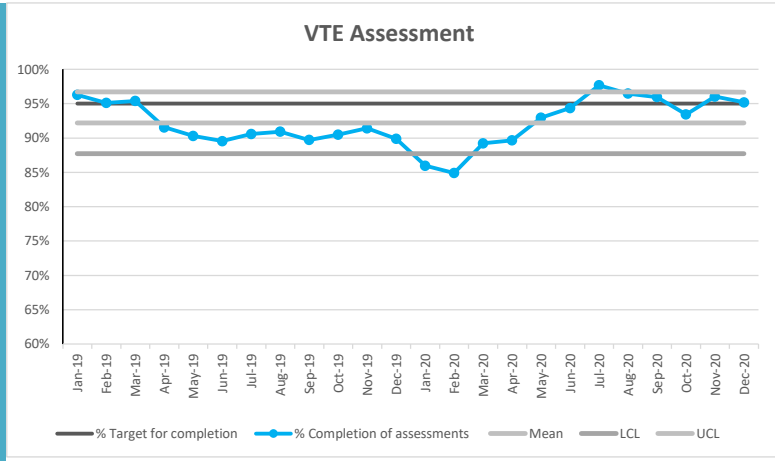
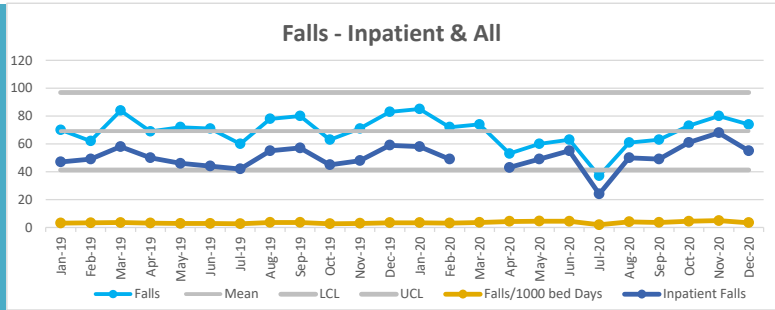
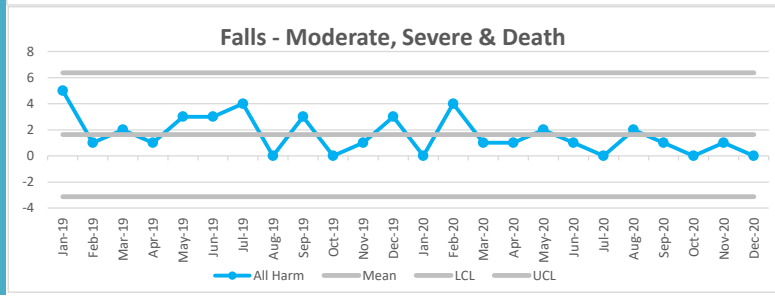
Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks

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 Infection (HCAI) objectives have not been published nationally by NHSE/I for Gram Negative bloodstream infection reduction or C. difficile. The current RAG rating is based on 2019/20 thresholds.	   	**In December, the following cases were reported:** **MRSA - 0 in reported December, 1 reported YTD (in September)** **MSSA – 2 reported in December, 16 reported YTD** **CDI – 2 reported in December, 36 reported YTD** **E-Coli – 4 reported in December, 28 reported YTD** **Klebsiella – 0 reported in December, 9 reported YTD** **Pseudomonas aeruginosa – 0 reported in December, 3 reported YTD.**	**Action plans are in place for the reduction of all HCAIs and will be applied throughout the COVID-19 pandemic and recovery period. Plans will be reviewed and adapted according to Root Cause Analysis report findings.** **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).** **Learning for COVID-19 outbreaks is being shared Trust wide.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework | Risk Register | Care Quality Commission | Trust Strategy

Quality Improvement - Trust Position

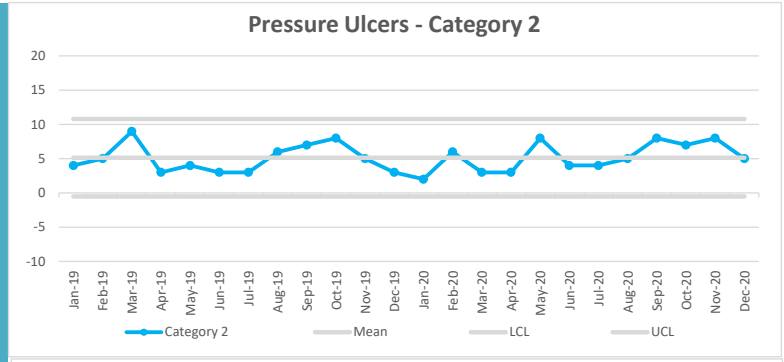
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
VTE Assessment Red: <95% Green: 95% or above based on previous months' figures due to timescales for validation of data	The Trust achieved 95.93% for VTE assessments on average in Q3 2020/21.		The Trust achieved 95.18% for VTE assessments in December 2020. This is just above the target in month. An average for this indicator is reported quarterly in relation to the National Trajectory of meeting the 95.00% target for VTE.	Focused work including "check and challenge" is taking place with clinical teams to improve VTE electronic risk assessment compliance. Daily progress updates are escalated to clinicians, supported by the Associate Medical Director to ensure completion of risk assessments and outstanding VTE assessments are communicated via the Trust Wide Safety Brief. A Clinical Data Capture (CDC) form on Lorenzo to document ward rounds is currently being piloted. This includes a prompt to complete a VTE risk assessment. Roll-out of the CDC form is anticipated in February 2021.
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	There were a total of 74 falls in the month; of which 55 were inpatient falls. There were no falls incidents reported which relating to harm.	 	The themes identified were: Inappropriate selection of preventative device, lack of recognition of enhanced care risk for semi independent patients and increased demand for enhanced care.	Visits to wards with identified high numbers of falls/or patients who have had repeated falls has been completed. This included a review of falls prevention equipment. The weekly falls meetings continues to learn and share themes. Triangulation of the falls in November 2020 was completed to establish any differences in themes across data sources. Falls quality improvement work recommenced in December with a Plan Do Study Act (PDSA) underway.

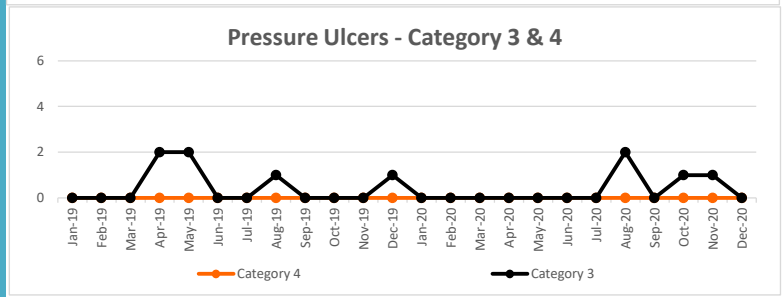
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework | Risk Register
Care Quality Commission | Trust Strategy

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.	CQC There were 5 hospital acquired Category 2 pressure ulcers, 0 Category 3 pressure ulcer and 0 Category 4 pressure ulcers reported in the month. The Trust has had a total of 53 Category 2 pressure ulcers reported YTD and 4 Category 3 pressure ulcers reported YTD.	The Trust has seen an increase in devices related pressure ulcers across the Trust. The COVID-19 pandemic has impacted on the number of pressure ulcers due to increased numbers of critically ill patients that have required proning and non invasive ventilation. In addition pressure ulcers have developed under TED Stockings (anti-embolism stockings).	The Trust has sourced specialised pressure relieving kit to support patients in ITU, sharing learning with colleagues from regional units. The new mattress contract commenced in December, this is a dual therapy mattress which provides enhanced pressure relief. In addition, the new static mattresses provide a higher level of pressure relief. Assessment of TED stockings is being undertaken to identify learning needs.

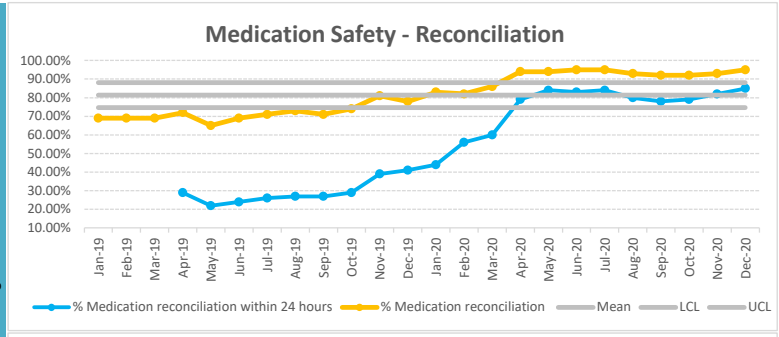
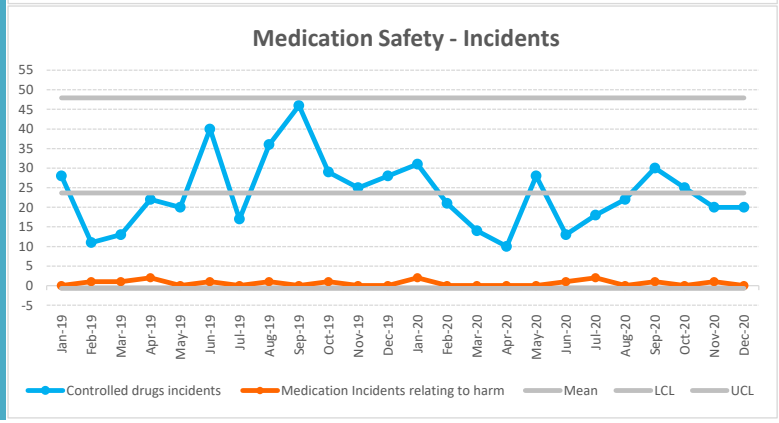
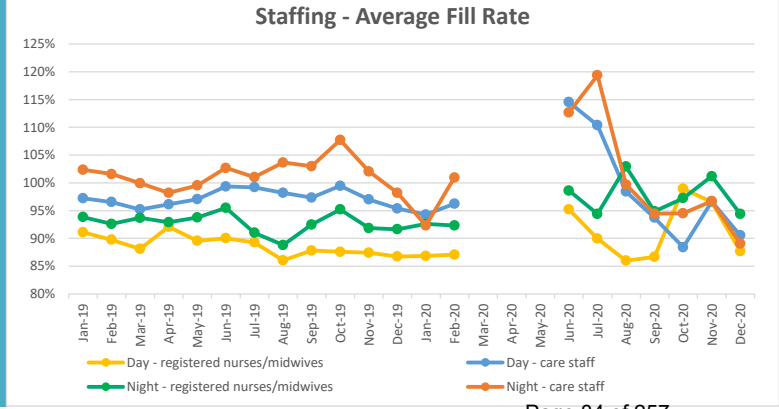




Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework | Risk Register | Care Quality Commission | Trust Strategy

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	The Trust achieved 85.00% for medicines reconciliation within 24 hours and 95.00% for overall medicines reconciliation. There were 20 controlled drug incidents in month. There were no incidents reported relating to harm.	 	In December, improvements were seen in both medicines reconciliation measures. Additional staff were rotated to work over the bank holiday period and this helped with admissions and discharges. All incidents are reviewed to identify learning which is then disseminated. Documentation in Controlled Drug (CD) registers is a key theme. The roll out of a new CD register will improve some documentation issues. An emerging theme relates to the patient's own CDs.	Medicines reconciliations improvements are being achieved by targeted activity on all wards where there are new admissions. Additional resource is being progressed to ensure a consistent service can be provided across the Wards and ED 7 days per week. Pharmacy controlled drug audits are undertaken every 3 months with themes identified and actions in place, tracked through the Medicines Governance Committee. A monthly ward CD check is reported to the Operational Safety Group.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	In month the average staffing fill rates were: Day (Nurses/Mwife) 87.68% Day (Care Staff) 90.54% Night (Nurses/Mwife) 94.41% Night (Care Staff) 89.07%		15 of the 21 wards reported staffing levels under 90.00% in December 2020 for registered nurses in the day . 8 wards were above 90.00% for HCA staff. The fill rate percentage has reduced during this month due to staff absence, reduced shift fill through bank and agency and the opening up of additional beds for the COVID-19 pandemic.	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. All wards have senior nurse oversight by a Matron and Lead Nurse, who will remain on the ward to support if required.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework | Risk Register | Care Quality Commission | Trust Strategy

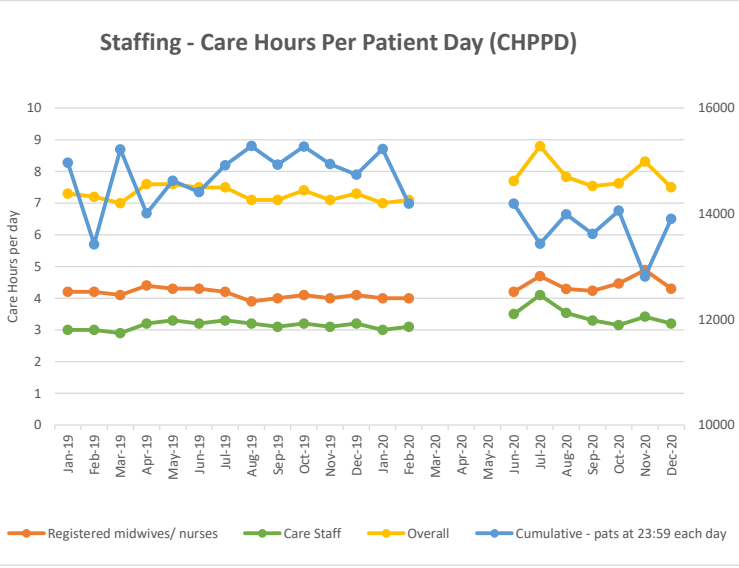
Quality Improvement - Trust Position

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

In month, the average CHPPD were:
Nurse/Midwife: 4.3 hours
Care Staff: 3.2 hours
Overall: 7.5 hours



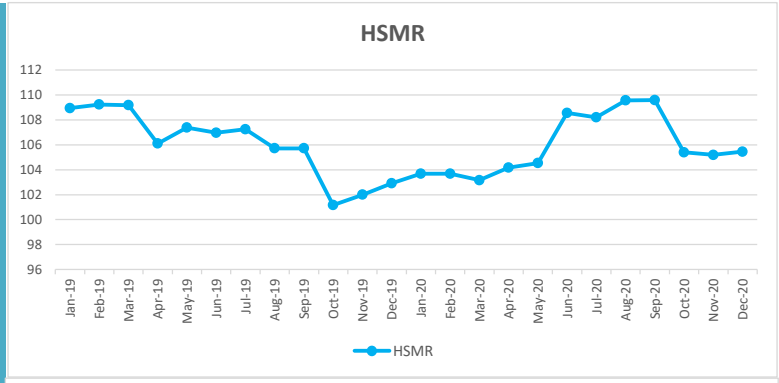
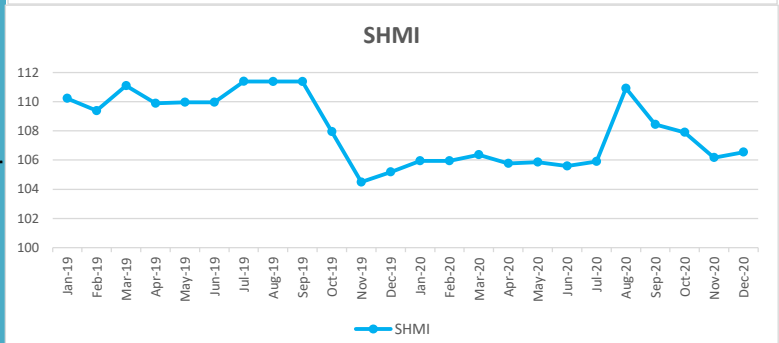
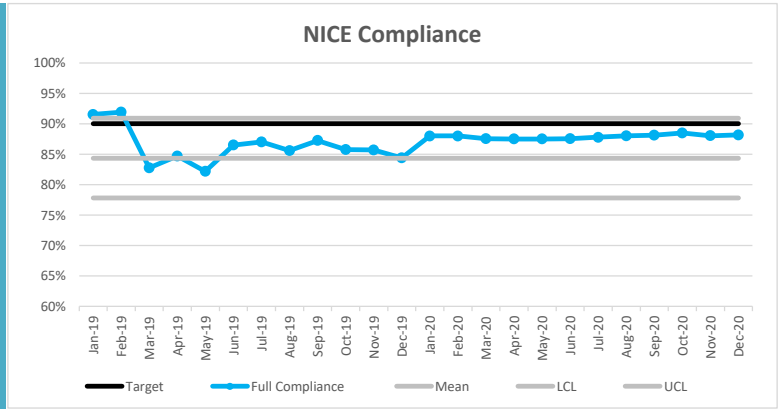
In December 2020, CHPPD was recorded at 7.5 in month with a 2020/21 YTD figure of 7.8, against the national median rate of 9.1 and peer median rate of 8.3.

Ward staffing levels continue to be systematically reviewed, which includes Planned vs. Actual staffing levels. These are reported monthly as part of the Unify submission and any ward that falls below 90.00% provides mitigation to ensure safe, high quality care is consistently being delivered in those areas.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single 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)?
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	CQC The most recent HSMR is within the expected range and is 105.45 against 102.27 for our peers. The Trust is ranked 9/18 in the peer group.		HSMR and SHMI have shown a slight increase when compared to the previous month. Both remain within the expected range: 105.45 for HSMR and 106.54 for SHMI.	Mortality reviews will continue to be undertaken alongside the governance incident process to ensure triangulation and learning. The process will continue to be overseen by the Trust Mortality Lead with escalation to the Deputy Director of Governance.
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	SOF CQC The most recent SHMI is within the expected range at 106.54 against 106.01 for our peers. The Trust is ranked 9/18 in the peer group.			
NICE Compliance Red: Below 75% Amber: 75% to 89% Green: 90% or Above	SOF The Trust achieved 88.17% in month.		The overall Trust compliance level is currently 88.17%.	The Trust expects a delay in assessing the outstanding NICE compliance due to the COVID-19 pandemic. This is reported to Patient Safety and Effectiveness Sub Committee

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework | Risk Register
Care Quality Commission | Trust Strategy

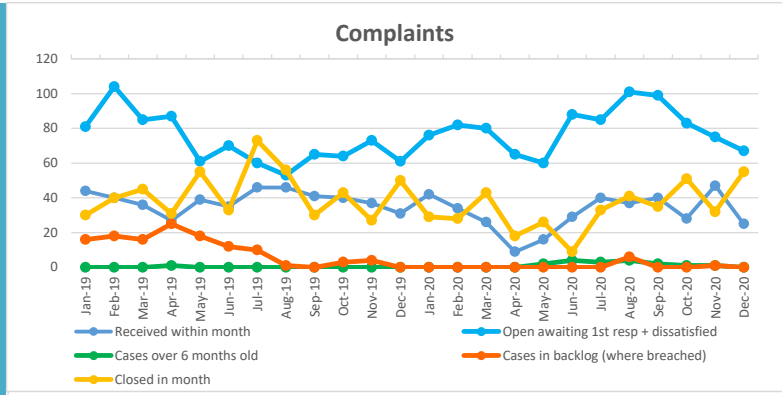
Quality Improvement - Trust Position

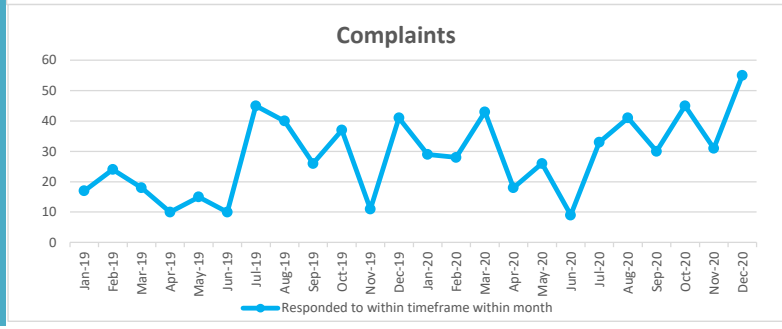
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Patient 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 there was a 46.80% reduction of new complaints into the trust. The Trust has continued to improve performance in the timely closure of complaints when compared to the previous month, closing 100% within timeframe, a 3.00% improvement. There were 67 open complaints, with no complaints open over 6 months old. This is a 10.6% reduction in open complaints from November 2020 and represents a 33.3% improvement in numbers open since September 2020.





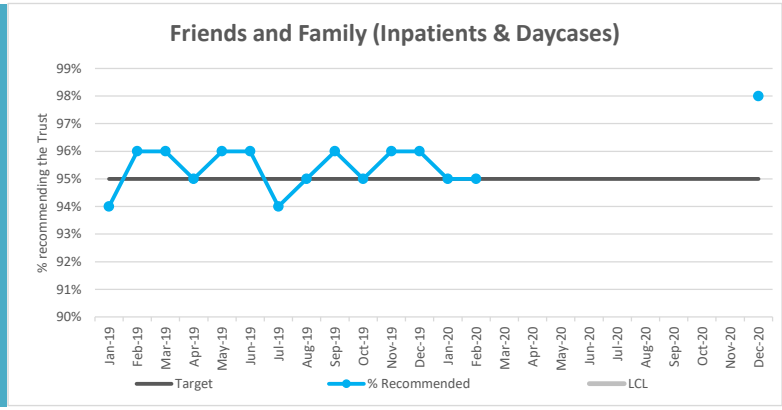
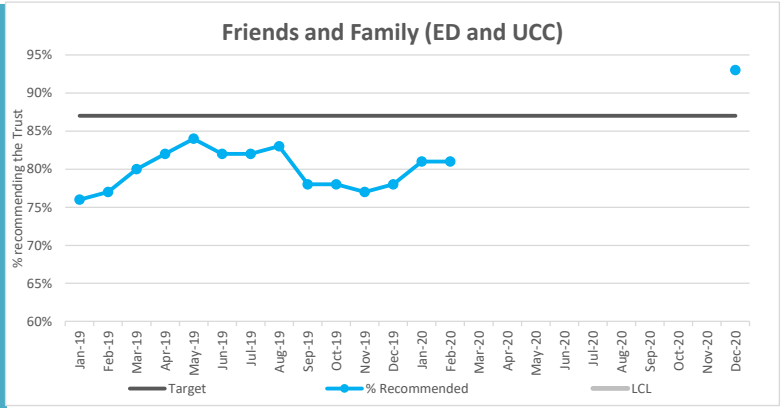
During December, 55 complaints were closed (43.7% increase from November). The trust improved performance in the timeliness of responding to complaints by 3.00%. CBUs continue to work closely with the Complaints Team. The Trust has established effective escalation processes.

Daily complaints progress reports and the weekly performance report are reviewed by the Associate Director of Governance and Deputy Director of Governance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework | Risk Register
Care Quality Commission | Trust Strategy

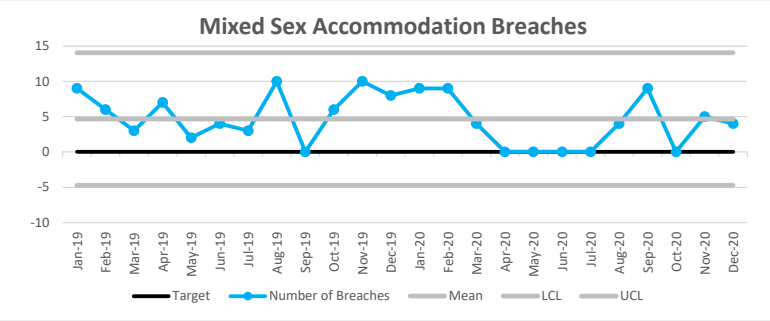
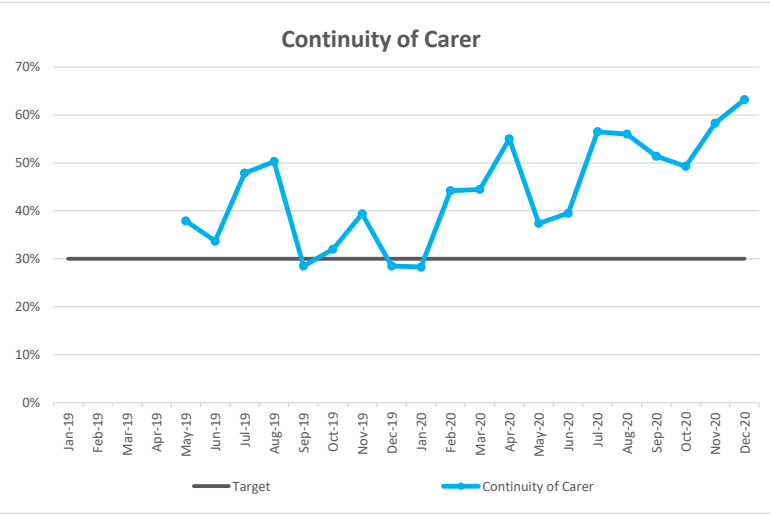
Quality Improvement - Trust Position

	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	SOF CQC S The Trust achieved 98.00% in month.		The Trust has met the standard set of 95.00% recommendation rate. The Trust recommenced FFT surveys in line with national guidance. The Trust achieved 98.00% recommendation rate in December 2020.	Clinical Business Units provide a high level briefing paper to the Patient Experience Sub-committee monthly, detailing FFT recommendation rates and FFT feedback response. Recommendation rates continue to be monitored through Quality Metric reports.
Friends and Family (ED and UCC) Red: Less than 87% Green: 87% or more	SOF CQC S The Trust achieved 93.00% in month.		The Trust achieved 93.00% recommendation rate against a target of 87.00% which is an improved position.	Alternative methods of gathering feedback within Urgent & Emergency Care have been implemented, such as online via IPads to increase the chance of real time or near real time feedback.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework | Risk Register | Care Quality Commission | Trust Strategy

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 Red: 1 or more Green: Zero	There were 4 mixed sex accommodation incidents during December 2020.		There were 4 MSA breaches reported in December 2020. National Trajectory: The Trust has not met the national target of 0.	Patients are cohorted to minimise breaches and step down is expedited as soon as is practicable.
Continuity of Carer Green: 35% or Above Amber: 25% - 34% Red: below 25%	The target for women being booked onto a continuity of carer pathway by March 2021 is over 51.00% of all women booked (in and out of area (National). The Trust achieved 63.20% of 'in area' women, if 'out of area' are included the figure is 50.20%. The Trust remains on target for 100% of in area women to be on a CoC pathway (including intrapartum care) by March 2021.		The Trust achieved 63.20% in December 2020 for 'in area' patients. The Trust is on target for March 2021.	New care models have been developed by the CBU to enable the Trust to deliver 100% against the Continuity of Carer standard. New models will require investment in staffing for which a business case is being progressed.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework | Risk Register | Care Quality Commission | Trust Strategy

Quality Improvement - Trust Position

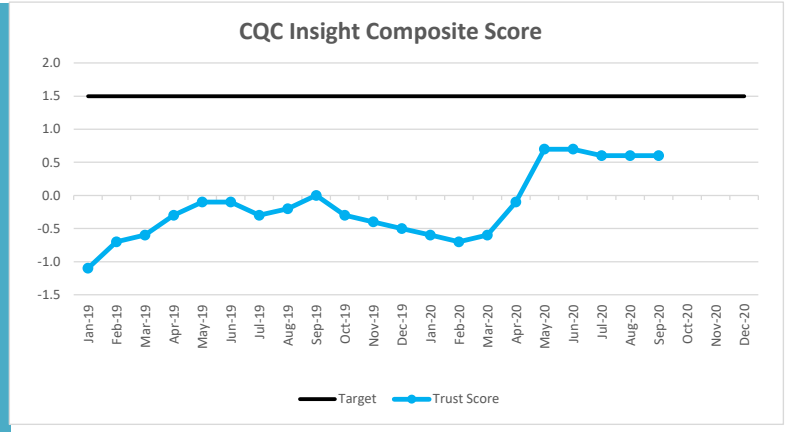
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

CQC

CQC Insight Composite Score

Red (inadequate): <-3
Amber (req improvement): >-2.9 - 1.5
Green (good/outstanding): >1.5

The Trust CQC Insight Composite Score is +0.6 (latest report as of September).



A number of areas of improvement have been noted:

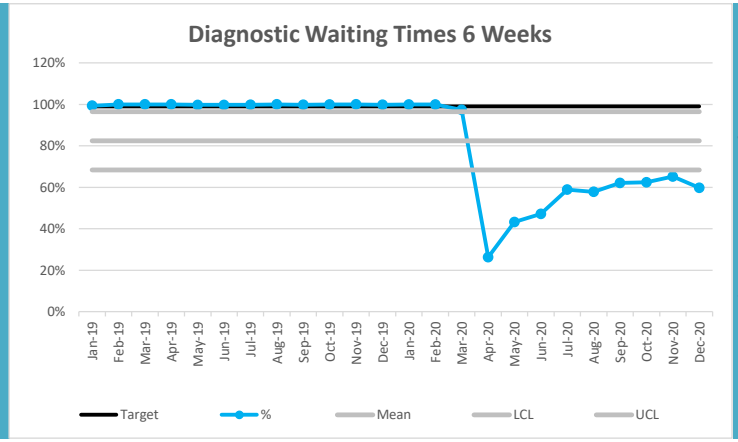
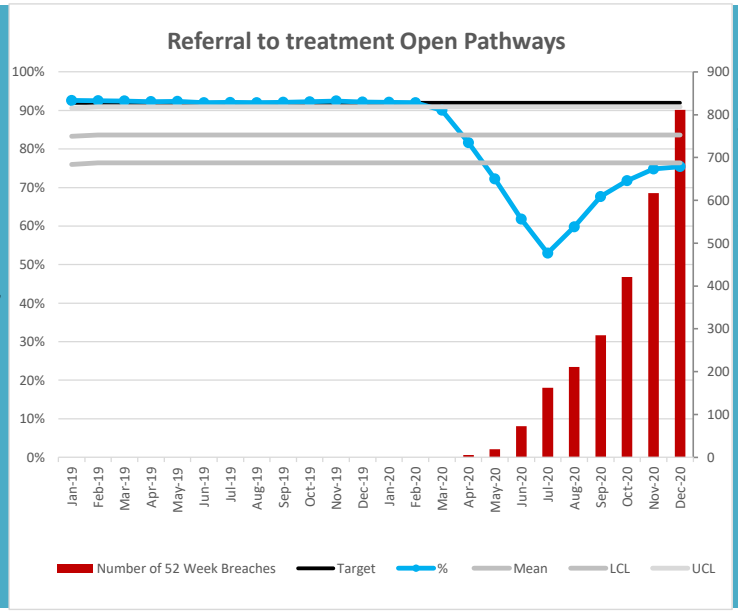
- Deaths in Low-Risk Diagnosis Groups
- Digital maturity capabilities score
- Digital maturity infrastructure score
- Digital maturity readiness score
- Morale
- Quality of appraisals
- Quality of care
- Ratio of ward manager nurses to senior and staff nurses
- Safety Culture
- Staff Engagement

At Moving to Outstanding Steering Group all actions from the CQC inspection in 2019 have been concluded. A revised plan has been drafted and is being shared at the next Moving to Outstanding meeting. Work is now being completed with the Maternity team and data warehouse to reflect CQC's change in methodology.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

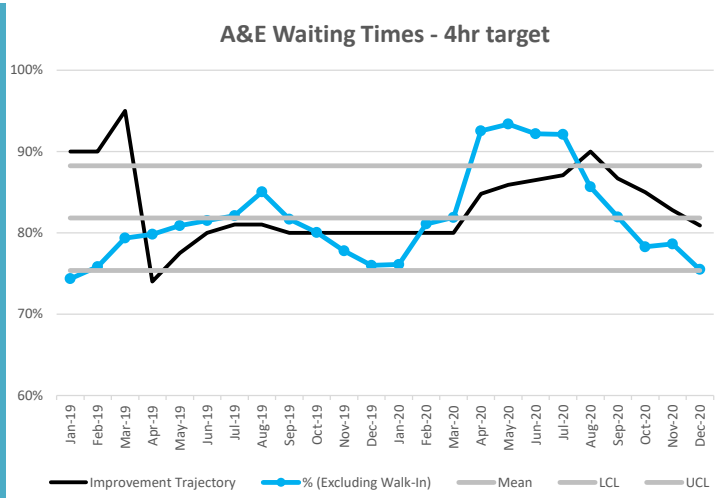
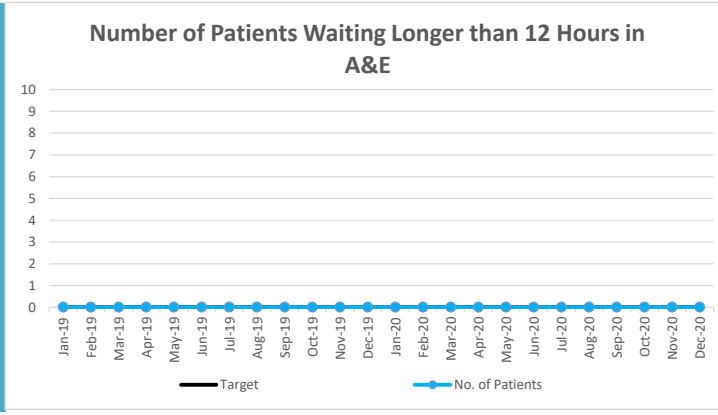
Key:
Risk Register RR116
Single Oversight Framework SOF
Care Quality Commission CQC

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)?
Diagnostic Waiting Times 6 Weeks **Red: Less than 99%** **Green: 99% or above**		**The diagnostic standard was not achieved in December 2020, this was due to the impact of the COVID-19 pandemic. The number of breaches have significantly increased as services were suspended due to adherence to national guidance.**	**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 on-line. 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 and Cystoscopy.**
Referral to treatment Open Pathways **Red: Less than 92%** **Green: 92% or above** **RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red**		**The Trust ceased all routine work in April 2020 following national guidance to prepare capacity to manage the anticipated demand from COVID-19. Performance has been maintained in December with a little movement in the number of patients waiting more than 18 weeks. The number of patients waiting 52 weeks + at the end of December was at 811. Since the temporary pause of some non urgent services in October, the phase 3 trajectory in December is not compliant.**	**Recovery of the elective programme is taking place with:** **• Urgent cancer and elective activity is being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of vulnerable 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.** **• Updated papers on the management of patients on waiting lists are reviewed by the Quality & Assurance (QAC) Committee. An updated report will be available for the Patient Safety and Effectiveness Committee and QAC as a regular agenda item on these committees.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

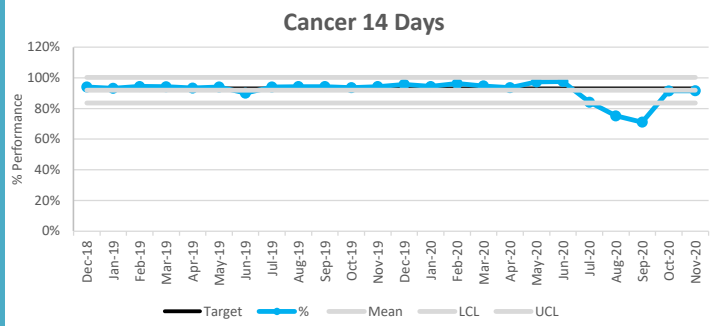
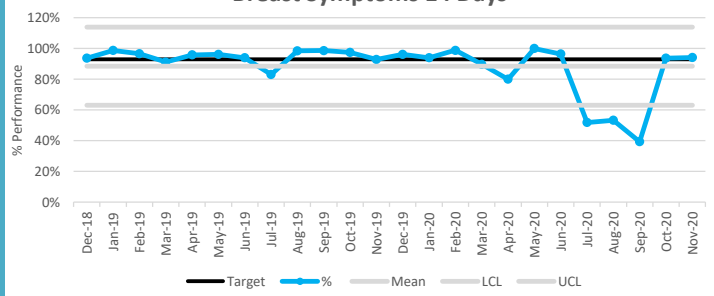
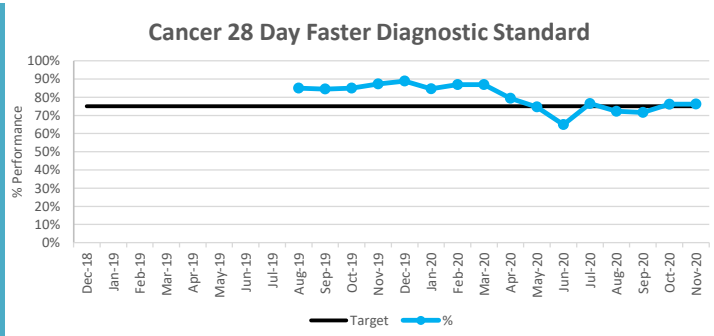
Key:
Risk Register
Single Oversight Framework
Care Quality Commission

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	SOF CQC The Trust achieved 75.50% excluding walk ins in month. RR224		There was a reduction in performance in December to 75.50% (excluding Widnes Walk-in activity). This is attributable to attendances reaching c80.00% in the same period as last year, whilst having to accommodate the complexities of caring for COVID-19 patients. In addition to this, the position was impacted by the activity typical of the festive period and long bank holidays. From the 26th December onwards, the position was impacted by the transition into Wave 3.	• System partners have been engaged to support the reduction of Super Stranded patients in the bed base to create capacity to support flow. • The Trust was successfully awarded capital funding to develop and build a new ED Plaza, this will in the longer term, support ED Flow. • The actions developed in response to the Royal College of Emergency Medicine guidance, Resetting Emergency Department Care, continue to be taken forward and monitored via the COVID-19 Recovery Group.
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	SOF There were 0 patients waiting longer than 12 hours in A&E in month.		The Trust has achieved the standard of not having any patients waiting longer than 12 hours from the decision to admit in December 2020. This standard has been consistently achieved over time.	Maintain compliance against the 12 hour standard from the decision to admit.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

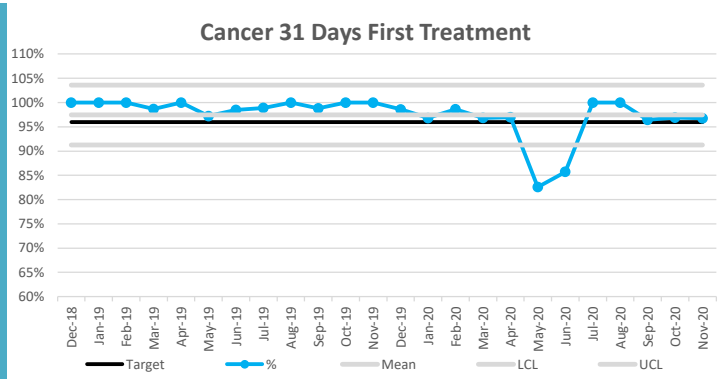
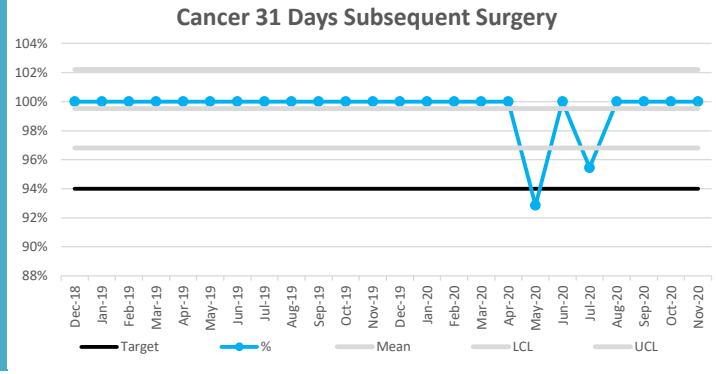
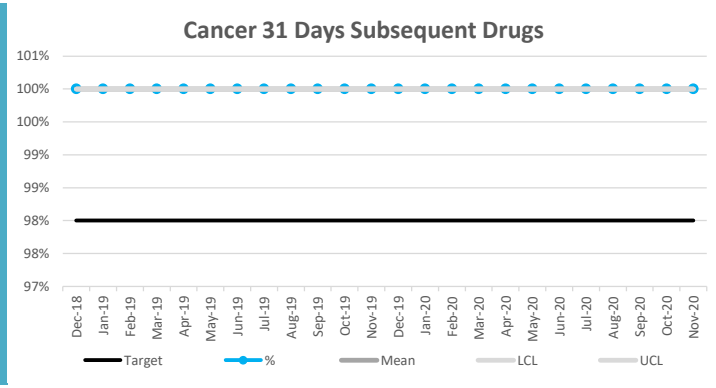
Key:
Risk Register
Single Oversight Framework
Care Quality Commission

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 RR116 **The Trust achieved 91.54% in November 2020.**		**The Trust did not achieve the 2 week wait standard in November 2020. However, it should be noted that there has been significant improvement since the appointment of a new locum in the Breast service at the end of August. The position is impacted by the availability of capacity due to COVID-19. The Trust did achieve the Breast Symptomatic standard in month.**	**The Trust will continue to review capacity.**
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above SOF CQC RR116 **The Trust achieved 94.12% in November 2020.**			
28 Day Faster Cancer Diagnosis Standard Red: Less than 75% Green: 75% or above **The Trust achieved 76.21% in November 2020.**		**The Trust continues to participate as the test site for the 28 day Faster Diagnosis standard as part of the clinical review of all cancer access standards. The Trust achieved the standard in November 2020 against a target of 75.00%.**	**Continue to maintain improvement against the FDS clinical review of standards pilot.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

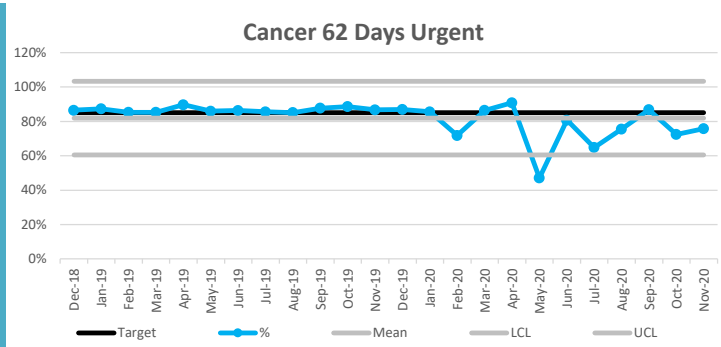
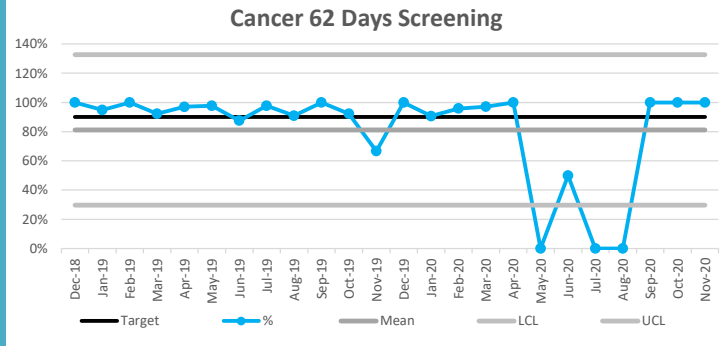
Key:
Risk Register | Single Oversight Framework | Care Quality Commission

	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 96.77% in November 2020.** RR116		**The 31 day cancer target was achieved in November 2020 at 96.77% This was the result of a positive action to utilise the capacity to treat these urgent cases in the same month.**	**There remains a risk for performance for approximately the next 2-3 months due to the number of patients who had their diagnostic suspended and are now returning to active management.**
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	SOF CQC **The Trust achieved 100% in November 2020.** RR116			
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	SOF CQC **The Trust achieved 100% in November 2020.** RR116		**The Trust achieved 100% in November 2020.**	**Maintain compliance against the 31 day subsequent treatment (drug) standard.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register RR116
Single 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**		**The 62 day urgent target was not achieved in November 2020 at 79.75%, however the Trust achieved 100% for screening.**	**There remains a risk for performance for approximately the next 2-3 months due to the number of patients who had their diagnostic suspended and are now returning to active management.**
Cancer 62 Days Screening **Red: Less than 90%** **Green: 90% or above**			

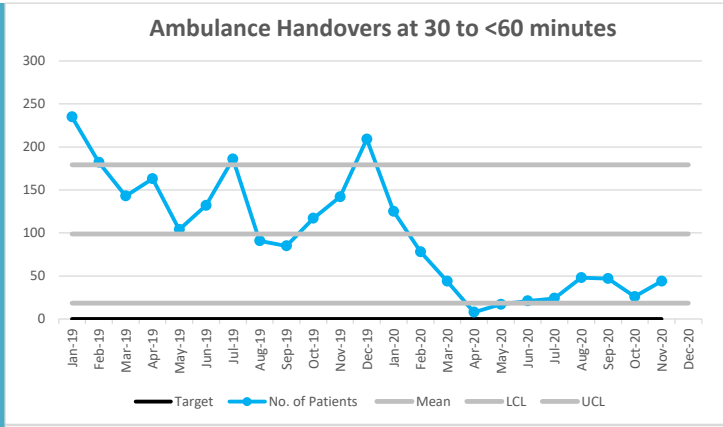
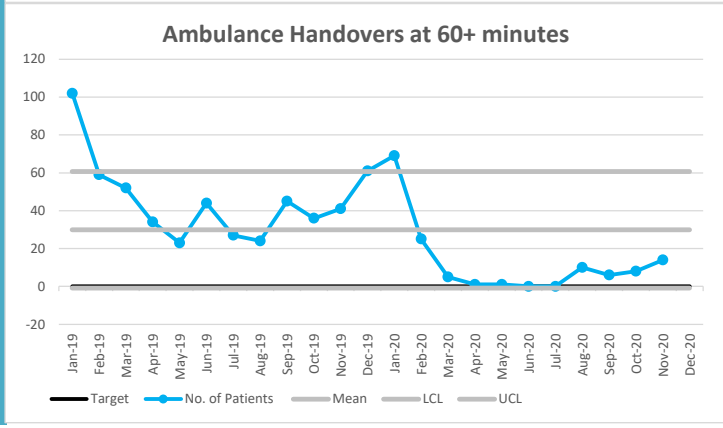
The Trust achieved 75.79% in November 2020.

The Trust achieved 100% in November 2020.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register
Single Oversight Framework
Care Quality Commission

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**		**Performance against this standard remains in line with operational predictions based on previous months. The data was not available at the time of writing this report.**	**Regionally, the Trust continues to perform well compared to peers for over 60+ minute delays and continues to participate within the regional collaborative aimed at reducing delays during the winter period. The Trust will continue to work in partnership with the North West Ambulance Service to identify and implement improvements. Ambulance waiting times are reviewed daily on the Cheshire and Merseyside Gold Call.**
Ambulance Handovers at 60 minutes or more **Red: More than 0** **Green: 0**			

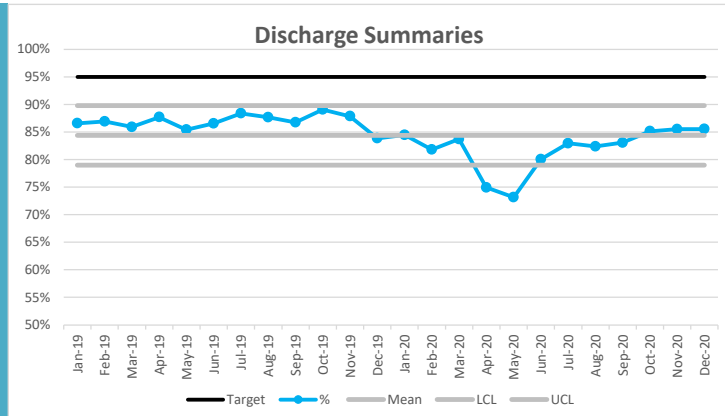
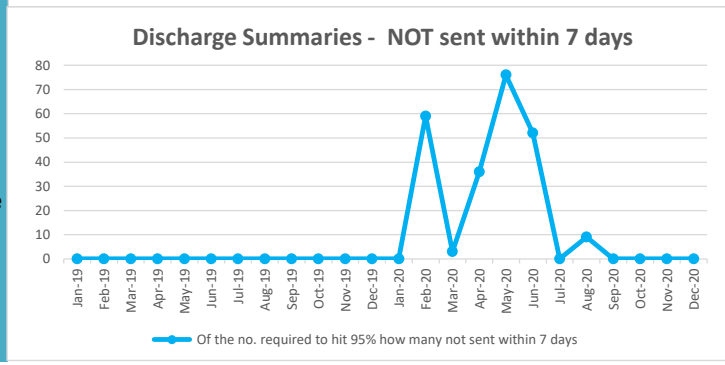
Ambulance handover data was not available in month from the North West Ambulance Service. In November 2020 there were 44 patients who experienced a delayed handover of between 30 and 60 minutes.

Ambulance handover data was not available in month from the North West Ambulance Service. In November 2020 there were 14 patients who experienced a delayed handover of over 60 minutes.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register RR110
Single Oversight Framework SOF
Care Quality Commission CQC

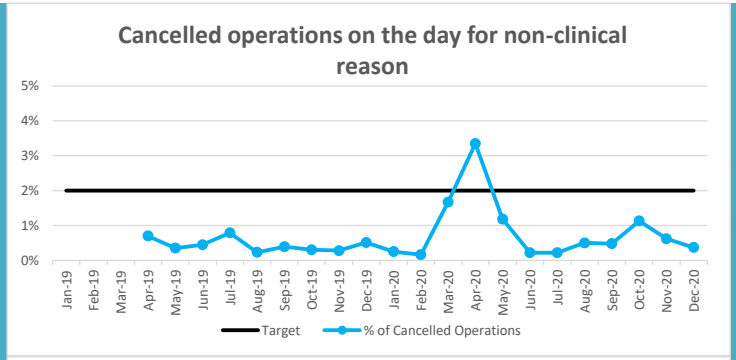
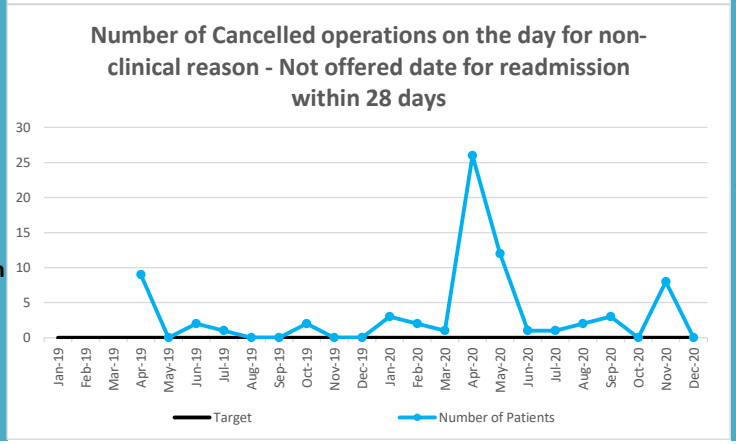
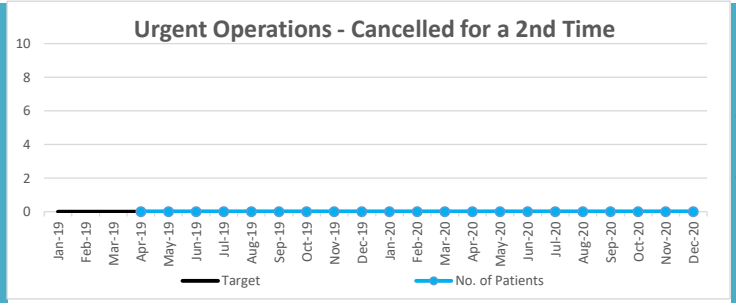
Access & Performance - Trust Position

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**	RR123 **The Trust achieved 85.54% in month.**		**There has been a sustained improvement in the number of discharge summaries sent within 24 hours in December. Performance is starting to return to pre COVID-19 levels. However, the standard remains a focus of the CBUs. There is weekly scrutiny at the PRG and monthly at the KPI meeting.**	**The Performance Review Group continues to monitor this standard to support improvements.**
Discharge Summaries - Number NOT sent within 7 days **Red: Above 0** **Green: 0**	RR123 **There were 0 discharge summaries not sent within 7 days required to meet the 95.00% threshold.**		**The Trust did achieve compliance against the 7 day discharge summary standard in December 2020.**	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

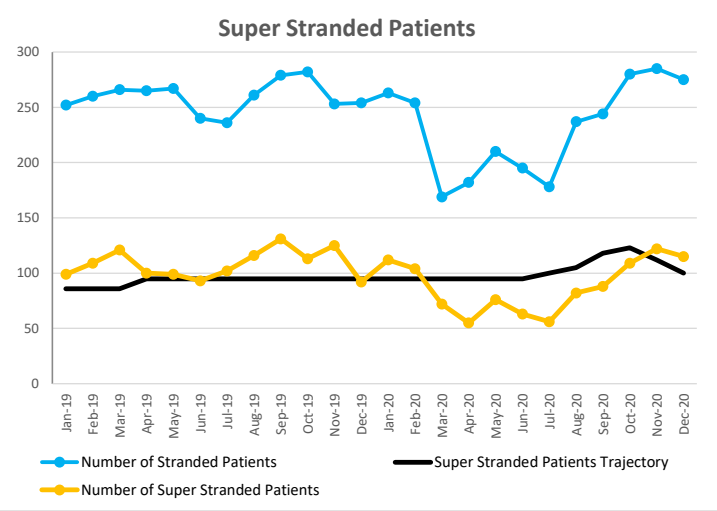
Key:
Risk Register
Single Oversight Framework
Care Quality Commission

	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%	0.37% of operations were cancelled on the day for non clinical reasons in month.		In December 2020, there was a decrease in the number of cancelled operations on the day. This remains below the monitored threshold of 2.00%.	Recovery of all activity as a consequence of the COVID-19 pandemic is being monitored via daily elective meetings, supported by Recovery Board.
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 0 cancelled operation on the day for non clinical reasons in month, where the patient was not re-booked in within 28 days.		There was 0 cancelled operation not offered a date for readmission within 28 days in December 2020.	
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

Access & Performance - Trust Position

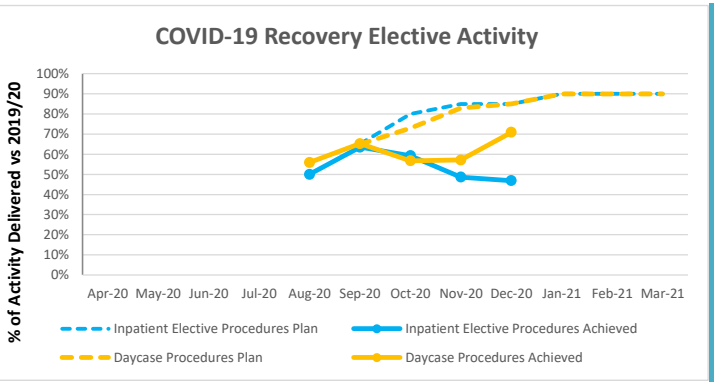
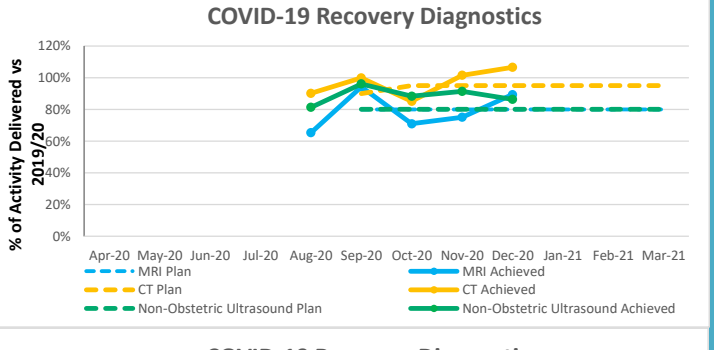
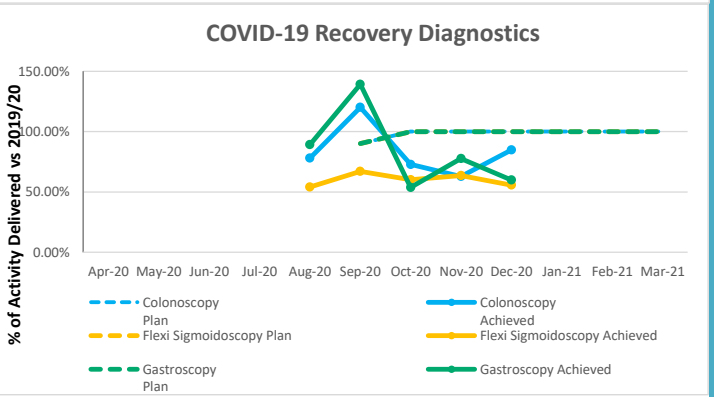
Key:
Risk Register
Single Oversight Framework
Care Quality Commission

	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 115 super stranded patients at the end of the December 2020.		The number of Stranded and Super Stranded patients on the last day of the month decreased in December. This position is being impacted by a longer length of stay as a result of Infection Prevention and Control (IPC) discharge issues. This is a national and regional challenge.	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 "Focus on Flow" Length of Stay meetings on a daily basis to support timely discharge.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

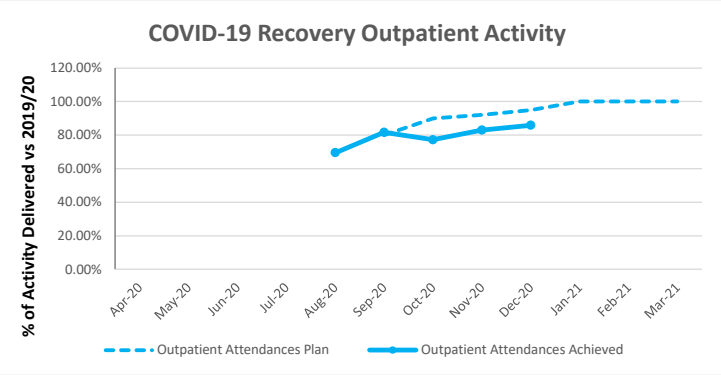
Key:
Risk Register
Single Oversight Framework
Care Quality Commission

	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 90% of 2019/20 Activity Green = 90% or greater of 2019/20 Activity	In December 2020, the Trust achieved the following % of activity against December 2019. This included 70.95% of Daycase Procedures and 46.89% of Inpatient Elective Procedures.		Progress against Elective activity recovery as per the Phase 3 submission has been stalled as a result of the impact of wave 2 COVID-19. Further curtailment of non urgent activity on a temporary basis at the end of October to support the rising number of COVID-19 positive patients and safe staffing levels, has deteriorated the position further.	The Trust monitors the impact weekly and will progress measures to switch services back on at the earliest opportunity based on the impact of COVID-19. The Trust actively engages and explores opportunities for mutual aid in the form of staffing, ICU and surgical capacity.
COVID-19 Recovery Diagnostics RED = Below 100% of 2019/20 Activity GREEN = 100% or greater of 2019/20 Activity	In December 2020, the Trust achieved the following % of activity against December 2019. This included: 89.30% of MRI 106.63% of CT 86.34% of Non Obstetric Ultrasound 84.80% of Colonoscopy 55.56% of Flexi Sigmoidoscopy 59.94% of Gastroscopy	 	Progress against Diagnostic recovery as per phase 3 has been stalled as a result of the impact of wave 2 COVID-19. Good progress has been maintained in Radiological modalities however challenges remain in Endoscopy, Cystoscopy and Cardiorespiratory.	The Trust monitors the impact weekly and will progress measures to switch services back on at the earliest opportunity.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register
Single Oversight Framework
Care Quality Commission

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 Recovery Outpatient Appointments RED = Below 100% of 2019/20 Activity GREEN = 100% or greater of 2019/20 Activity	In December 2020, the Trust achieved 85.90% of Outpatient activity against December 2019.		Progress against Elective activity recovery as per the Phase 3 submission has been stalled as a result of the impact of wave 2 COVID-19. Further curtailment of non urgent activity on a temporary basis at the end of October to support the rising number of COVID-19 positive patients and safe staffing levels, has deteriorated the position further.	The impact remains to be mitigated by the switch from face to face to non face to face methods such as telephone and video appointments.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance

Trend

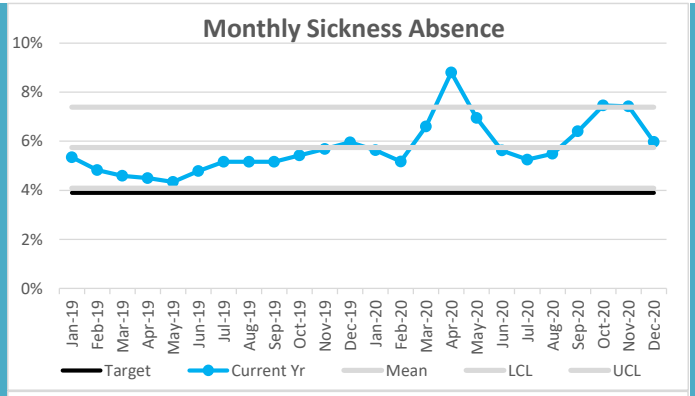
What are the reasons for the variation and what is the impact?

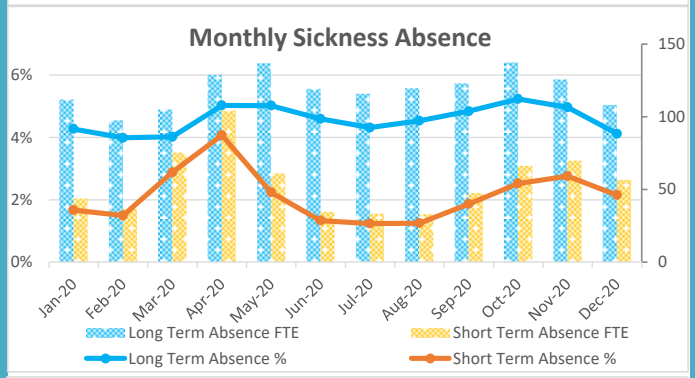
How are we going to improve the position (Short & Long Term)?

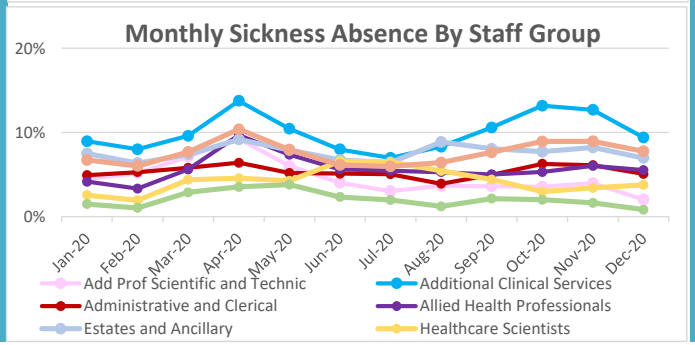
Sickness Absence

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

The Trust's sickness absence was 6.27% in month.
SPC - There is evidence of special cause variation for sickness absence.







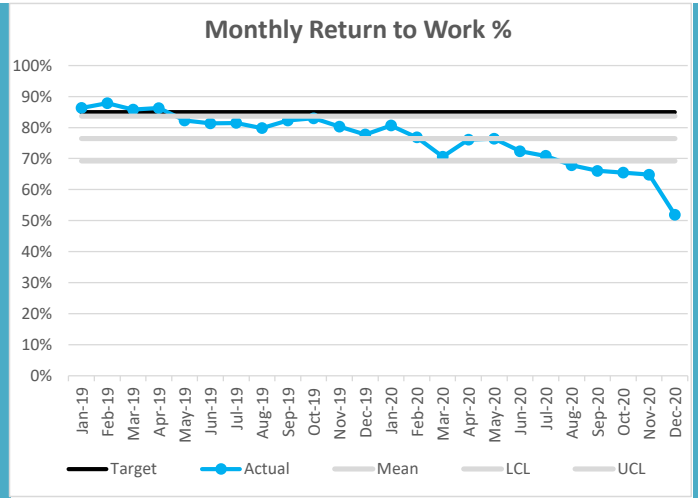
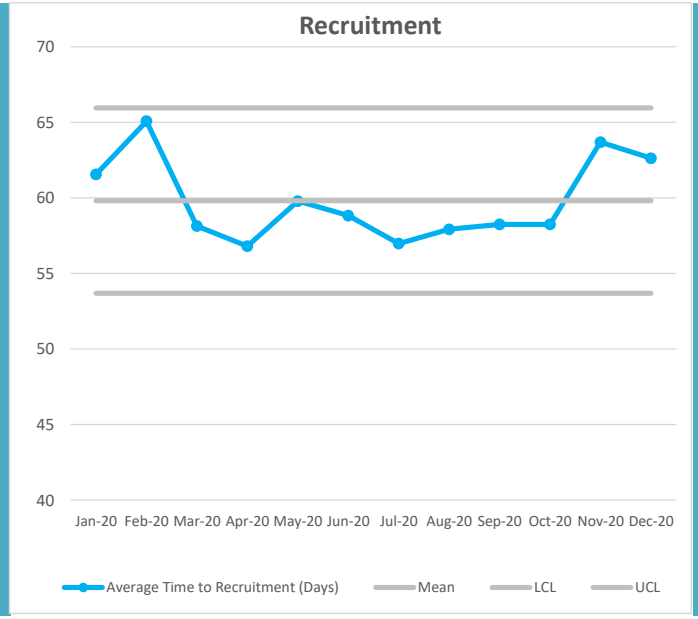
Sickness absence has decreased to 6.27% in December 2020. This is the first monthly decline since October 2020. The decrease is across both short and long term absence. The sharpest decrease has been amongst the Additional Clinical Services staff group, although they remain the group with the highest rate of absence.

Please see the end of this Workforce dashboard for additional detail around actions taking place to address sickness absence.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

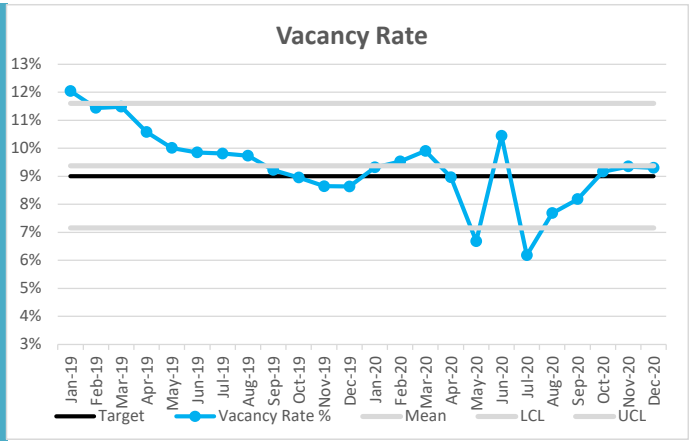
Key:
Single Oversight Framework
Use of Resources Assessment
Risk Register
Care Quality Commission
Trust Strategy

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 51.90% in month. SPC - There is evidence of special cause variation for Return to Work compliance.		Return to work interview compliance has reduced significantly due to pressures relating to COVID-19.	Return to work interviews remain a vital part of the support in place for our workforce and a review of this process will form part of workforce recovery planning. The HR Business Partners continue to support the CBUs to improve their compliance through monthly meetings. Completion of return to work interviews has been highlighted as an issue in the Attendance Management Deep Dive and is addressed within the recommendations.
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 63, based on the last 12 months average. SPC - Recruitment time is within common cause (expected) variation.		Recruitment time to hire has increased in November and December 2020, although remains below target (positive).	The Trust continues to take advantage of improved national guidance and support, this includes: • Verification of original documents: now able to accept scanned and emailed copies of original documentary evidence for urgent appointments. • References and Employment History – now able to accept one reference from the individual's current or previous employer (previously had to cover last 3 years). The Trust has also made a number of amendments to keep time to hire to a minimum: • Inductions are now weekly providing much more flexibility with start dates. • Managing expectations of both the candidates and recruiting managers through improved communications • Contractual change letters are now emailed using the information supplied on the contractual change form (ECF).

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
Single Oversight Framework
Use of Resources Assessment
Risk Register
Care Quality Commission
Trust Strategy

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 Trust vacancy rate was 9.30% in month. SPC - there is evidence of special cause variation for Vacancy Rates.**		**Vacancy rates remained static in December 2020 and at 9.30%, are slightly above the 9.00% target.**	**Recruitment has continued as per usual processes. During the last 12 months the Trusts headcount has increased, indicating an ability to both attract candidates and retain it's current workforce.**

Vacancy Rates

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
Single Oversight Framework
Use of Resources Assessment
Risk Register
Care Quality Commission
Trust Strategy

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)?

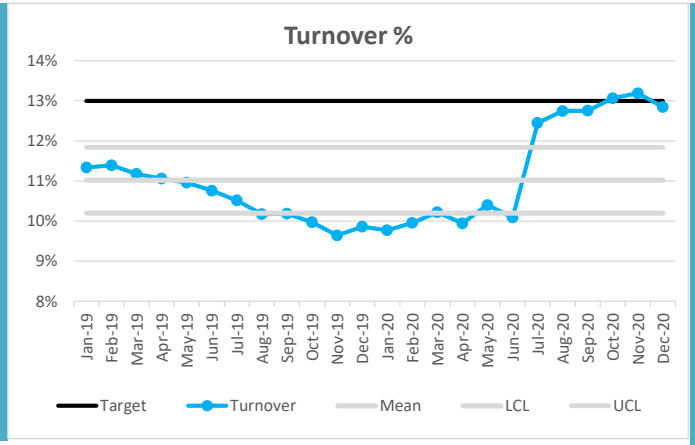
Turnover

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

CQC UoR

Trust Turnover was 12.85% in month.
SPC - There is evidence of special cause variation for Turnover.

S SOF



The increasing trend in turnover in October and November 2020, which was due to the increased number of leavers of temporary staff, has reversed in December 2020. Turnover is now 12.85% which is below target (positive). Similar to turnover, retention has improved in December 2020 and is above target at 87.30%.

A range of work delivered and on-going as part of the WHH People Strategy and the NHS People Plan support retention of staff, including:

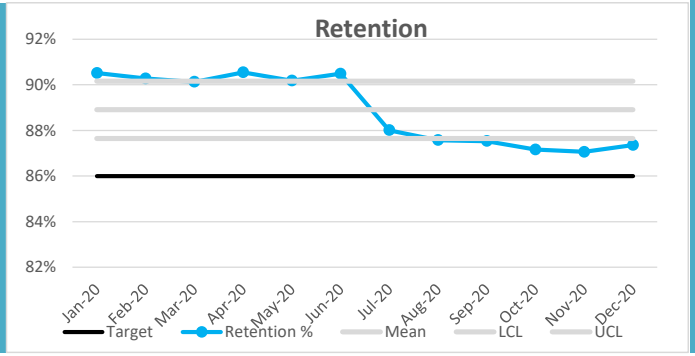
- **Compassionate Leadership Development Programmes**
- **Staff networks and celebrations of diversity**
- **Promotion of flexible working**
- **Review and marketing of the WHH Offer to staff**
- **Team development**
- **Health and wellbeing offers**

Retention

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

UoR

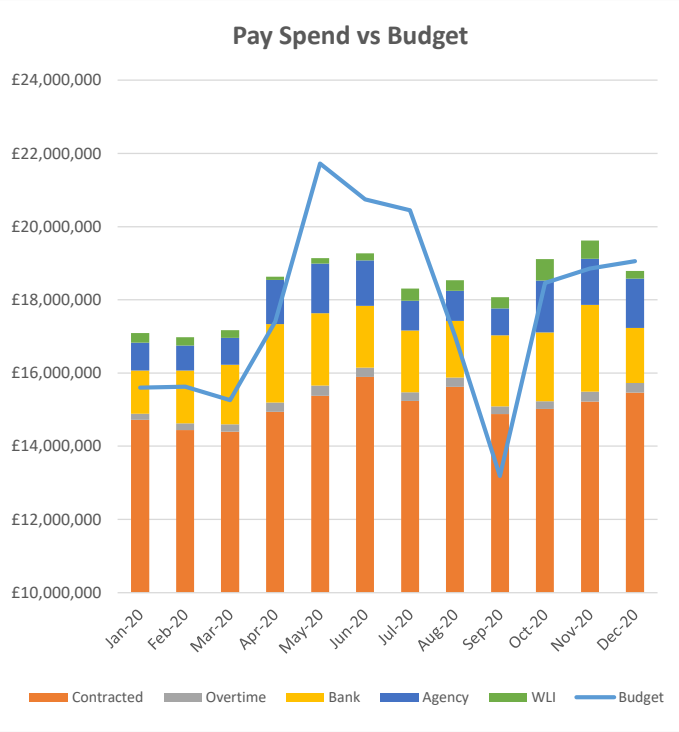
Trust Retention was 87.35% in month.
SPC - There is evidence of special cause variation for Retention.



Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

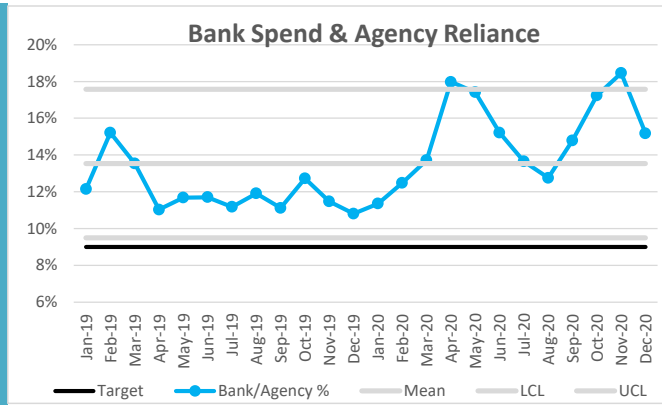
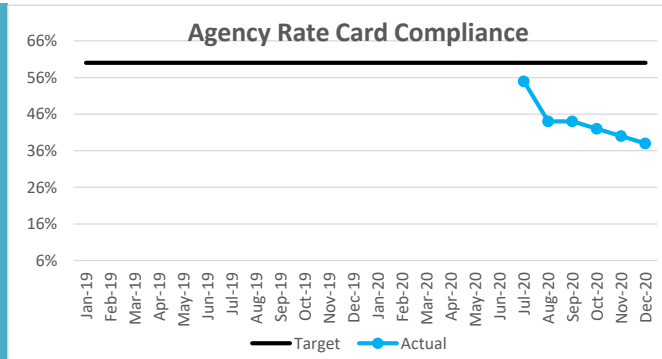
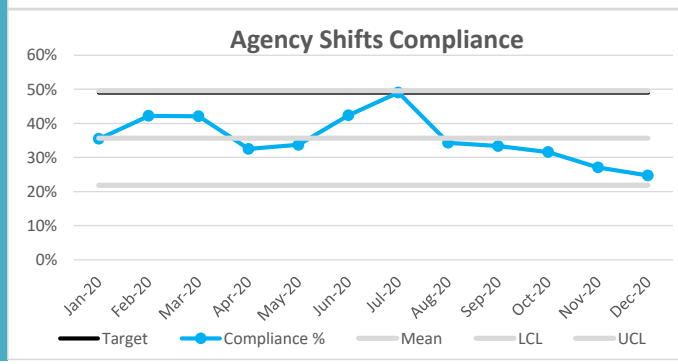
Key:
Single Oversight Framework
Use of Resources Assessment
Risk Register
Care Quality Commission
Trust Strategy

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		Total pay spend in December 2020 was £18.8m against a budget of £19.0m. The total pay spend is broken down into the following elements: • £15.5m Contracted Pay (i.e. substantive staff) • £1.5m Bank Pay • £1.4m Agency Pay • £0.21m Waiting List Initiative (WLI) Pay • £0.26m Overtime Pay	Additional controls and challenges around pay spend have been identified, to support a reduction in premium pay: • Enhanced ECF process for non-clinical vacancies; • Expanded ECF process for some temporary staffing pay spend; • Implementation of Cheshire and Mersey Rate Cards; • Introduction of Patchwork Medical Bank system; • Introduction of +Us Medical Agency System; • Introduction of central bank and agency team Through the Finance and Sustainability Committee, compliance against our processes and rate cards is being monitored. This has enabled the Trust to identify where additional support from the central bank and agency team is required.
	Trust pay spend was below budget in month.		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

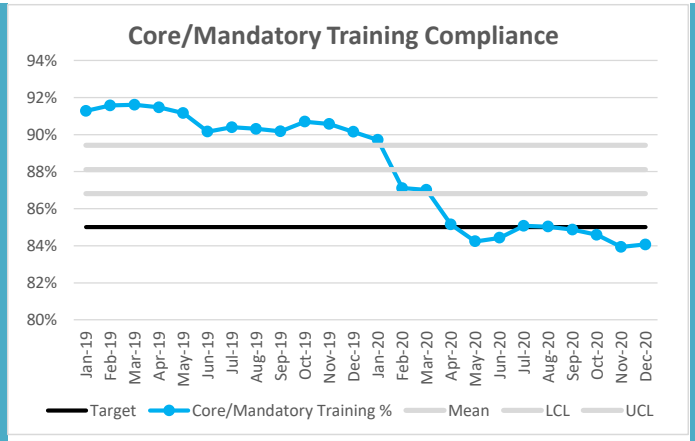
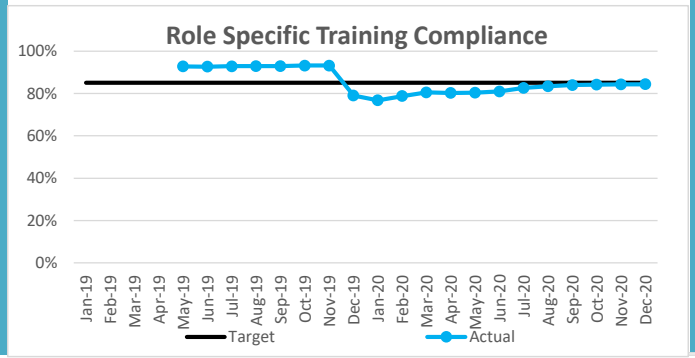
Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy ($)

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)?
Bank and Agency Reliance Red: 11% or Above Amber: 11% to 9% Green: 9% or Below	UoR RR199 **Bank and Agency Reliance was 15.18% in month. SPC - Bank/Agency reliance is within common cause (expected) variation.**		**Bank and Agency reliance reduced in December 2020 to 15.18%.**	**The Bank and Agency Team continue business as usual. Processes are in place to ensure appropriate sign off of the need for temporary staffing, the on-going negotiation of rates, recruitment onto the bank, removing the requirement for an agency worker.**
Agency Rate Card Compliance Red: below 50% Amber: 50-59% Green: 60% or above	UoR **Agency Rate Card Compliance was 38.00% in month.**		**24.68% of the overall agency shifts are compliant with the NHSI Price Cap and 38.00% of shifts are compliant with the C&M rate card.**	**As COVID-19 activity continues to increase, improved compliance will be a challenge. The central bank and agency team continue to support CBUs to negotiate rates down towards the Cheshire and Mersey Rate Card and the NHSI Price Cap compliance.**
Agency Shifts Compliant with the Cap Red: below 49% Green: above 49%	UoR **24.68% of shifts were compliant with the NHSI Price Cap. SPC - There is evidence of special cause variation within Agency Shift Compliance.**			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

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 70% Amber: 70% to 85%		Mandatory and Role Specific training were both 84% in December 2020, which is below target.	Current pressure mean that training compliance is a challenge, although staff are been encouraged to complete this via e-learning where possible.
Role Specific Training Red: Below 70% Amber: 70% to 85%			

CQC

Core/Mandatory training compliance was 84.07% in month.
SPC - there is evidence of special cause variation.

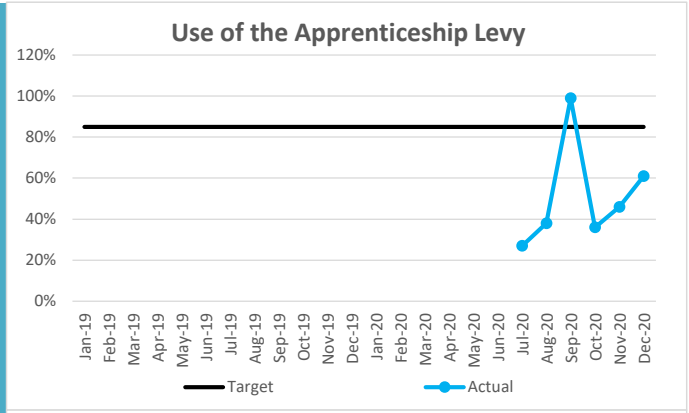
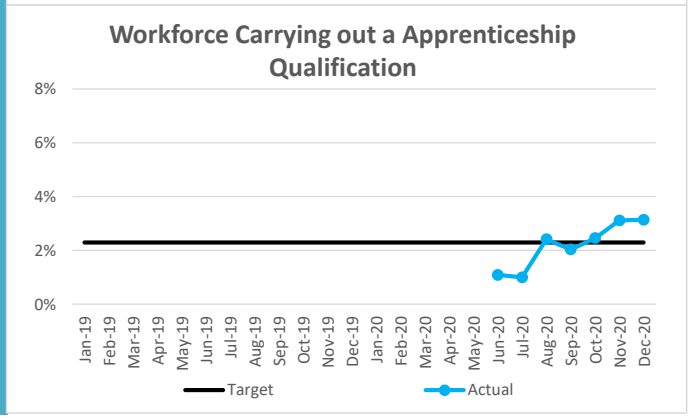
RR153

Role Specific Training compliance was 84.37% in month.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
Single 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		Utilisation of the apprenticeship levy has continued to increase and was at 61.00% in December 2020, with 3.14% of staff carrying out a qualification, which is above target (positive)	Use of the levy continues to be challenged for new recruitment and the uptake of formal training, using the apprentice levy.
Workforce carrying out an Apprenticeship Qualification Red: below 1.5% Amber: 1.5% - 2.2% Green: 2.3% or above			

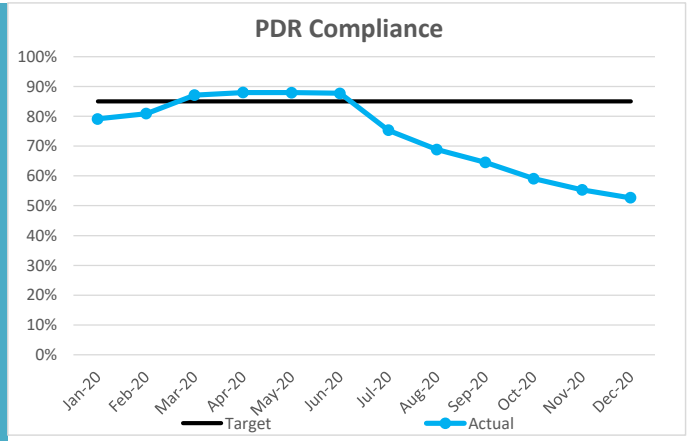
Use of the Apprenticeship Levy was 61.00% in month.

Percentage of the workforce carrying out a qualification was 3.14% in month.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
Single Oversight Framework
Use of Resources Assessment
Risk Register
Care Quality Commission
Trust Strategy

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 70% Amber: 70% to 85% Green: Above 85%		There was due to be a focus on PDR compliance during the month of October in line with the launch of the revised PDR process. The new PDR paperwork was launched, however due to the impact of COVID-19 the training sessions have been paused.	The Check in conversation tool designed by the Organisational Development team remains in use and can be used in lieu of the full appraisal where this is the preference of the staff member. The Trust is conscious that the pay step progression changes are due to go live in April 2021 and although it is anticipated to have a positive impact on PDR compliance, training and development will be required for staff and managers alike.
PDR compliance was 52.68% in month.			

Sickness Absence Actions

Occupational Health Support

The COVID-19 nursing advice line remains in place 7 days per week. The service includes a call handling team of non-clinical staff and a team of nursing staff. Opening hours have been extended from 4 January 2021 in response to the increase in demand for the service. This will be reviewed in early February 2021. The OH Team are also undertaking 'business as usual' functions such as management referrals and pre-employment clearances.

Staff Testing

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

Lateral Flow Testing is available to all asymptomatic patient-facing staff and staff working in Clinical Business Units. To date, 2174 staff members have volunteered to take part in the programme and there is a weekly positivity rate of 0.52%.

In January 2021, the Trust received notification that Cheshire and Mersey Trusts will be required to transfer to LAMP Testing for asymptomatic staff and the Trust has been assigned a tentative 'go live' date of 5 March 2021.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
Single Oversight Framework
Use of Resources Assessment
Risk Register
Care Quality Commission
Trust Strategy

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)?

Protecting Staff – Risk Assessments

COVID-19 Workforce risk assessments continue to be monitored and managed via the COVID-19 Workforce Risk Assessment tool. The Trust continues to submit compliance to NHS England. The Trust's current compliance is as follows:

- 89.88% of all staff have been risk assessed (all staff have been offered a risk assessment).
- 93.16% of known “at risk” staff have been risk assessed with mitigating steps agreed where necessary.
- 92.31% of staff known to be from a BAME background has been risk assessed with mitigating steps agreed where necessary.

The Trust recently sent a letter to all staff who still haven’t completed the self-risk assessment to encourage uptake.

COVID Vaccine

Over 5000 vaccines have been delivered to date - over 3000 to WHH staff. Analysis is underway to ensure that there is equitable access to the vaccine across the workforce.

Mental Health and Wellbeing

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

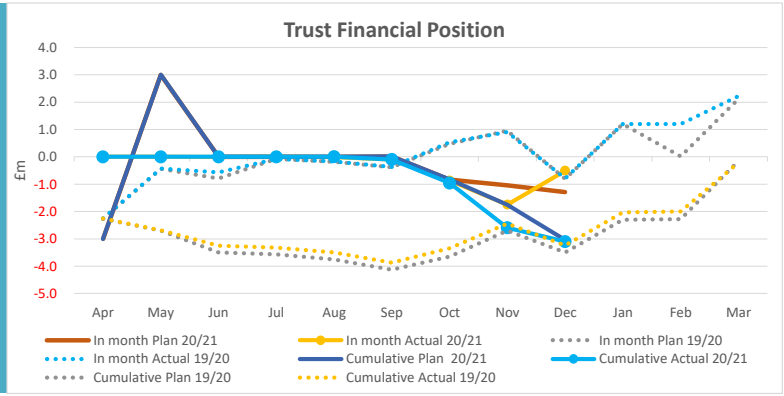
- One to one counselling
- Group counselling support sessions e.g. bereavement
- Team drop in sessions with counsellors
- Team development
- Facilitated debriefs
- Coaching
- Compassionate Leadership Programmes

In addition, bespoke interventions are provided across the OH, Wellbeing and OD Team, in response to the immediate and changing needs of staff.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
Single Oversight Framework | Care Quality Commission | Use of Resources Assessment | Trust Strategy | Risk Register

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 £3.1m as at 31 December.		For the period ending 31 December 2020 the Trust has recorded a deficit position of £3.1m against a deficit plan of £3.0m. The position includes a retrospective top up of £20.1m to support COVID-19 expenditure and income loss of £26.4m year to date.	The Trust is applying national guidance as this emerges in relation to financial planning.

Trust Financial Position

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

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:
Single Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy
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)?

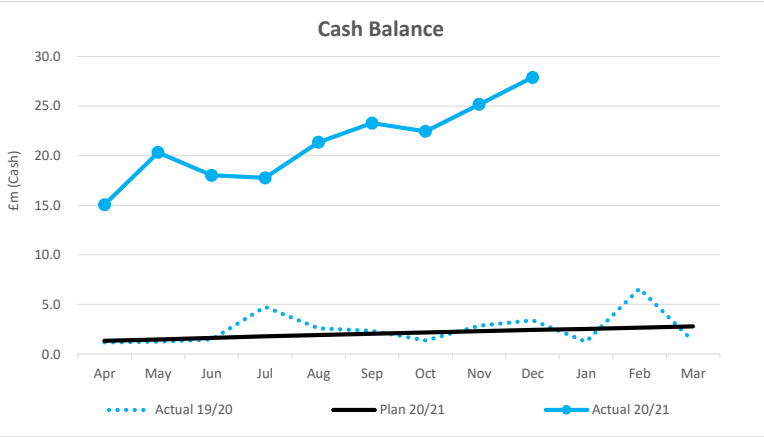
Cash Balance

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

UoR SOF

The current cash balance is £27.9m.

RR134



The current cash balance is £27.9m which is £25.5m better than plan. The current cashflow forecast shows a cash shortfall of circa £26m which is due to no block payment in March 2021 as two months were paid in April 2020. This was utilised to pay creditors of circa £16m in line with national guidance. This with the forecast deficit is a key driver of the cash position. It has been confirmed this week that PDC should be provided in March to cover the cash shortfall.

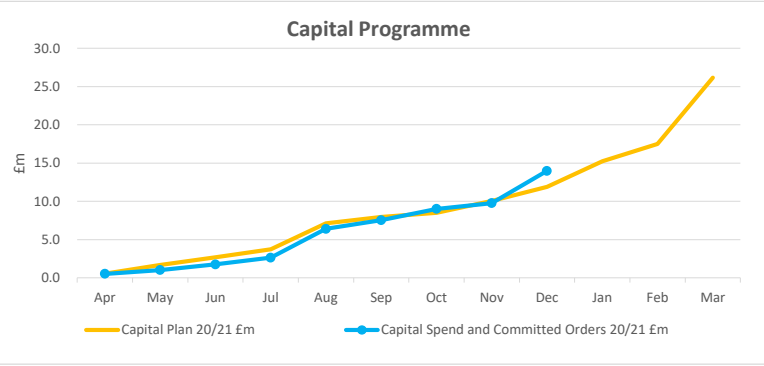
Capital Programme

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

UoR SOF

The actual capital spend YTD is £6.4m with £0.5m in month. In addition there are £7.6m committed orders on the system.

RR669



The Trust Board approved capital plan is £26.1m. The actual spend year to date is £6.4m which is £5.5m below the planned spend of £11.9m. However, the Trust has committed orders of £7.6m.

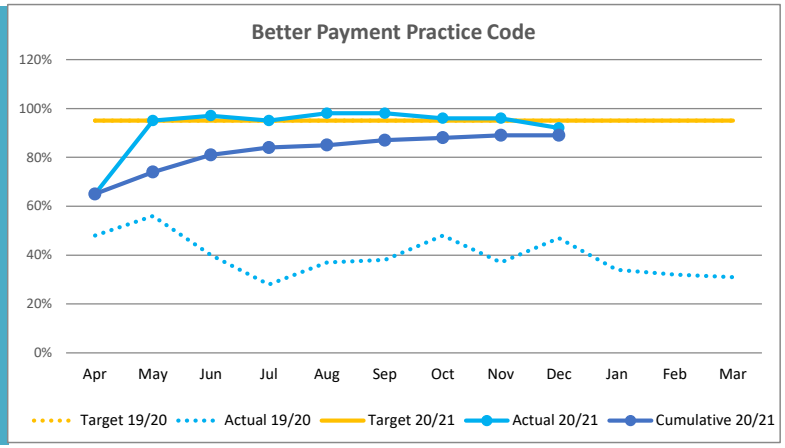
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

Better Payment Practice Code

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

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 **In month, the Trust has paid 92.00% of suppliers within 30 days. This results in a cumulative performance of 89.00%.**		**Performance of 92.00% is slightly below the national standard of 95.00%. This position has slightly reduced due to a significant supplier using an invalid purchase order which slowed down payment. Following a meeting with the Finance Planning and Performance Directorate of NHSE/I, it was made clear that prompt payment remains a clear priority.**	**Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
Single Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy
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)?

Use of Resources Rating
Red: Use of Resource Rating 4
Amber: Use of Resource Rating 3
Green: Use of Resource Rating 1 and 2

UoR SOF

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

Agency Spending

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

UoR SOF

The actual agency spend in month is £1.3m.

RR199

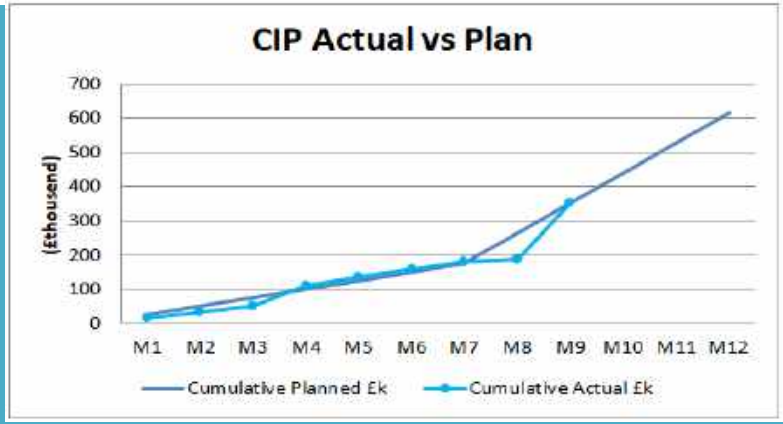
The spend of £1.3m is £0.6m above the plan of £0.7m. Of the total YTD expenditure of £10.0m, £5.3m relates to COVID-19.

The Trust continues to monitor and report the use and spend on agency as well as the use of efficient models to reduce costs. The Trust is part of a Cheshire & Mersey collaborative that has established a standard rate card across all staff groups and specialties to reduce rates and is enhancing processes and controls to ensure appropriate and best use of agency staff.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
Single Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy
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 monthly savings are £0.16m which increases the year to date savings to £0.35m.		The monthly saving are £0.16m against a target of £0.09m. The cumulative savings are £0.35m against a cumulative target of £0.35m.	CIP progress is reviewed on a monthly basis. Where possible the Trust seeks to accelerate schemes and is reviewing additional areas to support further cost reductions.

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

UoR

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

CIP reporting for the in year and recurrent plans in progress indicators will recommence in 2021/22.

UoR

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 actions breached. Number of open incidents is the total number of incidents that we have awaiting review. As part of the 2018 - 2021 Trust Quality Strategy, the Trust has pledged to Increase Incident Reporting to ensure that we don't miss opportunities to learn from our mistakes and make changes to protect patients from harm.
CAS Alerts	The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Timescales are individual dependent upon the specific CAS alerts.
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 (Inc Staff 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?
CQC Insight Composite Score	The CQC Insight report measures a range of performance metrics and gives an overall score based on the Trust's performance against these indicators. This is the CQC Insight Composite Score.
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.
Mixed Sex Accommodation Breaches	The number of occurrences of unjustified mixing in relation to sleeping accommodation.
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 patients 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 patients 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 Phase 3 Recovery.
COVID-19 Recovery Diagnostics	% of Diagnostic Activity against the same period in 2019/20, monitored as part of Phase 3 Recovery.
COVID-19 Recovery Outpatients	% of Outpatient Activity against the same period in 2019/20, monitored as part of Phase 3 Recovery.
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	% of agency shifts compliant with the Trust cap against peer average.

the Price Cap	
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 and Safeguarding.
Role Specific Training	A summary of role specific 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?

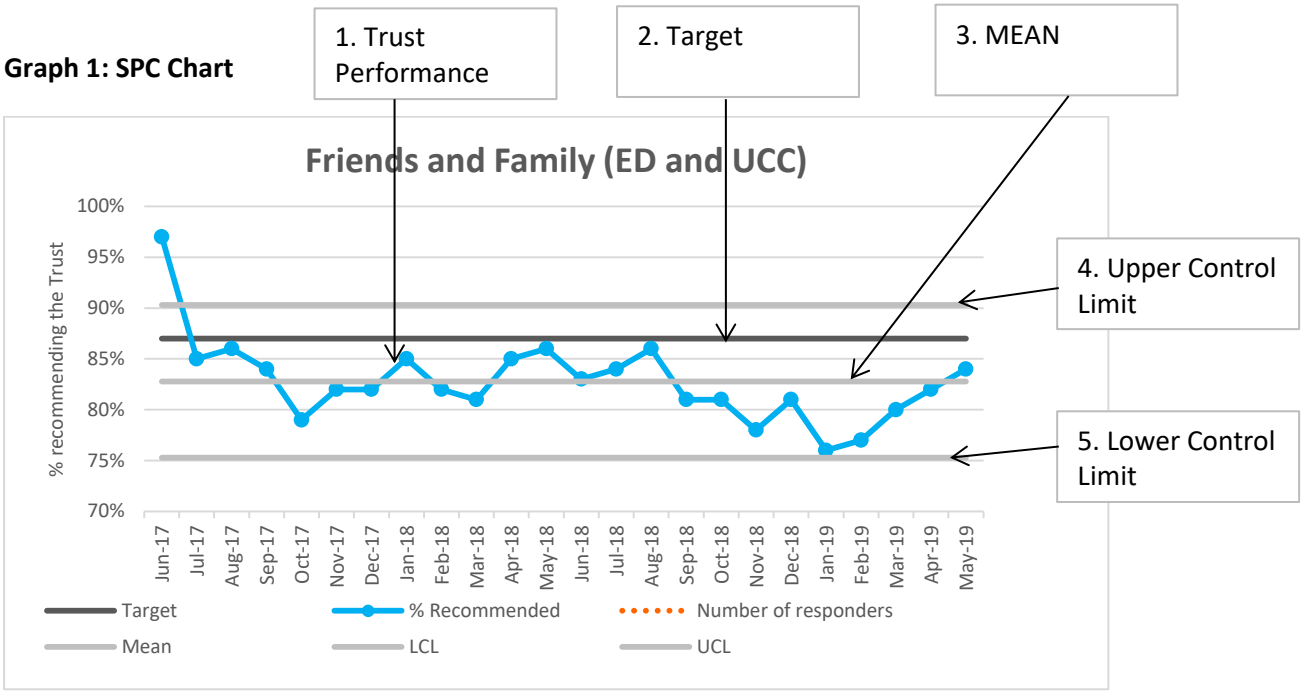
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

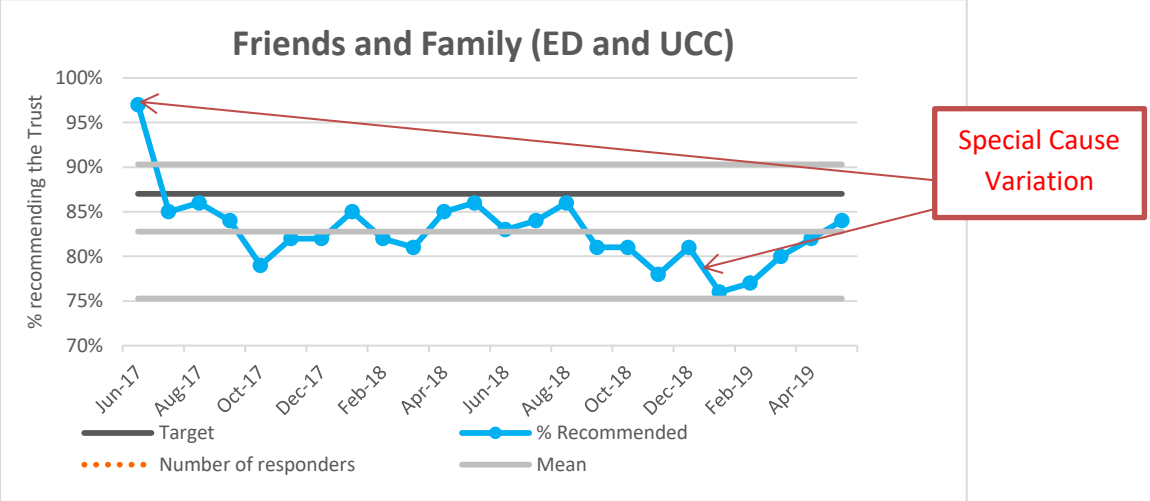
Graph 1: SPC Chart



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 2020

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	2,336	1,366	-969	23,384	10,861	-12,523
Elective Excess Bed Days	18	1	-17	165	21	-143
Non Elective Spells	5,798	4,791	-1,007	54,337	46,192	-8,145
Non Elective Bed Days	166	164	-3	1,498	1,518	20
Non Elective Excess Bed Days	105	56	-49	945	539	-406
Outpatient Attendances	2,791	2,297	-493	27,843	18,923	-8,921
Accident & Emergency Attendances	1,401	1,404	3	12,970	11,639	-1,331
Other Activity	6,222	8,751	2,529	49,571	81,444	31,873
Sub total	**18,837**	**18,832**	**-6**	**170,714**	**171,138**	**424**
Non NHS Clinical Income						
Private Patients	0	25	25	0	40	40
Non NHS Overseas Patients	6	0	-6	43	20	-23
Other non protected	30	102	72	357	373	16
Sub total	**36**	**127**	**91**	**400**	**433**	**33**
Other Operating Income						
COVID-19/Growth/NHS Top Up	3,777	3,771	-5	39,020	39,005	-15
Training & Education	679	968	289	6,114	6,344	229
Donations and Grants	0	0	0	0	0	0
Miscellaneous Income	522	870	348	3,955	6,786	2,831
Sub total	**4,978**	**5,609**	**631**	**49,089**	**52,135**	**3,046**
Total Operating Income	**23,851**	**24,568**	**717**	**220,203**	**223,706**	**3,503**
Operating Expenses						
Employee Benefit Expenses	-18,608	-18,094	515	-162,787	-163,385	-599
Drugs	-1,210	-1,234	-25	-10,894	-11,109	-215
Clinical Supplies and Services	-1,778	-1,423	355	-16,543	-16,895	-352
Non Clinical Supplies	-2,638	-2,980	-341	-24,768	-26,561	-1,792
Depreciation and Amortisation	-609	-706	-97	-5,702	-6,140	-438
Net Impairments (DEL)	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	-10	-10
Restructuring Costs	0	0	0	0	0	0
Total Operating Expenses	**-24,844**	**-24,437**	**407**	**-220,694**	**-224,101**	**-3,407**
Operating Surplus / (Deficit)	**-992**	**131**	**1,123**	**-491**	**-395**	**96**
Non Operating Income and Expenses						
Profit / (Loss) on disposal of assets	0	0	0	1	7	6
Interest Income	3	0	-3	11	-5	-15
Interest Expenses	-46	0	46	-230	-1	229
PDC Dividends	-276	-651	-375	-2,483	-2,858	-375
Total Non Operating Income and Expenses	**-319**	**-651**	**-332**	**-2,702**	**-2,857**	**-155**
Surplus / (Deficit)	**-1,311**	**-520**	**791**	**-3,193**	**-3,252**	**-59**
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	10	10
Less Donations & Grants Income	0	0	0	0	0	0
Add Depreciation on Donated & Granted Assets	17	15	-2	150	141	-9
Total Adjustments to Financial Performance	**17**	**15**	**-2**	**150**	**151**	**1**
Adjusted Surplus / (Deficit)	**-1,294**	**-504**	**790**	**-3,043**	**-3,101**	**-58**

Activity Summary	Planned	Actual	Variance	Planned	Actual	Variance
Elective Spells	2,515	1,865	-650	25,369	13,497	-11,872
Elective Excess Bed Days	68	0	-68	614	79	-535
Non Elective Spells	3,334	2,144	-1,190	31,895	19,997	-11,898
Non Elective Bed Days	466	443	-23	4,196	4,331	135
Non Elective Excess Bed Days	392	0	-392	3,524	1,976	-1,548
Outpatient Attendances	23,580	20,608	-2,972	235,251	174,966	-60,285
Accident & Emergency Attendances	9,494	7,494	-2,000	88,333	66,915	-21,418

Appendix 6

Capital Bid Analysis 2020/21

Scheme Name	Funding Source	Original Value £000's	Risk
Backlog - All Areas Fixed Installation Wiring Testing	Mandated	100	
6 Facet Survey	Mandated	55	
Backlog - HV Maintenance Annual	Mandated	40	
Backlog - Annual Asbestos Management Survey & Remedials	Mandated	30	
Fire - Remove Final Stepped Exits from Kendrick Wing	Mandated	20	
Anaesthetic Machines (ASCA accreditation standards) Was £260k	Mandated	167	
Call Alarms for all Anaesthetic Rooms (ASCA Accreditation standards)	Mandated	60	
MRI Turnkey/Enabling Work (Estimate)	Business Critical	200	Overspend
Devices Replacement (Tech Refresh)	Business Critical	194	
Electronic Patient Record Procurement (£70k for scoping / £180k for procurement)	Business Critical	250	Underspend
E-Outcome Resilience	Business Critical	100	
Additional Network Cabinets	Business Critical	30	
Backup Storage	Business Critical	20	
Replacement for Trackit	Business Critical	30	
EPMA Phase 1 & 2	Board Approved	20	
Balance of Midwifery Led Unit (Building Works)	Board Approved	289	Overspend
Induction of Labour Ward (Building £22k, Equipment £56k)	Board Approved	78	
Workplace Health & Wellbeing Service Development (Building works only)	Board Approved	52	
MRI Estates Work	Board Approved	1,008	Overspend
Estates Capitalisation of Staff Costs	Board Approved	177	
IM&T (current structure) Capitalisation of Staff Costs	Board Approved	316	
Bridgewater Executive Team Relocation	Board Approved	154	
EPMA Phase 1 & 2 (Additional areas)	Board Approved	60	
EPMA Phase 3 & 4	Board Approved	210	
Lorenzo Digital Exemplar plus	Board Approved	285	
Falsified Medicines Directive	Board Approved	83	
Finance & Commercial Development - Refurbishment	Board Approved	400	
Finance & Commercial Development - Office/Kitchen Equipment	Board Approved	50	
Refurbishment of Warrington Education Centre	Board Approved	5	
Contingency Spent ??	Board Approved	170	
Schemes carried forward from 2019/20	Board Approved	1,518	
MRI PDC Funded	PDC	875	
Fire - Replacement of Obsolete 5000 Series Fire Alarm Panels	CIR	600	
Backlog - Electrical Infrastructure Upgrade	CIR	200	
Fire - Halton 30 Minute Fire Compartmentation	CIR	150	
Appleton Wing Circulation Areas 60 Minute Fire Doors	CIR	100	
Warrington and Halton Gas Meter Replacement	CIR	100	
Fire - Thelwall House Emergency Lighting Final Phase	CIR	100	
Backlog - Kendrick Wing Works To Emergency Lighting	CIR	75	
Backlog - Water Safety Compliance	CIR	50	
Pharmacy Fire Doors Sliding Type	CIR	30	
Fire - Alarm System Monitoring	CIR	30	
Halton Residential Blocks 2 & 3 Fire Doors	CIR	25	
Estates Department Fire Doors	CIR	20	
Thelwall House - Improvements to Fire Alarm System	CIR	20	
Backlog - Kendrick Wing Fire Alarms to Portakabin Buildings	CIR	15	
Cheshire House Fire Alarm	CIR	25	
Cheshire House Emergency Lighting	CIR	20	
Replacement Water Tanks : Boiler House 1&2	CIR	280	
Appleton Wing Roof Repairs	CIR	570	
IM&T Digital Refresh	PDC (Loan)	1,048	
IM&T Cardiology Systems Upgrade – CRD	PDC (Loan)	16	
IM&T Health & Wellbeing Workplace	PDC (Loan)	13	
IM&T Labour Ward Bedside Touch Screens and Archiving Software/Licences	PDC (Loan)	101	
IM&T Medisoft diabetic retinopathy module software	PDC (Loan)	14	
IM&T Wi-Fi Upgrade	PDC (Loan)	240	
IM&T Integration of Coagucheks with POCcelerator	PDC (Loan)	12	
IM&T Interface connection of GeneXpert to MOLIS LIMS	PDC (Loan)	6	
IT 'Other'	PDC (Loan)	71	
Radiology - Dexa Scanner	PDC (Loan)	250	
Monitoring Equipment - Carescape Monitors	PDC (Loan)	203	
Ultrasound Machine for Vascular scanning	PDC (Loan)	71	
Microbiology Safety Cabinet	PDC (Loan)	13	
Portable ventilation/ extraction system for CT scanner	PDC (Loan)	15	
ENT Scope	PDC (Loan)	17	
Replacement of Electrocardiogram (ECG) Machines	PDC (Loan)	14	
Portable Echo ITU & CRD	PDC (Loan)	7	
Ebike EL Stress Echocardiogram	PDC (Loan)	11	
Visual Field Analyser - Halton	PDC (Loan)	36	
Optical Coherence Tomographs - Halton	PDC (Loan)	61	
Digital Gonioscope	PDC (Loan)	22	
Wide field non-contact fundus camera combined with ICG, FFA and swept source OCT	PDC (Loan)	174	
CMTC Endo (Estates £600k; Equip £200k)	PDC (Loan)	800	
Kendrick Wing Enhancements	PDC (Loan)	50	
Enhancements 'Other'	PDC (Loan)	120	
Creation of High Care Area on AMU	PDC (Loan)	146	
Install Hand Washing Station	PDC (Loan)	5	
OPD Configuration	PDC (Loan)	65	
X-Ray room 2	PDC (Loan)	250	
Mortuary	PDC (Loan)	1,000	
Plaza	PDC	4,300	Underspend
MRI Additional Equipment costs	BAU	326	
Covid pre 18th May	PDC	2,802	
Halton CMTC	BAU	2,000	Underspend
Contingency	BAU	390	
Endoscopy	PDC (Endo)	592	
Critical Care	PDC (Critical Care)	1,422	Underspend
Total		**26,139**	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 7

FINANCE & SUSTAINABILITY COMMITTEE

AGENDA REFERENCE:	**FSC**			
SUBJECT:	**Changes to Reporting Logic for Discharge Summaries (Sent within 24 hours and 7 days)**			
DATE OF MEETING:	23rd December 2020			
ACTION REQUIRED	**To Note**			
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance			
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer and Deputy Chief Executive Dan Moore, Chief Operating Officer			
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust is required to report the number of discharge summaries sent within 24 hours and those not sent within 7 days of discharge as a part of a locally agreed contractual requirement. As part of a recommendation made by Mersey Internal Audit Assurance (MIAA), the Trust has reviewed the reporting logic in relation to the Discharge Summaries Key Performance Indicators (KPI) on the Trust Integrated Performance Report (IPR). This paper sets out the proposed changes in reporting logic as a result of the audit. These changes will result in a decrease in performance in the percentage of discharge summaries sent within 24 hours by an average of 4.42% and a decrease in performance in the number of discharge summaries not sent within 7 days by an average of 149.			
PURPOSE: (please select as appropriate)	Information	Approval	To note X	Decision
RECOMMENDATION:	The Finance & Sustainability Committee is asked to: 1. Support the changes to the reporting logic and cohort group. 2. Note the impact on performance.			
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 41 – confidentiality			

1. BACKGROUND/CONTEXT

As part of a recommendation made by Mersey Internal Audit Assurance (MIAA), the Trust has reviewed the reporting logic in relation to the Discharge Summaries Key Performance Indicator (KPI) on the Trust Integrated Performance Report (IPR).

The Trust is required to report the number of discharge summaries sent within 24 hours and those not sent within 7 days of discharge. This is a local quality contractual requirement. For the majority of patients, the discharge summary is created within Lorenzo and the information team include this data in the reporting. However a number of services use alternative systems, these services are included within a "cohort" and for reporting purposes an assumption is made that the discharge summary is 100% compliant; with assurance provided by the CBUs.

2. KEY ELEMENTS

In November 2019, Mersey Internal Audit Assurance (MIAA) made a recommendation as part of the annual audit cycle. The recommendation noted that the cohort of patients included within the Discharge Summary KPI should be formally reviewed by the appropriate Executive lead. An extract of the audit report containing this recommendation is available in **Appendix 1**.

This review has now taken place by Clinical Business Unit (CBU) Managers with oversight from the Chief Operating Officer.

Removals from the Cohort

The following groups will be removed from the reporting cohort after confirmation from CBU Managers that a discharge summary should be generated in Lorenzo for these encounters. These groups will now be included in the Lorenzo reporting.

- Discharges from Ward B10
- Discharges from ITU
- Discharges from CBU (with only 1 ward stay)
- Discharges from Daycase Unit at Halton
- Discharges from Ophthalmic Day Surgery
- Discharges from Ward K24 - W (Ophthalmic)
- Discharges from Dental
- Discharges from B4 at Halton
- Discharges from Maxillo-Facial specialty
- Discharges from Ophthalmology
- Discharges from A1, SAU, PAU or GAU
- Admissions to A1, SAU, PAU or GAU with a LOS = 0
- Discharges from AMU (A1)
- Elective admission - Planned Procedures not carried out

Additions to the Cohort

The following group will be added to the reporting cohort. Patients in this group are admitted for a series of injections. A discharge summary will only be sent after the final injection.

- Discharges for specific Daycase Ophthalmology procedures (series of injections)

Updated Cohort

Table 1 sets out the groups which remain in the cohort. The Trust will continue to assume compliance based on assurances by the CBUs.

Table 1: Updated Cohort

Cohort	Rationale	
Died or stillbirth	The bereavement office is responsible for sending correspondence to the GP.	Existing Logic
Discharges from Home Births Ward	Hand-held maternity notes.	Existing Logic
Discharges from Delivery Suite		Existing Logic
Discharges from Ward C23		Existing Logic
Discharges from Well Babies		Existing Logic
Maternity or Birth admissions		Existing Logic
Discharges from Obstetrics and Midwife Episode Specialties		Existing Logic
Discharges from the Catheter Lab	An alternative discharge summary is created.	Existing Logic
Discharges from Endoscopy Units	An alternative discharge summary is created on Unisoft.	Existing Logic
Discharges from Ward PIU	Multiple, frequent admissions per patient for transfusion etc. Patients will not receive a discharge summary for each attendance; a single letter will be created after the final treatment.	Existing Logic
Discharges for specific Daycase Ophthalmology procedures	Patients will be admitted for a series of injections and a discharge summary will only be created after the last injection. Assurance by CBU that letter will always be generated.	New

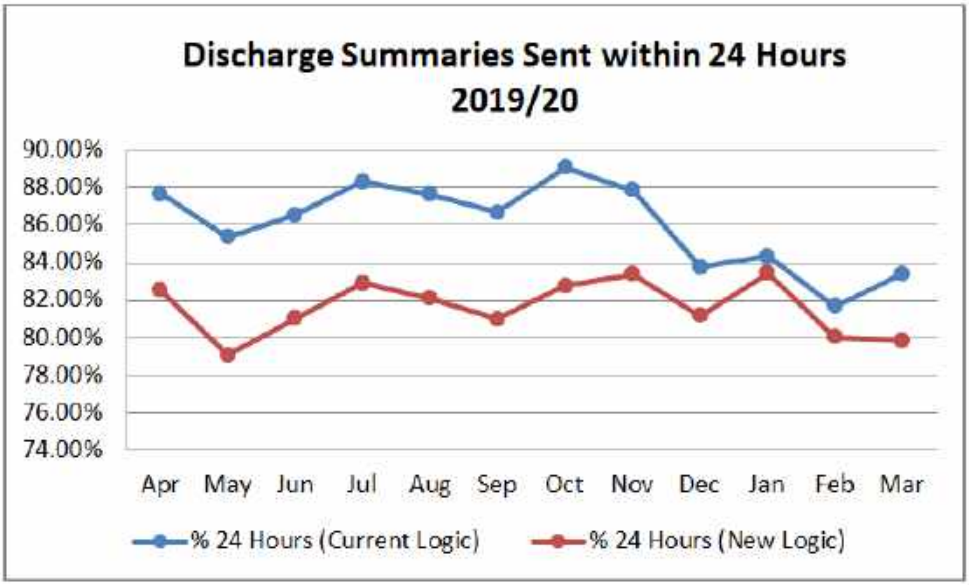
Impact

As a result of the change in cohort and a review of the reporting logic, the impact of this using 2019/20 performance data is outlined in **Table 2** and **Graphs 1 and 2**.

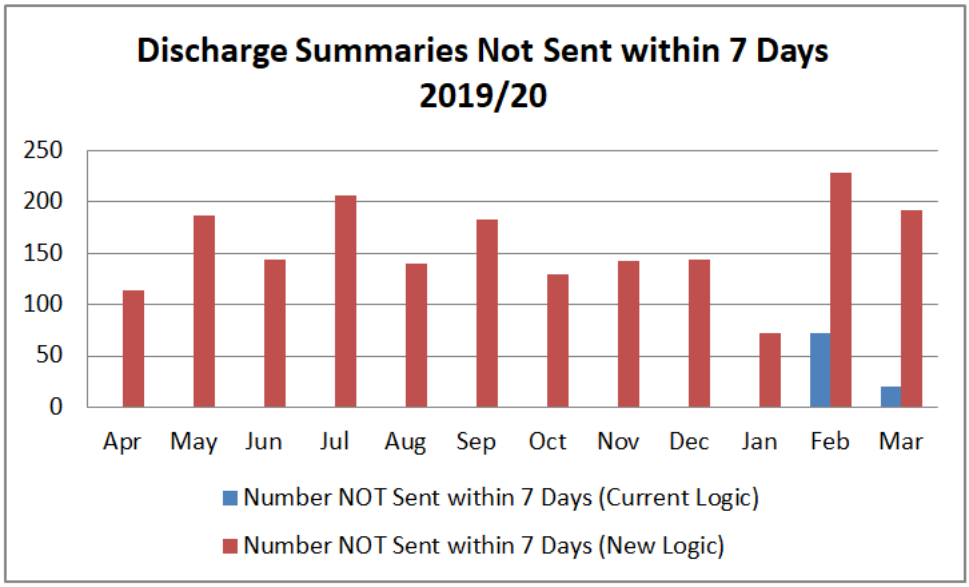
Table 2: Trust Discharge Summary Performance – Current and New Logic

	2019/20 Current Logic		2019/20 New Logic		Varation	
	% 24 Hours (Current Logic)	Number NOT Sent within 7 Days (Current Logic)	% 24 Hours (New Logic)	Number NOT Sent within 7 Days (New Logic)	% 24 Hours	Number NOT Sent within 7 Days
Apr	87.69%	0	82.54%	114	-5.15%	-114
May	85.38%	0	79.09%	187	-6.29%	-187
Jun	86.54%	0	81.02%	144	-5.52%	-144
Jul	88.30%	0	82.93%	207	-5.37%	-207
Aug	87.64%	0	82.09%	140	-5.55%	-140
Sep	86.68%	0	81.00%	184	-5.68%	-184
Oct	89.07%	0	82.77%	130	-6.30%	-130
Nov	87.86%	0	83.38%	143	-4.48%	-143
Dec	83.78%	0	81.17%	145	-2.62%	-145
Jan	84.33%	0	83.44%	72	-0.89%	-72
Feb	81.68%	73	80.04%	229	-1.64%	-156
Mar	83.43%	20	79.86%	192	-3.57%	-172

Graph 1: Comparison – Discharge Summaries sent within 24 hours 2019/20



Graph 2: Comparison – Discharge Summaries sent within 7 days 2019/20



The change in the cohort will result in improved accuracy of data. However, the change will result in a deterioration in performance in both Discharge Summaries sent within 24 hours by an average of 4.42% and Discharge Summaries not sent within 7 days by an average of 149 patients. An improvement plan will be developed by the Operations Team to address the change in performance and this will be monitored by the KPI Sub-committee on a monthly basis.

3. NEXT STEPS

The Trust Board will be asked to approve the change. The revised cohort group will be utilised from 1st April 2021.

4. RECCOMENDATIONS

The Finance & Sustainability Committee is asked to:

1. Support the changes to the reporting logic and cohort group.
2. Note the impact on performance.

Appendix 1

"Discussion noted that not all CBUs utilise Lorenzo for the production of discharge summaries, as they have other systems in place e.g. Endoscopy, ophthalmology, dental and maternity. These patients are included within a 'cohort group'. A significant assumption has been made that all patients within the 'cohort group' are fully compliant in terms of having a discharge summary that has been completed within 24 hours and these are therefore reported as such in the figures presented to Board (At April 2019, there were 3,294 cohort discharge summaries and 2,231 discharge summaries taken directly from Lorenzo). However to date, no review has been undertaken to ensure that this assumption is accurate and appropriate".

Recommendation

Discharge Summaries – Cohort Group - Consideration should be given as to whether it is appropriate that the assumption is made that this cohort of individuals are automatically deemed to be compliant. This could be verified by a series of ongoing periodic audits. The cohort group should be formally reviewed by the appropriate Executive Lead to confirm agreement of this treatment and should be reviewed every 12 months thereafter (M).

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/07 a**			
SUBJECT:	**Safe Staffing Assurance Report – October and November 2020**			
DATE OF MEETING:	27 January 2021			
AUTHOR(S):	Rachael Browning, Assistant Chief Nurse, Clinical Effectiveness			
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 2020. Ward staffing data continues to be systematically reviewed to ensure the wards and departments were safe. Mitigation was provided and the action when a ward falls below 90% of planned staffing levels. Sickness absence rates were recorded at 9.04% in October 2020 and 9.03 % in November 2020 for nursing and midwifery staff. In the month of October 2020 it was noted that 10 of the 21 wards were below the 90% target during the day, with a similar position noted in November with 9 of the 20 wards below the 90% target. In order to ensure safe staffing levels, mitigation and responsive plans were implemented daily to ensure that the safe delivery of patient care. CHPPD in October 2020 was 7.6 and 7.7 in November 2020, with a year to date rate 7.9. WHH have joined Wigan, Wrightington and Leigh NHS Trust to participate in a regional pilot for recruitment of international nurses. Following a successful business case we have recruited 30 registered nurses to join the Trust between the months of February and April 2021.			
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.	
	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 Assurance Report – October /November 2020	AGENDA REF:	BM/21/01/07 a

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report – October and November 2020.

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 2020. 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.

During the months of October and November 2020 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

The Trust 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 2020 Trust wide staffing data was analysed and cross-referenced, with ward level data for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (Clinical Effectiveness).

Table 1 illustrates the monthly CHPPD data. In the month of October CHPPD was recorded at 7.6 and November recorded at 7.7 with a 2020/21 YTD figure of 7.9. This is in comparison to the national YTD figure of 8.1.

During the COVID-19 Trust response the Trust was not required to submit staffing data to Unify as part of the pause of some activities, therefore the data has resumed collection in June 2020. During the

pause staffing reviews were undertaken three times per day with responsive and robust plans in place to ensure that all wards were adequately staffed. Staff data continued to be recorded on Gold Command and in E-roster.

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

Table 1 – CHPPDD Data 2020/21

		Data			
Financial year	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2020/21	June	14189	4.2	3.5	7.7
	July	13433	4.7	4.1	8.8
	August	13990	4.2	3.5	7.8
	September	13616	4.2	3.3	7.5
	October	14058	4.5	3.2	7.6
	November	12810	4.5	3.2	7.7
2020/21 Total		82096	4.4	3.5	7.9

Key Messages

Although there are areas above the 90% fill rate during this period, it is acknowledged that the percentage of registered nurses/midwives on 10 of the 21 wards in October 2020 and 9 out of 20 in November 2020 reported staffing levels under the 90% for registered nurses. 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.

In order to ensure safe staffing levels, mitigation and responsive plans continue to be put in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates continue to be monitored month on month.

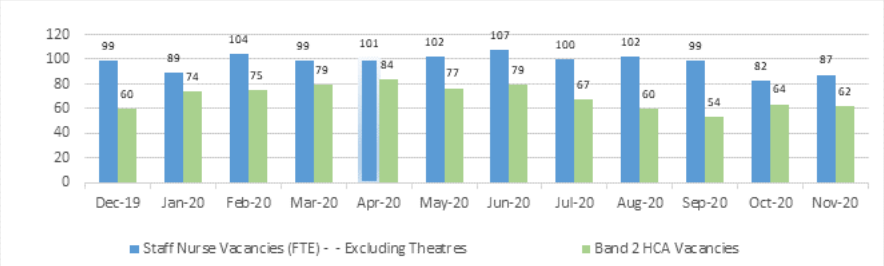
Maternity (ward C23) although showing below the 90% target on the ward in October 2020 at 78% there was an improvement noted in November 2020 at 94.2%. Ward C23 use their responsive staffing plans in the unit to move staff to support if acuity requires additional staffing.

In November 2020 the Trust ran and incentive scheme with NHSP to increase fill rates across all areas. The NHSP incentive scheme increased registered nurse fill rate by 10.8% in the first 4 weeks of November since its introduction on the 28th October 2020. Fill rates for health care assistant staff also increased by 16.8%, agency health care assistant staff are not routinely used in the Trust. There are plans in place to undertake the same process in January and February 2021.

Vacancy Summary

In October 2020 we had 82 registered nurse and 64 health care assistant vacancies at WHH, as seen in chart 1, which requires reliance on temporary staffing to ensure safe staffing levels on the wards. In November we maintained the vacancy levels with 87 registered nurse and 62 health care assistant vacancies.

Chart 1 - Registered Nurse and Health Care Assistant vacancies Dec 2019 – Nov 2020



Recruitment and retention remains a priority for the senior nursing team. A recruitment calendar is in place to ensure recruitment for both registered nurses and health care assistants. The recruitment campaign will include rolling adverts on NHS jobs and targeted recruitment campaigns.

WHH are working in collaboration with Wigan, Wrightington and Leigh NHS Trust participating in a regional pilot for recruitment of international nurses. The partnership includes HEE, recognising the need to address the urgent nursing workforce shortages across the region. This approach has utilised the 'toolkit' commissioned by the Department of Health and Social Care produced by NHS Employers (January 2020). A task and finish group has now been initiated to implement this programme. The Trust has submitted a bid to NHSI/E in order to access funding to support the international nurse recruitment programme, and we have been informed that we were successful in the bid and have been awarded £47,400 to support the arrival of our international nurses and undertaking their OSCE training. Through the programme 30 international nurses have been recruited who will join the Trust between January and April 2021.

In order to further expand the International Nurse Recruitment programme further WHTH have recently also submitted a collaborative bid with Mid- Cheshire Hospital under Strand B with a business case to future expand the International nursing recruitment plan. As a collaborative we have recently been informed that they have been successful with the bid receiving 400k to support further expansion of international nurse recruitment, a similar approach will be taken as detailed above to recruit these nurses and it is anticipated these nurses will arrive in the UK in June/July 2020.

Recruiting to HCA vacancies remains a challenge for the Trust and although we have recruited 103 HCA staff since February 2020, we still have 62 HCA vacancies across the Trust. We have adopted a different recruitment approach in order to improve the HCA vacancy position with interviews now taking place on a monthly basis which has resulted in a further 46 staff who have been recruited, who are currently undergoing pre-employment checks. The Trust has recently received funding from NHSI to enhance HCA recruitment and pastoral support in the clinical areas, progress against this will be reported monthly to the Workforce Group. The Trust continues with a rolling advert for HCA's advertised both locally and regionally.

Escalation Beds and Costs

In the months of October and November 2020 there were we opened two additional wards open, K25 and B3 both which are currently being managed by the Unplanned Care Group. These areas have had staffing support from the recently displaced staff from ward B1 after it closed in the summer months. Cost associate with these wards are detailed below in table 2 and 3.

Table 1 – Cost associated with additional beds in October 2020

	Oct-19			
	In Month			
Ward	No. Bed Days	Additional Costs £	Notional Bed Day Cost £	Total Cost £
B3	267	60,356	0	60,356
K25	558	126,137	0	126,137
Totals	**825**	**186,493**	**0**	**186,493**

Table 1 – Costs associated with additional beds in November 2020

	Nov-19			
	In Month			
Ward	No. Bed Days	Additional Costs £	Notional Bed Day Cost £	Total Cost £
B3	768	173,608	0	173,608
K25	540	122,068	0	122,068
Totals	**1308**	**295,676**	**0**	**295,676**

A number of additional beds have recently been opened following a Trust wide side room review. Any wards with additional beds have undergone a staffing review and have revised staffing levels, which have been funded before the beds have been opened.

The Trust continues to manage its bed occupancy and staffing in a responsive and planned way, and has recently started to move in more detailed staffing models as during the second wave of the COVID 19 pandemic.

Sickness Absence – October and November 2020

During the month of October registered nurse and midwifery absence rates were recorded at 9.04% showing a significant increase from the August/September report which was recorded at 6.28%. Sickness data in November 2020 details a similar position of 9.03%. The cost of bank/agency cover of qualified nursing sickness (at usual bank/agency fill rates) is £340,233 for October and £339,816 for November as detailed in the tables 4 and 5 below;

Table 4 - Registered nurse and midwifery sickness cover – October 2020

Contracted Nursing WTE (Band 5 to 7)	919.87
% Sickness	9.04%
WTE Equivalent of Sickness	83.16
NHSP Fill Rate	76%
WTE Covered by Temporary Staffing	63.20
Cost at Average NHSP Rates	***340,233***

Table 5 - Registered nurse and midwifery sickness cover – November 2020

Contracted Nursing WTE (Band 5 to 7)	919.76
% Sickness	9.03%
WTE Equivalent of Sickness	83.05
NHSP Fill Rate	76%
WTE Covered by Temporary Staffing	63.12
Cost at Average NHSP Rates	***339,816***

Sickness absence rates were recorded at 9.06% in October and 9.03% in November 2020 for nursing and midwifery staff, this is an increase of almost 3% from August and September 2020.

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

Temporary Staffing
Any shortfalls in staffing are covered using NHS Professionals (NHSP) which is managed by the Trust Temporary Staffing Lead, Associate Chief Nurse. Monthly NHSP usage reports are presented to the senior nursing team.

Patient Harm by Ward
In October 2020 we have reported 7 category 2 pressure ulcers on wards A2, A5, A6, A8, B12, B19 and C20. There has been 0 patient falls with major harm reported in October 2020.

In November 2020 we have reported 8 category 2 pressure ulcers on wards AMU, A5, A6 x2, A9, ITU x2 and C21. There has been 0 patient falls with major harm reported in November 2020

Infection Incidents
In both October and November2020 the Trust did not report any cases of MRSA bacteraemia.

Appendix 3	MONTHLY SAFE STAFFING DATA – October 2020																		
Monthly Safe Staffing Data – October 2020																			
		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
		= above 100%		= above 90%			= above 80%			= below 80%									
DD	Ward A5	1782.5	1523.5	1426	1523.5	85%	107%	1426	1184.5	1426	1242	83%	87%	1104	2.5	2.5	0.1	0.0	5.1
DD	Ward A6	1782.5	1472	1782.5	1529.5	83%	86%	1069.5	1173	1782.5	1472	110%	83%	1005	2.6	3.0	0.0	0.0	5.6
DD	Ward B4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
DD	Ward A4	1679	1259	1426	1472	75%	103%	1069.5	1069.5	1069.5	1150	100%	108%	781	3.0	3.4	0.2	0.0	6.6
MSK	CMTC	1069.5	1027	873.5	791.9	96%	91%	713	713	414	402.5	100%	97%	369	4.7	3.2	0.0	0.0	8.0
MSK	Ward A9	1069.5	1279	1782.5	1585	120%	89%	1069	1104	1782.5	1250	103%	70%	1054	2.3	2.7	0.0	0.0	5.0
W&C	Ward B11	2914.8	2729.8	814.8	799	94%	98%	1646.2	1595.5	322.4	322.4	97%	100%	322	13.0	3.4	1.3	0.0	17.7
W&C	NNU	1782.5	1290.5	356.5	237.5	72%	67%	1782.5	1180.5	356.5	356.5	66%	100%	213	11.6	2.8	0.0	0.0	14.4
W&C	Ward C20	1069.5	1030.5	713	660	96%	93%	713	713	0	322	100%	-	495	3.5	2.0	0.0	0.0	5.5
W&C	Ward C23	1426	1112	713	709	78%	99%	728.5	759	713	678	104%	95%	437	4.3	3.2	0.0	0.0	7.4
W&C	Birth Suite	249.5	2317	356.5	329.5	92%	92%	2495.5	2079.5	356.5	310	83%	87%	246	17.9	2.6	0.0	0.0	20.5
UEC	Ward A1	2000	2325	2312.5	1627.5	116%	70%	1627.5	1360.45	1293.32	1043.7	84%	81%	1116	3.3	2.4	0.0	0.0	5.7
UEC	Ward A2	1426	1111.5	1782.5	1422	78%	80%	1069.5	1035	1069.5	1058	97%	99%	930	2.3	2.7	0.0	0.0	5.0
IM&C	Ward C21	1069.5	793.5	1426	1206.5	74%	85%	736	713	1069.5	1153.5	97%	108%	183.49	8.2	12.9	0.0	0.0	21.2
IM&C	Ward A8	1782	1601	1782	1403	90%	79%	1782.5	1484	1426	1303	83%	91%	1054	2.9	2.6	0.0	0.1	5.7
IM&C	Ward B12	1069.5	849.5	2495.5	2112.25	79%	85%	713	713	1782.5	1725	100%	97%	651	2.4	5.9	0.0	0.1	8.6
IM&C	Ward B14	1069.5	1101	1782.5	1598.5	103%	90%	713	770.5	1069.5	1196	108%	112%	744	2.5	3.8	0.0	0.1	6.3
IM&C	Ward B18	690	790	690	425	114%	62%	713	644	356.5	207	90%	58%	99	14.5	6.4	0.0	0.0	20.9
IM&C	Ward B19	1426	1135	1782.5	1467	80%	82%	1069.5	1000.5	1426	1357	94%	95%	837	2.6	3.4	0.0	0.0	5.9
MC	Ward A7	1782.5	2061	1426	1499.5	116%	105%	1426	1890	1069.5	1157.5	133%	108%	973	4.1	2.7	0.0	0.0	6.8
MC	ACCU	2495.5	2110.5	1069.5	1006.5	85%	94%	1782.5	1748	1035	1046.5	98%	101%	756	5.1	2.7	0.0	0.0	7.8
MC	ICU	4991	5571.8	1069.5	1224.8	112%	115%	4991	5600.5	1069.5	989	112%	92%	679	16.5	3.3	0.0	0.0	19.7

Appendix 2

October 2020 - Mitigating Actions

The Unify Safe Staffing return guidance states that all wards with inpatient beds need to be included, with the exception of:

- Day care wards
- CDU/other clinical assessment units
- Additional capacity wards (B3)

Any temporary wards are not part of the Trusts Unify return.
Ward B4 is currently closed.

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
Ward A5	85%	107%	83%	87%	**Vacancy -** band 6 0.72 wte band 5 3.48 wte band 2 2.51 wte **Sickness rate** – 14.14% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support as appropriate. Attendance management policy followed. On-going recruitment plans in place
Ward A6	83%	86%	110%	83%	**Vacancy -** band 6 1.0wte band 5 1.81wte band 2 1.17 wte **Sickness rate** -9.32% **Action taken -** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support as appropriate. Attendance management policy followed. Targeted recruitment plan in place
Ward B4	-	-	-	-	Ward closed
Ward A4	75%	103%	100%	108%	**Vacancy -** band 5 3.8wte band 2 2.69 wte **Sickness rate** - 7.93% **Action taken -** Staffing and acuity reviewed daily. Recruitment programme in place. Sickness absence being managed in line with the Trust policy.
Ward CMTC	96%	91%	100%	97%	**Vacancy Rate**: band 6 0.92wte, band 5 3.77wte, band 2 1.92wte **Sickness Rate:**5.53% **Action Taken:** The ward re-opened 29/6/20 and not at full elective capacity Recruitment in process as establishment will change as the bed base will increase.
Ward A9	120%	89%	103%	70%	**Vacancy –** Band5 5.0 x 2 new starters in progress. Band 2 4.0wte **Sickness rate –** 20.71% **Action taken –** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support as appropriate.
Ward B11	94%	98%	97%	100%	**Vacancy –** Fully established **Sickness rate** – 7.01%

					Action taken - Sickness managed through Trust Attendance Policy
NNU	72%	67%	66%	100%	**Vacancy –** 1 wte Band 8a Matron 2.0 wte, band 6 **Sickness rate –** 8.30% **Action taken –** Staffing and acuity reviewed daily. Recruitment programme in place
Ward C20	96%	93%	100%	-	**Vacancy –** band 6 0.40 wte **Sickness rate -** 4.5% **Action taken -** Sickness managed through Trust Attendance Policy
Ward C23	78%	99%	104%	95%	**Vacancy –** band 6 2.34wte **Sickness rate** – 9.51% **Action taken -** Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. Sickness policy followed and supported by HR
Delivery Suite	92%	92%	83%	87%	**Vacancy –** Fully Established **Sickness rate** – 11.71% **Action taken** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness is being managed in line with Trust policy.
Ward A1	116%	70%	84%	81%	**Vacancy -** band 6 1.wte, band 5 3.74wte, , band 2 1.77 wte **Sickness rate –** 3.39% **Action taken** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness is being managed in line with Trust policy. NHSP usage and WM filling shortfalls in staffing.
Ward A2	78%	80%	97%	99%	**Vacancy** band 5 2.8wte **Sickness rate** – 10.21% **Action taken** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. On-going recruitment. Sickness is being managed in line with Trust policy.
Ward C21	74%	85%	97%	108%	**Vacancy:** 1.39 WTE band 5, 2.64 wte band 4 HCAs band 2 0.66 WTE posts **Sickness Rate:**26.93% **Action Taken**: Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Recruitment plans in place. Sickness is being managed in line with Trust policy. Backfill from B1 staff supporting to maintain safe staffing levels
Ward A8	90%	79%	83%	91%	**Vacancy -** band 5 5.0 wte **Sickness rate –** 19.34% **Action taken** - Trust wide recruitment in place Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support
Ward B12	79%	85%	100%	97%	**Vacancy -** band 5 2.57wte Band 2 9.92wte **Sickness rate** – 14.71% **Action taken -** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. managed as per policy 3.0 wte shielding 1.0 band 5 due to commence March 2021
Ward B14	103%	90%	108%	112%	**Vacancy -** Band2 4.0wte **Sickness rate** - 1.25% **Action taken** - - Ward reviewed daily for

					acuity and staffing.
Ward B18	114%	62%	90%	58%	**Vacancy –** band 5 - 1.32 wte Band 2- 2.0wte **Sickness rate** - 8.71% **Action taken** - - New transfer of ward team Ward reviewed daily for acuity and staffing.
Ward B19	80%	82%	94%	95%	**Vacancy –** band 5 1.6 wte Band 2 5.4 wte **Sickness rate** – 14.83% **Action taken –** Recruitment plan in pace. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward A7	116%	105%	133%	108%	**Vacancy**: ., band 5 8.61wte band 2 3.43wte **Sickness rate** – 2.95% **Action taken –** all sickness managed in line with policy. Ward reviewed daily for acuity and staffing.
ACCU	85%	94%	98%	101%	**Vacancy -** Band 2 1.68 wte **Sickness rate** -12% **Action taken** - Ward reviewed daily for acuity and staffing, sickness managed in line with policy
ICU	112%	115%	112%	92%	**Vacancy -** band 5 -5.86wte. **Sickness rate** – 5.53% **Action taken** - Ward reviewed daily for acuity and staffing. band 5 going through pre-employment checks
Total Fill Rate (%)	85%	107%	83%	87%	

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NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 3	MONTHLY SAFE STAFFING DATA – November 2020																		
Monthly Safe Staffing Data – November 2020																			
		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
		= above 100%		= above 90%			= above 80%			= below 80%									
DD	Ward A5	1725	1472	1380	1472	85.3%	106.7%	1380	1368.5	1380	1357	99.2%	98.3%	961	3.0	2.9	0.2	0.0	6.0
DD	Ward A6	1725	1610	1725	1529.5	93.3%	88.7%	1035	1115.5	1725	1575.5	107.8%	91.3%	950	2.9	3.3	0.2	0.0	6.3
DD	Ward B4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
DD	Ward A4	1621.5	1334	1380	1472.1	82.3%	106.7%	1035	1115.5	1035	1035	107.8%	100%	861	2.8	2.9	0.2	0.0	6.0
MSK	CMTC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
MSK	Ward A9	1069.5	1397	1725	1555	130.6%	90.1%	1081	1253.5	1725	1219	116%	70.7%	1020	2.6	2.7	0.0	0.0	5.3
W&C	Ward B11	2897	2861	805	775	98.8%	96.3%	1649.2	1617.1	322.4	322.4	98.1%	100%	328	13.7	3.3	1.3	0.0	18.3
W&C	NNU	1725	1444.5	345	296	83.7%	85.8%	1725	1403	345	322	81.3%	93.3%	337	8.4	1.8	0.0	0.0	10.3
W&C	Ward C20	1035	995.5	690	980.5	96.2%	142.1%	990	990	0	287	100%	-	420	4.7	3.0	0.0	0.4	8.2
W&C	Ward C23	1380	1299.5	690	655.5	94.2%	95%	690	655.5	690	632.5	95%	91.7%	411	4.8	3.1	0.0	0.0	7.9
W&C	Birth Suite	2415	2402.5	345	322	99.5%	93.3%	2415	2079	345	379.5	86.1%	110%	246	18.2	2.9	0.0	0.0	21.1
UEC	Ward A1	2250	2008.5	2250	2447.5	89.3%	108.8%	1575	1584.4	1251.6	990.9	100.6%	79.2%	1080	3.3	3.2	0.0	0.0	6.5
UEC	Ward A2	1380	1168.5	1725	1352.5	84.7%	78.4%	1034	1069.5	1035	1069.5	103.3%	103.3%	900	2.5	2.7	0.0	0.0	5.2
IM&C	Ward C21	1035	857.5	1380	1406	82.9%	101.9%	690	690	1035	1235	100%	119.3%	714	2.2	3.7	0.0	0.0	6.0
IM&C	Ward A8	1725	1591	1725	1534.5	92.2%	89%	1725	1511	1725	1550	87.6%	89.9%	1020	3.0	3.0	0.0	0.1	6.2
IM&C	Ward B12	1069	946	2415	2343	88.5%	97%	690	690	1725	1736.5	100%	100.7%	630	2.6	6.5	0.0	0.1	9.4
IM&C	Ward B14	1035	1065	1725	1616.5	102.9%	93.7%	713	966	1069.5	1150	135.5%	107.5%	720	2.8	3.8	0.0	0.0	6.7
IM&C	Ward B18	667	747.5	667	410	112.1%	61.5%	690	667	667	241.5	96.7%	36.2.%	99	14.3	6.6	0..0	0.0	20.9
IM&C	Ward B19	1380	1081	1725	1488.5	78.3%	86.3%	1380	1299.5	0	0	94.2%	-	810	2.9	1.8	0.0	0.0	6.1
MC	Ward A7	1725	2138	1380	1676.5	123.9%	121.5%	1380	1886.5	1035	1339	136.7%	129.4%	939	4.3	3.2	0.0	0.0	7.5
MC	ACCU	2415	2029.5	1035	948.5	84%	91.6%	1725	1656.5	1035	1000.5	96%	96.7%	602	6.1	3.2	0.0	0.0	9.4
MC	ICU	4830	5433.8	1035	994.8	112.5%	96.1%	4830	5152	1035	1104	106.7%	106.7%	726	14.6	2.9	0.0	0.0	17.5

Appendix 4

November 2020 - Mitigating Actions

The Unify Safe Staffing return guidance states that all wards with inpatient beds need to be included, with the exception of:

- Day care wards
- CDU/other clinical assessment units
- Additional capacity wards (B3)

Any temporary wards are not part of the Trusts Unify return.
Ward B4 is currently closed.

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
Ward A5	85.3%	106.7%	99.2%	98.3%	**Vacancy** - band 5 2.3 wte band 2 0.57 wte **Sickness rate** – 9.79% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support as appropriate. Attendance management policy followed. On-going recruitment plans in place
Ward A6	93.3%	88.7%	107.8%	91.3%	**Vacancy –** band 6 - 1.25wte trauma coordinator post going back out to advert in new year as recent interviews unsuccessful band 5 - 4wte awaiting approval and then out to advert band 2 - no vacancies currently **Sickness rate** -9.32% **Action taken** - Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support as appropriate. Attendance management policy followed.
Ward B4	-	-	-	-	Ward closed
Ward A4	82.3%	106.7%	107.8%	100%	**Vacancy -** band 5 2.3wte band 2 0.57 wte **Sickness rate** - 9.79% **Action taken -** Staffing and acuity reviewed daily. Recruitment programme in place. Sickness absence being managed in line with the Trust policy.
Ward CMTC	-	-	-	-	Ward Closed
Ward A9	130.6%	90.1%	116%	70.7%	**Vacancy –** Band5 2.0wte, band 2 3.0 wte **Sickness rate –** 15.87% **Action taken –** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support as appropriate. 1 band 5 awaiting start date CSWD's supporting band 2 vacancies sickness being managed in line with attendance policy
Ward B11	98.8%	96.3%	98.1%	100%	**Vacancy –** Fully established **Sickness rate** – 7.01% **Action taken -** Sickness managed through

					Trust Attendance Policy
NNU	83.7%	85.8%	81.3%	93.3%	**Vacancy –** Band 8a Matron 1.0 wte, band 6 1wte **Sickness rate –** 8.30% **Action taken –** Staffing and acuity reviewed daily. Vacancies have been advertised with interviews planned
Ward C20	96.2%	142.1%	100%	-	**Vacancy –** fully established **Sickness rate -** 20.10% **Action taken -** Sickness managed through Trust Attendance Policy
Ward C23	94.2%	95%	95%	91.7%	**Vacancy –** fully established **Sickness rate** – 7.11% **Action taken -** Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. Sickness policy followed and supported by HR
Delivery Suite	99.5%	93.3%	86.1%	110%	**Vacancy –** Fully Established **Sickness rate** – 9.35% **Action taken** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness is being managed in line with Trust policy.
Ward A1	89.3%	108.8%	100.6%	79.2%	**Vacancy -** band 6 1.0, band 5 3.74wte, band 2 1.77 wte **Sickness rate –** 3.39% **Action taken** – New ward manager in post from 30th Nov. NHSP usage and WM filling shortfalls in staffing.
Ward A2	84.7%	78.4%	103.3%	103.3%	**Vacancy –** band 5 0.8wte, band 4 1.0wte, band 2, 1.0wte **Sickness rate** – 4.79% **Action taken** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. On-going recruitment. Sickness is being managed in line with Trust policy.
Ward C21	82.9%	101.9%	100%	119.3%	**Vacancy**: band 5 1.39wte band 4 2.64wte, band 2 0.66wte posts **Sickness Rate:**18.77% **Action Taken**: Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Recruitment plans in place. Sickness is being managed in line with Trust policy. Backfill from B1 staff supporting to maintain safe staffing levels
Ward A8	92.2%	89%	87.6%	89.9%	**Vacancy -** band 5 5.0 wte, **Sickness rate –** 23.95% **Action taken** - Trust wide recruitment in place Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support
Ward B12	88.5%	97%	100%	100.7%	**Vacancy -** Band 2 3.0wte **Sickness rate** – 19.29% **Action taken -** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward B14	102.9%	93.7%	135.5%	107.5%	**Vacancy -** Band2 3.0wte **Sickness rate** - 5.93% **Action taken** - - Ward reviewed daily for acuity and staffing. CSWD x2 in post
Ward B18	112.1%	61.5%	96.7%	36.2.%	**Vacancy –** band 5 - 1.32 wte Band 2- 2.0wte **Sickness rate** - 6.60% **Action taken** - - Ward reviewed daily for acuity and staffing. Sickness managed as per Trust policy
Ward B19	78.3%	86.3%	94.2%	-	**Vacancy –** band 5 1.6 wte Band 2 5.4 wte **Sickness rate** – 16.64% **Action taken –** Recruitment plan in pace.

					Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward A7	123.9%	121.5%	136.7%	129.4%	**Vacancy**: ., band 5 8.61wte band 2 3.45wte **Sickness rate** – 2.95% **Action taken –** all sickness managed in line with policy. Ward reviewed daily for acuity and staffing.
ACCU	84%	91.6%	96%	96.7%	**Vacancy -** band 6 1.93, Band 2 0.78 wte **Sickness rate** -15.2% **Action taken** - Ward reviewed daily for acuity and staffing, sickness managed in line with policy.
ICU	112.5%	96.1%	106.7%	106.7%	**Vacancy -** band 5 -4.62wte. band 2, 1.92wte **Sickness rate** – 5.53% **Action taken** - Ward reviewed daily for acuity and staffing.
Total Fill Rate (%)	85.3%	106.7%	99.2%	98.3%	

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 21/01/XX b iii	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	27 January 2021

Date of Meeting	1 December 2020
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/20/12/ 230	**Matters arising**	The Committee received the following update: QAC/20/11/210 Urology Deep Dive weekly meetings continue, comprehensive RAG rated action plan in place. Workstreams progressing and monitored at Patient Safety Clinical Effectiveness Sub Committee (PSCESC). - Risk to be reviewed, update to January QAC. - Two weekly meetings in place (KSJ, JG and FW) to monitor action plan.	The Committee noted the updates and received moderate assurance.	**PSCESC 08.12.2020 & QAC 12.01.2021**
QAC/20/12/ 232	**Deep Dive - Ophthalmology**	The Committee received the following update: - Deep dive into six risks graded 15 or above, actions taken since the Deep Dive had been reported to PSCESC in August 2020. - One risk had been closed; remaining risk scores had reduced. Two risks linked due to estate issues to provide separate wait areas for Paediatrics and Elderly. Options being explored with Therapy Team, ED and Outpatients to explore further options. One risk increased from 8 to 15 - relating to appropriate temperature control within AMD clinical area, working with Estates to improve environment in this clinical area. Optos equipment to go live 7 December 2020.	**The Committee noted progress to date and received moderate assurance**	**PSCESC 28.01.2021 & QAC 12.01.2021**

		- Assurance provided that treatment required by patients is risk stratified against High/Medium/Low requirements. - Escalation through Associate Directors Planned and Unplanned Care. Further review on 5 December of where services can be moved to. - Future reporting of action plan at PSCESC and QAC through High Level briefing reports.		
QAC/20/11/ 233	**Board Assurance Framework**	The Committee noted the following: - Addition of 2 new risks 2020, Risks #1289 (risk score of 25) and #1290 (risk score of 12) approved at Trust Board 25 November 2020. -	The Committee noted the updates and received good assurance.	**QAC 12.01.2021**
QAC/20/10/ 235	**Phase 3 Recovery – Activity Update**	The Committee particularly noted: - Delivered 60% against plan of 73% in October. - 52 week waits – October 421 patients against trajectory of 418. November performance at risk due to Wave 2 challenges - Radiology – achieved 79% against 99% directive. - Endoscopy – small improvement in waits, additional virtual appointments taking place with face to face consultations where requested. - Out-Patients – on track, OP clinics to remain virtual with face to face consultations where required. - Mitigations include continuation of electives to 23 December 2020, restarted 28 December 2020 and additional capacity at Spire. - Surgical lists monitored at the weekly Performance Review Group (PRG) meeting. Proposals to Executives to support best/worst case scenarios relating to capacity required in January. - Diagnostic patients triaged with monthly review, patients contacted explaining delays, and if their treatment needs had changed / require urgent treatment to manage potential risk related to clinical need of patient. - PACU live January 2020, will increase throughput, supporting activity at both sites	The Committee noted the updates and received moderate assurance.	**QAC 12.01.2021**
QAC/20/12/ 231	**CQC Action Plan and Royal College Emergency Medicine**	Assurance provided on the work that had taken place and progress of M2O workstreams. - Significant improvement noted relating to EoL and Palliative Care workstream over the last 12 months and change and progress made	The Committee noted the updates and received good assurance.	**QAC 02.03.2021**

	(RCEM) Action Plan			
QAC/20/12/ 236	**IPC BAF Bi-Monthly Report**	No matters escalated and no further questions raised.	The Committee noted the report and good assurance provided of process in place to monitor, progress related actions and reporting to CQC.	**QAC 02.03.2021**
QAC/12/ 238	**Environmental Action Plan and NHSE/I Visit**	The Committee received and noted: - Action plan of 20 actions including five from NHSE/I incorporated into action plan of measures in place to prevent nosocomial transmission, supported by environmental risk assessments which had been completed for all wards and departments across the Trust. - Red rated actions – (1) Manning of PPE stations and (2) Halton signage - 2 metre distancing between bed and trolley spaces currently amber, also held as risk on Trust BAF with controls and actions in place, assurance provided that full risk assessments completed for all wards and where beds remain in place, and of mitigations in place - FFP3 Fit Testing on ESR – progressing alongside National Programme. - ED waiting area, mobile area outside of ED not feasible option, other options being explored. - Some staff experiencing an element of challenge from patients, looking to increase Security presence for additional support. - 8 week H&S programme to review ward risk assessments and environment, 5-6 inspections per week. - Action plan reported and monitored at Tactical Group and Silver Command and Regional Team. - Good staff morale reported, supported with measures put in place.	The Committee noted good assurance of progress to date and mitigations in place to address outstanding issues.	

QAC/20/12 242	**Safeguarding Bi-Annual Report**	The Committee noted the progress and work over the preceding 6 months particularly in support of the COVID-19 pandemic and the subsequent increase in referrals Committee requested a Safeguarding Deep Dive to future Quality Assurance Committee	The Committee noted the report and good assurance provided of monitoring processes in place.	**QAC 02.11.2021**
QAC/20/12/ 234 and QAC/20/12/ 246	**Strategies Mental Heallth Learning Disability**	The Committee approved the following Strategies - Three year Mental Health Strategy 2019-2024 - Three year Learning Disability Strategy 2019-2024 - Three year Safeguarding Adults, Young People and Children 2019-2021 three year Strategy 2019-2020	The Committee approved the strategies and received good assurance	

The Committee received the High Level Briefing Reports from the following Sub Committees:
- Safeguarding Sub Committee
- Infection Prevention and Control Sub Committee
- Equality Diversity Inclusion (EDI) Sub Committee Briefing

***Please note that due to operational pressures, the DIPC Q2 report was deferred to the January meeting**

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 20/01/07 b	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	27 January 2021

Date of Meeting	12 January 2021
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

Due to exceptional operational pressures, the agenda had been further streamlined to focus discussion on key matters. Additional questions were asked to be submitted after the meeting, questions and answers to be circulated with February papers.

Items deferred to future meetings due to operational pressures included:

- Urology Assurance Report
- COVID-19 Diabetes Service Report (Hot Topic)
- Cyber Security (Deep Dive)
- Prioritisation of restoration of key digital services
- Blood Inquiry Verbal Update

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/21/01/ 04	**COVID-19 Mortality Review Report**	The Committee received the following update and particularly noted: - Mortality Review Group (MRG) undertook randomised review of deaths of 30 patients during Wave 1. 50% percent had been actively managed and admitted to ITU and 50% had been triaged forward based care. - The review involved a wide scope of Clinicians, Wards, ICU and Respiratory and General Medicine expertise. - Off the total 138 deaths, average age of patients was 77 years;	The Committee noted the updates and received good assurance. EoL Dashboard developed, monitored and reported to Tactical Group	**Trust Board 27.01.2021**

		- COVID-19 related deaths occurred across 14 wards, the majority on Ward A5; - Of the 30 deaths reviewed, Hypertension was the most common co-morbidity; - Ethnicity - correlation of the small percentage of BAME deaths and Warrington BAME community. No worse outcome identified of patients from poorer backgrounds and additional co-morbidities than those with other groups unless male and black - Retrospective review of Ward COVID deaths, 112 patients reviewed, data validated, no cases disagreed. Palliative Care in place where appropriate and clinical and senior decision making documented. Where shortfalls identified, assurance that appropriate decisions had been made. Effective and safe robust screening tool suitable for future waves. - Appropriate escalation and DNACPR processes. - Some actions following recommendations progressing, improved and clear communication, clear documentation relating to CPR, MCA, death certificates and escalation of Palliative Care. - MRG identified evidence of very good care. Number of workstreams progressing through MRG including review of Arrhythmia Pneumonia, Fractured NoF, and UTIs to understand that data submitted is representative. - Following Structured Judgement Review (SJR) 19/30 cases reviewed as good, 7/30 adequate and 4/30 poor. The four patients identified as having received 'poor' care were discussed with the full MRG. Following review, none of the four cases required further investigation. - Currently reviewing Wave 2 Nosocomial infections for admissions to ICU.		
QAC/21/01/07	**Board Assurance Framework (BAF) and Strategic Risk Register**	The Committee **supported and approved** the following amendments to the BAF and Strategic Risk Register: - Reduction of risk ratings of two risks, Risk #1124 and Risk #1274 - Amendment to Description of Risk #1114 - Re-escalation of Risk #1126 (Oxygen flow) from a 15 to risk score of 25 on the BAF. - Proposal for additional risk related to ICU Capacity to reflect staffing levels when building additional wards. Currently one overarching Risk #1215. - Advised of proposal to review Risk #134 Part B to reflect current position	The Committee supported and approved the amendments to the BAF and received good assurance.	**Trust Board 27.01.2021 & QAC 02.02.2021**

		regarding loans and to reflect WHH cash position.		
QAC/21/01/09	**Review of Waiting Lists and Clinical Harm Review**	The Committee particularly noted: - Clinical and non-clinical wait times. - Improvement in a number of standards, despite COVID challenges. - Ongoing review of CRR and BAF to ensure Risks appropriately rated. - Clinical Harm Review meetings commenced with Panel representation from Primary and Secondary Care - PACU to receive first patients (4) on 13.01.2020	The Committee noted the updates and received moderate assurance.	**QAC 01.12.2020**
QAC/21/01/10 ii	**Maternity Safety Champion Report**	The Committee particularly noted: <u>Ockenden Benchmark Review</u> - Benchmark report identified 7 immediate and essential actions (IEA) and 12 urgent Clinical priorities from the IEAs - The Trust reported compliance with the IEAs on 21st December 2020, not full compliance on all elements except three, these were all partially compliant. These were: o IEA 1 b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB. WHHT response *'Robust reporting of SI's to the Trust Board including themes and trends. Routine reporting to LMS not in place and will be remediated.' The LMS are going to advise on the required process early in Jan 2021* o IEA 3 a) Implement consultant led labour ward rounds twice dai.ly (over 24 hours) and 7 days per week. WHHT response *'Currently in place 7 days a week occurring 2x each week day but only once each weekend day and bank holidays. New rota has been consulted on and agreed.'* On the 4th January 2021 the new Consultant Rota started enabling twice daily consultant ward rounds over 24 hours. o IEA 5 a) A risk assessment must be completed and recorded at every contact. This must also include on-going review and discussion of intended place of birth. This is a key element of the Personalised Care	The Committee noted the updated and received good assurance	**Compliance with Ockenden – Trust Board 27.01.2021** **QAC 02.02.2021**

		and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance. *'Currently takes place on booking and if risk features occur during pregnancy or on presentation in labour. Audit is in place. New policy guidance issued and risk assessment will be in place at each contact. With implementation of the new EPR in July 21 this will be captured electronically at each contact.'* - Desk top review to be undertaken by end of January 2021 using Birth Rate Plus tool. - On-going monitoring through newly convened Maternity Safety Group and Women's Health CBU Governance Group - On-going monitoring of Kirkup Report action plan through Women's Health CBU Governance Group <u>SI investigations</u> – 16 recommendations agreed, 12 completed, 4 ongoing. Deep dive to be undertaken by W&C CBU to seek assurance that systems and processes have changed in response to and learning taken place to improve care. Maternity Safety Champions to agree next steps for Deep Dive. - Maternity Safety Champion meetings have continued during the Pandemic to provide assurance of monitoring processes in place.		
QAC/21/01/11	**Position statement on key actions: Infection Prevention and Control and Testing**	The Committee rreviewed and noted thee report and standards of full compliance.	The report provided good assurance of monitoring processes in place against standards to achieve full compliance.	
QAC/21/01/18	**Fit Testing Compliance Report**	The Committee noted the report. During the COVID-19 pandemic, the Trust commenced fit testing staff in line with NHSE/I guidance to provide protection for staff and patients. Stocks of filtering face pieces (FFP)3 and 2 respirator masks were utilised in accordance with national availability. To support NHS Trusts and stabilise the stock of FFP3/2 masks a national programme of support from NHSE/I was launched in	The Committee noted the report and received good assurance	**QAC 02.02.2021**

		August 2020 and the following recommendations were made: • Trust Board oversight of compliance with fit testing • A central database to be maintained utilising ESR • Plan Do Study Act (PDSA) cycles should be completed to review fit testing process • Ensure access to fit testing for all staff groups There are 122 members of Trust staff who have been trained to fit test to the Health and Safety Executive (HSE) recommended standard. - Total Staff to be tested based on those in clinical roles – 2602 - Total Staff Tested Inclusive of non -clinical staff – 3528 - Outstanding clinical staff this includes, sickness/maternity - 388 Full compliance in 4 areas, 1 amber area to be completed by January 2021		
QAC/21/01/ 26	**Palliative Care and End of Life Care**	The Committee received the report and particularly noted: - Palliative and EoL Care Dashboard - there is now a weekly six Key Performance Indicator dashboard presented to the Tactical and Strategic Executive Oversight Groups - Palliative Care Unit & Hub - proposed new acute palliative care unit is a 12 bedded Specialist Palliative Care In-patient Unit and Hub - Serious Illness Care Programme UK - WHHFT is the national lead for the Serious Illness Care Programme UK in collaboration with the Palliative Care Institute Liverpool and Ariadne Labs, Boston USA. The Programme aims to improve the lives and personalise the care of all people with a serious illness through meaningful conversations about their goals and priorities. - CPR Decision Making - Dr Jude Raper, Consultant in Palliative Medicine is leading a Task and Finish Group to address the work streams including: 1. Audit report completed during COVID pandemic 2. Education and training- scheduled to launch in January 20210.	The Committee noted the report and received good assurance	**QAC 02.03.2021**

		3. Development of electronic DNACPR from.		

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

- Patient Safety and Clinical Effectiveness Sub Committee
- Safeguarding Sub Committee
- Patient Experience Sub Committee
- Health and Safety Sub Committee
- Infection Control Sub Committee
- Risk Review Group
- Information Governance and Corporate Records Sub Committee

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/21/01/07 c		TRUST BOARD OF DIRECTORS	DATE OF MEETING	27 January 2021

Date of Meeting	20 January 2021
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/21/01/ 03	**Matters Arising:**	**On-Call Harmonisation, Chief People Officer** The Chief People Officer confirmed that all organisational change continues to be reviewed and paused or progressed appropriately in line with the North West SPF agreement. The Committee were updated that the on-call harmonisation process remains paused as per previous discussions in the SPC but that where there is an immediate requirement for a review of on-call arrangements this is actioned in line with the new on-call policy.	**Assurance** **On-Call Harmonisation** The Committee were updated that the on-call harmonisation process remains paused as per previous discussions in the SPC but that where there is an immediate requirement for a review of on-call arrangements this is actioned in line with the new on-call policy. **Local Induction for Temporary Medical Staff,**	March 2021

		Local Induction for Temporary Medical Staff, Medical Director The Committee received a verbal update from the Medical Director on progress following discussions in the previous meeting: • Collaboration between Medical Cabinet Project Manager and Employment Services within HR and OD continues to work to address this issue; • A review of the platform for the e-form is underway, a campaign within CBUs and monitoring via Medical Cabinet.	**Medical Director** The Committee will receive a more detailed written update in March 2021.	
SPC/21/01/05	**Workforce Key Performance Indicator Recommendations**	**Workforce Key Performance Indicator (KPI) Recommendations, Deputy Director of HR and OD** The Committee received a recommendation to amend the KPIs on Turnover and Retention by including additional information relating specifically to permanent staff members.	**Decision** The Committee approved the recommendation for escalation to Trust Board	
SPC/21/01/07	**Chief People Officer Report**	**Chief People Officer Report, Chief People Officer** The Chief People Officer updated the Committee on: • COVID-19 Response Wave 3: Workforce • North West Social Partnership Forum Statement December 2021 • COVID-19 Asymptomatic Staff Testing • North West Black Asian and Minority Ethnic (BAME) Assembly	**Assurance** The Committee received assurance relating to the following key work streams: <u>COVID-19 Response Wave 3: Workforce</u> • Occupational Health • COVID-19 Testing for Staff and Household Members • Mental Health and Wellbeing – sanctuary email COVID Vaccine • Resourcing Additional updates will be provided in March 2021 relating to workforce risk assessments, COVID vaccines	March 2021

			and staff testing. North West Social Partnership Forum Statement December 2021 A statement has been published by the North West Social Partnership Forum relating to organisational change and employee relations. Working practices across the Trust continue to be in line with the principles set out in the statement. COVID-19 Asymptomatic Staff Testing The Trust launches Lateral Flow Testing for asymptomatic staff in November 2020. To date, 2174 staff members have volunteered to take part in the programme and there is a weekly positivity rate of 0.52%. In January 2021 the Trust received notification that Cheshire and Mersey Trusts will be required to transfer to LAMP Testing for asymptomatic staff and the Trust has been assigned a tentative 'go live' date of 5 March 2021. North West Black Asian and Minority Ethnic (BAME) Assembly The NW BAME Assembly provided information on their vision, mission and priority areas. The Trust have engaged well with the assembly and provided additional information relating to how the work of the assembly will implemented locally. The Trust continues to move forward positively with strategic work relating to EDI, which has been noted regionally.	
SPC/21/01/07	**Chief People Officer Report**	**Attendance Management Deep Dive, Deputy Director of HR and OD** The Committee received a paper updating on the Attendance Management Deep Dive agreed in Trust Board in November 2021.	**Assurance** The Committee received a detailed update on findings so far, summarised below: • Trust policy is legally compliant and is in line with ACAS guidance. • Trust policy and the framework of attendance	March 2021

			management within it are generally in line with other Trusts in the North West. • When specifically reviewing against some Trusts with lower absence rates, the Trust policy is less lenient. • Staff side colleagues feel that, in general the way that absence is managed by immediate line managers does not promote attendance. • Line managers feel that attendance management is time consuming and 'admin' heavy. Some feedback indicates that line managers do not see attendance management as part of their 'day-job'. • There is inconsistent application of the policy, particularly in relation to the actions which are not 'chased up' by HR. **Decision** The Committee supported the following recommendations: • Further work to engage with line managers directly and best practice Trusts referred to in the paper, with further actions and recommendations depending upon the findings. • Support from SPC to explore options around an electronic absence management system. • Refresh of the Attendance Management policy, particularly taking into account the findings of the review. Progress will be reported to the Chair of SPC and the Chief People officer ahead of the next Committee in March 2021, with a final report submitted to the Committee.	
SPC/21/01/08	**Policies and Procedures Report**	**Job Planning Policy, Deputy Director of HR and OD** The Deputy Director of HR and OD submitted the Job	**Decision** The policy was ratified by the Committee	

		Planning Policy for formal ratification.		
SPC/21/01/09	**Employee Relations Report**	**Improving People Processes, Deputy Director of HR and OD** The Committee received an update on progress against each of the Improving People Processes Recommendations.	**Decision** The Committee approved an amendment to the Employee Relations Report on a bi-meeting basis, to address the detailed level of reporting required within the Improving People Processes Recommendations.	March 2021.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/01/07 d i		TRUST BOARD OF DIRECTORS	DATE OF MEETING	27 January 2021

Date of Meeting	**23 December 2020**
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/20/12/168 FSC/20/12/169	Corporate Performance Report and Phase 3 Recovery report	The Committee considered and reviewed the report noting:- • 78.62% November A&E performance with year to date of 86.45% missing the target. • Urgent care activity 80-90% of same period last year • Super stranded patients circa 110 to 120 by the end of the month • Bed occupancy 93% - 96% impact on flow • Recovery is impacted by Wave 2 activity • Increase in 52 week waits is a concern as we move into 2021 • Improving in cancer targets • Independent sector indicating reduced access for our site with reduced specialties available • 50-60% of Phase 3 activity being delivered – Feb / Mar move to 60% - 70% supported by PACU starting mid January. Dependant on Wave 3 impact	The Committee **noted** the updates and received moderate assurance.	FSC Jan 2021
FSC/20/12/170	Discharge summary report	The Committee considered the report. These issues will be managed through KPIs moving forward, FSC supported changes to go forward to	The Committee **noted** the update and	Trust Board Jan 2021

		Trust Board	supported to go to Trust Board for approval	
FSC/20/12/171	Pay Assurance Report	The Committee considered and reviewed the report noting the following key points:- • Nursing and midwifery controls project is slower progress than predicted due to current situation with COVID-19 • Noted the quality and depth of information in the report • Rate card 40% against target of 60%	The Committee **noted** the updates and received good assurance.	FSC Jan 2021
FSC/20/12/172	COVID-19	The Committee considered and reviewed the report noting:- • The schemes with end dates in January which are being reviewed and will either be extended or switched off • Noted the potential increase expenditure relating to COVID-19 wave 3	The Committee **noted** the update	FSC Jan 2021
FSC/20/12/173	Digital Services Board	The Committee considered and reviewed the report noting:- • Number of projects remain delayed and are being managed and making progress. • E-observations progressing with real patient impact. • Reporting improvements noted and outstanding requests reducing • Outstanding audit actions reducing	The Committee noted the update	FSC Jan 2021
FSC/20/12/174	Monthly Finance report incl: (a) Draft Capital Planning Group minutes (27.11.2020) (b) FRG minutes (meeting cancelled)	The Committee considered the report and capital proposals key points to note included: • Off plan £0.8m worse as COVID-19 not offset by recovery expenditure reduction. • Range of forecast depending on COVID continuing for different periods £7.3m to £17m likely £13.9m. The revised forecast has not yet been accepted by NHSE/I • C&M asked to improve overall forecast • Another meeting planned with national team in January relating to the cash support the Trust requires	The Committee **noted** the updates and received good assurance. The Committee **approved** the changes to the capital plan as delegate by the Trust Board	FSC Jan 2021

		• Capital risks noted, Breast scheme shortfall noted and being managed through brought forward, critical care scheme is developing at pace, ED Plaza discussions externally taking place and looking to work with NHSE/I to develop alternative governance • Capital approved by the Committee • COVID-19 nursing incentives will increase the forecast outturn deficit		
FSC/20/12/175	Risk Register including Strategic Digital Risk (from EBM)	The Committee considered and reviewed the report which highlighted:- • No new BAF risks • Noted the proposal to amend the risk rating and description of Risk 1114 to simplify and clarify the risk	The Committee **noted** the updates and received good assurance.	FSC Jan 2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/01/07 d		TRUST BOARD OF DIRECTORS	DATE OF MEETING	27 January 2021

Date of Meeting	**20 January 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/21/1/05	Corporate Performance Report and Phase 3 Recovery report	The Committee considered and reviewed the report noting:- • 75.5% December A&E performance with year to date of 89.13% missing the target. • Urgent care activity 85% of same period last year • Closed K25 over Christmas • Super stranded patients circa 88 by Christmas and 115 by 31 December • RTT stable but not improving • Recovery is impacted by Wave 2 and Wave 3 activity • Increase in 52 week waits is a concern • Cancer targets - achieved 31 day and 2 week breast standard and narrowly failed 2 week standard • Ophthalmic , Gynaecology and urology were moved to Halton over December to support maintaining activity	The Committee **noted** the updates and received moderate assurance	FSC Feb 2021
FSC/21/1/05	Constitutional	The Committee considered the report which provided an update on	The Committee **noted**	

	Standards	performance for December 2020 against the key constitutional standards and the outcome of the harm review process implemented in the Trust. The report noted:- • 62 day Cancer target was not reached, • RTT waiting list is being monitored and increased from 19451 to 20190, • Diagnostic recovery increase in number waiting over 6 weeks by 637 taking the total to 3919, • Endoscopy slight increase on patients waiting • Outpatients in December achieved 85% of last years activity (first appointment)	the update	
FSC/21/1/07	Pay Assurance Report	The Committee considered and reviewed the report noting the following key points:- • Across the Trust in December 55 FTE was not utilised when compared to Funded Full Time Equivalent (FTE) • 2% of the Trusts overall temporary medical staff bookings were advertised straight to agency • In relation to pay rates, compliance against the various rate cards has reduced • 84% of the Trusts temporary staffing bookings are in advance, allowing opportunities to secure the best value booking The Committee noted the increased workforce data and information on the controls in the report although acknowledged the lack of opportunity to use it during the pandemic.	The Committee **noted** the updates and received good assurance	FSC Feb 2021
FSC/21/1/08	COVID-19	The Committee considered and reviewed the report noting:- • The schemes with end dates in January which are being reviewed and will either be extended or switched off • December COVID-19 expenditure was lowest it has been at £2m however anticipate an increase in Quarter 4 relating to wave 3 • Noted the potential increase in expenditure relating to COVID-19	The Committee **noted** the update	FSC Feb 2021

		wave 3		
FSC/21/1/9	Digital Services Audit Plan	The Committee considered and reviewed the report noting:- • 10 audits across 4 financial years are detailed with 16 open actions robustly reviewed leading to proposal to close 12 on the balance of risk and achievability leaving 4 achievable actions open.	The Committee **noted** the update	FSC Feb 2021
FSC/21/1/10	Digital Services Board Report	The Committee received a verbal update including:- • Schemes are stable with the team focusing on maternity and EPR, EPMA, E-rostering and E-observations • The reporting function is stable • There are some small back logs on some helpdesk calls but nothing major to note	The Committee **noted** the update	FSC Feb 2021
FSC/21/1/11	Budget setting and Capital Planning	The Committee received presentations on budget setting and capital planning for 2021/22. Whilst these are early drafts they assured the Committee of the timescale and process as it is currently understood and highlighted the current risks	The Committee **noted** the update	FSC Feb 2021
FSC/21/1/13	Monthly Finance report incl: (a) Draft Capital Planning Group minutes (27.11.2020) (b) FRG minutes (meeting cancelled)	The Committee considered the report and capital proposals. Key points to note included: • Deficit £3.1m against £3.0m deficit plan • The cashflow forecast shows that the Trust will require cash support of circa £26m in March, discussions with national team and regional team have confirmed this will be received as PDC not a loan • The vaccine costs are being collated and reported. They should be reimbursed in full • Capital risks were noted, including the Breast scheme shortfall which is being managed by bringing forward 2021/22 schemes. The critical care and ED Plaza schemes are under spending. This	The Committee **noted** the updates and received good assurance The Committee **supported** the changes to the capital plan and the Trust Board will be asked to **approve**	FSC Feb 2021

		presents a risk of losing £4.5m PDC funding and is being discussed with NHSE/I given the context the Trust is operating in and the necessity of completing these schemes. • Changes to the capital contingency are supported to go to Board for approval		
	MLU	The Committee considered the information in the presentation relating to an over spend position. It was agreed that an urgent review be undertaken by internal audit. A detailed initial report is being prepared by the Chief Operating Officer and an immediate review of all schemes is being undertaken. •	The Committee **noted** the position brought to their attention.	Board Jan 2021
FSC/21/1/15	Risk Register including Strategic Digital Risk (from EBM)	The Committee considered and reviewed the report which:- • Noted the change to the title of Risk 1114 • Proposed a change of wording to risk 134 "There is a risk that future loans will be required which would raise the question if the Trust is a going concern"	The Committee **noted** the updates, **supported** the changes and received good assurance.	FSC Feb 2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/08**			
SUBJECT:	**Infection Prevention and Control – Nosocomial Covid-19**			
DATE OF MEETING:	**27 January 2021**			
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	√		
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	√		
	SO3 We will.. Work in partnership to design and provide high quality, financially sustainable services.	√		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #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):	This report provides an overview of nosocomial Covid-19 cases and actions in place to reduce the risk of transmission within the Trust.			
PURPOSE: (please select as appropriate)	Information	Approval	To note √	Decision
RECOMMENDATION:	The Trust Board is asked to receive the 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)***	None			

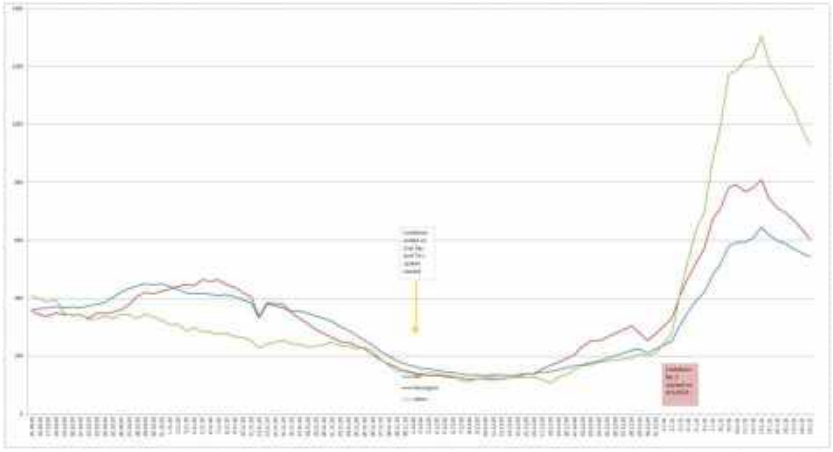
REPORT TO BOARD OF DIRECTORS

SUBJECT	Nosocomial Covid-19	AGENDA REF:	BM/21/01/08

1. BACKGROUND/CONTEXT

The WHO declared a global pandemic of Covid-19, caused by the SARS CoV-2 virus on 12 March 2020. There were 2 waves in 2020 and in January 2021 the pandemic entered wave 3. The northwest has a high prevalence rate per 100,000 population (7 day average) and both Warrington and Halton boroughs have higher rates than the northwest average (Data from 19/01/21).

Figure 1 Northwest/Warrington and Halton 7 day prevalence rate per 100,000 population



There is an increased demand on healthcare services and high numbers of patients admitted to the Trust diagnosed with Covid-19. At present, 19 January 2021, there are 243 inpatient cases at WHH (highest recorded number of inpatient cases). The current wards/departments supporting the care of patients with Covid-19 are:

- A7
- A8
- A9
- K25
- C21
- B18
- Critical Care including expansion into Theatre Recovery
- Theatre pod – theatre 8

The next steps in the escalation plan include the following wards/department:

- B19
- A4
- A2
- Theatre pod theatres – 7 for Critical Care

A new variant of SARS-CoV-2 has been identified and there is concern that there will be rapid transmission unless stringent infection control measures are applied.

Cases tested on the day of admission (day 1) or day 2 are considered community onset cases.
Nosocomial cases are defined by NHSE/I as:

- Hospital-Onset Indeterminate Healthcare-Associated (HO-iHA) – First positive specimen date 3-7 days after admission to Trust
- Hospital-Onset Probable Healthcare-Associated (HO-pHA) – First positive specimen date 8-14 days after admission to Trust
- Hospital-Onset Definite Healthcare-Associated (HO-dHA) – First positive specimen date 15 or more days after admission to Trust

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.

2. KEY ELEMENTS

The table below shows the numbers of SARS-CoV-2 results from 13/03/20 - 18/01/21 and length of stay at time of sampling.

Table 1 SARS-CoV-2 results and length of stay at time of sampling

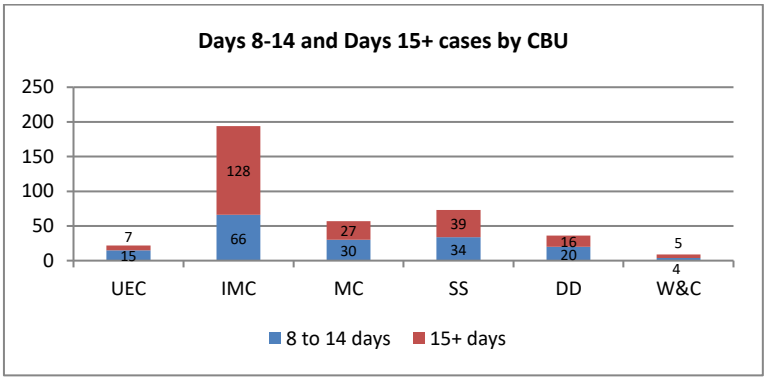
Financial Year	Month	0 to 2 days	3 to 7 days	8 to 14 days	15+ days	Grand Total
2019/20	Mar	54	11	2	6	73
2020/21	Apr	194	32	28	44	298
	May	61	5	11	20	97
	Jun	19	4	9	1	33
	Jul	6	3	0	1	10
	Aug	13	3	0	0	16
	Sep	66	9	1	4	80
	Oct	216	35	28	48	327
	Nov	191	45	29	49	314
	Dec	155	37	34	29	255
	Jan*	277	25	27	20	349
Grand Total		1252	209	169	222	1852

*January data incomplete at time of completing report

Nosocomial Cases

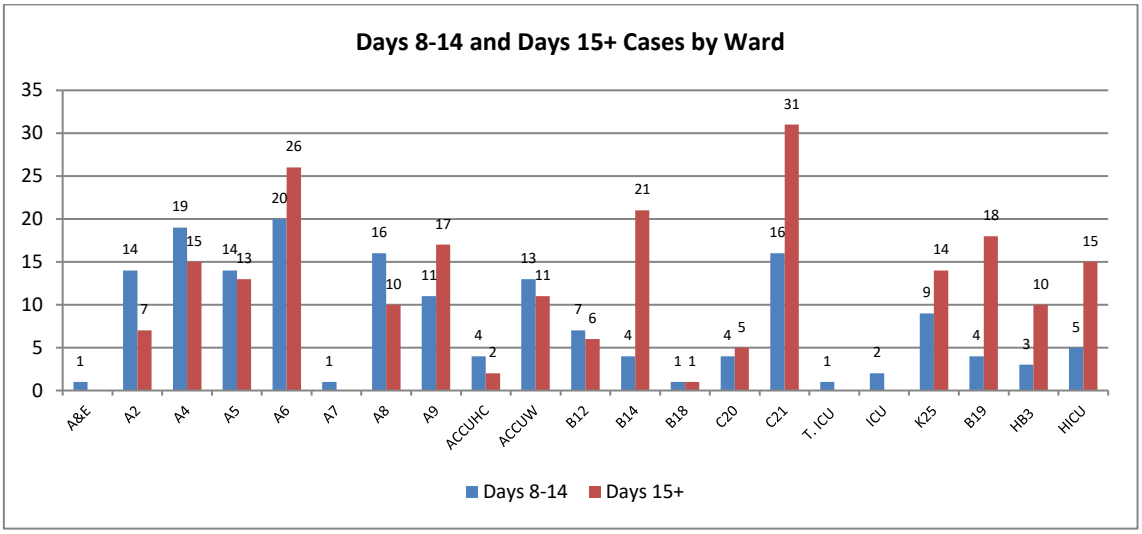
Probable and definite hospital onset cases, by CBU are shown on the Chart below.

Figure 2 SARS-CoV-2 Detected Days 8-14 and Days 15+ Length of Stay by CBU



Probable and definite hospital onset cases by ward from 13/03/20 - 18/01/21 are shown on the chart below.

Figure 3 SARS-CoV-2 Detected Days 8-14 and Days 15+ Length of Stay by Ward

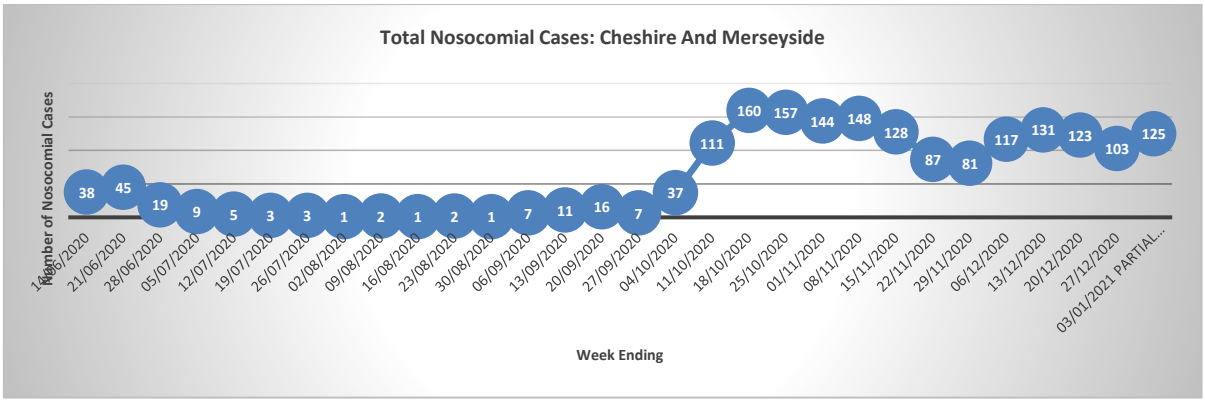


A&E specimen –mislabelled swab

The chart above shows patient location at time of testing and does not necessarily equate to where Covid-19 was acquired. A number of ward moves have taken place e.g. trauma orthopaedic ward move from C21 to A6 and therefore the patient speciality is not necessarily the same for each ward for the time period of the pandemic.

Nosocomial cases across Cheshire and Merseyside by week ending are shown on the chart below.

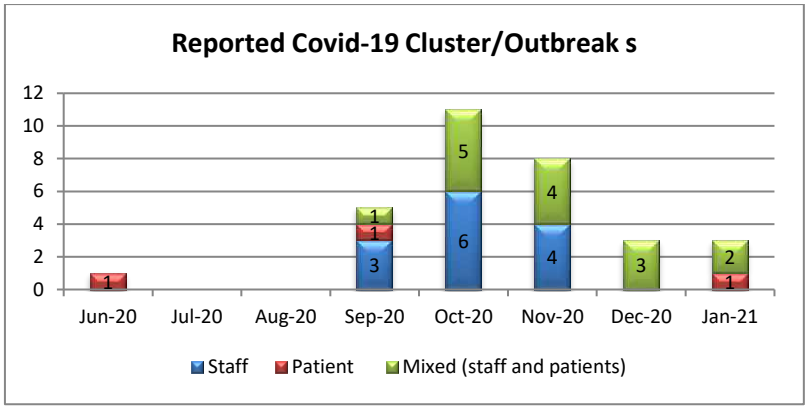
Figure 4 Nosocomial Cases by Week Ending from14/06/20



Outbreaks

Since June 2020, when NHSE/I published the Northwest Hospital onset Covid-19 Infection Standard Operating Procedure, 31 suspected Covid-19 outbreaks have been reported, of these 6 incidences were considered clusters of infection. From the 25 incidents considered outbreaks: 13 affected staff; 3 affected patients and 15 affected both staff and patients. One outbreak was re-opened following additional cases being identified during the 14 day surveillance period.

Figure 5 Covid-19 Cluster/Outbreak Reports from June 2020



The following is in place to support reduction of nosocomial cases:

- DIPC involvement /support
- Most test results same day (in-house lab) Turnaround times < 6 hours
- Patient placement SOP
- Staff symptoms screening SOP in all areas
- Lateral Flow Testing: uptake 2169 consented with 1891 staff submitting results
- Environment safety plan
- Programme for ward/departmental visits
- IPCT oversight
- Daily (or very frequent) outbreak meetings
- Weekly testing introduced
- Board Assurance Framework for IPC revised

Learning from Trust Outbreaks

Outbreak Control Groups are set up to investigate clusters of Covid-19 cases. A number of themes have emerged from investigation of outbreaks including:

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

Challenges include:

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

Next step include:

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

Health and Safety

The Health and Safety Executive has updated the RIDDOR guidance to include the reporting of staff contracting Covid-19 through exposure in the workplace. The Trust has not made any reports of this nature to date.

Ten Key Actions

On 17 November 2020 NHS England and NHS Improvement (NHSE/I) published a 10 point guide for key actions: infection prevention and control and testing (appendix 1). NHS Trusts were asked to provide assurance that the document has been reviewed by executive teams and Infection Prevention and Control colleagues and implementation has commenced. One area for further action relates to obtaining 2 negative tests prior to moving patients.

Environmental Action Plan

Work continues to complete the action items in the environmental action plan (appendix 2). Following the NHSE/I visit on 30 September 2021 an additional 4 hydrogen peroxide vapour decontamination machines have been purchased and have been put into use to ensure a high standard of environmental decontamination.

A draft consultation on SARS-CoV-2 transmission modes (Hospital Infection Society) and Mitigation to reduce transmission of new variant SARS-CoV-2 virus (Scientific Advisory Group) have been reviewed and recommendations made on further actions. One addition mitigating action relates to ventilation. The Trust has already commenced a 'healthy air' trial using air purification devices. To date 3 devices have been installed in ED, AMU and A7. Additional devices will be installed once received. Air sampling devises are being used to collect environmental samples with cartridges being referred for testing. Data will be shared once available. Additional recommendations are listed below.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Health and Safety Team to revise standard template for Covid-19 secure/mitigated risk assessment to include ventilation
- Targeted communication strategy: 3 Cs Avoid: Closed spaces, Crowds and Close Contact: Refresh PPE Signage, strengthen positive feedback on compliance and highlight potential risks for non-compliance promoting shared responsibility
- Review approach to eye protection: used for AGPs and at other times by risk assessment – in particular for prolonged close contact with patients e.g. bed bathing

- Review use of fluid repellent surgical masks and FFP3 where there are high numbers of patients with Covid-19 and consider sessional use of FFP3
- Strengthen regular cleaning of frequently touched items
- Set clear expectations and reinforce the role of PPE champions
- Strengthen the give fresh air to show you care campaign – open windows for 5 minutes every hour – dependant on patient comfort and consider additional wards to include in the health air trial
- Reinforce communication on reduction of staff numbers on ward rounds
- Refresh focus on hand hygiene
- Review use of screens to ensure in all appropriate areas
- Respiratory etiquette – strengthen offer of masks to inpatients
- Reiterate messages on symptoms and accessing testing. Lateral Flow Device testing plan for ED task and finish group is in place
- Reinforce message that IPC precautions still required after vaccination

4. IMPACT ON QPS?

- Q: A reduction in nosocomial Covid-19 cases will have a positive impact on patient outcomes
- P: Preparing staff is essential for safety in the workplace
- S: Reduction in nosocomial Covid-19 cases supports sustainability by reducing length of stay in hospital

5. MEASUREMENTS/EVALUATIONS

- Surveillance of hospital onset Covid-19 cases
- Outbreak detection and management
- Surveillance of staff cases

6. TRAJECTORIES/OBJECTIVES AGREED

- Objective to reduce the risk of transmission of SARS-CoV-2 as far as reasonably practicable

7. MONITORING/REPORTING ROUTES

- Infection Prevention and Control Team
- Tactical Pandemic Meetings
- Silver IPC Cell Meetings
- Senior Executive Oversight Group
- Quality Assurance Committee
- Trust Board

8. TIMELINES

- For the duration of the pandemic

9. ASSURANCE COMMITTEE

- Infection Control Sub-Committee and Senior Executive Oversight Group during the pandemic period

10. RECOMMENDATIONS

The Trust Board is asked to receive the report.

Appendix 1 - 10 Key Actions Assessment and NHSE/I submission

	Standard	Compliance	Evidence
1	Staff consistently practice good hand hygiene and all high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient	Compliant	• Designated sinks for hand washing • Hand hygiene Policy in line with WHO 5 moments • Uniform/Work wear policy including bare below the elbows • Alcohol based hand rubs available at the point of care and personal dispensers used where risk assessment precludes standalone dispensers • Signage on hand hygiene is available on all soap dispensers • Hand cream/emollients are promoted for hand care and available in all clinical areas • A programme of hand hygiene auditing is in place to assess compliance against the WHO 5 moments • Cleaning frequencies are available for all areas • Promotional campaign launched to increase cleaning of frequently touched surfaces a minimum of 3 times per day
2	Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace	Compliant	• Social distancing included in all risk assessments • Learning from outbreaks shared on avoiding car sharing • Break rooms are risk assessed and distance between chairs marked • Daily Trust wide Safety Brief includes advice on reducing the risk of Covid-19 • Staff information leaflet on Covid-19 Safety • Covid-19 Policy • Covid-19 care bundle in production
3	Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings	Compliant	• PPE stations are set up in all clinical areas • Covid-19 Policy • PPE guidelines • Posters displayed to demonstrate PPE required for aerosol/non-aerosol generating procedures • PHE videos used to provide education on donning and doffing • PPE champions (58) provide education, guidance and carryout spot checks • Face masks are worn throughout the Trust. Mask and hand hygiene stations are set up at entrances • PPE is disposed of via the orange waste stream
4	Patients are not moved until at least two negative test results are obtained, unless clinically justified	Compliant	• Triage of patients • Patient allocated to Covid-19/non-Covid-19 areas • National guidance is followed in relation to stepping down IPC precautions with policy in place • SOP for patient placement
5	Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse, and the Board Assurance Framework is reviewed and evidence of reviews is available	Compliant	• Data validation and executive sign off process in place • Board Assurance Framework for IPC revised 25 November 2020 and discussed at Quality Assurance Committee • Schedule in place for bimonthly review
6	Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients is considered, and wards are effectively ventilated	Compliant	• Trust wide assessment of bed spacing undertaken • Clear plastic curtains put up to add barrier protection • Windows are opened as far as practicable and patient comfort considered • Ward risk assessment Environmental Action Plan

	Standard	Compliance	Evidence
			• Ward Risk assessments • Environmental action plan (Appendix 2)
7	Staff testing: a. Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing. b. If your trust has a high nosocomial rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back	Compliant	• Programme of Lateral Flow Testing in place (greater than 1700 participants) • Staff screening implemented during outbreak investigations. Details of positive cases are included in outbreak meeting minutes. Where staff exposure is identified, members are excluded for the incubation period and monitored for development of symptoms
8	Patient testing: a. All patients must be tested at emergency admission, whether or not they have symptoms. b. Those with symptoms of COVID-19 must be retested at the point symptoms arise after admission. c. Those who test negative upon admission must have a second test 3 days after admission, and a third test 5-7 days post admission. d. All patients must be tested 48 hours prior to discharge directly to a care home and must only be discharged when their test result is available. Care home patients testing positive can only be discharged to CQC-designated facilities. Care homes must not accept discharged patients unless they have that person's test result and can safely care for them. e. Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission.	Compliant	• All patients requiring admission to the Trust are testing in ED – compliance audit requested • Evidence of symptomatic screening swab as per laboratory data • Currently repeat screening is carried out on day 2. This is being changed to day 3 screening • Policy in place for discharge screening. Patients with Covid-19 are discharged to a CQC designated facility (Lilly Cross) • Collaborative working with the Directors of Adult Social Services and Directors of Public Health (Warrington and Halton) has taken place to produce a risk assessment for discharge to care homes. This has been signed off by the Health Protection Board and the CCG and will be discussed at the clinical quality focus group with the CCG • Elective screening is carried out prior to admission - compliance audit requested
9	**Systems** **Local Systems must:** Assure themselves, with commissioners that a trust's infection prevention and control interventions (IPC) are optimal, the Board Assurance Framework is complete, and agreed action plans are being delivered.	Compliant	• Commissioner oversight takes place at Clinical Quality focus Group • Board Assurance Framework for IPC revised 25 November 2020 and action plan progress monitored at Infection Control Sub-Committee and Quality Assurance Committee
10	Review system performance and data; offer peer support and take steps to intervene as required.	Compliant	• Local data on Covid-19 surveillance is discussed at Tactical meetings • Covid-19 nosocomial and outbreak data is reviewed at Board level

17 November 2020

NHS

Key actions: infection prevention and control and testing

Organisations

It is the board's responsibility to ensure that:

1. Staff consistently practice good hand hygiene and all high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.
2. Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.
3. Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings.
4. Patients are not moved until at least two negative test results are obtained, unless clinically justified.
5. Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse, and the Board Assurance Framework is reviewed and evidence of reviews is available.
6. Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients must be considered, and wards are effectively ventilated.

Online COVID-19 guidance

www.england.nhs.uk/coronavirus | GOV.UK | NHS.UK

NHS

7. **Staff testing:**
   a. Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing.
   b. If your trust has a high nosocomial rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back.
8. **Patient testing:**
   a. All patients must be tested at emergency admission, whether or not they have symptoms.
   b. Those with symptoms of COVID-19 must be retested at the point symptoms arise after admission.
   c. Those who test negative upon admission must have a second test 3 days after admission, and a third test 5-7 days post admission.
   d. All patients must be tested 48 hours prior to discharge directly to a care home and must only be discharged when their test result is available. Care home patients testing positive can only be discharged to CQC-designated facilities. Care homes must not accept discharged patients unless they have that person's test result and can safely care for them.
   e. Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission.

Systems

Local systems must:

9. Assure themselves, with commissioners, that a trust's infection prevention and control interventions (IPC) are optimal, the Board Assurance Framework is complete, and agreed action plans are being delivered.
10. Review system performance and data; offer peer support and take steps to intervene as required.

Online COVID-19 guidance

www.england.nhs.uk/coronavirus | GOV.UK | NHS.UK

10 Key Actions Infection Prevention and Control and Testing Assurance Tool – NHSE/I Submission

	10 POINT PLAN	Compliance	Mitigations
1	Staff consistently practice good hand hygiene and all high touch surfaces, and items are decontaminated multiple times every day – once or twice a day is insufficient.	COMPLIANT	Hand hygiene and PPE audits in place as standard practice Clinell cleaning 3x daily in all clinical areas
2	Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.	COMPLIANT	Communication through Trust wide Safety Brief on a daily basis Part of the induction check-list for new starters Promote key messages on social media Signage around the Trust
3	Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings.	COMPLIANT	Embedded
4	Patients are not moved until at least two negative test results are obtained, unless clinically justified.	COMPLIANT	Patients are swabbed on the day of admission and on their second day. Swabbing then takes place on day 5 and subsequently weekly unless there is an onset of symptoms. Clinical reviews are in place for all patient moves.
5	Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse, and the Board Assurance Framework is reviewed, and evidence of reviews is available.	COMPLIANT	
6	Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients must be considered, and wards are effectively ventilated.	COMPLIANT	Plastic see-through curtains are used as physical segregation Beds are placed 1.8m apart - with risk assessments in place All bays are risk assessed to determine the maximum number of patients per bay
7	**STAFF TESTING**		
7a	Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing	COMPLIANT	The Trust was an early adopter of LFT PCR tests are in place as confirmatory to the LFT SIREN study continues Staff swabbing service located at Halton site
7b	If your trust has a high nosocomial rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back	COMPLIANT	Staff are swabbed when there has been an outbreak identified - this process is routine Outcomes are reported through daily outbreak submissions
8	**PATIENT TESTING**		
8a	All patients must be tested at emergency admission, whether or not they have symptoms.	COMPLIANT	

	10 POINT PLAN	Compliance	Mitigations
8b	Those with symptoms of COVID-19 must be retested at the point symptoms arise after admission.	COMPLIANT	Along with admission, day 2, 5 and subsequent weekly swabs, patients are swabbed at the onset of any symptoms
8c	Those who test negative upon admission must have a second test 3 days after admission, and a third test 5-7 days post admission.	NON-COMPLIANT	At WHH swabbing occurs upon admission, day 2, day 5 and then weekly
8d	All patients must be tested 48 hours prior to discharge directly to a care home and must only be discharged when their test result is available. Care home patients testing positive can only be discharged to CQC-designated facilities. Care homes must not accept discharged patients unless they have that person's test result and can safely care for them	COMPLIANT	All patients are swabbed on their day of discharge with same-day results and rapid swabs available when necessary
8e	Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission.	COMPLIANT	Currently patients have been asked to isolate for 14 days based on higher community prevalence and when Warrington and Halton have been in Tier 3 National guidance and recommendations from NICE are reviewed in-line with surveillance data and local restrictions
	SYSTEMS		
9	Local Systems must assure themselves, with commissioners, that a trust's infection prevention and control interventions (IPC) are optimal, the Board Assurance Framework is complete, and agreed action plans are being delivered.	COMPLIANT	
10	Local Systems must Review system performance and data; offer peer support and take steps to intervene as required.	COMPLIANT	NHSE and CCG visit October 2020 Peer Review - Countess of Chester November 2020

Appendix 2 – Environment Safety Action Plan

Legend

Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete, awaiting assurance evidence
Blue	Complete, assurance evidence embedded received and passed to CBU for monitoring

No	Recommendation	Action Required	Current Position	Lead	Completion Date	How do we know if will be effective	RAG	Risk ID and Grading
1	Restrict Site Access to reduce the risk of COVID 19 transmission	Identify access points to close and ensure all Staff, patients and public are made aware	All identified access points have been risk assessed and closed **Examples of evidence:** Site Lockdown Plan	Associate Director Estates & Facilities Head of Safety & Risk Deputy Chief Nurse Patient Safety & Clinical Education	07/07/2020	• Staff, patients and visitors will only be able to enter the hospital site at designated points only. **Monitoring Process** • To be monitored and reviewed through the Trust incident reporting system on a daily basis via Health and Safety • Health and Safety Inspections 3 times weekly will monitor that areas identify remain closed, records to be kept with H&S team • Findings from H&S inspections will report into the weekly Silver IPC meeting chaired by Chief Nurse, DIPC		
2	Ensure clear correct signage is in place across the Trust to support social distancing	Identify all areas that require signage to support social distancing safety	Signage in place across both sites Floor spots for all areas to be put in place	Associate Director Estates & Facilities Head of	29/07/20 This is an on-going action as signage gets updated	• All staff patients and visitors to the Trust will understand the expectations to maintain social distancing and keep left on corridors		

No	Recommendation	Action Required	Current Position	Lead	Completion Date	How do we know if will be effective	RAG	Risk ID and Grading
			Examples of evidence: Health & Safety Inspection reports Minutes from Weekly Silver meeting	Comms & Engagement Head of Safety & Risk Deputy Chief Nurse Patient Safety & Clinical Education	and/or replaced.	**Monitoring Process** • Health and Safety Inspections 3 times weekly will monitor the estate for correct appropriate signage records to be kept with H&S team • Findings from H&S inspections will report into the weekly Silver IPC meeting chaired by Chief Nurse, DIPC		
3	Ensure clinical pathways for Covid and non Covid patients are identified and ensure Trust staff are made aware	To ensure any changes with Covid pathways are circulated to ensure all staff aware	Currently the decisions for clinical pathways are discussed within the triumvirate groups and are communicated in the Planned / Unplanned Operational group meetings Changes are ratified at Tactical Board meetings and are subsequently cascaded within CBUs and SOPs are placed on the Hub. **Examples of evidence:** Escalation Plans Ward Admission SOPs SOPs for wards	Head of Emergency Planning	March 2020 and on-going	• Staff will be fully aware of Covid and non Covid patient pathways **Monitoring Process:** Tactical Board Meetings Planned and Unplanned Care Operational Group SOPs with review dates on the Hub		
4	All covid-19 related incidents to be monitored daily via the Health and Safety Team	Health and Safety Team to ensure that all incidents are monitored daily including those related to covid-19.	Health and Safety Team monitor all non-clinical incidents daily and escalate to Deputy	Head of Safety & Risk	25/03/2020 This remains on-going.	• Incidents related to Covid-19 will be escalated to the appropriate manager with the Head of Safety & Risk oversight.		

No	Recommendation	Action Required	Current Position	Lead	Completion Date	How do we know if will be effective	RAG	Risk ID and Grading
		Where necessary, incidents are escalated to Deputy Director of Governance.	Director of Governance as necessary. **Examples of evidence:** Incident Tracker			**Monitoring Process:** • All non-clinical incidents are monitored by the H&S Team to ensure all risks are identified and to determine if they need to be added to an appropriate risk register. All COVID19 related incidents are tracked on a separate spread sheet with actions taken		
5	Ensure that all areas across the Trust have risk assessments in place for the safety and health of patients, staff and visitors. To ensure appropriate use of social distancing and PPE to limit transmission. To include all clinical areas, office space, departmental areas, corridors and stairwells, communal restrooms, lifts.	All areas must have robust risk assessments in place to ensure assurance of social distancing measures and access / compliance to PPE Royal College Emergency Medicine benchmark process to be completed with associated action plan in place	All risk assessments in place. Any changes to the existing environment or reconfiguration must be reviewed and documented. **Examples of evidence:** Completed Risk Assessment documents RCEM action plan PPE compliance audit reports Ward Action Cards	Head of Safety & Risk Deputy Chief Nurse Patient Safety & Clinical Education Lead Nurse ED CBU manager ED	23/06/2020 Risk assessments are updated as required.	• All areas across the Trust will have a completed risk assessment and compliance is regularly monitored and achieved **Monitoring Process:** • Risk assessments for clinical areas will be reviewed weekly for compliance against risk assessments by the Matron/ Lead Nurse with support from the Deputy Chief Nurse and H&S Team and findings reported into the weekly Silver IPC meeting chaired by Chief Nurse, DIPC • All risk assessments will be held centrally with H&S Team • RCEM action plan compliance to be reported via Trust Tactical Board Meeting • Weekly PPE audits conducted in clinical areas • Health and Safety Inspections 3 times weekly will monitor the estate - records to be kept with H&S team		1194 Risk has now closed due to appropriate social distancing now in place
			Where there is evidence	Associate	This is an on-	• Incidents and complaints to be		

No	Recommendation	Action Required	Current Position	Lead	Completion Date	How do we know if will be effective	RAG	Risk ID and Grading
			of covid-19 outbreaks meetings are held daily by the Chief Nurse and Associate Chief Nurse for IPC, RCAs undertaken, reported through weekly meeting of harm **Examples of evidence:** Minutes of outbreak meetings Incident report Weekly Harm Paper Silver IPC meeting minutes	Chief Nurse IP&C Senior Governance Manager	going action and will continue to be monitored daily	monitored and reported accordingly and shared with appropriate areas. IPC to be made aware of relevant complaints. • Weekly harm paper monitored through the Strategic Oversight Group. • Monthly incident report continues to be shared at Patient Safety and Clinical Effectiveness Sub Committee and Quality Assurance Committee. • Outbreak update reported through Trust Tactical Board Meeting and weekly Silver IPC meeting		
6	Asymptomatic Staff swabbing for COVID19	Trust to undertake asymptomatic staff swabbing as per NHSE/I guidance	Staff swabbing is underway Lateral asymptomatic testing programme Reported absences as a result of asymptomatic staff swabbing **Examples of evidence:** Trust Tactical Board Minutes	Deputy Chief Nurse Patient Safety & Clinical Education Deputy Director HR	31/10/2020 This is an on-going action	• Swabbing of staff has now commenced **Monitoring Process** • Reported absence figures through Trust Tactical Board Meeting		
7	Ensure that mask stations and sanitisers are available at all entrances	All entrances have mask stations and sanitiser available.	All entrances have a mask station and sanitiser available	Deputy Chief Nurse Patient Safety &	This is an on-going action and will continue to	• All entrances have fully stocked hand sanitiser and mask stations **Monitoring Process:**		

No	Recommendation	Action Required	Current Position	Lead	Completion Date	How do we know if will be effective	RAG	Risk ID and Grading
			Examples of evidence: Daily checklist completed by Domestic Supervisor	Clinical Education Support Services Manager	be monitored daily	• Health and Safety inspection x 3 per week includes mask stations and gel availability at entrances • Spot checks are undertaken by senior teams throughout the day • Daily checklist completed by domestic staff • Daily monitoring provided by Estates and Facilities staff		
8	Ensure a presence at three "open" entrances at Warrington site to support entrance safety.	Fully staff rota to be in place to ensure a presence at: Main Entrance Croft Entrance Old Main Entrance	Partially staffed rota in place **Examples of evidence:** Entrance Safety Team rota in place Extra support sought from military personnel offer	Deputy Chief Nurse Patient Safety & Clinical Education	31/10/2020	• Three entrances fully managed by a mixture of volunteers and paid NHSP staff. The Entrance Safety Team are a complementary measure to support the actions in place to maintain environmental safety, the team have been recruited from Wingman volunteers to provide support over and above the existing redeployed Trust staff **Monitoring Process:** • Rota managed by Clinical Education Team admin and overseen by Deputy Chief Nurse Patient Safety & Clinical Education • Spot check assurance • Review of NHSP shift fill		
9	Agile working policy to be introduced to support staff to work from home	Agile working policy to be written and approved to facilitate agile working via	Agile working policy completed and available on the Trust Hub.	Deputy Director HR	17/06/2020 Policy ratified	• Managers will support their staff to work remotely where appropriate		1207 Current rating 16

No	Recommendation	Action Required	Current Position	Lead	Completion Date	How do we know if will be effective	RAG	Risk ID and Grading
	and across wider spaces. All risk assessments including all vulnerable staffing groups are to be completed and considered within decision making	the use of Microsoft teams. All vulnerable staff must have a risk assessment in place.	Risk assessments are completed as per Trust policy. **Examples of evidence:** Policy in place			**Monitoring Process:** • All individual risk assessments are monitored and signed off via HR • A daily SIPREP is provided to the Executive Team with number of risk assessments completed.		
10	Ensure Information Technology infrastructure in place to support remote working	To ensure that digital services upgrade remote access and provide additional devices to enable home working. To enable the Trust to work in an agile and safe manner utilising Microsoft teams.	Microsoft teams embedded across the organisation. A number of extra devices have been provided and will be reviewed as necessary. Additional technology to be ordered as necessary **Examples of evidence:** 250K Business Case approved to purchase additional kit	Deputy Director IT	March 2020	• All staff able to work from home will have appropriate IT kit provided to support **Monitoring Process:** • Microsoft Teams meetings have been successfully implemented • To add IT as standing item to Tactical Board agenda x 1 weekly for CBU feedback re demand • Add IT demand to Digital Board agenda for executive oversight		
11	Ensure full compliance with national visiting guidance throughout the pandemic	To ensure that all staff understand the restrictions in accordance with local and national visiting requirements as indicated by NHSE/I. Ensure that where there are caveats to this e.g. end of life care that this is clearly documented and communicated.	Fully compliant with visiting restrictions and individual cases are discussed with Ward Managers/ Matrons. Family liaison service in place to support communication between families. **Examples of evidence:**	Deputy Chief Nurse	March 2020	• Visiting restrictions in place **Monitoring Process:** • Any incidents/complaints are monitored and actioned by the Governance Department. • FLO team feedback • Nurse in charge to ensure appropriate visiting • A risk assessment is in place to support safe visiting where appropriate		

No	Recommendation	Action Required	Current Position	Lead	Completion Date	How do we know if will be effective	RAG	Risk ID and Grading
			Risk assessment					
12	PPE must be monitored and distributed accordingly	All PPE must be monitored via the Procurement Department in terms of ordering. Where there has been a service restart appropriate PPE burn out assessment documentation must be completed and signed off at Recovery Board.	PPE usage and ordering is being monitored by the Procurement team. All areas have individual responsibility to ensure that they have adequate stock and there is a clear escalation process in place. PPE and procurement is discussed daily and tactical / recovery board. A Specialist PPE room is also in place. This is staffed separately to the Incident Control room. Robust fit testing plan in place. PPE Champions in place PPE Safety Helpdesk in place **Examples of evidence:** Procurement order and distribution log PPE champion role descriptor Tactical Board minutes	Associate Director of Procurement Deputy Chief Nurse Patient Safety & Clinical Education Head of Emergency Planning	16/03/2020	• PPE will be fully accessible for all clinical staff **Monitoring Process:** • Monitoring of incidents and complaints for PPE • Stock reported via Trust Tactical Board • Fit testing rota for staff in place • Database of Fit Testing results • Recovery and PPE proforma log		1124 Current rating 25

No	Recommendation	Action Required	Current Position	Lead	Completion Date	How do we know if will be effective	RAG	Risk ID and Grading
			SOP for PPE					
13	Trust must make every attempt to optimise compliance with the 2m bed space requirement	To ensure there is adequate social distancing between bed spaces.	Trust has undertaken a full risk assessment of every ward to identify compliance or challenges in meeting this requirement as per ward risk assessment. **Examples of evidence:** SEOG Paper completed Risk assessments in place Silver IPC minutes	Head of Safety & Risk Deputy Chief Nurse Patient Safety & Clinical Education	August 2020	• All risk assessments are complete and monitored for compliance for safe social distancing where 2m bed spacing is not possible **Monitoring Process:** • Risk assessments for clinical areas will be reviewed weekly for compliance against risk assessments by the Matron/ Lead Nurse with support from the Deputy Chief Nurse and H&S Team and findings reported into the weekly Silver IPC meeting chaired by Chief Nurse, DIPC		1272 BAF (25) risk related to capacity as a result of 2m distancing
			Clear curtains are to be provided to all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains		28/10/2020	• Clear curtains to be in place across all clinical areas		

No	Recommendation	Action Required	Current Position	Lead	Completion Date	How do we know if will be effective	RAG	Risk ID and Grading
14	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	Increase frequency of corridor cleaning for all high touch areas toilets, door handles, lift buttons	Designated cleaning teams in place with appropriate training in required techniques Task Team and Domestic Assistant training for Covid-19 cohort ward areas has been carried out. Terminal cleaning and Decontamination polices in place. **Examples of evidence:** Record of terminal cleaning and touch points	Facilities Manager	On-going action monitored daily	• Clean clutter free appropriate environment **Monitoring Process:** • Cleaning is monitored daily by the Task Team. • Incidents are reviewed daily by Health and Safety Team and any actions are escalated to the relevant manager.		
15	Ensure any Estates concerns are escalated to clinical teams immediately	Introduce a system of daily correspondence to ensure clinical teams are fully briefed on any concerns from the Estates and Facilities Team	Tactical Board Meeting in place with representation from Estates and Facilities Daily Sitrep to be introduced and provided to Deputy Chief Nurse Patient Safety & Clinical Education and site cover OOH **Examples of evidence:** Trust Tactical Board minutes Example of Sitrep	Associate Director of Estates and Facilities	March 20 4/11/2020	• Early escalation of Estates and Facilities concerns **Monitoring Process:** • Daily Sitrep to be provided to Deputy Chief Nurse and OOH site • Reported through to Silver IPC weekly meeting		

No	Recommendation	Action Required	Current Position	Lead	Completion Date	How do we know if will be effective	RAG	Risk ID and Grading
Actions from NHSE/I visit dated 30/9/2020- awaiting formal report								
A	Record FFP3 Fit Testing on ESR	Identify IT issues preventing use of ESR	All records held on a local database	30/11/2020	Deputy Chief Nurse Patient Safety & Clinical Education	Fit Testing records will be held in ESR ***(See action 12 for details)***		In progress will be complete by end of January 2020
B	PPE and hand hygiene stations are manned at main entrances	Executive sign off of implementation plan	Paper being prepared for discussed by Executive Team	30/10/2020	Deputy Chief Nurse Patient Safety & Clinical Education	Rota for Entrance Safety Team in place. The Entrance Safety Team are a complementary measure to support the actions in place to maintain environmental safety, the team have been recruited from Wingman volunteers to provide support over and above the existing redeployed Trust staff ***(See action 7 for details)***		
C	Implement hands free opening for sliding doors on bays in Appleton Wing	Estates Team are reviewing feasibility of implementing recommendation	Bays in Appleton Wing have sliding doors due to space capacity for swinging doors.	30/10/2020	Associate Director of Estates and Facilities	Not pursued following consideration by executive team		Mitigation recorded
D	Review external area at Warrington ED to expand ED waiting room	Additional socially distance waiting space created	Review of temporary waiting area options in progress	30/10/2020	CBU Manager ED Associate Director of Estates and Facilities	Not pursued due to fire risk ***(See action 5 evidence for details)*** RCEM action plan contains details of progress		
E	Purchase 4 additional HPV machines	Develop business case to support purchase of additional HPV machines	1 HPV machine owned and operated by the Trust External Company used as and when required	30/11/2020	Deputy Chief Operating Officer	Capital request placed Business case for staff resource in train		
All documents referenced within the Environmental Action Plan will be located within a central folder managed on the Governance shared drive.								

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/09**
SUBJECT:	**WHH Maternity Services – Compliance with Ockenden**
DATE OF MEETING:	27th January 2021
AUTHOR(S):	Debby Gould (Consultancy), Professional Midwifery Advisor Interim
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.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1135 Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision. #1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #115 Failure to provide adequate staffing levels in some specialities and wards. #134 Financial Sustainability a) Failure to sustain financial viability, #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #1114 Failure to provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, caused by increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, resulting in poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. #224 Failure to meet the emergency access standard. #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. #145 a. Failure to deliver our strategic vision. #145 b. Failure to fund two new hospitals. #1126 Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets. #241 Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report to Trust Board (TB) provides assurance and an update on:

	• Warrington and Halton Teaching Hospitals Trust response to the 'Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust' (Ockenden Report) 11th December 2020. • Progress against the Kirkup Report Action Plan • High level thematic review of SI's in the last two years Update of review of compliance of maternity services with NICE guidance.			
PURPOSE: ***(please select as appropriate)***	Information Yes	Approval	To note Yes	Decision
RECOMMENDATION:	• To receive the content of the report. • To review the response to the publication of Donna Ockenden report 'Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust' on 11th December 2020 (Ockenden Report) and agree the on-going monitoring through the newly convened Maternity Safety Group and Women's Health CBU Governance group. • To agree the on-going monitoring of the Kirkup Report Action Plan through the Womens Health CBU Governance group. • Receive a high level summary of Serious Incidents (SI) and agree the deep dive into Serious Incidents to ensure learning and improvement. • To support the development and receive updates from the Maternity Safety Group.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/01/10		
	Date of meeting	12th January 2021		
	Summary of Outcome	For on-going monitoring as per work plan agreed.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Response to Ockenden Report 2020 and update on the Kirkup Action Plan**	**AGENDA REF:**	**BM/21/01/09**

1. BACKGROUND/CONTEXT

This monthly report focuses on the:

- Response to the publication of 'Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust' on 11th December 2020 (Ockenden Report) (Appendix i).
- Update on the Kirkup Action Plan (Appendix ii)

a. Following publication of the Ockenden Review of Maternity Services on 11th December 2020. A letter, headed 'Ockenden Review of Maternity Services – Urgent Action' was received in the Trust (Appendix iii) dated 14th December 2020 sent from

- Amanda Pritchard Chief Operating Officer, NHS England and NHS Improvement Chief Executive, NHS Improvement.
- Ruth May Chief Nursing Officer, England.
- Professor Steve Powis, National Medical Director, NHS England and NHS Improvement.

b. The letter was sent to all NHS Trust and Foundation Trust Chief Executives, Trust Chairs, STP and ICS Leaders and CCGs. The letter set out the immediate response required of all Trusts providing maternity services, and next steps to be taken nationally in relation to the seven Immediate and Essential Actions (IEA) required of maternity services and identified 12 urgent Clinical priorities from the IEAs which the Trust were required to confirm they had implemented by 5pm on 21st December 2020.

2. KEY ELEMENTS

2.1 The Seven Immediate and Essential Actions (IEA) are below with the additional twelve urgent clinical priorities are listed (under each related IEA) below.

IEA 1) Enhanced Safety

a) A plan to implement the Perinatal Clinical Quality Surveillance Model (Appendix iv)

b) All maternity SI's are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB.

IEA 2) Listening to Women and their Families

a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.

b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

IEA 3) Staff Training and working together

a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.

b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place.

c) Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety.

IEA 4) Managing complex pregnancy

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.

b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

IEA 5) Risk Assessment throughout pregnancy

a) A risk assessment must be completed and recorded at every contact. This must also include on-going review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

IEA 6) Monitoring Fetal Wellbeing

a) Implement the Saving Babies Lives Bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with Saving Babies Lives care bundle 2 and national guidelines.

IEA 7) Informed Consent

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

2.2 Workforce

The report is clear that safe delivery of maternity services is dependent on a multidisciplinary team approach (MDT). The Maternity Transformation Programme has implemented a range of interventions to deliver increases in healthcare professionals and support workers including: the development of the maternity support worker role, the expansion of midwifery undergraduate numbers, additional maternity placements and active recruitment. Alongside this, local maternity leaders should align assessments, safety, and workforce plans to the needs of local communities.

- Trust Boards are to confirm that they have a plan in place to the Birthrate Plus (BR+) standard by 31 January 2020, confirming timescales for implementation.

2.3 Confirmation of compliance

Confirmation of WHHT compliance with these immediate actions needed to be signed off by Simon Constable, CEO, along with a confirmation of sign off from Kathryn Thompson, Senior Responsible Officer, Cheshire and Mersey LMS and were sent to the Regional Chief Midwife on 21st December 2020 (Appendix v). WHHT reported full compliance (Appendix vi) on all elements except three, which were all partially compliant, and the CBU have plans in place to address them.

- **IEA 1 b)** All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

  WHHT response *'Robust reporting of SI's to the Trust Board including themes and trends. Routine reporting to LMS not in place and will be remediated.' The LMS are going to advise on the required process early in Jan 2021*
- **IEA 3a)** Implement consultant led labour ward rounds twice dai.ly (over 24 hours) and 7 days per week.

  WHHT response *'Currently in place 7 days a week occurring 2x each week day but only once each weekend day and bank holidays. New rota has been consulted on and agreed.'*
  On the 4th January 2021 the new Consultant Rota started enabling twice daily consultant ward rounds over 24 hours.
- **IEA 5a)** A risk assessment must be completed and recorded at every contact. This must also include on-going review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

  'Currently takes place on booking and if risk features occur during pregnancy or on presentation in labour. Audit is in place. New policy guidance issued and risk assessment will be in place at each contact. With implementation of the new EPR in July 21 this will be captured electronically at each contact.'

2.4 All Trust individual responses will form part of the presentation and discussion at the NHSEI Public Board in January 2021 when the report, and immediate and longer-term actions will be considered.

2.5 Trusts are also asked to review the Ockenden report at the next public Board. The Board should reflect on whether the assurance mechanisms within the Trust are

effective and, LMS there is assurance that poor care and avoidable deaths with no visibility or learning cannot happen in this Trust.

2.6 Trusts were required to complete and take to Trust board the assurance assessment tool (appendix vi) which included information on:-

- All 7 IEAs of the Ockenden report.
- NICE guidance relating to maternity.
- Compliance against the CNST safety actions.
- A current workforce gap analysis.

2.7 The WHHT completed assurance assessment tool (Appendix i) and it was signed off and reported by the CEO as required through Cheshire and Mersey LMS on 21st December 2020.

2.8 A subsequent gap and thematic analysis is planned and reported to the regional and national Maternity Transformation Boards.

2.9 NHSE has committed to working with regions, systems and Royal Colleges to implement the Ockenden 7 IEAs including:

- The LMS role
- The independent senior advocate role in Trusts
- Ensuring that networked maternal medicine is implemented across all regions.
- A review of the Maternity Transformation Plan (now entering its final year), to ensure future plans are in line with the Ockenden 7 IEAs.

3. Kirkup Report Action Plan Update

The Report of the Morecambe Bay Independent Investigation (Kirkup Report) (appendix ii) into the management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS in March 2015.

3.1 On 15th December 2020 NHSE and NHSI in addition to the response to the Ockenden Report also requested an update on the Kirkup Action Plan which was

drawn up in response to the Kirkup report recommendations. WHHT has submitted updates to NHSE in relation to progress against the Kirkup action plan in a template provided by NHSE[1] in 2015, 2016 and 2017 and all elements were reported as compliant in each submission.

3.2 The Kirkup Action plan template (Appendix vii) has information from the WHHT previous submissions on it. These have been kept intact and the 2020 updates are written in bold to make it easier to differentiate them from the historical entries. Compliance is also sub divided to reflect a then and now situation.

3.3 The update provided by the Trust on 23rd December 2020 reports all areas as compliant except for two areas which are reported as partially compliant. The change is due to re audit being required due to changes over time. The partially compliant elements are:-

- ***027473 To ensure there are robust processes in place for auditing transfers from and to the Neonatal and Labour Ward.***

This was deemed compliant in 2016 as an audit was due to be presented at the combined Child Heath /Obstetric Audit meeting in May 2016.

WHHT response 21/12/2020 reports compliance as completed/in progress (amber) and comments -

'There is Badgernet reporting throughout the Operational Delivery Network. Unanticipated term admissions are monitored locally through the Attain programme led by Consultant Obstetrician Chris Bentham) programme with an MDT review. All other admissions are discussed at the monthly perinatal mortality and morbidity meetings. Badgernet provides data for the Neonatal Critical Care linked to Neonatal Operational Delivery Network. Consultant Paediatrician Delyth Webb leads on the dashboard. Dashboard updates are received quarterly, Q2 2020 was the last update received. Consultant obstetrician Dr Furniss has scheduled an audit of transfers from

[1] Please note the template provided by NHSE for the Kirkup Action Plan attached in the appendix (vii) displays spelling errors and typos in places due to how the reporting template has been formatted. These have been impossible to remedy as doing so disrupts the layout of the template, and therefore have been left in.

and to the neonatal and labour ward (Birth Suite) for May 2021 Joint Obstetric and Child Health Audit meeting. Data will be used from the 2020 calendar year.'

- **030319 Audit of transfer of patients into and out of hospital (in utero transfers and transfer of women into hospital from a home birth setting).**

This was deemed compliant in 2016 as it was being audited and the audit was due to be presented at the combined Child Heath /Obstetric Audit meeting in May 2016.
WHHT response 21/12/2020 reports compliance as completed/in progress (amber) and comments –
'Review of audit planned for Jan – Mar 2021 using data from 2020 calendar year.'
Once these audits are completed and presented in the Child Heath /Obstetric Audit meeting May 2021 WHHT will be fully compliant.

4. Serious Incidents Summary of last two years

In the past two years the Trust has reported three Serious Incidents (SI) under the Obstetrics specialty. Two of the investigations have been completed, and the third is still on-going**.**

4.1 The high level themes of the two completed SI investigations included:-

- Inadequate Assessment
- Communication issues with the woman
- Communication issues between staff
- Documentation issues (including access to Maternity records in the Emergency Department)
- Failure to follow up abnormal symptoms
- Lack of senior review

4.1 As a result of the completed SI investigations 16 recommendations were agreed to ensure improvements were made. Of the 16 actions, 12 been completed. Four actions remain on-going. One of those actions, a quality improvement piece of work to improve communication between the Emergency department and the obstetric team has had an extension until 31st January 2021 to enable the work to be completed.

4.2 The CBU are undertaking a deep dive review of the SI's to better understand any commonalities, and seek assurance that systems and processes have changed in response and learning has taken place to improve care.

4.3 The CBU have allocated a lead for each of the IEA's and the other actions. A weekly Maternity Safety Group has been convened and will commence on the 7th January 2021, at which each of the leads will attend and will provide evidence against each of the actions, these will be tracked and will enable robust reporting for escalation and or assurance to the Board and its sub-committees. The maternity safety champions are invited to attend each meeting.

5. Update of compliance with NICE guidance.

A meeting was held on 23rd December 2020 to review the compliance of maternity with NICE guidance, and to develop an action plan to work towards full compliance.

- Simon Kumar, NICE Co-ordinator
- Debby Gould, Professional Midwifery Advisor
- Dr Rita Ariya, Associate Clinical Director to review the compliance of maternity with NICE guidance

Simon Kumar is Co-ordinating the CBU (with Dr Rita Ariya and Debby Gould) review of NICE compliance and regular meetings are now in place to work towards full compliance.

6. Assurance of compliance against the CNST safety actions and the workforce gap analysis will be included in the next Maternity Safety Champions report.

3. RECOMMENDATIONS

- To receive the content of the report.
- To review the response to the publication of Donna Ockenden's report 'Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust' on 11th December 2020 (Ockenden Report) and agree the on-going monitoring through the Womens' Health CBU Governance group.

- To agree the on-going monitoring of the Kirkup Action Plan through the Womens' Health CBU Governance group.
- Receive a high level summary of Serious Incidents and agree the deep dive into Serious Incidents to ensure learning and improvement.
- To support the development and receive updates from the Maternity Safety Group.

Appendices available on request if required.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/10**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	27th January 2021	
AUTHOR(S):	John Culshaw, Trust Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	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 risks has been added to the BAF; and included in the paper is a proposal to add two additional risks; • The rating of two risks have been amended. • The descriptions of one risk on the BAF has been amended and included in the paper is a proposal to amend the description 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 21/01/07
	Date of meeting	12th January 2021
	Summary of Outcome	The Committee reviewed, discussed and approved the amendments
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/21/01/10

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.

There are currently 19 risks on the Strategic Risk Register, 10 of which relate specifically to the COVID-19 pandemic. Moreover, the 6 highest rated risks refer directly to COVID-19.

The latest Board Assurance Framework (BAF) is included as Appendix 1.

2. KEY ELEMENTS

2.1 New Risks

Since the last meeting one new risks has been added to the BAF.

Following discussions at the Risk Review Group on 11th January 2021, and the Quality Assurance Committee on 12th January 2021, the escalation of the risk #1126 to the BAF was approved.

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
1126	Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.	15	25	BAF	Dan Moore	Quality Assurance Committee

The risk had previously appeared on the BAF during Wave 1 but was de-escalated in July 2020, when Oxygen usage had reduced significantly from its peak and all actions had been completed.

Following discussions at the Risk Review Group on 11th January 2021, and the Quality Assurance Committee on 12th January 2021, it is proposed to add two additional risks as detailed below:

Prosposed New Risks

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
TBC	Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the increase in critically unwell COVID-19 positive patients resulting in potential harm.	25	25	BAF	Dan Moore	Quality Assurance Committee

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
TBC	Failure to provide a suitable patient environment caused by the rapid creation and opening of additional capacity/wards resulting in potential harm	25	25	BAF	Dan Moore	Quality Assurance Committee

The Board is asked to consider and approve the addition these additional risks.

2.2 Amendment to Risk Ratings

Since the last meeting, there have been amendments to the ratings of two of the risks on the BAF

Risk #1124:

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

Following review of Risk #1124 and the significant mitigations now in place as detailed in section 2.5 and appendix 1, it was agreed that the risk rating was reduced from 25 to 15 (Likelihood 3, consequence 5)

Risk 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.

Following the introduction of Lateral Flow self-testing twice weekly and the resulting 1.8% positivity rate, it was agreed to reduce the rating of risk #1274 from 25 to 15 (Likelihood 3, consequence 5)

2.3 Amendments to descriptions

Following discussion at the Trust Board on 25th November 2020, the Finance & Sustainability Committee on 23rd December 2020, and subsequent approval at the Qualiy Assurance Committee on 12th January 2021; in order to provide clarity on the risk and associated mitigations, risk #1114 was amended as follows:

Risk 1114

The risk previously stated:

FAILURE TO *provide essential, optimised digital services in a timely manner in line with best practice governance and security policies* ***CAUSED BY*** *increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack* ***RESULTING IN*** *poor data quality and its effects upon clinical and operational decisions/returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.*

It was agreed to amend the risk to the following:

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.*

Following discussion and support and the Finance & Sustainability Committee on 20th Janaury 2021, it is proposed the amend the description of risk #134 as follows:

Risk 134

The risk currently states:

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.

It is proposed to amend the risk to the following

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.

The Board is asked to consider and approve the amendment to the description of risk #134 as described above.

De-escalation of Risks

Since the last meeting, no risks have been de-escalated

2.6 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
1124	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff	• National PPE Strategy in place to support the management and monitoring of stock levels. • On-site NHSE/I support for Fit Testing until February 2021 • PPE stock levels reported daily with early escalation via the tactical Board • Live database to demonstrate compliance with the number of staff Fit Tested • Entrance Safety Team in place across the three formal open entrances at Warrington site in accordance with the lockdown plan to help supply PPE to patients, public and staff. • The Health and Safety Team visit ward and departmental areas, which in addition to reviewing the environment, checks the stock and availability of PPE and addresses shortfalls at the time. • We have 58 PPE champions to support the clinical teams and ensure correct PPE is available • Implementation of a national managed inventory to keep trusts over 7/14 day supply (dependant on storage capacity) • National team are taking additional steps with quality control • Head of procurement will escalate any issues to the national team • The Trust has a back-up storage provision in the form of the Arena Conference and Convention Centre (ACC) in Liverpool • Nationally work is being undertaken for 80% off PPE to be manufactured in the UK • The Trust has a clearly defined escalation processes in place • The Trust has a clearly defined internal stock control systems in place	The risk rating has reduced from 25 to 15
1215	Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments,	<u>Assurances</u> • Pause of non-time critical elective services to support safe staffing across the organisation has continued beyond 2nd November. • Reconfiguration of Paediatric ED as per phase 1 of the ED Plaza business case commend in December 2020 and is due to be completed in January 2021 which will	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	treatments and potential harm	support an increase in paediatric capacity and further support compliance against RCEM guidance e.g. segregated flows. • Phase 2 ED Plaza due to commence in March 2021 for completion in Q2 2021 • Expected deployment of Bioquell Pods in ED & ICU in January 2021 to support flow and IPC compliance. This will help reduce instances of have to escalate capacity to the Main Theatre at the Warrington site. • Continued use of the independent sector (Spire Cheshire) under national contract until 31st December 2020. Contracting guidance produced w/c 7th December. Negotiation underway to support contracted arrangements in Quarter 4. This may mean less ISP activity in January 2021 but more in February and March 2021. • A review of other ISP providers to support waiting lists activity is underway in line with the new national framework arrangements. • 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. <u>Gaps</u> • Risk to funding of Phase 2 ED Plaza following national review of Urgent Care schemes by NHSE/E – awaiting outcome. Weekly progress and financial returns submitted to NHSE/I • New framework for ISP will not include all specialties currently being undertaken. This will increase waiting list pressure for those specialties on this site.	
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.	• 8 weeks environmental visit rota in place, supported by the Health & Safety Team and senior clinical nursing staff	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update 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.	• Home for Christmas event initiated in December 2020 with system partners to support safe discharge of patients with long lengths of stay to crate capacity through December and January expected winter pressures. • 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.	No impact on risk rating
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.	• Lateral flow self-testing twice weekly in place – 1.8% positivity rate	The risk rating has reduced from 25 to 15
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	• Continued use of the independent sector (Spire Cheshire) under national contract until 31st December 2020. Contracting guidance produced w/c 7th December. Negotiation underway to support contracted arrangements in Quarter 4. This may mean less ISP activity in January 2021 but more in February and March 2021. • A review of other ISP providers to support waiting lists activity is underway in line with the new national framework arrangements. • Expected deployment of Bioquell Pods in ED & ICU in January 2021 to support flow and IPC compliance. This will help reduce instances of have to escalate capacity to the Main Theatre at the Warrington site. • Plan being worked up to develop the ward B18 footprint adjacent to Critical Care to support alternative Critical Care escalation capacity and avoid the use of the main Warrington Theatre. This will	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		better protect elective flow on Warrington & Halton sites. • New framework for ISP will not include all specialties currently being undertaken. This will increase waiting list pressure for those specialties on this site.	
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.	• Care Hours Per Patient Day (CHPPD) currently 7.6 (Year to date position 7.9) <u>Recruitment Assurances</u> • International Nurses Business cases – 30 Nurses recruited in partnership with Wigan, Wrightington & Leigh. 10 arrived in November 2020. Further nurses to arrive in January 2021. Due to join the Trust in March 2021. • The Trust has joined the Mid Cheshire Collaborative after an additional successful business case – 30 Nurses to be recruited after April 2021. <u>COVID-19 Assurances</u> • Nursing Times Workforce Award winners in November 2021 – Best Recruitment Experience During COVID-19 Pandemic Response <u>Recruitment Gaps</u> • 82 RN Vacancies • 54 B2 Vacancies <u>Retention Gaps</u> • 10.50% nursing turnover	No impact on risk rating
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.	<u>Assurance updates</u> • Submitted revised forecast of £13.9m deficit which includes the impact of wave 2 COVID-19 <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 • Achieved 95% BPPC May, June & July 2020, 98% BPPC August, 98% September, 96% October, November 96%, December 92% • Deloitte due to commence audit of all capital and revenue COVID-19 Expenditure w/c 21 January 2021 • Financial Resources Group (FRG)that reports to FSC – currently paused due to pandemic • Working with national cash team to support potential PDC cash payment for March 2021. This is required to cover	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		payment of all creditors in April 2021 & forecast deficit.	
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..	• Oct & Nov security patching back on desktop-based machines as workaround is in place for the emergency peg board incompatibilities. <u>Gaps in Controls</u> • 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	No impact on risk rating
1079	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	• 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 2021	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	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.		
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 and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	• Circa 406 staff members yet to complete self-assessment	No impact on risk rating
1108	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by Covid, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team	• Midwifery management team strengthened – Four Matron in post until 31st March 2021 • 8.2 Midwives in post by 31st December 2020 with further 1 WTE Midwife in place before 31st January 2021 • Enhanced rates for NHSP Staff in place to help fill any gaps in rotas • Midwives redeployed across the unit as appropriate • 1:1 care rate currently @ 98% despite staffing challenges.	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 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 procurement department. • 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.	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
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
1126	Daniel Moore	Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.	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 meters apart, resulting in reduced capacity to admit patients and a potential subsequent major incident.	1	25 (5x5)	5 (5x1)	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
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	25 (5x5)	5 (5x1)	TBC	Quality Assurance Committee
1289	Daniel Moore	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	1	25 (5x5)	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	Trust Operations Board
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) 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	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee

Board Assurance Framework

		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	Phill James	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
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. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	2	16 (4x4)	8 (2x4)	TBC	Strategic People 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	Trust Operations Board

Board Assurance Framework

1108	Kimberley Salmon-Jamieson	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by Covid, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team	1	16 (4x4)	4 (4x1)	TBC	Quality Assurance Committee
1124	Kimberley Salmon-Jamieson	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff	2	15 (3x5)	8 (4x2)	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 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.	3	15 (3x5)	8 (4x2)	TBC	Trust Operations Board
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
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
1205	Phill James	FAILURE TO send accurate continuity of care information medication and / or allergies information from the Lorenzo EPR to external stakeholder. E.g. GPs CAUSED BY errors within the Lorenzo EPR electronic discharge summary code and/or configuration, i.e. the DXC PAN summarises the issue as: *"Discharge medications documented in Lorenzo do not match those showing on the discharge summary – this results in some medications being duplicated, missing completely or being incorrectly cited into appropriate sections." The medications section of the Discharge summary*	1	10 (2x5)	5 (1x5)	TBC	Quality Assurance Committee

Board Assurance Framework

		is split into the four heading of "Continued", "Stopped", "Changed" and "UnChanged" but the Trust response has deduced that medications are also appearing in the allergies section of the discharge summary. RESULTING IN patient harm due to errors and/or omissions within the medications and allergies information that is transmitted from the WHH FT Lorenzo EPR to its external stakeholders for approximately 4% of all patient discharges for the affected period. *** There is currently no evidence of patient harm but there is evidence of potential for harm to result ***					

Strategic Objective 1: We will … always put our patients first through high quality, safe care and excellent patient experience.
Strategic Objective 2: We will … be the best place to work with a diverse, engaged workforce that is fit for the future.
Strategic Objective 3: We will … work in partnership to design and provide high quality, financially sustainable services.

Board Assurance Framework

Risk ID:	1215	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe 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:

Phase 3 planning guidance received on 31st July 2020 expediting the return of near normal health services between August – December 2020

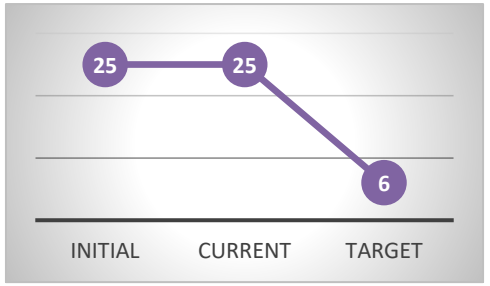
- Phase 3 second submission -10th September 2020
- Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery
- Temporary pause of non-time critical elective services to support safe staffing across the organisation - effective w/c 26.10.2020 & w/c 02.11.2020. This will be reviewed weekly by the Strategic Executive Oversight Group. Any decision is fed in to the Cheshire & Merseyside Chief Operating Officer Gold Command structure for regional and national oversight.
- Pause of non-time critical elective services to support safe staffing across the organisation has continued beyond 2nd November.

Radiology

- Capacity is reduced across Radiology by 30-40%.
- 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 capacity for CT and MRI (70 exams per week total) has been secured at Spire Cheshire under National Contract – due to finish end Dec 2020.
- 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 is sited at Whiston Hospital – WHH patient will have to travel to this site.
- 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.
- Current building works to increase the footprint of the CT department will bring increased patient areas. This will allow addition Outpatients to be imaged at Warrington where currently due to lack of waiting areas, the service is almost 100% Inpatient based. This completion if works will increase capacity and flexibility for CT. Completion date due end of September 2020
- Improvement against all modalities for numbers waiting more than 6 weeks noted in July performance.
- MR Waits now compliant with 6 week standard
- 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.



Board Assurance Framework

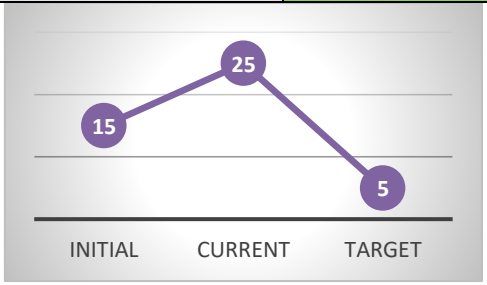
	• Minor injuries is provided in an area in close proximity but separate to the main emergency department. This has provided an opportunity to use the old minors department as Majors 2 to support management of surge demand and avoidance of corridor care. • New working arrangements are in place to maximise 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. • 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. • £4.3m Business Case for ED Plaza Scheme approved. • Reconfiguration of Paediatric ED as per phase 1 of the ED Plaza business case commend in December 2020 and is due to be completed in January 2021 which will support an increase in paediatric capacity and further support compliance against RCEM guidance e.g. segregated flows. • Phase 2 ED Plaza due to commence in March 2021 for completion in Q2 2021 • Expected deployment of Bioquell Pods in ED & ICU in January 2021 to support flow and IPC compliance. This will help reduce instances of have to escalate capacity to the Main Theatre at the Warrington site. Planned Care • 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. • Two theatre PODs have been retained in the event they are required and plans are in place to utilise if required. • Elective Surgery Standard Operating Procedure (SOP) in place • Capacity identified and being utilised at spire Healthcare • An elective meeting takes place three times a week to plan the recovery of individual services • Clean/green pathways have been developed and category 2 patients are being treated on B18 and at Halton Elective Centre • 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 • Theatre expansion programme in place to support delivery of Phase 3 guidance • Patients waiting more than 62 days & 104 days have reduced and is noted in August performance • Weekly theatre scheduling to ensure listing of patients in line with national guidance being 1) Urgent cancer, 2) 52 weeks, 3) Routine	

Board Assurance Framework

	• Post Anaesthetic Care Unit (PACU) Business Case approved by the Board on 10th September 2020 for implementation in November 2020. • Continued use of the independent sector (Spire Cheshire) under national contract until 31st December 2020. Contracting guidance produced w/c 7th December. Negotiation underway to support contracted arrangements in Quarter 4. This may mean less ISP activity in January 2021 but more in February and March 2021. • A review of other ISP providers to support waiting lists activity is underway in line with the new national framework arrangements. • As a consequence of the impact the second wave of Covid-19, the PACU implementation date has been revised until January 2021. The revision has been implemented to support safe staffing levels across the organisation. • 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. • 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 7. Risk to funding of Phase 2 ED Plaza following national review of Urgent Care schemes by NHSE/E – awaiting outcome. Weekly progress and financial returns submitted to NHSE/I 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.	

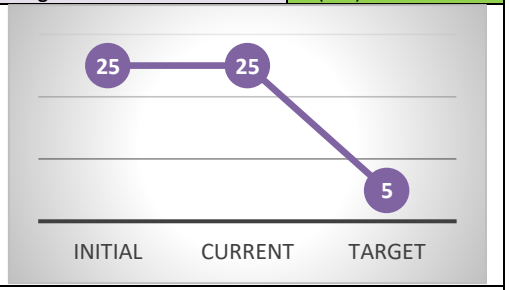
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
CT Department building works	Completion of building works increase CT Footprint	Complete Building work	Hilary Stennings	Phase 1 completed - 30/09/2020 Phase 2 due- 30/11/2020	
Post Anaesthetic Care Unit (PACU) building work	Completion of building works of Post Anaesthetic Care Unit (PACU)	Complete Building work	Val Doyle	31/01/2020	
ED Plaza building works	Completion of ED Plaza building works	Complete Building work	Sharon Kilkenny	31/03/2020	
Install of Bioquell Cubicles	Install of Bioquell Cubicles	Complete Installation	Sharon Kilkenny	31/12/2020	

Board Assurance Framework

Risk ID:	1126	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.			**Initial:**	25 (5x5)
				Current:	25 (5x5)
				Target:	5 (1x5)
Assurance Details:	Estates to manage evaporators and VIE supplies. Estates to regularly monitor site consumption and pressure. It has been agreed by Command that clinical staff will complete a return with the amount of oxygen in use on each Ward. ICU and Theatres will complete a separate return. This will be sent out by the Incident Management Team. Estates will monitor oxygen usage via the BOC website and provide daily updates at the Tactical Meeting. Maximum capacity of 3,000l/min but maximum2,400 l/m safe flow to be maintained to allow for unexpected surge in demand to provide a wider safety margin to deploy oxygen concentrators if necessary Re-commissioned CPAP devices available Receipt of Oxygen Concentrators Oxygen Concentrators to be deployed when the oxygen capacity for the site pipeline system reaches 2400 litres per minute so that the maximum flow rate is not exceeded and patients can be supported with the concentrators to keep them off the main system and maintain the supplies to the ventilated patients. Oxygen concentrators on-site and SOP in place. Oxygen usage monitored via ward staff and estates Daily SitRep reports oxygen usage on Warrington Site and monitored hourly 1.9.2020 - daily sitreps up to August 2020 revealed throughout the Covid management period the Trust's medical piped gassed capacity was not compromised. However, the risk is worthy of recognition up until April 2021 at the earliest.				
Assurance Gaps:	Maximum flow rate of 3,000l/min				

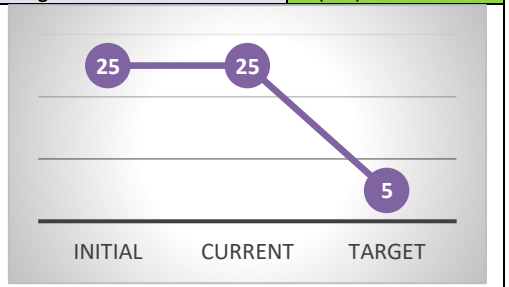
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Risk ID:	1272	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe 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:	25 (5x5)
				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 meter requirement. Risk assessments have been completed on each Ward. Clear curtains are to be provided to 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				
Assurance Gaps:	Individual Ward risk assessments identify challenges in meeting the 2 meter requirement.				

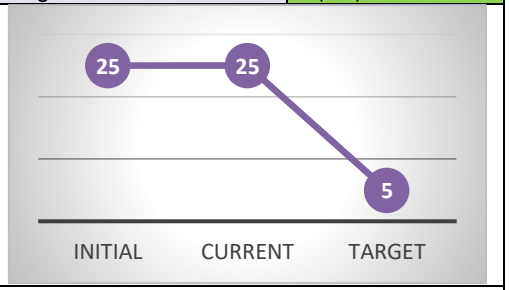
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
To develop a Trust Wide Environmental Plan to identify appropriate mitigations to minimise the risk of transmission.	Development of a Trust Wide Environmental Plan.	Develop Plan	Layla Alani	30.10.2020	30.10.2020
All individual clinical areas to complete a risk assessment to include bed space.	Completion of a Ward base risk assessment.	Completion of a Ward base risk assessment.	Layla Alani	30.10.2020	06.11.2020

Board Assurance Framework

Risk ID:	1273	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe 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. Twice weekly 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. Trust participates in daily Gold Command System call which supports regional decisions on discharge capacity e.g. access to Nightingale and other such supportive facilities 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. Home for Christmas event initiated in December 2020 with system partners to support safe discharge of patients with long lengths of stay to crate capacity through December and January expected winter pressures.				
Assurance Gaps:	Delays in discharge caused by adherence to Covid-19 infection control pathways and the patient's C0vid-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 Internal and external system required to undertake other services e.g. those relating to time critical pathways means that staff in these services paused in wave 1 are unable to support in wave 2. 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.				

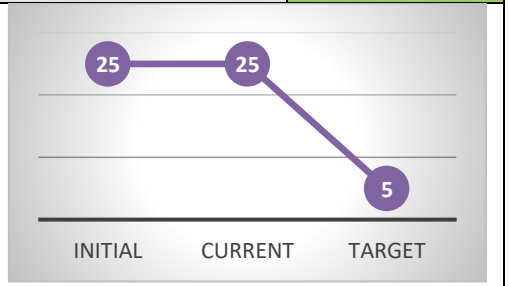
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Hospital Discharge Team to extend from a five to a six day working pattern from December 2020	Extend service hours from five to six days.	Extend service hours from five to six days.	Caroline Williams	26/01/2021	
DASS, DIPC and Microbiology to share proposed guidance with Care Homes for the safe transfer of COVID recovered and COVID contact patients week commencing 21.11.2020	Sharing of proposed guidance with care homes for the safe transfer of COVID recovered patients.	Sharing of proposed guidance with care homes for the safe transfer of COVID recovered patients.	Caroline Williams	21/12/2020	

Board Assurance Framework

Risk ID:	1275	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe 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:	25 (5x5)
				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.				
Assurance Gaps:	Non-compliance with social distancing				

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.	Health and Safety inspections to be carried out.	Health and Safety inspections to be carried out.	Ali Kennah	30/12/2020	

Board Assurance Framework

Risk ID:	1289	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	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			**Initial:**	25 (5x5)
				Current:	25 (5x5)
				Target:	5 (5x1)
Assurance Details:	Confirmed continued use of the private sector (Spire Cheshire) until 31st December 2020 Waiting lists monitored and measured weekly Continue to develop and plan for opening of the Post Anaesthetic Care Unit (PACU) in January 2021 Continue to undertake harm review process Continue to specifically focus on and monitor patients waiting greater than 52 weeks Continue to ensure urgent cancers are prioritised. Continued use of the independent sector (Spire Cheshire) under national contract until 31st December 2020. Contracting guidance produced w/c 7th December. Negotiation underway to support contracted arrangements in Quarter 4. This may mean less ISP activity in January 2021 but more in February and March 2021. A review of other ISP providers to support waiting lists activity is underway in line with the new national framework arrangements. Expected deployment of Bioquell Pods in ED & ICU in January 2021 to support flow and IPC compliance. This will help reduce instances of have to escalate capacity to the Main Theatre at the Warrington site. Plan being worked up to develop the ward B18 footprint adjacent to Critical Care to support alternative Critical Care escalation capacity and avoid the use of the main Warrington Theatre. This will better protect elective flow on Warrington & Halton sites.				
Assurance Gaps:	Confirmation awaited for continued use of the private sector after 31st December 2020 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
Develop plan for Ward 18 Footprint	Develop plan for Ward 18 Footprint to support alternative critical care escalation.	Develop plan for Ward 18 Footprint	Kilkenny, Sharon	31/12/2020	

Board Assurance Framework

Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe 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 with 12 nurses accepted an offer of employment at WHH in July 2020. 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 30 Registered Nurses – we have set up a task and finish group to implement this. We have recruited 73 HCAs since February 2020 with rolling HCA recruitment programme in place
- National staffing guidance has been utilised to inform new staffing models
- Care Hours Per Patient Day (CHPPD) currently 7.6 (Year to date position 7.9)

<u>Recruitment Assurances</u>

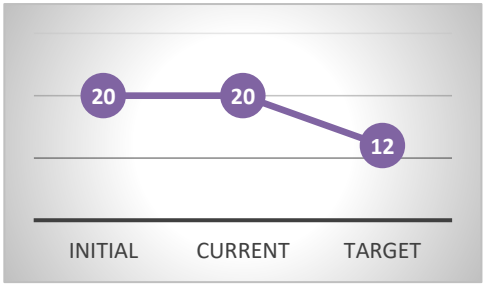
- Rolling advert for B5 Nurses
- 12 month recruitment plan in place taking into consideration social distancing restrictions
- Developing WHH recruitment campaign
- Career advice events in local schools and colleges
- Production of monthly and bi-annual staffing reports received by the Trust Board
- 119 HCAs recruited from February 2020 to October 2020 with 40 currently undergoing pre-employment checks.
- Students who have re deployed to the Trust have been offered substantive posts
- International Nurses Business cases – 30 Nurses recruited in partnership with Wigan, Wrightington & Leigh. 10 arrived in November 2020. Further nurses to arrive in January 2021. Due to join the Trust in March 2021.
- The Trust has joined the Mid Cheshire Collaborative after an additional successful business case – 30 Nurses to be recruited after April 2021.

<u>Retention Assurances</u>

- Workforce Dashboard reporting monthly in relation to leavers
- WHH Nursing retention plan to be refreshed for 2020
- Burdett Nursing Trust award winners
- Highly commended for nursing retention data provision
- 'Transfer Window' implemented allowing staff to move to other specialties without having to apply for role
- Registered Nurse Turnover for September 10.50%

<u>COVID-19 Assurances</u>

- 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

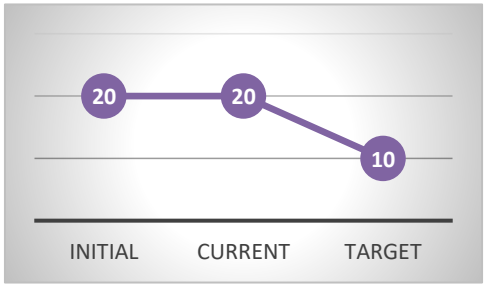


Board Assurance Framework

	• Strengthened daily staffing meetings chaired by the Associate Chief Nurse for senior oversight • Workforce expansion initiative in place, including the development of a redeployment Hub, local and national call to arms and student deployment • 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 • Nursing Times Workforce Award winners in November 2021 – Best Recruitment Experience During COVID-19 Pandemic Response	
Assurance Gaps:	Increase staffing pressure due to ongoing use of temporary winter ward for which there is no funded establishment Recruitment Gaps • 82 RN Vacancies • 54 B2 Vacancies Retention Gaps • 10.50% nursing turnover	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Targeted recruitment campaign	WHH to review international nurse recruitment to support registered nurse vacancy fill.	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.	R Browning C Roberts	31.03.2021	
To reduce HCA vacancies within the Trust to less than 20	Introduce a more targeted monthly recruitment campaign for HCA's which will be led by CBU's	Deep dive into HCA recruitment and retention data to inform a targeted approach to recruitment. Rolling programme for monthly recruitment in place. Any staff who are suitable for employment are offered to other CBU's as part of the monthly recruitment campaign. We have expansion of the CSWD programme through NHSP which supports WHH HCA recruitment as many of these staff successful gain substantive employment. Advertisement campaign in regional and local media	J McCartney R Browning	February 2021	

Board Assurance Framework

Risk ID:	134	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
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 current and future loans cannot be repaid and this puts into question if the Trust is a going concern.			**Initial:** **Current:** **Target:**	20 (5x4) 20 (5x4) 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 NHSI •Regular review at Executive team meeting and development sessions •Annual plan development process • Achieved 2019/20 Control Total. •Positive Value for Money conclusion & unqualified audit opinion •Head of Internal Audit Opinion of Significant Assurance •Block contract approach for all trusts for months 1 - 6 with income matched to expenditure. •Corporate Trustee Charities Commission Checklist, reporting bi-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)that reports to FSC – currently paused due to pandemic • Workshop undertaken with - Exec, CBU, Corporate to review of 2020/21 cost pressures • 2021 cost pressures supported by Trust Board. Business cases being developed to secure required levels of funding. •Trust Board approval of Capital Plan including the requirement for PDC as part of the final programme • Receipt of £51.8m PDC funding to repay revenue and capital loans in full in September 2020. •Completed MIAA Governance Checklist received by Audit Committee •£4.3m Business Case for ED Plaza Scheme approved •Critical Infrastructure Capital Funding (£2.41m) 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 3 plan submitted approved by Trust Board and submitted in October 2020. Planned deficit of £10.3m assuming R=1 •Submitted revised forecast of £13.9m deficit which includes the impact of wave 2 COVID-19 <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 • Reporting to NHSE/I • Regular attendance to regional and national conference calls • Attend Recovery Board to monitor financial impact of the changes relating to Covid19 Recovery plans – identifying revenue and capital expenditure • Review of latest guidance NHSE/I established block payments for the first 6 months of 2020/21 to ensure no impact of loss of elective activity • Accessed additional cash to pay outstanding creditors £16m paid in April 2020				

Board Assurance Framework

	• Achieved 95% BPPC May, June & July 2020, 98% BPPC August, 98% September, 96% October, November 96%, December 92% • Circulate latest guidance from MIAA Counter Fraud team • 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 • Weekly update to Strategic Executive Oversight Group in relation to the cost impact of COVID-19 – Monthly from June 2020 • Receiving Charitable donations that will support sustainability of Trust Charity • Submitted COVID-19 capital bids to NHSE/I & Hospital Cell to support Business as Usual & Recovery plans • Monthly Report to F&SC on COVID Pay Costs • Deloitte due to commence audit of all capital and revenue COVID-19 Expenditure w/c 21 January 2021 • Working with national cash team to support potential PDC cash payment for March 2021. This is required to cover payment of all creditors in April 2021 & forecast deficit.	
Assurance Gaps:	• Inability to develop a strategic plan to deliver a break even position over the next 5 to 10 years • Non-recurrent CIP presents a risk to in-year and future year financial position. No CIP identified in plan for 2020/21 • 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. • Hospital Infrastructure Programme (HIP) announcement. WHH not included in with phase 1 or phase 2 funding allocation.. • Submitted 5 Year Plan on 2nd March, jointly with Warrington & Halton CCGs & Bridgewater Community Healthcare NHS FT with system gap of £26.5m • Continue to work with NHSE/I on forecast. Unable to change plan as plan requires regulator agreement. • Capital schemes funded by PDC are at risk if not completed by 31st March 2021. This relates to the ED Plaza scheme and Critical Care • Trust funded capital incurred in full. There will be no carry forward to next year. Currently breast is forecast to underspend by £1m. Schemes that could be brought forward are being examined. <u>COVID-19</u> • Increased threat of fraud during COVID-19 global pandemic • Unclear on financial envelope to support COVID-19 capital & revenue needs. • Phase 3 plan (October '20 – March '21) provides a System gap. The Trust's share of this is £10.3m assuming R=1. Latest Forecast is including wave 2 COVID-19 is £13.9m No funding has been identified for wave 2 of COVID-19. • Awaiting confirmation of cash funding for March 2021 (c£30m required). National cash team instructed the Trust not to restrict creditor payments.	

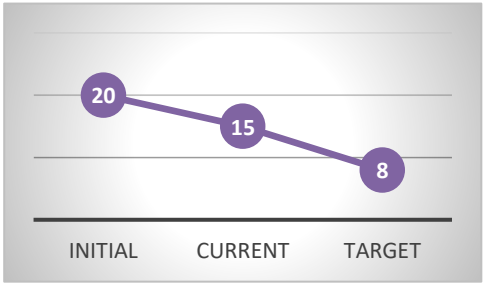
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Submit requested Workforce & CIP information to NW Intensive Support Director	Cheshire and Merseyside Health & Care Partnership in receipt of Tier 1 Intensive Support – Information requested by NHSE/I on workforce & CIP	Submit requested Workforce & CIP information to NW Intensive Support Director	Andrea McGee	30/03/2020	Paused

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:	15 (3x5)
				Target:	8 (4x2)

Assurance Details:

- A COVID-19 nursing advice line has been created, to provide a range of advice and guidance to the workforce.
- An OH call centre has been created, 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.
- An enhanced wellbeing offer has been developed, linked to learning from Wuhan, Italy and the British Psychological Society.
- A specialist extranet page has been developed 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 have been introduced 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 on-site.
- Telephone counselling.
- Alternative therapies such as relaxation therapy.
- 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.
- Staff events have been stood down to support socially distancing in work.
- Additional groups of staff were brought into the organisation, including:
  - Medical Students
  - Nursing Students
  - AHP Students
  - Medical 'Returners'
  - Nursing 'Returners'
  - AHP 'Returners'
- Work ongoing to retain returners within the Trust via Nursing Workforce Lead, specially final year student nurses.
- 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 has been established to support staffing levels by identifying staff who are available for redeployment and match them with demand. This hub has reduced its capacity as the Trust noved into Phase 3 of the Recovery plan in August 2020, but is ready to be re-established should this be required.
- Retirement Policy has been updated to allow a shorter break (24 hours) in service.
- National annual leave changes mean that staff can carry forward any untaken annual leave above 20 days into the next leave year. In addition, a local scheme has been introduced to allow substantive staff to sell annual leave back to the Trust during the period 26th March 2020 to 30th June 2020.



Board Assurance Framework

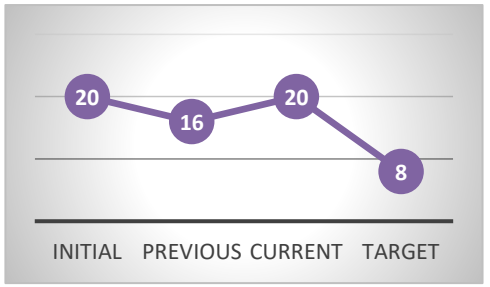
	• All additional hours and bank shifts worked by medical staff between 7th April 2020 and 31st May 2020, will be paid at the enhanced rates. This arrangement was extended until 9 June 2020 to review the scheme and consider whether this should continue – decision taken by Strategic Oversight Group to revert back to Pre-Covid Enhanced and Standard rates of pay. • A plan is in place to support workforce recovery including health, wellbeing, leadership, teams, HR and resourcing. • All staff who are shielding are have individual reviews with line managers, supported by HR, to discuss impact on role and support to work from home. • Partnership working is in place with Cheshire Fire and Rescue to utilise their staff members available for redeployment. • Antibody testing for staff is now in place. Approximately 3440 have been tested as at 15.06.2020. • Pilot of testing for asymptomatic staff complete. SOP signed off via Tactical Meeting. • Process in place for escalation of any potential local 'hot spots' of COVID-19 in teams on a weekly basis to Infection, Prevention and Control and Microbiology Teams • Central log in HR Department to capture all sheilding staff – process in place for on-going updates. National shielding ceased on 1 August 2020. A Covid Secure SOP was written to support the safe return of shielding staff 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 commenced in September 2020. • Electronic system is in place to support the roll out of a new COVID-19 Workforce Risk Assessment Tool in line with Risk Reduction Framework • Regular reporting on compliance with risk assessment requirements is in place • Regular training on COVID-19 Workforce Risk Assessment is in place • July sickness rate reduced to 5.55% • International Recruitment Business Case approved by Trust Board in September 2020 for an additional 30 nurses. Campaign to start immediately. • August sickness rate increased to 5.69%. • NHSE/I Letter received by Trust related to concerns around sickness absence rate. Nationally the North West has higher sickness absence rates and for the 10 worst performing Trusts a letter was sent requesting a detailed response from the CEO on actions being taken. A group of HR Directors from the 10 • A number of local outbreaks – Patient to Patient and Staff to Staff - are being managed within the Trust and have been reported to NHSE/I. This has led to ward closures and service changes to continue to provide the services. Staff have been isolating and supported via Occupational Health. • Increased capacity for staff swabbing in September 2020 to meet increased demand due to increased local prevalence, local lockdown introduced for Warrington & Halton and local outbreaks within the Trust. • Introduced an Outbreak Management Group (Microbiology, Infection Prevention & Control, Operational Management Team, Health and Safety, Clinical Governance and senior nurses) to trace and trace and manage the outbreaks and demand for information externally. • 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. • September daily SITREP reporting to Executive Team has indicated a continuing increase in sickness absence – 28.09.20 reported Covid-related absences 4.91% Other sickness absence 5.41%. Total absence 10.32% • National Trace and Trace app launched 24 September 2020. The national advice is less nuanced than local intelligence and so the risk of staff being instructed to self-isolate has increased. Issue raised with regional NHSE/I Chief People Officer as the local advice which is more specific to local circumstances would conflict with the national directives. Clear message to follow national directive received by Trust on 28.09.20 An organisation not complying with national directives would be breaking the law and subject to a corporate fine of £10,000 per incident. • Participation in Lateral Flow Testing	

Board Assurance Framework

Assurance Gaps:	• Unable to control staff selecting to use national track and trace system for swabbing rather than local service. Therefore staff will receive results and instructions from national Trace and Trace service and any contacts in the workplace could be instructed to self-isolate. Escalated to National & Regional Teams • Awaiting National Update from NHSE/I to concern raised about local management of staff self-isolating following symptoms & swabbing versus National Trace and Trace advice. No National or Regional solution to date. • National Policy on sickness absence monitoring and payments are being negotiated nationally - unable to influence outcome. May increase gaps in provision due to additional sickness absence allowances and associated pay arrangements. Negotiations ongoing. National Guidance expected in coming weeks.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Deliver the NHS People Plan 2020-2021	Deliver on the local implementation of the NHS People Plan 2020-2021, prioritising those elements that relate to supporting the workforce recovery.	• Produce integrated strategic workforce delivery plan, amalgamating WHH People Strategy priorities, WHH EDI Strategy workforce priorities, NHS People Plan. - *COMPLETE* • Monitor delivery of plan via Operational People Committee - *ONGOING*	Deborah Smith, Deputy Director of HR and OD	31 March 2020	

Board Assurance Framework

Risk ID:	1114	**Executive Lead:**	James, Phill	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe 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). • The Information Governance And Corporate Records Sub-Committee records assurances regarding Digital risks and incident management data. • 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. **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 Board • Secured annual capital investment to increase Digital skills and capacity. • Approval of a 7 Year Capital Profiling based upon asset replacement cycle and strategic roadmap (to deliver the approved Digital Strategy (January 2020)) plus the approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. • Oct & Nov security patching back on desktop-based machines as workaround is in place for the emergency peg board incompatibilities.				
Assurance Gaps:	**Gaps In Assurance:**				

Board Assurance Framework

	• 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, too many people clicked on the link. Next steps to be discussed • Current performance of Lorenzo and whether migration to the cloud will provide any benefit • Lack of a STP-wide benchmarking of cyber security and infrastructure • No parent committee for reporting **Gaps In Controls:** • Endorse of a 7 Year Capital Profiling based upon asset replacement cycle and strategic roadmap (to deliver the approved Digital Strategy (January 2020)) plus the **Implementation of an effective workforce plan** via an approved structure investment business case that delivers fit for purpose levels of skills, resilience and capacity. • Achievement of mandated compliance with DSPT, GDPR and Cyber Essentials Plus and the EU NIS directive. • Development of staff behaviours to protect data evidenced via reduced IG incident report levels. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Deployment of NHS Digital Secure Boundary for the Internet connection (end of Dec 2020) • Office 2010 being used while end of life for up to 5 months due to the N365 deployment plan • Not all Windows Server 2003 server will be migrated to Windows Server 2016 before the N365 agreement starts. (7 servers are at risk of not being migrated in time) • Deployment maternity services digitisation (EPR & CTG) see risk 1079 • 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

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) • Center for Internet Security (CIS) • Information Systems Audit and Control Association (ISACA) • National Institute of Standards and Technology (NIST) • Cyber Security Body Of Knowledge (CyBOK) [MIAA to make a proposal to secure funding for a resource to draft up the policy templates and iMersey exploring the platform to be used to hold and share the policy templates.]	Deacon, Stephen	28/02/2021	
Move medical devices into VLAN bubble. This will involve participation of multiple 3rd parties and internal WHH staff.	Add medical devices to the Medical VLAN bubble	• A better solution to isolate the medical devices have been devised. It's the same as the	Deacon, Stephen	29/01/2021	

Board Assurance Framework

[Delivers: Best Practice]		"VLAN bubble" in that it's a firewalled VLAN, its more secure as devices within a VLAN are not limited in communicating with each other, keeping all PACs devices separate is better than isolating them all together with other medical devices.			
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.	• Migrate the servers to Windows Server 2016 • Extend Support for Windows Server 2008 until Feb 2022 [Status September 20] Total Completed % Complete 2003 Servers 21 14 66.7% 2008 Servers 56 38 67.9% [Status October 20] Total Completed % Complete 2003 Servers 21 14 66.7% 2008 Servers 56 38 67.9% [Status November 20] Total Completed % Complete 2003 Servers 21 16 76.2% 2008 Servers 56 39 69.6% [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]	Deacon, Stephen	30/06/2021	
To upgrade all windows 7 to Windows 10 before end of March 2020 [Delivers: Best Practice]	To upgrade all windows 7 to Windows 10 before end of March 2020	• Deployment and Desktop Team to go out and reimage the devices around the Trust. [99% migrated – November 2020] 10 outstanding devices to be migrated:	Deacon, Stephen	31/01/2021	

Board Assurance Framework

		Department: Outstanding Pathology 2 (Issues with the software – a mitigation plan will be needed by IT Seniors) Catering 1 (Waiting on MenuMark system upgrade) Ophthalmology 4 (Waiting on 3rd party post Covid-19) Theatres 2 (Covid-19 hotspot, unable to access) ED 1 (Covid-19 hotspot, unable to access) The 5 devices in Audiology have now been migrated to windows 10. IT Services have completed the migration as far as they can until the issues above can be resolved. CIO/SIRO has been made aware and is happy with the current risk. IT to look at the rest during the IT Seniors meeting to give an evaluation on dates. IT are looking into Whitelisting these devices so that only the designed software can be run on these devices, mitigating the risk. The Virtual Desktops (VDI) Windows 7 and Blue Prism image migration to the Windows 10 image is set to be complete by the beginning of January 21..			
As part of Cyber Essentials+ all unsupported software should be updated or isolated from internet based networks. Office 2010 will need upgrading to the latest version of Office for all endpoint devices on the WHHT network. [Delivers: Best Practice]	Migrate from Office 2010	• Secure funding and take advantage of the NHS Digital's N365 discount licensing offer (May 20 – COMPLETE) • Submit the Trust's licensing requirement (June 20 - COMPLETE) • NHS Digital approval (August 20 - COMPLETE) • Migrate to N365 using remote installing software SCCM (Sept 20) • Phase 1 – IT Technical Team Migration (OCT 20) • Phase 2 – Rest of Digital Services and key system leads (DEC 20) • Phase 3 – Execs (DEC 20) • Phase 4 – Rest of the Trust (DEC 20)	Deacon, Stephen	26/02/2021	

Board Assurance Framework

		[The timescales for the above corporate Covid pandemic restrictions. Digital Services will do its upmost to complete the migration ahead of schedule.]			
Deliver fit for purpose Lorenzo EPR Performance and agility of changes to deliver the paperless strategy. [Delivers: Optimisation / Timeliness]	Work with supplier to assure EPR performance whilst enhancing Digital capability (people and finance).	• Work with EPR supplier to safely migrate Lorenzo to the modern cloud solution. • Implement staffing structure enhancements within financial opportunities (i.e. capitalisation of roles).	Gardner, Matthew	31/03/2021	
Scoping exercise for Secure Boundary for Trust Internet connection for the following services initially: • Staff Wi-Fi Internet • Potentially Govroam /Eduroam Internet Access • Inbound Web Services hosted within WHH	Scoping exercise for Secure Boundary	• Express our interest to NHS Digital (Phill Smith - COMPLETE) • Arrange a 1-2-1 scoping call to discuss our requirements (Phill Smith - COMPLETE) • Decide whether to take the service (Tracie Waterfield/Stephen Deacon/Phill Smith - COMPLETE) • Kick off meeting to start the project (24/08/20 - Tracie Waterfield/Stephen Deacon/Phill Smith – COMPLETE) • Project Management kick-off and discovery meeting (15/08/20 – Stephen Deacon/Phil Smith/Mark Ashton – COMPLETE) • Onboarding agreement (22/09/20 – Matt Gardner – COMPLETE) • Complete scope document (22/09/20 – Phil Smith – COMPLETE) • Complete DSPT documentation (22/09/20 – Mark Ashton / Stephen Deacon – COMPLETE) • Approval decision from NHS Digital (30/09/20) • Implementation (31/10/20) [NHS Digital have a change freeze from mid-December to early January so will delay the project until mid-January for the Primsa traffic configuration, however, we do have some services up and running on the secure boundary]	Deacon, Stephen	15/01/2021	
From the review of the first phishing exercise, provide a comms strategy and	Lessons learnt from previous phishing exercise and rerun phishing exercise	Lessons learnt from previous phishing exercise rerun phishing exercise	Deacon, Stephen	31/03/2021	

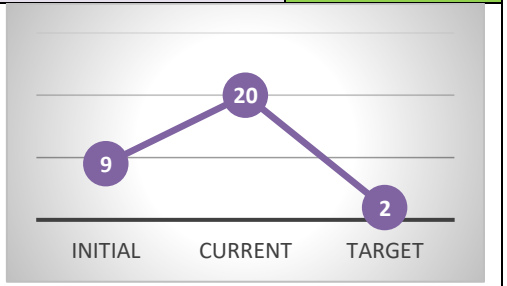
Board Assurance Framework

send it out to the users. Once finished rerun the phishing exercise next year.		• Produce a comms plan and send out comms to all staff • Arrange a rerun the phishing exercise • Examine the results and publish at the IGRSC			
DXC to create a RED Health Team	DXC to create a RED Health Team	Red Team liaises with local Digital Services and investigates performance-related issues and both DXC and Local Trust act on any recommendations • DXC to provide technical support to investigate performance-related issues (COMPLETE) • DXC to produce a findings report (COMPLETE) • Digital Services to review the report (IN PROGRESS) • Feedback local review back to DXC • Act on any recommendations • Retest for improvements *[DXC have provided a report and has been passed to key members of the Digital Services SLT and senior IT Services staff for review]*	Deacon, Stephen	31/01/2021	
2020/2021 rollout of new devices	2020/2021 rollout of new devices	• Obtain capital funding • Purchase the required devices • Build and deploy the new devices [1.18 million Capital funding agreed. Still to complete the backlog of 19/20. A plan has been devised to catch up on the backlog including a fixed term contract for extra help.]	Deacon, Stephen	30/03/21	
Implementation of the revised staff structure	Implementation of the revised staff structure	Draft costs have been obtained and the business case has been written with to exec approval and waiting on HR to give the go ahead to go to staff consultation. [Staff consultations had been paused by HR due to COVID-19 pandemic. End of JAN 20 to complete the consultation and staff in place.]	Deacon, Stephen	28/02/2021	
Mitigate 5 2008 servers not patching	Mitigate 5 2008 servers not patching	System Action Plan Symphony document server Move these documents to a new server as it is	Deacon, Stephen	29/01/2021	

Board Assurance Framework

		on a DFS share. (COMPLETE) Data warehouse app server MS was able to repair the Windows updates system manually, so it is up to date. Data Warehouse Team to progress migrating the apps off. (COMPLETE) Trust Print Server The OS is repaired and updating now. (COMPLETE) Dawn Anticoagulant system The OS cannot be repaired. Server Manager to contact DAWN and raise an order to migrate the system Winscribe dictation system The OS is repaired and updating now. (COMPLETE)			
From the review of the first phishing exercise, provide a comms strategy and send it out to the users. Once finished rerun the phishing exercise next year.	Lessons learnt from previous phishing exercise and rerun phishing exercise	Lessons learnt from previous phishing exercise rerun phishing exercise	Deacon, Stephen	31/03/2021	

Board Assurance Framework

Risk ID:	1079	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe 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 2021				
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 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.				

Board Assurance Framework

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Identification of appropriate system for maternity comply with new national maternity standard records	Identification of an appropriate IT system (Materntiy EPR)	Scoping exercise in alignment with Trust IT strategy and CNST Agreement to purchase. The following actions are required: Digital Maternity Group to agree statement of requirements, due 11.9.20. This will inform subsequent procurement. Business process mapping forecast for w/c 7.9.20 – key deliverable to support maternity EPR system selection, but also change initiative required beyond tech to transform maternity. Business case presented to Maternity Improvement Committee, due 16.9.20. At this stage it will explore options to procure. Commence procurement of maternity EPR - due 1.10.20. Likely to conclude JANUARY 2021 with formal business case / recommendation to FSC and Trust Board.	Gardner, Matthew	29/01/2021	
CTG archiving required to ensure data kept for claims, complaints. The current CTG archive expires on 19th Nov 2020 requiring a new CTG archiving solution that will be procured as part of the Maternity EPR.	Purchase new CTG archiving system	Purchase new archiving system to archive CTG traces. This will require: Engage K2 to resolve existing CTG + Archive solution challenges – 21.8.20. K2 remotely investigating, onsite visit completed 26.8.20 K2 GUARDIAN contract expires 19.11.20; likely to require interim extension. K2 will determine viability of support to Q1 FY21/22. Site visit will determine what is viable to capture CTGs using current solution in the interim. Resolution due	Gardner, Matthew	29/01/2021	

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		1.10.20			
The current system does not support appropriate referral to outside agencies. Required is a review of the current Data System with solutions put into place to overcome the lack of intra-operability.	Amendment to the Lorenzo Data System	Meeting held with the IT operations manager for WHHFT to highlight the concerns relating to Lorenzo as a Maternity Data system. Further meetings to be held to try to find a solution for this problem.	Loughman, Claire	26/02/2021	
Develop outline business case for Maternity EPR for Trust consideration and commence procurement for system in Oct 2020 in order to mitigate risk with current platform use for maternity pathway (Lorenzo_	Develop outline business case for Maternity EPR and commence procurement for system	Pre-Market engagement with incumbent suppliers (K2 and BadgerNet) – 21.8.20 COMPLETE Establish Digital Maternity Group with draft ToR for MIC approval – 21.8.20 COMPLETE Submit indicative capital costs to Capital Planning Group to ascertain prospect of funding implementation costs within Q4 FY20/21 – 21.8.20 - FSC and Board to then be sighted. COMPLETE MLCSU engagement to aid production of business case, statement of requirements and process mapping – due 29.9.20	Gardner, Matthew	29/01/2021	

Board Assurance Framework

Lorenzo will remain the platform supporting compliance with regulatory obligations and CNST incentives until new maternity EPR is deployed. The dates for new reporting obligations under the Maternity Record Standard (ISN) will require implementation prior to the date at which a new Maternity EPR can be deployed.	Optimise the existing Lorenzo platform to support new reporting obligations for CNST incentives (incl MSDSv2 and SBL)	Lorenzo will remain the platform supporting compliance with regulatory obligations and CNST incentives until new maternity EPR is deployed: MSDSv2 functionality planned Nov 2020, with compliance due Feb 2021. Detailed plan required with W&C CBU to map how this will be facilitated. Due Nov 2020. Saving Babies' Lives (SBL) data capture to follow MSDSv2 release. Due Nov 2020. Disconnected Maternity for community midwifery due to be piloted in Sept 2020. Though not related to reporting obligations nationally, it will improve data quality capture within the community which is a current challenge.	Gardner, Matthew	29/01/2021	

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, engaged workforce that is fit for 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. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)

Assurance Details:

The development of a Workplace Risk Assessment form (NHSI/E state, using online risk assessments to achieve better adoption) and accompanying database will enable the Trust to quickly and smartly deploy the workplace risk assessments and monitor completion and quality.

Trust Board and NHSI/E will seek assurance from the completion of the following metrics:

- Number of staff risk-assessed and percentage of whole workplace
- Number of black, Asian and minority ethnic (BAME) staff risk assessments completed, and percentage of total risk assessments completed and of whole workplace
- Percentage of staff risk-assessed by staff group
- Additional mitigation over and above the individual risk assessments in settings where infection rates are highest

Having already deployed a Workplace Risk Assessment for BAME staff, both managers and co-ordinators have gained experience in the process to enable improvements to be made.

Nominated accountable managers will take the lead for the completion of the Workplace Risk Assessments in their area, and will start ensuring their line managers are booked on the available training to ensure the Trust take a competent and consistent approach to completing the Workplace Risk Assessments.

As recommended by NHSI/E the Trust has a clear direction that this is an organisational priority by the leadership team, including CEO ownership and making it a standing item at board meetings.

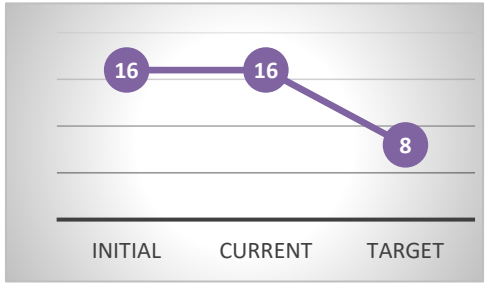
Training for line managers is in place and on-going Audit process is in place and live Staff communications have included:

- Trust-wide comms
- Individual letter from CPO to home addresses
- Flyers(I showed this to Naveed via Teams)
- Staff side
- Staff networks
- New starter paperwork
- Corporate Induction
- Local Induction

Regular reporting to Recovery Board (twice weekly) and Executive Team (daily) is in place
Daily meetings are held with Deputy Director of HR and OD and Deputy Chief Operating Officer to review all outstanding risk assessments with CBU/Corporate Managers.

Position @ 11th September

- 79.27% staff risk assessed
- % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary – 91.29%

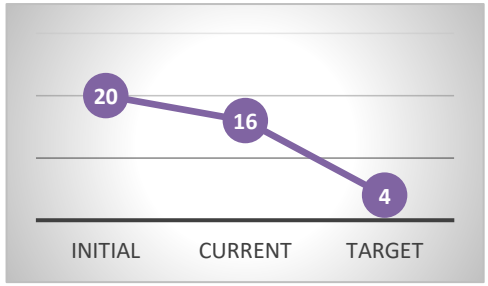


Board Assurance Framework

	• % of risk assessment have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary – 96.35% Re: c620 staff self- assessments not undertaken, mitigated by taking data from ESR to assess vulnerabilities and ensuring the managements of risk assessment plan is in place.	
Assurance Gaps:	The required quick turnaround requires enagement at all levels of the organisation. The Trust requires all staff to recognise the importance of the Workplace Risk Assessment and therefore make accessing the training and support available a priotiy. To ensure the Workforce Risk Assessments are completed in a timely manner and to a high standard. Due to the nature of COVID-19 our knowledge of it is changing constantly; therefore it is a challenge to keep up-to-date with the guidance and then react appropriately through changes in our processes Circa 406 staff members yet to complete self-assessment	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Close scrutiny and monitoring of compliance is required to ensure local implementation.	Ensure senior level oversight and awareness of the progress of compliance ant staff group and CBU / Department level.	• Daily reporting to Chief People Officer and follow up with accountable managers where required - *Complete* • Inclusion in daily SITREP • Weekly reporting to Recovery Board *(temporarily stood down and now reporting to SEOG)* • Monthly reporting to Operational People Committee *(temporarily stood down and now reporting to SEOG)*	Deborah Smith, Deputy Director of HR and OD	31/10/2020	

Board Assurance Framework

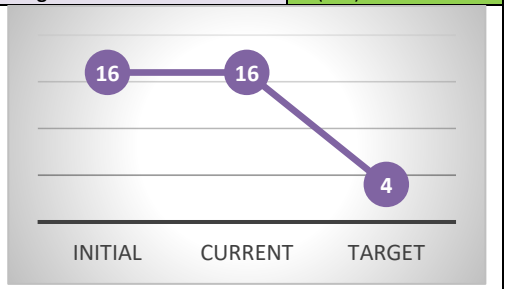
Risk ID:	125	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide a safe, secure, fit for purpose hospitals and environment 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.			**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 £4.3m Business Case for ED Plaza Scheme approved Critical Infrastructure Capital Funding (£2.41m) 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 Paediatric ED reconfiguration commencing in November 2020 to be completed by 31 December 2020. This will increase the Paediatric ED Urgent Care footprint allowing for a better segregated flow of paediatric patients to support Covid-19 Additional staff rest areas deployed to support social distancing and reduce staff nosocomial infection during rest and break times during the Covid-19 pandemic.				
Assurance Gaps:	Capital funding 19-20 (£ of requested schemes : £ of actual funding) Estates staffing - reduced staffing numbers since 2011 has impacted on ability to carry out elements of essential maintenance 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 Reduced estates compliance				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

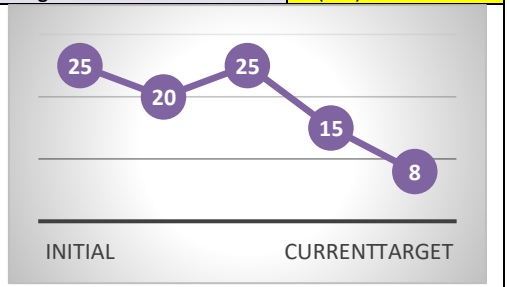
Complete Premises Assurance Model by April 2021	Set up working group with Estates and Finance team to complete the documentation and file the evidence required to complete the PAM)	By completing, analysing and actioning any gaps in compliance	Boyd, Desmond	31/03/2021	

Board Assurance Framework

Risk ID:	1108	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by Covid, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team			**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. Deputy Chief Nurse supporting the CBU Interim Head of Midwifery in post New CBU manager appointed and in post. Appointment of 10.2 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. Midwifery management team strengthened – Four Matron in post until 31st March 2021 8.2 Midwives in post by 31st December 2020 with further 1 WTE Midwife in place before 31st January 2021 Enhanced rates for NHSP Staff in place to help fill any gaps in rotas Midwives redeployed across the unit as appropriate 1:1 care rate currently @ 98% despite staffing challenges.				
Assurance Gaps:	Potential for uncertainty across the services as a result of COVID-19 pandemic				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Recruitment of midwives	Recruitment of midwives	Recruitment of midwives	Gould, Debby	29/01/2021	
Uplift of 7.5 WTE midwives to enable continuity of carer	Uplift of midwives for continuity of carer	Paper going to the board. To closely monitor vacancy rates so that the vacancies can be appointed to in timely manner	Gould, Debby	30/06/2021	

Board Assurance Framework

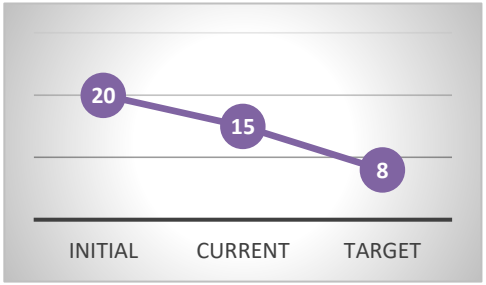
Risk ID:	1124	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff			**Initial:**	25 (5x5)
				Current:	155 (3x5)
				Target:	8 (4x2)
Assurance Details:	Centralised PPE store in place , giving out in accordance with the Control Centre approval (number of stock), supplies are controlling, in and out of hours process in place, daily monitoring process and escalation to the NSDR, extended opening hours in procurement and 7 day service, issuing PPE material management services i.e topping up areas, etc Centralised Cheshire & Merseyside mutual aid plan in place led by the Trust's Director of Finance & Deputy CEO Regional mutual aid arrangements in place Training and education of staff, Fit Testing programme in place for FFP3/FFP2 respirators, risk assessment and contingency plan in place if recommended PPE stock is not available. Where services are re-started, recovery forms and PPE burn rate to be documented on appropriate proformas with monitoring via the Elective Planning Meeting, with escalation to the Recovery and Strategic Groups. No staff member to work without appropriate PPE. Supplies are seeking alternative supplies of PPE with a safety check that essential standards are met before purchasing any items. Participation in Quality Improvement Programme with NHE/I on Fit Testing with focus on high risk areas National managed PPE inventory process starting in September. Plan is to have a more secure supply of FFP3 (and gowns etc. after FFP3 pilot). Inventory will include details of FFP3 masks required. There may be some additional support for Fit Testing where the product changes due to outage. There are anticipated issues with 3M supply. Government have made the purchasing decisions and this is reported as final. General consensus that Trusts need a ring fenced number of staff to provide a Fit Testing service Implementation of a national managed inventory to keep trusts over 7/14 day supply (dependant on storage capacity) National team are taking additional steps with quality control. Head of procurement will escalate any issues to the national team National PPE Strategy in place to support the management and monitoring of stock levels. On-site NHSE/I support for Fit Testing until February 2021 PPE stock levels reported daily with early escalation via the tactical Board Live database to demonstrate compliance with the number of staff Fit Tested Entrance Safety Team in place across the three formal open entrances at Warrington site in accordance with the lockdown plan to help supply PPE to patients, public and staff. The Health and Safety Team visit ward and departmental areas, which in addition to reviewing the environment, checks the stock and availability of PPE and addresses shortfalls at the time. We have 58 PPE champions to support the clinical teams and ensure correct PPE is available Implementation of a national managed inventory to keep trusts over 7/14 day supply (dependant on storage capacity) National team are taking additional steps with quality control Head of procurement will escalate any issues to the national team The Trust has a back-up storage provision in the form of the Arena Conference and Convention Centre (ACC) in Liverpool Nationally work is being undertaken for 80% off PPE to be manufactured in the UK The Trust has a clearly defined escalation processes in place The Trust has a clearly defined internal stock control systems in place				
Assurance Gaps:	Current shortage of specific PPE equipment e.g. small Solway FFP3 respirators and expected shortage of 8833 respirators, Repeated Fit Testing will be required as different makes/models of FFP3 respirators are supplied – with potential to disrupt service provision. Increased demand for PPE as recovery plans will increase demand, service provision may be affected if PPE is not available. Balance of usage required to ensure recovery plans do not impact on PPE for care of patients with Covid-19.				

Board Assurance Framework

	Supply of gowns with adequate fluid repellency level Availability of fluid resistant surgical masks and visors Current shortage in gowns which may lead to inadequate protection Fragile and uncertainty of future PPE availability 8833 respirators and small Alpha Solway are no longer available Revised IPC Guidance with 3 distinct pathways – Red, Amber and Green. Trustwide risk assessments in place. Visiting to be re-introduced which will impact PPE usage

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Support stable provision of FFP3 masks	Continue to trial aleternative FFP3 Masks	Continue to trial aleternative FFP3 Masks	Kennah, Ali	31/01/2021	

Board Assurance Framework

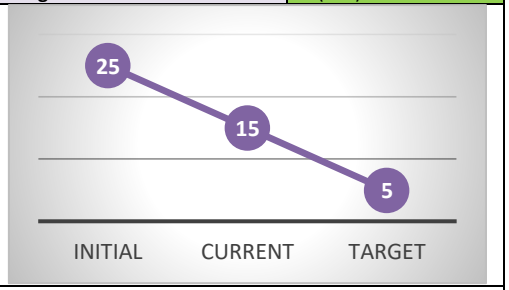
Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Influence within Cheshire & Merseyside a. Failure to deliver our strategic 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. - Collaboration with Bridgewater - 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 Warringotn & HaltonSystem Finacial Recovery Plan - Collaboration with STHK - Regular GP engagement events held - 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. - Successful in One Public Estate revenue funding bid for Halton - 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. - NHSE and local Commissioners supportive of draft strategy for breast screening. Breast Centre of Excellence being implemented as a priority to support COVID-19 recovery. - Initial meeting for Cheshire & Merseyside respiratory review held. Trust presentation well received. - DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. The Trust has written to NHSP to seek support in raising the profile of our needs – NHSP has used the Trust as a case study in their national campaign - Strategic Outline Case (SOC) for both new hospital developments approved by the Trust Board - Letter written to Government from senior stakeholders requesting funding as part of HIP - Positive meeting the Medical Director and Director of Strategy at Alderhey confirming their intention to work with the Trust to repatriate WHH patients. - 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 an Essential Services Lab				

Board Assurance Framework

	(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 ESL. 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. - 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 - 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. - Strategy refresh completed and approved at Trust Board to confirm 2020/21 priorities.	
Assurance Gaps:	Organisational sovereignty and the need for individual Trusts, CCGs and others to meet performance targets at an organisational level have the potential to slow or block progress. Risk to Women's and Children's future provision due to Cheshire & Merseyside led review. Risk to securing capital funding to progress new hospitals Progress in collaboration with Alderhey to repatirate activity hindered due to COVID-19. Focus on addressing waits with organisation prioritised	

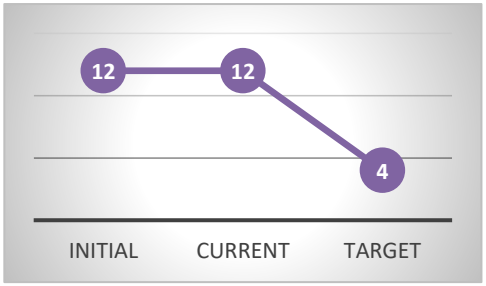
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Strengthen Women's & Children's Services	Establish Programme of Development	Develop & Complete Action Plan	Salmon-Jamieson, Kimberley	31/12/2020	
Progress plans for new hospitals to be best placed to secure funding when available	Develop SOCs and OBCs	Develop SOCs and OBCs	Lucy Gardner	SOCs – April 2020 OBCs – Q4 2021/22 Warrington Q3 2021/22 Halton	SOCs – March 2020
Retain contact and relationship with Alderhey	Retain contact and relationship with Alderhey	Regular meetings with Alderhey Director of Strategy	Lucy Gardner	31/03/2021	
Rapidly implement general surgery partnership as soon as reasonably possible given COVID-19 recovery	Rapidly implement general surgery partnership as soon as reasonably possible given COVID-19 recovery	Rapidly implement general surgery partnership as soon as reasonably possible given COVID-19 recovery	Dan Moore	31/03/2021	

Board Assurance Framework

Risk ID:	1274	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe 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				
Assurance Gaps:	Potential for unsafe staffing levels.				

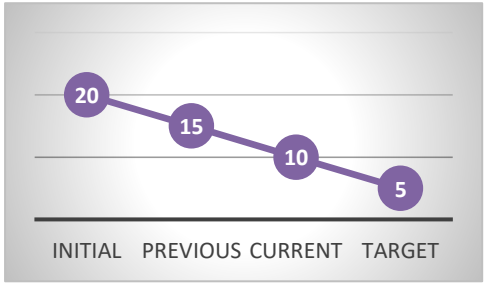
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Plan in place for the testing of staff over a ten day period.	Implementation of plan for the testing of Asymptomatic staff.	Implementation of plan for the testing of Asymptomatic staff.	Ali Kennah	16/11/2020	

Board Assurance Framework

Risk ID:	1290	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
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 have reviewed the national self-assessment contract review and continues to review suppliers which are out of the national scope. Collaborative work exists between partners in Cheshire and Merseyside to review supplies. 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. 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 procurement department. The Digital department have reviewed all the Trust key IT systems and data flows and continue to do this ahead of the end of the Transition period. EU. 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. Daily SitReps initiated late November. Re-instigated the Brexit Sub-Group on 9th September 2020 and the frequency of meetings will step up as the end of the transition period approaches. NHSE/I to undertake an assurance exercise with NHS Trusts to ensure EU Exit SRO and EU Exit Team in place. NHSE/I to communicate further details of the operational response and what is needed at the local level. Daily SitRep reporting continues to monitor the impacts of the EU Exit. Single point of contact in place for operational response, aligned with Winter Planning and COVID-19 response. 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.				
Assurance Gaps:	Continued national uncertainty on the terms of the EU exit. Trusts being requested not to stockpile supplies. National concern on shortages of radiopharmaceuticals and blood products. Potential price increases to supplies. Increased possibility of a no deal exit. 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	

Board Assurance Framework

Risk ID:	1205	**Executive Lead:**	Phill James, Chief Information Officer	**Rating**
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.			
Risk Description:	FAILURE TO send accurate continuity of care information medication and / or allergies information from the Lorenzo EPR to external stakeholder. E.g. GPs CAUSED BY errors within the Lorenzo EPR electronic discharge summary code and/or configuration, i.e. the DXC PAN summarises the issue as: *"Discharge medications documented in Lorenzo do not match those showing on the discharge summary – this results in some medications being duplicated, missing completely or being incorrectly cited into appropriate sections." The medications section of the Discharge summary is split into the four heading of "Continued", "Stopped", "Changed" and "UnChanged" but the Trust response has deduced that medications are also appearing in the allergies section of the discharge summary.* RESULTING IN patient harm due to errors and/or omissions within the medications and allergies information that is transmitted from the WHH FT Lorenzo EPR to its external stakeholders for approximately 4% of all patient discharges for the affected period. *** There is currently no evidence of patient harm but there is evidence of potential for harm to result *****	**Initial:**	20 (4x5)
				Current:	10 (2x5)
				Target:	5 (1x5)
Assurance Details:	**Assurance:** • Receipt and review of updates to the DXC Product Alert Notice (in response to new data as their investigation progresses and intelligence improves); • WHH FT has spoken with other Lorenzo Trusts to compare known information to inform the WHHFT response plan; • Registration of a BAF risk for this issue, to ensure the Trust Board are sighted on the salient and able to provide constructive challenge. • Creation of a Datix incident to manage the clinical investigation of the impact of the fault; • Presence of affected discharge summaries within the EPR (inpatients and discharged patients) • Confirmation that GPs have acted upon the alert and amended their records as required. • Receipt of confirmation of harm / no harm from GPs of affected patients and follow on actions where necessary; • Identification and correction of root cause within the Lorenzo EPR; • Proven identification of first date that the fault affected WHH Lorenzo ERP and subsequent manual review of all discharge summaries back to and including that date; • Formal investigation report closed by the Trust. **Controls:** • Immediate removal of affected discharge summary sections; • Manual review of all June 2020 and 1/3 of May 2020 discharge summary records; • Issue of an urgent communication to the CCG to inform the GPs of the issue, our actions and our plan; • Issuing of lists of all affected patients to GPs with a copy of the discharge prescription; • Safe re-introduction of known good headers in medications section of discharge summary. • Creation of a Datix incident to manage the clinical investigation of the impact of the fault • Manual review of all discharge summary records from 1st May 2020 through 10th July 2020; • Implementation of a script change to facilitate a simple list of medications and/or allergies appending to the discharge summary; • Provision of copies of the discharge prescriptions to the GPs for the period during which no medication information is provided on the discharge summary plus corrected medication information where discharge summaries have been identified as incorrect.				

Board Assurance Framework

	• De-risking of Lorenzo EPR releases via thorough WHHFT discharge summary tests;	
Assurance Gaps:	**Gaps In Assurance:** • No further gaps in assurance **Gaps In Controls:** • Issue, test and deployment of a proven resolution; • Robust WHHFT PAN receipt, review and act process for all PANs.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Recover As this is a third similar event in the past 12 months the Trust should now de-risk the lack of assurance demonstrated by DXC and implement more robust and comprehensive site testing.	Ensure a range of test patients records are exercised in all Lorenzo acceptance tests to incorporate a range of patient complexities and history permutations.	Document and implement strengthened Trust discharge summary acceptance test process for all Lorenzo EPR releases (Emma O'Brien) There is a meeting in Governance regarding the approval of the PAN process on the 13/10/20. Chased the Matron for Clinical Informatics to see if the PAN process is up-and-running.	O'Brien, Emma	31/12/2020	
Recover Ensure PAN notices are processed robustly and without delay and dovetail into clinical risk processes.	Document and implement more robust PAN receipt, confirmation, triage and management process.	• Review existing PAN management process (10/07/20 - Sue Caisley) • Consider automation of Datix for all PANs (10/07/20 - David Kelly) • Ensure Email is not a weakness (10/07/20 - Sue Caisley) • Ensue DXC seek formal response of receipt and action (10/07/20 - Sue Caisley) • Review PAN format for aiding Trust triage and prioritisation in response to potential threat to patient care, i.e. understand why the DXC assessment of this risk was "Medium" (17/07/20 - Sue Caisley) [The meeting in Governance went ahead, they are happy to assist the PAN process, however, due to workload created by Covid, the team are currently stretched supporting risk assessments, audits etc. so aren't able to pick this up at the moment. – IT Manager to chase.]	Caisley, Sue	31/12/2020	

Trust Board

DATES 2019-2021

All meetings to be held in the Trust Conference Room

Date of Meeting	Agenda Settings	Deadline For Receipt of Papers	Papers Due Out
2019			
Wednesday 27 November	Thursday 7 Nov (EXECS)	Monday 18 November	**Wednesday 20 November**
2020			
Wednesday 29 January	Thursday 9 January (EXECS)	Monday 20 January	**Wednesday 22 January**
Wednesday 25 March	Thursday 5 March (EXECS)	Monday 16 March	**Wednesday 18 March**
Wednesday 27 May	Thursday 7 May (EXECS)	Monday 18 May	**Wednesday 20 May**
Wednesday 29 July	Thursday 9 July (EXECS)	Monday 20 July	**Wednesday 22 July**
Wednesday 30 September	Thursday 10 September (EXECS)	Monday 21 September	**Wednesday 23 September**
Wednesday 25 November	Thursday 5 November (EXECS)	Monday 16 November	**Wednesday 18 November**
2021			
Wednesday 27 January	Thursday 7 January (EXECS)	Monday 18 January	**Wednesday 20 January**
Wednesday 31 March	Thursday 10 March (EXECS)	Monday 22 March	**Wednesday 24 March**