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 25 November 2020
10.00am-12.15pm
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 25 November 2020 time 10.00am -12.15pm

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/20/11	ITEM	PRESENTER	PURPOSE	TIME	
BM/20/11/ 110	Staff Story	Michelle Cloney Chief People Officer	PPT/Film	10.00	N/A
BM/20/11/ 111	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	10.15	Verb
BM/20/11/ 112 PAGE 7	Minutes of the previous meeting held on 30 September 2020	Steve McGuirk, Chairman	Decision	10:17	Encl
BM/20/11/ 113 PAGE 15	Actions & Matters Arising	Steve McGuirk, Chairman	Assurance	10:20	Encl
BM/20/11/ 114 PAGE17	Chief Executive's Report –to follow - Asymptomatic testing of staff update	Simon Constable, Chief Executive	Assurance	10:25	Encl
BM/20/11/ 115	Chairman's Report	Steve McGuirk, Chairman	Information	10:35	Verb

Quality People Sustainability

BM/20/11/ 116	COVID-19 Performance Summary Report and Situation Report	Simon Constable Chief Executive	To note for assurance	10.40	Enc
BM/20/11/ 117 PAGE 27	Integrated Performance Dashboar Assurance Committee Reports	All Executive Directors	To note for assurance	10:50	Enc
(a) i	Monthly Safe Staffing Reports – August & September	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO			Enc
(a) ii	- Quality Dashboard including	Alex Crowe, Executive Medical Director Daniel Moore, Acting Chief Operating Officer			
(b) PAGE 104	- Committee Assurance Report, Quality and Assurance Committee (06.10.2020 & 03.11.2020)	Margaret Bamforth Committee Chair			Enc
(c)	People Dashboard	Michelle Cloney Chief People Officer			
(c) i PAGE110	- Committee Assurance Report Strategic People Committee (18.11.2020)	Anita Wainwright Committee Chair			Enc
(d)	- Sustainability Dashboard	Andrea McGee Chief Finance Officer & Deputy CEO			
(d) i PAGE 115	- Key Issues Finance and Sustainability Committee (21.10.2020 & 18.11.2020)	Terry Atherton Committee Chair			Enc
(e)	- Key Issues Audit Committee (19.11.2020)	Ian Jones Committee Chair			Enc

Quality

BM/20/11/118 PAGE 122	Moving to Outstanding (M2O) Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	To note for assurance	11.20	Enc

People

BM/20/11/119 PAGE 137	WHH Mission and Values in COVID-19 era	Pat McLaren Director Communications & Engagement	Approval	11.30	Enc

GOVERNANCE

BM/20/11/120 PAGE 154	Strategic Risk Register & BAF	John Culshaw Trust Secretary	To note for assurance	11.40	Enc
BM/20/11/121 202 PAGE 202	Digital Assurance Report	Phillip James Chief Information Officer & SIRO	To note for assurance	11.50	Enc
BM/20/11/122 PAGE 210	Legal Considerations of Governance during COVID-19 Pandemic	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	To note for assurance		Enc

MATTERS FOR APPROVAL

	ITEM	Lead (s)				
BM/20/11/123	Director of Infection Prevention + Control (DIPC) Annual Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee	12.00	Enc
			Agenda Ref.	QAC/20/10/192		
			Date of meeting	06.10.2020		
			Summary of Outcome	**Supported**		
BM/20/09/124	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)	Michelle Cloney Chief People Officer	Committee	Strategic People Committee		Enc
			Agenda Ref.	SPC/20/11/90+91		
			Date of meeting	18.11.2020		
			Summary of Outcome	**Approved**		
BM/20/11/125	Quality Assurance Committee Terms of Reference	John Culshaw Trust Secretary	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/20/11/212		
			Date of meeting	03.11.2020		
			Summary of Outcome	**Approved**		
BM/20/11/126	Strategic People Committee Terms of Reference	John Culshaw Trust Secretary	Committee	Strategic People Committee		Enc
			Agenda Ref.	SPC/20/11/87		
			Date of meeting	18.11.2020		
			Summary of Outcome	**Approved**		
BM/20/11/ 127	Finance & Sustainability Committee Terms Reference	John Culshaw Trust Secretary	Committee	Finance + Sustainability Committee		Enc
			Agenda Ref.	FSC/20/09/131		
			Date of meeting	23.09.2020		
			Summary of Outcome	**Approved**		
BM/20/11/129	GMC Re-validation Annual Report incl Statement of Compliance for sign-off by Board	Alex Crowe Executive Medical Director	Committee	Strategic People Committee		Enc
			Agenda Ref.	SPC/2011/89		
			Date of meeting	18.11.2020		
			Summary of Outcome	**Supported**		

MATTERS FOR NOTING

	ITEM	Lead (s)				
BM/20/11/130	**Mortality Review Q2 report**	**Alex Crowe Executive Medical Director**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	QAC/20/11/219		
			Date of meeting	03.11.2020		
			Summary of Outcome	Noted		
BM/20/11/131	**Guardian of Safeworking Q1 & Q2 report**	**Alex Crowe Executive Medical Director**	**Committee**	Strategic People Committee		**Enc**
			Agenda Ref.	SPC/20/11/97		
			Date of meeting	18.11.2020		
			Summary of Outcome			
BM/20/11/132	**Engagement Dashboard Q2**	**Pat McLaren Director Communication & Engagement**	**Committee**	Council of Governors		**Enc**
			Agenda Ref.	COG/20/11/50		
			Date of meeting	12.11.2020		
			Summary of Outcome	**Noted**		
BM/20/11/133	**Use of Resources Q2 Report**	**Andrea McGee Chief Finance Officer & Deputy CEO**	**Committee**	N/A		**Enc**
			Agenda Ref.			
			Date of meeting			
			Summary of Outcome			
	Any Other Business	**Steve McGuirk**				
	Date of next meeting: Wednesday 27 January 2021, 10.00am Trust Conference Room					

CHAIRMAN AND NON-EXECUTIVES TO LEAVE THE MEETING.

ADDITIONAL ITEM FOR APPROVAL

	ITEM	Lead (s)				
BM/20/11/134	**Amendment to the Trust Constitution**	**John Culshaw Trust Secretary**	**Committee**	Council of Governors		**Enc**
			Agenda Ref.	COG/20/11/61		
			Date of meeting	12.11.2020		
			Summary of Outcome	**Approved**		

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 30 September 2020 Via MS Teams	
Present	
Steve McGuirk (SMcG)	Chairman
Simon Constable (SC)	Chief Executive
Terry Atherton (TA)	Non-Executive Director & Deputy Chair
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
Heather Harvey (HH)	Sister Intensive Care Unit Warrington Hospital (Patient Story only)
Observing	N Holding, Lead Governor, A Robinson Public Governor, C Murphy, E Richards NHS Providers

BM/20/09/90	**Engagement Story – Patient Story** The Chairman welcomed Heather Harvey, Intensive Care Unit Sister to the meeting who shared a patient story and journey of a patient who had been treated for COVID-19 at Warrington Hospital with no other pre-existing medical or co-morbidities. HH shared a high level summary of the patient's journey from admission through to eventual discharge and the complexities of treatment of a patient in critical care, which can be psychological and health related and the care and support in place through collaborative working and interventions from a wide range of services. As part of follow-up processes, patients are asked of any recollections they may have had of their treatment and given possible explanations and reasons if they are unable to recollect these accurately. They and their families are signposted to other support groups and outreach services. AW asked if the (1) visual disturbances experienced are similar for other patients and if any of the learning information is fed into national / regional networks. HM explained (1) only a small number of patients are affected and can be a combination of effects of critical illness and medication; (2) feedback is through the C&M Critical Care Network, National networks and Charities. The Chairman thanked Heather for sharing this story, acknowledging the tremendous efforts of all staff to treat and care for our patients.
BM/20/09/91	**Welcome, Apologies & Declarations of Interest** The Chairman welcomed all to the meeting. No declarations made in relation to the agenda.

BM/20/09/92	**Minutes of the meeting held 29 July 2020** Page 6 Sustainability 2nd bullet point to read.. £24m Critical Infrastructure funding awarded. With this amendment, the minutes of 29 July 2020 were agreed as an accurate record.
BM/20/09/93	**Actions and Matters Arising. Action log and updates noted and recorded.**
BM/20/09/94	**Chief Executive's report** The CEO referred to his report, which contained a number of items that will be addressed in other items in today's meeting and invited questions. In response to query raised by CR regarding safety and human factors and clinical simulation exercises supported by 'Wingman' colleagues, SC explained that collaborative work continues to support development of the Trust Simulation Suite. **The Board noted the report.**
BM/20/09/95	**Chairman's Report** The Chair reported since the last Board meeting, internal meetings with Non-Executives (NED) continue with the NED Assurance Committee meetings, Board, Council of Governors and Governor Briefing meetings. CEO appraisal had been undertaken and objectives will be shared with NED colleagues when approved. External meetings continue with NW Chairs, C&M Health & Care Partnership, local partners and stakeholders. A recent New Hospitals meeting had taken place with local MPs and Health Minister who pledged support for development of Outline Business Case and had supported the Trust in their request for Government funding to support. • **The Board noted the update** • **New Hospitals briefing following MP meeting to be circulated - LG.**
BM/20/09/96	**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. Current COVID-19 position reported, 32 COVID-positive in-patients, 8 in ICU compared to 24 COVID-positive in-patients on 24 September 2020. Gradual increase being experienced in number of in-patients primarily due to increase of cases within the community, challenges remain to maintain elective programme whilst maintaining elective capacity. National guidance remains for all elective programmes to continue. Capacity and bed pressures continue to be monitored daily through Tactical Group. In response to query by AW regarding demographics of patient population and if this is different from Phase 1 COVID. SC and AC commented it is anticipated that 'Phase 2' of COVID will not see a surge of patients but sustained activity rather than peaks and troughs, without any obvious change in demographics evident thus far. MB observed that data showed less in-patient deaths and more occurring at home and of any impact on Palliative Care Services. AC explained that Palliative Care patients are not admitted to hospital unnecessarily due susceptibility of this cohort of patients Referring to continuation of Elective Programme, AW asked if there is potential for some elective services to be cancelled in future and/or if this would be a national decision. SC explained COVID activity and Non Elective and Planned activity are to continue in parallel

	with daily monitoring of capacity and staffing constraints whilst maintaining patient safety and effective services, all in line with IPC guidance. Any intended consequences will be considered when releasing staff to support areas of increased demand and the knock-on effect on other wards/departments and before any services would be stopped. SC further explained that C&M Hospital and Out of Hospital Cells are leading on initial discussions for a preserved Elective Hub for C&M at Halton Hospital. DM added the Trust has robust activity and planning plans in place in the event of a COVID resurge, winter planning and Phase 3 Recovery planning. SC referred to the impact of Delayed Discharges of patients to Community settings. During the height of the first wave of the COVID-19 Pandemic this had reduced to less than 50; the current position 84 which impacts on patient flow and capacity within the hospital. Work continues with system partners to identify safe settings to discharge patients to. In relation to query raised by AW of utilisation of private sector, DM explained capacity continues to be used, primarily at SPIRE Cheshire for Surgery, Endoscopy and Radiology Diagnostics to the end of the year. • **The Board noted the report.**
BM/20/09/97 a i *BM/20/09/97 a ii*	**Monthly Safe Staffing Reports, June 2020 and July 2020** The reports were taken as read. KSJ reported both reports had been reviewed and discussed at the Strategic People Committee on 23 September 2020. AW explained the Committee had discussed the complexities and challenges to recruit and retain HCA staff and the multi-factorial reasons for these challenges. She also conveyed thanks on behalf of the Board for KSJ's continued endeavour to ensure robust staffing escalation plans are in place and the daily challenge this brings. **IPR Dashboard and IPR Key Issues** The CEO introduced the report and invited questions from colleagues relating to Quality, Access and Performance. **Performance** MB asked for clarification regarding (1) Breast Symptomatic and reduced capacity and (2) 52 week waits and if this was in particular specialities. DM explained (1) additional resource is supporting this area. All patients are tracked daily, and data referred to only a small number of patients. DM provided some context relating to 52 week waits, trajectories had been set as part of Phase 3 Recovery Plans, peak anticipated in October 2020, forecast 423; 324 in September 2020; today's position reported 276 patients against trajectory of 324. 52 week wait position in August 2020 - 211. There was no particular specialty affected, waits were spread across all. DM reassured the Board the situation is monitored at the Tactical Group and Performance Review Group. For further reassurance, AC explained these areas are scrutinised at Clinical Harm Review meetings by Chief Nurse, weekly harm meetings, and will report to Patient Safety Clinical Effectiveness Sub Committee and Quality Assurance Committee. CR commented on assurance received of controls in place to monitor waits, enquiring of

	mitigations the Trust have in place against unexpected increases. DM explained Theatre Capacity is being scaled up, particularly CMTC and private sector, supported by PACU at Halton with a robust programme to support delivery of Phase 3 Plans. IJ referred to reduction in A&E performance (68%). DM commented up to August 2020 the Trust had achieved 85% trajectory, near normal levels in August (96%) when compared to same period in 2019. Challenges in September due to resurgence in Urgent Care presentations whilst maintaining segregated flows. Factors affecting performance are multi-factorial and included; pressures in CAU and a rise in number of days when ED Ambulatory Care Unit had been bedded; when patients have a positive COVID test and stringent IPC protocols that need to be followed, closing bays etc. Additional capacity opening K25 in August 2020 to support demand, challenges remain including ward closure due to an outbreak. DM referred to earlier discussions relating to Super Stranded patients and ongoing work with system partners to discharge patients, circa 60 Care Home beds available in Warrington. TA provided assurance that all performance metrics are discussed and scrutinised at FSC in detail, particularly long wait patients and cancer waits who are clinically prioritised. DM referred to RTT and reduction in patients waiting 18 weeks by 724. Cancer reduction over 62 days, 38 patients in September, reduced from 60 in August; 104 day waits September 27 patients, reduced from 39 in August. KSJ clarified earlier discussions regarding outbreaks. A6 had been closed, other outbreaks had been in staff rest rooms. Early identification of positive COVID tests affects capacity of patient bays due to stringent IPC protocols followed to carry out deep clean etc. AMcG advised notification received 29 September 2020 of Trust Elective Scheme including the Independent Sector. Penalties anticipated when elective plans not achieved, regime and how incentives will be applied and implementation to be confirmed, anticipated from September 2020 onwards. MB referred to PLACE and C&M system support and if some of the challenges in WHH are due to primary care activity and delay of patients presenting and attending WHH for treatment and how the wider system could support. AC concurred that delay in patients presenting to primary care will, and is, impacting on secondary care and ED attendances due to acuity on presentation. <u>Quality Assurance Committee (QAC) Assurance Report 04.08.2020 + 01.02.2020</u> MB highlighted Medical Examiner (ME) Role which is an independent Senior Doctor to support families and the additional scrutiny of governance of Mortality Review process through the ME role. MB referred to escalation of Digital Agenda and pivotal role functioning Digital systems have to support performance of clinical, safe, effective services, particularly in relation to Lorenzo, Discharge summaries and IT upgrades. A further report had been presented to the September QAC which provided assurance of monitoring processes in place. CR referred to current Digital Risk on the BAF and would raise later in the meeting. CR also referred to VTE now included on IPR for robust monitoring. MC explained that reporting of Equality, Diversity & Inclusion Sub Committee from a Patient

/service user perspective had been included in QAC (+SPC) reporting structure to provide a route for escalation to Trust Board.

Workforce – MC provided an update on Trust and regional sickness absence

- Overall sickness absence - daily SITREP at the peak of Wave One was reporting 17% for all COVID and Non-COVID absences, current levels reported at 10-10.5% which is increasing week on week. Measures in place to monitor and support staff to safely return to work as soon as possible, increase primarily due to COVID-19 symptoms and self-isolation.
- Current position, 144 staff self-isolating due in part to outbreaks, coupled with other additional sickness absence and additional requests for staff to self-isolate due to Track and Trace (T&T).
- National T&T measures/guidance not as nuanced as the Trust which is impacting on the Trust's ability for staff to return to work if they have been advised by the national system to self-isolate.
- This had been raised nationally and is monitored at the Trust Tactical Group.
- WHH had been identified as one of the top 10 Trusts in the North West by NHSE/I. A letter was received in August 2020 highlighting high sickness absence rates in the NW. Robust response and mitigations in place to reduce sickness absence levels had been returned to NHSE/I. HRD Network analysing NW data, led by HRD at St Helens & Knowsley Hospital Trust supported by Deborah Smith, Deputy Chief People Officer at WHH.

Strategic People Committee (SPC) 23.09.2020 AW highlighted 3 areas, local induction of temporary medical staff, improvement noted but oversight to continue at SPC, primarily due to complexities of the turnaround of this cohort of staff; WRES and WDES data had been submitted. Action Plans discussed and reviewed, final action plans to be approved virtually prior to publication and discussed further at November SPC.

KSJ referred to staff outbreaks and COVID-related sickness absence. This relates to staff waiting for results from T&T system or staff with symptoms waiting for results. Only small staff absence related to nosocomial.
MC explained that reporting of Equality, Diversity & Inclusion Sub Committee from a Patient /service user perspective had been included in QAC (+SPC) reporting structure to provide a route for escalation to Trust Board.
MC reported she had been identified as the Executive Lead for Equality, Diversity & Inclusion (Workforce) and the Chief Nurse as Executive Lead for Equality, Diversity & Inclusion (Patients / Service Users).

Sustainability
AMcG advised notification received 29 September 2020 of Trust Elective Scheme including the Independent Sector. Penalties anticipated when elective plans not achieved, regime and how incentives will be applied and implementation to be confirmed, anticipated from September 2020 onwards.

AMcG reported:

- Payment had been processed to repay loans of £57.8m; Break-even position achieved August 2020.
- The Trust required additional top-up funding than COVID-19 related expenditure in

	August 2020 as Providers were required to accrue for the medical pay award (£0.4m) linked to back dating of the medical pay award. - Retrospective Top-up YTD £14.2m. - AMcG highlighted risk to achieving Capital Programme, 50% to be delivered in last quarter of the financial year which had been discussed in detail at the FSC in September. Finance & Sustainability Committee (FSC) 19.08.2020 and 23.09.2020 TA highlighted scale and profile of Capital Programme and had requested enhanced monitoring by the Capital Planning Group. Stocktake and projection of each capital scheme to FSC from October. C&M will be reviewing Capital spend and if behind profile capital money may be reallocated elsewhere. - Digital – oversight and assurance at FSC for oversight and assurance from September 2020. Presentation of position statement received at September FSC. October FSC to receive outcomes of deep dive of digital risks. - IJ enquired of any impact relating to the £57.8m loan payment of ongoing costs of interest compared to PDC dividend. AMcG responded that assurance had been given that there should be no negative impact on the position, however still waiting for confirmation of the financial envelope for the remainder of the year. Capital Programme - AMcG highlighted proposed changes detailed below which had been discussed and supported at September 2020 Finance + Sustainability Committee for the Board to review and approve: **The Board:** • **Noted the report.** • **Approved increase in the Capital Plan from £24.1m to £24.6m to include the new endoscopy funds, supported at FSC on 23.09.2020.** • **Approved the exchange of the Dexa Scanner for the additional X-Ray room refurbishment, supported at FSC on 23.09.2020.** • **Approved the use of contingency relating to the purchase of a Radio Frequency Generator for £0.042m, supported at FSC on 23.09.2020.** • **Approved the addition of 3 COVID19 Recovery KPIs in the Access & Performance section of the IPR.** Audit Committee 06.08.2020. IJ reported continued robust monitoring of internal audit plans and recommendations; Lorenzo concerns discussed, as referred to earlier. External Auditor term of office due to end October 2020. Following procurement exercise in August 2020, Grant Thornton had been reappointed following due governance process.
BM/20/09/	**Moving to Outstanding Action Plan (M2O)** The report was taken as read by KSJ highlighted key points to note: - Of the original 63 actions in the CQC action plan, 7 actions remain. All actions and timeframes had been agreed by Executive leads and core service leads. - These actions will be completed by October 2020 (6 Should, 1 However), overseen by the Associate Director of Governance and Compliance. Delays in the closure of actions has been due to operational pressures and the COVID-19 response. CQC Transitional Regulatory approach from September 2020 highlighted, which will bring

	together existing methodologies for learning and include the CQC visiting providers. Focus will also be on intelligence and data to identify risk within providers • **The Board discussed, received and reviewed the CQC action plan, progress and update on the approach to future inspections.**
BM/20/09/99	**Engagement Dashboard Q1 April 2020-June 2020** The report was taken as read and PMcL highlighted key areas for the Board to note: - Freedom of Information Requests (FOIs) highlighted providing assurance that the Trust had recommenced processing FOIs in July 2020 with focus to clear backlog with the aim of processing FOIs within the normal 20 working day time line. No penalties remain in place from the Information Commissioner Officer (ICO) if the 20 day limit is exceeded. • **The Board noted the report and its assurance on actions in place to meet legislative requirements.**
BM/20/09/100	**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 since the last meeting and the rationale: Since the last meeting, no new risks had been added to the BAF; the rating of one risk (#1134) had been reduced; there had been no amendments to the descriptions of any risks on the BAF and no risks had been de-escalated from the BAF since the last meeting. Proposed changes to reduce the rating of Risk #1134 had been approved at the Quality Assurance Committee 1 September 2020 from 20 to 15, following a reduction in sickness rates in June and July 2020 to 5.55%. JC explained that following earlier discussions in the meeting, a proposal will be presented to Risk Review Group on 5 October 2020 and Quality Assurance Committee on 6 October 2020 to increase risk rating back to 20. It had been agreed that the Finance and Sustainability Committee would assume responsibility for oversight and assurance for Digital Services, monitoring Risk #1114, including a deep dive into Digital BAF Risks raised by CR earlier. Also included in the report were notable updates to existing risks #1124; #1215; #115; #134; #1207; #125; #1134; #145; #1205. There had been no amendments to the descriptions of any of the risks on the BAF. • **The Board reviewed and noted the BAF and Strategic Risk Register.** • **The Board approved the proposal to increase rating of Risk #1134 (from 15 to 20) to the RRG and QAC in October.**
MATTERS FOR APPROVAL/RATIFICATION	
BM/20/09/101	**Council of Governors (CoG) Terms of Reference** The Board **ratified** the Council of Governors Terms of Reference which had been approved at the CoG on 13 August 2020.
BM/20/09/102	**Audit Committee Chairs Annual Report** The Board **ratified** the Audit Committee Chairs Annual Report which had been approved at the Audit Committee on 6 August 2020.
BM/20/09/103	**Flu Vaccination Programme** • **The Board noted the Workforce Flu Vaccination programme 2020.**

	• **The Board approved the self assessments against the best practice checklist.**
BM/20/09/104	**WHH Charity Annual Report and Accounts 2019-20** The Board **ratified** the WHH Charity Annual Report and Accounts for signing which had been approved at the Charitable Funds Committee on 4 June 2020.

	MATTERS FOR NOTING FOR ASSURANCE
BM/20/09/105	**Mortality Review Q1 Report** This report had been reviewed and supported at the Quality Assurance Committee (QAC) on 4 August 2020. TA referred to SHMI trends as stable and HMSR trend increased. AC explained that WHH is not an outlier and HMSR value in report is historical with improved values in future months. AC explained the format of the report is under review with NED and Governance colleagues, following discussion at QAC to ensure continued clear interpretation of conclusions where reviews have been undertaken and correlation with investigation such as SIs. AC assured the Board that 3 areas are being re-evaluated by the Mortality Review Group (MRG): COVID-19, Arrhythmia and Pneumonia • **The Board noted the report.**
BM/20/09/106	**Learning From Experience Q1 Report** This report had been reviewed and discussed at the Quality Assurance Committee on 1 September 2020 • **The Board noted the report.**
BM/20/09/107	**Director of Infection Prevention and control Q4 (2019-20) and Q1 (2020-21) reports** This report had been reviewed and supported at the Quality Assurance Committee on 4 August 2020. • **The Board noted the report.**
BM/20/09/108	**Freedom to Speak Up Guardian Bi-Annual Report** This report had been reviewed and supported at the Strategic People Committee on 23 September 2020. MB observed Board leadership and culture in place to support and encourage staff to raise concerns through FTSU and continued Board support required. • **The Board noted the report.**
BM/20/09/109	**Nurse Staffing Escalation Audit May – June 2020** This report had been reviewed and supported at the Strategic People Committee on 23 September 2020. • **The Board noted the report.**
	Any Other Business Staff support and welfare services visual summary supported for circulation to all staff and the wider community to highlight services support put in place for staff during COVID-19 and the services that have continued. - Chairs appraisal in process, colleagues asked to complete survey circulated.
	Next meeting to be held: Wednesday 25 November 2020

Signed …… Date …….

Chairman ……..

The agenda and minutes of this meeting may be made available to public and persons outside of Warrington and Halton Teaching Hospitals NHS Foundation Trust as part of the Trust's compliance with the Freedom of Information Act 2000.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE	BM/20/11/113	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	25 November 2020

1. ACTIONS ON AGENDA

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

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

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

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
	30.09.2020		Briefing following MP new hospitals meeting to be shared with Board members.	**Director of Strategy**		**02.10.2020**	Briefing shared 2 October 2020	

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/20/11/114**				
SUBJECT:	**Chief Executive's Briefing**				
DATE OF MEETING:	25th November 2020				
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/20/11/114

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 30th September 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 Bill McCarthy, Regional Director in relation to the impact of COVID-19 in the North West;
- North West Boroughs Healthcare NHS Foundation Trust Stakeholder brief;
- The Clatterbridge Cancer Centre NHS Foundation Trust Stakeholder Brief.

2.2 Key issues

2.2.1 Current COVID-19 Situation Report

WHH has been severely impacted by the second 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 2 (179 inpatients with COVID-19 on 9th November 2020) thus far has significantly exceeded that of wave 1 (124 inpatients with COVID-19 on 13th April 2020).

In all of this, as a Trust we have tried to carry on 'as normal' and have done so admirably, working within our well-thought out escalation plans. However, during the last half of October we reached a tipping point, especially from a ward staffing point of view which meant that, regretfully but with a clear mission in mind, we had to 'pause' certain non-urgent services to support staffing in critical services, especially those that are ward based. Critical care capacity was a particular area for focus and concern. In turn, this had a proportionate impact upon theatres and recovery capacity and, consequently our elective programme.

Our 'mission' was clearly specified to include the preservation of urgent or otherwise time-critical activity (including, but not limited to, cancer and diagnostic services such as endoscopy and radiology). This was a temporary 'pause' and is not a blanket one, carefully designed to impact the fewest number of patients – quite simply a pause to support either bed capacity or ward staffing. Although bed occupancy was, and still is high (and work is going to address that urgently), the main constraint was staffing for the non-elective pathways.

Services most affected were some non-urgent elective (planned) activity. This was constantly being reviewed, and subject to our established COVID-19 service change process,

tried and tested through wave 1. Decisions were clinically overseen and made as close to the patient as possible.

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.

I am pleased to say, albeit tentatively, that the impact of the public health measures regionally and nationally has now started to have a positive effect upon hospital admissions to WHH with a slow decline/plateau over the last two weeks.

As at the time of writing, 23rd November 2020, we have a total of 153 inpatients with COVID-19. That number was 179 on 9th November 2020. The number of inpatients with negative tests is currently 242, with 17 patients currently awaiting test results.

Since March, we have performed over 38507 COVID-19 tests and 2705 have been positive in total. We have discharged a total of 805 patients with COVID-19 to continue their recovery at home. Sadly, a total of 242 patients have died in our care.

The latest R number for the North West, updated on Friday 20th November, is once again down slightly at 0.8-1.0; the UK as a whole remains at 1.0-1.1.

In the latest 7 days fully reported (10th November – 16th November) in Warrington there were 248 cases per 100,000 people (the average area in England had 210); 520 new cases were reported in that week, down 273 compared with the previous week. In Halton, there were 235 cases per 100,000 people; 304 new cases in that week, down 26 compared with the previous week.

We are still using approximately 900 litres of oxygen per minute (approximately 31% 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 10.7%, still double what we would normally experience at this time of year.

Things appear to be going in the right direction both inside and outside our hospitals. However, the overall burden of COVID-19 remains high given that emergency attendances and admissions approximate normal for this time of year and that we endeavour to complete as much of our elective programme as possible. This is over and above wave 1 when the peak then was 124 inpatients with COVID-19 at any one time.

2.2.2 Asymptomatic NHS Staff COVID-19 Testing

We have been part of a pilot group of 11 Trusts in the North West who have participated in this programme. We tested over 3000 members of staff, with approximately 1.9% being COVID-19 positive without having symptoms. This would have been below the community prevalence at the time and was below the regional average of 2.9%. As an appendix to my report this month I have included a summary and 'lessons-learned' document about this

important project that was deployed very successfully at short notice. This was done at a time of significant operational pressure with the burden of COVID-19 disease in our Trust.

I am very grafeful to the entire team who have made this possible, under the leadership of Andrea McGee, Chief Finance Officer and Deputy Chief Executive. I am also extremely appreciative of the receptiveness of our staff to come forward and get tested without hesitation.

Asymptomatic NHS Staff COVID-19 testing is a key strategy for minimising nosocomial (healthcare associated) COVID-19 and the next phase of testing for our staff has alreading commenced. We are now one of three trusts in the North West to trial a 'home/self-test' kit (lateral flow test) that does not require a laboratory (so doesn't interfere with other testing) and gives quick results. Testing kits (enough for a 12 week period) have already been distributed to over 1500 members of staff and testing is now underway. Positive tests need confirmation by the laboratory in the usual way.

2.2.3 The Thank You Awards 2020

After much debate within the Executive Team about the timing, we have concluded it is entirely appropriate, and indeed important, that we take a little time out to pause and recognise what we, as an organisation have done this year, and before the end of 2020.

Despite the ongoing challenges, we believe that 4,500 members of our WHH Family have made an outstanding contribution to the care of our patients, their loved ones and each other in 2020. We therefore want to take the opportunity to say the biggest of 'Thank Yous' through our annual WHH Thank You Awards, although clearly the big gatherings of previous years are out of the question.

This does however represent an opportunuity to be even more inclusive this year.

The 2020 WHH THANK YOU AWARDS gives us the opportunity to have everyone at the 'party' this year. Thanks to the power of technology (MS Teams Live or similar) all staff are invited and all staff can follow along on with their wards or department in front of the computer screen. The much-simplified nomination process has already commenced, the deadline being midnight Wednesday 25th November 2020.

Finalists and winners will then be decided by our expert panel of judges, comprising the chairpersons of the LGBTQA+, BAME and Disability Staff Networks, Staff Side and the Executive Team. There are seven specific categories but I have no doubt there will be a number of special awards this year as well.

There are so many individuals and teams so very worthy of recognition, from right across the whole organisation.

The THANK YOU AWARDS 2020 live event will take place virtually on Friday 18th December 2020 at 7pm.

2.2.4 In support of our armed forced and veterans

November is obviously a significant month for our armed forces and our veterans. Remembrance Sunday this year was so very different from usual because of the pandemic. However its importance in the nation's calendar was reinforced by its continued presence, albeit in a limited form in a closed ceremony. Recognising and remembering the sacrifices of those in the armed forces (and their families) in the two World Wars and subsequent conflicts, seemed especially poignant and dignified this year.

There have been several conflicts in recent memory touching the lives of many in our communities.

As an NHS provider, WHH is committed to doing our very best in supporting our armed forces and our veterans. We can always do better and do more. In February we signed the Armed Forces Covenant and we are delighted that WHH has gone on to receive the Bronze award in the Ministry of Defence Employer Recognition Scheme. This is in addition to Veteran Aware Accreditation from the Getting it Right First Time Veterans Covenant Health Care Alliance.

A common ambition of these schemes and accreditations is to ensure that members of the armed forces community are not disadvantaged when accessing health care. They also encourage us to acknowledge the specific circumstances faced by serving armed forces personnel, veterans and their families.

However, achieving accreditation is only the start of what we want to achieve and, whilst managing our COVID-19 response has taken precedence in recent months, we are now at the point where we are progressing some important activity to support serving and former armed forces personnel.

We have a small but dedicated working group which has set out a number of pledges which we are working on. These aim to support and recognise the contribution and circumstances of current and former Armed Forces personnel as well as WHH staff who are reservists and members of armed forces families. They include:

- promoting WHH as an armed forces-friendly organisation; through recruitment advertising and development of our staff networks;
- supporting the employment of veterans, young and old, through a tailored employment pathway for service leavers;
- supporting the employment of armed forces service spouses and partners;
- offering a degree of flexibility in granting leave for service spouses and partners before, during and after a partner's deployment;
- supporting our employees who choose to be members of the Reserve forces, including accommodating their training and deployment, where possible;
- supporting our local cadet units and supporting and participating in Armed Forces Day;
- creating pathways for priority service, in line with current policy and procedure, and supporting the needs of veterans and armed forces personnel with a dedicated passport.

We will be sharing updates on aspects of the work programme being led by our WHH Armed Forces and Military Veterans Steering Group, along with opportunities for colleagues to get involved. Whilst there is still much to do, we can celebrate the significant steps we have already taken.

2.2.5 Special Days/Weeks for professional groups

Since our last Board meeting in September, 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 been a busy couple of months, I think reflecting the depth, breadth and diversity of WHH in terms of healthcare delivery in our communities. These include:

Black History Month – whole month of October 2020
Physician Associate's Day – 6th October 2020
World Mental Health Day – 10th October 2020
Allied Health Professions Day – 14th October 2020
International Clinical Engineering Day – 21st October 2020
'Movember' (men's health awareness) – whole month of November 2020
Occupational Therapy Week: 2nd – 8th November 2020
Medication Safety Week: 2nd – 8th November 2020
Advanced Clinical Practive Week: 8th - 14th November 2020

2.2.6 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 me questions on behalf of their constituents, and asked if they could do anything to assist us.

They have all, unanimously passed on their sincere thanks and good wishes to WHH staff for all that we have been doing through the pandemic thus far.

I was also delighted to be invited to contribute to one of Warrington Borough Council's Leaderhip Live broadcast events, on 14th October 2020.

2.2.7 Partnership with Cheshire Fire and Rescue Service

There is no doubt that during the COVID-19 pandemic we have faced many and varied challenges as health professionals and the impact has been felt across all sectors of the health and care system. However, during these most difficult of times and thanks to COVID-19 we have seen numerous examples of collaboration and innovation at a remarkable scale and pace and which have delivered positive outcomes for patients.

Not only have our partners in our local health and care systems come together to develop a co-ordinated response to the pandemic, our wider public sector and community partners have made significant resources available to support us in our efforts.

Recently we launched a self-swab at home service for elective patients, made possible through the offer of resources and personnel from Cheshire Fire and Rescue Service (CFRS). The launch of this service in late August has been vital in the re-start and recovery of elective surgery through our COVID-secure 'Green Pathway' on our Halton site.

This partnership is the first of its kind in the country. We are really proud to see how WHH is leading the way in exploring creative partnerships, not only to maximise the use of all available resources but to bring our community together.

Since the start of this partnership project patients, who are self-isolating ahead of planned surgery, have been able to self-swab without leaving their home, through a process in which CFRS staff deliver the swab kit to the patient's home, post it through the letterbox and wait whilst the swab is taken and safely re-packaged. This is then handed back to the CFRS staff through the letterbox and returned to our lab at Warrington Hospital. Once the result is confirmed, patients are contacted to discuss next steps on their planned surgery journey.

2.2.8 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 (November 2020): Dan Birtwistle

Dan is Deputy Head of Contracts & Performance, sitting within the corporate Finance Team. Dan volunteered to be the operational lead and deliver the first phase of asymptomatic staff COVID-19 testing at exceptionally short notice, and delivered a successful programme without it adversely affecting the operational capacity of the clinical and operational teams.

A feature of the whole WHH reponse to the pandemic has been that so many individual members of staff and teams have positively embraced new roles, new tasks and new ways of working. There are so many examples of this, the most frontline of which is the way our anaesthetists, theatres and recovery staff have moved into a critical care role so competently. Dan's contribution here, from a corporate team and working above and beyond his job description, typifies the approach of so many.

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

The following members of staff have also been recognised:

- Katie Daly, ED Porter, Urgent & Emergency Care
- Kate Brizell, CBU Manager, Integrated Medicine & Community
- Alison Williams and Team, Ward Manager, Ward A3 ACCU
- Holly Pleavin and Team, Ward Manager, Ward A4
- Sue Lewis and Team, Ward Manager, Ward A6
- Hannah Birtles, Midwife, Women's & Children's Health

- Sarah McFarlane, Student Midwife, Women's & Children's Health
- Stephanie Tutty, Midwife, Women's & Children's Health
- Leona Lally, Midwife, Women's & Children's Health
- Jonathan Cliffe, Midwife, Women's & Children's Health
- Sarah Spencer, Midwife, Women's & Children's Health
- Jonathan Cliffe, Midwife, Women's & Children's Health
- Gail Millward-Jackson Midwife, Women's & Children's Health
- Angela Parfitt, Associate Director of Governance, Corporate Nursing
- Ellen Quinn and Team, Ward Manager, Ward B19
- Sarah Brennan and Team, Ward Manager, ITU
- Dr Zaman Qazzafi, Consultant Microbiologist & Deputy DIPC, Microbiology
- Katherine Summers, Infection Control Nurse, Corporate Nursing
- Charlene Liptrot, Infection Control Nurse, Corporate Nursing
- Paula Atherton and Team, Audiology Manager, Surgical Specialities
- Trevor Wain, Radiology Clerical Worker, Radiology
- Stuart Easton, Radiographer, Radiology
- Jerry Nykiel, Medical Records Clerk

3) MEETINGS ATTENDED/ATTENDING

The following is a summary of key external stakeholder meetings I have attended in October and November 2020 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)
- NHSE/I COVID-19 System Leadership (Weekly)
- Warrington & Halton COVID-19 Health Protection Board (Weekly/Biweekly)
- C&M CEO Provider Group Calls (Biweekly)
- C&M Medical Directors Clinical Prioritisation & Mutual Aid meeting (Weekly)
- NHS 111 Oversight Group (Biweekly)
- 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
- C&M Hospital Cell (Weekly)
- C&M Gold Command (Daily)
- NW Hospital Cell Gold Command (Weekly)

4) RECOMMENDATIONS

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

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/20/11/114			
SUBJECT:	**COVID-19 Asymptomatic Testing Pilot – Closure and Lessons Learned**			
DATE OF MEETING:	25th November 2020			
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance			
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee - Chief Finance Officer and Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	x		
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	x		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate*)	#115 Failure to provide adequate staffing levels in some specialities and wards.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	On 11th October 2020, the Trust was informed by NHSE/I of the requirement to carry out COVID-19 testing for Asymptomatic staff within a specified cohort of staff groups. The Trust was 1 of 9 pilot sites across the North West (later extended to 11 Trusts). The original ask was for testing to commence from 15th October over a 7 day period. However, due to concerns voiced by all Trusts involved, the requirement was made flexible and Trust could select when to commence testing within a 14 day window with the latest end date of 2nd November. The Trust opted to commence testing over a 10 day period from 20th October – 29th October inclusive. This paper outlines the approach taken and lessons learned which can be taken forward for any future deployment.			
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**			
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	COVID-19 Asymptomatic Testing Pilot – Closure and Lessons Learned	**AGENDA REF:**	BM/20/11/114

1. BACKGROUND/CONTEXT

On 11th October 2020, the Trust was informed by NHSE/I of the requirement to carry out COVID-19 testing for Asymptomatic staff within a specified cohort of staff groups. The Trust was 1 of 9 pilot sites across the North West (later extended to 11 Trusts). The original ask was for testing to commence from 15th October over a 7 day period. However, due to concerns voiced by all Trusts involved, the requirement was made flexible and Trust could select when to commence testing within a 14 day window with the latest end date of 2nd November. The Trust opted to commence testing over a 10 day period from 20th October – 29th October inclusive. This gave the Trust less than 7 days to prepare deployment at a time with significant operational pressures over a school half term.

Task & Finish Group

A Task & Finish Group was established, led by the Chief Finance Officer and Deputy Chief Executive. This group was made up of staff from a number of areas/disciplines including; Finance/HR staff who lead the project operationally, Clinical Leads, Procurement, Communications, IM&T, EPRR, Estates and Pathology. A structured project management approach was utilised.

Regional Team

Support was provided to the NHS by Deloitte who were responsible for the logistics of delivering, collecting and processing the tests. There was a daily call with the NHSE/I regional team and Deloitte to report progress and discuss any issues. A daily Single Point of Contact was provided by Deloitte.

Identified Cohort/Staff Groups

The Trust was provided with a list of staff groups which were to be included in the pilot, generally these were mainly patient facing clinical roles. The Trust used the ESR system (Electronic Staff Record) to produce a list of eligible staff. This was to exclude bank and agency staff. However during the pilot, the Trust opted to open up the testing to Bank/Agency staff and wider staff groups from within the Trust. A list of additional medical staff was provided by the medical team as not all medical staff were listed on ESR, for example lead employer Junior Doctors who are employed by St Helen's & Knowsley NHS Trust.

Approach

The approach taken was discussed in detail by the Task & Finish group and Operational/Nursing colleagues. It was agreed that a hybrid approach would be taken utilising a mixture of mobile testing teams, which would visit the wards at specific times during the day to capture staff on different shifts and central testing teams where staff could visit to have their test completed. The Kendrick Wing was identified in Warrington

and Ward B1 was identified in Halton for the Central Testing Areas with appropriate cleaning, equipment and infection control procedures.

Each team was made up of a clinical swabber and an administrator. Staff were encouraged to self-swab where possible. The administrator would ensure the staff members details were captured accurately with the correct barcodes being placed on the correct forms and ensuring that these matched the tests. This was then logged onto a central local spreadsheet followed by the national upload process via the government portal. Hand held barcode scanners were used to accurately match the test to the person, this part of the process was completed centrally.
The Trust opted to receive staff results, therefore a registration and consent form was designed to capture staff member information as well as for staff to consent for the Trust to receive their results. Staff would receive their own results via text message and the Trust would receive results via email for which a dedicated email address was established.

Scheduling
Based on the identified cohort of staff, the Trust estimated that 3,597 staff across the organisation would require a test, this included additional groups not on the original list including students and lead employer medical staff. The original staff groups targeted were:

- Additional Clinical Services (our Clinical Support Staff including Healthcare Assistants, Pharmacy Assistants, Phlebotomists, Nursing Associates and Assistant Practitioners)
- Allied Health Professionals
- Estates and Ancillary (staff working in Estates and Facilities roles including maintenance, portering, housekeeping, domestic, post room, security and catering services)
- Medical and Dental
- Nursing and Midwifery Registered

It was agreed that due to feedback from colleagues in Operations and Nursing, that testing would be staggered across the 10 day period to ensure services could continue to operate in the event that a high number of positive cases were identified. Each team was given a slot each day either on the mobile route or in the central testing area. A schedule was created which split the number of staff each day over the testing period so that each ward/team had a maximum number of staff tested each day. Ward/Teams were asked to co-ordinate who would be attending for testing each day.

Communications
The Task & Finish Group established daily calls at 10:30am and at 16:00pm during the planning phase and early stages of delivery; this was reduced to 1 call per day as the delivery process was bedded in. Communications were produced for staff in the form of bulletins and leaflets. A dedicated telephone line and email address was provided for any staff enquiries.

Training
A training presentation which covered both Clinical Swabbing Staff and Administration Staff was designed and delivered via MS TEAMS. This was backed up by guidance every day to ensure the processes were followed accurately.

Reporting

During the pilot, Trusts were asked to include Pillar 1 tests (those conducted in house) into the Sit Rep, backdated to 15th October. The Trust's COVID-19 executive summary was amended to include detail on asymptomatic testing delivery. Sitreps were produced which detailed the number of tests completed, results received, positivity rate and inconclusive rates. The COO and Deputy COO were provided with a list of staff tested each day and the Deputy Medical Director was provided with a list of Medics tested each day.

Positive results were reviewed by the Occupational Health Team and also sent to the Infection Control Team to ensure appropriate action was taken and to identify any potential outbreaks.

Inconclusive results were checked to identify the swabber in case any training issues were identified. 1.40% of results (39) came back inconclusive, the Trust is clarifying whether the inconclusive results need to be removed prior to calculating the positivity rate.

2. Lessons Learned

Planning

Due to the requirement for rapid deployment, the Trust did not have the opportunity to explore in detail different models of how the requirement could be delivered. Additional planning time would have been useful to fully explore the models and ensure the planning/scheduling was improved.

Task & Finish Group

The Task & Finish Group worked well together and had the right mix of staffing representing all the areas required. It was found that staff were very responsive and prioritised accordingly given the urgent requirement. Initially operational staff were unable to attend and felt disconnected. The Chief Finance Officer and Deputy Chief Executive met with the Senior Operations Team to provide an update. Subsequently, the EPRR Manager attended the group to represent Operations.

Identified Cohort/Staff Groups

Under the circumstances, the Task & Finish Group best utilised the available information from ESR to identify and target the cohorts. However, it was agreed that if this exercise was to be repeated, it would be beneficial to spend time to refine the list, working with services to fully understand those staff who were in patient facing roles and those who could be excluded. For example, the list didn't include dental nursing staff and a large group of pharmacy staff who were patient facing but did include switchboard staff who are not.

The Trust based the original trajectory on the potential number of staff but did not take into account sickness, annual leave etc. This should be reflected in future trajectories.

The original request from NHSE/I did not include Ward Clerks, Bank/Agency or Students. Additionally, other staff groups made requests to be tested including Medical Records Staff who regularly come into contacts with patients and visitors. This should be considered when planning future deployments.

Approach

It was agreed that a combination of mobile testing units and central testing areas worked well. For mobile testing units, the early starts to capture the night staff and change over worked well. However with the exception of the first couple of days, the central testing areas were quiet from 06:00am – 08:30am. The weekends were not as busy as anticipated as many non-based ward teams do not work the weekends, this was not taken into consideration in the original plan. Therefore the service times/days would need to be modified in order to maximise use of resources, there were times where there were too many administration staff and swabbers. It was noted that very few staff are on the Halton site at the weekend, although it was acknowledged this may change in the future.
The Operational Team has fed back that the staggered approach of testing staff spread out through the 10 day period worked well.

The Women's & Children's CBU requested a modified approach for their testing. The tests were picked up at the beginning of the day and dropped off at the end of the day. Whilst this approach worked on the whole, this would need to be reconsidered in the future as there were a number of reports of tests left within these areas which should have been utilised by night staff.

Medical Staff – the approach taken for medical staff was to capture them during the medical and surgical handovers as well as on the ward during mobile testing and at various training events. In future rollouts, this approach would need to be reconsidered as not as many medics were captured as planned. Excluding lead employer Junior Doctors – the Trust tested or excluded (due to sickness, leave etc) approximately 54% of Medical and Dental Staff.

During the first couple of days of testing, the test kit was taken out of the bag at the point of testing. This approach was changed in that the boxes were made up in the central testing area prior to testing. This saved time but also included an additional check of the barcodes to ensure these all matched. This was particularly useful as there were several tests within a box which had several mismatched barcodes.

It was agreed it would be useful to have a list of staff names who should be attending for testing as these could be chased up if the person did not attend. Line managers could also be emailed if their staff did not attend for a test.

During the last few days of the pilot, Ward/Line managers were emailed with a list of staff who had not attended for testing. This was useful as line managers then informed the testing team of staff who were unavailable, on leave, off sick or refused. This should be repeated once per week during any future deployments.

Communications

Communications to staff were clear and concise. Reponses from team/ward managers to schedule staff was positive. Responses for Administration and Swabbing volunteers was also positive. It was unclear what staff needed to do if they had not received their results. The original communication was for the staff to contact the internal results email address.

This was altered to call 119 as there was concerns the Trust could not give out this information as there were a risk that the wrong result could be provided. The 119 helpline (external) was inconsistent, asking for barcodes but couldn't always provide the result even with the barcode. This was compounded due to the Trust not holding an electronic version of the barcode (only the paper copy). It would be useful to scan the barcode into the local database for future deployments. It was agreed it would also be useful to provide a note of the barcode to the individual staff member at the point of testing.

It was noted that several staff tested did not bring their glasses or know their mobile telephone number. It was agreed this would be useful to add to any future communications.

Signs were provided to direct staff within the central testing areas which worked well.

Estates

The estate used in both Warrington & Halton was adequate; however the temperature in the Warrington central testing area was high and unconformable for staff. This meant tests could not be stored in the central testing area for any length of time as they had to be stored at a maximum of 22oc. Additional equipment would need to be purchased for any future rollout such as tables and trollies which were borrowed during the pilot. Mirrors were brought in to help staff do their own swab, which would be helpful during any future deployment.

There was some overcrowding in the central testing area in Warrington in the first few days; lines were marked on the floor to ensure social distancing measures were adhered to.

Logistics

There were a few issues at the beginning of the process where tests were not delivered or not enough tests were delivered. This was reported to Deloitte by liaising with the Trust's Single Point of Contact, however this took considerable time and effort. The Trust opted for a 7pm courier to pick tests up which was not required in the end. The Procurement Team ensured that appropriate stocks of PPE were provided at all times.

Administration

Volunteers were recruited to provide the administration support; the Trust had a good response via Communications, however it was acknowledged that further detail around expectations and what was involved would be useful to ensure we get the right support. Additionally, staff were provided from the Finance & HR teams. It was noted that where possible, the same group of staff should be utilised to ensure consistency.

It was agreed that the consent and registration form may need a re-design to ensure information is captured and is legible – for example asking to be completed in block capitals only and listing the different ethnic origin options. Individual boxes for telephone numbers and postcodes would also be useful.

A process was established where forms were counted and tests were counted to ensure the numbers matched. Tests were then logged on a local database. This was then passed to another number of staff who was responsible for the national upload. This happened throughout the day. The use of handheld barcode scanners was really important for speed and accuracy. The upload process was problematic for some Trusts, however WHH did not experience this. It's important to note that the national upload spreadsheet has several validation fields which need to be entered correctly for the upload to be verified. The registration and consent form matched the spreadsheet.

All staff who worked on this pilot contributed to its success. A full list of staff that contributed to the success of the pilot is outlined in **Appendix 1.**

3. OUTCOME

Pilot Outcome – 5th Novemeber 2020

- Pillar 2: Original Plan: 3,597 (3,237 Warrington, 459 Halton)
- Pillar 2: Delivered: 2,780 (2,398 Warrington, 382 Halton)
- Pillar 1: Delivered: 292
- Total Delivered: 3,072

Exclusions

- Staff Tested Positive in the last 90 days = 65
- Staff who declined the test = 113
- Staff who were unavailable to take the test = 113 (reasons include; retired, left the trust, unavailable to come into work, external secondment, career break, annual leave).
- Staff on Maternity Leave = 52
- Siren/Swabbed Elsewhere (declared on form/by manager): 35
  Total Exclusions: **378**

- Estimated Sickness/COVID-19 related absence: 371 (10.77%)
  Total Reduction: **749**

Pillar 2: Positives: 48 (1.80%)

Pillar 1: Positives: 9 (3.08%)

Total Positives: 57 (1.92%)

Total Inconclusive: 39 (1.40%)

Total Outstanding Results: 109 – this has been reported to NHSE/I & Deloitte

4. FUTURE

On 29th October 2020, the Trust received a letter from Professor Stephen Powis, National Medical Director and Ruth May, Chief Nursing Office advising all Trusts within areas identified as very high risk (Tier 3) would be required to carry out weekly staff asymptomatic tests for the period in which the area remains in that category, this was prior to the announcement on 31st October regarding the national lockdown.

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.

Appendix 1

Task & Finish Group

Andrea McGee, Operational Lead
Jane Hurst, Operational Lead
Dan Birtwistle, Operational Lead
Michelle Cloney, Operational Lead
Debs Smith, Operational Lead
Phil Owen, Operational Lead
Louise Rylett, Operational Lead
Paul Lyons, Reporting Lead
Neil Gaskell, Pathology Lead
Alison Parker, Logistical Lead
Alison Aspinall, Communications Lead
Ian Wright, Estates Lead
Jane Green, Clinical Lead
Deborah Hatton, Clinical Lead
Ali Kennah, Clinical Lead
John Goodenough, Clinical Lead
Rachael Clint – EPRR Lead

Support

Lynda Ellison, Swabbing Rota Co-ordinator
Dawn Cunliffe, Pathology Support
Lee Bushall, Estates Support
Simon Whitfield, IM&T Support
Rick Atherton, IM&T Support
Louise Ainsworth, IM&T Support
Oliver Connell, IM&T Support
Mark Garland, IM&T Support
Michael Gray, IM&T Support
David Ovien, IM&T Support
Helen Wood, IM&T Support
Michael Lysons, IM&T Support
John Bedson, IM&T Support
Derek Willoughby, IM&T Support
Carl Roberts, Workforce Information Support
Mark McEvoy, Logistics Support
Carl Pownell, Logistics Support
Kelli Clucas, Logistics Support
Matthew Brimelow, Logistics Support
Gareth Davies, Logistics Support
Matthew Percival, Logistics Support
Paul Tully, Logistics Support
Jason Bell, Logistics Support
Daniel Taylor, Logistics Support

Matthew Reddington, Logistics Support

Administration Team

Michelle Faulker, Sue Donegan, Julie Storey, Joanne Lowe, Jane Twigg, Amanda Nicholson, Janet Hughes, Amber Unsworth, Rachael Atkin, Kerry Benjamin, Francesca Maclaren, Jessica Finney, Laura Bailey, Nicola Burrows, Caroline Thornton, Dee Taylor, Heather Farrington, Carl Mackie, Claire Hunt, Jenny Barber, Chris Mulhall, Mandy Burke, Jessica Craynor, Gaynar McGuire, Lucy Garnett, Luke Gandy, John Vis, Karen Lunt, Samantha Holmes, Amanda Glover, Bethany Wright, Jennifer Robinson, Anne Holme, Louise Lomas, Louise Howard, Christine Ellis, Carolyn Hart, Joanne Litherland, Victoria Barton, Jim Brazendale, Anita McClean, Debbie McNamee, Sophie Van Veldhoven, Karen Welsh, Joanne Bright, Kathryn Tocher, Jackie Gifford, Lyn Mannion, Sarah Gilbody, Sarah Turner, Sue Mossford, Matt Abbott, Pamela Hibbert, Chelsea Hill, Cath Ryder Helen Stringer, Alison Critchley, Steve McGuirk, Sally Proffitt, Marie Garnett.

Swabbing Team

Victoria Barton, Sarah Jackson, Kaley Long, Amanda Penketh, Georgia Hatton, Eloise Baxendale, Maria Keena, Lisa White, Laura Knell, Hayley Leather, Deb Howard, Anais Mason, Katie Nixon, Lynn Simpson, Gill Whitfield, Danielle Caughey, Sue Price, Kelvin Wilkes, Beth Wright, Louise Spence, Catherine Edwards, Elizabeth Houston, Heather Davis, Deb Mallet, John Duffield Pete Sutton, Ann Buchannen, Angie Morrison, Melissa Franklin, Debbie Marshall, Rachael Nesbitt Michelle Waterfall, Lorna Smith, Greg Dixon, Tracey Beamer, Lisa White, Carol Baskett, Karen Taylor, Helen Quinn, Melanie Burgess, Katie Nixon, Huw Mazey, Yvonne Mahambrey

REPORT TO THE BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/20/11/116			
SUBJECT:	**COVID-19 Performance Summary and Situation Report**			
DATE OF MEETING:	25th November 2020			
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.	x		
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	x		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate*)	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 seventh 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 21st November 2020 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			

REPORT TO THE BOARD OF DIRECTORS

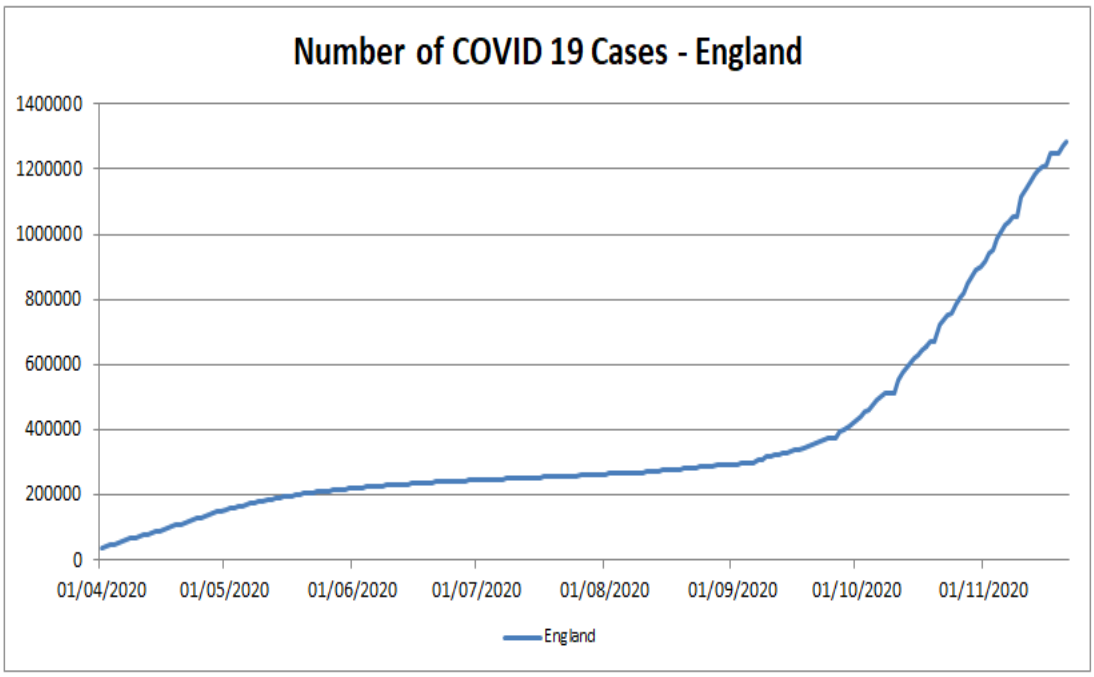
SUBJECT	COVID-19 Performance Summary	AGENDA REF:	BM/20/11/116

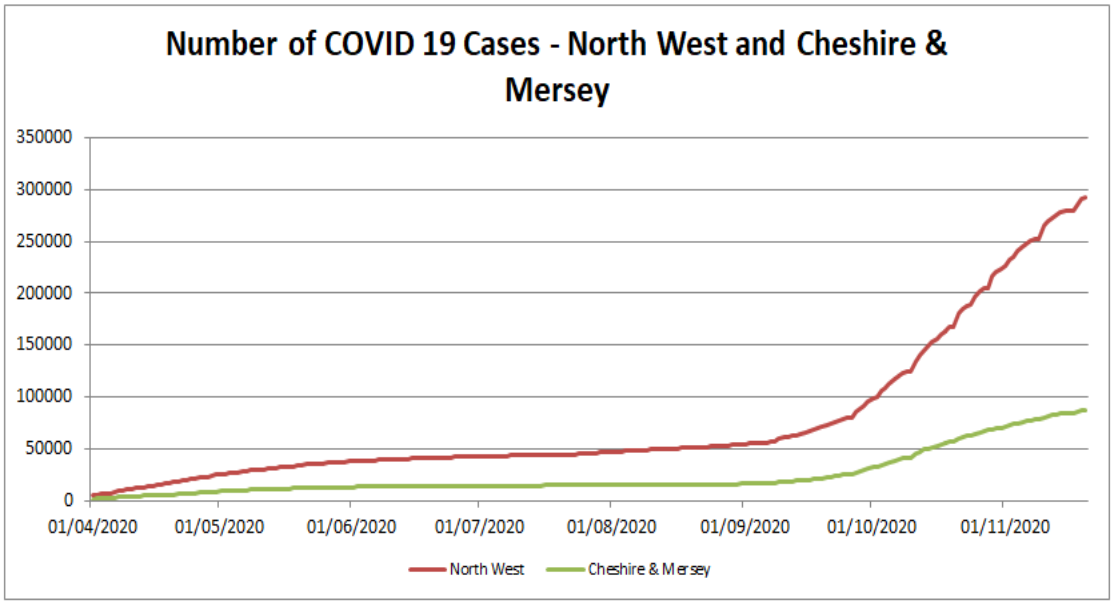
1. BACKGROUND/CONTEXT

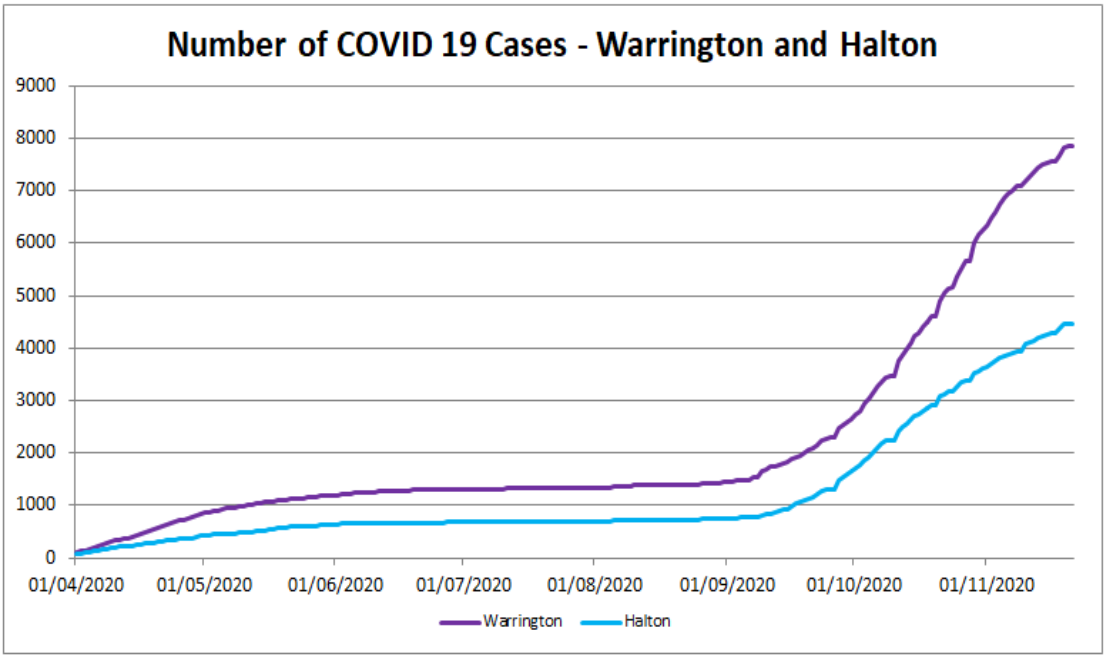
The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily COVID-19 Executive Summary which outlines key information pertinent to the command and control of the situation. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where possible. This is the seventh 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 21st November 2020 is included. The report has been refreshed in line with the development of the COVID-19 Executive Summary.

2. KEY ELEMENTS

2.1 Number of Reported Cases

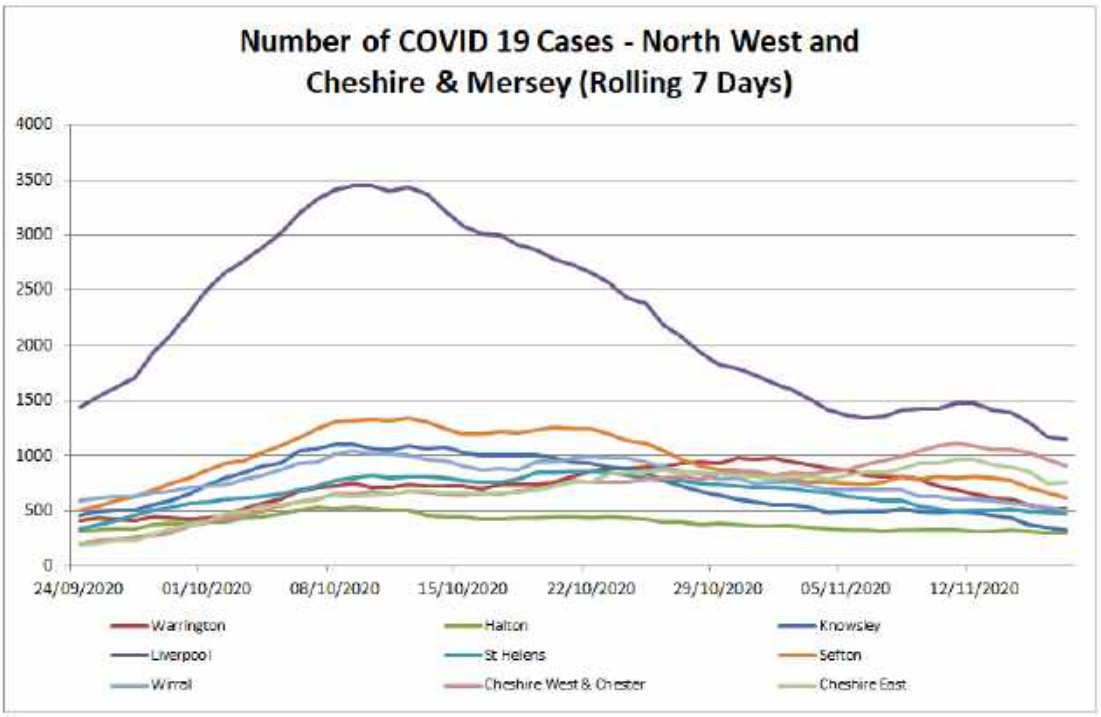


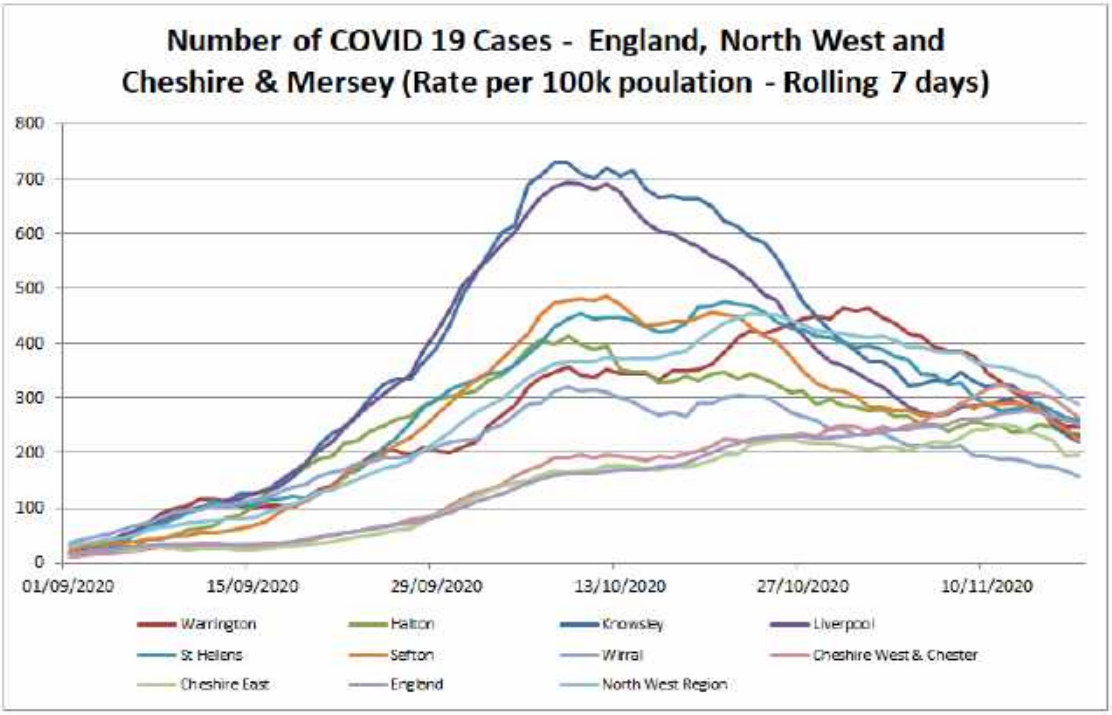




Narrative: As of 21/11/2020, there were 7,865 cases (from 5,179 on 24/10/2020) of confirmed COVID-19 reported in Warrington and 4,474 (from 3,184 on 24/10/2020) cases reported in Halton. There has been a sharp rise in cases over the last 8 weeks. The Trend is in line with Cheshire & Mersey and the North 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)

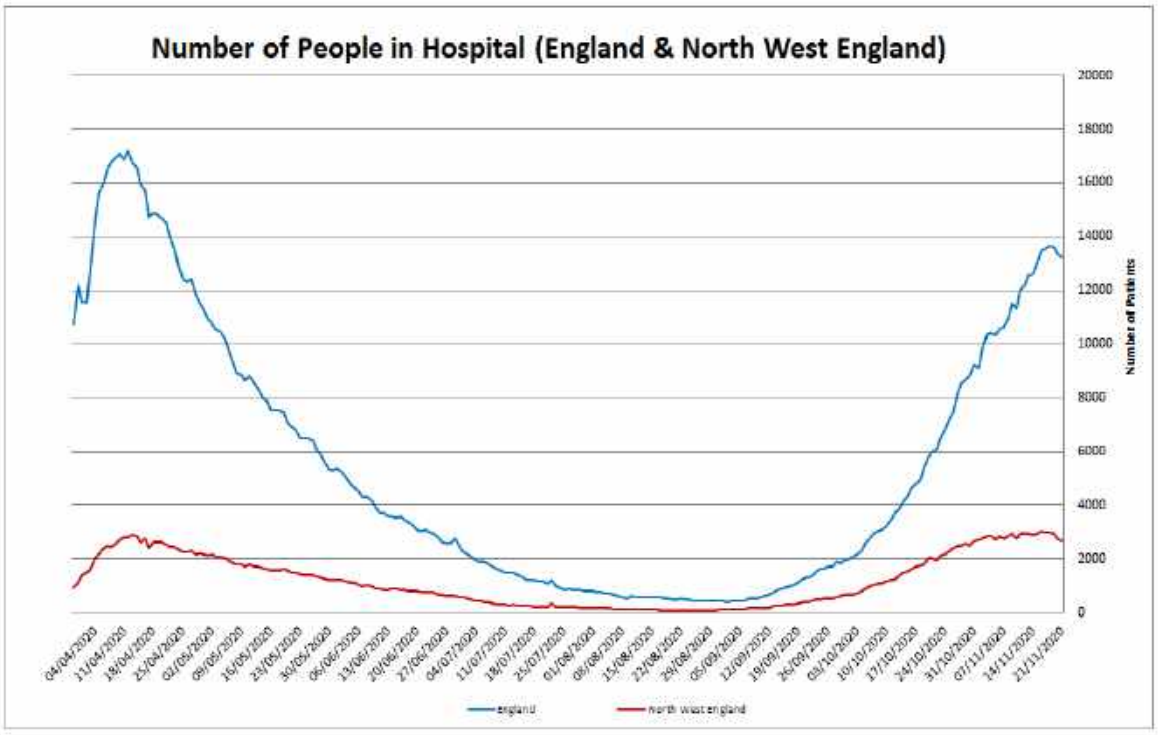


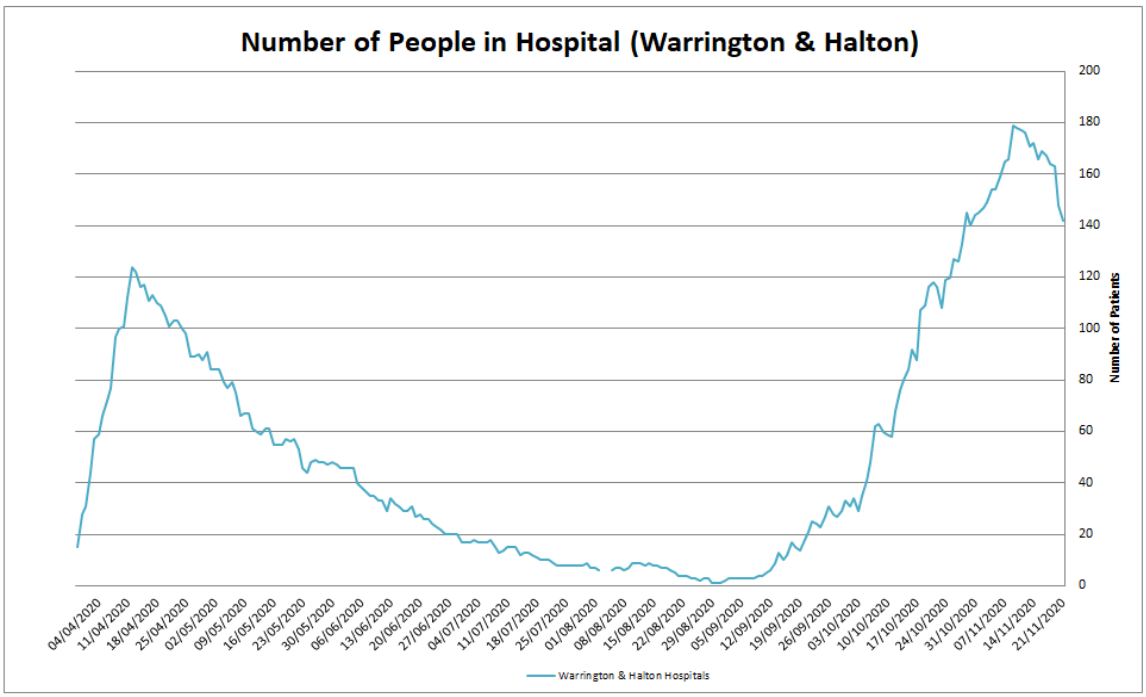


Narrative: The graphs show the infection count and rates per 100k population over a rolling 7 day period. This is a fairer comparison than total number of cases due to the different populations. The infection rate in Halton reduced in line with the North West and Cheshire and Mersey positions, however there was a slight lag in the reduction in the Warrington infection rate, however this has seen a reduction within the last 7 days.

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

2.3 Number of People in Hospital

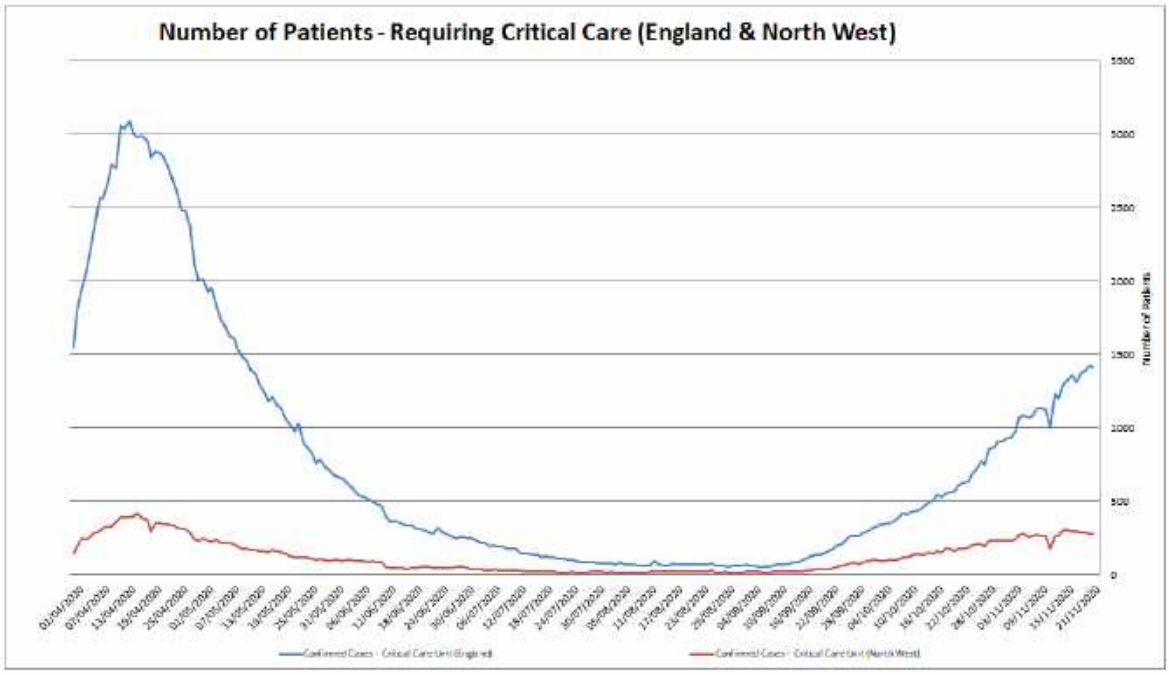


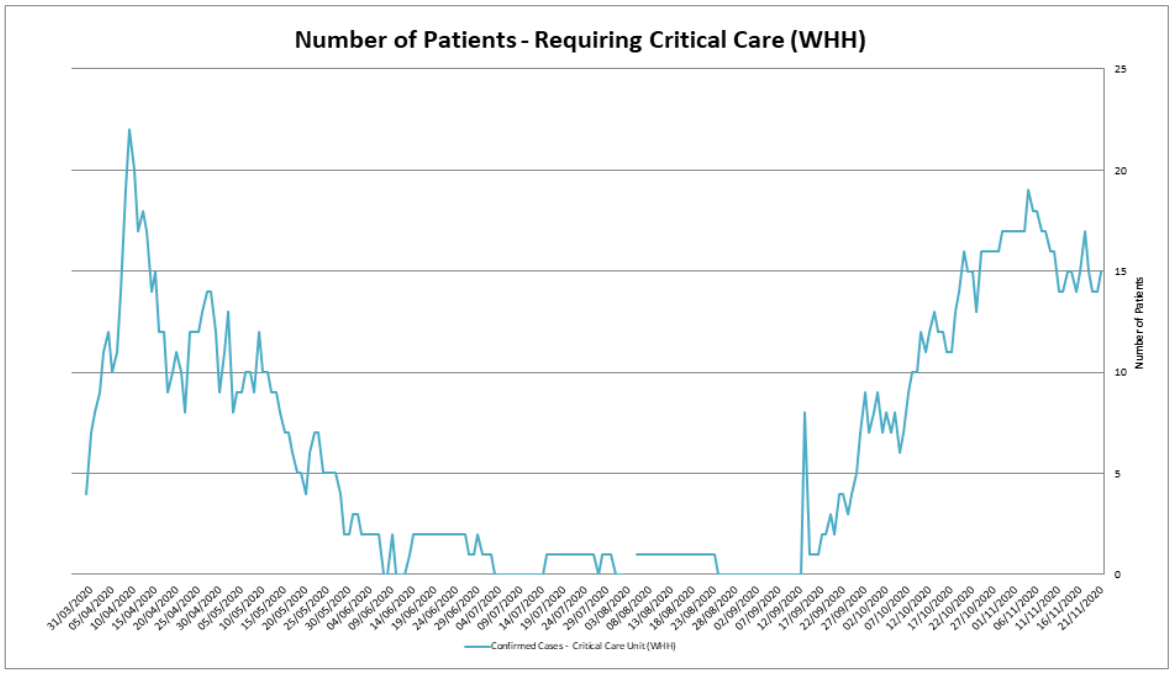


Narrative: As of 21/11/2020, there were 142 inpatients being treated by the Trust with confirmed COVID-19 (from 119 on 24/10/2020). On 26/10/2020 the Trust surpassed the peak of the first wave (on 12/04/2020 - 124 inpatients with confirmed COVID-19) The peak of wave 2 thus far has been 179 inpatients with confirmed COVID-19 on 09/11/2020. The increase is higher than the England and North West averages. 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

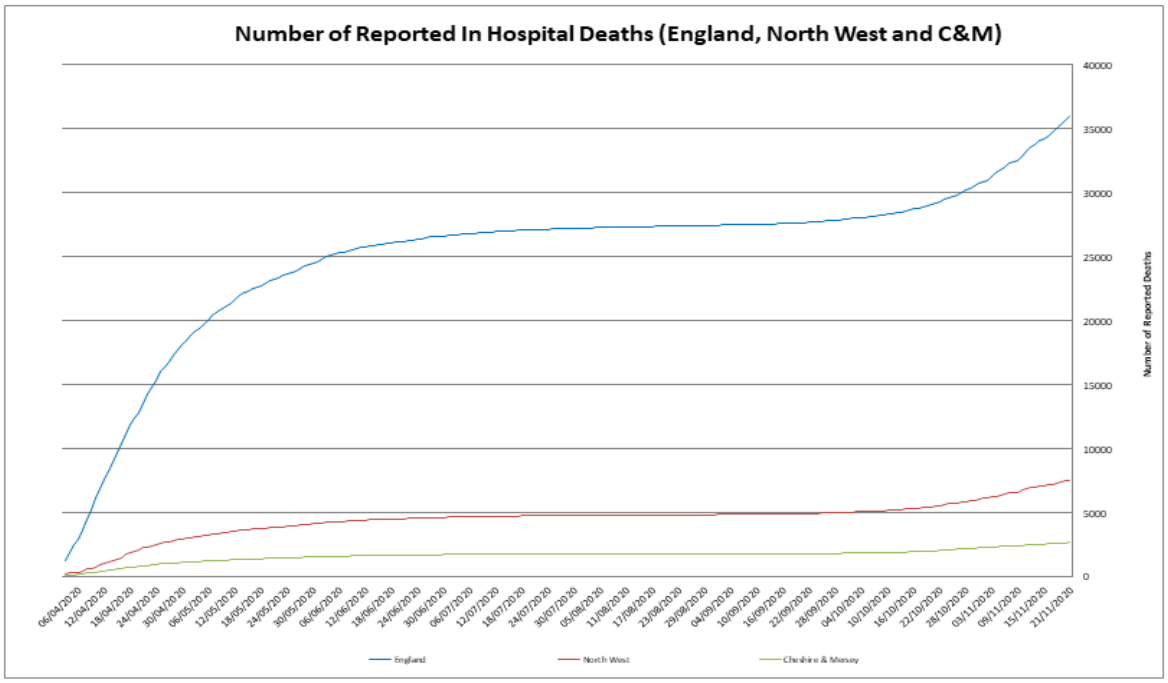


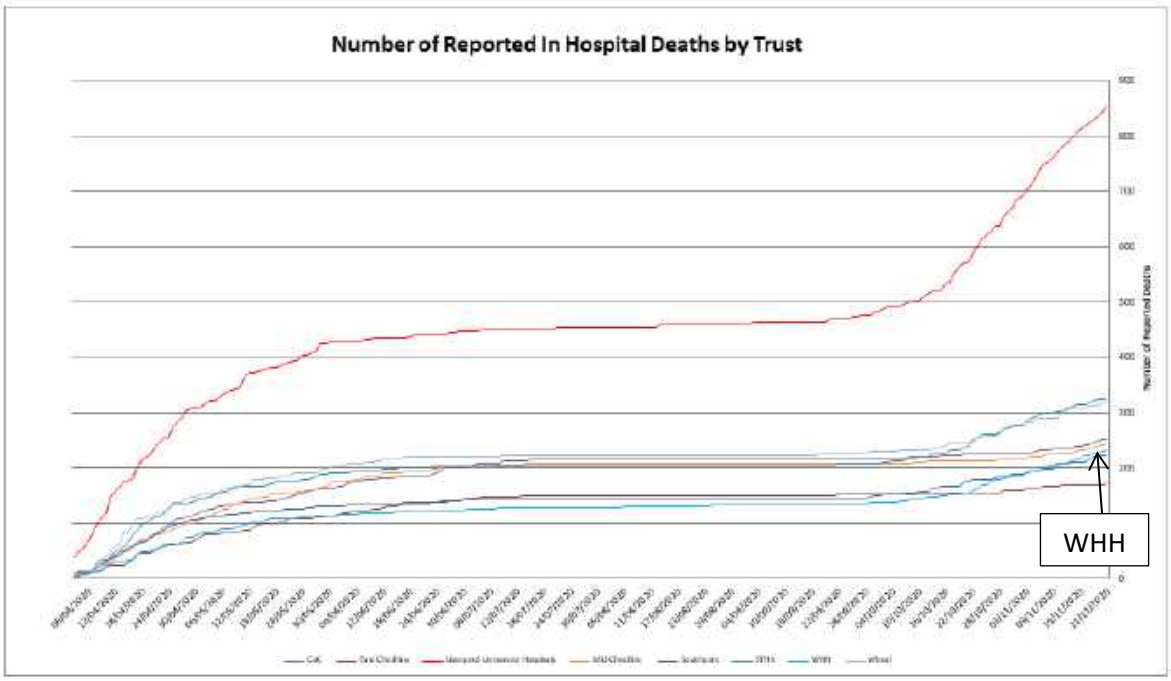


Narrative: As of 21/11/2020, there were 15 inpatients with confirmed COVID-19 and 0 inpatients with suspected COVID-19 in critical care (from 16 confirmed cases and 0 suspected cases on 24/10/2020). Positively, the Trust has not surpassed the peak of the first wave where there were 22 COVID-19 positive inpatients requiring critical care on 09/04/2020. However, the non-COVID-19 burden on critical care has been significant and WHH has been one of the most escalated trusts from a crictical 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



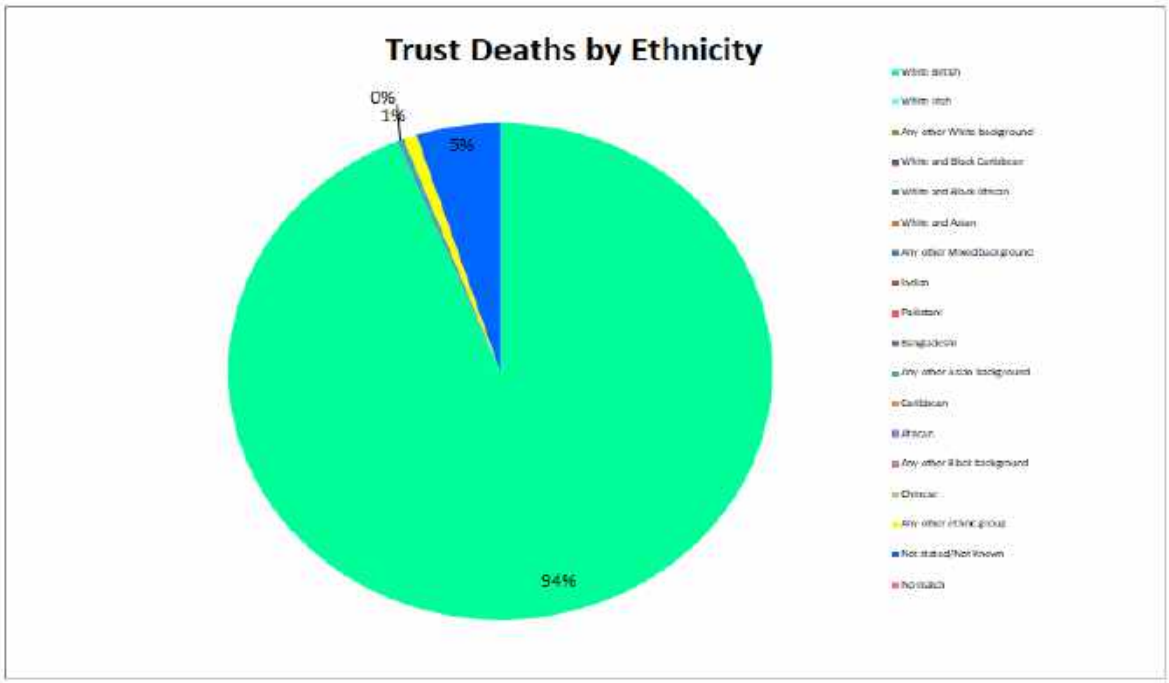


Narrative: As of 21/11/2020, the Trust had reported 241 deaths of inpatients with confirmed COVID-19 (from 176 on 24/10/2020). The trend is in line with the North West and Cheshire & Mersey positions. From April – October 2020, the Trust recorded 602 inpatient deaths in total (all causes). Between April – October 2019, the Trust recorded a total of 532 deaths (all causes).

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 Number of In Hospital Deaths (Ethnicity)

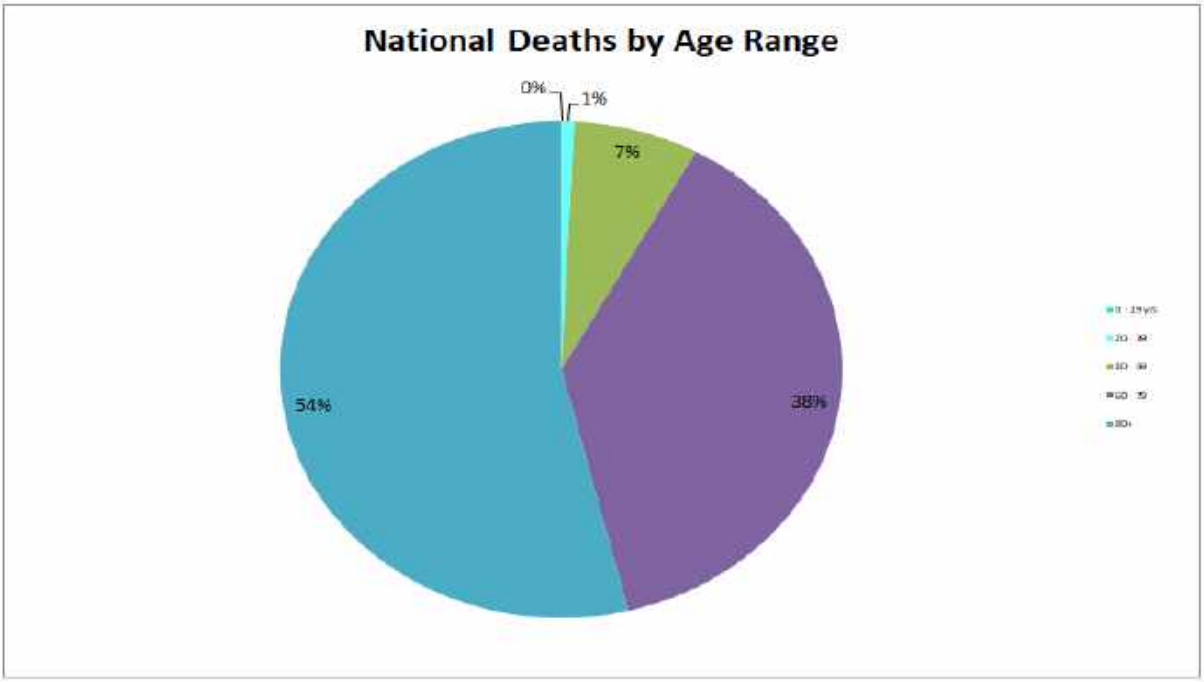


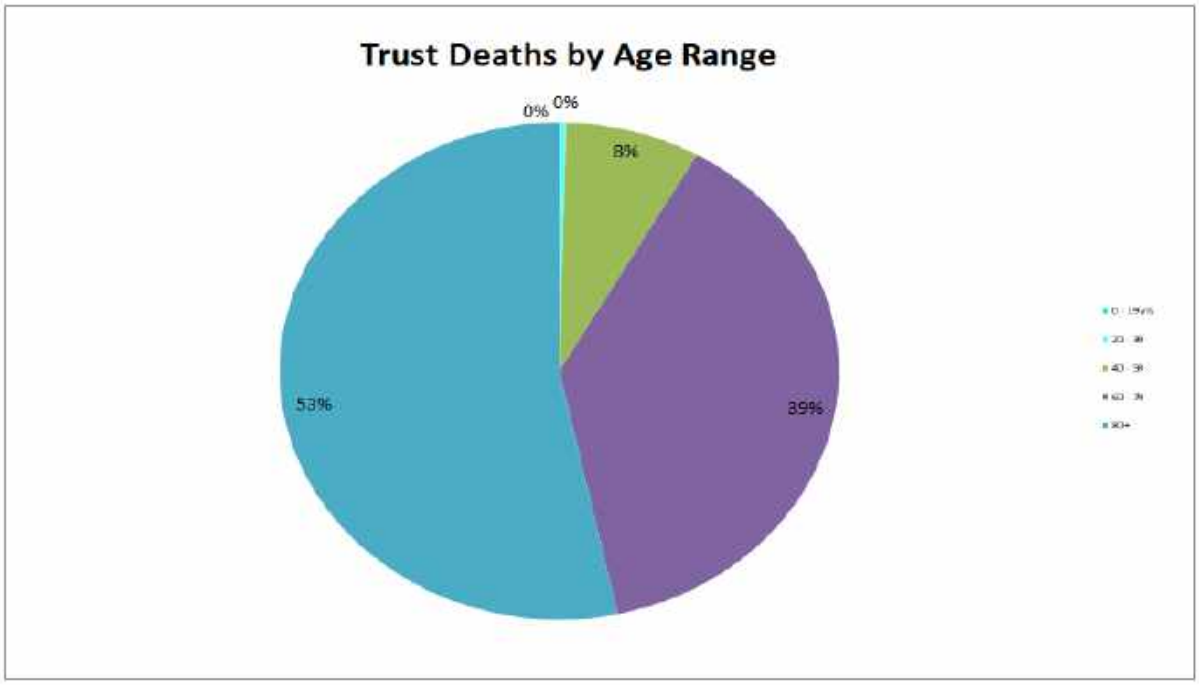
Narrative: As of 21/11/2020, 226 of the 241 reported deaths were patients who identified as "White British", with 12 patients' ethnicity "Not Stated/Not Known", 2 patients' ethnicity stated as "Any Other Ethnic Group" and 1 patient stated as "Asian" or "Asian British". The proportion of White British 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)

2.5.3 Number of In Hospital Deaths (Age Range)



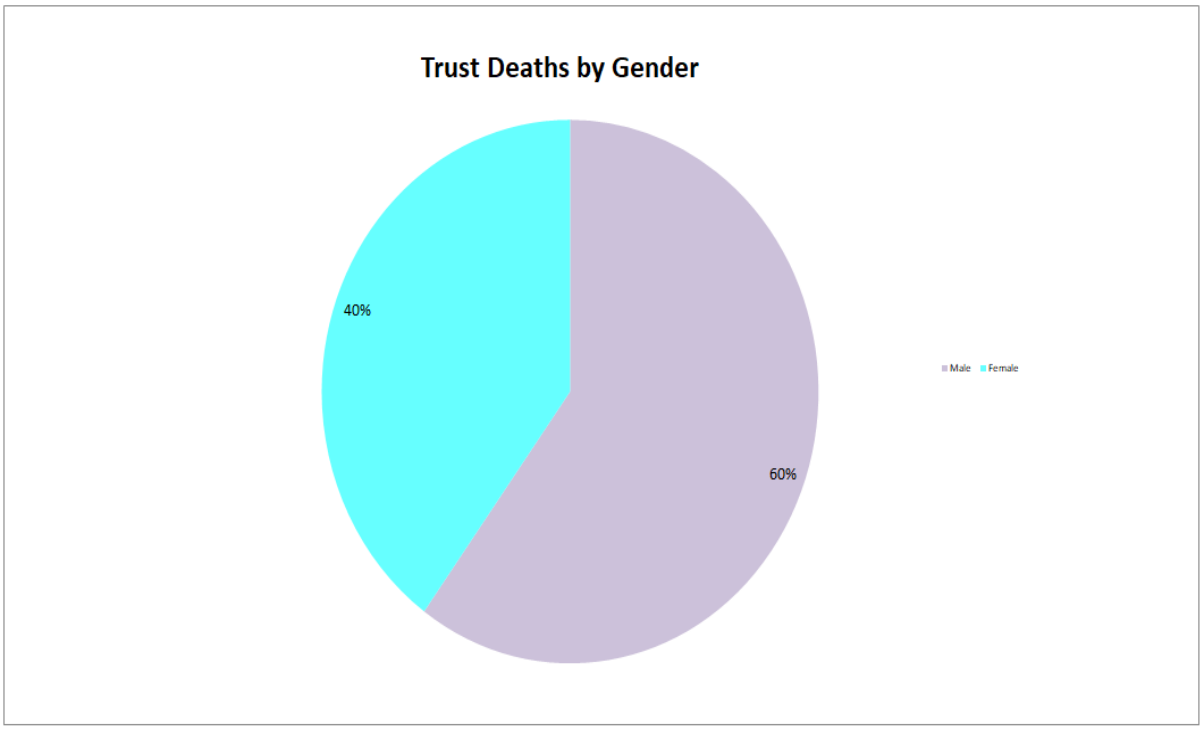


Narrative: As at 21/11/2020, 92.00% of COVID-19 related deaths were inpatients over the age of 60, which is line with the national position. The average age of death was 78 years.

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)

2.5.4 Number of In Hospital Deaths (Gender)

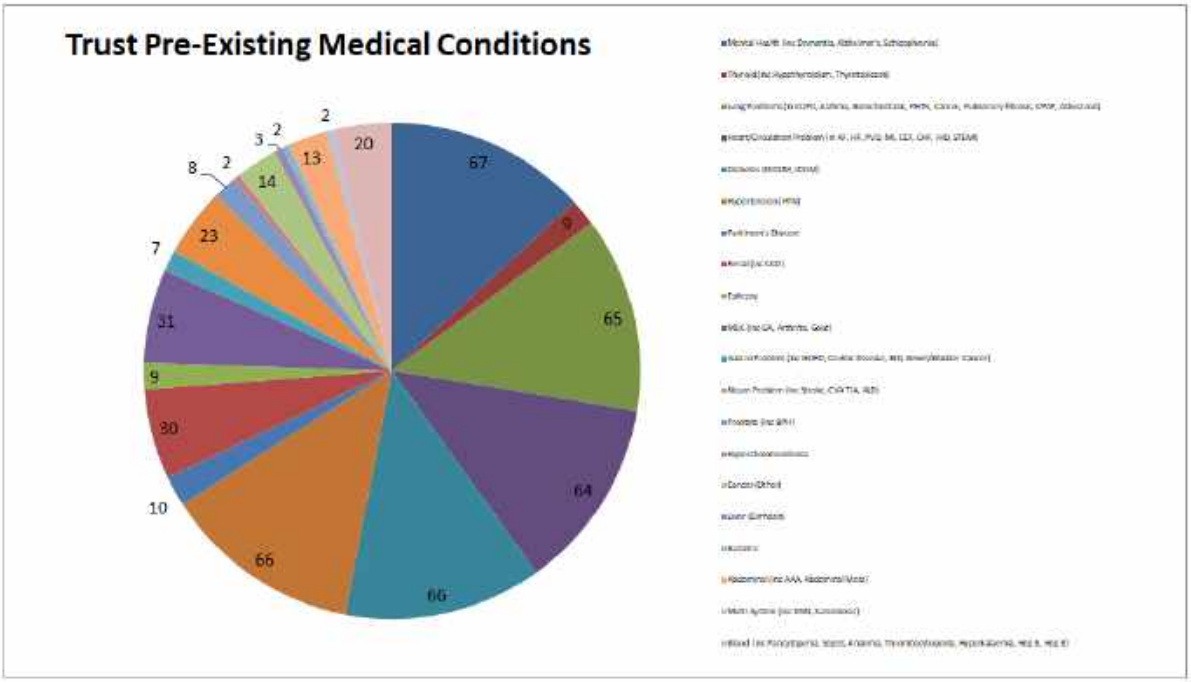


Narrative: As at 21/11/2020, 59.00% of COVID-19 deaths were male patients and 41.00% of deaths were female patients.

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)

2.5.5 In Hospital Deaths - Pre-Existing Medical Conditions



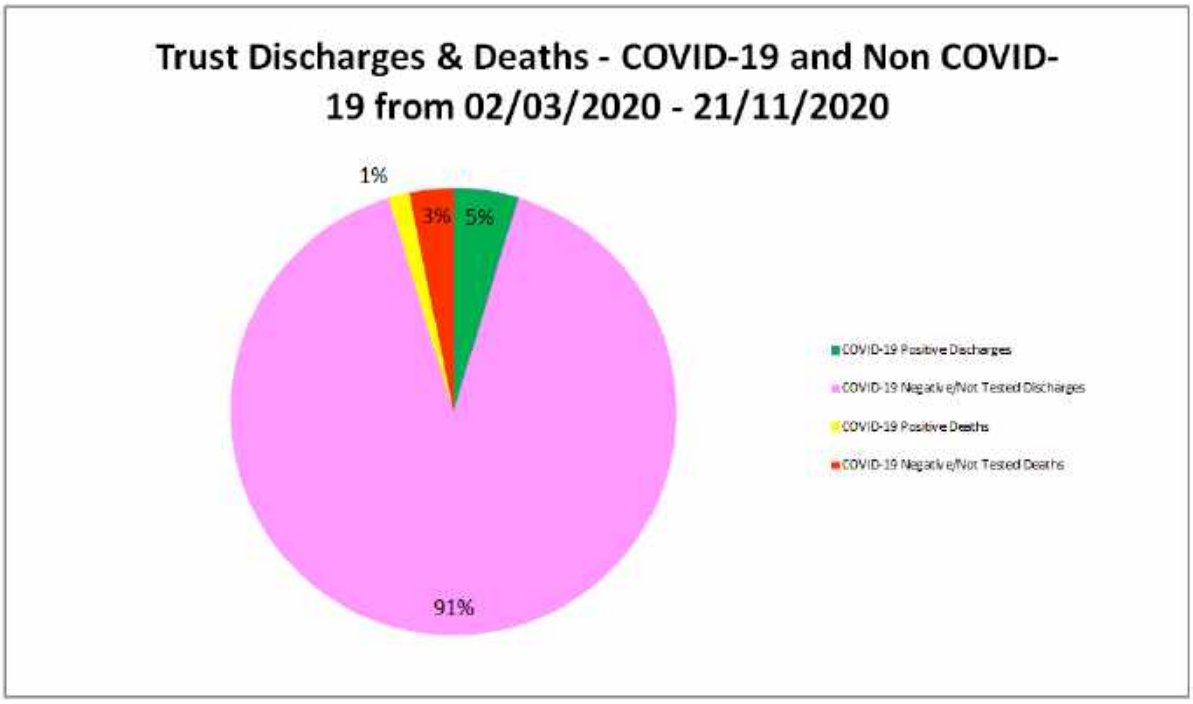
Narrative: As at 21/11/2020, 89.00% of Trust inpatients who have died as a result of COVID-19 had a pre-existing medical condition recorded. The most common of these were Heart and Lung conditions in additional diabetes and organic mental health conditions such as Dementia and Alzheimer's.

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

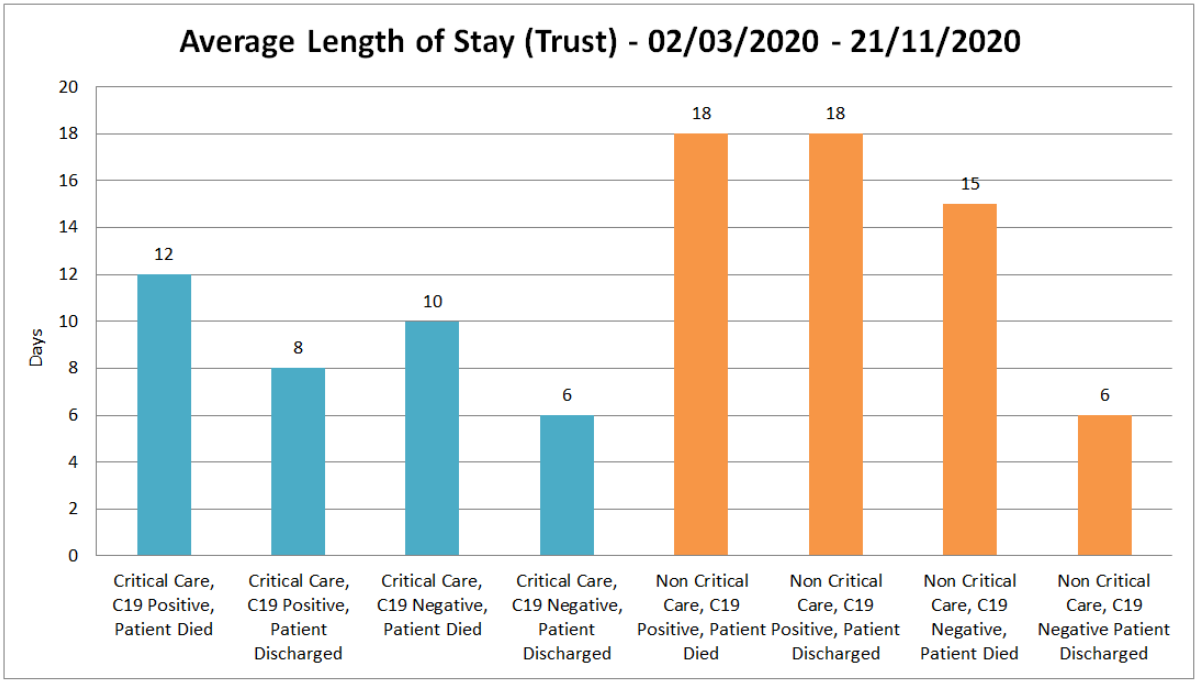


Narrative:

- Between 02/03/2020 – 21/11/2020, the Trust treated 16,137 inpatients (any patient with at least 1 night stay).
- 1004 (6.22%) inpatients had tested positive for COVID-19.
- 95.32% of all patients were discharged from hospital.
- There were a total of 754 inpatients (all causes) who have died, this represents 4.62% of all inpatients.
- 242 inpatient deaths were related to COVID-19 which represented 1.49% of all inpatients, 32.00% of all inpatient deaths and 24.10% of all inpatients who had tested positive for COVID-19.
- 61 patients who have died and who had tested positive for COVID-19 were admitted from a care home, 6.07% of all COVID-19 positive inpatients.

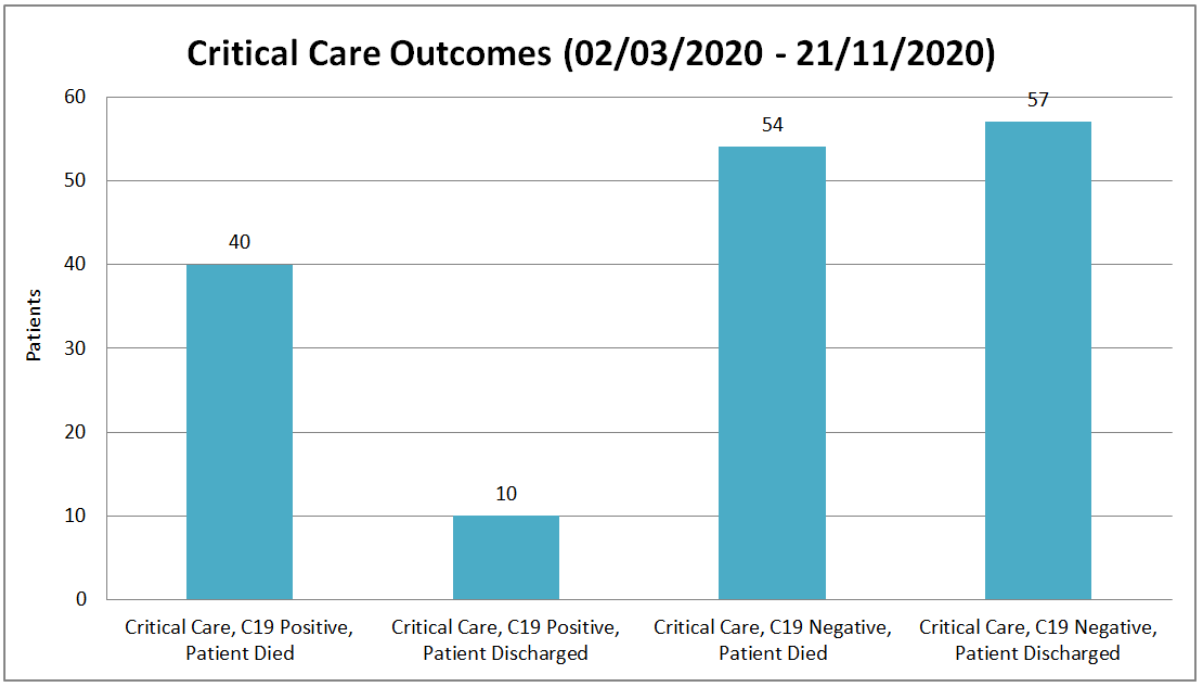
Source: Trust Data

2.6.1 Average Length of Stay



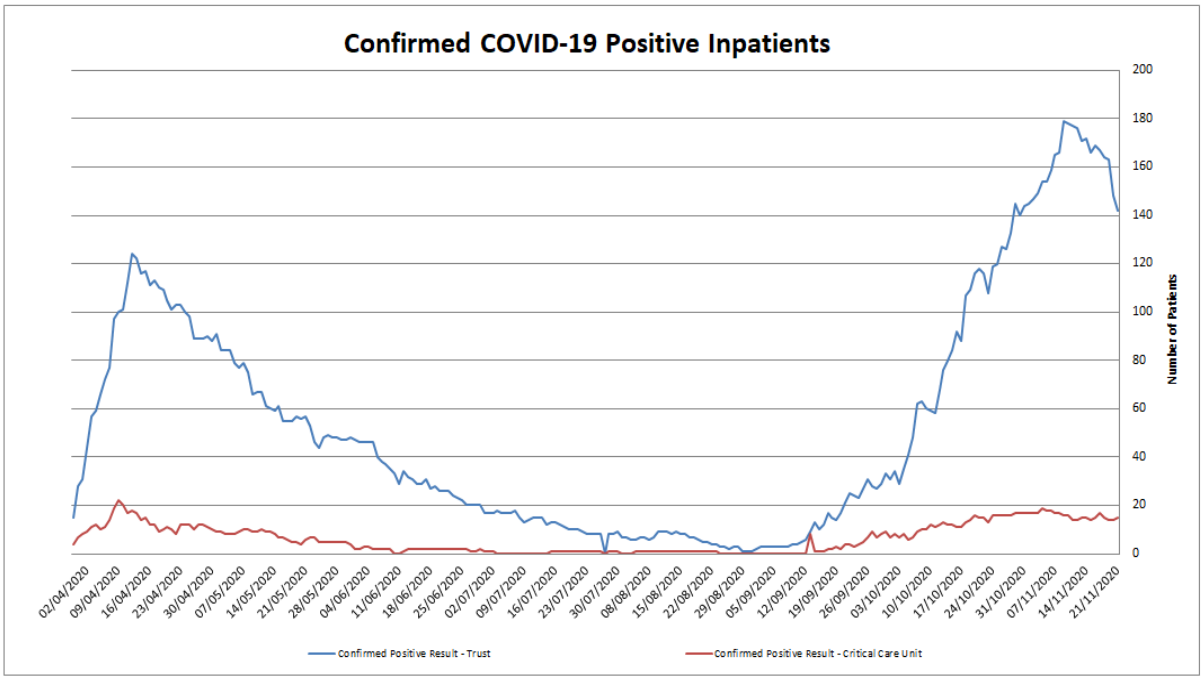
Narrative: From 02/03/2020 - 21/11/2020, the average length of stay for patients who had tested positive for COVID-19 was 14 days - 11 days in critical care, 18 days non-critical care.
Source: Trust Data

2.6.2 Critical Care Outcomes



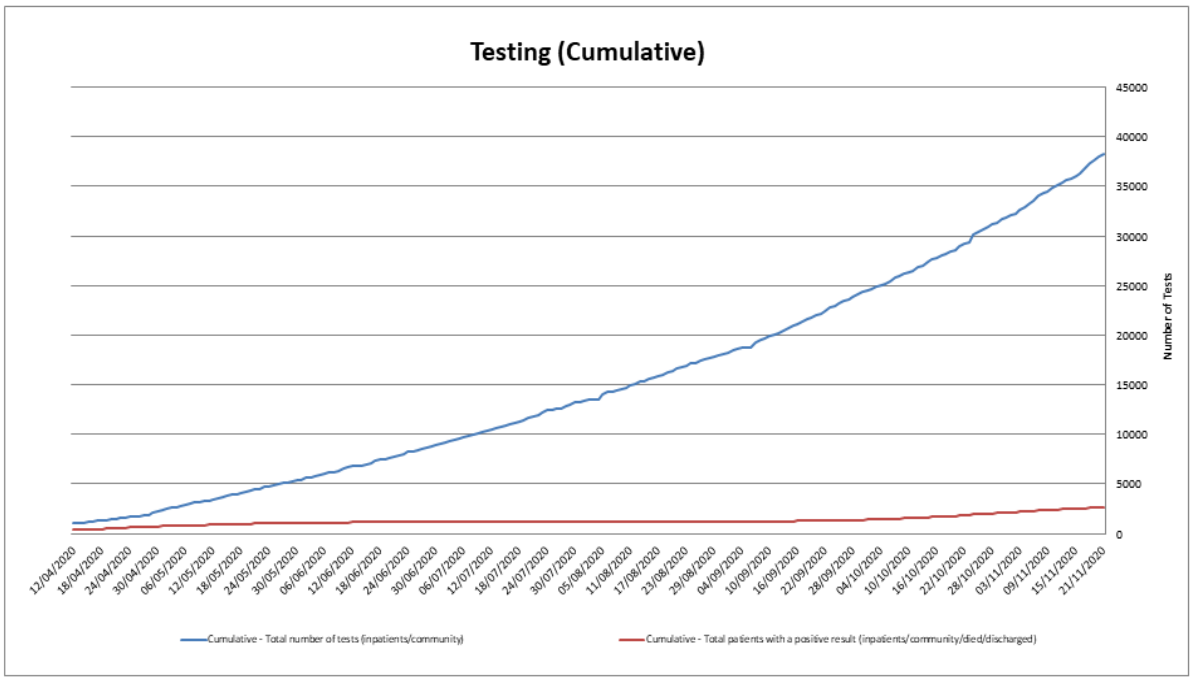
Narrative: From 02/03/2020 – 21/11/2020, there were 94 critical care inpatient deaths (40 COVID-19, 54 Non-COVID-19) and 67 critical care inpatient discharges (10 COVID-19, 57 Non-COVID-19).
Source: Trust Data

2.7 Confirmed Positive COVID-19 Patients



Narrative: As of 21/11/2020, there were 142 confirmed COVID-19 positive inpatients with 15 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 the with the national position.

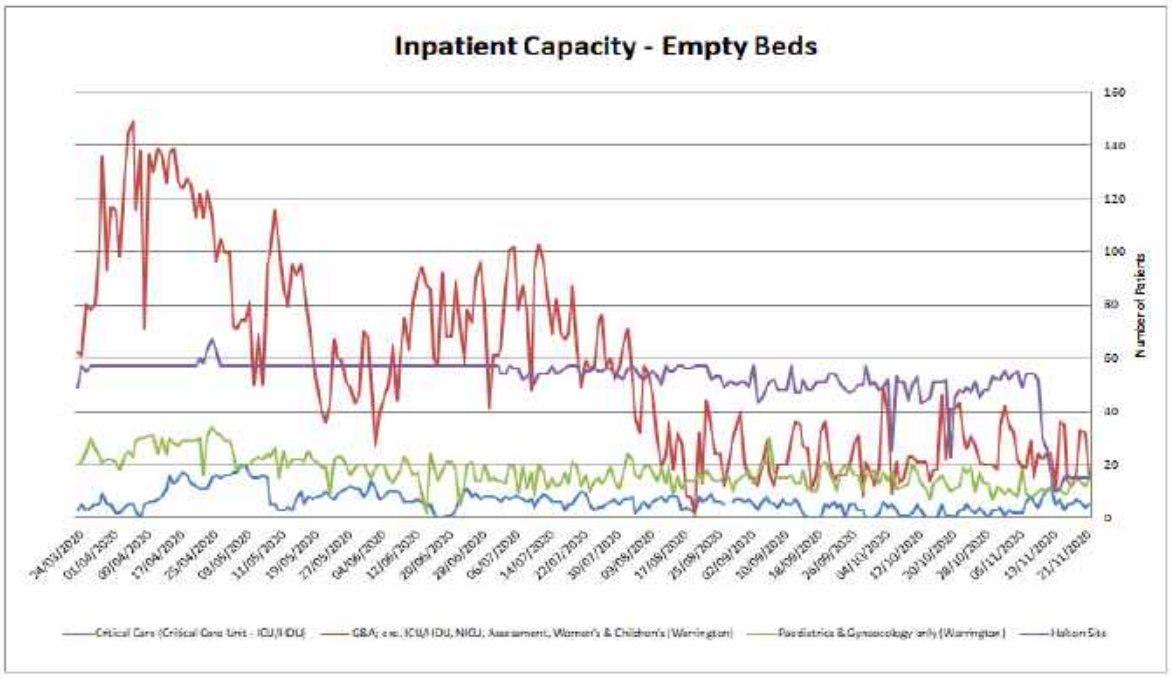
2.8 COVID-19 Testing



Narrative: As of 21/11/2020, 38,507 patients (inpatients & community) have been tested and 2,943 staff tests have been carried out (internally). Of the 38,507 patients tested, 2,684 (6.97%) patients have tested positive. Staff tests do not include the Asymptomatic Testing Pilot or ongoing Asymptomatic Testing.

Source: Trust Data

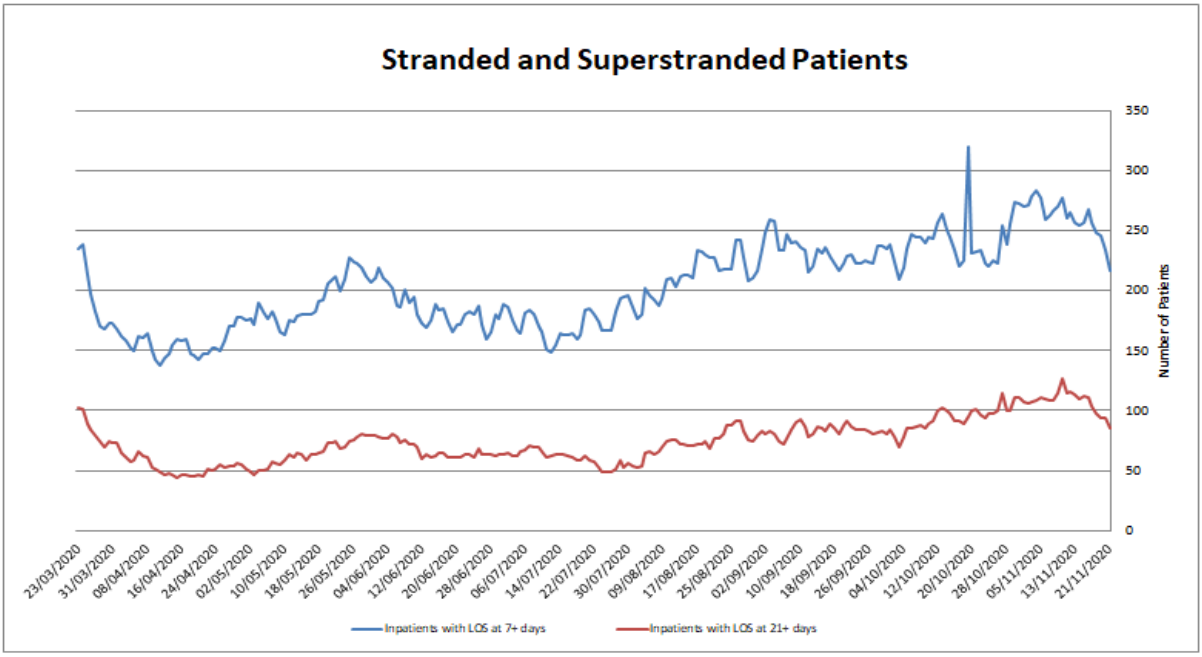
2.9 Capacity/Empty Beds



Narrative: There were 0 critical care beds available on 28/10/2020 which was the only day in the previous 4 weeks.

Source: Trust Data

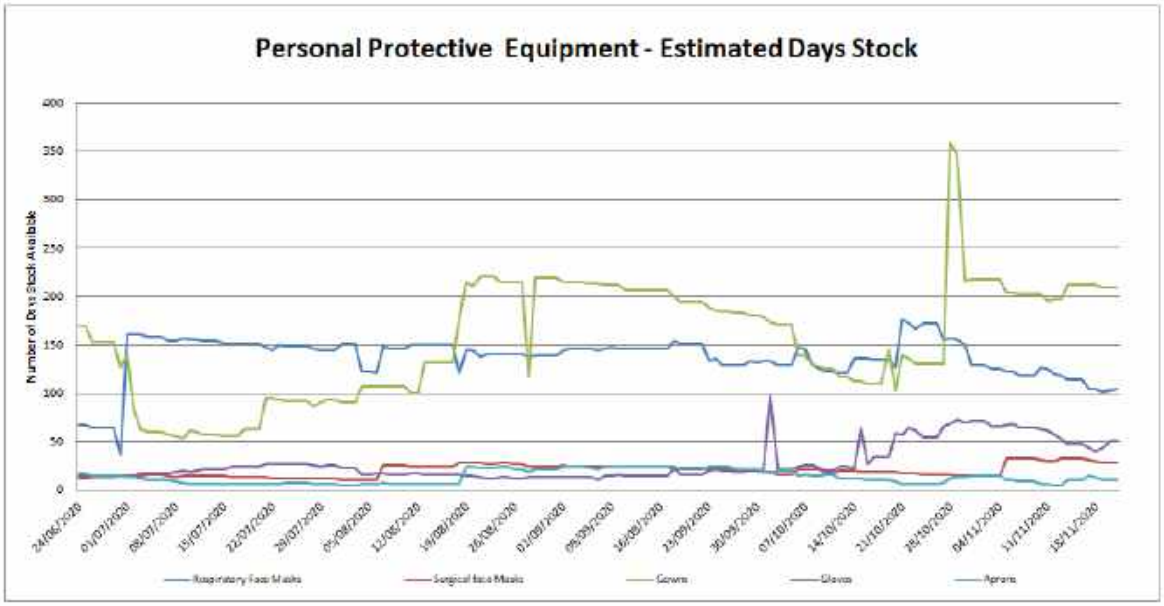
2.10 Stranded/Super Stranded Patients



Narrative: On 21/11/2020, there were 217 Stranded and 86 Super Stranded patients.

Source: Trust Data

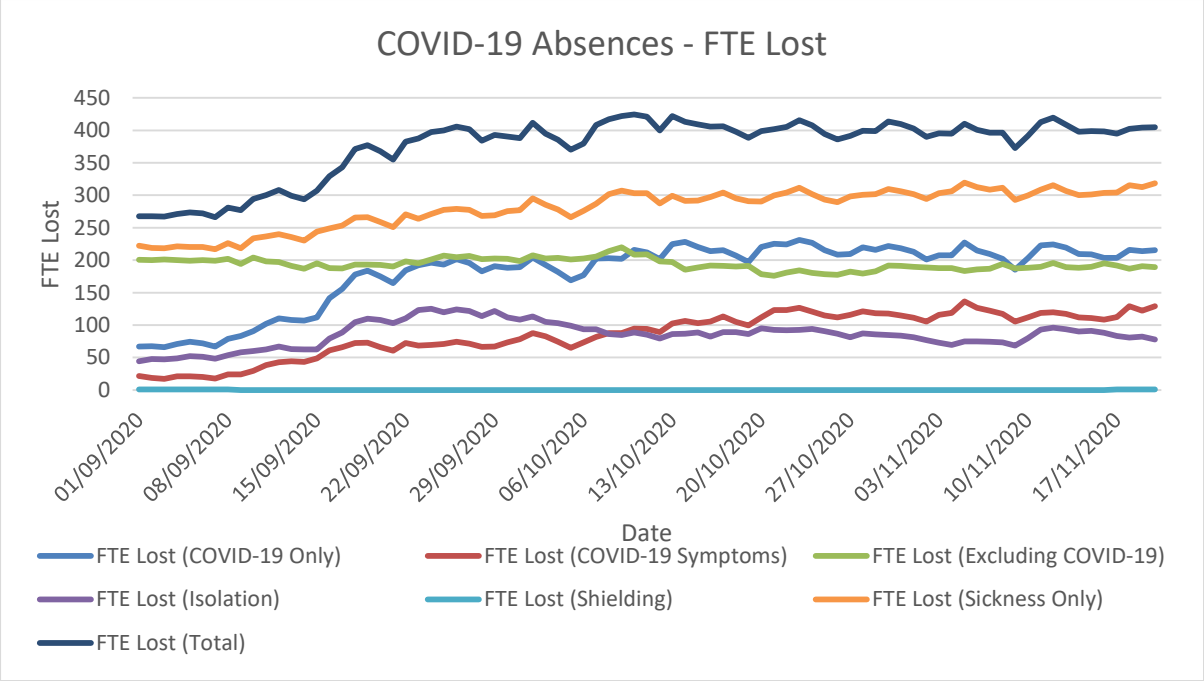
2.11 Personal Protective Equipment (Stock Days)

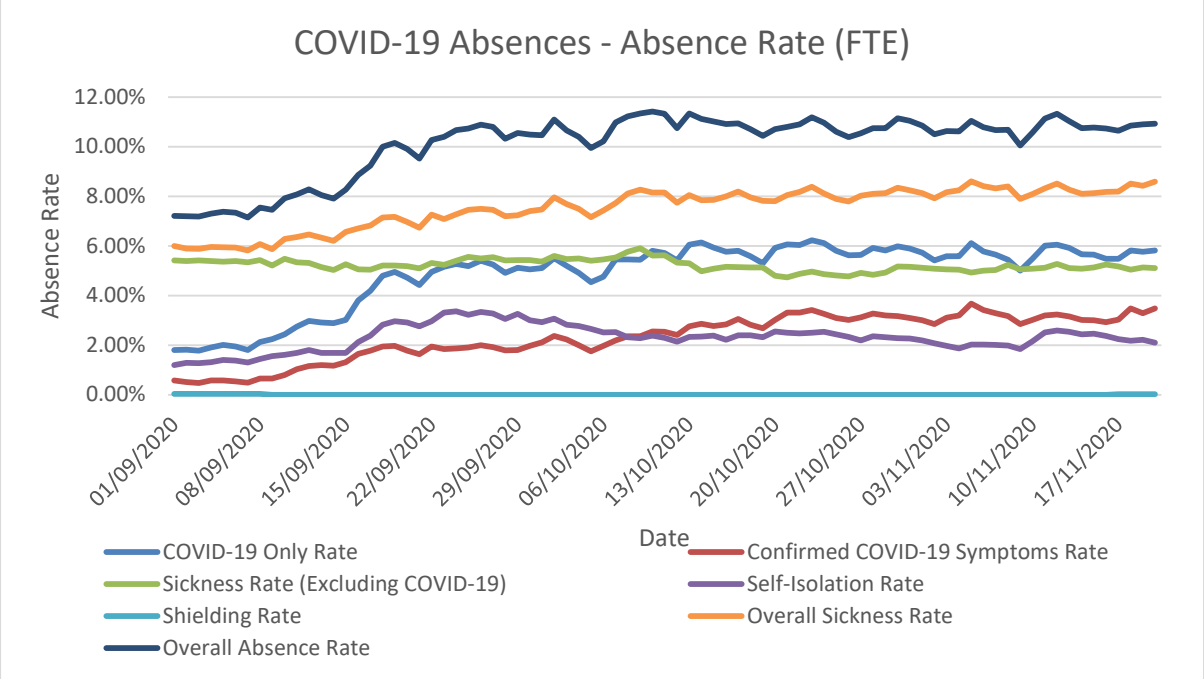


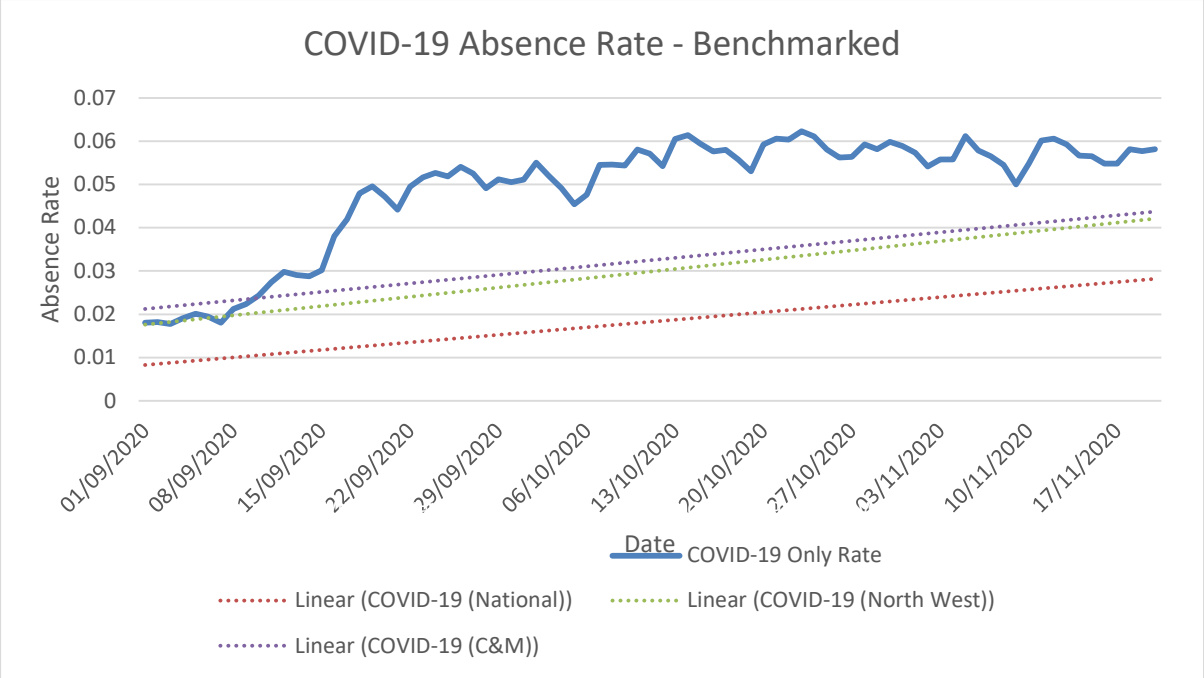
Narrative: The Trust closely monitors PPE stock on a daily basis and any concerns are escalated regionally and nationally. Between 24/10/2020 – 21/11/2020, the minimum stock levels of PPE was 5 days (Aprons) on 12/11/2020.

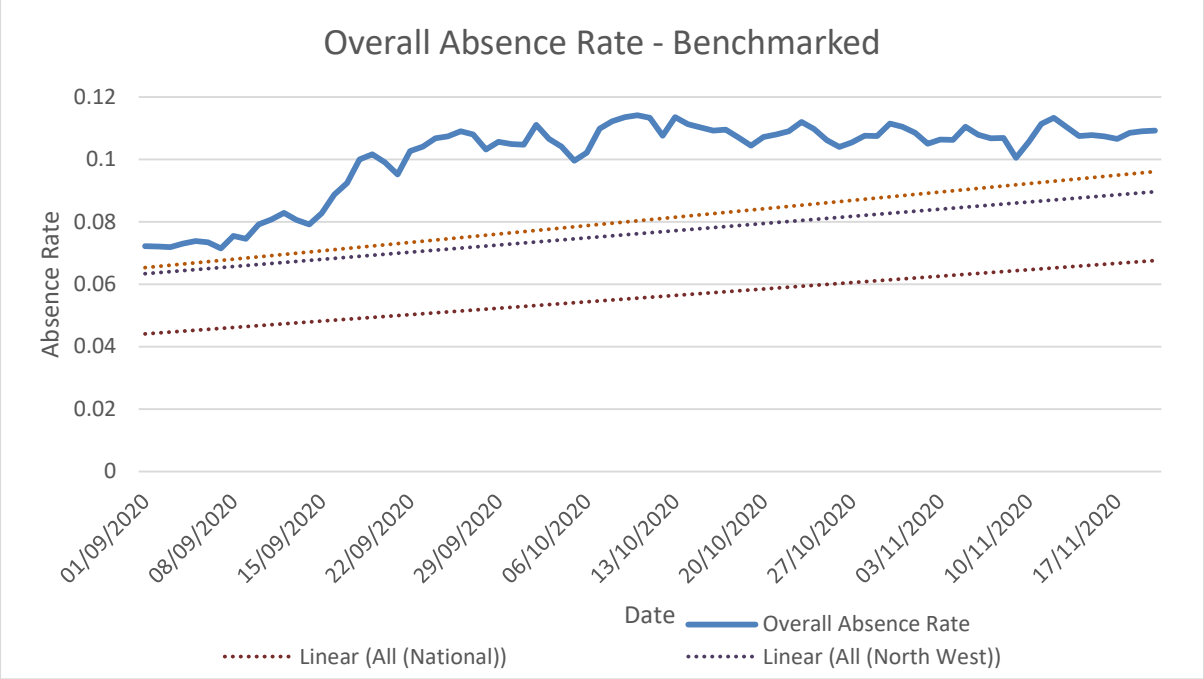
Source: Trust Data

2.12 Staff Sickness





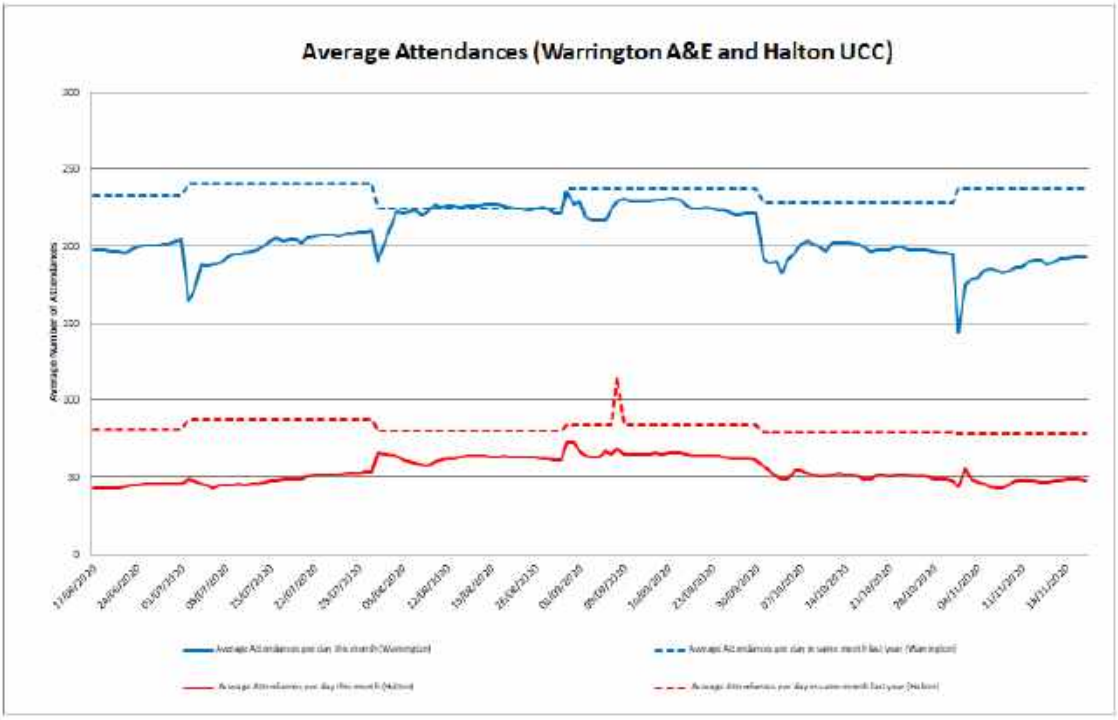


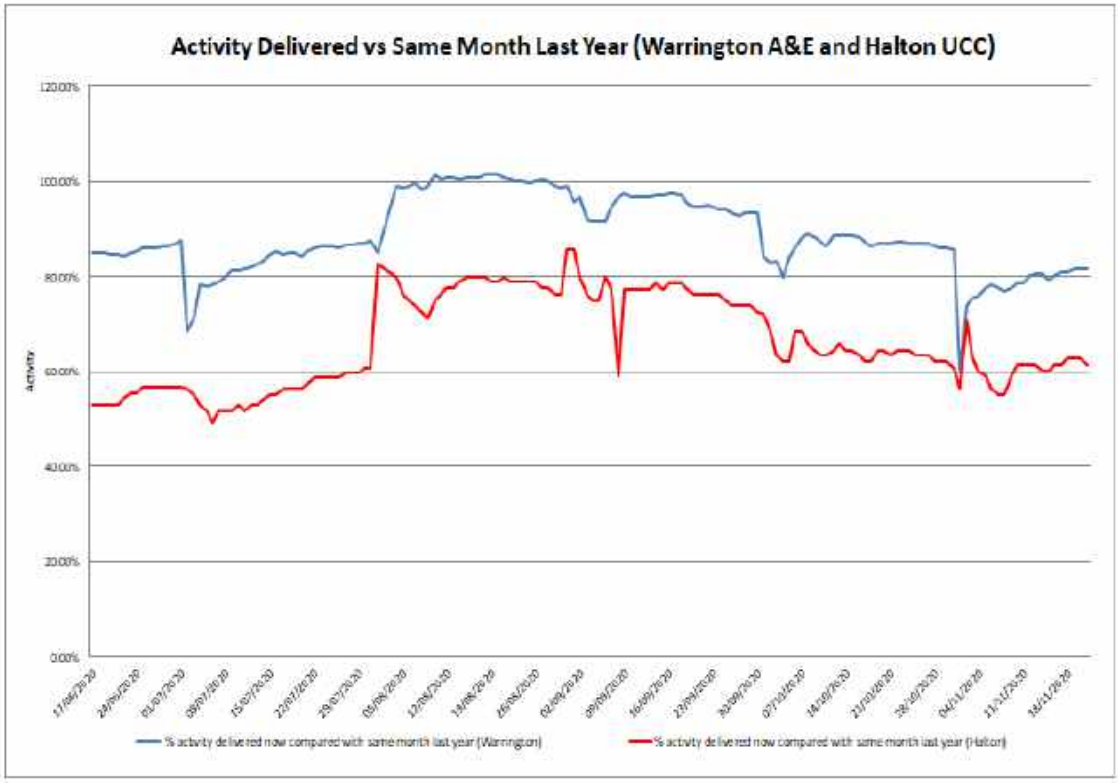


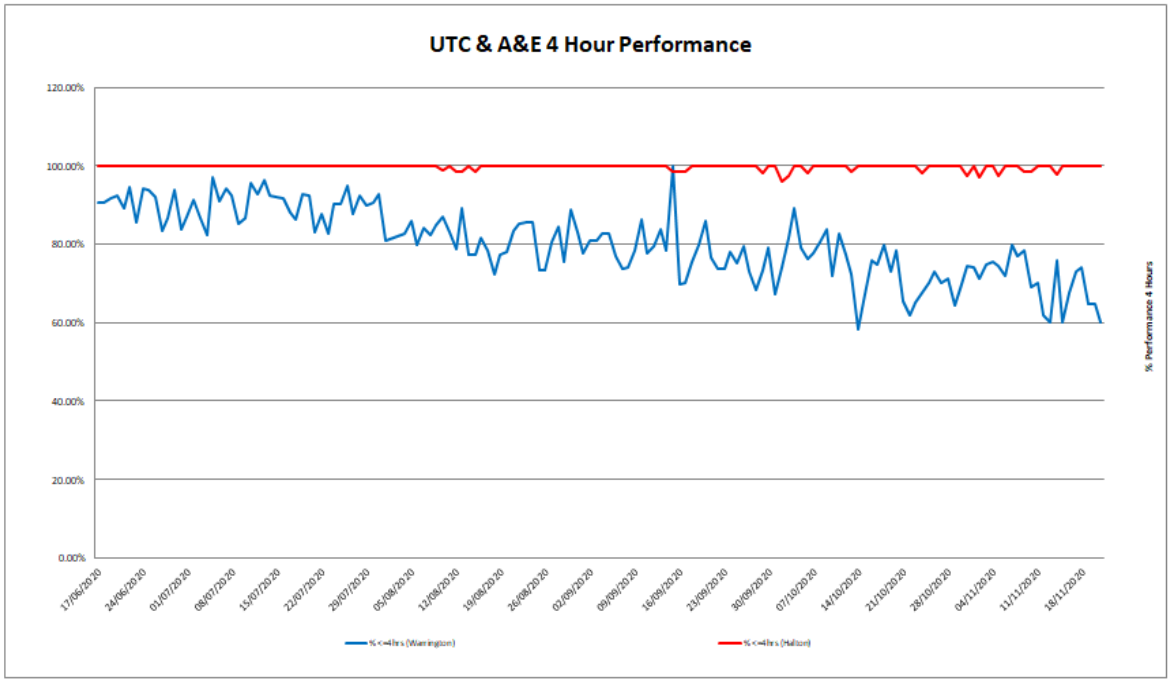
Narrative: Non COVID-19 related sickness absence has increased to 5.1%. COVID-19 related sickness absence has increased to 3.5%, an increase of 0.2% (20/11/2020). There has been an reduction in the number of staff isolating from 149 FTE to 99 FTE. The Trust continues to support those staff shielding back into the workplace when Risk Assessments are approved.
Nationally absences are increasing, COVID-19 absence rate (sickness and isolation/shielding) is 3.1%, 3.8% in the North West and 3.89% in Cheshire & Mersey compared to a Trust rate of 5.8%.

Note: The Walton Centre and The Clatterbridge Centre are included in the C&M averages, these specialist Trusts have low absence rates, reducing the whole C&M average.
Source: Trust Data

2.13 Urgent Care

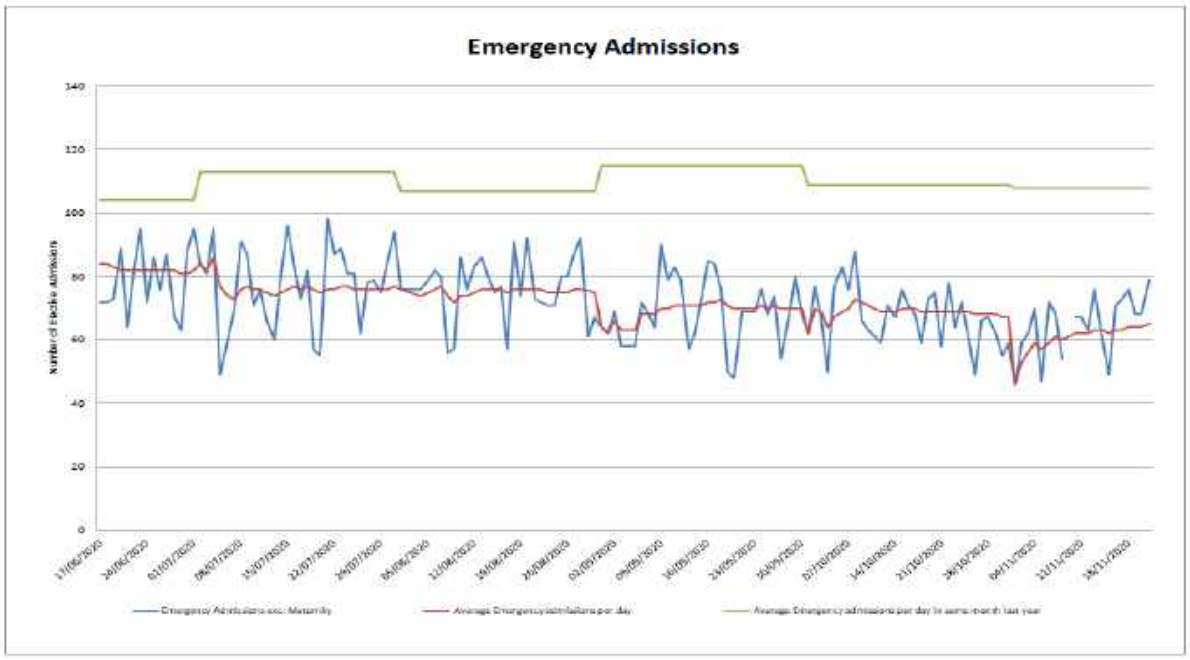






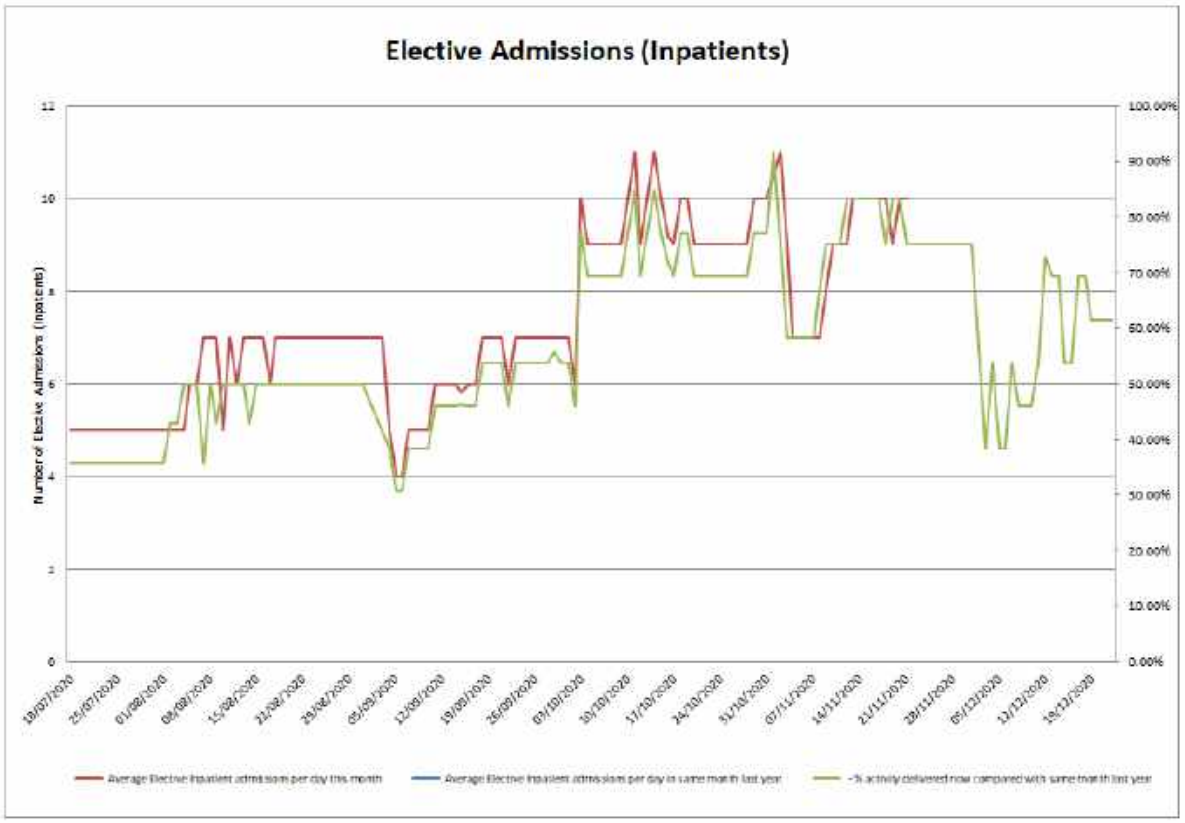
Narrative: Activity in November 2020 in Warrington A&E has averaged c80.00% of activity in November 2019. Activity in November 2020 at the Halton UTC has averaged c61.00% of activity in November 2019.
Source: Trust Data

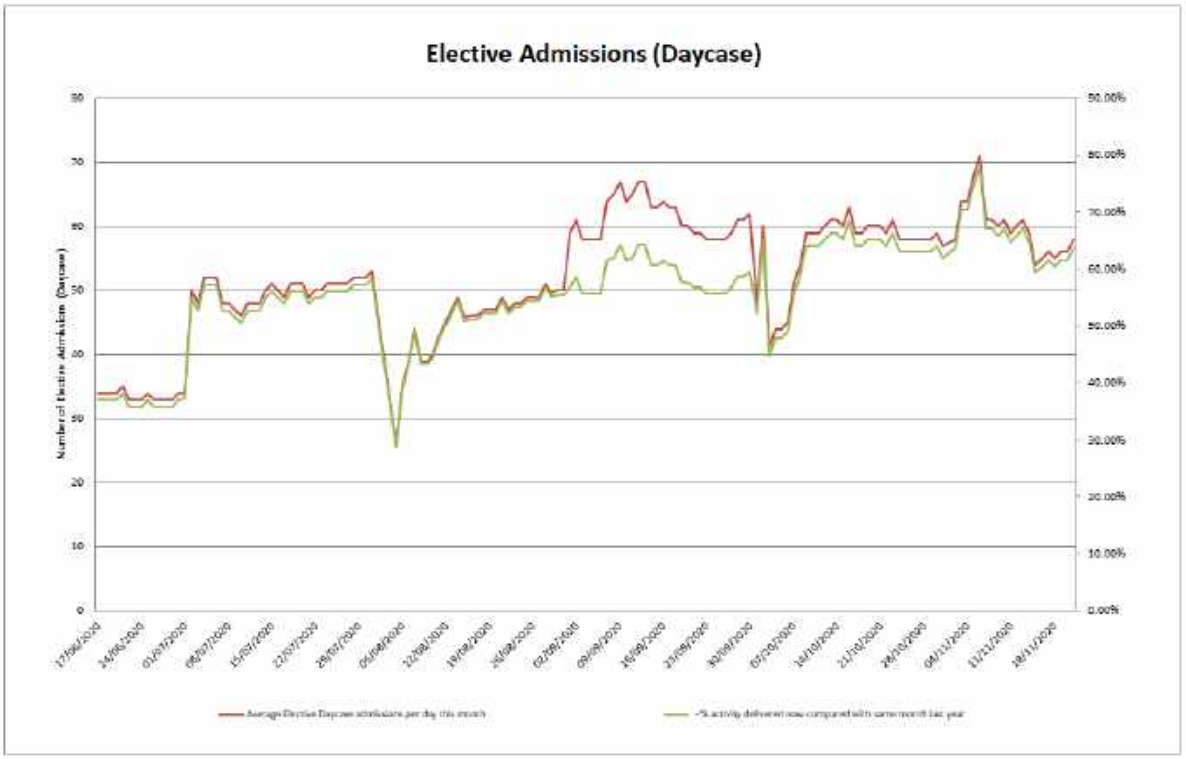
2.14 Emergency Admissions



Narrative: The average number of emergency admissions in November 2020 was c53.00% of the average number of emergency admissions in November 2019.
Source: Trust Data

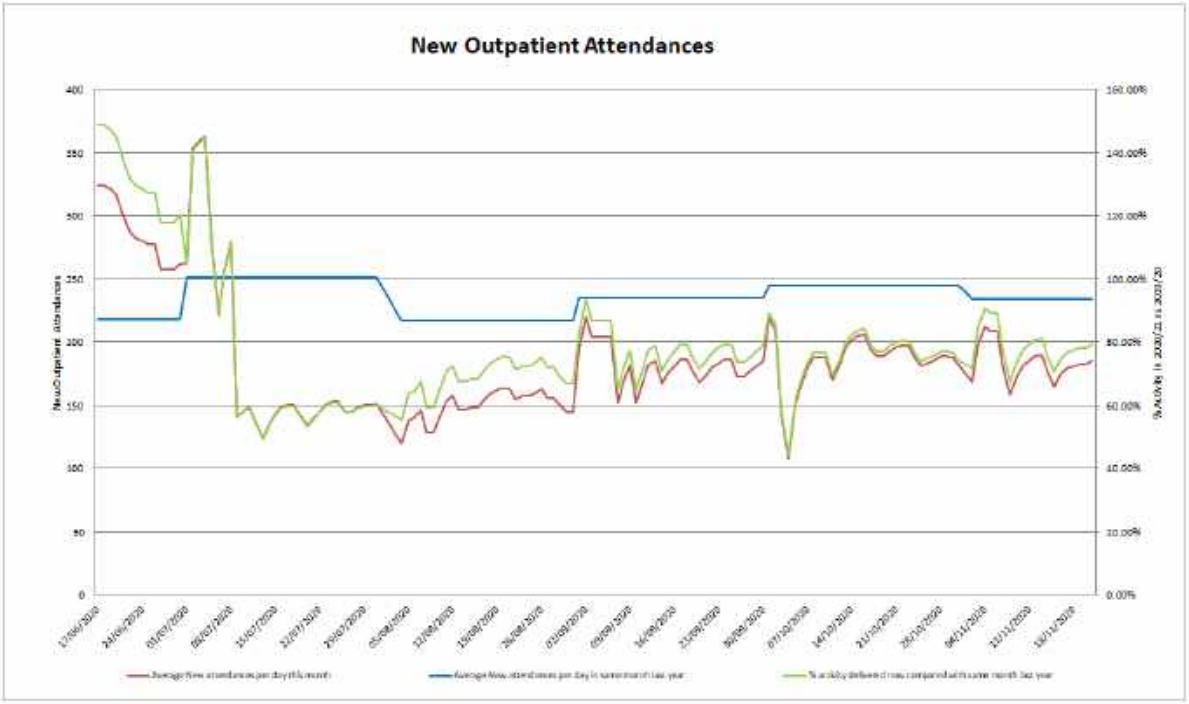
2.15 Elective Admissions

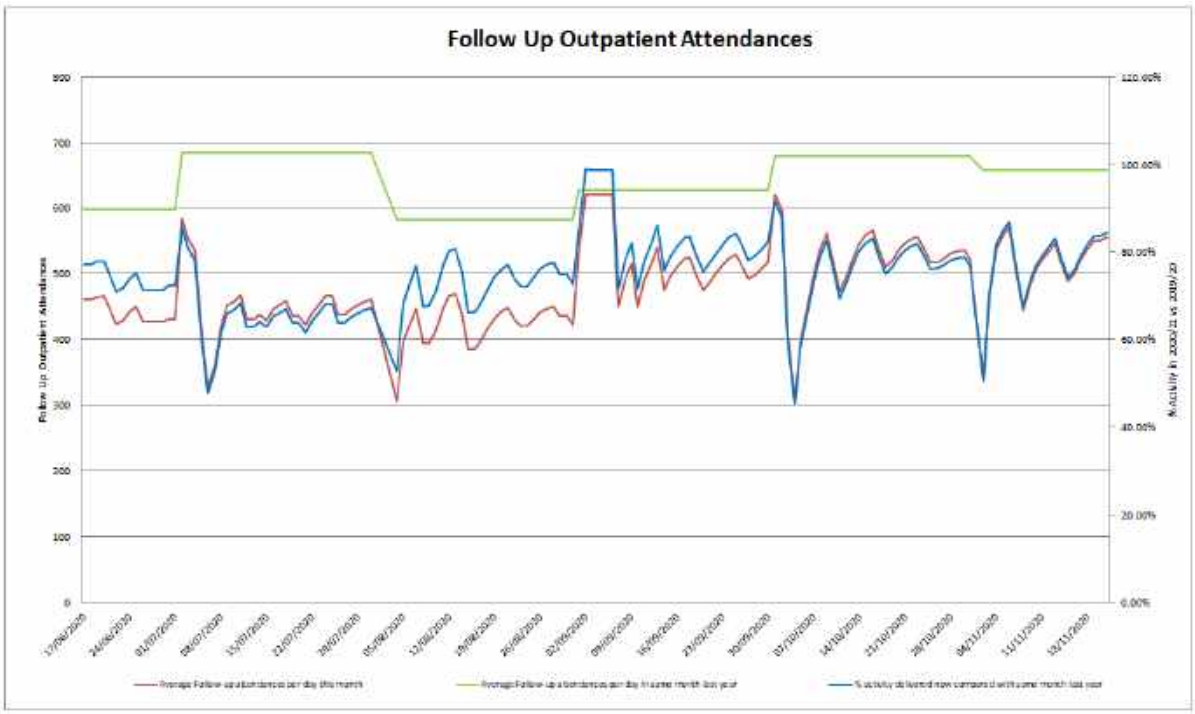




Narrative: The average number of elective inpatient admissions in November 2020 was c57.00% of the average number of elective inpatient admissions in November 2019.
The average number of elective daycase admissions in November 2020 was c62.00% of the average number of elective daycase admissions in November 2019.
Source: Trust Data

2.16 Outpatient Attendances





Narrative: The average number of new outpatient attendances in November 2020 was c75.00% of the average number of new outpatient attendances in November 2019.

The average number of follow up outpatient attendances in November 2020 was c75.00% of the average number of follow up outpatient attendances in November 2019.

Source: Trust Data

3. CONCLUSION

The Executive Team will continue to monitor this data on a daily basis 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/20/11/117	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	25th November 2020	
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 October as follows: **Red: 26 (from 29 in September)** **Amber: 10 (from 11 in September)** **Green: 25 (from 24 in September)** **Not RAG Rated: 11 (from 8 in September)** 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 the 28 day faster diagnostic standards. Prior to COVID-19, the Trust had consistently met these standards. The Trust has established robust recovery plans in line with the Phase 3 planning guidance and clinical prioritisation is in place to address this, 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. Falls, Pressure Ulcers and Healthcare Acquired Infections continue to be monitored and action is taken to address any concerns as they arise. The financial plan for October to March assumes R=1. During October, £1.1m of Wave 2 COVID-19 costs were incurred. These were offset by underspends on recovery plans and a non-recurrent income receipt. The financial position is a £0.8m deficit against a plan of £0.7m deficit. Should R continue to be over 1, it is anticipated that additional costs of c£1.0m per month will be incurred that are not within plan. It is anticipated that guidance will be issued to formally revise the financial forecast. As at 31 October 2020, the cash balance was £22.4m.			
PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the contents of this report. 2. Approve the decrease of the capital plan from £26.3m to £26.0m due to adjustment to the critical care funds. 3. Approve the increase in the contingency budget due to underspend. 4. Note the SeraSep scheme approved as an emergency by the Chief Finance Officer & Deputy Chief Executive. 5. Approve the additional capital schemes outlined in Table 3 to be funded from the revised contingency.			
PREVIOUSLY CONSIDERED BY:	**Committee**			
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	**AGENDA REF:**	BM/20/11/117

1. BACKGROUND/CONTEXT

The RAG ratings for all 72 IPR indicators from November 2019 to October 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

	September	October
Red	29	26
Amber	11	10
Green	24	25
Not RAG Rated	8	11
Total:	72	72

Due to the validation and review timescales for Cancer, the RAG ratings on the dashboard for these indicators are based on September's validated position. VTE is reported as a quarterly position and is therefore not RAG rated in month.

Due to the impact of COVID-19, 9 indicators cannot be RAG rated in month as the data is not available or not reportable. These are:

Quality

- Friends & Family Test (Inpatients & Daycases) – the FFT has been suspended nationally.
- Friends and Family Test (ED & UCC) – the FFT has been suspended nationally.

Access & Performance

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

Finance

- Use of Resource Rating – UoR rating is not currently reportable. The Trust is awaiting further guidance from NHSE/I.
- CIP x 3 (In Year, Recurrent & Plans in Progress) – CIP was suspended nationally during the pandemic.
- 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 October, reduced from 4 in September.

The 3 indicators rated Red in September, which have remained rated Red in October are as follows:

- Incidents - There were 27 open incidents over 40 days old at the end of October, a deterioration from 20 incidents at the end of September, 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.
- Complaints - There was 1 complaint open over 6 months at the end of October, an improvement from 2 open complaints at the end of September, against a target of 0.

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

- Mixed Sex Accommodation Breaches – there were 0 breaches in October, an improvement from 9 breaches in September, against a target of 0.

Access and Performance

Access and Performance KPIs

There are 13 Access and Performance indicators rated Red in October, decreased from 17 in September, this includes 2 indicators where data was unavailable in October. Performance against Access & Performance indicators has been significantly impacted by the COVID-19 pandemic.

The 13 indicators which were rated Red in September and remain rated Red in October are as follows:

- Diagnostic 6 Week Target – the Trust achieved 62.36% in October, an improvement from 62.13% in September, against a target of 99.00%.

- Referral to Treatment Open Pathways – the Trust achieved 71.75% in October, an improvement from 67.67% in September, against a target of 92.00%.
- Referral to Treatment 52+ Week Waiting – there were 421 patients waiting over 52 weeks in October, a deterioration from 285 patients in September, 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 in place.
- A&E Waiting Times 4 hour National Target – the Trust achieved 78.28% (excluding Widnes Walk ins) in October, a deterioration from September's position of 81.95%, against a target of 95.00%.
- A&E Improvement Trajectory – the Trust did not achieve the improvement trajectory of 85.00% in October.
- Cancer 14 Days – the Trust achieved 71.12% in September, a deterioration from 75.19% in August, against a target of 93.00%.
- Breast Symptomatic – the Trust achieved 39.34% in September, a deterioration from 53.33% in August, against a target of 93.00%.
  There has been a reduction in capacity due to a consultant leaving the Trust, however a locum consultant has been appointed which will address capacity issues.
- Cancer 28 Day Faster Diagnostic Standard – the Trust achieved 71.60% in September, a deterioration 72.28% in August, against a target of 75.00%.
- Discharge Summaries % sent within 24 hours – the Trust achieved 85.40% in October, an improvement from 83.21% in September, against a target of 95.00%.
- Cancelled Operations on the Day (for non-clinical reasons, not rebooked within 28 days) – there was 1 patient whose operation was cancelled on the day and not rebooked within 28 days in October. This is an improvement from 3 patients in September, against a target of 0.
- COVID-19 Recovery Elective Activity – the Trust achieved 59.60% of inpatient elective activity and 56.58% of daycase activity in October, against the target of 90.00% of activity in the same period in 2019/20.
- COVID-19 Recovery Outpatient Activity – the Trust achieved 76.14% of outpatient activity in October, against the target of 100% of activity in the same period in 2019/20.
- COVID-19 Recovery Diagnostic Activity – the Trust achieved 70.95% of MRI Activity, 85.14% of CT Activity, 88.37% of Non-Obstetric Ultrasound Activity, 72.73% of Colonoscopy Activity, 60.12% of Flexi Sigmoidoscopy Activity and 53.70% of Gastroscopy Activity in October, against the target of 100% of activity in the same period in 2019/20.

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

- Cancer 62 Days Urgent Treatment – the Trust achieved 85.25% in September, an improvement from 75.51% in August, against a target of 85.00%.
- Cancer 62 Days Screening - the Trust achieved 100% in September, an improvement from 00.00% in August, against a target of 90.00%. There were 4 patients on this pathway in September and 1 patient in August.

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 September.

PEOPLE

Workforce KPIs

There are 8 Workforce indicators rated Red in October, an increase from 7 in September.

The 7 indicators which were rated Red in September and remain rated Red October are as follows:

- Sickness Absence – The Trust's sickness absence was 7.62% in October, a deterioration from 6.64% in September, against a target of less than 4.20%.
- Return to Work Compliance – interview compliance was 63.18% in October, a deterioration from 65.28% in September, against a target of 85.00%.
- Bank/Agency Reliance – The Trust's reliance was 17.71% in October, a deterioration from 15.20% in September, against a target of less than 9.00%.
- Agency Shifts Compliant with the Cap – 31.56% of agency shifts were compliant with the cap in October, a deterioration from 33.31% in September, against a target of 49.00%.
- Agency Rate Card Compliance – 42.00% of agency shifts were compliant with the rate card in October, a deterioration from 44.00% in September, against a target of 60.00%.
- Monthly Pay Spend – the monthly pay spend in October was £18.5m against a budget of £18.0m.
- PDR Compliance – The Trust's PDR compliance was 62.65% in October, a deterioration from 66.76% in September, against a target of 85.00%.

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

- % Use of the Apprenticeship Levy – the Trust's use of the apprenticeship levy was 36.00% in October, a deterioration from September's position of 99.00%, against a target of 85.00%. This was due to a number of apprentices completing their apprenticeship in September.

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

- Vacancy Rates – the Trust vacancy rate was 9.13% in October, a deterioration from 8.08% in September, against a target of less than 9.00%.

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

- % of Workforce carrying out an apprenticeship qualification – 2.42% of the Trust's workforce was carrying out an apprenticeship qualification in October, an improvement from 2.01% in September, against a target of 2.30%.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 2 Finance & Sustainability indicators rated Red in October, the same number as September.

The 2 indicators which were rated Red in September and remain rated Red in October are as follows:

- Capital Programme – The actual spend year to date is £5.4m which is £3.1m below the planned spend of £8.5m. However, the Trust has committed orders of £3.6m.
- Agency Spending – The actual spend in October was £1.2m which is £0.5m above plan. Year to date actual expenditure is £7.2m of which £3.8m relates to COVID-19.

The Income and Activity Statement for month 7 is attached in **Appendix 5**.

The financial plan for October to March assumes R=1. During October £1.1m of Wave 2 COVID-19 costs were incurred. These were offset by underspends on recovery plans and a non-recurrent income receipt. The financial position is a £0.8m deficit against a plan of £0.7m deficit. Should R continue to be over 1, it is anticipated that additional costs of c£1.0m per month will be incurred that are not within plan. It is anticipated that guidance will be issued to formally revise the financial forecast.

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	3,550	1,676	-1,874	
MRI (PDC)	875	0	0	0	
PDC / Loan Programme *	4,851	1,899	1,099	-795	
Critical Infrastructure Risk (CIR) Funding	2,410	250	160	-90	
A&E Plaza	4,300	0	10	10	
Phase 1 Covid-19	2,802	2,802	2,495	-307	
Endoscopy	511	0	0	0	
Critical Care (revised from £1.7m)**	1,422	0	0	0	
Total Planned Capital Investment	**26,058**	**8,501**	**5,440**	**-3,056**	

* The Trust submitted a PDC loan request in August for £4.9m, supported by the regional C&M NHSE/I team. This was formally approved in October 2020.
**Confirmation of reduction in critical care funding to exclude neonatal requires Board approval to adjust plan.
*** In addition to the expenditure, there are also committed orders of £3.6m.

A&E Plaza funding of £4.3m has been approved. A memorandum of understanding was signed in October and the planning and design meetings have commenced. There are a number of challenges in completing the A&E scheme due to operational pressures. Construction of the Paediatric area for hot and cold assessment has commenced and is on target for completion on 7th February 2020.

A cash payment of £2.5m for COVID-19 Phase 1 funding is expected in November 2020, the remaining £0.3m is being checked and verified by the national team.

Due to the higher than usual value of the capital programme, additional governance and oversight has been implemented. Weekly meetings with the key capital leads have been set up and 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.

Requests for changes to the capital plan are set out in **Table 3**. The first section highlights budget underspend on schemes which could be put into the contingency. These changes would increase the contingency budget from £247k to £992k.

The Chief Finance Officer and Deputy Chief Executive has approved an emergency request for a SeraSep analyser for £106k, this would leave £886k in the contingency budget.

The Capital Planning Group received several bids requesting funding from the Trust's capital contingency, these are outlined in **Table 3.** If the Board approves these requests, the contingency would then be reduced to £437k.

Table 3: Requests changes to the contingency budget

£000's	
247	**Contingency budget at 31 October**
745	Underspend on Budget
992	**Contingency budget at 6 November**
-106	SeraSep (Emergency Request approved by CFO/Deputy CEO)
886	**Contingency budget after emergency requests**
-12.4	Radiology server
-190	Kendrick ground floor increase costs
-125	Lift replacement Thelwall
-120	4 Misting machines linked to COVID-19
-1.8	Thelwall dining room
436.8	**Revised Contingency budget**

The Trust Board is requested to:

A. **Approve the decrease of the capital plan from £26.3m to £26.0m due to adjustment to the critical care funds.**
B. **Approve the increase in the contingency budget due to underspend.**
C. **Note the SeraSep scheme approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.**
D. **Approve the additional capital schemes outlined in Table 3 to be funded from the revised contingency.**

It should be noted that the capital programme is profiled with 50.00% expenditure occurring in the last quarter, this includes; the ED Plaza, MRI purchase and estates, Captain Sir Tom Moore Building (formally CMTC), X-ray and WI-FI. Increased monitoring is being provided to SEOG and the Finance & Sustainability Committee given the risk to delivery.

A draft revised capital programme is attached in **Appendix 6**.

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 contents of this report.
2. Approve the decrease of the capital plan from £26.3m to £26.0m due to adjustment to the critical care funds.
3. Approve the increase in the contingency budget due to underspend.
4. Note the SeraSep scheme approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.
5. Approve the additional capital schemes outlined in Table 3 to be funded from the revised contingency.

Key

Improvement in Performance	↕
Deterioration in Performance	↕
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating November 2019 – October 2020

	KPI		Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 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 November 2019 – October 2020

	KPI	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 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 November 2019 – October 2020

	KPI	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 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 November 2019 – October 2020

	KPI	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 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.

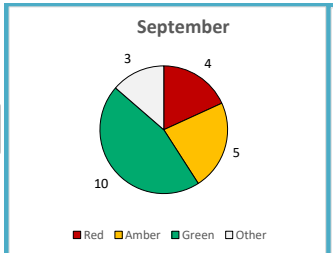
Warrington and Halton Teaching Hospitals NHS Foundation Trust

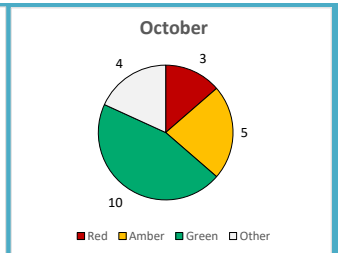
Integrated Dashboard - October 2020

Appendix 2

Key Points/Actions

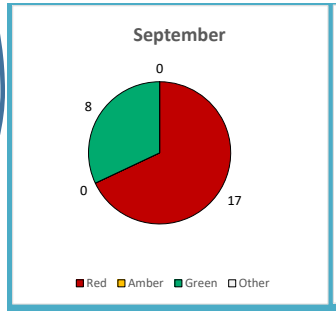
Quality Improvement

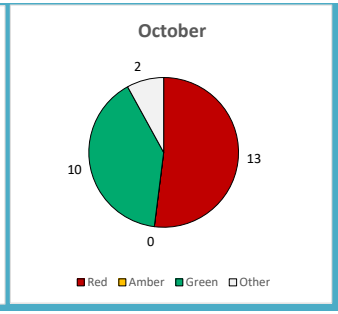




There were 239 open incidents that required review and sign off, of which 27 have been open over 40 days. Compliance in relation to Duty of Candour remains 100% in month. Healthcare Acquired Infection objectives have not been published nationally and CDI reviews with the CCG have been delayed due to COVID-19. There were 6 cases of CDI (under review), 3 cases of E.coli, 0 cases of MRSA, 0 cases of MSSA, 1 case of Pseudomonas aeruginosa and 2 cases of Klebsiella reported in month. There were 7 category 2 pressure ulcers, 1 category 3 pressure ulcer and no category 4 pressure ulcers reported in month. There were 73 falls reported in month, of which 61 were inpatient falls. Medication reconciliation within 24 hours was 79.00% and overall reconciliation was 92.00%. NICE compliance was at 88.48%. There were 0 mixed sex accommodation breaches in month. Care Hours Per Patient Day was at 7.6. Continuity of Carer compliance was 49.30%. There was 1 open complaint over 6 months old.

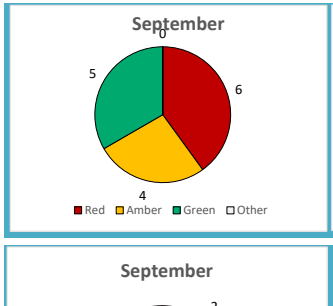
Access & Performance

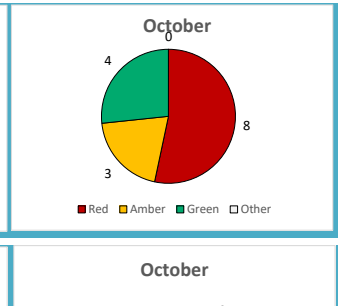




Performance against the Access & Performance standards has been significantly impacted by COVID-19. In October, the Trust did not achieve the RTT (71.75%) or the 6 week Diagnostic Standard in month (62.39%). The Trust is in the process of implementing recovery plans to address this. The Diagnostic standard is still an improving position month on month, driven by the Radiological modalities. The Trust did not meet the 4 hour A&E standard (78.28%) or the improvement trajectory in month. The Trust did not meet the Cancer two week wait (71.12%), Breast Symptomatic (39.34%) or Faster Diagnostic Standard (71.60%) in month; however the Trust did achieve all other Cancer Standards. The Trust did not achieve the 24 hour discharge summary standard (85.40%) but did achieve the 7 day standard. There was 1 patient whose operation was cancelled and not rebooked within 28 days, however the number of operations cancelled on the day for non-clinical reasons has met the standard (1.25%). The number of Super Stranded patients (110) is in line with the trajectory. The Trust did not meet the COVID-19 Phase 3 recovery plans in month. Data was unavailable from the North West Ambulance Service for Ambulance Handovers in October.

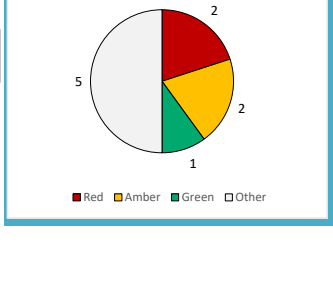
Workforce

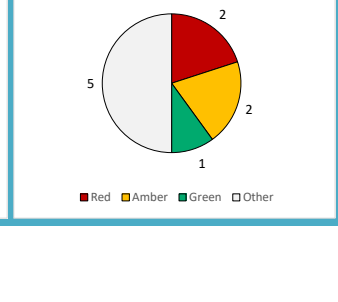




In October, the Trust's sickness absence was 7.62%. Return to work compliance was 63.18%. Average recruitment timeframes over the 12 month rolling period are on target at 58 days. Turnover was at 14.50% and Retention was 85.26%. Vacancy rates were 9.13%. Bank and Agency reliance was 17.71%. Core Skills Training was at 85.15% with Role Specific Training at 92.82%. Agency shift compliance against the pay cap was at 31.56% and compliance against the rate card was 42.00%. Pay spend was £18.5m against a budget of £18.0m. PDR compliance was 62.65%.

Finance





The financial plan for October to March assumes R=1. During October £1.1m of Wave 2 COVID-19 costs were incurred. These were offset by underspends on recovery plans and non-recurrent income received. The financial position is a £0.8m deficit against a plan of £0.7m deficit. Should R continue to be over 1, it is anticipated that additional costs of c£1.0m per month will be incurred that are not within plan. It is anticipated that guidance will be issued to formally revise the financial forecast. The actual capital spend year to date is £5.4m which is £3.1m below the planned spend of £8.5m. However, the Trust has committed orders of £3.6m. Year to date agency spend was £7.2m of which £3.8m relates to COVID-19. Better Practice Payment Code was 96.00% in month which is 1.00% above the target of 95.00%.

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

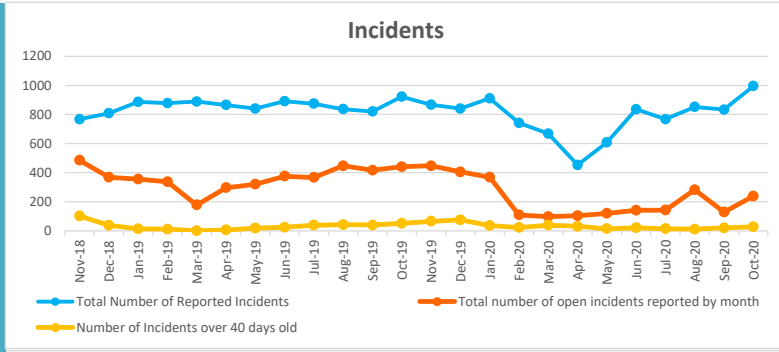
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Patient Safety

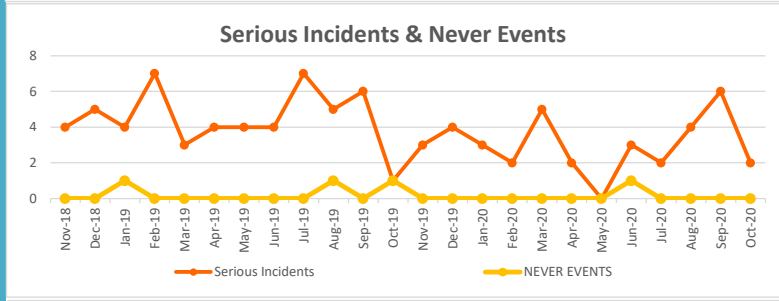
SOF CQC

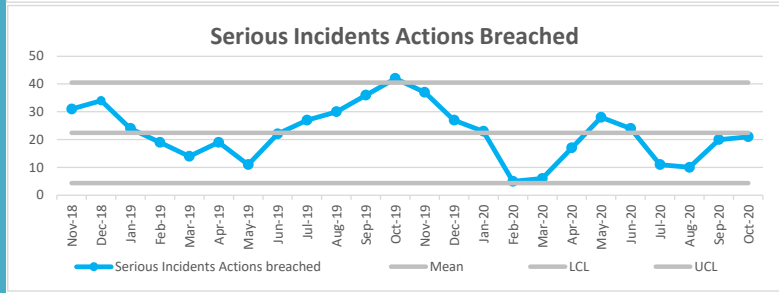
Incidents

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 27 incidents over 40 days old open in October 2020 across the 6 CBUs and Clinical Support Services. This is an increase of 35.00% compared to the previous month.





There were 2 Serious Incidents reported in October 2020. This is monitored via the Patient Safety & Clinical Effectiveness Sub Committee in addition 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 (RR116)
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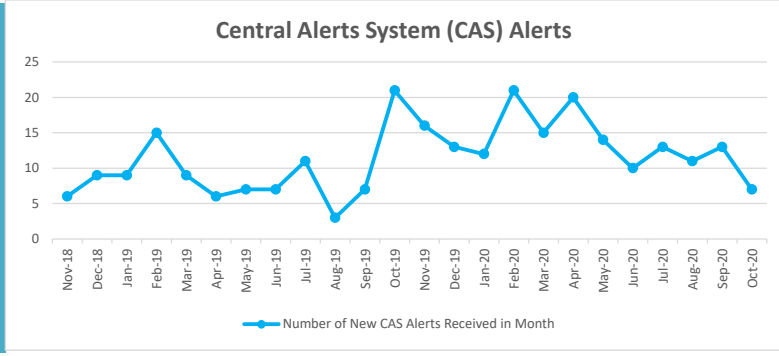
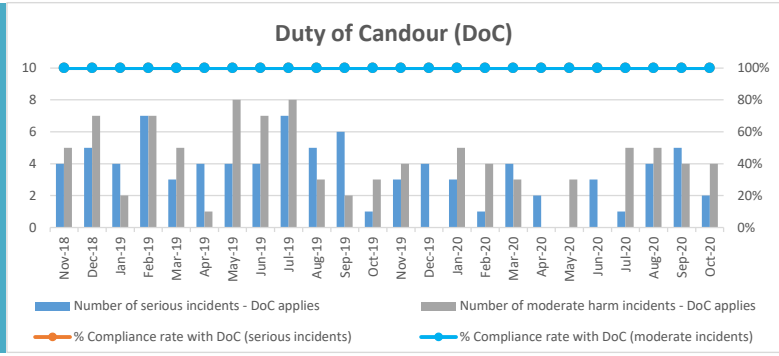
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
CAS Alerts - Green - All relevant CAS Alerts actioned within timescales Red - Applicable CAS Alert not actioned within the timescale.	CQC There were 7 new CAS Alerts received in month. There were no CAS alert actions which have breached the timescales in month.		The Trust received 7 CAS alerts in month with no breaches of any actions required.	There is ongoing monitoring and oversight of CAS Alerts at the Health and Safety and Patient Safety and Clinical 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

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Quality Improvement - Trust Position

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

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

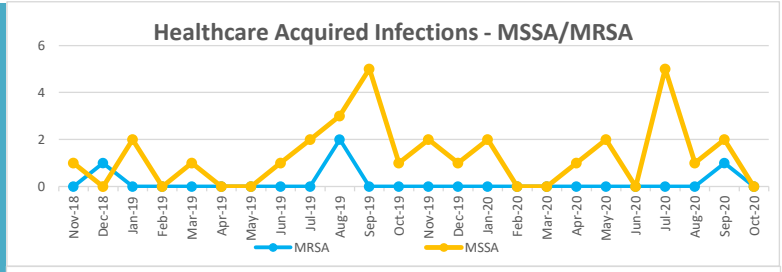
E-Coli
Red: 47+ per annum
Green: Less than 47 per annum
Pseudomonas aeruginosa & Klebsillea - No Threshold Set

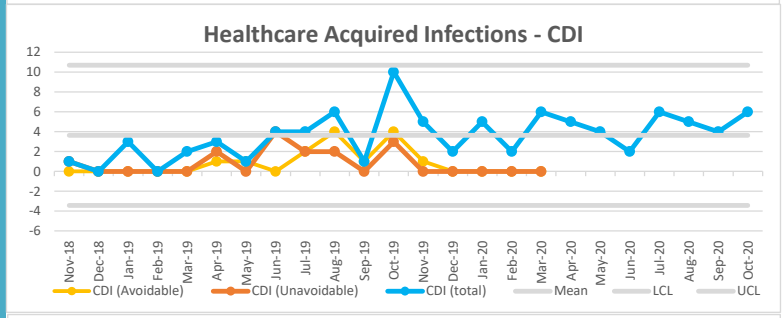
Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks

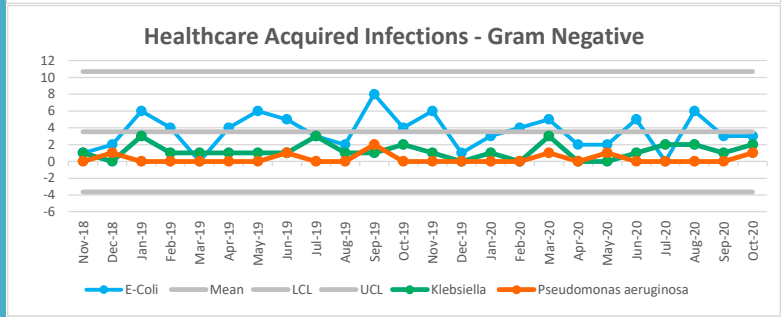
CQC SOF S

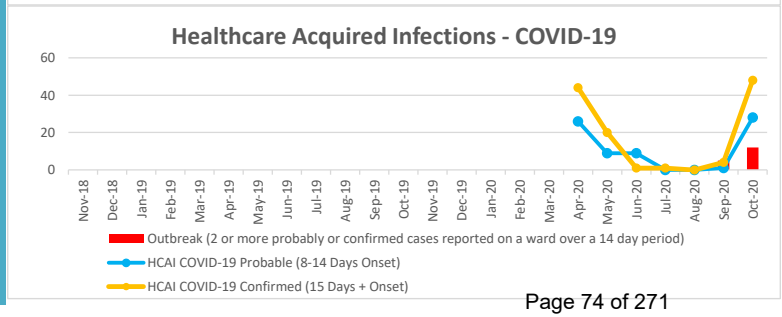
Healthcare Acquired Infection (HCAI) objectives have not been published nationally by NHSE/I for Gram Negative bloodstream infection reduction or C. difficile. The current RAG rating is based on 2019/20 thresholds.
In October, the following cases were reported:
MRSA - 0 in reported October, 1 reported YTD (in September)
MSSA – 0 reported in October, 11 reported YTD
CDI – 6 reported in October, 32 reported YTD
E-Coli – 3 reported in October, 21 reported YTD
Klebsiella – 2 reported in October, 8 reported YTD
Pseudomonas aeruginosa – 1 reported in October, 2 reported YTD

12 COVID-19 outbreaks were reported in October including 1 in a corporate services office.









There may be an increase in pneumonia cases following viral infection with SARS-CoV-2 (COVID-19). A different inpatient profile due to the coronavirus pandemic will make comparisons with previous year's data difficult.
COVID-19: Caution is required on data interpretation. Testing of all patient admissions was introduced on 24/04/2020. The definitions for hospital onset cases and the definition of an Outbreak was published by NHSE/I on 09/06/2020.

Action plans are in place for the reduction of all HCAIs and will be applied throughout the COVID-19 recovery period. Plans will be reviewed and adapted according to Root Cause Analysis report findings.
Robust processes are in place for COVID-19 admission and day 5 testing with Infection Prevention and Control (IPC) guidance on isolation and Personal Protective Equipment (PPE).

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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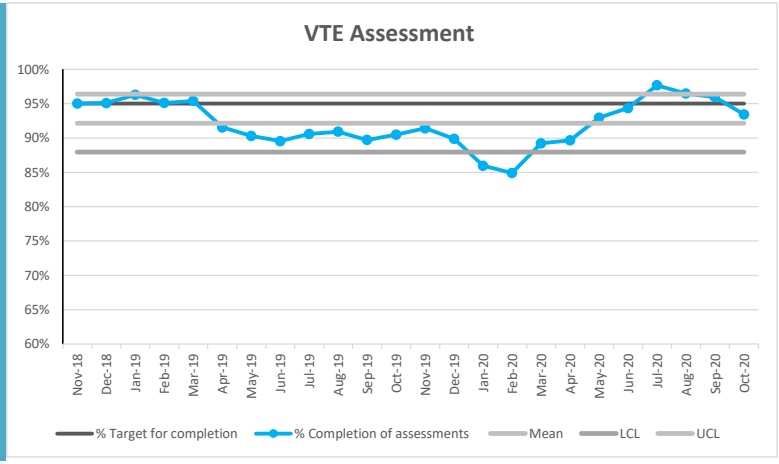
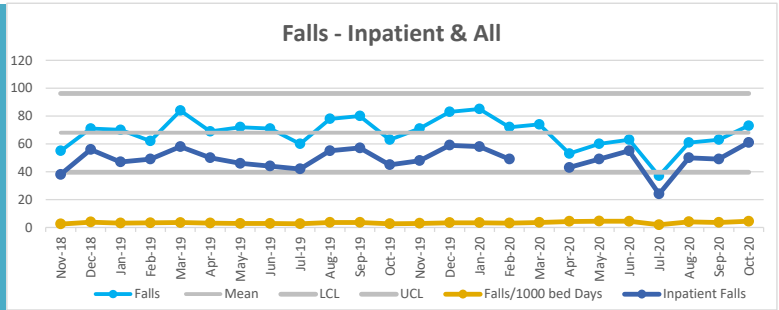
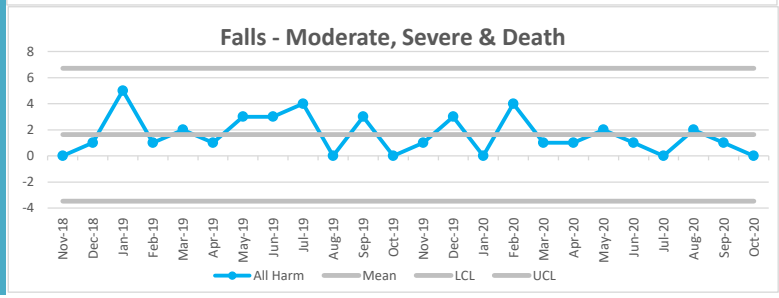
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
VTE Assessment **Red: <95%** **Green: 95% or above based on previous months' figures due to timescales for validation of data**	SOF, S **The Trust achieved 96.73% for VTE assessments on average in Q2 2020/21.** RR128		**The Trust achieved 93.43% for VTE assessments in October 2020. This is 1.57% below 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 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.**
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**	CQC, S **There were a total of 73 falls in the month; of which 61 were inpatient falls.** RR120	 	**There was 1 severe harm fall reported in October 2020 on ward A6.**	**The Trust continues to review falls daily at the Trustwide Safety Huddle and weekly at the Inpatient Falls Review meeting. Triangulation of the October data is underway to establish any themes across different data sources. The Trust Falls action plan has been updated to reflect the Trust Falls Quality priority for 2020/21.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
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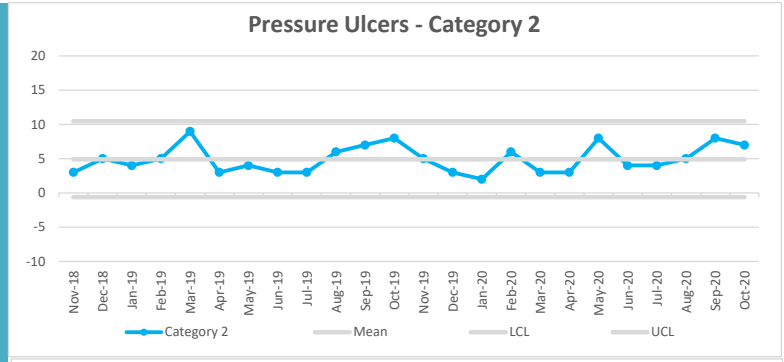
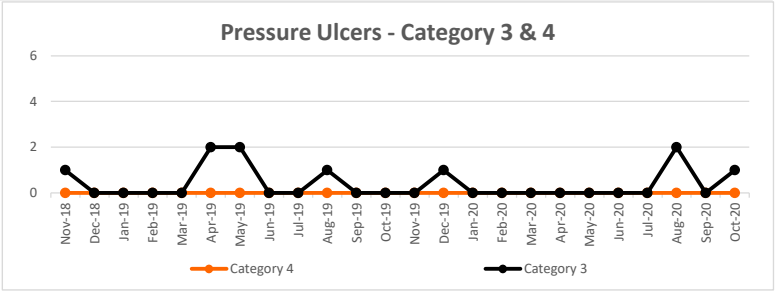
Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
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 7 hospital acquired Category 2 pressure ulcers, 1 Category 3 pressure ulcer and 0 Category 4 pressure ulcers reported in month.	The Trust has had a total of 39 Category 2 pressure ulcers YTD, which is an increase of 6 pressure ulcers compared the same reporting period in 2019. The Trust has had a total of 3 Category 3/ Unstageable pressure ulcers which year to date is a reduction of 2 pressure ulcers compared the same reporting period in 2019. Overall moderate harm from pressure ulcers has reduced by 6.00% compared to the same reporting period in 2019.	Pressure Ulcer reduction is a key collaborative supported by the Quality Improvement team. A new pressure relieving dynamic mattress contract is to commence in December. All foam mattresses are to be replaced with higher specification mattress (early 2021). Fluid immersion therapy mattresses and specialist ICU bedframes are currently being evaluated in ICU with the aim of reducing the risk of pressure ulcers related to proning.





Warrington and Halton Teaching Hospitals NHS Foundation Trust

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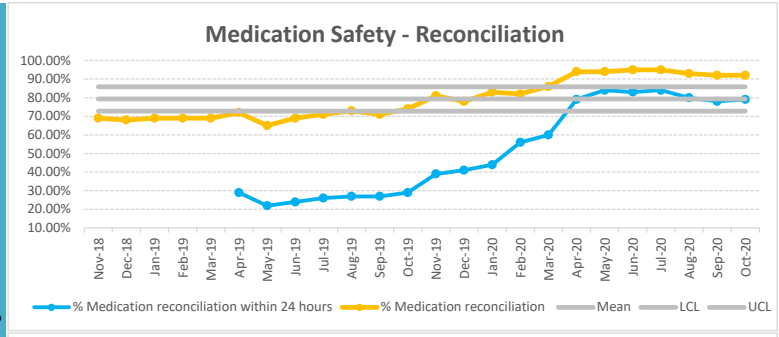
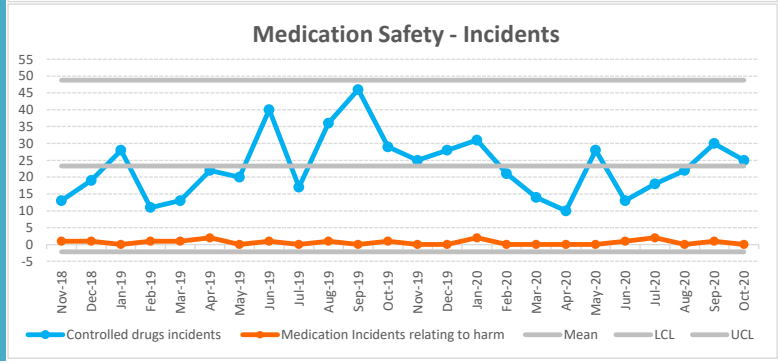
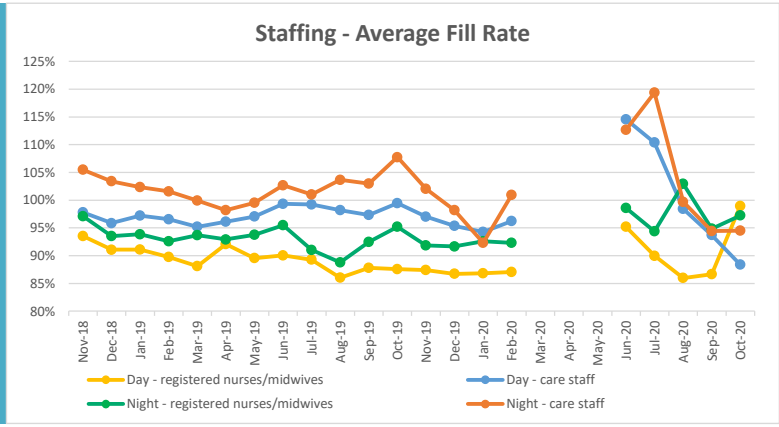
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Medication Safety Reconciliation within 24 hours Red: below 60% Amber: 60% - 79% Green: 80% or above	S, RR415 The Trust achieved 79.00% for medicines reconciliation within 24 hours and 92.00% for overall medicines reconciliation. There were 25 controlled drug incidents.	 	Performance against both medicines reconciliation targets in October were maintained at a similar level to that achieved in September. Resources are targeted towards Medicines Reconciliation with additional staffing at weekends to reduce the impact of Trust patient flow related issues (opening of additional beds, impact of increased ward transfers and focus on discharge). All incidents are being reviewed to identify learning and need for safety communications.	Early learning from the harm incident was communicated in a Safety Alert. Controlled drug audits are undertaken for each ward on a monthly basis with themes identified and actions in place, tracked through the Operational Safety Group. A new Controlled Drugs register for wards and patients own medications has been rolled out from 16th November and will support improvements with Controlled Drugs documentation.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	RR115 In month the average staffing fill rates were: Day (Nurses/Mwife) 99.61% Day (Care Staff) 88.38% Night (Nurses/Mwife) 97.24% Night (Care Staff) 94.50%		11 of the 21 wards reported staffing levels under 90.00% in October 2020 for registered nurses in the day. However, 10 wards were above 90.00% for HCA staff in response to the recruitment of student nurses into the HCA vacancies as part of the COVID-19 pandemic response. Some of these staff are remaining on the wards until they receive their registration with the Nursing & Midwifery Council.	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.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

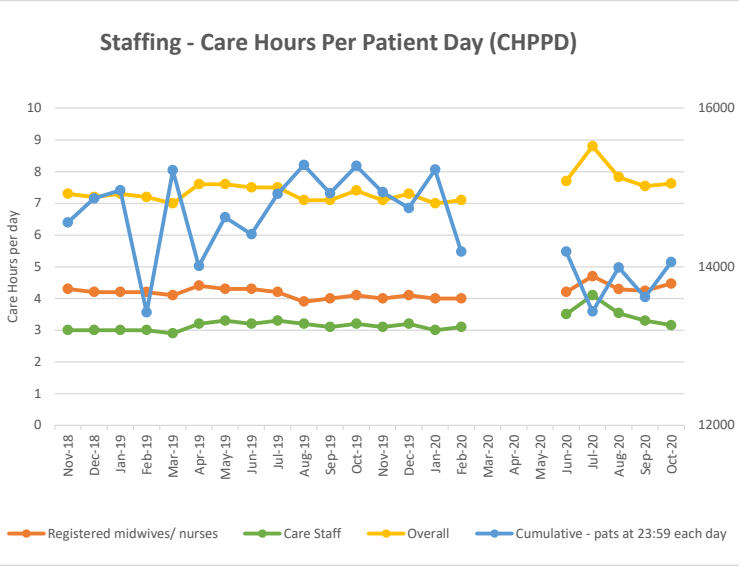
Quality Improvement - Trust Position

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)?

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: 4.5 hours
Care Staff: 3.2 hours
Overall: 7.6 hours



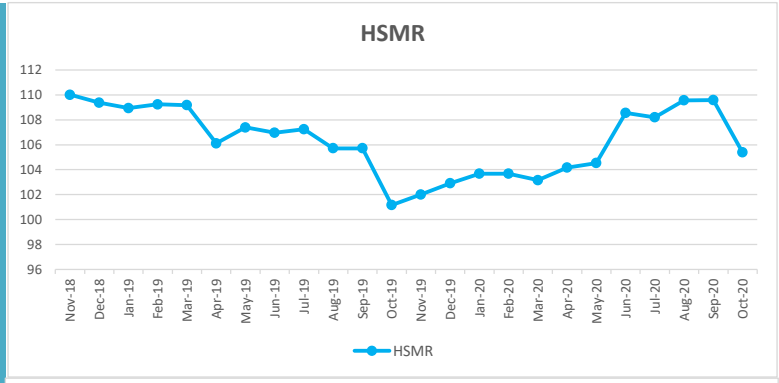
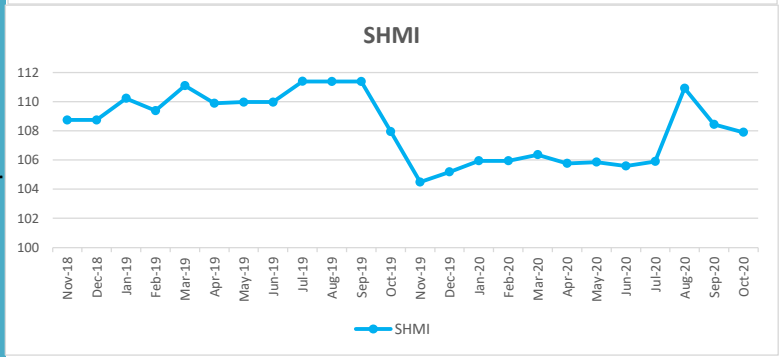
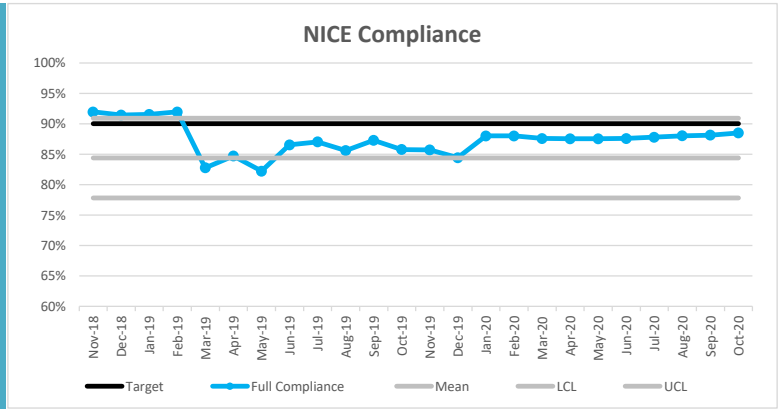
In October, CHPPD was recorded at 7.6 with a 2020/21 YTD figure of 7.9, against the national YTD figure of 8.1. The reduction in CHPPD is in response to student nurses deployed to support the Trust as part of the COVID-19 pandemic response leaving the Trust to return to their studies. Another factor that has influenced the change in month is the number of ward changes with areas such as K25 opening to support the operational needs of the Trust.

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
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)?
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	CQC The most recent HSMR is within the expected range and is 105.40 against 101.53 for peers. The Trust is ranked 10/18 in the peer group.		HSMR and SHMI have shown a decrease when compared to the previous month. Both remain within the expected range: 105.40 for HSMR and 107.90 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 107.90 against 105.76 for peers. The Trust is ranked 10/18 in the peer group.			
NICE Compliance Red: Below 75% Amber: 75% to 89% Green: 90% or Above	SOF The Trust achieved 88.48% in month.		The overall Trust compliance level is currently showing as 88.48%.	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

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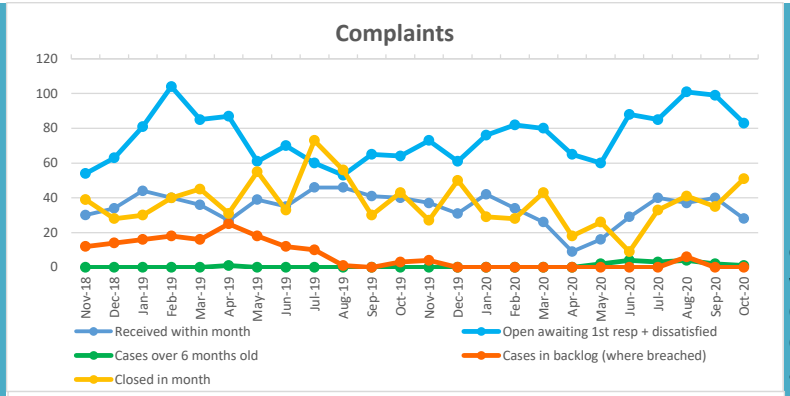
Quality Improvement - Trust Position

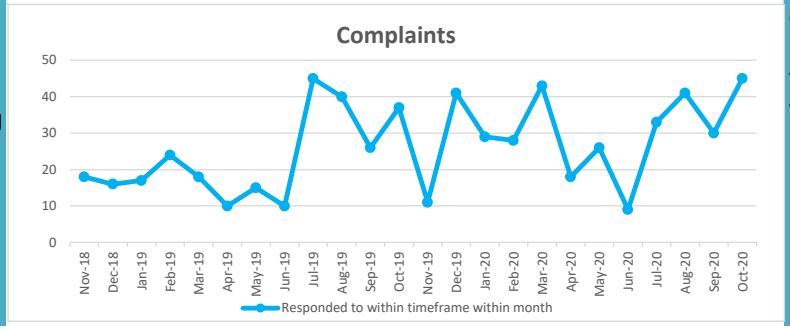
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

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.

The Trust has improved performance in the timely closure of complaints when compared to the previous month, closing 88% within timeframe a 2.00% improvement. There are 83 open complaints, 1 of which is over 6 months old. This is due to the complainants request to place the complaint on hold until 31 January 2021.





During October, 51 complaints were closed. This an increase of 46.00% when compared to the previous month. CBUs continue to work closely with the Complaints Team who have had additional paralegal support to address challenges in demand during the COVID-19 pandemic. This support has been temporarily funded from existing vacancies.

The complaints service is being overseen by the Associate Director of Governance and Compliance alongside the Head of Complaints, Claims and PALS. Methods by which to identify additional support for the Complaints Team is being sought during the pandemic. A weekly complaints performance report is provided to the Associate Director of Governance and Compliance with escalation as appropriate to the Deputy Director of Governance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:

Single Oversight Framework (SOF) | Risk Register (RR116)

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Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	SOF CQC S	The Friends and Family Test has been suspended as per NHSE/I COVID-19 pandemic guidance.		
Friends and Family (ED and UCC) Red: Less than 87% Green: 87% or more	SOF CQC S	The Friends and Family Test has been suspended as per NHSE/I COVID-19 pandemic guidance.		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework (SOF) | Risk Register (RR116)
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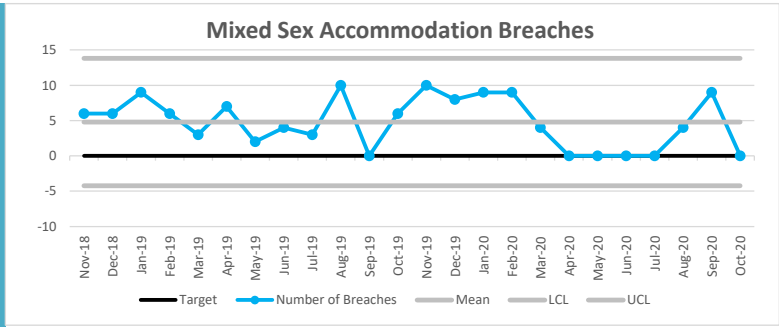
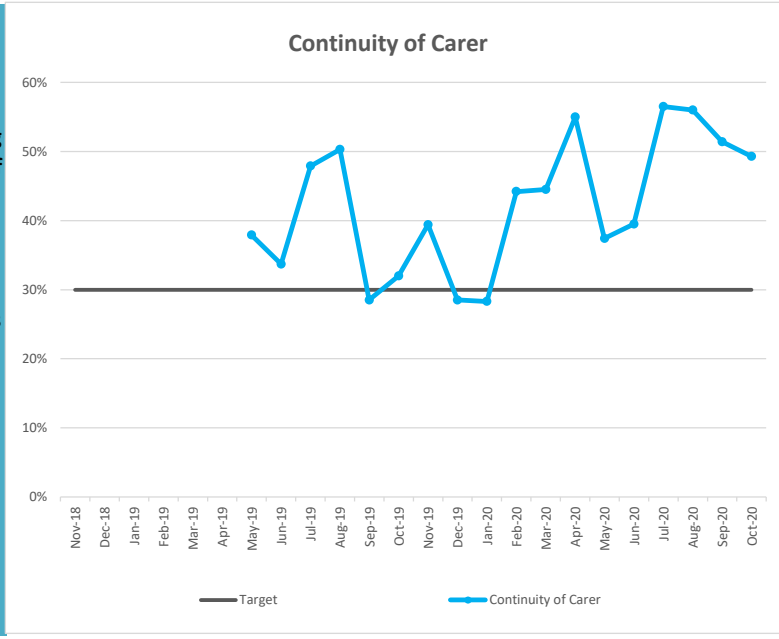
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	SOF There were no mixed sex accommodation incidents during October 2020.		The Trust has met the national trajectory of having zero mixed sex accommodation breaches in month.	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% (National). The Trust achieved 49.30% in October. The Trust remains on target to achieve 100% women to be on a CoC pathway by March 2021.		The Trust achieved 49.30% in October 2020 which meets the current standard but is below the 51.00% target for March 2021.	New care new 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

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Quality Improvement - Trust Position

CQC

Trust Performance

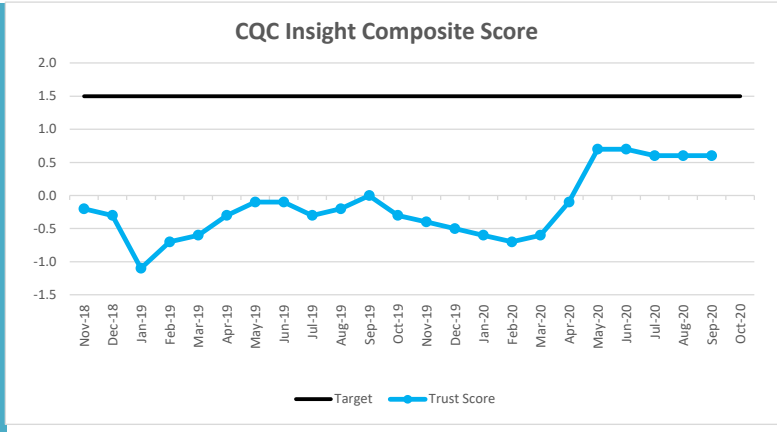
CQC Insight Composite Score

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

CQC RR115

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

Trend



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

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**

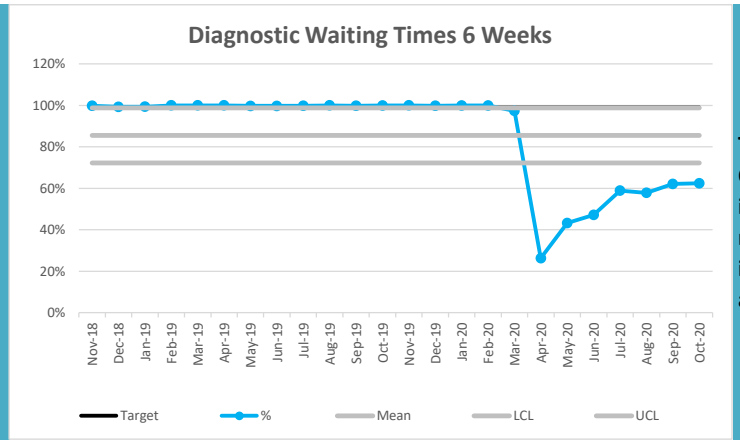
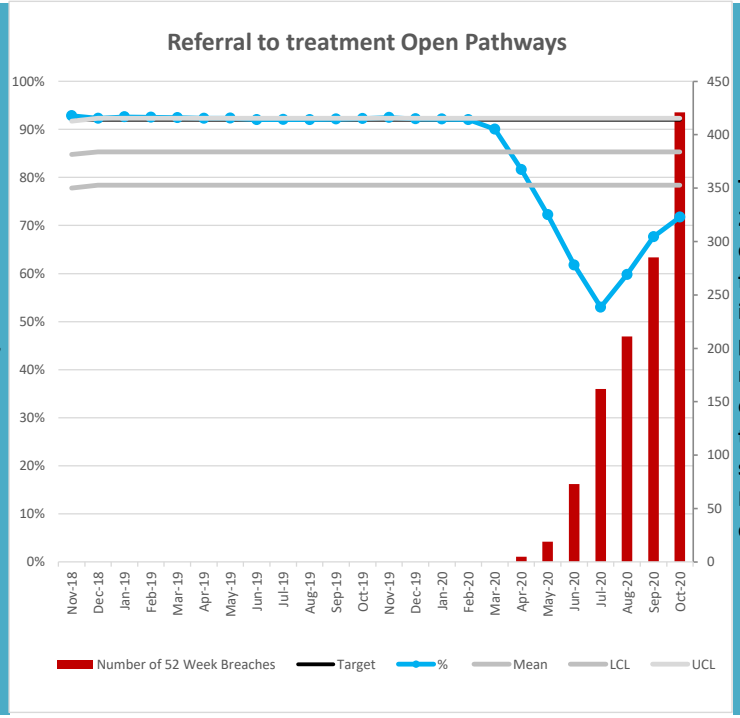
How are we going to improve the position (Short & Long Term)?

The Moving to Outstanding Steering Group continues to track and review the Trust's response to the CQC inspection report. The closure of actions has been impacted by the COVID-19 pandemic, all actions will be closed by 20 November 2020 and a new action plan is in draft. The Trust has undertaken the 'Patient First' assurance meeting with the CQC and the Provider Collaboration Review.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

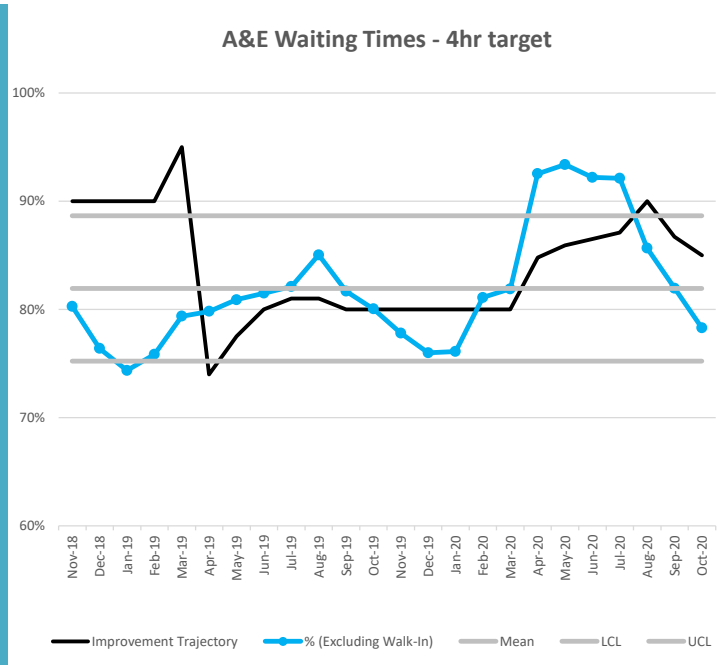
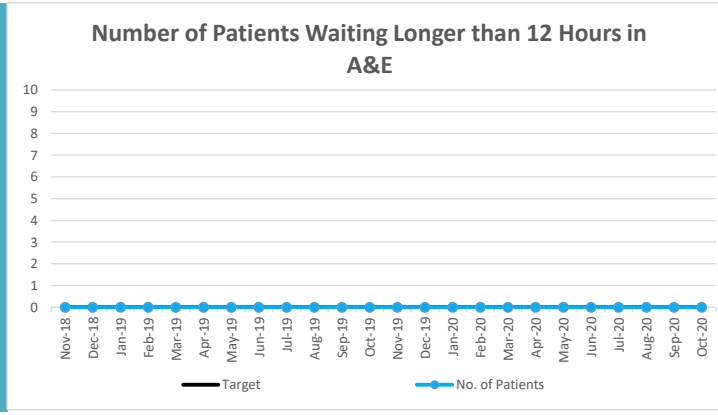
Key:
Risk Register RR116
Single Oversight Framework SOF
Care Quality Commission CQC

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 October 2020, this was due to the 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 improved in October with a reduction in the number of patients waiting more than 18 weeks. The number of patients waiting 52 weeks + at the end of October was at 421. Since the temporary pause of some non urgent services in October, the phase 3 trajectory in November is not expected to be compliant at c650 patients.**	**Recovery of the elective programme is taking place with:** **• Urgent cancer and elective activity 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.** **• 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 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

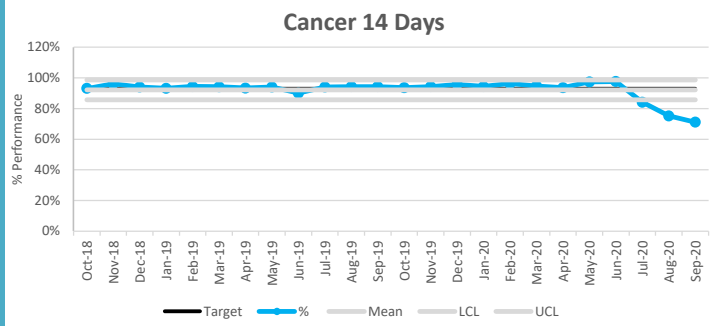
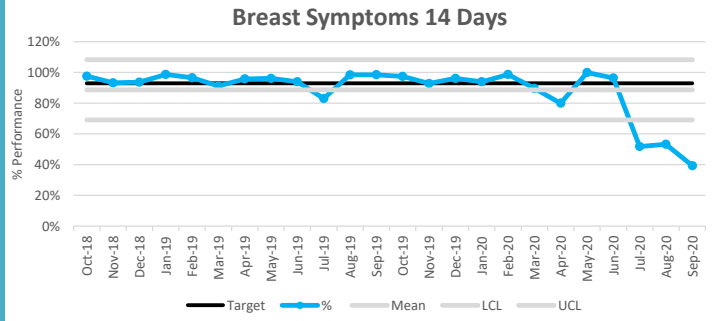
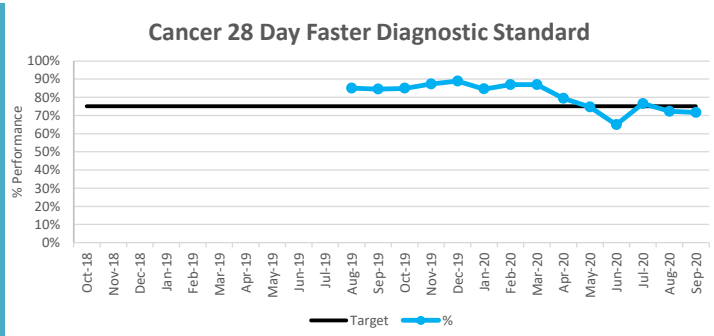
Key:
Risk Register RR110
Single Oversight Framework SOF
Care Quality Commission CQC

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)?
SOF CQC The Trust achieved 78.28% excluding walk ins in month. RR224 Four Hour Standard - National Target Red: Less than 95% Green: 95% or Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory		There was a reduction in performance in October to 78.28% (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. As activity has increased on the Warrington site in line with Phase 3 planning, bed capacity has become more constrained. In support of maintaining urgent and cancer services, the rising number of COVID-19 positive inpatients and urgent care pressures, ward B3 was opened to provide additional bed capacity. However, the Trust still needs to manage the complexities of segregated flows throughout the department which has been successfully achieved.	• 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.
SOF There were 0 patients waiting longer than 12 hours in A&E in month. 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		The Trust has achieved the standard of not having any patients waiting longer than 12 hours from the decision to admit in October 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

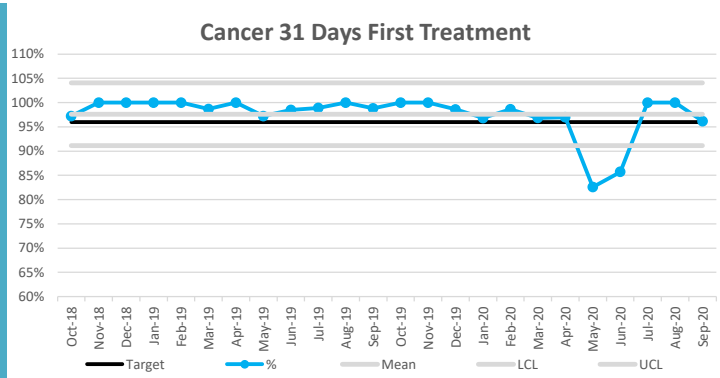
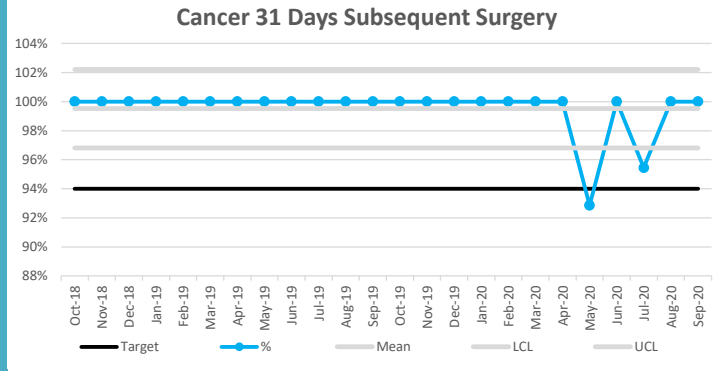
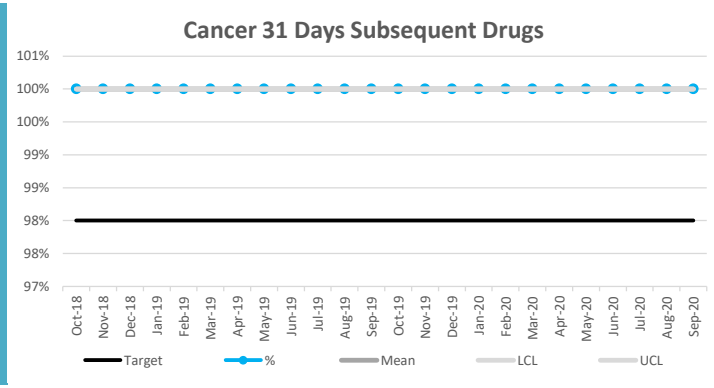
Key:
Risk Register RR116
Single Oversight Framework SOF
Care Quality Commission CQC

	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)?
Cancer 14 Days Red: Less than 93% Green: 93% or above	SOF CQC **The Trust achieved 71.12% in September 2020.**		**The Trust did not achieve the 2 week wait standard or breast symptomatic standard in September 2020. However, it should be noted that this is being actively monitored due to a reduction in capacity within the breast service following a consultant leaving the Trust in recent months. Following the appointment of a new locum at the end of August, it is expected that this standard will be compliant from October 2020.**	**A locum consultant has been appointed to support capacity whilst a longer term plan is developed.**
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	RR116 SOF CQC **The Trust achieved 39.34% in September 2020.** RR116			
28 Day Faster Cancer Diagnosis Standard Red: Less than 75% Green: 75% or above	**The Trust achieved 71.60% in September 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 71.60% in September 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

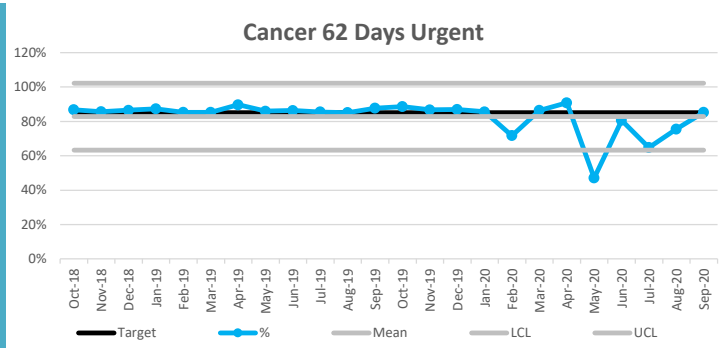
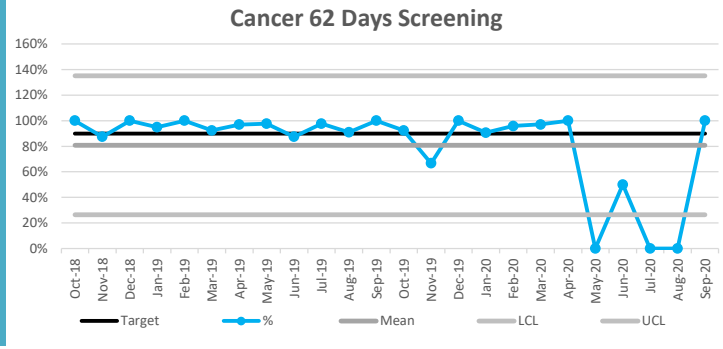
Key:
Risk Register | Single Oversight Framework (SOF) | Care Quality Commission (CQC)

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)?
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	**The Trust achieved 96.15% in September 2020.**		**The 31 day cancer target was achieved in September 2020 at 96.15% 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	**The Trust achieved 100% in September 2020.**			
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	**The Trust achieved 100% in September 2020.**		**The Trust achieved 100% in September 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

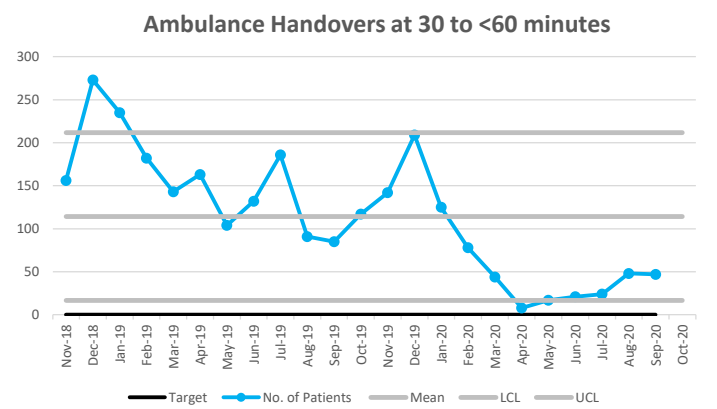
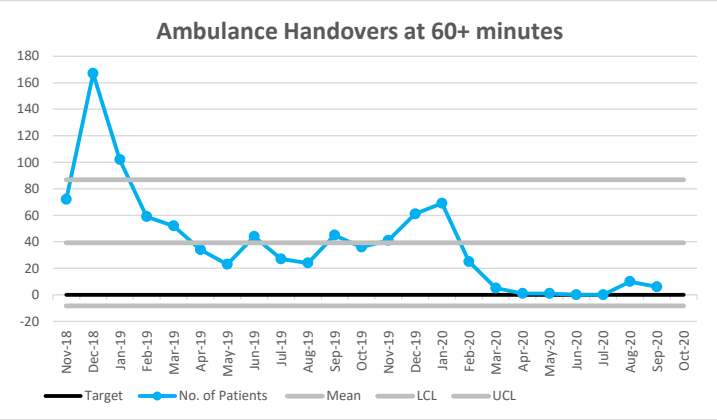
Access & Performance - Trust Position

	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	SOF CQC The Trust achieved 85.25% in September 2020. RR116 SOF CQC		The 62 day targets was achieved in September 2020 at 85.25% (Urgent) and 100% (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 100% in September 2020. RR116			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

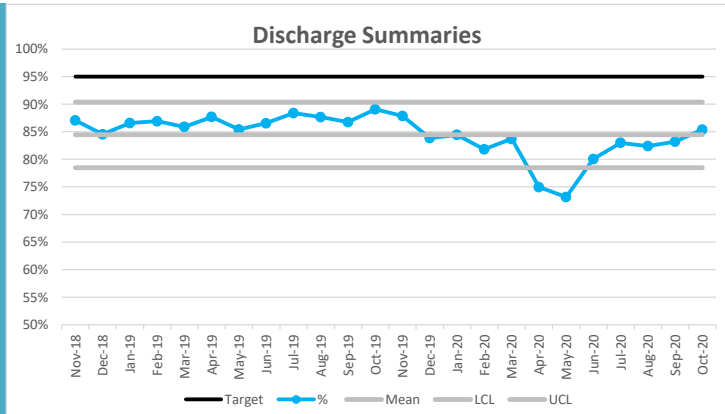
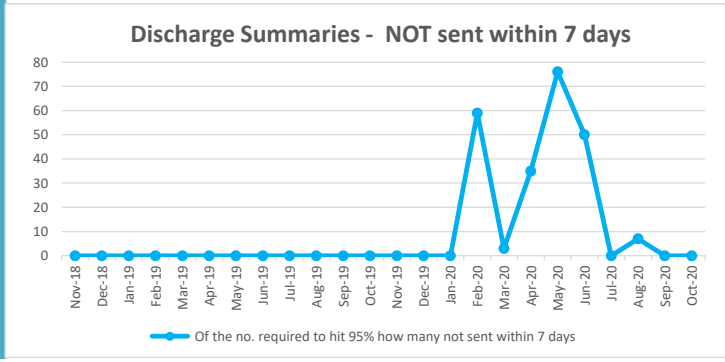
Access & Performance - Trust Position

	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	Ambulance handover data was not available in month from the North West Ambulance Service. In September there were 47 patients who experienced a delayed handover of between 30 and 60 minutes.		Performance against this standard remains in line with operational predictions based on previous months. There were 47 patients handed over between 30-60 mins in September and 6 over 60 minutes. The latter is an improvement in performance on the previous month. It is acknowledged that the impact of the second wave of COVID-19 is impacting ambulance turn around times regionally.	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 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 September there were 6 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

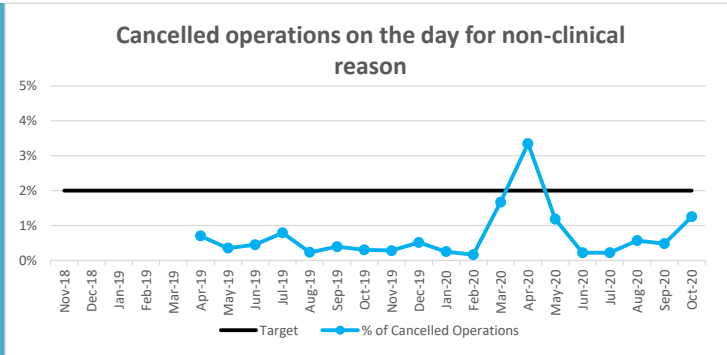
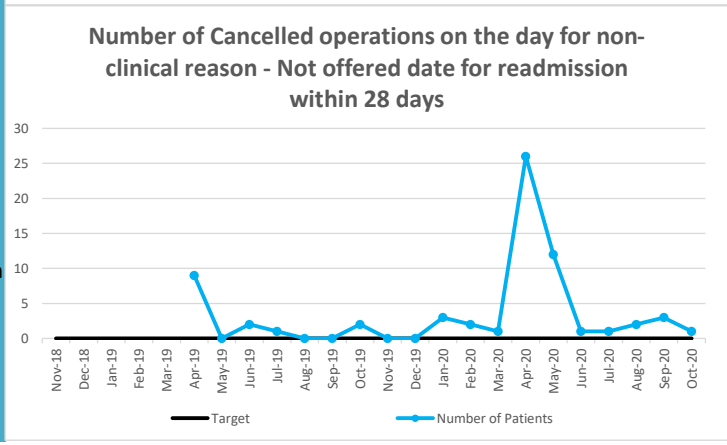
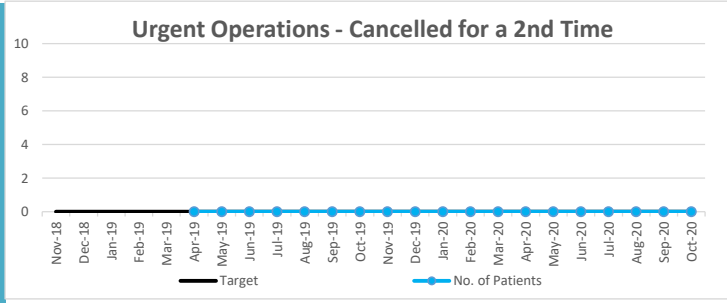
Access & Performance - Trust Position

	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 85.40% in month.		There has been a sustained improvement in the number of discharge summaries sent within 24 hours in October. 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 October 2020.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register
Single Oversight Framework
Care Quality Commission

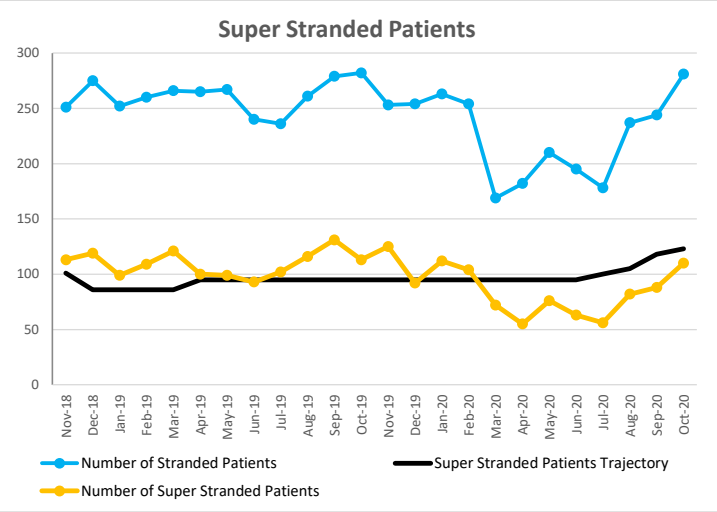
Access & Performance - Trust Position

	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)?
Cancelled Operations on the day for a non-clinical reason Red: > 2% Green: < 2%	CQC 1.25% of operations were cancelled on the day for non clinical reasons in month.		In October 2020, there was a slight increase 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 1 cancelled operation on the day for non clinical reasons in month, where the patient was not re-booked in within 28 days.		There was 1 cancelled operation not offered a date for readmission within 28 days in October 2020 due to unavailability of a consultant.	
Urgent Operations - Cancelled for a 2nd Time Green = 0 Red = > 0	There were 0 urgent operations cancelled for a second time in month.		This is an additional standard to enhance monitoring of cancelled operations. The Trust continues to maintain this standard.	Maintain the standard that no urgent operations are cancelled for a second time.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

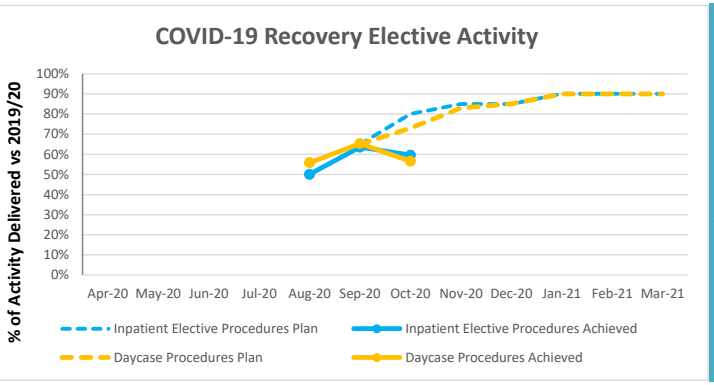
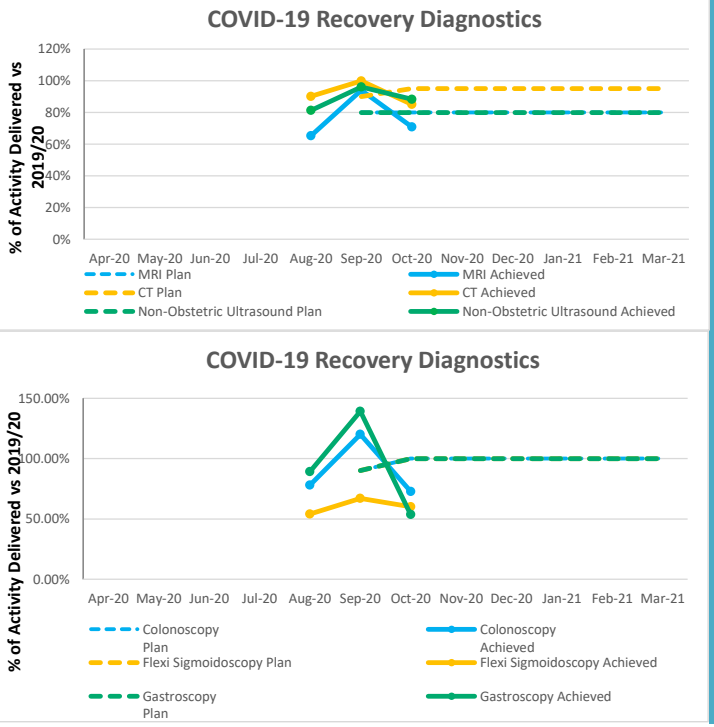
Access & Performance - Trust Position

	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)?
Super Stranded Patients Green: Meeting Trajectory Red: Missing Trajectory	There were 281 stranded and 110 super stranded patients at the end of the October 2020.		The number of Stranded and Super Stranded on the last day of the month increased in October. This position is being impacted by a longer length of stay as a result of IPC discharge issues. This is a national and regional challenge.	The Trust is working in collaboration with partners from the Local Authorities and community providers to ensure community capacity has been 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

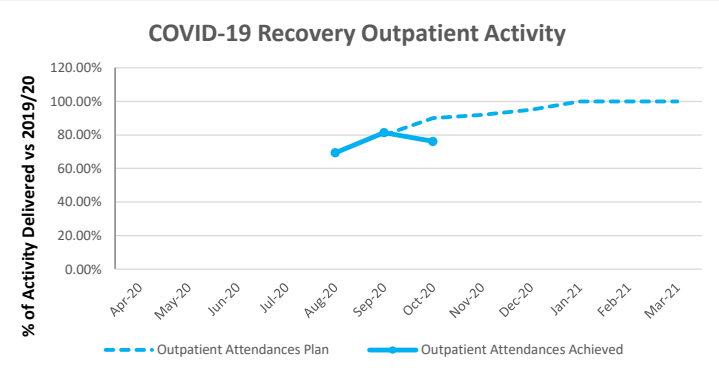
Key:
Risk Register
Single Oversight Framework
Care Quality Commission

	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 October 2020, the Trust achieved 56.58% of Daycase Procedures and 59.60% of Inpatient Elective Procedures against the same period in 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 in September 2020. 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 October 2020, the Trust achieved the following % of activity against October 2019. This included: 70.95% of MRI 85.14% of CT 88.37% of Non Obstetric Ultrasound 72.73% of Colonoscopy 60.12% of Flexi Sigmoidoscopy 53.70% of Gastroscopy		Progress against Diagnostic recovery as per phase 3 has been stalled as a result of the impact of wave 2 COVID-19 in September 2020. 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 October 2020, the Trust achieved 76.14% of Outpatient activity against October 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 in September 2020. 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)

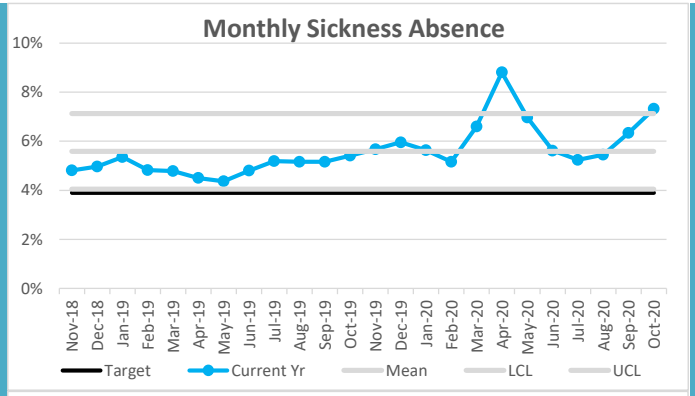
Trust Performance

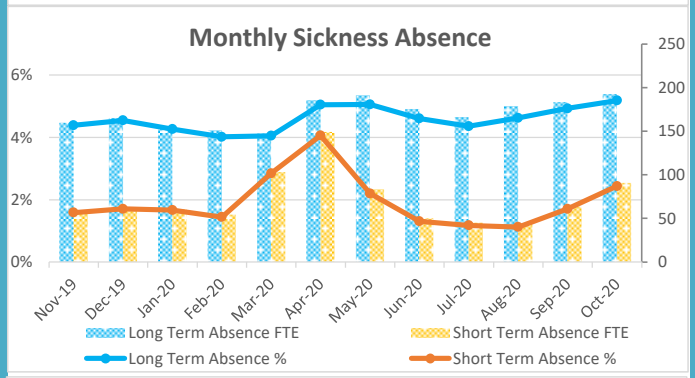
Sickness Absence

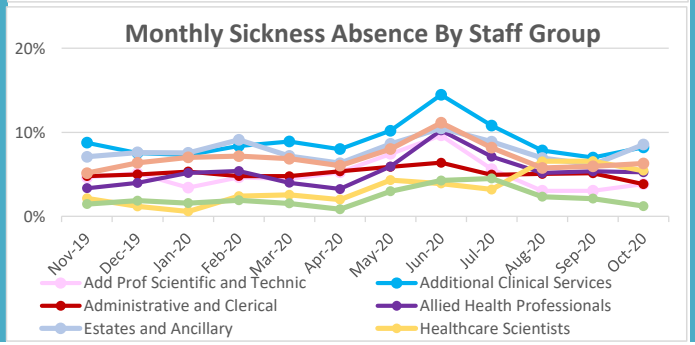
Red: Above 4.5%
Amber: 4.2% to 4.5%
Green: Below 4.2%

The Trust's sickness absence was 7.62% in month.
SPC - There is evidence of special cause variation for sickness absence.

Trend







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

Since July 2020 there has been a gradual increase in sickness absence. In October 2020 the Trust reported 7.60% sickness absence, only April 2020 at 9.10% was higher in the last 24 months.
Both short term and long term sickness has increased since July 2020.
Compared to April 2020, October's long term absence is higher whereas short term sickness is significantly lower.
COVID-19 related sickness absence has increased to 3.00%, demonstrating the increasing impact.
Overall COVID-19 absence (sickness and Isolation) is 5.50%.
The Additional Clinical Services, Estates and Ancillary, Nursing and Midwifery and Medical and Dental Staff Groups sickness has increased by over 0.8% in October 2020 when compared to August 2020, with the Additional Clinical Services staff group increasing by 4.5%.

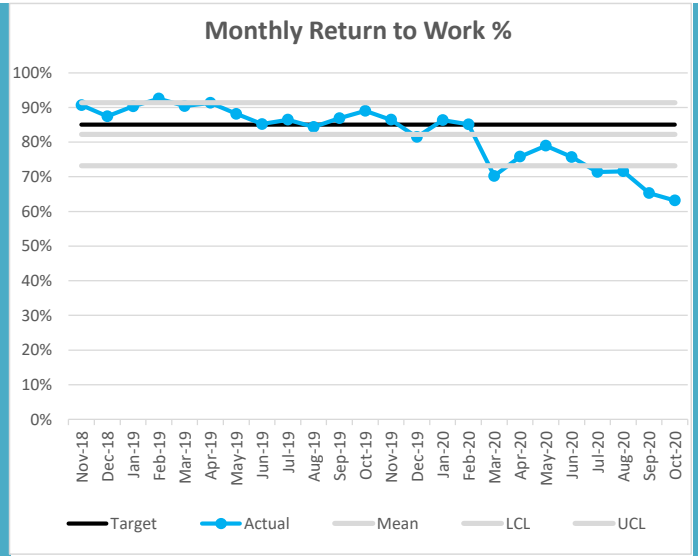
How are we going to improve the position (Short & Long Term)?

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

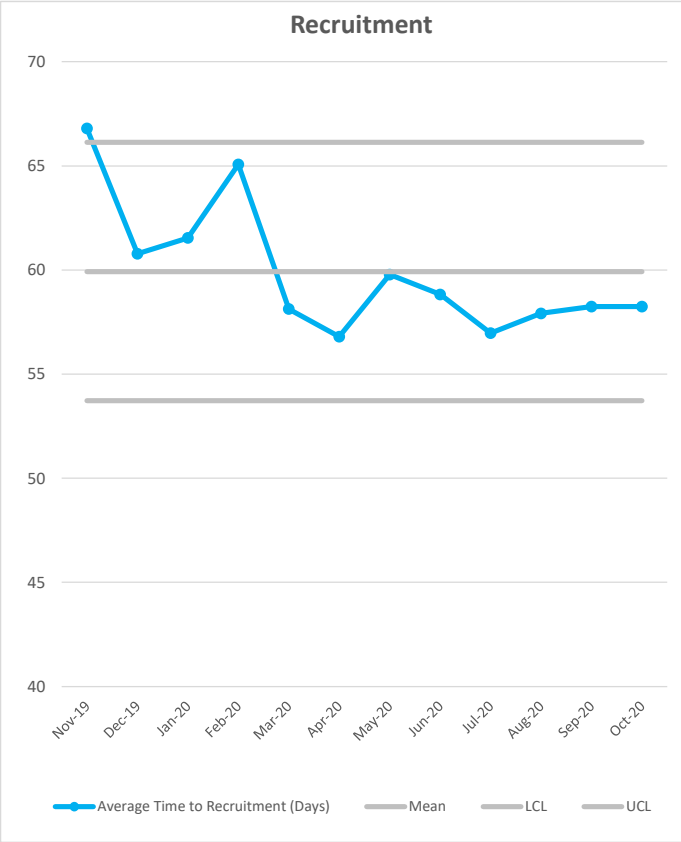
Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

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)?
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	The Trust's return to work compliance was 63.18% 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. A review of this process will form part of workforce recovery planning. The HR Business Partners continue to support to the CBUs to improve their compliance through the monthly meetings. Following a review of the Trust's Essential Manager programme, the importance of Return to Work interviews remains a key focus to absence management within the new "How am I Developed" programme.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

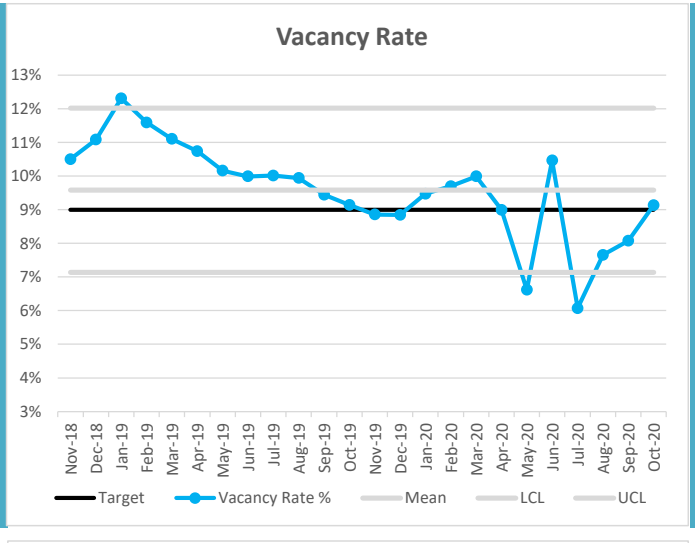
Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

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)?
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or below		Recruitment time to hire remains below target, taking an average of 58 working days as at October 2020, there has been very little change in the last 6 months.	The Trust continues to take advantage of national guidance and support, that includes: • Verification of original documents: the Trust is now able to accept scanned and emailed copies of original documentary evidence for urgent appointments. • References and Employment History – the Trust is 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. • Management of 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). The NHS Jobs system is currently under review and the Trust expects a new version to be launched in early 2021, which will further support reducing our time to hire.
The average number of working days to recruit is 58, based on the last 12 months average. SPC - Recruitment time is within common cause (expected) variation.			

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)?
UoR **The Trust vacancy rate was 9.13% in month. SPC - there is evidence of special cause variation for Vacancy Rates.**		**Vacancy rates increased in October 2020, the current vacancy rate is 9.13%, and these are now similar to the rate in April 2020 – 9.00%.**	**Recruitment has continued as per usual processes. During the last 12 months, the Trust's headcount has increased by 139 and by 306 in the last 24 months.** **The significant increase in the Trusts headcount demonstrates the improved 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 (SOF) | Care Quality Commission (CQC) | Use of Resources Assessment (UoR) | Trust Strategy (S) | Risk Register (RR200)

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

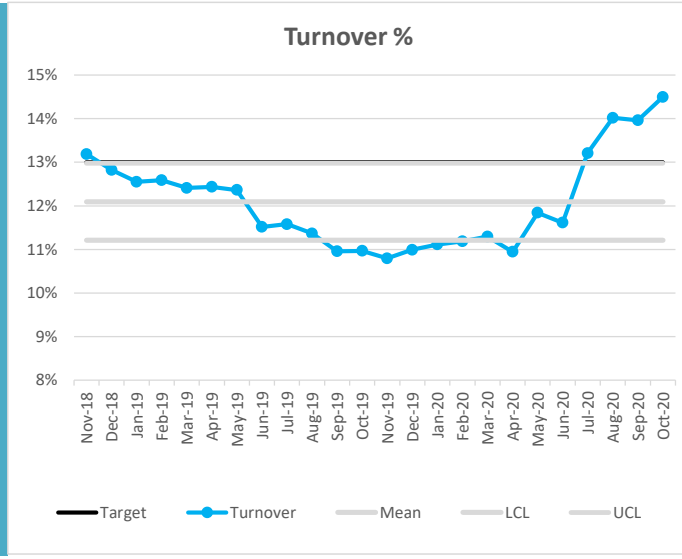
Turnover

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

CQC UoR

Trust Turnover was 14.50% in month.
SPC - There is evidence of special cause variation for Turnover.

S SOF



Turnover continues to increase above target due to the increased number of leavers of temporary staff recruited to support the Trust during the months of March to July. Turnover is now 14.50%.

To provide context the Turnover of the Trusts permanent staff is 9.60% and voluntary turnover (removing leavers due to end of fixed term contracts, dismissals etc) is 8.30%.

This is testament to improved employee engagement (as evidenced by the 2019 Staff Survey results) and to the work undertaken as part of the NHSI Retention Programme.

Similar to turnover Retention has been impacted on the temporary support for COVID-19 leaving the Trust. Retention is 85.26% in October 2020 compared to the peak in June of 88.67%.

The Trust continues to offer a range of health and wellbeing interventions to support our staff. The Trust is supporting minority groups across the workforce such as Black Asian and Minority Ethnic staff and LGBTQ+ staff through various Networks.

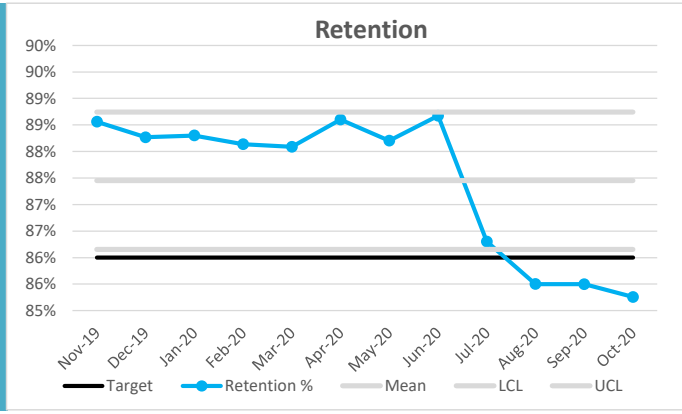
The workforce recovery plan includes consideration relating to:
- **Restarting and enhancing training and development opportunities for staff.**
- **Review of the Exit Interview process.**
- **Review of the WHH Offer to staff.**

Retention

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

UoR

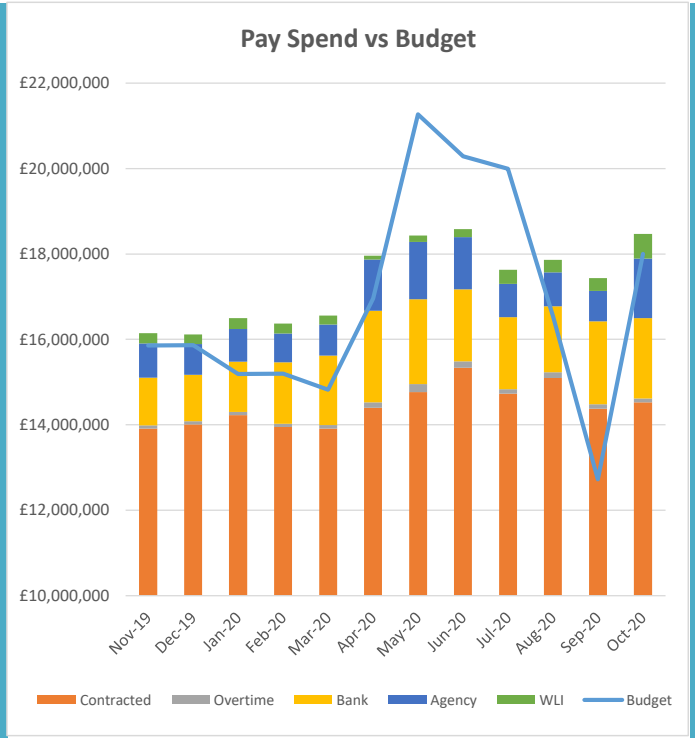
Trust Retention was 85.26% in month.
SPC - There is evidence of special cause variation for Retention.



Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

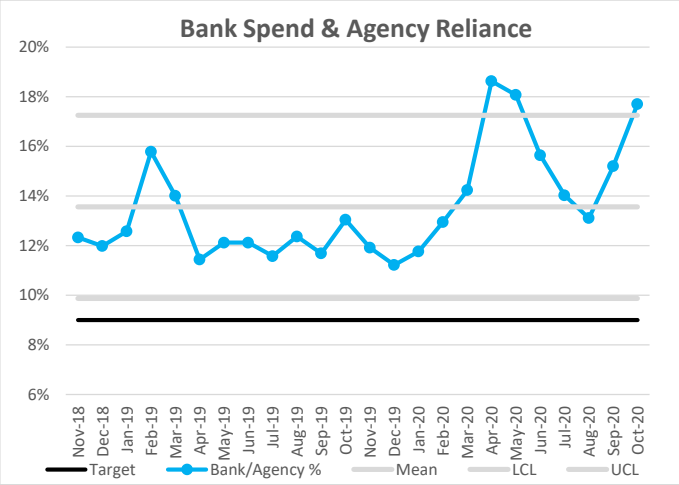
Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

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)?
Pay Red: Greater than Budget Green: Less than Budget		Total pay spend in October 2020 was £18.5m against a budget of £18.0m. The total pay spend is broken down into the following elements: • £14.5m Contracted Pay (i.e. substantive staff) • £1.9m Bank Pay • £1.4m Agency Pay • £0.6m Waiting List Initiative (WLI) Pay • £0.09m Overtime Pay	Additional controls and challenge 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 above 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 (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)?
Bank and Agency Reliance Red: 11% or Above Amber: 11% to 9% Green: 9% or Below	UoR RR199 **Bank and Agency Reliance was 17.71% in month. SPC - Bank/Agency reliance is within common cause (expected) variation.**		**Reliance on both bank and agency has increased since August and in October 2020 it's now 17.71% of the overall pay bill.**	**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.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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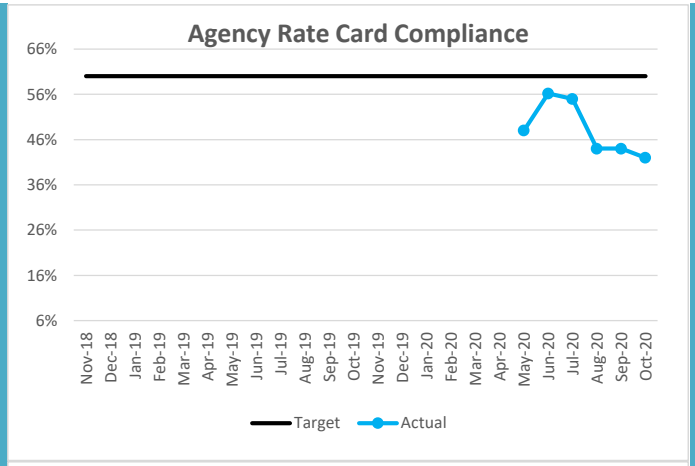
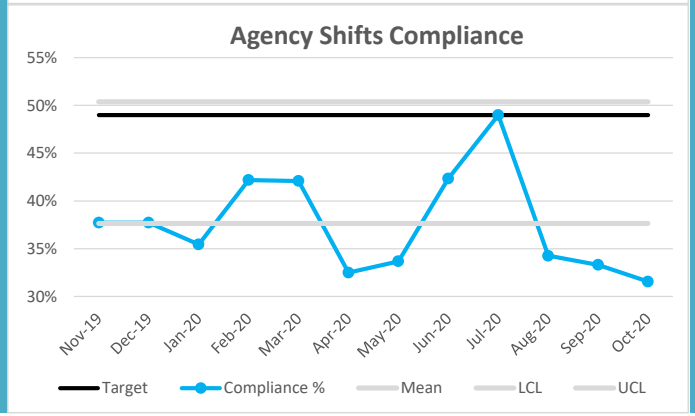
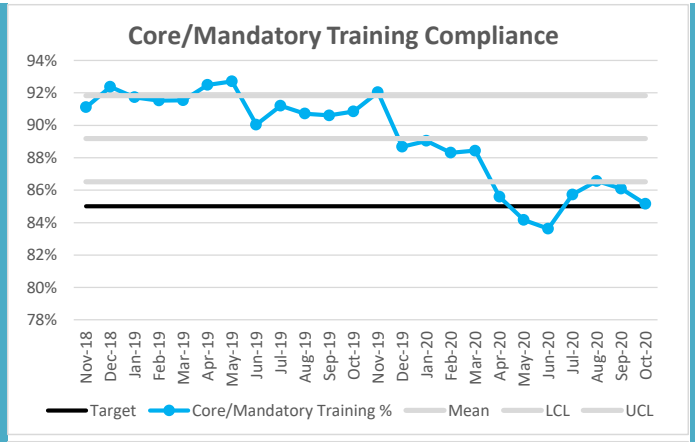
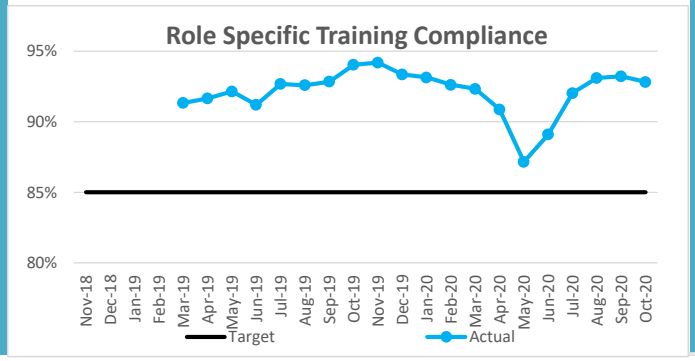
Care Quality Commission (CQC)
Trust Strategy (S)

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)?
Agency Rate Card Compliance Red: below 50% Amber: 50-59% Green: 60% or above		31.56% of the overall agency shifts are compliant with the NHSI Price Cap and 42.00% of shifts are compliant with the C&M rate card.	The central bank and agency team continue to negotiate rates down towards the Cheshire and Mersey Rate Card and the NHSI Price Cap. Increasing medical bank usage will support improving the compliance. Where the rates are more generous (unsocial), the Trust is able to meet the rate card. The Trust will work with NHSP to challenge the agencies.
UoR **Agency Rate Card Compliance was 42.00% in month.**			
Agency Shifts Compliant with the Cap Red: below 49% Green: above 49%			
UoR **31.56% 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 (S)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Core/Mandatory Training Red: Below 70% Amber: 70% to 85%		Mandatory and Role Specific training have both above their respective target compliance.	Mandatory and role specific training requirements have been paused again, although it should be noted that staff have 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 85.15% in month.
SPC - there is evidence of special cause variation.

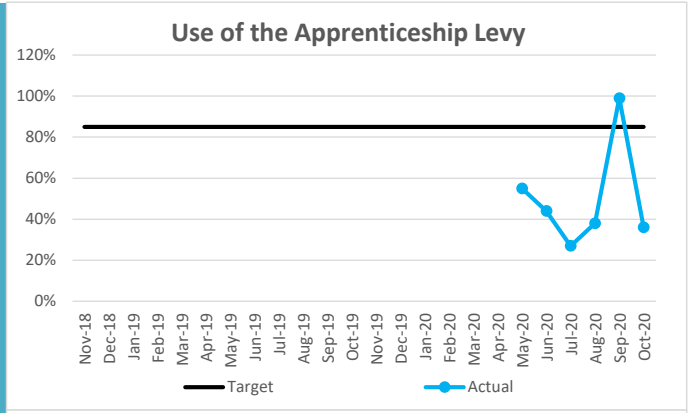
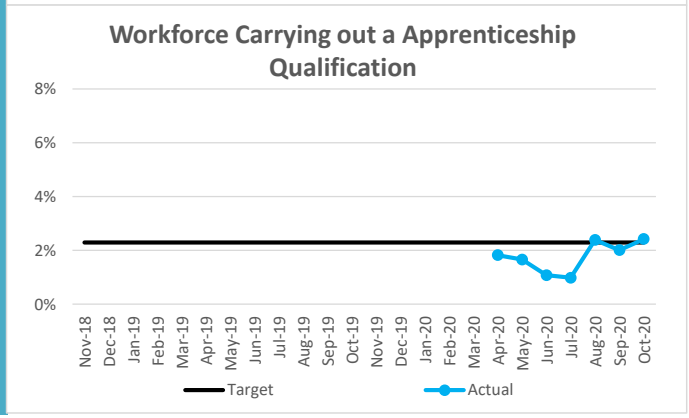
RR153

Role Specific Training compliance was 92.82% 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 (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)?
Use of Apprenticeship Levy Red: below 50% Amber: 50-84% Green: 85% or above		Utilisation of the apprenticeship levy was at 36.00% in October 2020. 2.42% of the workforce are currently using the apprentice levy to study towards a formal qualification.	The Trust currently has 107 members of staff undertaking an Apprenticeship and continues to challenge new recruitment and promote 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 36.00% in month.

Percentage of the workforce carrying out a qualification was 2.42% in month.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
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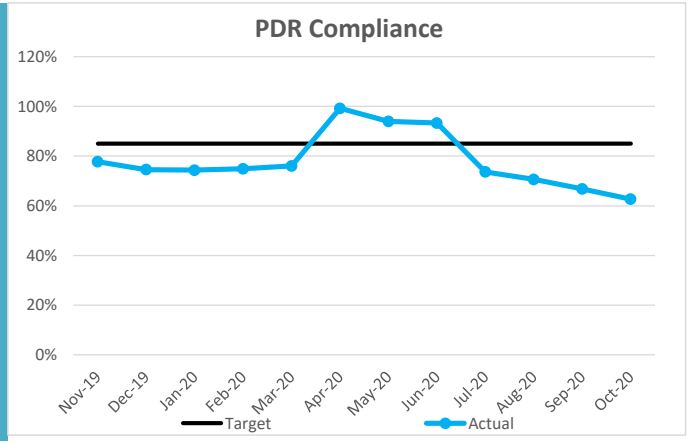
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

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)?
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 62.65% in month.

Sickness Absence Actions

Occupational Health Support

The COVID-19 nursing advice line remains in place across 7 days per week. The OH Team are also undertaking 'business as usual' functions such as management referrals and pre-employment clearances.

Staff Testing

COVID-19 testing continues to be available to staff, both on and off-site, booked via OH Team. The demand in the service is high indicating more individuals are experiencing symptoms.

The Trust is currently in the very early stages of rolling out the lateral flow antigen testing for all front line staff.

Protecting Staff – Risk Assessments

COVID 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:

- 84.80% of all staff have been risk assessed (all staff have been offered a risk assessment).
- 96.40% of known "at risk" staff have been risk assessed with mitigating steps agreed where necessary.
- 97.30% 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.

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)?

Workforce Recovery

Workforce recovery following the pandemic is likely to be long term and could significantly impact the health and wellbeing of our workforce. The following interventions are currently available to staff and managers:

- Health and Wellbeing booklet
- Health and Wellbeing Extranet Page
- Expansion of Mental Health First Aiders (+PFA)
- Care First Employee Assistance Programme
- Occupational Health Service
- Mental Health Drop in Sessions
- Facilitated Debrief Conversations
- Going Home Healthy
- MSK telephone clinics
- Project Wingman
- BAME Staff Network
- LGBTQ+ Staff Network
- Managers Guidance: Workforce Implications of Restarting Services
- COVID-19 Recovery Check In
- Self-Compassion at Work Programme
- Understanding each other as a team
- Coaching
- Resilience Sessions (Virtual and Face to Face)
- Bite Size Wellbeing Sessions online
- Outstanding Teams Principles Guide
- Bringing Teams Together' workshops
- Enhanced On-site Staff Counselling Service
- Sharing Stories Sessions
- Bite Size On-line Master classes
- Understanding my Leadership Style

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 (S) | Risk Register (RR116)

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

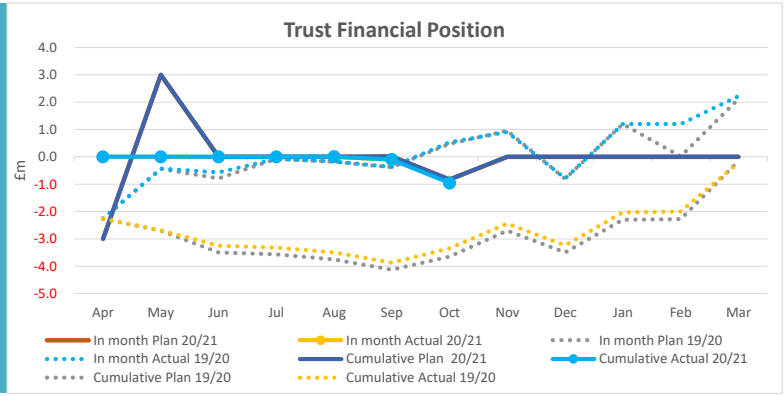
Trust Financial Position

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

UoR SOF S

The Trust has recorded a deficit position of £0.8m as at 31 October.

RR134



For the period ending 31 October 2020 the Trust has recorded a deficit position of £0.8m against a deficit plan of £0.7m. The position includes a retrospective top up of £17.9m to support COVID-19 expenditure and income loss of £21.6m year to date.

The Trust is applying national guidance as this emerges in relation to financial planning.

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.

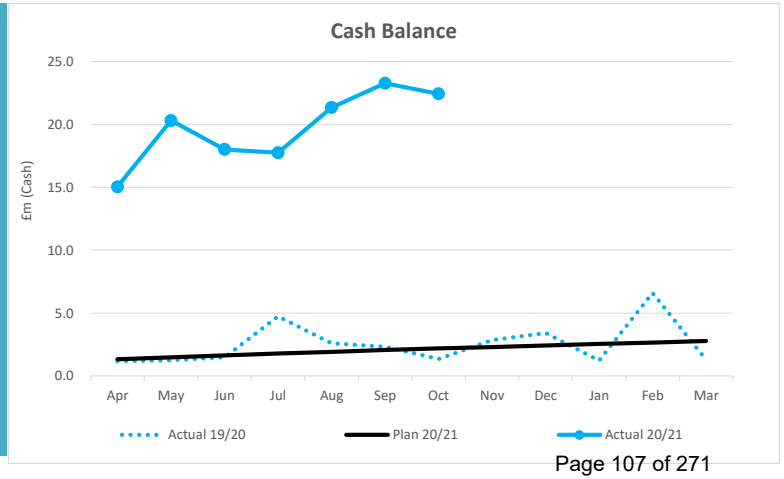
Cash Balance

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 £22.45m.

RR134



The current cash balance is £22.45m which is £20.27m better than plan. This is due to early receipt of block income and top ups as part of the new financial regime. The cash is to be used to achieve the new target of paying suppliers within 7 days for the receipt of goods and services.

The cash flow forecast has been remodelled based on the current phase 3 plan. The cashflow will need to be updated as any further guidance emerges.

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 (S) | Risk Register (RR116)

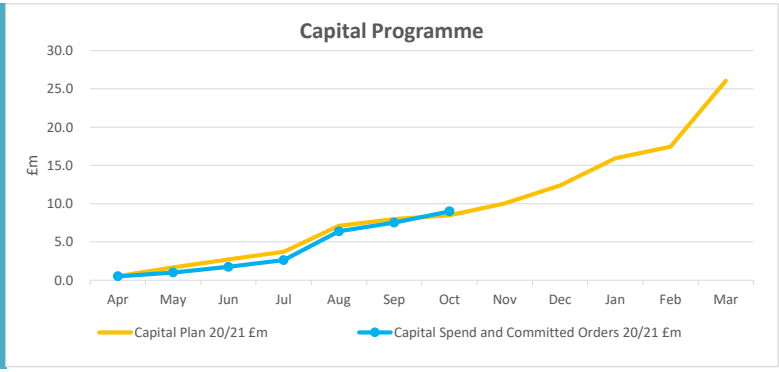
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Capital Programme

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

UoR SOF RR669

The actual capital spend in month is £0.54m.



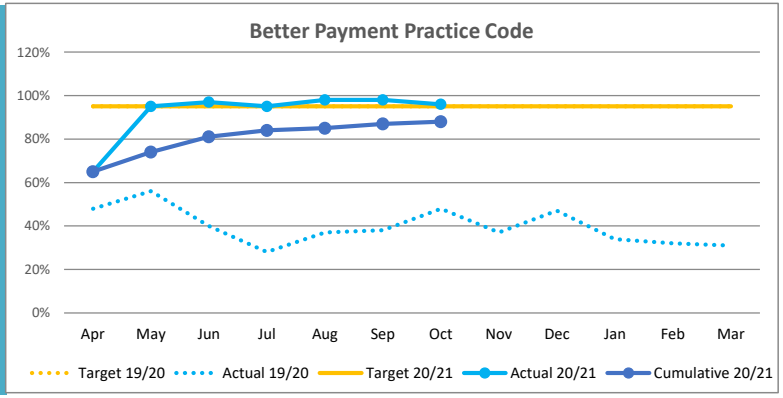
The Board approved capital plan is £26.3m, however there is a reduction to the anticipated critical care award by £0.3m which will reduce the programme to £26.0m. The actual spend year to date is £5.4m which is £3.1m below the planned spend of £8.5m. However, the Trust has committed orders of £3.6m.

Better Payment Practice Code

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

UoR SOF

In month, the Trust has paid 96.00% of suppliers within 30 days. This results in a cumulative performance of 88.00%.



Performance of 96.00% is above the national standard of 95.00%. This position is supported by the availability of cash.

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 (S)
Risk Register (RR116)

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

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.

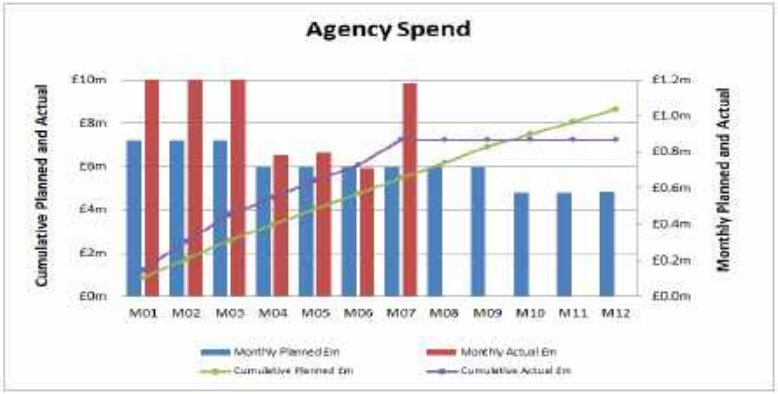
Agency Spending

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 £1.2m.

RR199



The spend of £1.2m is £0.5m above the plan of £0.7m. Of the total YTD expenditure of £7.2m, £3.8m 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 (S)
Risk Register (RR116)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR		**CIP has been suspended nationally during the COVID-19 Pandemic.**	

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

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).
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.
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.
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 the Price Cap	% of agency shifts compliant with the Trust cap against peer average.
Agency Rate Card Compliance	% of agency shifts which comply with the Cheshire & Mersey rate card.
Pay Spend – Contracted and	A review of Contracted and Non-Contacted pay against budget.

Non-Contracted	
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?

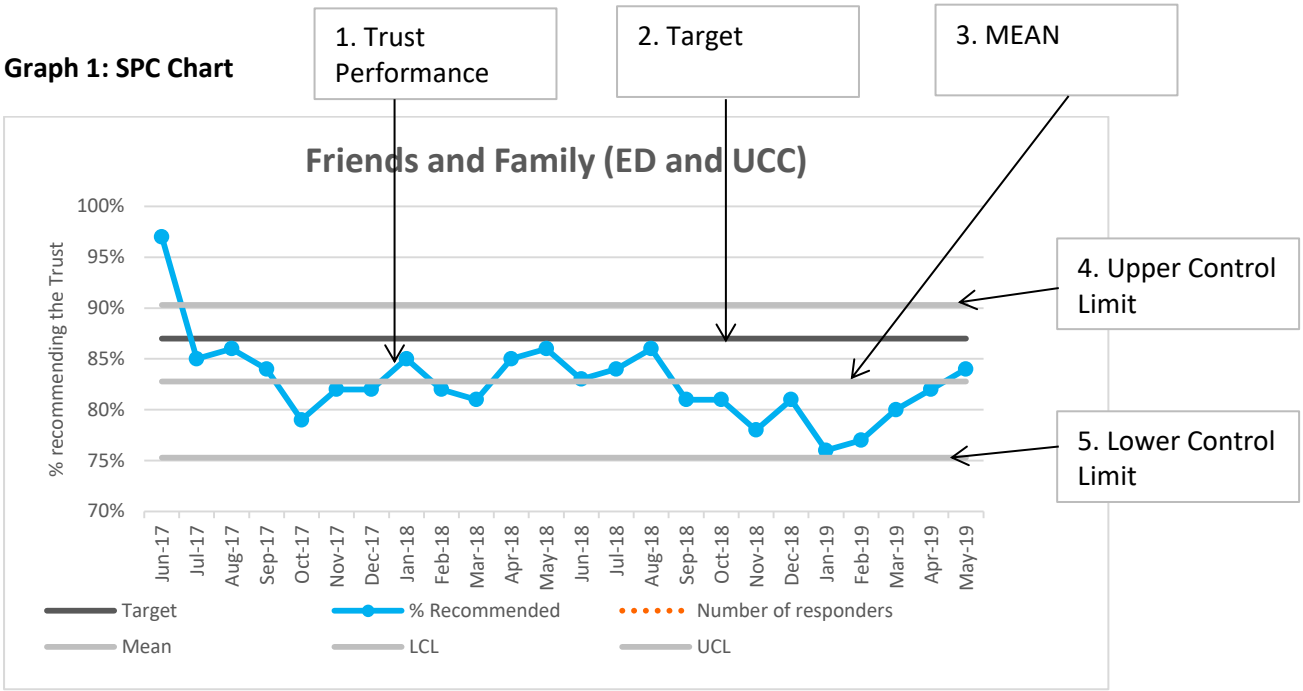
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

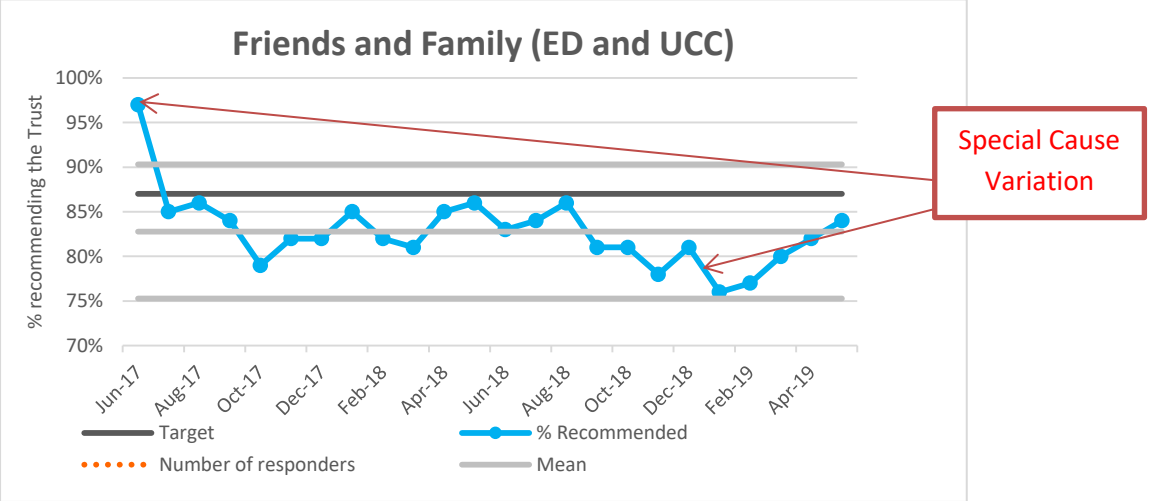
Graph 1: SPC Chart



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 October 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	2,772	1,849	-922	18,254	8,162	-10,092
Elective Excess Bed Days	18	2	-16	128	17	-111
Non Elective Spells	6,021	5,386	-635	42,368	36,650	-5,718
Non Elective Bed Days	166	260	94	1,165	1,289	124
Non Elective Excess Bed Days	105	64	-41	735	424	-311
Outpatient Attendances	3,314	2,434	-880	21,785	14,146	-7,639
Accident & Emergency Attendances	1,447	1,366	-81	10,152	8,976	-1,176
Other Activity	4,970	7,780	2,809	38,428	63,815	25,386
Sub total	**18,814**	**19,142**	**328**	**133,015**	**133,478**	**462**
Non NHS Clinical Income						
Private Patients	0	1	1	0	6	6
Non NHS Overseas Patients	6	7	1	31	21	-10
Other non protected	30	62	32	297	240	-57
Sub total	**36**	**70**	**34**	**328**	**266**	**-62**
Other Operating Income						
NHSE Top Up	2,351	2,351	0	13,547	13,546	-1
Retrospective Income	0	0	0	15,343	16,494	1,151
Covid/Growth	1,426	1,426	0	1,426	1,426	0
Training & Education	679	680	0	4,756	4,612	-144
Donations and Grants	0	0	0	0	0	0
Miscellaneous Income	519	1,139	621	4,063	4,990	927
Sub total	**4,975**	**5,596**	**621**	**39,134**	**41,067**	**1,933**
Total Operating Income	**23,825**	**24,807**	**983**	**172,478**	**174,811**	**2,333**
Operating Expenses						
Employee Benefit Expenses	-18,002	-18,472	-469	-125,785	-126,381	-596
Drugs	-1,210	-1,264	-54	-8,476	-8,612	-135
Clinical Supplies and Services	-1,779	-1,987	-208	-12,984	-13,600	-616
Non Clinical Supplies	-2,739	-2,972	-233	-19,507	-20,512	-1,005
Depreciation and Amortisation	-609	-701	-92	-4,484	-4,730	-246
Net Impairments (DEL)	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0
Total Operating Expenses	**-24,340**	**-25,396**	**-1,056**	**-171,236**	**-173,835**	**-2,599**
Operating Surplus / (Deficit)	**-515**	**-588**	**-73**	**1,242**	**976**	**-266**
Non Operating Income and Expenses						
Profit / (Loss) on disposal of assets	0	0	0	0	1	1
Interest Income	3	0	-3	4	-5	-9
Interest Expenses	-46	0	46	-138	-1	137
PDC Dividends	-276	-276	0	-1,930	-1,930	0
Total Non Operating Income and Expenses	**-319**	**-276**	**43**	**-2,064**	**-1,935**	**129**
Surplus / (Deficit)	**-834**	**-864**	**-30**	**-822**	**-959**	**-137**
Adjustments to Financial Performance						
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0
Less Donations & Grants Income	0	0	0	0	0	0
Add Depreciation on Donated & Granted Assets	82	16	-66	116	110	-6
Total Adjustments to Financial Performance	**82**	**16**	**-66**	**116**	**110**	**-6**
Adjusted Surplus / (Deficit)	**-752**	**-848**	**-96**	**-706**	**-849**	**-143**

Activity Summary	Planned	Actual	Variance	Planned	Actual	Variance
Elective Spells	3,054	1,907	-1,147	19,844	9,753	-10,091
Elective Excess Bed Days	68	0	-68	477	62	-415
Non Elective Spells	3,508	2,101	-1,407	24,991	15,838	-9,153
Non Elective Bed Days	466	702	236	3,263	3,611	348
Non Elective Excess Bed Days	392	111	-281	2,741	1,550	-1,191
Outpatient Attendances	28,013	22,586	-5,427	184,063	130,881	-53,182
Accident & Emergency Attendances	9,863	7,391	-2,472	69,217	51,937	-17,280

Appendix 6 - Capital Bid Analysis 2020/21

Scheme Name	Funding Source	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	
Devices Replacement (Tech Refresh)	Business Critical	194	
Electronic Patient Record Procurement (£70k for scoping / £180k for procurement)	Business Critical	250	
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	
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	
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	
MRI Additional Equipment costs	BAU	326	
Covid pre 18th May	PDC	2,802	
Halton CMTC	BAU	2,000	
Contingency	BAU	390	
Endoscopy	PDC (Endo)	511	
Critical Care	PDC (Critical Care)	1,695	
Total As agreed at October Board		**26,331**	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/10/117**	
SUBJECT:	**Safe Staffing Assurance Report – August and September 2020**	
DATE OF MEETING:	25 November2020	
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 August and September 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 6.28% in August 2020 and 6.31% in September 2020 for nursing and midwifery staff. In the month of August 2020 it was noted that 17 of the 21 wards were below the 90% target during the day, with an improvement noted in September with 14 of the 21 wards below the 90% target. In order to ensure safe staffing levels, mitigation and responsive plans were implemented daily to ensure that the safe delivery of patient care. CHPPD in August 2020 was 7.8 and 7.5 in September 2020, with a year to date rate 7.9. As part of the COVID-19 Pandemic response in line with NMC guidance a total of 133 nursing students were welcomed to the Trust and supported the wards during the pandemic. 29 of the students who are due to register in September 2020 have accepted a substantive post at Warrington and Halton Hospitals. WHH have joined Wigan, Wrightington and Leigh NHS Trust to participate in a regional pilot for recruitment of international nurses. Following a successful business case we are working on the plans to recruit 30 registered nurses to join the Trust in the next 3 months. The report demonstrates the progress that continues to be made across the organisation in nursing and midwifery staffing levels as the number of wards reporting staffing levels below the 90% and CHPPD.	

	In September 2020 the Trust has also commenced the COVID Wave 2 staffing response plan as we started to see case numbers rise in the Trust. The staffing response is being undertaken in a gradual and systematic way in order to manage the demands in activity and workforce challenges.			
PURPOSE: ***(please select as appropriate)***	Information *	Approval	To note *	Decision
RECOMMENDATION:	Trust Board asked to receive the contents of this report as discussed and received at the Strategic People Committee.			
PREVIOUSLY CONSIDERED BY:	**Committee**	**Strategic People Committee**		
	Agenda Ref.	SPC/20/11/XXX		
	Date of meeting	18 November 2020		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Safe Staffing Assurance Report – August /September 2020	AGENDA REF:	BM/20/11/117

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report – August and September 2020.

The purpose of this report is to provide assurance with regard to the nursing and midwifery ward staffing levels during the months of August and September 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 August and September 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 August and September 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 August CHPPD was recorded at 7.8 and September recorded at 7.5 with a 2020/21 YTD figure of 7.9. This is in comparison to the national YTD figure of 8.1. The reduction in CHPPD is in response to student nurses deployed to support the Trust as part of the COVID 19 pandemic response leaving the Trust to return to their studies. Another factor

that has influenced the change in month is the number of ward changes with areas such as Ward K25 opening to support the operational needs of the Trust.

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
2020/21 Total		55228	4.3	3.6	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 17 of the 21 wards in August 2020 and 14 out of 21 in September 2020 reported staffing levels under the 90% for registered nurses. August data demonstrated an increase in the number of wards reporting rates below 90%, which is can be related to peak holiday season and reduced fill rates in NHSP workers during these months. 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.

It is important to note that there have been a number of ward changes during this time, with the introduction of Ward K25 in September providing a step down facility for medically fit patients. We have utilised staff from Ward B1 and any shortfalls have been managed by accessing temporary staffing through NHSP.

In September 2020 the Trust has also commenced the COVID Wave 2 staffing response plan as we started to see case numbers rise in the Trust. The staffing response is being undertaken in a gradual and systematic way in order to manage the demands in activity and workforce challenges.

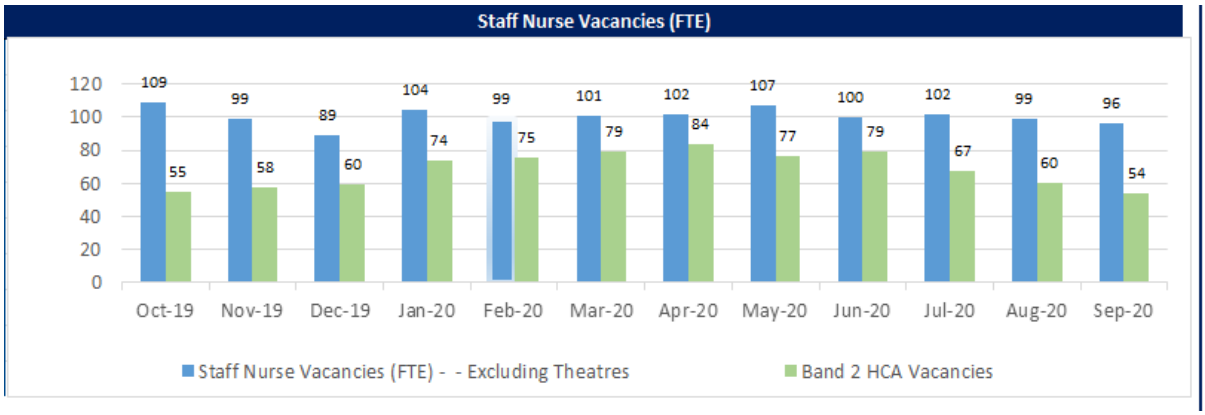
In order to ensure safe staffing levels, mitigation and responsive plans continue to be put in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates continue to be monitored month on month.

Maternity (ward C23) although showing below the 90% target on the ward (82.3% in August 2020 and 80.4% in September 2020), use their responsive staffing plans in the unit to move staff to support if acuity requires additional staffing.

Vacancy Summary

In August 2020 we had 99 registered nurse and 60 health care assistant vacancies and a slightly improved position in September with 96 registered nurse and 54 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.

Chart 1



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. Since July 2020 18 registered nurses have accepted a job offer with WHH. This is an improvement from previous adverts, allowing WHH to secure a number of experienced nurses from neighbouring organisations.

WHH have been approached by Wigan, Wrightington and Leigh NHS Trust to participate in a regional pilot for recruitment of international nurses. The partnership includes HEE and aims to establish a North West Hub, 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.

WHH have recently submitted a bid to HEE to secure funding for on apprenticeship programme for 2020/21 to support 10 registered nurse associates or assistant practitioners to undertake the Registered Nurse Degree Apprenticeship.

Recruiting to HCA vacancies remains a challenge for the Trust and although we have recruited 90 HCA staff since February 2020, we still have 54 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 40 staff who have been recruited, who are currently undergoing pre-employment checks. The Trust continues with a rolling advert for

HCA's advertised both locally and regionally. The number of vacancies is monitored monthly at the workforce group.

Escalation Beds and Costs

In the months of August and September 2020 there were we opened Ward K25, which is currently being managed by Medical Care CBU and supported in staffing by the displaced staff from ward B1 after it closed in the summer months. 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 – August 2020

During the month of August registered nurse and midwifery absence rates were recorded at 6.28% showing a slight increase from the July report at 5.92%. Sickness data in September 2020 details a similar position of 6.31%. The cost of bank/agency cover of qualified nursing sickness (at usual bank/agency fill rates) is £232,312 for August and £236,608 as detailed in the tables 2 and 3 below.

Table 2 - Registered nurse and midwifery sickness cover – August 2020

Contracted Nursing WTE (Band 5 to 7)	904.13
% Sickness	6.28%
WTE Equivalent of Sickness	56.78
NHSP Fill Rate	76%
WTE Covered by Temporary Staffing	43.15
Cost at Average NHSP Rates	***232,312***

Table 3 - Registered nurse and midwifery sickness cover – September 2020

Contracted Nursing WTE (Band 5 to 7)	916.47
% Sickness	6.31%
WTE Equivalent of Sickness	57.83
NHSP Fill Rate	76%
WTE Covered by Temporary Staffing	43.95
Cost at Average NHSP Rates	***236,608***

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 August 2020 we have reported 5 category 2 pressure ulcers on wards A1, A5, A6, A8 and ITU. There has been 0 patient falls with major harm reported in August 2020.

In September 2020 we have reported 9 category pressure ulcers on wards A2, A5 x2, A6 x2, A7, A9, B19, and ITU. There has been 1 patient fall with moderate harm reported in September 2020.

Infection Incidents

In both August and September2020 the Trust did not report any cases of MRSA bacteraemia.

Appendix 3	MONTHLY SAFE STAFFING DATA – August 2020																		
Monthly Safe Staffing Data – August 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	1379.9	1426	1433.2	80%	100.5%	1069.5	1138.5	1069.5	1265	106.5%	118.3%	871	2.9	3.1	0.1	0.0	6.2
DD	Ward A6	1782.5	1575.5	1782.5	1575.5	88.4%	88.4%	1069.5	1242	1782.5	1748	116.1%	98.1%	958	2.9	3.5	0.0	0.0	6.4
DD	Ward B4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
DD	Ward A4	1667.5	1294.5	1426	1772	77.6%	124.3%	1069.5	1000.5	1069.5	1150	93.5%	107.5%	960	2.4	3.0	0.0	0.0	5.5
MSK	CMTC	1007.5	903	690	536.5	89.6%	77.8%	713	667	713	345	93.5%	48.4%	199	7.9	4.4	0.0	0.0	12.3
MSK	Ward A9	1782.5	1404.5	1782.5	1995	78.8%	111.9%	1069.5	1173	1782.5	1679	109.7%	94.2%	1034	2.5	3.6	0.0	0.0	6.0
W&C	Ward B11	2939	2663	807.5	787.5	90.6%	97.5%	1627.6	1627.6	322.4	322	100%	99.9%	261	16.4	4.3	1.8	0.0	22.5
W&C	NNU	1782.5	1247	365.5	149.5	70%	40.9%	1782.5	161.5	365.5	264.5	9%	72.3%	145	20.9	3.6	0.0	0.0	24.4
W&C	Ward C20	1054	966	713	660	91.7%	92.6%	713	713	0	172.5	100%	-	456	3.7	1.8	0.0	0.0	5.7
W&C	Ward C23	1426	1173.5	713	667	82.3%	93.5%	713	713	713	678.5	100%	95.2%	457	4.1	2.9	0.0	0.0	7.1
W&C	Birth Suite	2495.5	2216.5	356.5	386.5	88.8%	108.4%	2495.5	2079.5	356.5	356.5	83.3%	100%	246	17.5	3.0	0.0	0.0	20.5
UEC	Ward A1	2325	2012.5	2325	2912.5	86.6%	125.3%	1627.5	1519.7	1293.3	1116	93.4%	86.3%	1116	3.2	3.6	0.0	0.0	6.8
UEC	Ward A2	1426	1127	1782.5	1702	79%	95.5%	1069.5	1069.5	1069.5	1288	100%	120.4%	930	2.4	3.2	0.0	0.0	5.6
IM&C	Ward C21	1069.5	928	1426	1542	86.8%	108.1%	736	736	1069	1391	100%	130.1%	772	2.2	3.8	0.0	0.0	6.0
IM&C	Ward A8	1725	1529	2070	1667.5	88.6%	80.6%	1426	1368.5	1426	1276	96%	89.5%	1054	2.7	2.8	0.0	0.2	5.8
IM&C	Ward B12	1069.5	852.8	2495.5	2331.8	79.7%	93.4%	713	713	1782.5	2081.5	100%	116.8%	651	2.4	6.8	0.0	0.1	9.5
IM&C	Ward B14	1069.5	1070	1782.5	1637.5	100%	91.9%	713	713	1069.5	1046.5	100%	97.8%	744	2.4	3.6	0.0	0.1	6.3
IM&C	Ward B18	690	905.5	690	661	131.2%	95.8%	713	609.5	713	322	85.5%	45.2%	142	10.7	6.9	0.0	0.0	17.6
IM&C	Ward B19	1426	1197.5	1782.5	1485.5	84%	83.3%	1069.5	1069.5	1426	1690	100%	118.5%	837	2.7	3.8	0.0	0.0	6.5
MC	Ward A7	1782.5	1502.8	1426	1641	84.3%	115.1%	1426	1518	1035	1679	106.5%	162.2%	937	3.2	3.5	0.0	0.0	6.8
MC	ACCU	2495.5	2228.5	1069.5	1205.5	89.3%	112.7%	1782.5	1771	1069.5	1207.5	99.4%	112.9%	801	5.0	3.0	0.0	0.0	8.0
MC	ICU	4991	4266.5	1069.5	799.3	85.5%	74.7%	4991	4370	1069.5	747.5	87.6%	69.9%	419	20.6	3.7	0.0	0.0	24.3

Appendix 2

August 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	80%	100.5%	106.5%	118.3%	**Vacancy -** band 6 0.72 wte band 5 3.48 wte band 2 2.51 wte **Sickness rate** – 7.82% **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	88.4%	88.4%	116.1%	98.1%	**Vacancy -** band 6 1.25wte band 5 5.11wte band 2 3.95 wte **Sickness rate** -10.72% **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	77.6%	124.3%	93.5%	107.5%	**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	89.6%	77.8%	93.5%	48.4%	**Vacancy Rate**: band 6 1.92wte, band 5 4.77wte, band 2 1.92wte **Sickness Rate:**4.92% **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	78.8%	111.9%	109.7%	94.2%	**Vacancy –** Band5 x 2 new starters in progress. Band 2 CSWD's in post **Sickness rate –** 6.8% **Action taken –** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support as appropriate.

Ward B11	90.6%	97.5%	100%	99.9%	**Vacancy –** Fully established **Sickness rate** – 5.23% **Action taken -** Sickness managed through Trust Attendance Policy
NNU	70%	40.9%	9%	72.3%	**Vacancy –** Band 8a Matron 1.0 wte, band 7 2wte **Sickness rate –** 4.28% **Action taken –** Staffing and acuity reviewed daily. Recruitment programme in place with
Ward C20	91.7%	92.6%	100%	-	**Vacancy –** band 6 0.40 wte **Sickness rate -** 4.5% **Action taken -** Sickness managed through Trust Attendance Policy
Ward C23	82.3%	93.5%	100%	95.2%	**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	88.8%	108.4%	83.3%	100%	**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	86.6%	125.3%	93.4%	86.3%	**Vacancy -** band 6 1.74wte, band 5 6.66wte, band 4 3.75wte, band 2 3.96 wte **Sickness rate –** 4.40% **Action taken** - New starters in September. 1x B6/ 4xB5 NQ / Awaiting recruitment of CSWD. Nhsp usage and WM filling shortfalls in staffing.
Ward A2	79%	95.5%	100%	120.4%	**Vacancy –** band 6 1.0 wte, band 5 2.0wte **Sickness rate** – 0.61% **Action taken** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. On-going recruitment. New starters in September. 1x B6/ 4xB5 NQ / Awaiting recruitment of CSWd Sickness is being managed in line with Trust policy.
Ward C21	86.8%	108.1%	100%	130.1%	**Vacancy:** RN 5.8 WTE band 5/6 posts, HCAs band 2 7.6 WTE posts **Sickness Rate:**15.89% **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	88.6%	80.6%	96%	89.5%	**Vacancy -** band 5 4.0 wte, band 2 0.64 wte **Sickness rate –** 11.4% **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	79.7%	93.4%	100%	116.8%	**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. 4.0 wte CSWD's in post to support Band. 2.0

					new starters in post September sickness managed as per policy 3.0 wte shielding
Ward B14	100%	91.9%	100%	97.8%	**Vacancy -** Band2 7.0wte **Sickness rate** - 9.43% **Action taken** - - Ward reviewed daily for acuity and staffing.CSWD x2 in post & awaiting new starters to commence
Ward B18	131.2%	95.8%	85.5%	45.2%	**Vacancy –** band 5 - 1.32 wte Band 2- 2.0wte **Sickness rate** - 6.60% **Action taken** - - New transfer of ward team Ward reviewed daily for acuity and staffing.
Ward B19	84%	83.3%	100%	118.5%	**Vacancy –** band 5 1.6 wte Band 2 5.4 wte **Sickness rate** – 10.53% **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	84.3%	115.1%	106.5%	162.2%	**Vacancy**: ., band 5 7.61wte band 2 1.14wte **Sickness rate** – 4.93% **Action taken –** all sickness managed in line with policy. Ward reviewed daily for acuity and staffing.
ACCU	89.3%	112.7%	99.4%	112.9%	**Vacancy -** Band 2 2.6 wte **Sickness rate** -3.44 % **Action taken** - Ward reviewed daily for acuity and staffing, sickness managed in line with policy
ICU	85.5%	74.7%	87.6%	69.9%	**Vacancy -** band 5 -5.86wte. **Sickness rate** – 5.10% **Action taken** - Ward reviewed daily for acuity and staffing. band 5 going through pre-employment checks
Total Fill Rate (%)	80%	100.5%	106.5%	118.3%	

Appendix 3	MONTHLY SAFE STAFFING DATA – September 2020																		
Monthly Safe Staffing Data – September 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	1293.8	1426	1374	75%	96.4%	1069.5	1127	1069.5	1219	105.4%	114%	856	2.8	3.0	0.1	0.0	6.1
DD	Ward A6	1782.5	1506.5	1782.5	1560.5	84.5%	87.5%	1069.5	1058	1782.5	1552.5	98.9%	87.1%	822	3.1.	3.8	0.2	0.0	7.1
DD	Ward B4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
DD	Ward A4	1663	1269	1269	1380	76.3%	108.7%	1035	1092.5	1035	1081	105.6%	104.4%	928	2.5	2.7	0.1	0.0	5.3
MSK	CMTC	943	931.4	598	598	98.8%	100%	690	690	690	379.5	100%	55%	386	4.2	2.5	0.0	0.0	6.7
MSK	Ward A9	1069.5	1351	1725	1718.5	126.3%	99.6%	1035	1092.5	1725	1621.5	105.6%	94%	1020	2.4	3.3	0.0	0.0	5.7
W&C	Ward B11	2894	2673.5	757.5	757.5	92.4%	100%	1574.4	1553.2	312	311.6	98.7%	99.9%	279	15.1	3.8	1.2	0.0	20.1
W&C	NNU	1725	1253.5	345	218.5	72.7%	63.3%	1725	1104	345	322	64%	93.3%	192	12.3	2.8	0.0	0.0	15.1
W&C	Ward C20	1035	1000.5	690	659.5	96.7%	95.6%	690	690	0	230	100%	-	420	4.0	2.1	0.1	0.0	6.2
W&C	Ward C23	1380	1109	690	621	80.4%	90%	690	747.5	690	621	108.3%	90%	457	4.1	2.7	0.0	0.0	6.8
W&C	Birth Suite	2415	2039	345	341	84.4%	98.8%	2415	2079.5	345	333.5	86.1%	96.7%	246	16.7	2.7	0.0	0.0	19.5
UEC	Ward A1	2250	1875	2250	2500	83.3%	111.1%	1575	1427.1	1251.6	979.9	90.6%	78.3%	1080	3.1	3.2	0.0	0.0	6.3
UEC	Ward A2	1380	1104	1725	1460.5	80%	84.7%	1035	1035	1035	1127	100%	108.9%	900	2.4	2.9	0.0	0.0	5.3
IM&C	Ward C21	1069.5	806	1380	1330	75.4%	96.4%	736	736	1035	1345	100%	130%	750	2.1	3.6	0.0	0.0	5.8
IM&C	Ward A8	1725	1502	1725	1537.5	87.1%	89.1%	1380	1403	1380	1284	101.7%	93%	1020	2.8	2.8	0.0	0.1	5.8
IM&C	Ward B12	1069	835.5	2415	2149.8	78.2%	89%	690	690	1817	1713.5	100%	94.3%	630	2.4	6.1	0.0	0.1	8.8
IM&C	Ward B14	1035	1053.5	1725	1513.5	101.8%	87.7%	690	690	1035	1000.5	100%	96.7%	720	2.4	3.5	0..1	0.0	6.0
IM&C	Ward B18	667	802	667	569	120.2%	85.3%	713	690	713	322	96.8%	45.2%	217	6.9	4.1	0.0	0.0	11.0
IM&C	Ward B19	1380	1095.5	1725	1398	79.4%	81%	1035	1035	1725	1403	100%	81.3%	810	2.6	3.5	0.0	0.0	6.1
MC	Ward A7	1725	1596.5	1380	1358.5	92.6%	98.4%	1380	1564	1035	1321	113.3%	127.6%	875	3.6	3.1	0.0	0.0	6.7
MC	ACCU	2415	2059	1035	993.5	85.3%	96%	1725	1667.5	1035	1069.5	96.7%	103.3%	575	6.5	3.6	0.0	0.0	10.1
MC	ICU	4830	4191.8	1035	977.5	86.8%	94.4%	4830	4180.3	1035	678.5	86.5%	65.6%	433	19.3	3.8	0.0	0.0	23.2

Appendix 4

September 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	75%	96.4%	105.4%	114%	**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	84.5%	87.5%	98.9%	87.1%	**Vacancy -** band 6 1.25wte band 5 5.11wte band 2 3.95 wte **Sickness rate** -10.72% **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. With 4 HCA's going through pre-employment checks.
Ward B4	-	-	-	-	Ward closed
Ward A4	76.3%	108.7%	105.6%	104.4%	**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	98.8%	100%	100%	55%	**Vacancy Rate**: band 6 1.92wte, band 5 4.77wte, band 2 1.92wte **Sickness Rate:**4.92% **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	126.3%	99.6%	105.6%	94%	**Vacancy –** Band5 4.0wte, band 2 3.0 wte **Sickness rate –** 13.12% **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	92.4%	100%	98.7%	99.9%	**Vacancy** – Fully established **Sickness rate** – 5.23% **Action taken** - Sickness managed through Trust Attendance Policy
NNU	72.7%	63.3%	64%	93.3%	**Vacancy –** Band 8a Matron 1.0 wte, band 7 2wte **Sickness rate –** 1.0% **Action taken –** Staffing and acuity reviewed daily. Vacancies have been advertised with interviews planned
Ward C20	96.7%	95.6%	100%	-	**Vacancy –** band 6 0.40wte band 2 0.40 wte **Sickness rate** - 10.32% **Action taken** - Sickness managed through Trust Attendance Policy
Ward C23	80.4%	90%	108.3%	90%	**Vacancy –** band 6 2.34wte **Sickness rate** – 9.5% **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	84.4%	98.8%	86.1%	96.7%	**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	83.3%	111.1%	90.6%	78.3%	**Vacancy** - ward manager 1.0wte, band 6 1.0, band 5 6.66wte, band 4 3.75wte, band 2 3.96 wte **Sickness rate –** 5.23% **Action taken** - New starters in September. 1x B6/ 4xB5 NQ / Awaiting recruitment of CSWD. Nhsp usage and WM filling shortfalls in staffing.
Ward A2	80%	84.7%	100%	108.9%	**Vacancy –** band 5 2.8wte **Sickness rate** – 0.25% **Action taken** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. On-going recruitment. New starters in September. 1x B6/ 4xB5 NQ / Awaiting recruitment of CSWd Sickness is being managed in line with Trust policy.
Ward C21	75.4%	96.4%	100%	130%	**Vacancy**: band 4 2.5wte, band 2 1.5wte posts **Sickness Rate:**15.89% **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	87.1%	89.1%	101.7%	93%	**Vacancy** - band 5 4.0 wte, **Sickness rate –** 14.41% **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	78.2%	89%	100%	94.3%	**Vacancy** - band 5 2.35wte Band 2 3.0wte **Sickness rate** – 21.89% **Action taken** - Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward B14	101.8%	87.7%	100%	96.7%	**Vacancy** - Band2 4.0wte **Sickness rate** - 4.12%

					Action taken - - Ward reviewed daily for acuity and staffing.CSWD x2 in post & awaiting new starters to commence
Ward B18	120.2%	85.3%	96.8%	45.2%	**Vacancy –** band 5 - 1.32 wte Band 2- 2.0wte **Sickness rate** - 6.60% **Action taken** - - New transfer of ward team Ward reviewed daily for acuity and staffing. Sickness managed as per Trust policy
Ward B19	79.4%	81%	100%	81.3%	**Vacancy –** band 5 1.6 wte Band 2 5.4 wte **Sickness rate** – 10.04% **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	92.6%	98.4%	113.3%	127.6%	**Vacancy**: ., band 5 7.61wte band 2 2.5wte **Sickness rate** – 13.55% **Action taken –** all sickness managed in line with policy. Ward reviewed daily for acuity and staffing.
ACCU	85.3%	96%	96.7%	103.3%	**Vacancy -** Band 2 2.6 wte **Sickness rate** -3.44 % **Action taken** - Ward reviewed daily for acuity and staffing, sickness managed in line with policy. Band 2 posts recruited to awaiting start dates
ICU	86.8%	94.4%	86.5%	65.6%	**Vacancy -** band 5 -5.86wte. band 2, 1.86wte **Sickness rate** – 1.88% **Action taken** - Ward reviewed daily for acuity and staffing. band 5 going through pre-employment checks
Total Fill Rate (%)	75%	96.4%	105.4%	114%	

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 20/11/117 b i	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	25 November 2020

Date of Meeting	6 October 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/20/10/ 185	**Matters arising**	The Committee received the following update: <u>Lorenzo Downtime, upgrades and Trust-wide Digital Solutions</u> - An oversight Risk IT report, short/medium and long term solutions. Mitigations to November QAC of any impact on quality of clinical services. - MB to escalate risk identified regarding additional IT resource and investment to Chair of FSC. - Committee to receive exception reports for areas of clinical/safety/quality concerns via Digital Board reporting as required.	The Committee noted the updates and received moderate assurance.	**FSC 21.10.2020 QAC 03.11.2020**
QAC/20/10/ 187	**Hot Topic - Radiology Review**	The Committee received report following review of all radiology incidences and complaints over the last 12 months. - All incidents investigated and reviewed in line with Trust Governance process. - Process for reflective and shared learning in place. - The Committee received assurance that the Department is fully compliant with RCR guidelines as above and assurance of process in place to monitor incidences and share learning**.**	The Committee noted the updates and received good assurance.	**n/a**

QAC/20/10/188	**Moving to Outstanding Action Plan update**	The Committee received an update on the Moving to Outstanding action plan and noted the following: - Of the original 63 actions in the CQC action plan, 7 actions remain. All actions and timeframes had been agreed by Executive leads and core service leads and should be completed by October 2020 (6 should, 1 However).	**The Committee noted the updates and received good assurance.**	**QAC 03.11.2020 Trust Board 25.11.2020**
QAC/20/10/189	**Deep Dive**	<u>Urology (Part 1)</u> The Committee received an update on progress of work of the Urology Service Improvement Group consisting of 4-5 workstreams, including workforce/governance/clinical pathways. - Risk #1048 Prostrate and Cathetar risks to be updated on CRR. - Part 2 of report to November QAC to include actions to date, actions to be taken and timeframe for completion.	**The Committee noted progress to date and received moderate assurance**	**QAC 03.11.2020**
QAC/20/10/189	**Deep Dive**	<u>Infection Control COVID-19 Outbreak Ward C21</u> The Committee received a high level summary of incidences that occurred during the outbreak, learning and mechanisms to share learnng. - Assurance provided that recent staff outbreaks had not resulted in delays to patient treatment. - Visit from NHSE/I and CCG w/ending 2 October 2020. No areas of concern reported. Exception report to next QAC.	**The Committee noted the updates and received good assurance.**	**QAC 03.11.2020**
QAC/20/10/193	**Phase 3 Recovery – Activity Update**	The Committee particularly noted: - Clinical and non-clinical wait times. - Joint report following RCA of clinical and non-clinical waits at Harm meeting. - Report and review of waiting lists to November QAC as Hot Topic.	**The Committee noted the updates and received moderate assurance.**	**QAC 03.11.2020 Trust Board 26.11.2020**
QAC/20/10/193	**Legal Considerations of Governance during COVID-19 Pandemic**	The Committee particularly noted: - Anticipated risks the Trust may encounter due to COVID-19, expected challenges, processes put in place during COVID-19. - Progress of the action plan against the recommendations to be monitored at PSCESC and reported to QAC through the High Level Briefing report.	**The Committee noted the updates and received good assurance.**	**PSCESC 08.12.2020 QAC 01.12.2020 Trust Board 26.11.2020**

QAC/20/10/200	**High Level Briefing - Patient Safety & Clinical Effectiveness Sub Committee**	The Committee received updates from the Patient Safety & Clinical Effectiveness Sub-Committee and particularly noted: - Diagnostics Policy Review Report, significant progress against original MIAA recommendations. - Internal audit of compliance with revised Policy and process on how diagnostic test results are reviewed to report to QAC in 6 months.	The Committee noted the updates and received moderate assurance	**QAC 06.04.2021**

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 20/11/117a iii	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	25 November 2020

Date of Meeting	3 November 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/20/11/ 208	**Matters arising**	The Committee received the following update: QAC/20/09/162 – MB had met with CR, PJ and AC 19.10.2020 to discuss clinical functionality of IT systems, assurance provided of action plan in place, particularly engagement of maternity staff in the process (EPMA).	The Committee noted the updates and received moderate assurance.	**F&SC 18.11.2020 & QAC 01.12.2020**
QAC/20/11/ 209	**Hot Topic – COVID-19 Clinical Harm Reviews**	The Committee received the following update: - Findings of the review undertaken to establish if harm had been caused to any patient harm due to excessive delay of treatment. - Assurance provided that Clinical Harm Reviews will be undertaken on each individual patient delayed on high risk pathway with involvement from Primary Care colleagues to ensure that tracking process in place to identify where patients have seen a clinician in Primary and Secondary Care. - On completion of reviews, direct communication with the patient and Primary Care of outcome and plan for treatment. - 40 patients had breached cancer pathway (104 days) and are being reviewed as a priority. RRT 52 week wait patients to be reviewed, focus continues on individual case reviews with Cluster review for patients in low/medium risk pathways.	The Committee noted the updates and received good assurance.	n/a

QAC/20/11/210	**Deep Dive**	Urology (Part 2) The Committee received an update on progress of work of the Urology Service Improvement Group consisting of 4-5 workstreams, including workforce/governance/clinical pathways. - Risk rating reduction from 16 to 12 on the Risk Register which had been reduced before the Urology Service Improvement Group (SIG) had been established due to limited assurance provided of progress over the last year,. - May 2019/June 2020 deep dive – themes identified included clinical care risks, coding issues, a deep dive had been repeated this year and similar themes identified; themes highlighted in previous deep dive relating to medical grade, decompression of job plans not identified in last deep dive. - This year's deep dive found less SIs, reduction from 7 to 4. - Progress of some actions limited due to the challenges during the COVID pandemic. - Acute and Cancer Care pathway being progressed, Bladder and Prostate Cancer pathways to be implemented by end of the year. Prostate pathway to be redesigned with Biopsy template. - Full action plan with timelines to be received by the Patient Safety Clinical Effectiveness Sub Committee and assurance report to Quality Assurance Committee	**The Committee noted progress to date. limited Assurance**	**PSCESC 08.12.2020 QAC 12.01.2021**
QAC/20/11/211	**Board Assurance Framework**	The Committee approved the following: - Addition of 6 new risks, for of which were directly related to the COVID-19 pandemic; - The amendment of the ratings of two risks; - The amendment to the description of one risk.	The Committee noted the updates and received good assurance.	**QAC 01.12.2020**
QAC/20/10/213	**Phase 3 Recovery – Activity Update**	The Committee particularly noted: - Clinical and non-clinical wait times. - Improvement in a number of standards, despite COVID challenges - Stocktake to be undertaken over last 6 weeks, review trajectories. Holding statement in next month's report to ensure correlation with clinical harm review	The Committee noted the updates and received good assurance.	**QAC 01.12.2020**

		process and any impact on patients		
QAC/20/11/214	**Maternity Safety Champion Report**	The Committee particularly noted: - Assurance provided relating to the strengthening of the Senior Leadership team in W&C, with dedicated leadership and clinical expertise from the Deputy CN supported by DG providing professional maternity leadership, DC as Programme Director for the W&C CBU and LG as programme support. Two additional Matrons had also been appointed. Updates received relating to: - NHS Resolution CNST Maternity Incentive Scheme - relaunched October 2020, reporting of actions from 1.10.2020 to 20.05. - Continuity of Care progress; EMPA October 2020 – implemented October 2020, to support improved safety medications administration - Saving Babies Lives v2. - Perinatal mortality data highlighted including reviews and actions, reviewing data over last 3 years as part of rolling 3-5 year period for accuracy. - ATAIN action plan – work continues to reduce the number of unexpected term admissions of infants >37 weeks to the Neonatal Unit.	The Committee noted the updates and received good assurance.	**QAC 01.12.2020**

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/20/11/117 c		TRUST BOARD OF DIRECTORS	DATE OF MEETING	25 November 2020

Date of Meeting	**18 November 2020**
Name of Meeting + Chair	**Strategic People Committee** **Anita Wainwright, Non-Executive Director**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
SPC/20/11/84	**Matters Arising:** Local Induction for Temporary Medical Staff:	**Local Induction for Temporary Medical Staff, Medical Director** The Committee received a reporting updating on progress following discussions in the previous meeting: • Communications have been issued by the Medical Director to Assistant CBU Managers	**Decision** The Committee approved the recommendation to remove any paper elements of the local induction for the temporary workforce and ensure that the electronic system in place is the only mechanism for completion, thus removing any risks associated with hard copy documentation.	January 2020

		• The checklist will be reviewed as part of continuous improvement • The procedures put in place centrally by the HR Team are appropriate and fit for purpose		
SPC/20/11/8	**Chief People Officer Report**	**Chief People Officer Report,** **Chief People Officer** The Chief People Officer updated the Committee on: • Equality, Diversity and Inclusion – Commissioned Review into Embedding ED&I • Public Sector Exit Payments • Supporting Staff to Stay Safe During COVID-19 • Asymptomatic Staff Testing	**Assurance** The Committee received assurance relating to the following key work streams: <u>Commissioned Review into Embedding ED&I</u> The Chief People Officer has commissioned Jagtar Singh, Director, JS Limited to undertake a strategic review of equality, diversity, and inclusion practice within the organisation, specifically covering: • Phase 1: Vision and Ambition • Phase 2: Awareness and Challenge • Phase 3: Development and Confidence The final report and recommendations for next steps were received by the Committee. <u>Public Sector Exit Payments</u> The implementation of a £95,000 cap on exit payments in the public sector received final approval from parliament in October 2020. <u>Supporting Staff to Stay Safe During COVID-19</u> On 1 November 2020 the Government announced new national restrictions which will come into force on 5 November 2020. Systems and processes are in place to ensure compliance across the workforce.	

			<u>COVID-19 Asymptomatic Staff Testing</u> On 11th October 2020 the Trust was informed by NHSE/I of the requirement to carry out COVID-19 testing for asymptomatic staff within a specified cohort of staff groups. The Trust was 1 of 11 pilot sites across the North West. In total 3,072 were undertaken, with a positivity rate of 1.92%. On 9 November 2020 the Trust volunteered to be 1 of 3 Trusts in the North West to roll out Lateral Flow Testing for asymptomatic staff. The project involves twice weekly self-testing for all patient-facing staff. A full roll out is commencing 17 November 2020.	
SPC/20/11/87	**Revised Terms of Reference**	**Revised Terms of Reference** **Trust Secretary**	**Decision** The Committee approved the proposed amendments to the Terms of Reference, which set out that Equality, Diversity and Inclusion Committee will report directly to Strategic People Committee.	
SPC/20/11/89	**GMC Revalidation Annual Report + Statement of Compliance**	**Medical Appraisal and GMC Revalidation Annual Report** **Medical Director** The Committee received the Medical Appraisal and GMC Revalidation Annual Report	**Assurance** The Committee were assured in relation to both appraisal and revalidation compliance.	
SPC/20/11/90	**Workforce Race Equality Standard**	**Workforce Race Equality Standard** **Deputy Director of HR and OD** The Committee received a report detailing the findings of a review into indicators in the 2020 Workforce Race Equality Standard relating to formal disciplinary processes, bullying and	**Assurance** The Committee were assured that appropriate actions are in place to address any specific concerns and approved the WRES action plan.	

		discrimination.		
SPC/20/11/91	**Workforce Disability Equality Standard**	**Workforce Disability Equality Standard** **Deputy Director of HR and OD** The Committee received a report detailing the findings of a review into indicators in the 2020 Workforce Disability Equality Standard relating to bullying, career progression and presenteeism.	**Assurance** The Committee were assured that appropriate actions are in place to address any specific concerns and approved the WDES action plan.	
SPC/20/11/93	**People Strategy Equality, Diversity and Inclusion Strategy (workforce)**	**People Strategy Equality, Diversity and Inclusion Strategy (workforce)** **Deputy Director of HR and OD** The Committee received a report detailing progress against the strategic priorities relating to the People Strategy and the workforce elements of the Equality, Diversity and Inclusion Strategy	**Assurance** The Committee were assured that a robust delivery plan is in place to deliver the objects and the NHS People Plan. The Committee were also assured that appropriate progress is being made against the objectives. Detailed updates were provided in relation to the following objectives: • Implement an enhanced mental health offer to support our workforce during and • following COVID-19 pandemic • Introduce team support programmes, for teams reforming and developing following • the pandemic • Clarify and promote the WHH offer • Develop international recruitment • Develop and embed new ways of working based on comprehensive workforce plans. • Introduce compassionate leadership development programmes and recruitment • Approaches • Introduce Staff Networks for disabled staff	

			and LGBTQ+ staff. • Introduce reverse mentoring The Committee noted the significant amount of work in place to delivers the priorities and support the workforce.	

BOARD OF DIRECTORS CHAIR'S ASSURANCE REPORT

AGENDA REFERENCE:	BM/20/11/117		TRUST BOARD OF DIRECTORS	DATE OF MEETING	21 October 2020

Date of Meeting	21 October 2020
Name of Meeting + Chair	Finance & Sustainability Committee – Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	RECEIVING BODY (eg Board or Committee)	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
FSC/20/10/135	Corporate Performance Report	• 81.95% September A&E performance below trajectory of 86.7% - fallen below trajectory for second consecutive month • Increase in super stranded remains a concern at c100 patients • RTT 8.41% improvement in September, those waiting in excess of 18 weeks has reduced for the second month • Failed 62 day standard and 2 week breast symptomatic wait (breast associated with patient choice) • Diagnostics 40.26%, improvement in Radiology however sickness has affected other areas which are expected to improve from October.	Committee	The Committee noted the report.	FSC November 2020
FSC/20/10/136	Phase 3	• Spire national contract extended to 31 December and local negotiations underway for post December.	Committee	The Committee noted the report.	FSC November

		• Risk of deterioration from October due to peak in Covid positive patients at rate of height of pandemic			2020
FSC/20/10/137	Pay Assurance Report	• Highlighted over established areas • Discussed link to comprehensive medical review to address over establishment • 21% decrease in agency rate card compliance, more granular information including opportunity cost to be included in next report	Committee	The Committee noted the report.	FSC November 2020
FSC/20/10/138	Covid-19 Nurse Staffing Update	• 60 HCA and 99 RN vacancies • Increased number of escalation areas and reduction in shift fill rates • Off framework agency usage at high cost – monitoring and procurement reviewed by Executive Team • To be highlighted to Trust Board	Committee – update to be reported to Board	The Committee noted the report.	FSC November 2020
FSC/20/10/139	Covid-19 Expenditure	• Review of Covid-19 spend and forecast, noting the change in forecast from August to September linked to self-isolation and recovery schemes	Committee	The Committee noted the report.	FSC November 2020
FSC/20/10/140	Medical Establishment Review Interim Report	• Key drivers in over spend are vacancies, sickness and over establishment • Comprehensive review undertaken • Workplan identified	Committee and Strategic Executive Oversight Group	The Committee noted the report.	FSC December 2020
FSC/20/10/141	Deep Dive into Digital Risks on BAF	• Comprehensive review of the 2 digital BAf risks • Review of maternity digital risk on corporate risk register	Committee	The Committee noted the report and support the proposed changes to risk scores.	???? TERRY WHEN DO YOU WANT THIS TO COME BACK TO THE FSC?
FSC/20/10/142	Digital Services	• Positive digital compliance report particularly in	Committee	The Committee noted	FSC

	Board Report	respect of cyber security • Business cases being prepared for Maternity, EPR and Lorenzo planned for November 2020.		the report.	November 2020
FSC/20/10/143	Lilly Cross Update	• Visit to Lilly Cross postponed due to outbreak • Care model being developed	Committee	The Committee noted the update.	FSC November 2020
FSC/20/10/144	WHH System Governance	• System recovery meetings on hold due to operational pressures	Committee	The Committee noted the update.	FSC November 2020
FSC/20/10/145	Committee Effectiveness 6 Month Review	• Positive scores all either strongly agree or agree • Improvement continues to be an aspiration • Discussion about the quality of reports and need to avoid jargon and ensure clear for audience	Committee	The Committee notes the report.	FSC April 2021
FSC/20/10/1246	Monthly Finance Report	• Achieved breakeven position with retrospective top up of £16.5m. Year to date top up remains below the level of Covid spend. • Delay in receipt of full funding for August which is now expected in November • Penalties expected for activity under performance to be introduced in September however mechanism and calculation not yet clarified and not in the position (estimate £130k). • Agreement in place to resolve ward B1 and B3 debtor • The Cabinet Office Procurement Policy has been applied to a small business that supports the Trust. This was endorsed by the Committee. • The financial plan for October 2020 to March 2021 was approved by Board at a £19.0m deficit. Notified of additional income (£0.1m) and requirement to adjust plan to £18.9m deficit. This excludes share of covid and growth funds. • Capital - Board approved £24.6m programme.	Committee	The Committee reviewed, discussed and noted the report. Committee endorsed the use of the Cabinet Office Procurement Policy, supported the revised financial plan and increase to capital budget. Requested additional information from CPG on the RAG rating/confidence level for each scheme.	FSC November 2020

		Additional funding of £1.7m for critical care awarded which will increase the programme to £26.3m. To add to the programme at October Board. • Scale of the capital programme and Q4 profile presents a delivery challenge. Additional oversight and scrutiny in place however risk with over 50% to be delivered in Q4. RAG rating/confidence factor requested for each scheme			
FSC/20/10/147	BAF/Risk Register	• Noted the report • Approved BAF risks rating amendments	Committee	The Committee noted the report and approved the changes to risk ratings.	FSC November 2020
FSC/20/10/148	Key issues to the Board	• Note the performance levels for A&E • Note the concerns around the super stranded patients and the impact on patient flow • Note the increasing reliance on off framework agencies for nursing • Note the concern of the capital profile in Q4 and additional monitoring required • Note the year to date financial position, the penalties and the lack of clarity • Note the deep dives into the Digital Board risks • Note the comprehensive review of medical staffing	Board		Board November 2020

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/20/11/117 d		TRUST BOARD OF DIRECTORS	DATE OF MEETING	25 November 2020

Date of Meeting	**18 November 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/20/11/153	Corporate Performance Report	The Committee considered and reviewed the report noting:- • 78.31% October A&E performance with year to date of 87.54% missing the target. • Urgent care activity 80-90% of same period last year • Super stranded patients are circa 100 • Recovery is impacted by Wave 2 activity	The Committee **noted** the updates and received moderate assurance.	FSC Dec 2020
FSC/20/11/154	Phase 3 Recovery Activity Report	The Committee noted the impact of the increase in prevalence of Covid-19 during October which will affect our recovery performance going forward.	The Committee **noted** the updates and received moderate assurance.	FSC Dec 2020
FSC/20/11/155	MRI Business case changes	The Committee considered and reviewed the business case. Discussed the additional costs outlined and the benchmarking with other Trusts. The Committee also noted the need for a timely decision.	The Committee **noted** the update and further discussion to take place in Private Board	Trust Private Board November 2020

FSC/20/11/156	Pay Assurance Report	The Committee considered and reviewed the report noting the following key points:- • Overview of additional staff paid above funding split by staff type. • Reviewed the Establishment Control process for all staff and noted robustness. • Highlighted bank incentive scheme which has been implemented and the impact on costs. • Noted the lack of monitoring of the rate card across Cheshire and Mersey. • Off framework required for high skilled areas and there are on-going conversation to reduce the rate under local negotiations. • The Committee noted the increase in data available but reduced capacity to act on this due to Covid19.	The Committee **noted** the updates and received good assurance.	FSC Dec 2020
FSC/20/11/157	Maternity EPR Business Case	The Committee considered and reviewed the business case noting:- • Cost will be £1m over 5 years • Benefits of £0.5m but the quality impact is greater than the cash releasing benefits • CNST data and benchmarking data with peers will improve	The Committee **noted** the business case and **supported** to take to the Board for approval	Trust Board November 2020
FSC/20/11/158	Lorenzo Contract Extension Business Case	The Committee considered and reviewed the business case in respect of Lorenzo for support & consideration by next week's Trust Board	The Committee **noted** the business case and **supported** to take to the Board for approval	Trust Board November 2020
FSC/20/11/159	Reference Cost Draft Report	The Committee considered and reviewed the report which outlined the basis of the submission, revised timescales and actions being taken linked to EY audit report	The Committee **noted** the updates and received good assurance.	FSC Feb 2021
FSC/20/11/160	Monthly Finance report incl: (a) Draft Capital Planning Group	The Committee considered the report and capital proposals key points to note included: • This is the first month of the new financial regime with Phase 3 plan of £10.3m deficit plan based on R=1	The Committee **noted** the updates and received good assurance.	FSC Dec 2020

	minutes (30.10.2020) (b) FRG minutes (19.10.2020) (c) Commissioner Contract Minutes 15.07.2020	• For the period ending 31 October 2020 the Trust recorded a deficit position of £0.8m. The position is £0.1m worse than plan, the expenditure includes £1.1m Covid19 Wave 2 expenditure, which has been offset by income that had been provided as a bad debt and underspends on recovery schemes in month. • Activity is behind trajectory and expect penalties but these are not currently in the Trust position as per NHSE/I advice. • Highlighted recording issue in coding and further review being undertaken. • Note and support the changes to the capital plan and the risk associated with A&E plaza, Critical Care, Breast at Halton and MRI schemes • Noted the Trust will be submitting a forecast position for a deadline of 4 December 2020	The Committee **supported** the changes to the capital plan to go to Board for approval	
FSC/20/11/161	Risk Register including Strategic Digital Risk (from EBM)	The Committee considered and reviewed the report which highlighted:- • No new BAF risks • Proposal to amend the risk rating and description of Risk 1114. Recent events surrounding loss of access to Lorenzo resulted in the re-scoring of the risk from 16 to 20 to increase its current consequence and acknowledge that the achievable target risk also increases from 8 to 15 • Proposal to amend the risk rating of Risk 1205. The risk rating was decreased from 15 to 10. The risk and its scoring reflect an intense and focused multidiscipline piece of work.	The Committee **noted** the updates and received good assurance.	FSC Dec 2020

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/20/11/117 e	COMMITTEE/ GROUP	TRUST BOARD OF DIRECTORS	DATE OF MEETING	25th November 2020

Date of Meeting	19 November 2020
Name of Meeting + Chair	Audit Committee, Chaired by Ian Jones, Non-Executive Director
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
AC/20/11/76	**Changes or updates to the BAF**	The Committee received an update on changes to the BAF since the last meeting and particularly noted: • 6 new risks added • Description of one risk amended • Ratings of three risks amended.	**The Committee discussed the report and received good assurance**	**Trust Board 25.11.2020 Audit Committee 20.02.2021**
AC/20/11/76	**Progress report on Internal Audit Follow-Up actions**	The Committee received a report providing details of Internal Audit Reports with any outstanding management actions. The Committee particularly noted: • The outstanding actions for the IT Service Continuity and Resilience Review are close to completion. • Outstanding actions for the CQC action plan review scheduled for completion by 30th November 2020 • No critical or high recommendations overdue	**The Committee discussed the report and received good assurance**	**Audit Committee 20.02.2021**
AC/20/11/79	**Internal Audit Progress report**	The Committee particular noted the following: • Stage one of Assurance Framework Review Completed – robust arrangements in place.	**The Committee noted and discussed the report and progress against actions**	**Audit Committee 20.02.2021**

		• Serious Incidents (including Duty of Candour) – (Moderate Assurance) compliance levels 0x Critical, 1x High, 4x Medium, 6x Low. Assurance that adequate processes in place reporting of StEIS and application of Duty of Candour within 10 days of incident reported on StEIS. • Change Management – Clinical Systems (Moderate Assurance) compliance levels 0x Critical, 1x High, 2x Medium, 0x Low. Completed by Technology Risk and Assurance Team. The Committee approved a change in the Audit Plan to include a review of the Patient Level Information and Costing System (PLCIS) to replace the joint review with Bridgewater Community Healthcare NHS Foundation Trust	**will be reported at the next meeting. Moderate assurance was received**	
AC/20/11/ 80	**External Audit Report**	The Committee received a report from External Auditors Grant Thornton that highlighted the key changes relating to the new approach for Value for Money for 2020/21. Of particular note was: • Three criteria have changed to Governance, Financial Sustainability and Improving Economy, Efficiency and Effectiveness. • The Annual Audit Letter will be replaced by Auditors Annual Report • Practical implications – more engagement with Board and Governors for views. Implications on fees had been factored into the new contract.	**The Committee discussed the report and received good assurance**	**Audit Committee 20.02.2021**
AC/20/11/ 81	**Counter Fraud Progress Report**	The Committee received a report detailing the anti-fraud activity undertaken 14 July 2020-31 October 2020 and an update on progress made in addressing fraud referrals received by the Trust's Anti-Fraud Specialist. The Committee particularly noted: • Fraud Risk Management - thematic fraud risks in the process of being considered in light of COVID-19 risks. • Referrals – one new referral to AFS, further referral created by AFS, three further queries, two closed requiring no further action, one being dealt with by AFS and the Trust.	**The Committee discussed the report and received good assurance**	**Audit Committee 20.02.2021**

AC/20/11/82	**Losses and Special Payments Report Q2 1 July 2020 - 30 September 2020**	The Committee particularly noted: • The value of Losses and Special Payments for the quarter 1 July 2020 to 30 September 2020 reported at £154,568. • The value of Losses and Special Payments for the year to date £175,283. • Increase in store losses during COVID-19 pandemic due to additional surgical items being written off due to pause in elective programme. • Increase in Employer Liability Claims payments to in Q2 – Thematic review to be undertaken.	**The Audit Committee reviewed and discusses the report noting and received moderate assurance**	**Audit Committee 20.02.2021**
AC/20/11/83	**Tenders and Waivers Period 1 April 2020 - 30 September 2020**	The Committee particularly noted: • Between 1 April – 30 September 2020, 41 waiver received 16 specifically related to COVID-19. • 9 waivers raised retrospectively The committee discussed and noted the strengthened process in relation to retrospective waivers resulting in a reduction in received.	**The Audit Committee noted the report and assurance provided of processes in place to monitor the Tender and Waiver process and received good assurance.**	**Audit Committee 20.02.2021**
AC/20/11/83	**COVID-19 Data Protection Checklist**	The Committee received and reviewed the checklists demonstrating the Trust's response during the Pandemic and assurance provided of the robust processes and procedures had been implemented. Abriefing on key elements to be included in the IG High Level briefing to QAC in January 2021	**The Committee discussed the report and received good assurance**	**Quality Assurance Committee 12.01.2021 Audit Committee 20.02.2021**
AC/20/11/83	**Trust Register Report – Declarations of Interest**	The Committee received a report detailing the Trust's current compliance with Declarations of Interest. Of particular note: • 679 out of 1211 members of staff identified as required to make an annual declaration have submitted declarations year to date. • Increase in Consultant compliance.	**The Committee discussed the report and received good assurance**	**Audit Committee November 2021**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/03/118**	
SUBJECT:	**M2O update**	
DATE OF MEETING:	**25 November 2020**	
AUTHOR(S):	Angela Parfitt	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	X X 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 #135 Failure to provide adequate and timely IMT system. #224 Failure to meet the emergency access standard. #125 Failure to maintain an old estate. #701 Failure to provide continuity of services caused by the planned EU Exit. #145 (a) Failure to deliver our strategic vision. #145 (b) Failure to fund two new hospitals. #143 Failure to deliver essential services, caused by Cyber Attack. #414 Failure to implement best practice information governance and information security. #241 Failure to retain medical trainee doctors.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The CQC post inspection action is completemaining actions by 15 December 2020. The remaining actions had been delayed due to the pandemic. An overview is provided regarding interactions in October and November 2020 with the CQC including: • A summary of the Trust's participation in a Provider Collaboration Review, CQC's latest assessment tool of how providers are working collaboratively in an Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP) in response to COVID-19. The Trust received positive feedback for this. • Overview of CQC's Patient First assessment of the Trust, focusing on specific KLOE in relation to Safety, Responsiveness and Leadership predominantly in relation to the Emergency Department. • A summary of the six enquiries the Trust have received from CQC since 1 September 2020.	

	• Confirmation that the next quarterly CQC Provider Engagement Meeting is due to be held on 13th January 2021. • Overview of CQC's draft strategy Updates of M2O work streams are also provided confirming progress made.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note √	Decision
RECOMMENDATION:	Assurance can be offered to the Board that the CQC action plan is complete.			
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	M2O update	AGENDA REF:	BM/20/11/118

1. BACKGROUND/CONTEXT

Following receipt of the CQC inspection reports, a 63 point action plan was created, which was approved by the Executive Directors and core service leads. This has been monitored by the Moving to Outstanding Steering Group, which is chaired by the Chief Nurse.

In addition to the CQC action plan, work has recently been initiated to assess how CQC's change in strategic direction could impact on the Trust with a specific focus on our ambition to become an outstanding organisation. Next steps are being discussed in benchmarking the Trusts position for the moving to outstanding agenda. Data driven mock inspections are being considered as one method by which to ensure focus and direction.

The next quarterly CQC Provider Engagement Meeting is due to be held on 13th January 2020. CQC are currently changing their strategy and are in a transitional phase. This means our next meeting will focus on KLOE relating to Safety (Safe domain), Accessibility to services (Responsive domain) and Leadership (Well-led domain). Dates for future meetings for 2021 should follow from this meeting.

2. KEY ELEMENTS

2.1 CQC action plan

Following inspection there were 63 actions outstanding. Five of these actions were closed (3 actions) or moved for further monitoring at CBU meetings (2 actions). For actions being moved sufficient progress has been made to progress actions. This will be overseen by the Associate Director of Governance and Compliance.

The outstanding actions and proposals are listed below:

Ref	Core Service	Action	Type	Executive Lead	Action Lead	Suggested Proposal
Recommendation / Finding / Areas for Improvement The trust should consider increasing the number of isolation rooms with negative and positive ventilation, in accordance with Department of Health guidelines. The unit only had two isolation rooms with negative and positive ventilation. This was below the recommended number in national guidance.						
CC01a	**Critical Care**	Ensure capital bid is developed and timeframe agreed	**SHOULD**	Dan Moore	Allen Hornby	Moved to CBU with monitoring at Moving to Outstanding meeting

Ref	Core Service	Action	Type	Executive Lead	Action Lead	Suggested Proposal
Recommendation / Finding / Areas for Improvement The Trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.						
MC01c	**Medical Care**	Implementation of electronic rostering for Medical Staff	**SHOULD**	Alex Crowe	Anne Robinson	Moved to CBU and monitored at Moving to Outstanding meeting
MC01d	**Medical Care**	Review escalation processes for medical staff and develop a Standard Operating procedure	**SHOULD**	Alex Crowe	Mark Forrest	SOP approved at Clinical Policy Review Group 30/9/20 and embedded – Closed at Moving to Outstanding Meeting

Ref	Core Service	Action	Type	Executive Lead	Action Lead	Suggested Proposal
Recommendation / Finding / Areas for Improvement The trust should review the progress of the implementation of strategies for patients living with dementia and with a learning disability and consider the implementation of a strategy for patients with mental health needs. The trust did not currently have strategies to support patients living with dementia, learning disabilities or mental health illness. Some of the enabling strategies lacked clear delivery plans.						
TW03b	**Trustwide**	Ensure there is a strategy and implementation plan for patients living with Mental Health	**SHOULD**	Kimberley Salmon-Jamieson	John Goodenough	Strategy has been finalised and is going to Safeguarding Committee then QAC at next cycle of business

TW03c	**Trustwide**	Ensure there is a strategy and implementation plan for patients living with Learning Disabilities	**SHOULD**	Kimberley Salmon-Jamieson	John Goodenough	Strategy has finalised and is going to Safeguarding Committee then QAC at next cycle of business

2.2 CQC Issues Log

There were 50 Issues listed on the Issues Log, all of which are now complete. This includes four issues that were removed as they are being reported and monitored elsewhere.

2.3 Provider Collaboration Review (Urgent Care)

CQC are using their unique position of having oversight of health and adult social care, and building on the work of their Local System Reviews as well as international thinking, to carry out a programme of reviews – which they are calling Provider Collaboration Reviews – of how providers are working collaboratively in an Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP) in response to COVID-19.

The reviews have been developed in response to providers and public groups requesting that CQC look at quality across systems. The aim of the reviews is to capture good work between providers, to help share good practice consistently and to identify national themes where things haven't worked as well.

Each Provider Collaboration Review has a separate focus. The first 11 reviews focused on the interface between health and adult social care for the over-65 population group. CQC are now in their second phase, where they are carrying out eight system reviews on how providers are collaborating to provide urgent and emergency services together in light of COVID-19. On Thursday 22nd October 2020 the Trust were invited to participate in the Cheshire and Merseyside STP Provider Collaboration Review. The Executive Team were interviewed across a range of KLOE, covering:

- how have providers collaborated to ensure that people moving through health and care services have been seen safely in the right place, at the right time, by the right person
- The shared plan and system wide governance and leadership for UEC
- The strategy for ensuring the safety of UEC staff, and sufficient health and care skills across UEC providers during the COVID-19 period
- The impact digital solutions and technology have had on providers and services during the COVID-19 period

The Trust were commended for their enthusiasm and passion despite the challenging current climate.

Following this review each system will receive a summary of findings and be asked to provide a response including planned actions. A full summary report for all eight provider collaboration reviews with all of the themes and trends the CQC found will be published in January 2021 on the CQC website. At the same time CQC will also publish the individual system summaries including responses from the systems. Individual providers or systems will not be named within the national report or individual system summaries.

It should be noted that CQC are seeing Provider Collaboration Reviews as an opportunity for them to explore their approach to working across systems and their future approach to provider regulation as we move beyond the COVID-19 pandemic. CQC also expect the reviews will form part of the monitoring element of their next strategy. The reviews are also being used as an opportunity to assess national risks.

2.4 Patient First assessment

On 3 November 2020 CQC assessed the Trust against Patient First, their latest guidance document, which focuses predominantly on the Emergency Department. The Trust were assessed against specific KLOE across the safe, responsive and well-led domains. The information will be used by CQC to help inform their winter programme of inspections but also as part of their monitoring programme. We will not receive feedback from the CQC in relation to this assessment. It is likely this type of assessment will be used going forwards by CQC focusing on different services within or across the Trust.

2.5 Enquiries from CQC

Since 1 September 2020 the Trust have received 6 enquiries from the CQC:

- Timely pain relief on CAU
- Concerns regarding staff conduct on antenatal clinic
- Concern regarding cleaning in A&E
- A request for a copy of a complaint response
- Neurophysiology reviews
- A compliment in relation to family members experience from mortuary staff

The Deputy Director of Governance has fully responded to the CQC's enquiries.

2.6 CQC Quarterly Engagement Meetings

The next meeting will be on 13 January 2021. Meetings for 2021 are likely to be agreed at this meeting.

2.7 CQC Strategy

CQC are currently seeking feedback on their draft strategy before formal consultation takes place. The strategy is split into four key pillars; People, Smart, Safe and Improve.

In summary:
People is about CQC being an advocate for change, that they ensure that regulation is driven by what people expect and need from services, rather than how providers want to deliver them. CQC also want to improve how people move between services.

Smart is about smarter (more intelligence led) regulation, with an ambition to provide an up-to-date, consistent, and accurate picture of the quality of care in a service and in a local area.

Safe is about CQC's desire for all services to promote strong safety cultures. This includes transparency and openness that takes learning seriously –both when things go right and when things go wrong, with an overall vision and philosophy of achieving zero avoidable harm.

Improve is about CQC's aim to play a much more active role to ensure services improve.
More comprehensive information, including potential impact for the Trust, will be provided via M2O to QAC during the next cycle of business.
The CQC are also seeking organisations to work with to pilot areas of their new monitoring mechanisms.

2.8 Hospital food

Following the death of seven patients from Listeria in another hospital trust, a review was undertaken by Phillip Shelley and reported on last month. The review makes several recommendations including:

- for a board member to be "responsible for the food service" (It is suggested this role should either be filled by the chief nurse or director of estates and facilities)
- to provide an NHS catering apprenticeship scheme and developing a certificated course for hospital caterers;
- to raise hospital chefs' pay from band two to band three;
- for every hospital to implement a digital meal ordering system by 2022; and
- Trusts to agree a common method of recording and monitoring food waste.
- The review also called for boards and chief executives to "regularly eat the same meal as patients to ensure quality is driven from the top".

The government has accepted the recommendations. Mr Shelley will lead a group of experts to oversee the review's implementation across the NHS during the next three years. CQC have been asked to undertake an "enhanced role" when it inspects NHS trusts.

3. MOVING TO OUTSTANDING WORK STREAMS

Moving to Outstanding work streams have been established in areas where we anticipate Core Service Visits. The work streams have developed action plans for Child Health

Improvement, End of Life and Well Led. Each of the work streams has identified enablement projects to support moving the service from a rating of 'Good' to 'Outstanding'.

We have also established a Medicines Improvement Group, working towards improving the following areas which will be a key focus for CQC;

- Safe and Secure handling of medicines
- Medicines reconciliation
- Omitted and delayed medicines
- Controlled drugs

Each of the work streams provide a High Level Briefing Paper monthly to M2O giving update on progress and highlighting any items for escalation.

3.1 End of Life Work Stream

The two appointed Palliative Medicine Consultants, Dr Alison Coackley and Dr Jude Raper have now been in post for 12 months.
The Palliative and End of Life Care Strategy has been reviewed, is currently in draft and will be relaunched in early 2021.
There are three key areas to develop as part of the plan to move the trust to a rating of outstanding for End of Life Care:-

- **Palliative Care Unit and Hub** - The proposed new acute palliative care unit is a 12 bedded Specialist Palliative Care In-patient Unit and Hub – following a "Hospice in Hospital" model – within the Warrington and Halton hospital site. The capital funding required forms part of the bid the Trust has registered centrally with NHSI. A draft business case for the new unit has been completed. There have been early discussions with the Estate team.

Aims of the new unit include:

- ✓ To enhance patient and carer experience, patient choice and safety in the palliative phase and develop a specific appropriate environment for the support of patients and those important to them
- ✓ To reduce the length of stay whenever possible so as to allow patients to return to their home or alternatively transfer to another place of care for those patients with the most complex specialist palliative care needs
- ✓ To enhance quality and promote productivity, partnership working and academic development of personnel by providing a hub for best palliative and end of life care practice to ensure focused high quality, effective, equitable specialist palliative care services
- ✓ To deliver an enhanced local, national and international reputation and profile of the Hospital as part of the integrated End of Life Care Programme within the Trust and the development of our research portfolio

- **Palliative Care at the Front Door** - The Recovery and Development Plan Business Case includes an increase in the Clinical Nurse Specialist (CNS) workforce to facilitate a daily palliative care presence in the Emergency Department. Once this workforce is in place the pilot within ED can commence, providing education and pro-active clinical input.

- **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. We are providing implementation expertise to: London Northwest Healthcare Trust, Royal Liverpool University Hospitals and the recently joined partnership of three Trusts from the North East of England as well as within our own hospital.

  During the COVID 19 pandemic the team provided intranet access to COVID 19 specific tools and educational videos describing how clinicians could approach serious illness conversations with their patients. The Royal College of Physicians have a strong interest in the Programme and are keen to support us. The team will be delivering education via the RCP Player in early 2021 and hosting a Foundations workshop under the RCP umbrella in the spring

  The NIHR Applied Research Collaborative for the Northwest has adopted the Programme as one of its key work streams and will be helping us to develop a bid for a NIHR multicentre research project in collaboration with the Ariadne team. They will also be providing implementation expertise to help with refinement of our national rollout strategy

  The Steering Group for WHHFT implementation is chaired by Alison Coakley and had a first meeting in July 2020. The Foundation and Implementation phases have continued on track. Pilot sites in Gastroenterology and Cardiology have been identified with clinical leads agreed for both specialties. A template in Lorenzo has been finalised which allows clinicians to record the conversation and then automatically communicates the content of the conversation with clinicians in primary care. Training initially scheduled for 23rd November has been moved to January 2021 because of the pandemic. Training of the first cohort of clinicians is scheduled for 23rd November with the first conversations starting to happen in early December 2020.

  WHHFT will be leading a national research study looking at impact and outcomes from these conversations. The research proposal has been submitted to IRAS (The Integrated Research Application System) which is a single system for applying for the permissions and approvals for health and social care / community care research in the UK. We have also submitted a bid for a combined implementation project with primary care colleagues in the Warrington locality

Additional important work streams include:

- **Innovative** ALERT system implemented in July 2020 so that when any patient known to the community, hospice or hospital specialist palliative care teams is admitted to the WHH , the SpPCT are informed within 12 hours via twice daily data warehouse reports. The system is proactively identifying patients where either a referral may be made late or not at all and has allowed the team to make early contact with the patient, assessing their needs and providing of expert palliative care input.
- The **CPR decision-making policy** has been reviewed and updated via the Task and Finish Group. Work includes development of an electronic form to allow documenting of the discussions and decision making. This will facilitate clinical audit focusing on the quality of conversations.
- The supporting education and training programme has been finalised. There will be education at induction and regular role specific training as well as bespoke experiential training for certain groups**.** Training is expected to commence in winter 2020.
- Review of the key performance Indicators for Palliative and End of Life Care across the Trust.

3.2 Well Led Work Stream

During the first wave of COVID-19 and continuing in to the second wave, the Trust Board has continued to hold, via MS Teams, Public Board meetings on the scheduled bi-monthly basis and held Extra-ordinary meetings in the intervening periods.

Board Committees have also continued to meet, albeit, some with rationalised, focussed agendas. In response to the required assurances in relation to patient safety and quality, the schedule of meetings for the Quality Assurance Committee was amended from bi-monthly to monthly.

The Trust has a Covid-19 Tactical meeting (held Monday, Tuesday, Thursday and Friday at 8am, an additional Friday afternoon Tactical handover for on-call teams at 3.45pm, weekend Tactical Huddles occur at 10am on Saturday and Sunday) which discusses high-level operational challenges including nursing and medical staffing, latest IPC guidance, current position in relation to Covid positive patients being cared for, and anything requiring immediate action.

In order to help ensure Governors have been able to fulfil their responsibilities and be effectively engaged and informed, the majority of the scheduled Governor meetings have taken place, along with the scheduled Governor briefings with the Chair and working party meetings.

Since the beginning of Covid the Trust has actively invested in an enhanced provision to support workforce recovery, promote their sense of wellbeing, provide individual and team based debriefing sessions.

Provision continues to be focused on:

- Enhanced mental health and wellbeing support
- On-going physical health and wellbeing support
- Fostering psychological safety through compassionate leadership
- Focusing on teams and individuals– realigning purpose, vision, objectives
- Supporting specific groups of staff who may have vulnerability factors
- A safe re-opening of services within a planned recovery phase
- Learning from our current offer and employee voice
- Providing safe spaces for staff to decompress
- Enabling staff to talk about their experiences
- Actively preparing managers for workforce recovery
- Implementing a planned process for bringing staff back (either back into work or back into substantive posts)
- Ensuring offers are culturally sensitive and inclusive

A Health and Wellbeing plan has been developed to support workforce recovery following COVID-19 which has been presented to the Strategic People Committee for approval. Each element of the health and wellbeing offer is linked to the key learning above and targets either individual members of staff, people managers or teams.

A summary of each 'offer' is set out below.

- **Health and Wellbeing booklet**
  A one stop shop for staff to access information and signposting to other support mechanisms available to them.
- **Health and Wellbeing Extranet Page**
  A one stop shop for staff to access information and signposting to other support mechanisms available to them.
- **Expansion of Mental Health First Aiders (+PFA)**
  Staff will have access to psychological support, guidance and advice at a time to suit them. Mental Health First Aiders available in targeted areas, providing mental health support, resilience support as and when require and a listening ear. Mental Health First Aiders will be part of a supportive network, led by trained Counsellor.
- **Care First Employee Assistance Programme**
  Staff members are able to speak to trained counsellors 24 hours per day, 7 days per week for mental health support.
- **Occupational Health Service**
  Staff members can access clinical advice and support 7 days per week for telephone support and advice.
- **Mental Health Drop in Sessions**
  Mental health drop in sessions with a trained counsellor in identified areas mental health drop in session will be made available to the team with the support of the organisation's trained counsellor.

- **Wellbeing Sanctuary Hubs**
  Through charitable funds the Trust has purchased a wellbeing chalet to host additional wellbeing sessions and counselling services on the Warrington Site. This will be available during autumn/winter 2020
- **Facilitated Debrief Conversations**
  Facilitated debrief conversations available to teams upon request through a network of trained staff to provide
- **Going Home Healthy and On Time**
  A visual reminder of the importance of going home on time and the steps to take in order to adequately rest and recuperate.
- **MSK telephone clinics**
  Staff members can talk to a physiotherapist about any concerns relating to MSK, Monday-Friday without booking an appointment.
- **Project Wingman**
  A space to un-wind, de-compress and de-stress before, during and after hospital shifts.
- **BAME Staff Network**
  A peer support network for our Black, Asian and Minority Ethnic Staff.
- **LGBTQ+ Staff Network**
  A peer support network for our LGBTQ+ Staff.
- **Managers Guidance: Workforce Implications of Restarting Services**
  A guidance document for managers on how to support staff as services restart following COVI-19
- **COVID-19 Recovery Check In**
  Based upon best practice from the Army promoting team leaders/line managers to connect with each team member 12 weeks after the team has reformed to review any wellbeing or development needs.
- **Self-Compassion at Work Programme**
  Provide a learning opportunity for leaders at all levels to grow awareness of self-compassion and the impact this has on being a compassionate leader
- **Understanding each other as a team**
  A more bespoke offer, utilising a range of tools such as Team MBTI, Strength deployment index, Pack types
- **Coaching**
  Offer of coaching to all leaders at all levels either from within WHH or sign posting to the coaching offer via NHS People - to support in achieving individual goals

3.3 Children and Young People

As Child Health services were rated as “GOOD” in the 2015 CQC inspection, the CBU are now aiming for Outstanding in the next inspection. The CBU Management Team have benchmarked against the “Outstanding” Key Lines of Enquires (KLOEs) and have agreed to focus on three key areas as well as some further essential programmes. Visits to other “Outstanding” Child Health Units were organised but had to be stood down due to COVID 19 restrictions. However, the team have researched other CQC reports for these Trusts to

look at what was in place and what the Child Health Team could look at implementing at WHH.

Working groups were set up in January 2020 with monthly steering Groups chaired by the CBU Manager. However, due to COVID-19 the last formal Child Health Improvement Committee took place in February 2020. The Steering Group meetings have not yet formally reconvened. Nevertheless a significant amount of work has taken place during this time on each of the three key aras as well as other essential areas of focus for Moving Child Health Services to Outstanding. The meetings are planned to recommence in December, which will ensure progress is monitored and reported accordingly:

The three essential areas of focus for Child Health Services are:

1. **First 1000 days**
    a. Health Promotion –Training and education, discharge check, leaflets, board on the wards, parent room. Age and condition specific (where reasonable).
    b. Creation and management of High Risk Clinics for women identified as being high risk of pre-term birth – offer and education, pre-term clinics.
    c. Reducing the number of babies separated for pre term births – 10 step action plan for BAPM
    d. Transitional Care for Neonatal Babies - (Reducing the number of babies separated from their mothers)
    e. Community Hospital at Home for neonatal and paediatric care (early discharge and prevention of hospital admission)
2. **Mental Health/Camhs and adolescents**
    a. CAMHS cubicles are ligature free environments across the wards
    b. Pathways for acute and community care
    c. Adolescent pathways and appropriate inpatient and outpatient facilities (especially for those with additional needs)
3. **Transition care (young adults)**
    a. Integrated Pathways for transitioning young people with a long term condition into adult services
    b. Joint clinics across paediatrics and adults commencing from 15 years old to 18.
    c. Pathways for the management of acute admission during the transition phase
    d. Complex care pathways with AlderHey and the Walton Centre for those young adults with complex needs

First 1000 days

A Significant amount of work has been undertaken on this to implement Transitional Care for Neonatal Babies in the Postnatal Ward. The Transitional Care steering group has agreed the relevant pathways. Bay C on Ward 23 has been identified as a suitable area for this cohort of women and their babies. Double glazing is required to ensure this space is warm enough for the Neonatal babies and the team are waiting for a date for works to commence by Everite. It is anticipated these works will take 3 days to complete for the area to be ready for the team to move the Transitional Care women and their babies into. Consultation has

been completed for the Neonatal Teams and the team are now commencing the Maternity Support Worker (MSW) Consultation. An opening date will be agreed once the team have a completion date for the capital works and the consultation is complete.

Mental Health/Children and Adolecent Mental Health Services (CAMHS) and adolescents
A charitable bid was put forward and agreed for improvements to the exisiting counselling room to make it a more friendly and safe environment for children and young people. Staff have worked well with CAMHS staff during the COVID pandemic. Most of the assessments that have taken place during this time have been virtual with face to face interventions where required.

Transition care young adults
The Team completed the National Programme with NHS I/E and presented their work nationally on the 16th September 2020. The work done to date was well received by a number of Trusts and the National Team, headed by Angela Horsley. The team will now be looking to ensure the work is embedded across all pathways supported by the Transitional Care Nurse.

The Transition Care Nurse will also be reaching out to the relevant CBU Management Teams for relevant services, such as Respiratory to discuss Transition Care. The Transition Care Nurse are looking to establish key working relationships with the speciality leads to ensure the full implementation of Transition Care Pathways much sooner in our patients journey (i.e. the national gold standard of multiple appointments joined up across the pathways from 15 years old rather than the standard single clinic ahead of Transition).

The Transition Care Nurse role is already having a substantial impact with Young People cared for on the Child Health Ward who are under the care of adult services.

On top of the three essential areas of focus the team are also looking at:

1. **Community Hubs** – provision of clinics and assessment unit in community across Warrington and Halton. This piece of work is in the early stages of scope and is part of the Trust's Strategic Programme led by Director of Strategy. The vision is to initially create a joint Child Health and Maternity Hub in the Halton area and then look to expand work in the Warrington Communtiy such as in Childrens Centres and Youth Clubs.
2. **HDU** – the Clinical Director for the CBU is working with other leads in the Cheshire and Mersey Network to similar bed bureau approach to what is embedded across Greater Manchester, to ensure our Children and Young People are being looked after in the most appropriate locations.
3. **Child Health Ambulatory Pathways** and how these integrate with Child Health Emergency Pathways. This piece of work is led clinically by one of the Emergency Department Paediatricians and by the Nurse Consultant for Child Health who works across both clinical areas.
4. **Expansion of paediatric surgery – AlderHey with model**
   Conversations with Alder Hey and the Trust regarding an "AlderHey With" model commenced in late 2019 and have moved in a positive direction with Warrington being identified as a Pilot Trust. This piece of work is led by Director of Strategy with

an appropriate MDT membership. Due to COVID 19 the pilot has not yet been agreed but this is a key piece of work for the CBU and the wider Trust.

5. **Outstanding Paediatric Experience** – A business case was developed in June 2020 with the vision of creating a "Warrington Children and Young People Centre" within the previous Surgical Assessment Unit space. This work will enable a new entrance and increased clinic spaces, which meet the needs for all of our Children and Young People and their parents. This has been submitted for prioritisation in the Capital Planning for 21/22 and will be key for the team.
   Child Health have also been working closely with HealthCare Comms and will be the first CBU to have created an online survey bespoke to Children and Young People. The team has developed a Young Peoples Charter which has been agreed by the Trust Communications Team.
   There has also been an enormous amount of positive work going on to improve the experience of Young People and this has been reflected in positive friends and family feedback. An action plan is being formulated following the pilot CQC Children's and Young People's survey which took place from September to November 2020. This is being monitored through the Patient Experience Sub-Committee .

3.4 Use of Resources

Progress of Use of Resources has been impacted by COVID-19. However, KLOE leads continue to look for opportunities to improve their positions and identify and implement good and outstanding practice. The Use of Resources Group re-commenced meetings in October 2020. The Trust continues to benchmark positively in Pathology, Procurement, Estates, Pharmacy and Staffing Costs with action/mitigations identified to address Sickness Absence, Corporate Costs and the DNA rate. It is currently unclear when Use of Resources Assessments will re-commence nationally and the format these will take in the future given the impact of COVID-19 on costs.

4. RECOMMENDATIONS

The Trust Board is asked to support:

- CQC action plan progress and update

Kimberley Salmon-Jamieson
Chief Nurse & Deputy Chief Executive

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/11/119**			
SUBJECT:	**Change to Vision, Values, Objectives and Corporate Branding**			
DATE OF MEETING:	25th November 2020			
AUTHOR(S):	Pat McLaren, Director of Communications & Engagement			
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):	#145 a. Failure to deliver our strategic vision.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In reviewing what the WHH COVID-19 legacy might look like it has become apparent that our vision, values and objectives need to better reflect the new and wider needs of our staff, patients, volunteers and our communities as we emerge from the pandemic. Engagement and involvement exercises have been carried out to refresh our Vision, Values and Objectives and these are described. Further, our site at Halton has also been renamed to unite the site as one hospital with two buildings. Our staff, stakeholders and our Governors have been involved in this process and the recommendations supported by all. The chosen package is enclosed.			
PURPOSE: *(please select as appropriate)*	Information	Approval X	To note	Decision
RECOMMENDATION:	The Trust Board is the guardian of and sets the Trust's Mission, Vision, Values and Objectives of the organisation and is therefore asked to approve the recommendations as described.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors		
	Agenda Ref.	COG/20/11/56		
	Date of meeting	12 November 2020		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Change to Vision, Values, Objectives and corporate branding**	**AGENDA REF:**	**BM/20/11/119**

1. BACKGROUND/CONTEXT

Since March WHH has faced and worked through many extreme challenges requiring new levels of partnership, fortitude, innovation, stamina, patience, commitment, kindness, compassion and inclusion. Our patients, their loved ones, our staff, volunteers and wider community continue to live through the COVID-19 pandemic but we together we recognise that WHH is a very different organisation to that at the beginning of 2020.

In reviewing what our COVID-19 legacy might look like it has become apparent that our vision, values and objectives need to better reflect the new and wider needs of our staff, patients, volunteers and our communities. As a very large organisation in both Halton and Warrington boroughs, we have much to offer our communities as they emerge from the pandemic and its economic and emotional challenges and begins a form of recovery. This includes apprenticeships, work experience and employment opportunities, training and development, volunteering, community support and inclusion as well as economic regeneration through more local procurement, estate development and diversification.

Together, our vision, mission, values and objectives provide the direction for everything that happens at WHH. They keep our staff focused on where our organisation is going and what it is trying to achieve. They define our core values and how our staff and volunteers are expected to behave in everything they do.

a) The way that we describe our future aspirations is through **our vision**, and here we wish to change our current statement *To be the change we want to see in health and social care* to more clearly and meaningfully state this:

We will be a great place to receive healthcare, work and learn

b) **Our mission** defines what we do, our objective and our approach - this is a commitment that remains valid, embraced by all 4500 WHH staff and remains unchanged:

We will be outstanding for our patients, our communities and each other

c) **Our values** describe how we behave and in living and working through the pandemic it has become clear that **'Inclusive'** and **'Kind'** better reflect the values that we as an organisation wish to live and work by. Inclusive and Kind replace former values *'Accountable' and 'Role Model'* Our values will be:

Working Together, Excellence, Inclusive, Kind, Embracing Change

d) **Our objectives** of Quality, People and Sustainability – QPS – are firmly embedded at WHH and are frequently identified as our 'DNA', remarked positively upon by the CQC in previous inspections. WHH staff are able to recite our QPS objectives, regardless of role or rank. QPS remains unchanged, however we are changing the descriptor of our **Sustainability objective** to

better reflect our commitment to our communities in a post-COVID era from *We will work in partnership to design and provide high quality, financially sustainable services* to:

We will... Work in partnership with others to achieve social and economic wellbeing in our communities.

It is accepted that an organisation revisit and refresh its mission, vision, values and objectives periodically and the timing is appropriate. We have also included the achievement of Teaching Hospital status in all refreshed branding.

2. KEY ELEMENTS

a) Engagement

Significant engagement has been carried out with our staff starting with the renaming of our Halton Hospital site in the summer, with our staff suggesting a variety of names for the two buildings. The final choice was to name the site 'Halton Hospital' with the two buildings renamed The Nightingale Building (formerly Halton General) and Captain Sir Tom Moore Building (formerly CMTC).

Further engagement was carried out with staff in September through a very well attended Team Brief led by the CEO on the new Mission, Vision, Values and Objectives which were well received. We involved our Governors both at the Engagement Group and at Council and wrote to all of our partners, stakeholders and advocates with limited feedback but suggested amendments welcomed and adopted.

We also took the opportunity to refresh our colour palette, adopting the turquoise colour that has become synonymous with our quality branding.

b) Branding

- Patient letters (for Halton patients only) will be changed to reflect the new building names
- External branding of the buildings and approach will be changed
- Roadway signage will be changed at the same time that NHS Halton CCG renames the Urgent Care Centre to Urgent Treatment Centre
- Staff lanyards (overdue for upgrade) and values cards will replace existing
- Website and social platforms will be changed to reflect branding and name changes

c) Budget

For assurance, most of this work has been carried out by our design/communications team to limit unnecessary expenditure. Costs incurred will relate to the new signage and the MVVO posters for our hospitals. The remaining assets are for electronic use only; there will be no loss in terms of discontinued or wasted paper stock.

3. RECOMMENDATIONS

The Trust Board is the guardian of and sets the Mission, Vision, Values and Objectives for the organisation, these recommendations are therefore commended to the Board for approval.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WHH Corporate Branding

Signage

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WELCOME TO

Warrington Hospital

MAIN ENTRANCE

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WELCOME TO

Warrington Hospital

CROFT WING ENTRANCE


WELCOME TO
Warrington
Hospital
MAIN ENTRANCE
No Smoking
No Smoking


WELCOME TO THE
Nightingale Building
MAIN ENTRANCE 1
NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust
WELCOME TO THE
Nightingale Building
REAR ENTRANCE 2
NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust


WELCOME TO THE
Nightingale Building
MAIN ENTRANCE

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

WELCOME TO THE

Captain Sir Tom Moore Building

MAIN ENTRANCE

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

WELCOME TO THE

Captain Sir Tom Moore Building

MAIN ENTRANCE


WELCOME TO THE
Captain Sir Tom Moore Building
MAIN ENTRANCE


WELCOME TO THE
Captain Sir Tom Moore Building

Additional Assets

Chief Executive's Award

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

We are WHH & We are PROUD to make a difference

Chief Executive's Award

This is awarded to

Microbiology

For

the pivotal role of the whole team in the ongoing WHH response to the COVID-19 pandemic

Signed:

Chief Executive

Date

Proud Poster

Our Mission is to be Outstanding

Proud to complete our Forget me Not Garden

We are WHH & We are PROUD

To make a difference for our patients, our communities and each other

We are proud of to have completed phase 2 of our Forget Me Not Garden thanks to the support of our Corporate supporters who donated their time, money and materials to complete the garden. **Contact our team today to become a corporate partner of Warrington and Halton Hospitals' Charity #Togetherweareamazing email WHH.Charity@nhs.net, call 01925 662666 or use the QR Code to visit our website**

Our Values

- Working Together
- Excellence
- Inclusive
- Kind
- Embracing Change

Warrington & Halton Hospitals' Charity
Registered Charity: 1051858

Letterhead

We are WHH & We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

01925 664222 whh.communications@nhs.net www.whh.nhs.uk

Powerpoint

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Presentation Title Here

SUBTITLE HERE

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Values Poster

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Our Mission, Vision, Values, Aims and Objectives

Our Mission

We will be outstanding for our patients, our communities and each other

Our Vision

We will be a great place to receive healthcare, work and learn

Our Objectives

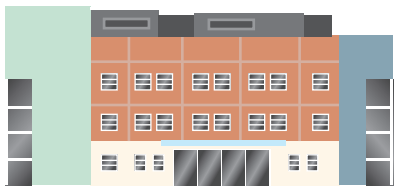
Quality

We will... **Always put our patients first** delivering safe and effective care and an excellent patient experience.

People

We will... **Be the best place to work** with a diverse and engaged workforce that is fit for now and the future.

Sustainability



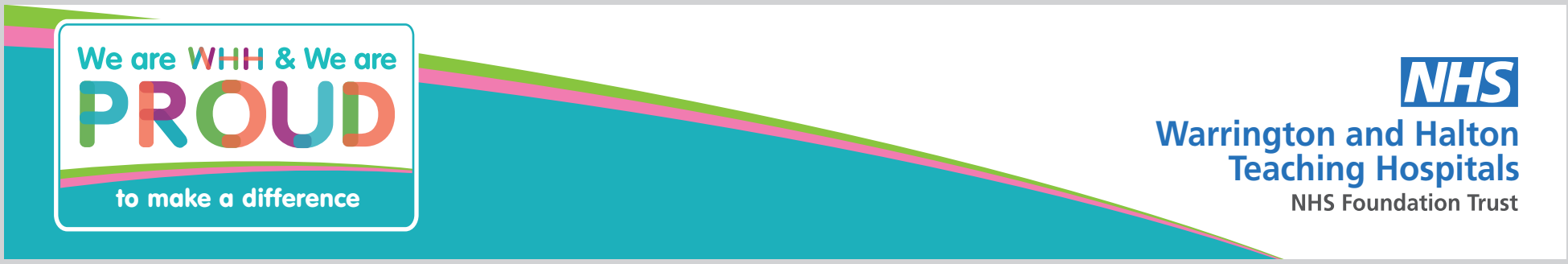
We will... **Work in partnership** with others to achieve social and economic wellbeing in our communities.

We are WHH and together we make a difference

Our Values

Working Together
Excellence
Inclusive
Kind
Embracing Change

Email Footers



Good Morning WHH Header

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/11/120**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	25th November 2020	
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: • Six risks have been added to the BAF; • The rating of three risks have been amended. • There descriptions of one risk on the BAF has been amended. • No risks have been de-escalated from the BAF since the last meeting . Also included in the paper is the proposal to add two additional risks to the BAF - #1289 and #1290 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 20/11/211
	Date of meeting	3rd November 2020
	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/20/11/120

1. BACKGROUND/CONTEXT

This is an update of strategic risks on the Trust Strategic Risk Register. It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately.

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

2. KEY ELEMENTS

2.1 New Risks

Since the last meeting a total of six risks have been added to the BAF.

The following four risks were approved for addition to the BAF at the Quality Assurance Committee that took place on 3rd November 2020, and have been added as a result of the COVID-19 pandemic:

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
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.	25	25	BAF	Kimberly Salmon-Jamieson	Quality Assurance Committee

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
1273	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely	25	25	BAF	Daniel Moore	Quality Assurance Committee

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
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.	25	25	BAF	Kimberly Salmon-Jamieson	Quality Assurance Committee

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
1275	Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks	25	25	BAF	Kimberly Salmon-Jamieson	Quality Assurance Committee

Following review and discussion of the Women's and Children's risk register at a Risk Review Group meeting on 7th October 2020, and subsequent agreement at the Quality Assurance Committee on 3rd November 2020, the following risk was escalated to the BAF at a rating of 16:

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
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	16	16	BAF	Kimberly Salmon-Jamieson	Quality Assurance Committee

Following review and discussion of the Women's and Children's risk register at a Risk Review Group meeting on 7th October 2020, further evaluation as part of the review of Digital Risks at the Finance & Sustainability Committee on 21st October 2020, and subsequent agreement at the Quality Assurance Committee on 3rd November 2020, the following risk was escalated to the BAF:

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
1079	Failure to provide an IT 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.	9	20	BAF	Kimberly Salmon-Jamieson	Quality Assurance Committee

Prosposed New Risks

Since the last Quality Assurance Committee meeting on 3rd November, two additional risks have been idtenfied to inclusion on the BAF.

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
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	25	25	BAF	Dan Moore	Quality Assurance Committee

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
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.	12	12	BAF	Andrea McGee	Finance & Sustainability Committee

The Board is asked to consider and approve the addition of risks #1289 and #1290 to the BAF

2.2 Amendment to Risk Ratings

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

Following approval at the Quality Assurance Committee on 6th October, the rating of the following risk has been increase from 15 to 20.

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

It was agreed that the risk rating should be increased as a result of increased COVID-related sickness absence evidenced in the daily SITREP and the Trusts compliance with the national track and trace system.

Following a focussed review of Digital Risks at the Finance and Sustainability Committee on 21st October 2020 and subsequent approval at the Quality Assurance Committee on 3rd November 2020, the ratings of the following risks were amended:

- **Risk 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.

Recent events surrounding loss of access to Lorenzo resulted in the re-scoring of the risk from 16 to 20 to increase its current consequence and acknowledge that the achievable target risk also increases from 8 to 15 (whilst business continuity measures are in place experience has shown they are only sustainable for a limited period as the gap between digital and manual processes has widened).

- **Risk 1205 -** ***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.*

The risk rating was decreased from 15 to 10. The risk and its scoring reflect an intense and focused multidiscipline piece of work. The results of the activities led to a reduction in the likelihood of a re-occurrence, although confidence in the Lorenzo solution per se remains a concern leading to a raised target risk that now matches the current. The key takeaway is the work to improve the management of PANs and the additional testing undertaken during Lorenzo releases.

2.3 Amendments to descriptions

Following review and discussion of the Women's and Children's risk register at a Risk Review Group meeting on 7th October 2020, and subsequent approval at the Quality Assurance Committee on 3rd November 2020, it was agree to amend the description of one risk:

- **Risk 1079 -** The risk previously stated:

Failure to provide an IT 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

It was agreed to amend the description to:

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.

2.4 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	• 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	No impact on risk rating
1215	Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm	**Assurances** • 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. • Continued use of the independent sector (Spire Cheshire) under national contract until 31st December 2020. Negotiation underway to support contracted arrangements in Quarter 4. • 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. **Gaps** • Estates work required to increase general ICU Capacity & ICU cubicle capacity e.g. Installation of Bioquell cubicles • As a consequence of the impact the second wave of Covid-19, the PACU	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		implementation date has been revised until January 2021. The revision has been implemented to support safe staffing levels across the organisation.	
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.	• 119 HCAs recruited from February 2020 to October 2020 with 40 currently undergoing pre-employment checks. • Registered Nurse Turnover for September 10.50% <u>COVID-19 Assurances</u> • Implementation of NHSP incentive scheme for staff to improve fill rates – update monitored weekly <u>Recruitment Gaps</u> • 96 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> • Phase 3 plan submitted approved by Trust Board and submitted in October 2020. Planned deficit of £10.3m assuming R=1 <u>COVID-19</u> • Governance process in place to ensure all additional costs are being approved and monitored – re-introduced for Wave 2 • Achieved 95% BPPC May, June & July 2020, 98% BPPC August, 98% September, 96% October <u>Assurance Gaps</u> • Non-recurrent CIP presents a risk to in-year and future year financial position. No CIP identified in plan for 2020/21 • Phase 3 plan (October '20 – March '21) provides a System gap. The Trust's share of this is £10.3m assuming R=1. No funding has been identified for wave 2 of COVID-19.	No impact on risk rating
1207	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line	• Circa 620 staff members yet to complete self-assessment • 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.	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	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.		
125	Failure to provide a safe, secure, fit for purpose hospitals and environment caused by the age and condition of the WHH estate and limited availble resource resulting in a risk to meeting compliance targets, staff and patient safety, increased backlog costs, increased critical infrastructure risk and increased revenue and capital spend	• 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.	No impact on risk rating
1134	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	<u>Assurances</u>: • Work ongoing to retain returners within the Trust via Nursing Workforce Lead, especially final year student nurses. • 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. • 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.	Risk rating has increased from 15 to 20

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• Campaign to start immediately. • 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. • 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	

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		Gaps: • Unable to control staff selecting to use national trace 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 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.	
145	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services 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	• £22.1m secured through Warrington Town Deal. • Competitive process confirmed to assign 8 remaining places on HIP scheme. The Trust has confirmed intention to compete in effort to secure funding for new hospitals. • Value for money exercise completed and shared with DHSC to improve value for money ratio for new hospitals. • OPE 8 bid submitted in partnership with both Local Authorities with aim to accelerate redevelopment of Halton site and development of health and wellbeing hub in Warrington Town Centre. • Trust confirmed as 1 of 2 pilot sites for C&M prevention pledge.	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	population and organisation, potential impact on patient care, reputation and financial position.		
1205	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	• Formal Investigation report closed by the Trust	Rating reduced from 15 to 10

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	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* **		
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 Contigency measures) and subsequent reputational damage.	• 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. <u>Gaps in Assurance</u> • 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	Rating increased from 16 to 20

3 RECOMMENDATIONS

The Board is asked to discuss and approve the changes and updates to the Board Assurance Framework and consider and approve the addition of risks #1289 and #1290 to the BAF

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
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	25 (5x5)	8 (4x2)	TBC	Quality Assurance 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
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
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	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
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 future loans cannot be repaid and this puts into question if the Trust is a going concern.	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee

Board Assurance Framework

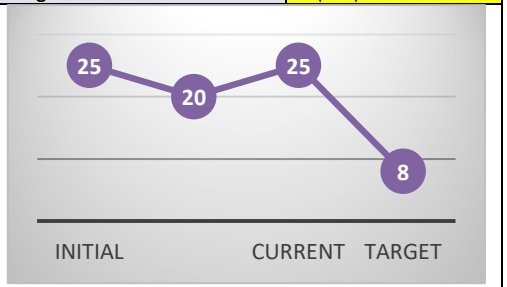
1134	Michelle Cloney	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee
1114	Phill James	Failure to provide essential, optimised digital services 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.	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	Chris Evans	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
1108	Kimberley	Failure to maintain staffing levels, caused by high sickness and absence,	1	16 (4x4)	4 (4x1)	TBC	Quality Assurance

Board Assurance Framework

	Salmon-Jamieson	including those affected by Covid, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team					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
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 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 *****	1	10 (2x5)	5 (1x5)	TBC	Quality Assurance Committee

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:	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:	25 (5x5)
				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				
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. 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				

Board Assurance Framework

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Provide sufficient PPE for all staff.	PPE	Sourcing alternative suppliers, escalation into NSDR (National Supply Disruption Service), establish procurement networking, interhospital cel, looking at alternative PPE, etc	McKay, Lesley	31/11/2020	

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 ongoing 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

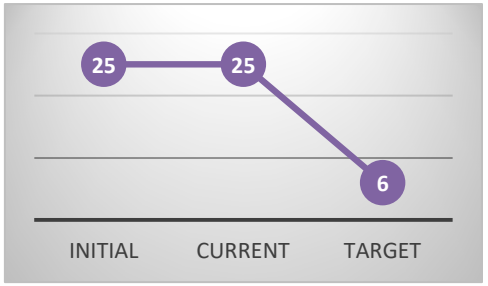
- Phase 3 second submission -10th September 2020
- Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery
- Temporary pause of non-time critical elective services to support safe staffing across the organisation - effective w/c 26.10.2020 & w/c 02.11.2020. 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.

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

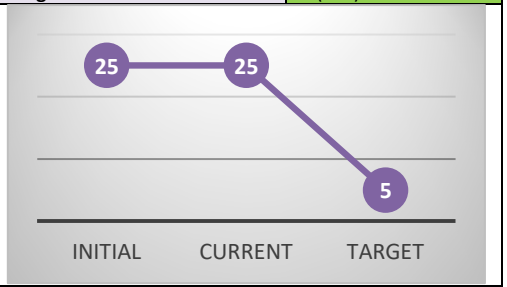
	• Minor injuries is provided in an area in close proximity but separate to the main emergency department. This has provided an opportunity to use the old minors department as Majors 2 to support management of surge demand and avoidance of corridor care. • New working arrangements are in place to maximise 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. 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 • Post Anaesthetic Care Unit (PACU) Business Case approved by the Board on 10th September 2020 for implementation in November 2020. • 52 week backlog stabilising in line with trajectory. • Continued use of the independent sector (Spire Cheshire) under national contract until 31st December 2020. Negotiation underway to support contracted arrangements in Quarter 4. • 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.	

Board Assurance Framework

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 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	

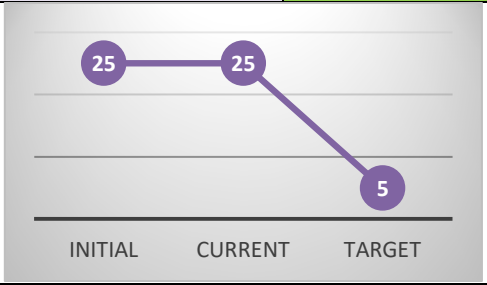
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
CT Department building works	Completion of building works increase CT Footprint	Complete Building work	Hilary Stennings	Phase 1 completed - 30/09/2020 Phase 2 due- 30/11/2020	
Post Anaesthetic Care Unit (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:	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			
Assurance Gaps:	Individual Ward risk assessments identify challenges in meeting the 2 meter requirement.			

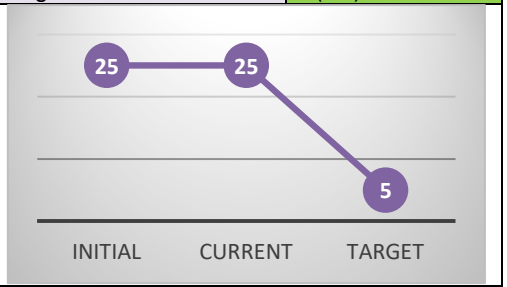
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
To develop a Trust Wide Environmental Plan to identify appropriate mitigations to minimise the risk of transmission.	Development of a Trust Wide Environmental Plan.	Develop Plan	Layla Alani	30.10.2020	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.				
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.				

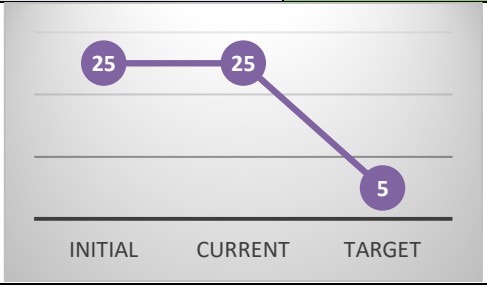
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Hospital Discharge Team to extend from a five to a six day working pattern from December 2020	Extend service hours from five to six days.	Extend service hours from five to six days.	Caroline Williams	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:	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:** 25 (5x5) **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. Staff groups have been split to ensure only 5 members of staff from each service are tested at any one time.			
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:	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:	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 increase to 8.8 in July, which is an improvement from June of 7.7. This change was largely due to the employment of students as part of the COVID-19 response.

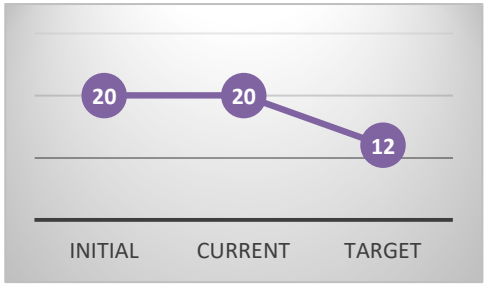
<u>Recruitment Assurances</u>

- 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 recruitment is part of the Trusts overall plan for recruitment in the next 12months. As such WHTH have produced a business case in partnership with Wigan Wrightington and Leigh and HEE as part of a North West Hub within the Global Training and Education Centre. The business case has recently been signed off by the Board of Directors. Task and Finish group in place with plans in place to welcome 30 international nurses by the end of March 2021 in two cohorts.

<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>

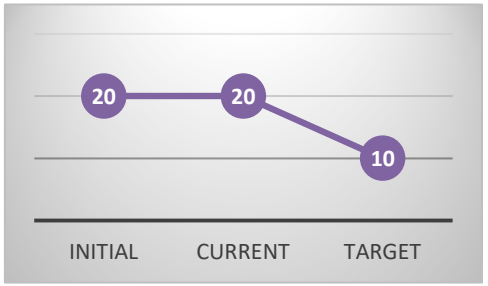


Board Assurance Framework

	• Implemented a graduated and planned nurse staffing response to the COVID-19 Pandemic. • Revised staffing models for the expansion of critical care capacity, acute and supportive respiratory wards • Strengthened daily staffing meetings chaired by the Associate Chief Nurse for senior oversight • 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	
Assurance Gaps:	Increase staffing pressure due to ongoing use of temporary winter ward for which there is no funded establishment <u>Recruitment Gaps</u> • 96 RN Vacancies • 54 B2 Vacancies <u>Retention Gaps</u> • 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 and similar anticipated for the whole year due to the impact of Covid19 with additional controls and constraints •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 • 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 <u>COVID-19</u> • Governance process in place to ensure all additional costs are being approved and monitored – re-introduced for Wave 2 • 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 • Achieved 95% BPPC May, June & July 2020, 98% BPPC August, 98% September, 96% October • Circulate latest guidance from MIAA Counter Fraud team				

Board Assurance Framework

	• Ensure governance and processes in place including checks in place for all expenditure in particular procurement, contracts, payroll and HR. • Highlighted the different methods of fraud/ scam in operation to all staff and share it as widely through Trust • 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	
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 COVID-19 • Increased threat of fraud during COVID-19 global pandemic • Unclear on financial envelope to support COVID-19 capital & revenue needs. • Awaiting further information re: Financial regime post September 2020 • Phase 3 plan (October '20 – March '21) provides a System gap. The Trust's share of this is £10.3m assuming R=1. No funding has been identified for wave 2 of COVID-19.	

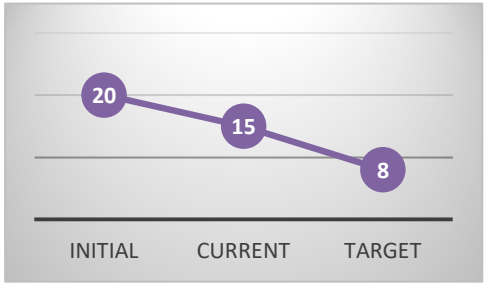
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Submit requested Workforce & CIP information to NW Intensive Support Director	Cheshire and Merseyside Health & Care Partnership in receipt of Tier 1 Intensive Support – Information requested by NHSE/I 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.
- 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



Board Assurance Framework

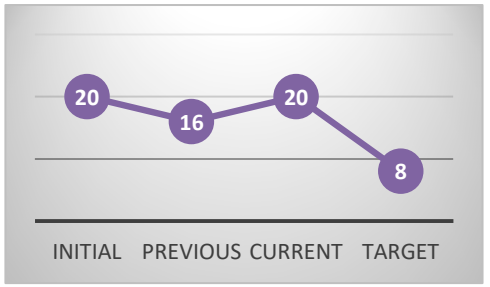
	continue – decision taken by Strategic Oversight Group to revert back to Pre-Covid Enhanced and Standard rates of pay. • A plan is in place to support workforce recovery including health, wellbeing, leadership, teams, HR and resourcing. • All staff who are shielding are have individual reviews with line 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	
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	

Board Assurance Framework

	• 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
Produce and deliver a workforce recovery support plan based on evidence and learning.	Ensure that a range of support offers are designed, in place and easily accessible by staff. Ensure that they are designed based on the learning from the available evidence relating to the impact of COVID-19 and other events such as the Manchester Arena bombing.	• Produce and deliver all offers set out within the workforce recovery support plan. • Undertake an equality impact assessment of all offers within the plan.	Deborah Smith, Deputy Director of HR and OD	30 September 2020	
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	
Participation in pilot of Lateral Flow Testing for patient facing staff	Produce project plan and infrastructure and confirm go live date	• Deliver plan	Deborah Smith, Deputy Director of HR and OD	13/11/2020	

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.				
Assurance Gaps:	**Gaps In Assurance:** • 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				

Board Assurance Framework

	• 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

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	31/12/2020	
Act on recommendations made in the Cyber essentials report to ensure improved cyber security. [Delivers: Best Practice]	Implement the recommendations made in the Cyber essentials report and DSPT to ensure improved cyber security. *NHS Digital have commented they are looking at whether to continue with Cyber Essentials+ revision (relies upon NHS Digital negotiations).*	• Cyber and External Audits Task and Finish Group set up to track the remaining Cyber Essentials recommendations. The outcomes will be reported regularly to the Information Governance and Corporate Records Sub-Committee.	Deacon, Stephen	31/11/2020	

Board Assurance Framework

		• Enhanced Firewall controls on Trust network (30/09/20 - Simon Whitfield) • Fully documented Firewall infrastructure (31/10/20 - Phil Smith) • Enforced 90 Day System Password refresh (30/11/20 - Joe Garnett) • Regular vulnerability scans of internal network via IT Health Assurance Dashboard (30/04/20 - Stephen Deacon) (COMPLETE) [Outstanding tasks been to be discussed at the next Cyber and External Audits Task and Finish Group (25/09/20)]			
Move medical devices into VLAN bubble. This will involve participation of multiple 3rd parties and internal WHH staff. [Delivers: Best Practice]	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 "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.	Deacon, Stephen	29/01/2021	
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).	Migrate all 2003 and 2008 servers to 2016.	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to Windows Server 2016 • Extend Support for 2008 [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	Deacon, Stephen	30/06/2021	

Board Assurance Framework

[Delivers: Best Practice]		2003 Servers 21 16 76.2% 2008 Servers 56 39 69.6% *[All simple migrations have been completed by IT Services. The remaining servers are complex migrations and require more analysis to look at licenses, resources and impact on other systems. A business case may be needed for any associated costs. A report on the current status of the migration is on October's Digital Board.]*			
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: 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. 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 October 20.	Deacon, Stephen	30/11/2020	
As part of Cyber Essentials+ all unsupported software should be updated or isolated from internet based	Migrate from Office 2010	• Secure funding and take advantage of the NHS Digital's N365 discount licensing offer (May 20 – COMPLETE)	Deacon, Stephen	31/12/2020	

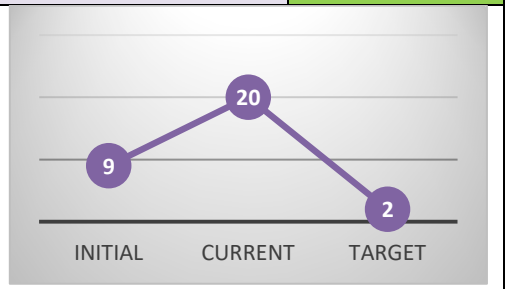
Board Assurance Framework

networks. Office 2010 will need upgrading to the latest version of Office for all endpoint devices on the WHHT network. [Delivers: Best Practice]		• 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) *[£1.7 million investment currently identified within Trust capital plan for 20/21]*			
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)	Deacon, Stephen	31/12/2020	
From the review of the first phishing	Figures of successful clicks on links	Lessons learnt from previous phishing	Deacon, Stephen	31/03/2021	

Board Assurance Framework

exercise, provide a comms strategy and send it out to the users. Once finished rerun the phishing exercise next year.	dropped.	exercise rerun phishing exercise • 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	31/03/2021	
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		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	31/01/2021	

Board Assurance Framework

Risk ID:	1079	**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 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:**	9 (3x3)
				Current:	20 (4x5)
				Target:	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.				
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 mid-Nov 2020 with formal business case / recommendation to FSC and Trust Board.	Gardner, Matthew	31/12/2020	
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 1.10.20	Gardner, Matthew	19/11/2020	

Board Assurance Framework

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	31/12/2020	
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	25/12/2020	
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	30/11/2020	

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.

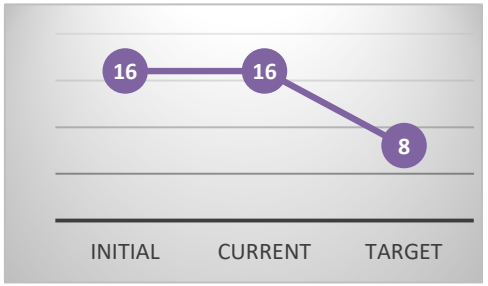
Training for line managers is in place and on-going Audit process is in place and live Staff communications have included:

- 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%

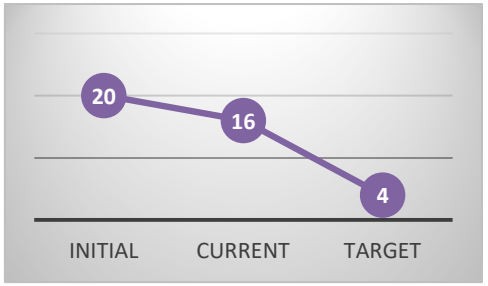


Board Assurance Framework

	• % 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 620 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	Deborah Smith, Deputy Director of HR and OD	31/10/2020	
Write to home address of each of the c620 staff members to stress importance of completion of self-assessments	Write to staff members yet to complete self-assessments	• Write to staff members yet to complete self-assessments	Deborah Smith, Deputy Director of HR and OD	13/11/2020	

Board Assurance Framework

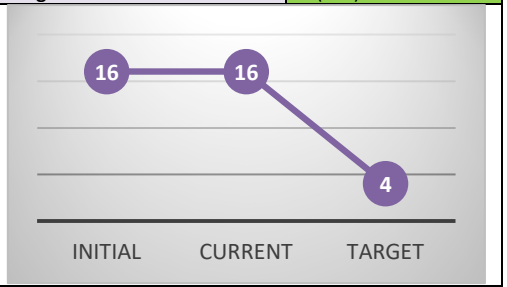
Risk ID:	125	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide a safe, secure, fit for purpose hospitals and environment 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 Trust Ops Board 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

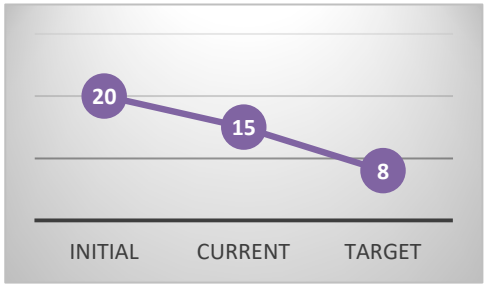
Develop and monitor action plan to address compliance	Action plan to address non compliance issues highlighted in report (Nov 2019)	Develop and monitor action plan to address compliance	Wardley, Darren	31/12/2020	

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 currently going through recruitment process 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.				
Assurance Gaps:	Potential for uncertainty across the services. Current sickness in senior CBU team and across maternity staffing.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Recruitment of midwives	Recruitment of midwives	Recruitment of midwives	Gould, Debby	31/12/2020	
Appointment of additional 8a matron for 6 months to support the CBU management team	Appointment of matron	Interview and appointment matron	Gould, Debby	27/11/2020	
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

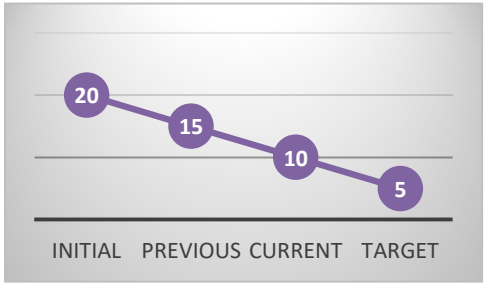
Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Influence within Cheshire & Merseyside a. Failure to deliver our strategic 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 (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards				

Board Assurance Framework

	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:	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. • De-risking of Lorenzo EPR releases via thorough WHHFT discharge summary tests;				

Board Assurance Framework

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	31/11/2020	
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) 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.	Caisley, Sue	31/11/2020	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/11/121**	
SUBJECT:	Digital Assurance Report	
DATE OF MEETING:	25th November 2020	
AUTHOR(S):	Phillip James, Chief Information Officer	
EXECUTIVE DIRECTOR SPONSOR:	Phillip James, Chief Information 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
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1114 Failure to provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, caused by increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, resulting in poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. #145 a. Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report seeks to assure the Board of Digital activities via the minuting of the Digital Board in respect of the Digital Programme, DXC Vendor Management Meeting, IT Services Update, Digital Analytics Programme, Digital Compliance And Risks, Clinical Safety and Risk Review and Digital Maternity.	

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

RECOMMENDATION:	The Board is recommended to note the assurances including responses to the following escalations: • the Tranche 1 projects that are reported as delayed due to resource availability result in no material impact to Trust financial plans nor stakeholder expectations; • the review of scope and re-baselining of the current Digital Analytics programme has completed and an action to confirm the robust role of appropriate stakeholders in prioritisation the programme has been agreed; • the response to a recent international cyber-attack acknowledging the role of Trust cyber investments.	
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	Digital Assurance Report	AGENDA REF:	BM/20/11/121

1. BACKGROUND/CONTEXT

This report seeks to assure the Board of Digital activities via the minuting of the Digital Board in respect of the Digital Programme, DXC Vendor Management Meeting, IT Services Update, Digital Analytics Programme, Digital Compliance And Risks, Clinical Safety and Risk Review and Digital Maternity.

The content summarises the detail provided to the Finance And Sustainability Committee.

2. KEY ELEMENTS

Key items for assurance:

Digital Programme

- In the last reporting period the Digital Programme (known as the Paperless Care Programme) reported:
  - 9 projects on track (down from 14 last month).
  - 18 projects off track (up from 13 last month) – including 3 on pause – COVID operational pressures continue challenge progress and integration/testing issues also contributing – investment plans remain unaffected.
  - 6 completed projects (up from 5 last month – including ePMA Maternity). Planned Ward Round form remains to complete due to interdependencies.
  - 2 go-lives in the next reporting period – Innovation Fund Community Aide Proof Of Concept and GP Connect.
  - Lorenzo Digital Exemplar scope continues to respond to Trust conditions with MCL/DOLS form removed due to safeguarding changes, replaced by a Coroners Form and DASH Safeguarding Form, thus no change to LDE value or benefits.
  - Tranche 2 (2021 Paperless Care) planning progressing.
- *Escalations:*
  - *Tranche 1 projects that are reported as delayed result in no material impact to Trust financial plans nor programme benefits.*

DXC Vendor Management Meeting

- Good progress reported on EPR release management.
- Recent updates include ability to redirect prescriptions between Warrington and Halton sites.
- EPR known issues were discussed 1 long standing issue resolved and Maternity MSDS v2 target release date remaining to be confirmed.
- The work to migrate Lorenzo EPR to a new cloud platform, key to Lorenzo performance improvement activities, proposes a migration date of February 2021 but remains subject to progress of the testing programme.

- *There are no Vendor Management Items for escalation in this reporting period.*

IT Services Update

- In the last reporting period the IT Services dashboard reported the following assurances in line with the International ITIL standard framework:
  - 13 Green Support Indicators and 3 Amber Support Indicators (Call resolution levels, Outstanding Calls levels and Windows Server Migration Levels) – reflecting the impact of a staff COVID outbreak which is now complete.
  - 1 Blue (Complete), 6 Green and 3 Amber Deployment Indicators (Call resolutions, Outstanding Calls, Desktop Patching and Device Refresh) – reflecting the impact of a staff COVID outbreak which is now complete and a Lorenzo EPR issue which has been escalated by the Trust.
  - 9 Blue (Complete), 3 Green and 4 Amber Infrastructure Projects – reflecting the impact of COVID operational pressures upon staff resources. Resourcing and prioritisation of the competing schemes is continuously assessed against prevailing circumstances including 6 schemes the remain to be initiated.
  - In month, 8 Blue (Complete) and 3 Green Change Controls. 1 scheme remains to be assessed.
- *There are no Digital Services Items for escalation in this reporting period.*

Digital Analytics Programme

- In the last reporting period the Digital Analytics Programme reported:
  - Statutory Reporting – Resources are adapting to meet fluctuating needs including staff swabbing.

- Prioritisation And Value Assessment – the assessment has completed but future stakeholder involvement in the prioritization of new work remains to be confirmed as part of a prioritisation and escalation process trial.
- 7 projects are now in delay (down from 12) with the 2 longest reports resolved, 4 removed via the review and 2 new external reports introduced.
- Assurance is provided by the planned arrival of a new information Analyst is in January and the assessment of Automation opportunities.

- *The Digital Board agreed to escalate the action to confirm the robust involvement of stakeholders in the prioritisation process.*

Digital Compliance & Risks

- In the last reporting period the Digital Compliance And Risks reported continued steady progress against Audits and Risks:
  - Internal & External Audits;
    - 10 total audits;
    - 4 scheduled audits;
    - 6 active audits;
    - 20 outstanding actions;
    - 1 action completed.
  - Risks;
    - 11 open Digital Service risks;
    - 2 BAF risks, 5 Corporate risks & 4 Departmental risks;
    - 3 extreme, 6 high & 2 moderate risks;
    - 27 outstanding risk actions;
    - 4 new risk actions;
    - 8 risk actions completed.
  - NHS Digital Data Security and Protection Toolkit - Year-end submission was completed by March 31st 2020.
  - Security Tools – three solutions are deployed to monitor internal and external networks and devices and provide assurance.
  - Cyber Essentials Plus – The Trust continues to work to complete 10 outstanding actions whilst a national review of the standard continues.
  - New Cyber Security Initiatives – The Trust is trialling a Police Cyber Alarm and a free National Cyber Security Centre Web Check service.

  - MIAA IT continuity and Resilience Review – 34 of 37 actions are complete. Outstanding actions are due to complete December 2020.
  - Excellence In Informatics Level 1 – Following accreditation in 2018 an internal review of current compliance is underway.
- *The Digital Board agreed to escalate the outcome of a recent international cyber attack which resulted in no harm to the Trust, acknowledging the role of Trust cyber investments.*

- Clinical Safety and Risk Review
  - 2 Customer Safety Notices and 1 Product Alert Notice raised in month.
  - Lorenzo EPR Microsoft patching issue that affects Trust cyber patching was noted.
- *There was no escalation in this reporting period.*

- Digital Maternity project update was received and noted with reference to the associated Business Case and its governance via Executive, FSC and Trust Board.
- *There was no escalation in this reporting period.*

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Head Of Digital Analytics is to confirm the robust role of appropriate stakeholders in prioritisation of the Digital Analytics programme.

4. IMPACT ON QPS?

Assured delivery of Digital Activities contributes to Quality of Care, People Wellbeing and Sustainability of Services.

5. MEASUREMENTS/EVALUATIONS

The programme reports progress against target project timescales and international service standards.

6. TRAJECTORIES/OBJECTIVES AGREED

Individual project milestones are available on request.

7. MONITORING/REPORTING ROUTES

The Digital Services activities are monitored by the Digital Board with assurances and escalations submitted to the Finance and Sustainability Committee on a monthly basis.

Safety and quality issues are escalated to the Quality Assurance Committee by exception.

8. TIMELINES

The programme reports state target completion timescales.

9. ASSURANCE COMMITTEE

Finance And Sustainability Committee.

10. RECOMMENDATIONS

The Board is recommended to note the assurances including responses to the following escalations:

- the Tranche 1 projects that are reported as delayed due to resource availability result in no material impact to Trust financial plans nor stakeholder expectations;
- the review of scope and re-baselining of the current Digital Analytics programme has completed and an action to confirm the robust role of appropriate stakeholders in prioritisation the programme has been agreed;
- the response to a recent international cyber-attack acknowledging the role of Trust cyber investments.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/11/122**	
SUBJECT:	**Coronavirus (COVID-19): Potential Legal and Regulatory Challenge**	
DATE OF MEETING:	25th November 2020	
AUTHOR(S):	Kimberley Salmon-Jamieson, Chief Nurse and Deputy Chief Executive Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper describes the anticipated legal challenges resulting from the COVID-19 pandemic and the controls in place to address these. The current global COVID-19 pandemic has brought along many challenges, and it is anticipated that once the pandemic is over, there is the potential risk of multiple areas of legal and regulatory challenge. The most significant potential risks and the actions taken in addition to the controls put in place by Warrington and Halton Hospital (WHH) to mitigate against these, are outlined in this paper. The following areas are covered: • Coronial inquests. • Public inquiries: How Warrington and Halton Hospitals (WHH) has managed the pandemic. • Police investigations. • Health and Safety Executive (HSE) for example potential investigations into allegations of inadequate Personal Protective Equipment (PPE), unsafe systems of work or testing. • Litigation. • Care Quality Commission (CQC) investigation into alleged breaches of requirements. • Referrals to the General Medical Council/Nursing Midwifery Council/other regulatory bodies. • Human Resource challenges.	

	• Media interest. • Information Governance – confidentiality and Freedom of Information requests. • Governance and public law challenges by patient groups/individuals to challenge new policies. • Delayed discharge. • Mental Health and Learning Disabilities. • Safeguarding.			
PURPOSE: ***(please select as appropriate)***	Information	Approval x	To note x	Decision
RECOMMENDATION:	The Committee is asked to note the report and agree the recommendations.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/20/10/195		
	Date of meeting	6 October 2020		
	Summary of Outcome	Supported		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Coronavirus (COVID-19): Potential Legal and Regulatory Challenge**	**AGENDA REF:**	**BM/20/11/122**

1. BACKGROUND/CONTEXT

The COVID-19 pandemic has brought a number of challenges for all Trusts and it is anticipated that legal challenges will arise. It is therefore fundamental to understand the controls that have been introduced to provide assurance of safe and appropriate decision making.

Throughout the COVID-19 pandemic, the Trust has utilised a decision making framework consisting of a variety of cells and supportive decision making structures including an initial daily Tactical meeting and Strategic Oversight Group. This was further expanded to include a twice weekly Recovery Board. This structure has and will be flexed dependent upon Covid-19 pressures. The Framework has ensured that unilateral decision making has not occurred and there has been clear oversight and discussion where decisions have been made. Despite the robust decision making structure, it is important that the Board of Directors understands the potential legal and regulatory challenges that may arise as a result of the COVID-19 pandemic.

This paper outlines the most significant risks with assurance provided relating to control measures and actions taken by the Trust to mitigate potential risks identified in the following areas:

- Coronial inquests.
- Public inquiries: How WHH has managed the pandemic.
- Police investigations.
- Health and Safety Executive (HSE) for example investigations into allegations of inadequate Personal Protective Equipment (PPE), unsafe systems of work or testing.
- Litigation.
- Care Quality Commission (CQC) investigation into alleged breaches of requirements.
- Referrals to the General Medical Council/Nursing Midwifery Council/other regulatory bodies.
- Human Resource issues.
- Media interest.
- Information Governance – confidentiality and Freedom of Information requests.
- Governance and public law challenges by patient groups/individuals to challenge new policies.
- Delayed discharge.
- Mental Health and Learning Disabilities.
- Safeguarding.

2. KEY ELEMENTS

2.1 Coronial Inquests

It is anticipated that particular coronial issues that may arise as a result of the COVID -19 pandemic are in relation to the following:

- Staff alleged to have died of COVID -19.
- Patients alleged to have died of or with COVID -19.
- Patient alleged to have died from delayed treatment due to the COVID–19 pandemic.
- A coronial backlog of cases caused by the COVID-19 pandemic is likely to be heard in a short space of time possibly via the implementation of virtual inquests.

2.1.2 Reportable deaths

It is vital that the following measures are adhered to with regard to coronial requirements:

- COVID-19 as a natural disease, is an acceptable direct or underlying cause of death for the purpose of completing the Medical Certificate of Cause of Death (MCCD). There is **NO** requirement for this to be reported to the Coroner unless concerns have been raised; for example, access to Personal Protective Equipment (PPE) or concerns with medical care.

- All healthcare professionals, emergency personnel and front line key workers who die as a result of COVID-19 should be referred to the Coroner. There is a duty to investigate any staff death where the deceased may have contracted a disease or virus through failure of personal protective equipment or failure to provide adequate protection. These cases will be reviewed by an external Medical Examiner.

- The Deputy Director of Governance has made enquiries with the Coroner's office to seek clarity on how far the reporting requirement extends. The Trust have been advised that a staff member's death should only be referred to the Coroner if there is a reason to suspect that human failure contributed to the staff member being infected with the virus at work.

- Inquests are in the process of being re-listed. There is the potential that inquests may be held virtually.

- As a result of the COVID-19 pandemic it is anticipated that there will be an increase in the number of inquests from September 2020. There is the potential that this will impact heavily on staff to produce statements and attend Court / virtual representation.

CONTROLS TO ADDRESS RISK

- An assurance paper dealing specifically with the governance and legal issues around PPE was presented by the Chief Nurse and Deputy CEO to the Board of Directors (meeting held on 27 May 2020) detailing the significant arrangements that have been taken to ensure that all staff have the PPE they require including the contingency plans in place.

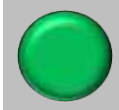
- The Deputy Director of Governance has liaised with the Coroner's office to obtain clarity as to which staff deaths need to be reported.

- The Deputy Director of Governance and the Senior Governance Manager have reviewed all inquests and are progressing statements from clinicians for inquest where possible to minimise any backlog when inquests resume.

- The Trust is awaiting for correspondence from the Coroner regarding the possibility of holding remote or virtual inquest hearings. It is hoped that some inquests can be held via telephone or other remote means in order to reduce any backlog when the Court reopens.

- An internal investigation is undertaken into all staff deaths detailed as COVID-19 that are reportable to the Coroner.
- At the height of the pandemic the Strategic Oversight Group comprising of the Trust Executive Team met daily to review the Trust position including risks, decisions and further escalation. This is another forum in which incidents/deaths are monitored on a regular basis.
- A harm dashboard is reviewed at the Strategic Oversight Group weekly. A monthly incident paper is also produced and reviewed in this forum. Incidents that note PPE are reviewed daily by the Health and Safety Department and Senior Governance Manager.
- There is a weekly governance meeting led by the Deputy Director of Governance reviewing all incidents identified as moderate and above.
- The 'Weekly Meeting of Harm' continues to discuss Serious Incidents (SI's), rapid reviews, incident actions and any challenges or concerns.
- Various methods of communication are available to brief staff and patients on COVID-19. The Public Board meetings provide a Covid-19 summary report presented by the Chief Executive Officer (CEO). 'Your Hospitals - Our Hospital' newspaper keeps Foundation Trust members, the public and staff updated on COVID-19 and this is published on the Trust's internet. A daily email communication is sent to all staff from the Chief Executive which includes core messages derived from meetings.
- Ward C21 had a COVID-19 outbreak on 2nd June 2020 in which 8 cases underwent the Structured Judgement Review (SJR) process to support the formulation of Root Cause Analysis (RCAs). The SJR tool was used to maximise the potential for learning and improvement, and encourages the development of quality improvement initiatives when problems in care are identified. The analysis of information following these reviews was submitted in a report to NHS England/NHS Improvement on 7 July 2020.
- As of 29th May 2020 the Secretary of State for Health and Social Care wrote to the Chair of the Health and Social Care Select Committee, describing a process for Medical Examiners to provide independent scrutiny of the deaths of all health and social Care workers from COVID-19. The role of the Medical Examiner has been introduced. The Trust has appointed a Chief Medical Examiner, Medical Examiner and Medical Examiner Officer. This role will enhance the governance and regulatory systems by scrutinising the deaths of patients not under review or inquest by the Coroner. This is further supported by the Medical Examiner Officer role forming part of the wider Bereavement Service Team. This will be overseen by the Deputy Director of Governance with a plan to ensure implementation across the Trust by February 2021.

RISK RATING



Recommendation: To provide assurance that the number of COVID-19 deaths are not under reported. The Medical Director should ensure a sample of Structured Judgement Reviews are

undertaken on a sample size of 15 deaths where COVID-19 is identified on completing a Medical Certificate of Cause of Death (MCCD). This should consider if the patient died from COVID-19, identify any areas of learning and to confirm if the death was / should have been reported to the Coroner**.** There has been a review of 8 SJRs to date with a 'deep dive' due to be completed by the end of October 2020.

2.1.3 A public inquiry

- There has been a lot of discussion in the media about a possible Public Inquiry into COVID-19. A Public Inquiry is established by the Government to investigate events which have or could cause public concern. It is usually led by a senior barrister who takes evidence in the form of documents, such as policies, and witness statements and oral evidence to a panel. An inquiry would report on events and deliver key findings and recommendations should this occur**.**

- It is unlikely that there would be an inquiry solely into the actions of WHH unless, for example, the Trust mortality rate was significantly higher than the national number.

- Any Public Inquiry is likely to cover actions taken by the NHS nationally, including the Department of Health, NHS England and Public Health England. The Trust involvement with regard to such an inquiry is likely to relate to the provision of evidence on for example, availability of PPE or testing and how shortages of PPE were addressed.
- Any inquiry is likely to be some years away and it is important to create a database of the steps taken to ensure organisational memory is captured.

CONTROLS TO ADDRESS RISK

- As referred to above an assurance paper on PPE was presented to the Board of Directors meeting held on 27 May 2020. This outlines the steps taken by the Trust to ensure adequate provision of PPE supplies.

- The Trust has been very clear throughout the pandemic that no staff must work without appropriate PPE. Where services have been restarted a PPE proforma must be completed alongside the recovery proforma and signed by the Chief Nurse/ Director of Infection Prevention and Chief Operating Officer. These can be signed at Deputy level where appropriate. All proformas are discussed at recovery board prior to agreement. These logs are held within the governance department.

- In line with Regional and National requirements, WHH implemented a major incident plan in conjunction with the health network across Cheshire and Mersey. The Trust is part of the regional Hospital Cell, bringing acute sector organisations together to ensure a coordinated response to ensure safe and timely care is provided for all patients. This has supported ensuring sufficient capacity for critical care along with supporting the out of hospital cell with capacity for community provision.

- An assurance paper on 'Site Access and Egress During COVID-19' was presented to the Board of Directors on 19 May 2020 outlining options to change access and flow across the hospital sites to give confidence to staff, patients and visitors that entering sites is controlled and restricted to essential persons. Masks and sanitiser are available at all entrances.

- The WHH Board of Directors monitors the demographics to provide assurance that it is not outside the national position and this information is included in the Annual Report and Accounts 2019/ 20 which was approved by the Board on 17 June 2020,submitted to NHS Improvement on 25 June 2020 and accepted by Parliament on13 July 2020

- A new risk assessment template has been produced to assess staff members who might be at higher risk of developing COVID-19 symptoms. Clear guidance on completion was sent to all managers. Compliance is monitored and reported via the Tactical Group meeting and Recovery Board. A presentation regarding the risk reduction framework was also presented at the Strategic Oversight Committee on 23rd June 2020. This presentation confirmed the accountable manager for the compliance and completion of risk assessments. The Chief People Officer also wrote to all staff (home addresses) outlining their responsibility to undertake a self-assessment highlighting the PHE vulnerable groups and the responsibility to notify their line manager for full risk assessment.

- The Trust developed as Agile Working Policy. This included the framework for staff to work from home and be redeployed temporarily with responsibility for health and safety risk assessments to be undertaken as appropriate without substantively changing the terms and conditions of employment.

- The Trust has ensured that necessary measures are in place to evidence compliance with Public Health England (PHE) risk stratification guidance as it emerges, initially prioritising those staff who were extremely clinically vulnerable, clinically vulnerable, pregnant and BAME later adding obesity, age (over 60 years white and >55 years BAME) and gender male.

- The Trust's Freedom to Speak up Guardian assists staff in flagging any concerns.

- Governance Managers continue to support all CBUs and attend the daily safety brief to ensure that incidents are being captured and staff concerns identified. Staff are prompted daily as to whether they require support with incident reporting.

- Reporting to improve campaign re-launch for areas that may show signs of reduced reporting. This is monitored within the governance department.

- A daily email communication is sent to all staff from the Chief Executive which includes core messages derived from meetings within the decision making framework; for example, reminding colleagues who wear scrubs that these should not be worn on their journey to and from work in line with Infection, Prevention and Control national and local guidance.

- An internal testing line has been implemented for any staff member to contact if they show signs of COVID-19. This was established through the Occupational Health Team following multi-disciplinary ratification of standard operating procedures via Tactical Group and/or Recovery Board. The Trust has been compliant with all NHS England/NHS Improvement, Health and Safety Executive (HSE) and Public Health England (PHE) guidance throughout the pandemic with a timely response.

- Specific measures have been implemented to test particularly vulnerable patients, for example all cancer patients are tested for COVID-19 prior to undergoing a procedure. There are clearly defined clinical pathways in place agreed by the multi-disciplinary team with oversight at Recovery Board. Compliance with NICE guidance NG179.

- The Clinical Advisory Group has also issued guidance on performing COVID-19 swab testing for asymptomatic patients attending Endoscopic procedures across WHH. These have

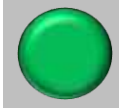
formed part of a WHH Standard Operating Procedure (SOP) which is adhered to as Endoscopy services are restored. This is overseen as part of the daily Elective Planning meeting. The same SOP is followed with external capacity provided by the Independent Sector (SPIRE Cheshire).

- WHH have ensured that appropriate patient and staff testing programme is in place. The Trust has been compliant with all necessary requirements throughout the pandemic. Staff testing centre was set up at the Halton site via the UCC and Emergency Department. Testing was also extended to symptomatic household family members and staff across the workforce in its entirety. Occupational Health also provided results and supported the introduction of asymptomatic pilot testing and pastoral support. Microbiology support was sought. Relevant SOP's in place via ratification at Recovery Board or Tactical.

- The Antibody testing programme was overseen by the Cheshire and Mersey Health and Social Care partnership on behalf of the pathology network. Panther which is a molecular test purchased by the Trust during the pandemic, facilitated on site testing. Polymerase chain reaction (PCR) testing commenced in June 2020 and antibody testing is facilitated using the Siemens platform.

- WHH has been accepted onto the SIREN study. The purpose of this study is to understand whether prior infection with SARS-CoV2 (the virus that causes COVID-19) protects against future infection with the same virus

RISK RATING



2.1.4 Police investigations

The following information details possible lines of inquiry:

- Corporate manslaughter – this is an action brought against an organisation not an individual. If found guilty the organisation can be fined.

- For an organisation to be found guilty of this offence the way in which activities are managed or organised has to cause the person's death and amount to a gross breach of the duty of care owed to that individual. The breach is 'gross' if it falls far below what can be expected in the circumstances. As part of this offence the way the organisation's activities are managed or organised by the Senior Management Team has to be a substantial element of the breach. The classification of a Senior Manager will depend upon specific facts of the alleged failing. This could include Consultants, Matrons, Medical Directors and or Executive Directions. For additional understanding the following scenarios are examples of such an occurrence:

  - **Example 1:** If a service is set up during the pandemic for elective care without taking appropriate precautions (i.e. screening patients) and the patient contracts COVID-19 and subsequently dies, this could constitute corporate manslaughter. However it would have to be proven that the organisation of the service is what caused the death, specifically how this was managed by the organisation's Senior Management, and the steps taken

(or not taken) would have to fall far below what would be expected in the specific circumstances of the pandemic.

- **Example 2:** If a staff member dies following contracting COVID-19 and there are allegations that appropriate PPE was not provided or if a patient dies as a direct consequence of resource issues (i.e. lack of ventilators).

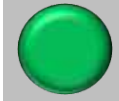
- The following information details gross negligence manslaughter allegations against individual staff members:

  - **Example 3:** if a staff member made a decision to ration access to critical care for a patient in favour of another (without any clinical reason) who subsequently dies.

CONTROLS TO ADDRESS RISK

- Incident reporting process as described above.
- Governance arrangements supported through Decision Making Framework with clear process for escalation.
- As referred to above an assurance paper on PPE was presented to the Board of Directors meeting held on 27 May 2020. This outlines the steps taken by the Trust to ensure adequate provision of PPE supplies. Where services are reinstated as part of recovery, PPE proforma must be completed and agreed via Recovery Board and signed off by Chief Nurse / Director of Infection Prevention and the Chief Operating Officer. In some circumstances these can be agreed at deputy level. The Trust has been very clear throughout the pandemic that staff must NOT work without appropriate PPE.
- Details of the staff testing programme is outlined above.
- The Novel Coronavirus policy was ratified at the Tactical meeting which formed part of the Decision Making Framework implemented during the COVID-19 period. This policy was updated on numerous occasions through the Tactical Group meeting as new national guidance was received to provide assurance of full compliance. This was further supported by weekly updates at Medical Cabinet. The Trust appointed a Respiratory Consultant and a COVID-19 Consultant rota 7 days per week who supported the implementation of the Clinical Guidance and decision making process. There was close working between these individuals and the Trust control room to ensure the co-ordination of efficient, safe care. The policy endorses NICE guidance COVID-19 rapid guideline (NG159), Critical Care in Adults. There was capacity throughout the pandemic to meet the care needs of all patients.
- The North West Ethics Clinical Advisory Committee can support organisations in the North West if required. A Clinical Ethics Committee Terms of Reference for WHH has been submitted to establish an internal Clinical ethics Committee if required in the future.

RISK RATING



Gross negligence and corporate manslaughter charges can be brought concurrently against individual doctors and NHS Trusts.

2.1.5 Health and Safety Executive (HSE) investigations

- The HSE could investigate allegations of inadequate PPE, implementing social distancing, unsafe systems of work or testing for COVID-19.

- Employers have a duty to ensure, so far as is reasonably practicable, the health, safety and welfare of their employees at work. HSE considers that if an employer is following the relevant Public Health England guidance for their sector in terms of controlling the public health risks, they will be taking reasonably practicable precautions to control workplace risks.

- As referred to above an assurance paper on PPE was presented to the Board of Directors meeting held on 27 May 2020. This outlines the steps taken by the Trust to ensure adequate provision of PPE supplies.

- Deaths of staff would be reportable to the HSE (RIDDOR) if there is a suggestion of workplace exposure to COVID-19.

- As the country moves into the recovery phase social distancing will be an area closely monitored by the HSE. Guidance produced advises how organisations must work safely and emphasises that more stringent measures need to be put in place in order to protect staff. Agile working should be agreed where possible.

CONTROLS TO ADDRESS RISK

- Staff have been provided with appropriate PPE and Public Health England advice followed throughout.

- A specific paper on PPE was presented to the Board of Directors meeting held on 27 May 2020 by the Chief Nurse and Deputy Chief Executive

- A standard operating procedure has been put in place to address Covid-19 RIDDORs which will be managed by the Health and Safety Team.

- WHH risk assessments have been developed and undertaken to support the implementation of social distancing rules across the Trust.

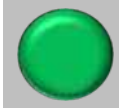
- An assurance paper on 'Site Access and Egress During COVID-19' was presented to the Board of Directors on 19 May 2020 outlining options to change access and flow across the hospital sites to give confidence to staff, patients and visitors that entering sites is controlled and restricted to essential persons .

- As referred to above, in early June 2020 an internal testing line has been implemented for any staff member to contact if they show signs of Covid-19. This remains in place and the Trust extended Occupational Health Support to support staff avoiding unnecessary delay.

- In relation to any decision to report COVID-19 Incidents to RIDDOR – staff have been reminded to ensure the rationale for any decision made is fully documented in the case notes. This includes documenting when there is reasonable evidence that a worker who

has been diagnosed with COVID-19 contracted it from exposure to the virus at work.

RISK RATING



Recommendation: The Deputy Director of Governance to ensure COVID-19 Incidents are reported to RIDDOR to ensure consistency, compliance with the Standard Operating Procedures (SOP) and emerging themes.

2.1.6 Litigation

2.1.7 Claims by staff

- Employer's Liability (EL) claims for illness sustained as a result of inadequate PPE, inadequate fitting of PPE, or inadequate training especially if they have been redeployed/deployed contrary to Government advice in respect of shielding (even if employee willing and deemed fit to work). Ordinarily the Trust carry an excess for each EL claim brought (<£10,000 for any employer's liability claim).

- Possible stress claims or bullying claims if staff experience Post-Traumatic Stress Disorder, are not treated appropriately, or are overworked and they develop psychiatric injury as a consequence.

- Employer liability claims by employees for Mental Health related injuries associated with dealing with COVID-19 response as well as those dealing with non-COVID patients. There is also the potential for injuries from sub-optimal workstations where not properly assessed when working from home.

2.1.8 Claims by patients

- Negligent treatment / contraction COVID-19 due to alleged inadequate segregation, testing, or cleaning of clinical areas.

- WHH must ensure that an enhanced consent process is followed for surgical and non-surgical treatment. Alternative options should always be considered with the patient where possible. Assessment and treatment conversations should limit risk without negative impact on patient choice.

- WHH needs to ensure there is informed consent for treatment decisions in all settings where either time or lack of face to face contact inhibit this process.

- Failure to bring in patients who require admission but are not given appropriate advice / safety netting in a video or phone consultation – or similar advice to primary care practitioners. All Trust waiting lists are reviewed in line with national prioritisation guidance (Cancer & Elective Surgery). All 2 week wait cancer referrals have continued along with appropriate diagnostic and subsequent treatment in line with the guidance issued. In addition, all urgent cases have been clinically reviewed and categorisation according to

clinical prioritisation. A review paper was submitted to Quality and Assurance Committee in July 2020.

- Claims from patients not suffering from COVID-19 who suffer harm as a result of delays in investigation/ diagnosis/ treatment. This could be a significant cohort and the Courts will inevitably see cases over the coming years where they need to decide how much tolerance is warranted for delay. At the very least the Trust should stay in line with national figures on waiting times.

- Claims relating to NHS treatment which WHH has outsourced to the private sector but for which we retain legal responsibility.

2.1.9 Maternity claims

- Issues regarding lack of choice – e.g. where the mother says she has been denied informed consent around choice of birth.

- Reduction in availability of anaesthetists for elective/emergency caesarean sections, leading to worse outcome for the mother or child.

- Pausing of mandatory reporting requirements for maternity incentive scheme reducing the focus on this area. The maternity incentive scheme has been recommenced and NHS Resolution have proposed submission by November 2020.

2.1.10 COVID-19 indemnity from the Government

- NHS Resolution has confirmed that indemnity will be in place for all COVID-19 related activity. Attention is required for any outsourced services to confirm who will be legally responsible.

2.1.11 Claims under Human Rights Act 1998 (HRA) and Equality Act 2020

- Claims arising out of a ban on visiting patients especially as they near the end of life, including failing to prioritise remote contact with loved and trusted relatives and friends.

- Claims of discrimination and breach of the HRA based on decisions of prioritisation of critical care and access to life sustaining treatment.

2.1.12 Impact on the WHH NHS Resolution Tariff and payment of Employer's Liability/ Public Liability excess

- NHS Resolution contributions are based on a 10 year period so short term fluctuations of new claims and activity ought not to have an immediate impact.

- Guidance awaited from NHS Resolution /DHSC on how COVID 19 related claims are to be administered and if they will be funded from existing contributions

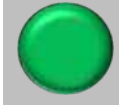
- WHH currently pay an excess of £10,000 for each Employer's liability claim and £3,000 for each Public Liability claim. In the event of multiple staff claims the totals could be significant. Government announcement of death in service payments was made on 27th April 2020.

Detail waited to see if this will be taken into account in any claims made and how the government would administer any large group action**.**

CONTROLS TO ADDRESS RISK

- Deputy Chief Nurse to support maternity services and to achieve NHS Resolution maternity standards.
- Regular site based claims meetings are being scheduled to ensure new trends are identified and acted upon, with appropriate staff support. The claims process has continued.
- An assurance paper dealing specifically with the governance and legal issues around PPE to reduce risk to staff and patients in all areas was presented by the Chief Nurse and Deputy CEO to the Board of Directors meeting held on 27 May 2020.
- Patient information letters to explain risks and processes during Covid-19 have been sent in advance of all elective procedures and followed up with appropriate pre-operative clinic appointments.
- WHH have updated consent flow chart for patients for elective treatments to ensure risks around recovery of surgery and COVID-19 are documented. This links in with the Trust's overarching consent policy.
- A risk assessment template has been produced to assess staff members who might be at higher risk of developing COVID-19 symptoms. This has been brought to the attention of all managers.
- Freedom to Speak up Guardian assists staff to flag any concerns.
- PPE champions in place undertaking daily walk rounds to advise on PPE and address any concerns raised by staff which is being overseen and supported by the IPC team.
- Strong Duty of Candour compliance processes.
- Clear open and honest culture.
- COVID-19 Learning Framework.
- The Deputy Director of Governance and along with our external legal providers regularly review guidance/relevant changes to the law that impacts the organisation.

RISK RATING



Recommendation: Themes identified from incidents to be presented as part of the 'Learning from Experience' Report at the Quality Assurance Committee.

WHH has an online risk assessment tool for staff to complete self-assessments and for individual / line managers to complete full risk assessments with identified PHE vulnerabilities.

Review contracts and outsourcing arrangements to ensure clear lines of responsibility: Currently working with the independent sector under the national contract until September 2020. Further guidance awaited.

Deputy Director of Nursing to work with the Deputy Director of Governance to ensure risk issues are addressed and NHS R maternity standards complied with.

Staff advised to shield were supported by Occupational Health and their line managers to where possible work from home. This is supported by the agile working policy.

2.1.13 CQC investigations

- It is possible that the CQC could initiate investigations into alleged breaches of their requirements.
- One specific area the CQC may be interested in is compliance with Duty of Candour during the pandemic and afterwards once complaints start to increase.
- They will also monitor compliance with "business as usual" requirements and service provision to non COVID-19 patients.
- There is a modified approach to Disclosure and Barring Service (DBS) checks for people who are joining to help during the pandemic.
- There is also an expedited process for changes to registration, where a provider is changing the range of regulated activities it is providing, including adding new sites, as part of the response to COVID-19.
- The manner in which the CQC undertake engagement meetings during the pandemic is being reviewed. The Trust is awaiting further information.

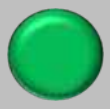
All Trusts have been asked to provide an Infection Prevention and Control Board Assurance Framework.

CONTROLS TO ADDRESS RISK

- Difficult decisions around access to intensive care are not made by one individual but by a group of appropriate individuals, utilising the Trust's Standard Operating Procedure for Management of Novel Coronavirus (COVID-19) in Adults and Children which details ICU escalation requirements to ensure a comprehensive rationale for the recording of clinical decisions.
- Duty of Candour is monitored on a weekly basis at the SI assurance meeting. The Patient Safety Manager provides assurance that all families are informed. The Trust have worked to maintain the 60 day timeframe of response to SIs.
- The Chief Nurse and Deputy Director of Governance have strong relationships with the CQC and the commissioners. Regular communication ensures openness and transparency with the CQC and commissioners regarding any issues that arise which may constitute breaches of their requirements. A CQC log is also maintained. These standards have been maintained throughout the pandemic.

- The Trust statement of purpose has been completed and submitted.
- The CQC will begin to utilise alternative methods for assurance. The Trust are awaiting further information.
- Infection Prevention and Control Board Assurance Framework is in place with an action plan to provide appropriate assurance. This has been reviewed by the CQC who were satisfied that the Trust had robust proactive IPC measures in place.
- A paper has been provided to the Strategic Oversight Group to provide assurance with regard to CQC requirements during the pandemic.
- M20 action plan has been revised and updated.

Rating



2.1.14 Referrals to regulatory bodies (i.e. GMC/NMC)

- There has been some debate about the potential regulatory consequences for staff working in the pandemic. For example;

  - Refusal to treat without adequate PPE and regulatory consequences.
  - The Medical Defence Union has issued guidance entitled, 'Can I refuse to treat a patient if there is inadequate PPE?' (27 April 2020).

- This refers to an event such as:
  a) A clinician makes a decision to ration access to critical care for one patient (patient A) in favour of another,

  b) Withdraw treatment from one patient (patient A) in favour of another who is likely to have a greater chance of benefiting from that treatment - as a consequence of this patient a dies.

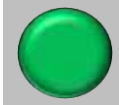
- There is also the possibility of referrals to regulatory bodies arising from future PPE coronial inquests, incidents and complaints.

CONTROLS TO ADDRESS RISK

- Steps taken regarding PPE, has ensured that there have been no instances where a patient has not received treated due to a lack of PPE. Clear daily oversight of PPE availability at daily Tactical and Recovery Board with escalation to Strategic Oversight Group as necessary. There has been clarity with staff throughout the pandemic that clinical work must only be undertaken with the correct PPE. Guidance has been followed throughout the pandemic including PPE for aerosol generating procedures
- A new ICU escalation policy has been implemented to ensure difficult decisions are not made by one individual but a group of relevant individuals. This policy was discussed at the Trust Safety Brief and has been uploaded to the hub where it is easily accessible to all.

- There are no serious incidents which suggest that a patient has been denied ventilation due to lack of ICU bed/ventilator.
- Incident reporting process – incidents are monitored to ensure any concerns can be picked up at an early stage; for instance, trends of incidents concerning the same clinician. This is monitored at a monthly triangulation meeting for doctors, nurses and Allied Health Professionals, chaired by the Director of Nursing or Medical Director as appropriate.
- Incidents are also monitored via the Weekly Harm Dashboard and Weekly Meeting of Harm.

RISK RATING



2.1.15 Human Resource (HR) issues

NHS Employers have developed guidance with trade unions at a national level, on a number of staffing issues caused by the COVID-19 situation. WHH should keep the guidance under regular review and follow it wherever possible (https://www.nhsemployers.org/covid19).

2.1.6 Public Interest Disclosures (Whistleblowing)

Whistleblowing e.g. inadequate PPE, inadequate testing is a potential issue. WHH should be mindful of employees raising concerns around the COVID-19 situation. Any such concerns are likely to amount to Public Interest Disclosures.

WHH should ensure such employees are not subject to detriment as result of raising any concerns about COVID-19. Risk is unlikely to arise from the actions of Directors or Senior Managers, who are likely to be well aware of the relevant legislation. Risk is more likely to arise from the actions of first line management, particular those on the front line, who may have been working under considerable pressure for a prolonged period and may not perceive the concern raised as reasonable or valid.

WHH should remind colleagues of the need to follow its values and behave in a respectful manner to each other, even at times of increased pressure on the Trust's services.

Some Trusts have experienced staff raising concerns via social media channels. WHH should ensure its Communications Team are fully appraised of this potential issue. WHH should consider whether to remind employees of the preferred channels through which employees can raise concerns.

2.1.17 Working Time Regulations

Employees are working additional hours to meet the demands of the services provided. Employees are likely, for a period, to exceed the maximum number of working hours per week. At present the Trust does not have a central rostering system for all disciplines. The expectation is that this is monitored by individual line managers with appropriate escalation as required. When staff commence work at the Trust they are informed of the working time regulations.

To assist WHH in monitoring the working time regulations, Nursing & Midwifery rosters are created using the Allocate HealthRoster electronic system. This has in built rules for the shift pattern of each individual which includes the EU working time directive alongside agreements such as not mixing days and nights in a week. The system also ensures that that each staff member must have a 48 hour break every week. The system will therefore not allow a shift to be allocated to an individual if it will mean the rule would be broken. The same process applies for our staff that book extra shifts with NHS Professionals.

With regards to monitoring the working time regulations for Medical Rotas, once a roster has been created it is shared with the Medical Education and Medical Staffing who make sure that it is compliant from a training point of view as well as EUWTD. Once it is signed off it is then shared with the doctors. Consultants and other Trust career grade doctors are subject to a job plan. This process ensured that the medical staff were always given an EUWTD compliant work pattern during the COVID lockdown.

2.1.18 Constructive dismissal claims

Any feature of the COVID-19 working environment which an employee considers to be unacceptable, could lead to a resignation and constructive dismissal claim. An example may be a requirement to work excessive hours, over a prolonged period. To some extent, this is unavoidable, but working hours should be managed in the best way possible, to minimise employees working hours. There is no evidence of this to date at WHH.

A further example, linked to 5.1, if employees perceive they are in danger due to inadequate PPE, training or supervision, or any other situation they perceive as a danger to their health, they may decide to resign and claim Constructive dismissal. WHH should ensure employees are provided with a safe system of work. There is no evidence of this to date at WHH.

WHH should also be mindful of any emerging groups of staff who are perceived to be at increased risk (e.g., shielding staff, staff from BAME background, etc.) and take appropriate steps in line with the recommendations. This will minimise the prospect of such staff resigning and bringing claims of constructive dismissal.

2.1.19 Equality Act claims

Equality Act claims could be brought by employees arising from some of the circumstances mentioned. This could involve claims from employees with disabilities or employees from a BAME background, who feel that they should not be deployed on the front line, or in a clinical environment.

2.2.20 Employee relations issues on hold

The placing on hold or delaying of some employee relations issues may create difficulty when WHH later tries to resolve these issues. For example, it may be more difficult to re skill excluded/restricted doctors if they have been away from practice for a longer period. WHH should ensure any delay is kept to a minimum on this issue.

2.1.21 WHH staff on secondment at other organisations/locations

WHH may have increased staff on secondment with other organisations and/or at other locations. This will bring WHH staff into contact with staff from other organisations and may lead to detrimental treatment of WHH staff, for example:

- Staff may be subject to detriment for raising concerns.
- Staff may be subject to detriment by reason of a protected characteristic.
- Staff may suffer personal injury/death while under the supervision of another organisation.
- Staff may be subject to general unreasonable treatment, which could lead to resignation and constructive dismissal claim.

To minimise risk, WHH should ensure that appropriate secondment arrangements are entered into, with host organisations providing assurance they will take reasonable care of WHH staff and host organisations accepting reasonable liability for risk.

Equally, WHH may currently have day to day supervision for a larger than usual number of employees of other organisations. WHH should ensure such staff are treated considerately and WHH should not accept an unreasonable level of risk in relation to such employees.

2.1.22 Reduction in pay

Staff may be unable to fulfil their duties during the COVID-19 pandemic for a variety of reasons:

- Ill health.
- Need to isolate.
- Need to shield.
- Need to look after dependants who must shield.
- Loss of work due to reduced activity in certain areas.

If staff lose income as a result, they may seek to claim the reimbursement of that income. There are a myriad of different possibilities under this heading. WHH should ensure in relation to each situation that it considers the legal principles relating to deduction from wages and complies with the law, wherever possible.

2.1.23 Temporary/Casual/bank/zero hour staff

WHH should also consider employees working under flexible arrangements, such as bank workers or zero hour contracts. Managers should be mindful that such workers may acquire additional contractual or statutory employment rights if they work a regular and settled pattern of shifts for WHH over a sufficient period**.**

2.1.24 Potential redundancy liability

If WHH has been required to increase the size of its workforce, to cope with the pressures of COVID 19, that workforce may contract again once activity levels drop off. Dismissing staff who have been employed to cover the period of peak activity could amount to a redundancy situation.

Employees may be entitled to redundancy payments if they have two years continuous NHS Service, even if they only have very short service with WHH.

CONTROLS TO ADDRESS RISK

- During April, May and June 2020 twice weekly meetings on COVID-19 were held with the

Staff Side Chair, Deputy Staff Side Chair and Chief People Officer.

- Achieve a common approach to any issues affecting staff.
- We regularly review the NHS Employers and the NHS Improvement/NHS England guidance.
- Agreed a new WHH whistleblowing Freedom to Speak Up (FTSU) policy in place and have established a working group to promote FTSU specifically to minority groups within the workforce.
- We are triaging ER cases, understand about deductions to pay and flexible working arrangements in line with the national Social Partnership Forum agreement (Version 1 – due for review by 30 June 2020).

RISK RATING

Whilst the Trust is compliant if there was a central monitoring system for working time regulations this would be more robust.

Recommendation:

- WHH should continue to keep workforce guidance under regular review and follow it wherever possible (https://www.nhsemployers.org/covid19). Weekly reviews are in place within HR and OD Teams.
- WHH should be aware of employees raising concerns around the COVID-19 pandemic. Any concerns are likely to amount to Public Interest Disclosures.
- Consider reminding staff about the most effective channels for raising concerns. A working group has been established to promote FTSU specifically to minority groups within the workforce. The FTSU Guardian chairs the working group, attended by the Head of Staff Engagement and Wellbeing; Equality, Diversity and Inclusion Manager, and the chair of the BAME Staff Network.
- Ensure working environment, conditions, hours are all as reasonable as possible, given unprecedented challenge.
- Ensure reasonable additional measures are taken to protect groups of staff at increased risk (in line with Section 5 above). A workforce risk assessment template and guidance has been issued.
- Remind staff of the need to treat each other with respect and in accordance with organisational values.
- WHH should examine what reference periods it has in place for measuring working hours. The Trust are reviewing the feasibility of this and whether this can be achieved via e-

rostering for those staff with access to these systems as unfortunately this cannot be undertaken centrally.

- Need to consider that the placing on hold or delaying of some employee relations issues may create difficulty when WHH later tries to resolve these issues. Ensure any delay is kept to a minimum in line with national Social Partnership Forum (SPF) agreement.

- Ensure appropriate secondment arrangements are entered into with host organisations providing assurance they will take reasonable care of WHH staff and host organisations accepting reasonable liability for risk.

- Ensure any staff seconded to WHH are treated considerately and WHH should not accept an unreasonable level of risk in relation to such employees.

- Regarding reductions in pay, in each situation (wherever possible) consider the legal principles relating to deduction from wages and comply with the law. Please note that the Trust has made provisions for protection of pay where reduction is a result of COVID-19

- Consider employees working under flexible arrangements, such as bank workers or zero hours employees, and be mindful that such workers may acquire additional employment rights, if they work a regular and settled pattern of shifts for WHH over a sufficient period.

- Be mindful that if activity levels fall in future and employees are dismissed, there may be a liability to pay redundancy payments, in some circumstances.

2.1.25 Media interest

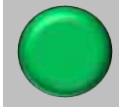
- All legal issues arising out of COVID-19 will attract negative publicity. This is likely to be seen in the autumn with an increased number of inquests.
- Currently the media are describing the NHS as heroes but this is likely to change.
  Staff may voice concerns about issues such as PPE, lack of testing, etc. on social media channels.

CONTROLS TO ADDRESS RISK

- The communications team are regularly kept updated of any relevant legal developments and this process has been maintained throughout the pandemic.

- Various methods of communication are available to brief staff and patients on COVID-19 and particularly when there is media interest. The Public Board meetings provide a Covid-19 summary report presented by the Chief Executive Officer (CEO). 'Your Hospitals - Our Hospital' newspaper keeps Foundation Trust members, the public and staff updated on COVID-19 and this is published on the Trust's internet. A daily email communication is sent to all staff from the Chief Executive which includes core messages derived from meetings.

RISK RATING



2.1.26 Information Governance – Confidentiality and FOI requests

- The Information Commissioner's Office (ICO) has issued a statement outlining the regulatory approach during the coronavirus Public Health emergency (15 March 2020). There is also a Public Health regulation on responsibility for sharing information on positive cases to other care providers.

- This statement recognises that organisations' resources could impact their ability to comply with aspects of freedom of information law, such as how quickly FOI requests are handled. It has reiterated that it will act pragmatically and proportionately.

- It recognises that the reduction in organisations' resources could impact their ability to respond to access requests or address backlogs, where they need to prioritise other work due to the current crisis. Organisations should recognise the public interest in transparency and seek as far as possible to continue to comply with their obligations for particularly high-risk or high profile matters.

- It acknowledges that in extreme circumstances where public authorities have no option but to temporarily reduce or suspend elements of their information access function.

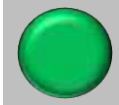
- It encourages public authorities to proactively publish information they know will be of importance to their communities.

- The actions taken by all public bodies, NHS trusts in particular, are likely to be the subject of considerable public scrutiny once the pandemic is over. During or after the pandemic there is a potential for an increase in FOI requests, hot topics may be PPE, testing etc.

CONTROLS TO ADDRESS RISK

- Under Section 19 of the Freedom of Information Act 2000, WHH has a legal duty to adopt and maintain a Publication Scheme for the publication of trust information. Wherever possible, FOI requests have been handled as normal.

RISK RATING



Recommendation: Act transparently and publish information proactively when appropriate e.g. publicise the FOI policy on the Trust's intranet. Publish information regarding the compliance rate for responding to FOI's within 20 working days which will commence the day after it receives the required clarification from the requester.

2.1.27 Governance and public law challenges

- There is the potential for governance and public law challenges by patient groups / individuals to challenge new policies, for example an urgent judicial review claim regarding prioritisation / allocation of resources during the pandemic.

- Section 242 of the NHS Act 2006 refers to NHS Trusts responsibilities to involve service users directly or through representatives in the planning, development and operation of services. How this duty can be met during the current pandemic has been the subject of discussion between claimant solicitors and barristers. Smaller Trusts and District General Hospitals are less likely to experience this when compared to larger organisations.

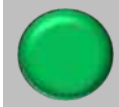
- This is relevant to all policies implemented or amended during this pandemic. With specific reference to the ICU escalation policy, it is important that key information about how care is being prioritised is made public; however, in the current circumstances it would not be practical to allow for a period of public engagement and then consideration of those responses, due to the urgency in which these policies need to be implemented. Also, in the current circumstances staff certainty is extremely important, and therefore continual amendment of key policies is not appropriate.

CONTROLS TO ADDRESS RISK

- All new policies and process changes have gone through Tactical Committee or Recovery Board following review within specialist areas and relevant teams.

- A leaflet has been devised to detail all changes to policies and processes that have been released during the pandemic for managers. This will be updated every 2 months. Trust communications also support.

RISK RATING



Recommendations: Act transparently and publish information proactively when appropriate - Policies and SOPs are uploaded to the Trust intranet.

Explicitly consider Public Sector Equality Duty – particularly given the ICU policy may have a disproportionate impact on those with protected characteristics of age and disability.

2.1.28 Delayed discharges/premature discharges – CCGs, private care homes and social care

New COVID-19 Hospital Discharge Service Requirements have brought about a number of changes to free up hospital beds including rapid discharges from hospital once it is clinically safe to do so. Screening for Covid-19 was introduced on 16 April 2020. The following are potential issues that may result:

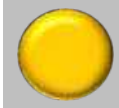
- During the COVID-19 pandemic patients will not be able to wait in hospital until their first choice of care home has a vacancy.
- Fewer options on discharge creates the potential for issues with objections from patients/families and the potential for Court of Protection proceedings being instigated.
- Less effective discharge planning and handover due to requirement for timely discharge from hospital.
- Other potential issues with quick discharges include problems with supplying take home medication, and risk of less robust documentation around rationale for discharge.

- Measures brought in for local authorities (via Coronavirus Act 2020), if utilised, may affect care and support assessments for patients relevant to discharge.
- Delays to discharge due to the availability of care home placements and home care providers affected by COVID-19 resource implications.
- Delays to discharge due to requirements to test prior to discharge.
- Legal challenges to the suspension of patient choice in relation to care home.
- No obligation on CCGs to undertake NHS Continuing Healthcare assessments at present.

CONTROLS TO ADDRESS RISK

- Daily email communication is sent to staff which includes core messages from the Chief Executive
- Communication via Safety Huddle on any emerging issues or changes to guidance
- Pre-discharge COVID swabbing in place for all patients transferring into care homes.
- Calls with system partners and care homes to assure that patients transferring to care homes will only transfer with the care homes acceptance and their COVID status.
- Councils have made grants available for care homes to support with the prevention and control of infection
- Care homes supported by the Trust with infection prevention and control training
- WHH have a joint post for Warrington Borough Council, Associate Director Integrated Care who leads the Trust Integrated Hospital Discharge Team. This guidance has been shared and adhered to appropriately. The join post is for Warrington BC only, not Halton
- Where there are safeguarding or mental capacity concerns, these are fully understood prior to transfer.
- Community Single Point of Contact in place to provide connection between the Trust and patients with on-going health needs.

RISK RATING



Risk rating amber due to risk and number of super stranded patients.

Recommendation: Continue to monitor guidance developing via the link here: https://www.gov.uk/government/publications/guidance-for-those-involved-in-managing-covid-19-deaths/guidance-for-those-involved-in-managing-COVID-19-deaths

Create an efficient system of testing those patients being discharged to a care home / supported living setting.

Ensure there is clear liaison with patients under the Hospital Discharge Requirements as to steps being taken to discharge (through correct issue of leaflets/information).

Consider any safeguarding issue arising for the patient and/or those they live with prior to discharge e.g. patient non-compliant with COVID-19 guidance, and co-habitant at home at risk due to vulnerable status including whether Health Protection Team should be contacted.

Ensure close and timely liaison with local commissioning bodies and establishing which body is the lead on discharge arrangements once patient allocated to appropriate pathway.

Consider adopting the non COVID-19 patient discharge discussion document and process

developed by Stockport NHS FT within the WHH.

Support the implementation of the new hospital discharge requirements and discharge to assess model.

2.1.29 Mental Health

There have been no changes to the Mental Health Act (MHA) legislation and all organisations and staff should continue to operate in line with existing MHA law and Code of Practice. The Coronavirus Act 2020 brought in a number of emergency provisions but these will only come into force if there are unprecedented resource constraints that put patients' safety at significant risk.

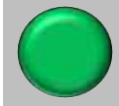
The COVID-19 pandemic raises the following potential issues for Mental Health:

- Increase in Mental Health related admissions due to direct impact of COVID-19 on Mental Health i.e. due to increased anxiety and isolation
- Increase in Mental Health admissions due to indirect impact of COVID-19 e.g. homeless people who may have lost income and be facing reduced access to drugs and alcohol on which they depend.
- Potential claims for inappropriate use of MHA i.e. to enforce treatment, restrictions or isolation that is unrelated to the management of a person's Mental Health.
- Unlawful detentions periods arising from pressures related to compliance with the under MHA due to lapses in s5 holding powers, s136 detentions etc. due to inadequate access to s12 doctors and AMHPs.
- If the emergency provisions, referred to above, are implemented this could lead to confusion amongst staff over their implementation, a failure to protect patients' basic human rights to freedom and a family life, or a failure to appreciate that whilst rights may have been limited under the emergency provisions, they do still exist, e.g. patients may need additional support to access/effectively communicate during tribunal or court hearings being held remotely.

CONTROLS TO ADDRESS RISK

- There have been no changes to the Mental Health Act (MHA) legislation and WHH continues to operate in line with existing MHA law and Code of Practice.
- The adult safeguarding team are supporting staff. The WHH has not relaxed the MCA/DoLS processes (not in an acute or community setting).
- WHH continues to ensure that systems and processes are in place and that existing and new staff are able to access specialist support and advice wherever necessary.
- Daily email communication is sent to staff which includes core messages from the Chief Executive

RISK RATING



Recommendation: Continue to review the national guidance daily for any updates via this link https://www.england.nhs.uk/coronavirus/ including but not limited to the following legal guidance:

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0072-MHLDA-COVID-19-Guidance-Legal-300320.pdf

Create a COVID-19 specific protocol for MH related admissions in conjunction with local MH trusts and professionals and share between organisations

Allocate resources to Mental Health staff (via the psychiatry liaison service if there is one) to undertake timely assessments of patients in MH related admissions

Liaise with S12 doctors and Approved Mental Health Professional's to establish response times and share between organisations

Engage in practical measures to support patients with creative ways in which to contact key people in their life

2.1.30 Safeguarding

The Coronavirus Act 2020 does not have any impact on usual safeguarding procedures and these are expected to remain fully functioning. However, wider provisions brought in to allow local authorities to modify their duties in relation to assessing care and support needs, may impact on what can be done by a local authority in terms of assessment of care and support needs which may indirectly affect safeguarding of patients.

Potential issues are detailed below:

- Increase in incidents of abuse and safeguarding related admissions to hospital.
- Potential claims for inadequate safeguarding measures during hospital admission due to limited and diverted resources and staff to the frontline, both internally and from external sources of support.
- Issues with discharge of patients to homelessness (Hospital Discharge Requirements – Annex E).
- Issues around safe recruitment and movement of staff (including volunteers).
- Patients living alone being at increased risk of abuse due to increased social isolation e.g. accepting assistance from a fraudster posing as a volunteer or similar – district nurses need to be aware of this.
- Patients living with others also being at increased risk of abuse due to the lock down i.e. patient and abusive partner cannot leave property so risk increases – again the district nurses need to be aware of the increased risk.
- Possible increased risk to health professionals in the community due to pressure of lock down on individuals living on their own and households (especially if there is a history of domestic abuse). The children's safeguarding team shared domestic abuse during COVID-19 advice trust wide and this was also discussed at SGC.
- A reduction in normal services by commissioning bodies (Local Authorities and CCG's) will create service gaps which may increase the pressures on health services.
- An increase in patients presenting with self-neglect due to self or advised isolation, either because of reduced services or because of decreased family support will create increased pressure across acute and community services in ensuring a safe discharge or alternative discharge placement, there will be pressure on services as additional support packages may

be required where they were not before, staff have been supported to help them recognise signs of self-neglect.

2.1.31 Mental Health

- An increase in patients exhibiting Mental Health symptoms either acutely in A&E or whilst in-patients. The adult safeguarding team are raising awareness with ward teams encouraging them to ask how their patients are feeling, posters have been ordered to be placed around the organisation encouraging patients to seek help and informing staff how to support their patients to ensure they are supported.

- NHSE Mental Health Establishment of 24hr Urgent NHS Mental Health (MH) Lines in all areas. We were asked to complete a template of services available to service users and patients across Warrington and Halton; this included the numbers of the new urgent Mental Health lines available via North West Boroughs. I updated our Trust web page (with Pat) to include all services and help groups available to MH patients during COVID-19 and submitted the template to the regional Mental Health lead. Information was shared across the Trust so that patients and service users were aware of the service. This was discussed at SGC and Mental Health subgroup

2.1.32 Mental Capacity Act

- The amendment to the act did not affect the principals of the Mental Capacity Act or DoLS, where necessary staff were to continue to apply the act, the amendments meant that extra restrictions attributable to Covid-19 care could, where appropriate, be considered as lifesaving treatment and may not require DoLS. The safeguarding adult team have been supporting all DoLS applications at this time and maintaining welfare checks with ward teams to monitor any DoLS more closely, at times completing the applications on behalf of the wards. Applications have needed extra support as the responsible body (local authority) are not attending the Trust to assess for standard DoLS, none were authorised during this period.

- Covid-19 Hospital Discharge Service Requirements guidance contained information that supported the discharge of patients without capacity. Ward nursing and medical teams need to assure themselves of the recommendations of covid-19 hospital discharge service requirements where patients lack capacity and are being discharged to a place they are unable to consent to and do not want to go to. We should ensure that this guidance is considered where patients without capacity are being discharged to place they don't want to go to. Trust solicitors will assist its use where required.

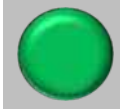
CONTROLS TO ADDRESS RISK

- WHH took the decision at the start of the COVID-19 pandemic to maintain a fully functioning Safeguarding and Adult, Children. The team continues to ensure that systems and processes are in place and that existing and new staff are able to access specialist support and advice wherever necessary.

- To disseminate learning and shared practice, the safeguarding team have continued to share resources including 7 minute briefings.

- The WHH has not relaxed the MCA/DoLS processes (not in an acute or community setting). Of note in regards to DNR/CPR any divergence from the proper processes would place the WHH at risk if families were to challenge the decisions made, specifically in respect to learning disability and dementia patients.

RISK RATING



Recommendation: Create a COVID-19 flyer/circular for staff to be aware of key safeguarding issues.

Hold a meeting/forum with key multi agency partners (Housing Association, local authorities/CCG's, police and GP's for example) to address action plan for mitigating safeguarding risks.

Carry out risk assessments for staff carrying out community functions.

Consider if any Public Health Officer Powers are required to safeguard the patient or their family if not following COVID-19 guidance, there will need to be consideration of patients without capacity in this situation as this will further complicate the management of such incidents.

3. RECOMMENDATIONS

The Committee is asked to approve and note the report and agree the recommendations.

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**