WHH Board of Directors Meeting Part 1

Wednesday 28 JULY 2021
10.00am-12.30pm
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 28 July 2021 time 10.00am -12.30pm - **via MS Teams**

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

REF BM/21/07	ITEM	PRESENTER	PURPOSE	TIME	
BM/21/07/85	Overview of Staff Networks Q&A 15 minutes	Adam Harrison, Chair of LGBTQ Staff Network, Suresh Krisshna Chair BAME Staff Network	Presentation	10.00	
BM/21/07/86	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	10.15	Verb
BM/21/07/87 PAGE 8	Minutes of the previous meeting held on 26 May 2021	Steve McGuirk, Chairman	Decision	10:17	Encl
BM/21/07/88 PAGE 18	Actions & Matters Arising	Steve McGuirk, Chairman	Assurance	10:20	Encl
BM/21/07/89 PAGE 19	Chief Executive's Report	Simon Constable, Chief Executive	Assurance	10:25	Encl
BM/21/07/90	Chairman's Report	Steve McGuirk, Chairman	Information	10:30	Verb

Quality People Sustainability

BM/21/07/91 PAGE 27	Integrated Performance Dashboard and Committee Assurance Reports	All Executive Directors	To note for assurance	10:35	Enc
(a i)	- Quality & Performance Dashboard including o Monthly Nurse Staffing Report	Daniel Moore Chief Operating Officer Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO			Enc
(b)	- Quality Assurance Committee – Committee Assurance Report (01.06.2021, 06.07.2021)	Margaret Bamforth, Committee Chair			Enc
	People Dashboard	Michelle Cloney, Chief People Officer			Enc
(c)	- Strategic People Committee (21.07.2021) - Committee Assurance Report	Anita Wainwright, Committee Chair			
	- Sustainability Dashboard	Andrea McGee Chief Finance Officer & Deputy CEO			
(d)	- Finance and Sustainability Committee (23.06.2021, 21.07.2021) – Committee Assurance Reports	Terry Atherton Committee Chair			Enc
(e)	- Key Issues Clinical Recovery Oversight Committee (25.05.2021, 08.06.2021, 22.06.2021) – Committee Assurance Reports	Terry Atherton Committee Chair			Enc
(f)	- Audit Committee – Committee Assurance Report (24.06.2021)	Ian Jones Committee Chair			Enc

Quality

BM/21/07/ 92 PAGE 149	Moving to Outstanding (M2O) Update Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	To note for assurance	11.05	Enc
BM/21/07/ 94 PAGE 154	National COVID-19 Inquiry and Trust Look Back	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	To note for assurance	11.20	Enc

Sustainability

BM/21/07/ 95 PAGE 180	NHS System Oversight Framework (SOF) 2021/22 and metrics	Andrea McGee Chief Finance Officer & Deputy CEO	To note for assurance	11.30	Enc
BM/21/07/ 96 PAGE 217	Use of Resources (UoRA) Q1 Report	Andrea McGee Chief Finance Officer & Deputy CEO	To note for assurance	11.40	Enc

People

BM/21/07/ 97PAGE 240	Health and Wellbeing Stocktake and Wellbeing Guardian Update	Michelle Cloney Chief People Officer	To note for assurance	11.50	Enc & PPT
BM/21/07/ 98 PAGE 253	Engagement Dashboard (January - June 2021	Pat McLaren Director of Communications & Engagement	To note for assurance	12.05	Enc

GOVERNANCE

BM/21/07/ 99 PAGE 261	Strategic Risk Register & BAF	John Culshaw Trust Secretary	To note for assurance	12.10	Enc
BM/21/07/ 100PAGE310	Annual Senior Information Responsible Officer (SIRO) Report	Alex Crowe Executive Medical Director	To note for assurance		Enc

MATTERS FOR APPROVAL *(see supplementary pack)*

	ITEM	Lead (s)				
BM/21/07/ 101	Quality Assurance Committee – Committee Chair's Annual Report Approved via Quality Assurance Committee Chairs Action 06.07.2021	John Culshaw Trust Secretary	Committee	Quality Assurance Committee	12.15	Enc
			Agenda Ref.	QAC/21/07/178		
			Date of meeting			
			Summary of Outcome	Approved via Chairs Action		
BM/21/07/ 102	Nursing & Midwifery Strategy 2021-2024 Approved via Quality Assurance Committee Chairs Action 06.07.2021 Reviewed SPC 21.07.2021 SPC/21/07/61	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/21/07/180		
			Date of meeting			
			Summary of Outcome	Approved via Chairs Action		
BM/21/07/ 103	Safeguarding Annual Report Approved via Quality Assurance Committee Chairs Action 06.07.2021	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/21/07/196		
			Date of meeting			
			Summary of Outcome	Approved via Chairs Action		
BM/21/07/ 104	Terms of Reference: - Strategic People Committee (SPC) 21.07.2021, Agenda SPC/21/07/40 - Clinical Recovery Oversight	John Culshaw Trust Secretary	Committee			Enc
			Agenda Ref.			
			Date of meeting			
			Summary of Outcome	Approved		

	Committee (CROC) 25.05.2021, Agenda CROC/21/05/40					
BM/21/07/105	Finance and Sustainability Committee – Committee Chair's Annual Report	John Culshaw Trust Secretary	Committee	Finance + Sustainability Committee		Enc
			Agenda Ref.	FSC/21/06/100		
			Date of meeting	23.06.2021		
			Summary of Outcome	Supported		
BM/21/07/106	CNST Maternity Incentive Scheme evidence of compliance. Virtual approval on 19.05.2021	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee			Enc
			Agenda Ref.			
			Date of meeting			
			Summary of Outcome			

MATTERS FOR NOTING FOR ASSURANCE

	ITEM	Lead (s)				
BM/21/07/107	DIPC Annual Report Noted via Quality Assurance Committee Chairs Action 06.07.2021	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/21/07/195		
			Date of meeting			
			Summary of Outcome	Noted		
BM/21/07/108	Infection Prevention and Control Board Assurance Framework Compliance Bi-monthly Report Noted via Quality Assurance Committee Chairs Action 06.07.2021	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/21/07/184		
			Date of meeting			
			Summary of Outcome	Noted		
BM/21/07/109	Medicines Management & Controlled Drugs Annual Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/21/06/168		
			Date of meeting	01.06.2021		
			Summary of Outcome	Noted		
BM/21/07/110	Risk Management Strategy Annual Update Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/21/05/144		
			Date of meeting	04.05.2021		
			Summary of Outcome	Noted		
BM/21/07/111	Emergency Preparedness Annual Report **Approved:** Event Planning Group 28/06/21, Reference EPG/280621/03 WPRR Annual Report Brexit Subgroup 28/06/21 agenda reference BSG/280621/08	Daniel Moore Chief Operating Officer	Committee			Enc
			Agenda Ref.			
			Date of meeting			
			Summary of Outcome			
BM/21/07/112	Guardian of SafeWorking Q4 Report (def from May)	Alex Crowe Executive Medical Director	Committee	Strategic People Committee		Enc
			Agenda Ref.	SPC/21/07/57		
			Date of meeting	21.07.2021		
			Summary of Outcome	Noted		
BM/21/07/113	Digital Board Report	Alex Crowe Executive Medical Director	Committee	N/A		Enc
			Agenda Ref.			
			Date of meeting			
			Summary of Outcome			

BM/21/07/ 114	**Charities Commission Checklist (annual update)**	**Pat McLaren Director of Communications & Engagement**	**Committee**	Charitable Funds Committee		**Enc**
			Agenda Ref.	**CFC/21/06/65**		
			Date of meeting	**10 June 2021**		
			Summary of Outcome	**Noted**		
BM/21/07/ 115	**Confirmation of breast unit development decision, following consultation**	**Lucy Gardner Director of Strategy & Partnerships**	**Committee**	N/A		**Enc**
			Agenda Ref.			
			Date of meeting			
			Summary of Outcome			
BM/21/07/ 116	**Confirmation of Shopping City development decision, following consultation**	**Lucy Gardner Director of Strategy & Partnerships**	**Committee**	N/A		**Enc**
			Agenda Ref.			
			Date of meeting			
			Summary of Outcome			
BM/21/07/ 117	**Quality Strategy 2021-2024**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	QAC/21/06/156		
			Date of meeting	01.06.2021		
			Summary of Outcome	Supported		
BM/21/07/ 118	**Annual Health & Safety Annual Report Approved via Quality Assurance Committee Chairs Action 06.07.2021**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	**QAC/21/07/193**		
			Date of meeting			
			Summary of Outcome	**Supported**		

	Any Other Business	**Steve McGuirk, Chairman**	**N/A**	**16:55**	**Ver**
	Date of next meeting: Wednesday 29 September 2021				

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 26 May 2021 via MS Teams	
Present	
Steve McGuirk (SMcG)	Chairman
Simon Constable (SC)	Chief Executive
Terry Atherton (TA)	Deputy Chair, Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
Alex Crowe (AC)	Executive Medical Director & Chief Clinical Information Officer
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Andrea McGee (AMcG)	Chief Finance Officer & Deputy Chief Executive
Daniel Moore (DM)	Chief Operating Officer
Cliff Richards (CR)	Non-Executive Director
Anita Wainwright (AW)	Non-Executive Director
In Attendance	
Michelle Cloney (MC)	Chief People Officer
Lucy Gardner (LG)	Director of Strategy & Partnerships
John Goodenough (JG)	Deputy Chief Nurse
John Culshaw (JC)	Trust Secretary
Julie Burke	Secretary to The Trust Board
Debby Gould	Xxx *Patient story item only*
Deborah Carter	Xxx *Patient story item only*
Apologies	Pat McLaren, Director of Communications & Engagement
	K Salmon-Jamieson, Chief Nurse & Deputy CEO and Director of Infection Prevention & Control (DIPC)
Observing N Holding, Lead Governor Members of the public (21)	P Bradshaw, K Keith, S Fitzpatrick, S Hoolachan, Linda Mills C McKenzie, A Robinson Public Governors, D Birtwistle Staff Governor

Patient Story	The Chairman welcomed D Gould and D Carter to the meeting. JG introduced the story of a patient with complex care and mental health needs receiving 1:1 care from 6 healthcare professionals, who became under the care of WHH after no resolution following escalation to Specialist Commissioners, NHSE/I to find a place of care, including Specialist Peri-Natal MH Service due to risks involved. Through multi-disciplinary and collaborate working in extremely challenges circumstances, the Maternity Team shared the excellent patient care provided to support mum. The case was very rare and unique and no similar cases to share best practice/guidance. All safeguarding protocols enacted following transfer of care to WHH. Risk Assessments and clinical plan had been produced collaboratively with place of care before transfer including Pharmacy, Midwifery, Obstetrics and Estates to ensure safe environment. Two WHH Midwives offered to care for and support mum. They produced a diary, memory box and other gifts to give to mum post-natal. On discharge back to original secure placement, the Trust had received feedback the patient had been de-escalated, 10 days after discharge for the first time, did not require segregation and was receiving 1:1 care from only one healthcare professional. The Midwifery team had subsequently received thank you message from the patient for the outstanding care and support provided. CR commended the team on the outstanding care and expertise provided in a challenging environment.

	SMcG concurred observing the range of services within the system that were not able to offer a place of treatment, commending the way the WHH team had modified the care package to meet the patient's specific needs. DG and DC thanked the Board for their observations, assuring the Board that learning is being shared through various regional and national Maternity Networks. SC concurred with comments, reassuring the Board that he had been fully briefed throughout the process due to risks involved. He also thanked DG and DC for their ongoing effective leadership support in Maternity Services. • **The Board thanked DG and DC for sharing this patient story, commending themselves and Maternity staff involved in the patients care in challenging circumstances.** • **The Board proposed the story is written up as a Case Study to share learning with partner organisations and CQC as evidence of outstanding care.**
BM/21/05/62	**Welcome, Apologies & Declarations of Interest** The Chairman welcomed all to the meeting. No declarations made in relation to the agenda.
BM/21/05/63	**Minutes of the meeting held 31 March 2021** Pg 2, 3rd paragraph to read role of Deputy Chair on the NWCRN Board., minor typographical amendment paragraph 6. With these amendments the minutes of 31 March 2021 were agreed as an accurate record. **CROC????**
BM/21/05/64	**Actions and Matters Arising. Action log and updates noted and recorded.** BM/18/05/57 Junior Doctor /Trainee engagement. Agreed to close this action at Board meeting 31 March 2021. Action closed. BM/20/1/117c C&M People Summit in June 2021 to include focus on Attendance Management. WHH to present findings of recent Attendance Management deep dive. Action closed. BM/21/11/118 M2O Report (Hospital Food National Review. Deputy CN producing a new Governor schedule of visits alongside a new walkaround schedule for Board members, linked into the quality priorities. Board sample of patient menu to be arranged for future Board meeting. Action closed.
BM/21/05/65	**Chief Executive's report** The report was taken as read. The CEO referred to the progress and significant impact made during the first week of the Operation Reset Programme to support patient flow and continued improvements in the second week. A future report will include conclusions of the second week and how to sustain improvements going forward. Unprecedented levels of attendance in Urgent and Emergency Care with some resilience to support demand. Questions were invited. CR referred to refreshed Trust Vision, Values and Behaviours, demonstrated during the pandemic, Health & Wellbeing, how Trusts will deal with health inequalities, how this will become a workstream or is the need to look more formally into health inequalities as an organisation. SC explained these had been refreshed following staff feedback following Wave 1 of the Pandemic, captured in 'People' 'Quality' and 'Sustainability' and social and economic wellbeing within the community, demonstrated with the Trust's strategic priorities.

	LG further explained she had been nominated as Executive Lead for Health Inequalities following request from CQC. A paper to be shared with Executives on what this means for the Trust, role and future focus. SMcG proposed a facilitated Board session to discuss Health & Wellbeing wider to have clear practical steps on what WHH could take and outcome measures in relation to Health Inequalities. CR congratulated the Trust winners and nominees in the recent Warrington Guardian Lockdown Heroes, particularly the CEO on his Special Recognition Award. SMcG concurred, congratulating the Sikh Community for their award and their support to the Trust particularly during the Pandemic. **The Board noted the report.**
BM/21/05/66	**Chairman's Report** The Chair reported meetings continue with internal and external meetings including with CEO/NED briefings, Board, Council of Governors, Governor Briefing meetings and 1:1 meetings with the Lead Governor. External meetings continue with Local Authority CEOs, NW Chairs, local partners and stakeholders. SMcG explained the COVNED Assurance meetings had been stood down, replaced informal CEO/NED briefings. SMcG was pleased to open the Stroke Garden. He had also observed an Operation Reset meeting to understand the process, observing positive energy and efforts of staff involved. Following recent local elections, the Chair advised that Cllr R Knowles had not been re-elected and recorded thanks for her contribution as Warrington Council Partner Governor. Her successor to be confirmed. P Lloyd-Jones, Halton Council Partner Governor had been re-elected but due to a change in role at the Council had stood down as Governor due to potential conflict of interest. His successor to be confirmed. NED and Associate NED recruitment process had commenced **The Board noted the update**
BM/21/05/67	**COVID-19 Performance Summary and Situation Report** The CEO referred to the situation report which is part of the continuing development and understanding of demand, capacity and outcomes that will determine future strategic planning. The report demonstrates the robust operational and reporting procedures in place to respond to the COVID-19 pandemic with the Executive Summary outlining key information pertinent to the command and control of the situation, providing an overview and trends and benchmarking data where possible. The current position in WHH, 1 COVID-19 patient. Due to low levels of COVID-19 patients, SC proposed pausing the report and to reinstate if required due to further wave. SC explained some changes to internal governance processes, providing assurance that all elements of restoration and recovery are being monitored and scrutinised through the Governance Framework. SEOG had been stood down and pre-COVID-19 Executive Team meetings had been reinstated but the same level of oversight remained and would be reinstituted as necessary. As referred to earlier, the COVNED Committee had been stood

	down and replaced with informal CEO/NED briefings; however, this could also be reinstated if required. Newly established Clinical Recovery and Oversight Committee had assumed responsibility for oversight and scrutiny of quality and performance aspects of restoration and recovery. No change reported to external command and control reporting. • **The Board noted the report.** • **Reflective report of COVID and summary of summer activity to future meeting at an appropriate timepoint.**
BM/21/05/68	**IPR Dashboard and IPR Key Issues** The CEO introduced the report, asking Executive leads to provide an update on pertinent matters for each of their portfolios. **Quality & Performance -** DM provided an overview of 4 hours constitutional standards and Ambulance Handover Times, Restoration and Recovery. - A&E 4-hour standard – 78.33%, deterioration of less than 2% from March. - Significant increase in attendances (additional 1544 in March), demand is nationally and regionally not just WHH, primarily due to increase in primary care attendances. To support improvement, weekly Urgent Care Restart Working Group established with Primary Care/GPs to influence system working. - Paediatric ED Department opened 18 May 2021 helping with Paediatric demand in ED. - Cancer – March 2021 2-week standard achieved 97.3% against 93%; Breast 2-week wait achieved 96.55% against 93%, 31-day standard achieved 98% against 96%; 62-day standard not achieved, achieved 66.67%, still in line with C&M position. - Elective trajectories for over 62 day and 104 days will impact on standard as breaches are still reported up to when treatment commenced. - AW enquired of ED national issues, where WHH is in overall picture of numbers and if some areas are more affected than others. - DM explained attendances have continued to increase in NW and C&M since March for Type 1 and Type 1, national messaging and work continues to support reduction. As patients begin to seek primary care appointments, decrease in attendances anticipated supported by system infrastructure. - TA observed ED data to end of April, C&M overall performance WHH in middle of Trusts, slight better than middle for Type 1. SC added NW is not an outlier for regional performance. Recovery and Restoration – DM shared data packs providing an overview of performance and trajectories to measure electives against day and in-patient performance, trajectories achieved, 70% April and 75% May, tracking 80% for May, plans for May-July to achieve 85%. - Elective - 52 weeks restoration on admitted and non-admitted waiting lists, May 1622 patients, tracking 1195 admitted patients, below forecast, trajectory on track to achieve by March 2022. - Patients overdue P2, waiting in excess of 4 weeks, 215 patients, 243 reported to CROC 25.05.2021, outside achieving trajectory by end May, expect to meet forecast of 197 patients by end of June 2021. - Recovery target 70% achieved 75% May, internal trajectory 100%, May tracking 88%,

	confident of meeting national trajectory. Working with services to understand actions not switched on to rectify by end of June. Some restrictions in some clinics due to IPC restrictions. - Cancer – over 62-days and 104 days April and May trajectories achieved, tracked by C&M Cancer Alliance. - DM reassured the Board the Trust is on track to meet required trajectories, which will support the ICS to be able to reclaim support from Recovery funds if all ICS achieves their own individual plans. Sepsis Indicator – JG reported indicator had been escalated back to the IPR through the Quality Assurance Committee. Assurance provided that patients are receiving correct antibiotics. Deep dive to be undertaken to look at how data is represented, including time of delays to receiving antibiotics. A robust action plan is in place in ED, 2 lead Consultants had been identified to drive from a medical perspective. AC added other areas of focus including, reinforcement of Sepsis screening in addition to COVID-19 screening, clear documentation, reinforced at Medical Cabinet and during medical handover. MB further added she had been briefed by the Chief Nurse and agreed for a Sepsis Deep Dive to be undertaken, outcomes reported to July QAC, to provide assurance to QAC on actions in place, recognising and understanding 'unknowns'. Future update to be provided in future QAC Chairs Assurance Report No other questions/comments were raised in relation to the IPR.
BM/21/05/68 (a)	**Monthly Safe Staffing Reports, February 2021 and March 2021** The reports were taken as read providing detail of ward staffing data which 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. CHPPD in February was 7.9 and 8.1 in March, with a year to date rate 7.8. No issues were highlighted for escalation to the Board.
BM/21/05/68 (b)	<u>Quality Assurance Committee (QAC) Assurance Report 06.04.2021 & 04.05.2021</u> MB - no matters of escalation from the Quality Assurance Committee (QAC). Good assurance continues to be provided with continued deep dives and hot topics into specific areas. Comprehensive DNACPR report and assurance received. Report and excellent assurance provided relating to Nosocomial Mortality through scrutiny of deep dives through a number of governance routes, including MRG, IPC and Medical Examiner.
BM/21/05/68	**<u>People</u>** MC reported, following sharing of deep dive into Sickness Absence with NHSE/I CPO, the Trust has been invited to participate in a pilot to look at further analysis of NW Trusts who current perform well and those who are more challenged to learn lessons and consider different approaches. One comparison with other Trusts highlighted Trust's with better attendance rates have more enhanced Physical H&WB offers for staff. - Non-COVID related absence mainly due to Stress/Depression/Respiratory. - MSK – high reporting for some staff groups, particularly Estates and Facilities, triangulation of data underway of age/profile/gender/workload. - Deep dive into how often staff have accessed medical suspension to ensure correct support in place for managers and individuals, proposal and ToR to be agreed with

	Executives. - Turnover rate 50%, increase in activity to enable flexible workforce. - Time to recruit - some improvement, ensuring interview date set before going to advert. More focussed work required. - Turnover of temporary workforce now included in reporting. AW enquired relating to temporary staffing adding to turnover, why this figure is included as expectation this cohort of staff would move on. MC explained it is due to external reporting, these staff are included in ESR reporting. AW enquired of decrease in number of completed Return To Work interviews and for this to be an area of focus. MC explained a targeted approach is to be adopted in specific areas with senior HR Manager support. SMcG concurred with AW and that cultural shift required to ensure that RTWs are competed on time to ensure appropriate support to all staff. SMcG referred to Time to Recruit and for focus on this area, if Managers do not provide an interview date prior to advert, the post should not be posted No report from Strategic People Committee, May meeting had been stood down due to Operation Reset. **Sustainability** – AMcG highlighted year to date position deficit of £1.5m against a deficit plan of £1.4m, primarily due to COVID costs not being fully switched off, particularly relating to cover for staff still shielding and ITU staff pressures. Capital Programme – AMcG had approved emergency funding for Clinical Doors and Screens of £10k in April. Schemes over £500k will be presented to Trust Board for approval to support delivery of the Capital Programme. **The Board:** • **Noted, reviewed and discussed the IPR.** • **Noted and supported approved emergency capital by the Chief Finance Officer & Deputy Chief Executive as above**
BM/21/05/68 (c)	Finance & Sustainability Committee (FSC) 21.04.2021) and Committee Chairs Q&A's (19.05.2021). TA reported FSC had not met in May due to Operation Reset, 4 items requiring NED scrutiny were considered by himself and AW, particularly Capital expenditure. Recovery data now monitored at the CROC.
BM/21/05/68 (d)	Audit Committee (29.04.2021). IJ reported delays to implement recommendations following MIAA reviews had disappointingly impacted on the lower than last year's Head of Internal Audit Opinion from Significant to Moderate. However, the Audit Committee had commissioned specific reviews into areas of concern which could have had a counter-intuitive effect. SMcG observed the increase in the number of retrospective waivers. IJ assured the Board these are scrutinised in detail at FSC and AC. AMcG added that reports are provided to Finance Resources Group for scrutiny. In addition a new training package is to be rolled out reinforcing the process, for additional oversight, a monthly report to be

	presented and discussed at Executives of any delays to deliver review recommendations and impact of delays.
BM/21/05/68 (e)	Clinical Recovery Oversight Committee (CROC) 14.04.2021, 27.04.2021 & 13.05.2021. TA reported CROC had assumed responsibility for oversight of Recovery Programme, Chaired by himself, with QAC Chair and CR in attendance. Four meetings had taken place, External Auditors had observed a meeting and positive feedback provided of assurance being provided. No further matters escalated or questions raised.
BM/21/05/69	**Moving to Outstanding Update Report** The report was taken as read, providing an update on CQC compliance and the new methods of assessment being undertaken. JG highlighted: - First Transitional Monitoring Assessment (TMA) had taken place 12 May 2021, CQC looking at all KLOE, positive feedback had been received. - TMA undertaken 24 May 2021 with focus on Maternity Services, positive verbal feedback given, awaiting formal feedback. - TMA's being used as a risk-based approach to determine if formal inspections of organisations required with national focus under Ockenden on Maternity and ED's. - Mock Maternity inspection had been undertaken and action plan in place. - ED Mock Inspection to be undertaken during June 2021. - SMcG queried Governor interaction with CQC and their involvement in TMAs and how they would receive feedback. SC explained there had been no change to involvement and engagement with stakeholders as part of CQC assessment processes. • **The Board reviewed, noted and discussed the report.**
BM/21/05/70	**Maternity Serious Incident Report** The report was taken as read which provided detail on the number of Maternity incidents report at WHH during March 2021 and any closed investigations with learning identified under the umbrella of Ockenden. - 59 no harm incidents; 4 low harm incidents; and top 10 themes highlighted. SMcG referred to one particular incident, Delayed Scan, and for consideration to be given to narrative/language in future reports to be more empathetic/personal, to add some context for a sense of perspective, whilst acknowledging the balance between clinical reporting, clinical terminology and patient confidentiality. JG explained the incident referred to is very rare, reassuring the Board that monthly audits are undertaken with Sonographers of second opinion and changes had been made to the SOP. All incidents within the report have a full detailed RCA report. MB provided reassurance that an independent Family Liaison support is in place in Maternity to support families through any investigation. • **The Board noted the report and assurance of oversight and monitoring of Maternity SIs.**
BM/21/05/71	**Use of Resources Assessment (UoRA) Q4 Report** The report was taken and provided a current status of the UoRA Dashboard, noting that many of the indicators had not been updated on the Model Hospital. AMcG reported the

	Trust's UoRA Group recommenced April 2021 following its pause during COVID-19 highlighting: - Movements since the last report, Nursing Costs Per WAU Green to Red, could be viewed as a positive movement as indicator does not include agency staff therefore as vacancies are filled the cost per WAU increases. Due to COVID-19 and increase in staffing, tracking of reduction in agency costs continues to ensure the benefit is realised. - AMcG referred to positive engagement from staff in UoRA processes to identify where benefits can be realised. - AC referred to medical establishment costs and how job planning is supporting benefits realisation. • **The Board noted the report and assurance provided relating to progress in relation to Use of Resources Dashboard.**
BM/21/05/72	**H1 Operational Plan 2021/22 Final Submission** AMcG provided an overview and background in methodology to develop the plan for submission 26 May 2021. Key matters/ changes highlighted, particularly: - Allocations from CMHCP advised 20 May 2021; Trusts asked to achieve break-even position. Further analysis undertaken 21 – 25 May 2021 - Workforce – no changes; Activity – small changes <u>Proposed Income & Expenditure Budgets 2021/22 highlighted</u> - Submission 26 May 2021 Deficit Plan agreed £7.5m, including £0.9m CIP delivery, improvement to position of £3.8m, revised deficit/gap to close to breakeven (£4.6m) Revisions to plan highlighted to achieve breakeven position of £4.6m including ERF (not in the Plan) £2.5m; £0.3m CNST budget realignment; £.04m annual leave accrual reduction; H1 CIP in plan £0.9m; reduction to accruals/delays to start dates £0.5m. ERF dependent on system-wide achievement of national trajectories which could impact WHH. <u>Activity</u> - minor changes in elective and out-patient first and follow-up appointments trajectories revised from 72% to 75%. Risks and Next steps summarised: - Month 1 over-spend; Switch off COVID costs in line with budget - Delivery of CIP, weekly Executive oversight; Ability to deliver activity - System performance delivery and access to ERF income - Monitor activity and productivity. TA reported, he had discussed plan with AMcG, concerns relating to ERF and request from C&MHCP to achieve breakeven position. Potential to achieve plan with mitigations outlined, however ability to achieve EFR reliant on system-wide achievement. - TA supported the Plan with these caveats. Providing further reassurance of mechanisms in place for oversight and monitoring through CROC and FSC. - SC supported the Plan, concurring with TA comments. - SC recorded thanks to AMcG and Finance Team for their efforts to produce revised break-even plan in restricted timeframe.

	- SMcG concurred with comments above, recognising the Trust can only do what is within their control, whilst being assured of internal mechanisms in place to monitor delivery of the plan. • **The Board supported the submission of the Operational Plan 2021/ 22 for the period April 2021 to September 2021**
BM/21/05/73	**Strategic Risk Register and Board Assurance Framework (BAF)** The report was taken as read. JC highlighted the following for the Board to review and consider proposals for the BAF since the last meeting and the rationale. The proposals had been approved at Quality Assurance Committee in April and May 2021: Since the last meeting: - No new risks had been added to the BAF; there had been amendments to the descriptions of any risks on the BAF. - The ratings of six risks had been reduced; Risk #1126 from 15 to 10, expected reduction in use of 02, as COVID-19 demand had significantly reduced, continues to do so and as the number of COVID-19 patients reduce. - Risks #1272 and #1275 from 25 to 20, as the number of COVID-19 positive patients had reduced and the Nosocomial outbreaks had also reduced. - Risk #1289 from 25 to 20 due to continued reduction COVID-19 positive patients, reduction in staff absences, installation of Bioquell Pods, B18 development and confirmed continued use of the private sector. - Risk #1131 and #1132 due to the falling numbers of COVID-19 positive patients and reduction in community prevalence. - Risk #1126 reduction in rating as above and had been de-escalated from the BAF. Also included in the report were notable updates to existing risks #1215; #1272 #1273; #1275; #1289; #115; #134; #1134; #1114; #1207; 125; #1108; #145; 1274; #1290. • **The Board reviewed and noted the BAF and Strategic Risk Register providing assurance of processes for oversight, scrutiny, management and escalation of strategic and corporate risks.** **The Board approved:** • **The amendment to ratings of six risks as above.** • **The de-escalation of one risk as above from the BAF to the Corporate Risk Register.**
	Any Other Business Discussion took place regarding the how the Trust can contribute to local borough's 'Green' agenda to recognise their responsibility as a major employer in the area. SMcG proposed a dedicated Board session to discuss further. CR referred to added Governance implemented during the Pandemic (COVNED) which had provided real-time data allowing focus on specific issues and how this can be continued, whilst ensuring sufficient discussions of matters as meeting is held in public. AW concurred in that all items are discussed in a variety of Committees prior to Trust Board and reports provided from these meetings. SMcG acknowledged comments, the meeting is not a public meeting, but held in public to ensure transparency of discussions whilst allowing the Board to still debate technical matters as required. In addition to internal governance meetings taking place, comprehensive Committee

	Assurance reports enabling triangulation of information, supported by comprehensive BAF, SMcG proposed quarterly meetings with the Chair of each Assurance Committee for further oversight to inform strategic discussions at Board.
MATTERS FOR APPROVAL/RATIFICATION	
BM/21/05/74	**Quality Priorities 2021-22** The Board **ratified** the 2021-22 Quality Priorities by the Quality Assurance Committee on 4 May 2021.
BM/21/05/75	**CNST Maternity Incentive Scheme evidence of compliance** The Board **ratified** the submission of evidence which had been approved virtually by Quality Assurance Committee on 19 May 2021.
BM/21/05/76	**Clinical Recovery Oversight Committee (CROC) Cycle of Business 2021-22** The Board **ratified** the Cycle of Business which had been approved at the CROC on 27 April 2021.
BM/21/05/77	**G6 & CoS7** The report was taken as read and provided the Trust's Self-Certification annual compliance declarations required by General Condition 6 (G6(3)) and Continuity of Service Condition 7 (CoS7) of the NHS Provider Licence. • **The Board approved the Self-Certification compliance declaration.**

MATTERS FOR NOTING FOR ASSURANCE	
BM/21/05/78	**Complaints Annual Report** This report had been reviewed and discussed at the Quality Assurance Committee on 4 May 2021. **The Board noted the report.**
BM/21/05/79	**Learning from Experience Q4 Report** This report had been reviewed and discussed at the Quality Assurance Committee on 4 May 2021. **The Board noted the report.**
BM/21/05/80	**Infection Prevention and Control Board Assurance Framework (BAF)** This report had been reviewed and discussed at the Quality Assurance Committee on 14 May 2021. **The Board noted the report**
BM/21/05/81	**Infection Prevention and Control (DIPC) Q4 Report** This report had been reviewed and discussed at the Quality Assurance Committee on 4 May 2021. **The Board noted the report**
BM/21/05/82	**Quality Strategy Annual Update Report** This report had been reviewed and discussed at the Quality Assurance Committee on 6 April 2021. **The Board noted the report**
BM/21/05/83	**Maternity Monthly SI Report** This report had been reviewed and discussed at the Quality Assurance Committee 4 May 2021. **The Board noted the report**
BM/21/05/84	**Mortality Review Q4 Report** This report had been reviewed and discussed at the Quality Assurance Committee on 4 May 2021. **The Board noted the report**
Any Other Business	TA proposed a dedicated Board session for discussion on how the Trust can contribute to local boroughs 'Green' agenda as one of the largest employers in both boroughs.
	The Chairman on behalf of the Board **Next meeting to be held: Wednesday 28 July 2021**

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.

BOARD OF DIRECTORS ACTION LOG

Warrington and Halton Teaching Hospitals NHS Foundation Trust

AGENDA REFERENCE	BM/21/07/88	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	28 July 2021

1. ACTIONS ON AGENDA

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

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
	26.05.2021	Any other business	Dedicated Board session to discuss how the Trust can contribute to local boroughs 'Green' agenda	**Chairman / Director of Strategy & Partnerships/ Chief Operating Officer**	**October Board session 27.10.2021**			
BM/21/05/67	26.05.2021	COVID Situation Report	Reflective report of COVID and summary of summer activity to future meeting at an appropriate time point.	**CEO**	**Date TBC**			
BM/21/05/	26.05.2021		Facilitated Board session to discuss wider health inequalities contribution from WHH.	**Chairman/ Director of Strategy & Partnerships**	**DATE TBC**			

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

RAG Key

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/89**			
SUBJECT:	**Chief Executive's Briefing**			
DATE OF MEETING:	28th July 2021			
AUTHOR(S):	Simon Constable, Chief Executive			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO BAF RISK:	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

SUBJECT	Chief Executive's Briefing	AGENDA REF:	BM/21/07/89

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 26th May 2021, some of which are not covered elsewhere on the agenda for this meeting.

2) KEY ISSUES

2.1 Current COVID-19 Situation Report

As of the time of writing (22nd July 2021) we have a total of 24 inpatients testing positive for COVID-19 at WHH; 8 of those patients are in critical care. We have discharged a total of 2086 patients with COVID-19 to continue their recovery at home. A total of 506 patients with COVID-19 have died in our care.

In terms of community numbers, the number of cases continues to rise. In the latest 7 days fully published (11th July – 17th July) in Warrington there were 680 cases per 100,000 people (the average area in England had 483); 1429 new cases were reported in that week, up 544 compared with the previous week. In Halton, there were 447 cases per 100,000 people; 578 new cases in that week, up 93 compared with the previous week.

For context, the last time I reported those kind of local population figures on the upward part of the curve in Wave 3 was in the first week of January. At that time we were already looking after over 130 inpatients with COVID-19.

2.2 WHH COVID-19 Vaccination Programme

As of 18th July WHH had administered 52,704 doses. We have vaccinated 92.90% of WHH staff and 88.95% of WHH staff have now had their second doses.

We are now engaged in forward planning; booster doses are being considered at a national and regional level. Hospital hubs are likely to be asked to 'stand-up' from September to December and we are likely to be asked to vaccinate our own staff as well as NHS, health and social care staff from other organisations. A discussion is also underway about co-administration with the 'Flu Jab, probably using a different COVID-19 vaccine than the original course. All of this, of course, is subject to ongoing consideration. Recommendations will be made on the basis of the scientific evidence by the Joint Committee on Vaccination and Immunisation (JCVI). We wil be ready to implement those recommendations.

2.3 Overview of Trust Performance

The last few weeks has continued to see urgent and emergency care under real pressure across Cheshire and Merseyside, and WHH has been no different. Emergency Department attendances at Warrington have reached record levels – 300 attendances appearing to be the new 'normal' and we have regularly been seeing approximately 100 attendances at our Halton Urgent Treatment Centre. Whilst attendances and admissions have been high, the legacy of the impact of May's Operation Reset has meant that discharges have been better at

keeping pace. As a result we are in a better position with regards to patient flow than my last Board report. Our super-stranded position of patients with a length of stay greater than 21 days was at 87 on Wednesday 21st July 2021. Although this is better than it has been, it is still not good enough and it remains a significant challenge for us to manage patient flow effectively.

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

WHH has achieved or exceeded the minimum threshold set by NHSEI for the restoration and recovery against a 2019/20 out-turn activity for elective and outpatient activity. In June 2021, the Trust delivered above plan for outpatient and elective activity, whilst also surpassing the national target for the month. We are working with all system partners, most notably the collaboration between all 12 acute and specialist trusts in Cheshire and Merseyside, in continuing to do so.

As a result of the COVID-19 pandemic, the Trust has not met the RTT 18 week, RTT 52 week, Diagnostics 6-week, Breast Symptomatic or Cancer 62-day urgent standards. The Trust has achieved all other cancer standards.

The Trust has been set a control total for the first half of the financial year 2021-2022 of breakeven and has submitted a plan to the Cheshire and Merseyside Health and Care Partnership (CMHCP) to deliver this. For the period ending 30th June 2021 performance is £0.6m deficit against a planned £0.4m deficit, a £0.2m adverse variance.

Total staff absence, including COVID-19 related-absence approximates at just over 8.6% and remains the most challenging 'People' metric at the current time. This is a higher figure than we have had for many months, reflecting the increase in community COVID-19 prevalence and its impact on staff self-isolation.

2.4 Senior Leadership Changes

Executive Medical Director, Dr Alex Crowe, is set to leave WHH later this year to take up a national role with NHS Resolution. His role will see him developing new incentive schemes for Trusts across England that support learning from incidents and sharing that learning across organisations to improve patient and staff safety. One of the important areas relates to the use of digital technology to support clinicians.

We will commence our recruitment and selection process for our new Executive Medical Director at the end of July 2021 to enable a seamless transition and handover during the autumn.

2.5 Ajitha Kaliyath Antony

It was with deep sadness that, in June, I shared the news of the death of Ajitha Kaliyath Antony, one of our international nurses.

Ajitha came to the UK from India to join our nursing workforce in January of this year; she tested positive for COVID-19 during her induction period whilst living at Crewe Campus. She was never able to join us and became seriously unwell very quickly, and was admitted to intensive care in Manchester.

Ajitha was 31 years old. She leaves behind a husband and young child in India, and a sister in the UK. As her employing trust we are supporting her family as much as we can, as well as supporting her fellow international nursing colleagues who are working across our hospitals.

Like all of our international colleagues, Ajitha was set to make a valuable contribution to WHH. She was one of 68 international nurses from around the world who have joined the Trust between December 2020 and May 2021. In total, nearly 10% of our workforce, 420 people, are from overseas.

2.6 NHS' 73rd Birthday

The month of July has seen the amazing NHS' 73rd year. The NHS was honoured to learn that Her Majesty The Queen has awarded The George Cross to NHS staff for serving "…with courage, compassion and dedication for more than 70 years."

The NHS' 73rd birthday offers us all a chance to pause and appreciate what it is to have a free-at-point-of-care health system that is the envy of the world.

2.7 'Big NHS Tea'

On 8th July 2021 we had the pleasure of seeing sense of purpose and social value in action as our local community came together to celebrate with a 'Big NHS Tea' in Thelwall village, Warrington. 75 people bought tickets for afternoon tea in a socially-distanced garden party atmosphere. Our community baked cakes and donated prizes for the tombolas and raffles and in just two hours we had raised £1,100 for our hospitals' charity general fund. By bringing everyone together like this, creating a safe space and an occasion to meet, the WHH Charity team had unwittingly given many a sense of purpose and created social value as well as raising funds to invest in our staff and patients.

Since the pandemic began WHH Charity has successfully bid for a share of the Captain Sir Tom monies which have been boosted to £150m so far. We still have another £390K to apply for, our £300k bid to support earlier, safer patient discharge by working in partnership with the third sector has reached the final stages and we wait to hear if we have been successful. The balance of £90k is to be invested in staff health and wellbeing.

2.8 Recognition through NHS Choices

The last few weeks has seen some lovely positive feedback through NHS Choices, a selection of which I shall share here verbatim:

- *Fabulous from start to finish ★★★★★ out of 5*

  I attended A&E due to a knee injury. I booked in a reception and spoke to a lovely young gentleman who directed me then to minor injuries. I attended there and was seen within 5 minutes,. I was assessed and sent for an x-ray. I had the x-ray and the whole

procedure was explained to me by a lovely radiographer - it was her manner which stood out to me. Exceptional. I arrived back in minor injuries and was seen again with my results. Thankfully there was nothing of major concern and my mind was put at rest. All I can say is this was an exceptional experience and the whole journey from arriving at A&E to leaving was a credit to Warrington. Carry on guys you're doing amazing.

Visited July 2021

- *So speedy, reassuring and caring ★★★★★ out of 5*

  We arrived in A and E with blood gushing from my son's leg. A really kind paramedic offered to park my car for me so I could stay with my son. We were seen immediately (my only slight issue was that in my panic I couldn't decipher which was the actual bell to ring amidst the technology on the door to the paediatrics' area so maybe a little sign could help) and were reassured all would be OK. All of the staff who looked after my son were so kind but also got the job done of stitching him up really efficiently. We were home in no time. This is the latest of many visits and each time we have been treated brilliantly. Thank you yet again, 'NHS staff' it is so reassuring to know that we can bring our children to you after their bumps and bangs and you will fix them up and do your upmost to make them good as new and no matter how stressed or tired you might be, you always greet us with a smile.

  Visited Paediatric Surgery on July 2021

- *FABULOUS ★★★★★ out of 5*

  I attended A&E just before 8am on a Monday morning. I was greeted by a very pleasant gentleman who took my details then directed me to minor injuries. On arrival I was greeted by another pleasant gentleman who took all my history and I explained the reason for my attendance there. I was examined and then sent for an x-ray. The radiologist was a young blonde lady who immediately put me at ease and explained the whole procedure. I returned to minor injuries and was called back in in less than ten minutes. I was reassured my injury was nothing major and my x-ray was clear. I was given the appropriate advice and then discharged. I was back at my desk within an hour of arriving at A&E. The whole experience, although not what I wanted to have, was pleasant and all staff are a credit to WHH. Thanks so much

  Visited Don't know on July 2021

- *A real change ★★★★★ out of 5*

  Visited the Ultrasound service on 9/7/21. Fantastic service, friendly Sonographer who was very knowledgeable. The main thing I noticed was the general transformation of the site. Main car park now dedicated to patients and visitors which is fantastic. Also the hospital is clean tidy calm atmosphere, which it hadn't always been . Really pleasant experience and I would highly recommend the hospital

Visited Don't know on July 2021

2.9 Special Days/Weeks for professional groups

Since our last Board meeting in May, 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.

There have been several over the last couple of months, reflecting the depth, breadth and diversity of WHH in terms of healthcare delivery in our communities. These include:

Pride month: June 2021
National Volunteers Week: 1st –7th June 2021
Carers Week: 7th – 13th June 2021
Armed Forces Week: 21st – 27th June 2021

2.10 Local political leadership communication

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

2.11 Employee Recognition

During the COVID-19 pandemic the WHH employee recognition scheme (*Employee of the Month and Team of the Month)* was suspended. A brand new scheme - *You Made a Difference* – has been launched this month. I will be sharing the stories of the winners here in this report. In the meantime I have my own award; the winners since my last Board report have been the following:

Chief Executive Award (June 2021): Ward B12

On 11th June 2021 I attended the Ward B12 (Forget Me Not Unit) Queen's Birthday Garden Party. Katie Nixon, Ward Manager, and the team had done a fantastic job putting on something really different and unusual for their patients, with drinks, cakes and canapes alongside an Elvis tribute act. For me, the huge additional effort, care and kindness was palpable. This was truly outstanding care and I have recognised this with a Chief Executive Award.

Chief Executive Award (June 2021): Acute Medical Unit (A1)

This award has recognised the teamwork on AMU/A1 following what can only be described as one of the nicest written pieces of feedback about patient care that I have ever read. It was from the family of an elderly man who sadly died from a stroke a few weeks ago.

"Bizarrely, despite the circumstances, the time we spent as visitors at Warrington Hospital will I think be remembered as a very positive and uplifting experience. Without exception, every single person we came into contact with over those six days – and there was many of them – was a credit to the hospital and the profession. From the person directing us in the car park - who had no idea why we were there – to the consultants. From the cleaners to the ward sisters. Everyone. Without exception."

"The consideration, sensitivity and compassion that everyone showed was exceptional."

"Everyone spoke so politely to each other. They really came across as a team, which must be a challenge given there's so many staff coming and going on a 24/7 basis."

"Please let them know that they are doing a great job. They're a credit to Warrington Hospital, their profession and themselves."

Chief Executive Award (July 2021): Finance Team

This award has recognised the herculean efforts of our Finance Team in securing our final accounts for the financial year ending March 31st 2021. Our Audit Committee signed off our Annual Report and Accounts on 24th June 2021.

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

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

- Sue Marsh, Health Care Assistant - Ward A2
- Mary Lynn Fallon, Catering Assistant - Estates and Facilities
- Christine Guy, Staff Nurse - Outpatients
- Gordon McNie, Security Officer - Estates and Facilities
- Anne Holmes, Ward Clerk - Ward A1
- Rachel Lamb & Team, Matron - Emergency Department
- Wendy Johnson, Nursing Recruitment Team - Corporate Nursing
- Denise Adams, Ward Manager - Captain Sir Tom Moore Building
- Interventional Radiology Team, Clinical Support Services
- Mr Sri Bathala, Consultant ENT Surgeon - Surgical Specialities
- Janet Oxley, Executive Assistant
- Lisa Taylor, Ward Sister - Ward A5
- James Holden, Head Gardener - Estates and Facilities
- Jonathan Jones, Gardener - Estates and Facilities
- Rebecca Broadbent, Clerical Officer - Recruitment Team
- Jo Ballard, Foundation Programme Administrator - Medical Education
- Kate Henry, Associate Director of Communications - Communications
- Dr Sarika Raghunath, Speciality Trainee - Medical Care
- Michelle Cloney, Chief People Officer
- Katie Armstrong, Financial Accountant - Finance & Procurement
- Diane Skidmore, Assistant Accountant - Finance & Procurement
- Bill McCarthy, Regional Director - NHSEI
- Gillian Seddon, Catering Support Assistant - Estates and Facilities

- Debbie Cahill, Housekeeping Supervisor - Urgent & Emergency Care
- Ms Virag Varga, Consultant Ophthalmologist - Surgical Specialities
- Linda McGowan, Catering Assistant - Estates and Facilities
- Rosemarie Brew, Catering Assistant - Estates and Facilities

2.12 Signed under Seal

Since the last Trust Board meeting, the following items have been signed under Seal by myself:

- Lease Renewal for Car Park at Wellfield Street, Warrington
- Endoscopy Unit Refurbishment – Halton Hospital

3 MEETINGS ATTENDED/ATTENDING

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

- North West Coast Vaccine Alliance Steering Group (Monthly)
- Clinical Reseach Network North West Coast Partnership Board (three times yearly)
- NHSE/I COVID-19 System Leadership (Biweekly)
- C&M CEO Provider Group Calls (Bi-weekly)
- C&M Medical Directors Clinical Prioritisation & Mutual Aid meeting (Weekly)
- C&M Critical Care Network Gold Command Calls (Twice Weekly)
- Update calls with our local MPs: Andy Carter MP and Derek Twigg MP
- Steve Broomhead, Chief Executive, Warrington Borough Council
- David Parr, Chief Executive, Halton Borough Council
- Dr Andy Davies, Clinical Chief Officer, NHS Warrington and Halton CCG
- Colin Scales, Chief Executive, Bridgewater Community Health NHSFT
- John Heritage, Director of Partnerships, Mersey Care NHS Foundation Trust
- C&M Hospital Cell (Weekly)
- C&M Gold Command (Twice weekly)
- Warrington Health & Wellbeing Baord Workshop
- Warrington Health Scrutiny Committee

4) RECOMMENDATIONS

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

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/21/07/91	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	28th July 2021	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Andrea McGee - Chief Finance Officer and Deputy Chief Executive Dan Moore - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1215 Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic. #1272 Failure to provide enough beds caused by the requirement to adhere to social distancing guidelines. #1273 Failure to provide timely patient discharge caused by system-wide COVID-19 pressures. #1275 Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission. #1289 Failure to deliver planned elective procedures caused by the Trust's decision to pause some elective procedures in order to ensure safe staffing and critical care capacity during the COVID-19 pandemic. #115 Failure to provide adequate staffing levels in some specialities and wards caused by the inability to fill vacancies and staff sickness. #134 Financial Sustainability a) Failure to sustain financial viability caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has 74 IPR indicators which have been RAG rated in June as follows: Red: 31 (from 33 in May) Amber: 6 (from 4 in May) Green: 34 (from 34 in May) Not RAG Rated: 3 (from 3 in May)	

	As a result of the COVID-19 pandemic, the Trust has not met the RTT 18 week, RTT 52 week, Diagnostics 6-week, Breast Symptomatic or Cancer 62-day urgent standards. The Trust has achieved all other cancer standards. A&E and Ambulance Handover performance remains challenging with increased attendances. During the COVID-19 pandemic measures of assurance for both quality and safety have remained in place. Sepsis screening and anti-biotics administration within the one hour timeframe is a key focus. A focussed improvement plan is in place with oversight from the Deputy Chief Nurse for Patient Safety and Clinical Education. The Trust has been set a control total for H1 of breakeven and has submitted a plan to the Cheshire and Merseyside Health and Care Partnership (CMHCP) to deliver this. For the period ending 30 June 2021 performance is £0.6m deficit against a planned £0.4m deficit, a £0.2m adverse variance. There are a number of risks that have emerged in Quarter 1 that have been offset by under spends. If these are not managed they pose a risk to the delivery of a break even position. A national Elective Recovery Fund (ERF) has been set up in 2021/22, with £1bn available for recovery. The Elective Recovery Fund (ERF) trajectories have been updated for July to September. The Trusts latest forecast position is £3.9m for H1. This is subject to the delivery of the revised performance trajectories and delivery of the gateway requirements across the Cheshire and Merseyside system. The position of breakeven for H1 is reliant on achievement of ERF of £3.9m. The cash position at the end of month 3 is £41.1m against a plan of £22.2m.

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

RECOMMENDATION:	The Trust Board is asked to: 1. Note the capital schemes approved as an emergency by the Chief Finance Officer & Deputy Chief Executive. 2. Approve the following capital requests: a. New Hospital Strategic Outline Case of £96k b. Clinical Skills Programme request of £30k c. Electric Charging Points – reallocation of £200k d. A Band 6 fixed term post for 12 months within the Capital Projects Team of £25k in 2021/22 (September – March) and £18k in 2022/23 (April to August). 3. Note that the NHSE/I Provider Finance Return for month 3 matches this report. 4. Approve the recommended amendments to the Quality section of the IPR. 5. Note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	QAC
	Agenda Ref.	QAC 21/07/179
	Date of meeting	6th July 2021
	Summary of Outcome	QAC meeting was cancelled – supported as a Chair's action.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/21/07/91

1. BACKGROUND/CONTEXT

The RAG ratings for all 74 IPR indicators from July 2020 to June 2021 are set out in **Appendix 1.** The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the Trust Board with assurance in relation to the delivery of all Key Performance Indicators (KPIs) across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

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

Table 1: RAG Rating Movement

	May	June
Red	33	31
Amber	4	6
Green	34	34
Not RAG Rated	3	3
Total:	74	74

Due to the validation and review timescales for Cancer, the RAG ratings on the dashboard for these indicators are based on May's validated position. Performance against VTE assessment compliance is reported as a quarterly position.

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

Quality

Quality KPIs

There are 5 Quality indicators rated Red in June, the same number as in May.

The 5 indicators rated Red in May, which have remained rated Red in June are as follows:

- Sepsis % Screening for Emergency Patients within 1 hour – the Trust achieved 41.00% in June, a deterioration from 60.00% in May, against a target of 90.00%.
- Sepsis % Screening for Inpatients within 1 hour – the Trust achieved 80.00% in June, a deterioration from 89.00% in May, against a target of 90.00%.

- Sepsis % Emergency Patients Administered Antibiotics Within 1 Hour – the Trust achieved 21.00% in June, a deterioration from 58.00% in May, against a target of 90.00%.
- Sepsis % Inpatients Administered Antibiotics Within 1 Hour – the Trust achieved 73.00% in June, a deterioration from 89.00% in May, against a target of 90.00%.
  A focussed improvement plan is in place with oversight from the Deputy Chief Nurse for Patient Safety and Clinical Education.
- Friends and Family Test (ED) – the Trust achieved 78.00% in June, the same position as in May, against a target of 87.00%.

Access and Performance

Access and Performance KPIs

There are 13 Access and Performance indicators rated Red in June, an improvement from 15 indicators rated Red in May. Performance against Access & Performance indicators has been significantly impacted by the COVID-19 pandemic and recovery plans are in place to address this performance.

The 13 indicators which were rated Red in May and remain rated Red in June are as follows:

- Diagnostic 6 Week Target – the Trust achieved 75.18% in June, an improvement from 73.06% in May, against a target of 99.00%.
- Referral to Treatment Open Pathways – the Trust achieved 77.15% in June, an improvement from 75.74% in May, against a target of 92.00%.
- Referral to Treatment 52+ Week Waiting – there were 1,016 patients waiting over 52 weeks in June, an improvement from 1,196 patients in May, against a target of 0. RTT and Diagnostic performance is as a result of the reduction in the elective programme, suspension of services and the associated backlog during the initial phases of the pandemic. The Trust has robust recovery plans in place with clinical prioritisation.
- A&E Waiting Times 4-hour National Target – the Trust achieved 79.50% (excluding Widnes Walk ins) in June, an improvement from May's position of 79.06%, against a target of 95.00%.
- A&E Waiting Trajectory – the Trust did not achieve the trajectory in month.
- Cancer 2 Week Beast Symptomatic - the Trust achieved 89.39% in May, a deterioration from 90.41% in April, against a target of 93.00%.
- Cancer 62 Days Urgent - the Trust achieved 65.00% in May, a deterioration from 76.47% in April, against a target of 85.00%.
- Ambulance Handovers 30 – 60 minutes – there were 42 patients who experienced a delayed handover in June, an improvement from 63 patients in May against a target of 0.
- Ambulance Handovers 60 minutes plus - there were 6 patients who experienced a delayed handover in June, an improvement from 32 patients in May against a target of 0.
- Discharge Summaries % sent within 24 hours – the Trust achieved 82.71% in June, an improvement from 82.16% in May, against a target of 95.00%.
- Discharge Summaries NOT sent within 7 days (to achieve the 95.00% standard) – there were 329 discharge summaries not sent within 7 days to achieve the 95.00% standard in June, a deterioration from 256 discharge summaries not sent in May.

- Cancelled Operations on the day for non-clinical reasons, not rebooked within 28 days – there was 1 patient in June, the same number as in May, against a target of 0.
- Super Stranded Patients – there were 100 super stranded patients at the end of June, a deterioration from 94 patients at the end of May, against a trajectory of 85 patients.

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

- Cancer 31 First Treatment - the Trust achieved 96.34% in May, an improvement from 95.00% in April, against a target of 96.00%.
- Cancer 62 Days Screening - the Trust achieved 100.00% in May, an improvement from 64.71% in April, against a target of 90.00%.

PEOPLE

Workforce KPIs

There are 8 Workforce indicators rated Red in June, the same number as in May.

The 7 indicators which were rated Red in May and remain rated Red June are as follows:

- Sickness Absence – The Trust's sickness absence was 5.83% in June, an improvement from 5.98% in May, against a target of less than 4.20%.
- Return to Work Compliance – interview compliance was 64.00% in June, a deterioration from 71.77% in May, against a target of 85.00%.
- Turnover – staff turnover was 17.09% in June, a deterioration from 16.47% in May, against a target of less than 13.00%. However, when excluding temporary staff, the position is 11.62% in June 2021.
- Bank/Agency Reliance – The Trust's reliance was 13.89% in June, an improvement from 15.34% in May, against a target of less than 9.00%.
- Agency Shifts Compliant with the Cap – 30.63% of agency shifts were compliant with the cap in June, an improvement from 22.96% in May, against a target of 49.00%.
- Agency Rate Card Compliance – 36.82% of agency shifts were compliant with the rate card in June, an improvement from 32.31% in May, against a target of 60.00%.
- Monthly Pay Spend – monthly Trust pay spend was £0.06m above budget in June, reduced from £0.27m above budget in May.

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

- Recruitment – the average time to recruit was 73 days over the last 12 months as of June, an improvement from 76 days in May, against a target of less than 65 days.

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

- % Use of the Apprenticeships Levy – the Trust achieved 44.00% in June, a deterioration from 77.00% in May, against a target of 85.00%.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 5 Finance & Sustainability indicators rated Red in June, the same number as May.

The 5 indicators which were rated Red in May and remain rated Red in June are as follows:

- Trust operating surplus / (deficit) – The year to date position is a deficit of £0.6m against a deficit plan of £0.4m.
- Capital Programme – The actual spend year to date is £2.4m which is £1.2m below the planned spend of £3.6m. However, the Trust has committed orders of £0.7m.
- Agency Spending – The year to date spend of £3.1m is £0.5m above the plan of £2.6m.
- Cost savings schemes in-year compared to plan. No target in Quarter 1
- Cost savings schemes recurrent compared to plan. No target in Quarter 1

The CIP target was increased from £2.6m to £4.8m to provide more time to plan for efficiencies that may be required in H2. At 30 June, £1.5m CIP was identified. Further work to increase identification of CIP schemes is underway across the Trust.

The Trust delivered a minimal CIP in Quarter 1, however no CIP is required as per planning guidance until Quarter 2.

The Income and Activity Statement for month 1 is attached in **Appendix 5**.

COVID-19 expenditure at Month 3 2021/22 is £2.45m, this is higher than the planned spend of £1.48m. M1 was £0.4m above plan, M2 was £0.3m above plan and M3 is £0.2m above plan. This is mainly due to £1.0m cost of COVID-19 sickness and isolation that has not been switched off at 31 March 2021 as anticipated.

In June 2021, the Trust delivered above plan for outpatient and elective activity, whilst also surpassing the national target for June 2021. The delivery against the national target and Trust plan is shown in **Table 2.**

Table 2: Activity targets by Point of Delivery

Point of Delivery	National Target	Plan June 2021	Actual June 2021
Elective	80%	90%	104%
Day Case	80%	86%	86%
Outpatients (SUS data)	80%	97%	100%

Based on this performance, the Trust remains on target to receive planned ERF for April to June 2021 totalling c£1.6m and the ERF forecast calculation at June for H1 is £3.9m (subject to the system position).

On 9th July NHSE/I notified providers of a change to thresholds for the period July to September.

Trajectories have been increased from 85.00% to 95.00% of 2019/20 activity, presenting a significant challenge for the Trust in the next 3 months.

In addition to this change, activity delivered above the 95.00% threshold will be paid at a lower rate (100% of tariff, previously 120% when surpassing monthly thresholds. For any activity over 100% of 2019/20 activity levels payment will be made at 120% of tariff).

In addition, Trusts are unable to access the ERF for any uncoded activity. The Clinical Coding Team is up to date in its coding of activity as at June and plans are in place to ensure this continues.

Cash

The cash position at the end of month 3 is £41.1m against a plan of £22.2m. This is due to several reasons:

- A delay in both creditor and capital creditor payments due to orders of goods and services being made later than originally anticipated.
- Cash has been received for the annual leave accrual which has not yet been incurred.
- An improvement in the year end deficit position due to central income and cash awards made in March 2021.

Cash balances are being reviewed by NHSE/I following the central cash award provided in March 2021. A new cash flow forecast has been developed and will be shared with NHSE/I in July. This is challenging to prepare with no funding agreement in place for H2.

Capital Programme

The Capital Programme for 2021/22 has been approved at £19.6m. **Table 3** provides a high-level summary.

Table 3: Capital Expenditure as at 30 June 2021

Capital	Annual Plan	Plan To Date	Expenditure to Date	Variance
	£000	£000	£000	£000
Trust Funded	12,870	3,634	2,395	1,239
PDC Funded:				
ED Plaza (emergency)**	5,000	0	0	0
Radiology (Diagnostic PDC)*	800	0	0	0
Urology (emergency)**	900	0	0	0
Total Approved Capital Programme	**19,570**	**3,634**	**2,395**	**1,239**
Total Planned Capital Investment	**19,570**	**3,634**	**2,395**	**1,239**

*A bid has been submitted for diagnostic PDC for the radiology scheme. It is anticipated the outcome will be known in September.
**Emergency requests for PDC have been submitted, queries have been responded to and the Trust awaits the outcome.

All capital cases over £0.5m have been approved by the Trust Board.

A number of emergency capital cases were approved by the Chief Finance Officer and Deputy CEO in June 2021:

- Laboratory Air Conditioning – Halton for £8k
- Nurse call system – Ante Natal Day Unit for £25k
- Emergency generator repair – Nightingale for £24k
- Damper power supply – Burtonwood for £9k
- Modular building road surfacing/street lighting - Halton for £30k

The following new capital schemes have been reviewed by the Executive Team and the Finance & Sustainability Committee (FSC):

1. A request for additional capital has been made to support the new hospital Strategic Outline Case for £96k. This is linked to the revised NHSE/I framework in which significant capital bids will be assessed. This new framework increases the requirements at SOC stage to include much more detailed financial modelling, which previously would not have been expected until Outline Business Case stage.
2. Additional work costing £30k for the clinical skills programme due to a requirement to create a corridor for the clinical coding team to access the Kendrick wing.
3. Electric car charging points to Warrington and Halton sites costing £0.2m which replaces an electrical estates scheme which is no longer required.
4. The Estates team has requested a full-time Band 6 post fixed term for 12 months to support the capital projects team at a cost of £25k in 2021/22 (September – March) and £18k in 2022/23 (April to August).

A number of schemes that began in 2020/21 remain underspent YTD in 2021/22:

- MRI - £408k underspent
- Modular building - £161k underspent
- Breast unit relocation - £52k underspent

The monthly profile of expenditure continues to be monitored at the monthly Capital Planning Group meetings.

The Trust Board is asked to:

1. Note the capital scheme approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.
2. Approve the following capital requests:
    a. New Hospital Strategic Outline Case of £96k

b. Clinical Skills Programme request of £30k
c. Electric Charging Points – reallocation of £200k
d. A Band 6 fixed term post for 12 months within the Capital Projects Team of £25k in 2021/22 (September – March) and £18k in 2022/23 (April to August).

3. Note that the NHSE/I Provider Finance Return for month 3 matches this report.

The Trust 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. RECCOMENDED UPDATES/AMENDMENTS TO THE IPR

Table 5 and Table 6 outline the recommended amendments to the IPR which were supported by the Quality Assurance Committee as a chair's action on 6th July 2021.

Table 5 – New Indicators

KPI	RAG Criteria	Rationale
Freedom of Information Act Requests - % responded to within 20 working days	**RAG Criteria:** Green: meeting or better than trajectory. Red: worse than trajectory. **Trajectory:** July: 75% August: 80% September: 85% October: 90% November onwards: 100%	To strengthen oversight of Freedom of Information Act Requests, improving response times to meet statutory requirements and reducing the backlog of overdue responses. There is a potential legal risk as well as a reputational risk if the Trust fails to respond to FOI requests and a potential financial risk if the Trust fails comply with a enforcement/information notices or alters, destroys, blocks or conceals information.
Freedom of Information Act Requests – number of overdue FOI requests	**RAG Criteria:** Green = meeting or better than trajectory. Red = worse than trajectory. **Trajectory:** July: Less than 40 August: Less than 30 September: Less than 20 October: Less than 10 November: 0	
Ward Moves between 10:00pm and 06:00am	It is proposed this indicator will not be RAG rated. There will always be a need to move patients during these times due to clinical need. The indicator will be shown on the IPR to provide assurance that ward moves between 10:00pm and 06:00am are minimised. The graph will show a daily comparison against the same month in the previous year. A number of appropriate exclusions including transfers from Assessment Units and the ITU will be excluded from this indicator.	Root Cause Analysis findings in relation to serious incidents has shown that patients who are transferred at night are more susceptible to a longer length of stay. It is also best practice not to move patients between 10:00pm and 06:00am unless there is a clear clinical need as research shows restful sleep aids recovery.

Table 6 – Presentational Amendments

KPI	Suggested Updates	Rationale
ED Sepsis Screening 1 hour Inpatient Sepsis Screening 1 hour ED Sepsis Antibiotics Administration 1 hour Inpatient Sepsis Antibiotics Administration 1 hour	It is proposed these graphs are split into 4 with one for each sepsis indicator. Each indicator will continue to show the % of patients screened for sepsis or administrated anti-biotics within 1 hour. The graphs will contain additional lines which will show: • Percentage of patients screened/administered anti-biotics within 1-2 hours. • Percentage of patients screened/administered anti-biotics within 2-3 hours. • Percentage of patients screened/administered anti-biotics over 3 hours. • Percentage of patients not screened/administered anti-biotics.	The Trust is undertaking a programme of work to improve sepsis screening and antibiotics administration within 1 hour. This additional information will provide assurance to show that the screening took place and that antibiotics were administered and what the timeframe was.
Probable Community Acquired Pressure Ulcers	To include an additional graph for pressure ulcers to show any pressure ulcer which were suspected to have been acquired in the community and brought into hospital. These community acquired pressure ulcers will remain in the overall Trust position for reporting purposes.	This will provide additional assurance to show the true number of pressure ulcers acquired in the hospital.

The Trust Board is asked to approve the recommended amendments to the Quality Section of the IPR.

These updates/amendments will increase the overall number of indicators on the IPR from 74 to 77. If approved by the Trust Board, the changes will take place from September's IPR Board Report (August's Data).

5. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

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

6. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the capital schemes approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.
2. Approve the following capital requests:
    a. New Hospital Strategic Outline Case of £96k
    b. Clinical Skills Programme request of £30k
    c. Reallocation in the capital programme to replace circuit breaker funding with electrical infrastructure for £200k
    d. A Band 6 fixed term post for 12 months within the Capital Projects Team of £25k in 2021/22 (September – March) and £18k in 2022/23 (April to August).
3. Note that the NHSE/I Provider Finance Return for month 3 matches this report.
4. Approve the recommended amendments to the Quality section of the IPR.
5. Note the contents of this report.

Key

Improvement in Performance	↑
Deterioration in Performance	↓
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating July 2020 – June 2021

	KPI	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21
	QUALITY												
1	Incidents (over 40 days old)	↑	↑	↓	↓	↑	↓	↔	↑	↑	↔	↔	↔
2	Duty of Candour	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
3	Healthcare Acquired Infections - MSRA	↔	↔	↓	↑	↔	↔	↔	↔	↔	↔	↔	↔
	Healthcare Acquired Infections – Cdiff	↓	↑	↑	↓	↑	↔	↓	↕	↓	↔	↓	↑
5	Healthcare Acquired Infections – Gram Neg	↑	↓	↑	↓	↑	↑	↑	↕	↓	↓	↑	↓
6	Healthcare Acquired Infections – COVID-19 Hospital Onset & Outbreaks												
7	VTE Assessment	↑	↓	↓	↓	↑	↓	↓	↓	↑	↑	↑	↑
8	Total Inpatient Falls & Harm Levels	↑	↓	↓	↓	↓	↑	↓	↑	↓	↑	↓	↑
9	Pressure Ulcers	↔	↓	↓	↑	↓	↑	↓	↑	↓	↑	↔	↓
10	Medication Safety (24 Hours)	↑	↓	↓	↑	↑	↑	↑	↓	↑	↓	↑	↑
11	Staffing – Average Fill Rate	↓	↓	↑	↑	↑	↓	↑	↑	↓	↑	↑	↑
12	Staffing – Care Hours Per Patient Day	↑	↓	↓	↑	↑	↓	↑	↑	↑	↓	↑	↓
13	Mortality ratio - HSMR												
14	Mortality ratio - SHMI												
15	NICE Compliance	↑	↑	↑	↑	↓	↑	↑	↑	↓	↑	↑	↑
16	Complaints							↔	↔	↔	↔	↔	↔
17	Friends & Family – Inpatients & Day cases	-	-	-	-	-		↔	↓	↔	↑	↔	↓
18	Friends & Family – ED and UCC	-	-	-	-	-		↑	↓	↓	↓	↓	↔
19	Mixed Sex Accommodation Breaches (Non ITU Breaches Only)											↔	↔
20	Continuity of Carer	↑	↓	↓	↓	↑	↑	↓	↑	↑	↓	↑	↓
21	Sepsis - % screening for all emergency within 1 hour.											↑	↓
22	Sepsis - % screening for all inpatients within 1 hour.											↑	↓
23	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag sepsis.											↓	↓
24	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis.											↓	↓

Key

Improvement in Performance	
Deterioration in Performance	
Static Performance	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating July 2020 – June 2021

	KPI	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21
	ACCESS & PERFORMANCE												
25	Diagnostic Waiting Times 6 Weeks	↑	↓	↑	↑	↑	↓	↓	↑	↑	↓	↑	↑
26	RTT - Open Pathways	↓	↑	↑	↑	↑	↑	↓	↓	↑	↓	↑	↑
27	RTT – Number of Patients Waiting 52+ Weeks	↓	↓	↓	↓	↓	↓	↓	↓	↓	↑	↑	↑
28	A&E Waiting Times – National Target	↓	↓	↓	↓	↑	↓	↓	↑	↑	↓	↑	↑
29	A&E Waiting Times – STP Trajectory	↓	↓	↓	↓	↑	↓	↓	↑	↑	↓	↑	↓
30	A&E Waiting Times – Over 12 Hours	↔	↔	↔	↔	↔	↔	↔	↔	↓	↑	↔	↔
31	Cancer 14 Days*	↑	↓	↓	↓	↑	↑	↓	↓	↑	↑	↓	↑
32	Breast Symptoms 14 Days*	↓	↓	↑	↓	↑	↑	↓	↓	↑	↑	↓	↓
33	Cancer 28 Day Faster Diagnostic*	↓	↑	↓	↓	↑	↑	↑	↓	↑	↓	↓	↑
34	Cancer 31 Days First Treatment*	↑	↑	↔	↓	↑	↓	↑	↓	↑	↑	↓	↑
35	Cancer 31 Days Subsequent Surgery*	↑	↓	↑	↔	↔	↔	↔	↔	↔	↔	↔	↔
36	Cancer 31 Days Subsequent Drug*	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
37	Cancer 62 Days Urgent*	↑	↓	↑	↑	↓	↑	↓	↓	↓	↓	↑	↓
38	Cancer 62 Days Screening*	↑	↓	↔	↑	↔	↔	↔	↓	↑	↓	↓	↑
39	Ambulance Handovers 30 to <60 minutes	↓	↓	↑	↑	↓	↓	↓	↑	↑	↓	↑	↑
40	Ambulance Handovers at 60 minutes or more	↔	↓	↑	↓	↓	↓	↓	↑	↑	↓	↓	↑
41	Discharge Summaries - % sent within 24hrs	↑	↓	↑	↑	↑	↑	↓	↑	↑	↓	↓	↑
42	Discharge Summaries – Number NOT sent within 7 days	↑	↓	↑	↔	↔	↔	↑	↑	↑	↓	↓	↓
43	Cancelled Operations on the day for a non-clinical reasons	↔	↓	↑	↓	↑	↑	↑	↓	↑	↓	↑	↓
44	Cancelled Operations– Not offered a date for readmission within 28 days	↔	↓	↓	↑	↓	↑	↔	↔	↔	↔	↓	↔
45	Urgent Operations – Cancelled for a 2nd time	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
46	Super Stranded Patients	↑	↓	↓	↓	↓	↓	↓	↑	↓	↓	↑	↓
47	COVID-19 Recovery Elective Activity												
48	COVID-19 Recovery Diagnostic Activity												
49	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 July 2020 – June 2021

	KPI	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21
	WORKFORCE												
50	Sickness Absence												
51	Return to Work												
52	Recruitment												
53	Vacancy Rates												
54	Retention												
55	Turnover												
56	Bank & Agency Reliance												
57	Agency Shifts Compliant with the Cap												
58	Agency Rate Card Compliance												
59	Monthly Pay Spend (Contracted & Non-Contracted)												
60	Core/Mandatory Training												
61	Role Specific Training												
62	% Use of Apprenticeship Levy												
63	% Workforce carrying out an Apprenticeship Qualification												
64	PDR												

Key

Improvement in Performance	↕
Deterioration in Performance	↕
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating July 2020 – June 2021

	KPI	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21
	FINANCE												
65	**Trust Financial Position**	↔	↔	↓	↓	↓	↓	↓	↑	↑	↑	↓	↑
66	**System Financial Position**	-	-	-	-	-	-	-	-	-	-	-	-
67	**Cash Balance**	↓	↑	↑	↓	↑	↑	↓	↑	↑	↑	↓	↑
68	**Capital Programme**	↑	↑	↑	↑	↑	↑	↑	↓	↑	↑	↓	↕
69	**Better Payment Practice Code**	↑	↑	↑	↑	↑	↔	↔	↑	↔	↑	↔	↓
70	**Use of Resources Rating**	-	-	-	-	-	-	-	-	-			
71	**Agency Spending**	↓	↑	↑	↓	↓	↓	↓	↓	↓	↑	↑	↑
72	**Cost Improvement Programme – Performance to date**	-	-	-	-		↑	↓	↓	↑			
73	**Cost Improvement Programme – Plans in Progress (In Year)**	-	-	-	-	-	-	-	-	-			
74	**Cost Improvement Programme – Plans in Progress (Recurrent)**	-	-	-	-	-	-	-	-	-			

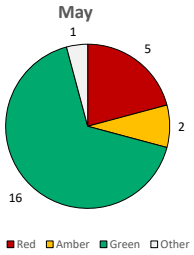
*RAG rating is based on previous month's validated position for these indicators.

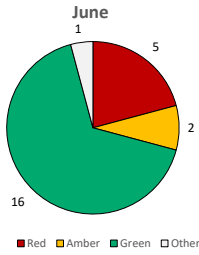
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Integrated Dashboard - June 2021

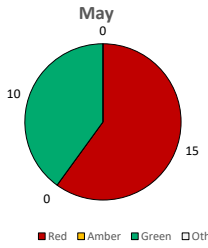
Appendix 2

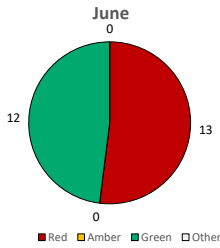
Quality Improvement



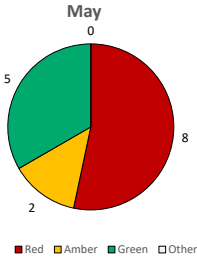


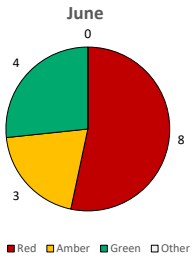
Access & Performance



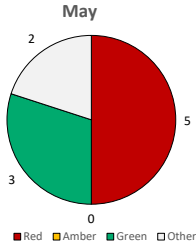


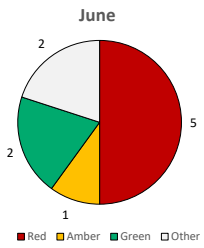
Workforce





Finance



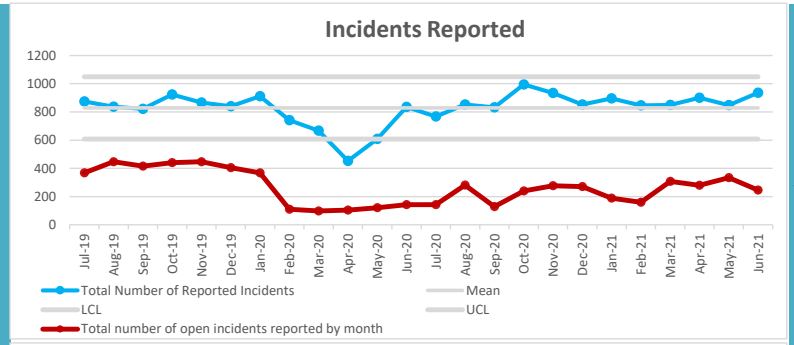
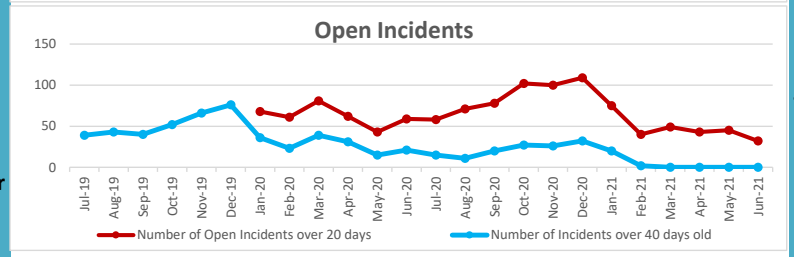
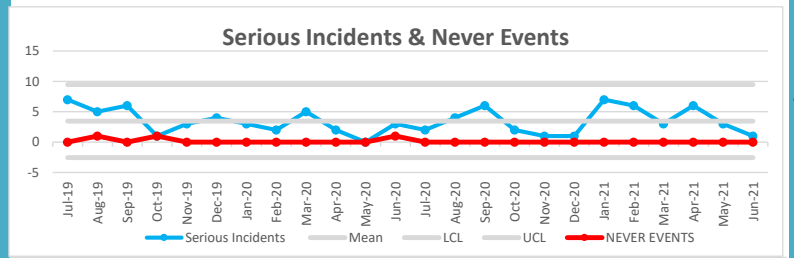
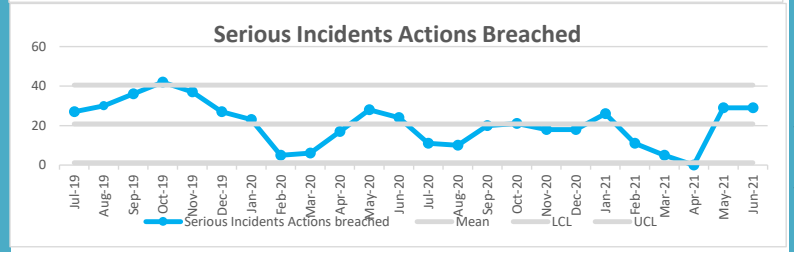


Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

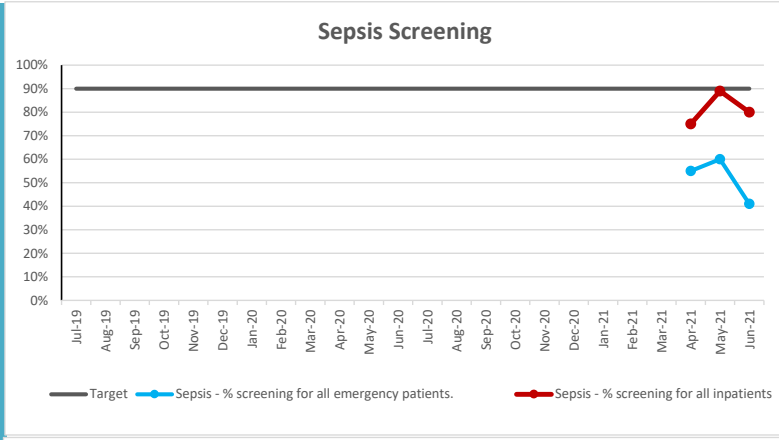
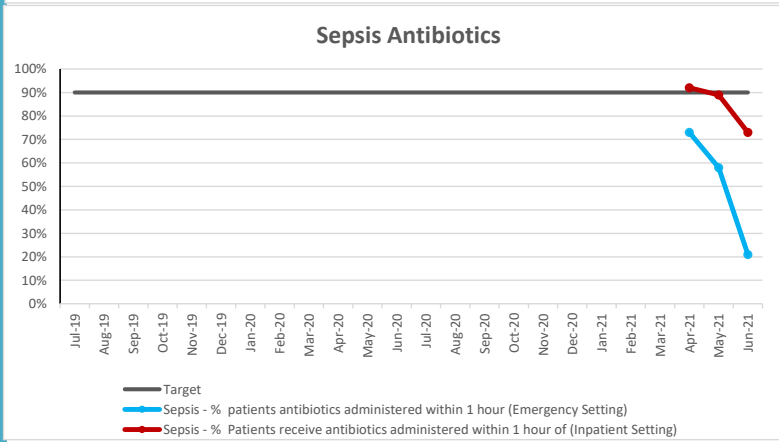
Quality Improvement - Trust Position

Patient Safety

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 Incidents Red: Open incidents outside 40 day timeframe Amber: Open incidents between 20 - 40 days old. Green: Open incident within timeframe of 20 days. **There were 0 incidents over 40 days old open in June 2021.**		**Incident reporting remains within range with little variance across the Trust.**	**The report to improve campaign will continue as will focused learning with all CBUs.**
		**There is no variance compared to the previous month with a sustained position of 0 incidents over 40 days.**	**Plans are in place to work toward a position of 0 incidents over 20 days old. This will provide assurance of full compliance. The Patient Safety Manager will meet with CBUs weekly with timely escalation to the Associate Director of Governance as required.**
		**There has been positive variation. 1 serious incident was reported in June 2021 compared to 3 in May 2021.**	**Learning is shared across CBU's and the wider organisation via Trust Safety Brief, CBU governance meetings and the weekly meeting of harm, supporting a wider learning framework.**
		**Breached Serious incident actions remains at 29, however this remains within expected normal variation. This has been static since previous month with little variation.**	**A breached actions position is now provided to the Deputy Director of Governance with weekly appropriate escalation to the CBU leads.**

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

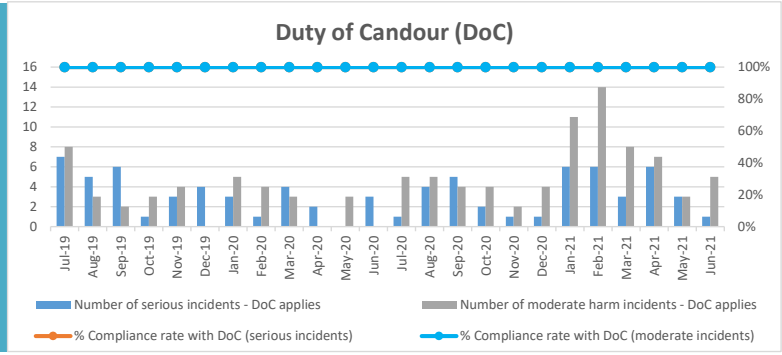
Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Sepsis - % screening for all emergency patients. Red: Below 90% Green: 90% or Above Sepsis - % screening for all inpatients Red: Below 90% Green: 90% or Above Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag sepsis Red: Below 90% Green: 90% or Above Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis Red: Below 90% Green: 90% or Above	The Trust achieved: • 41.00% (29/70) screening for all emergency patients within 1 hour. • 80.00% (12/15) screening for all inpatients within 1 hour. • 21.00% (11/54) of emergency patients with red flag for Sepsis, administered anti-biotics within 1 hour. • 73.00% (11/15) of inpatients have antibiotics administered within 1 hour of a diagnosis of Sepsis.	 	The reason for the variance in screening is the delay in obtaining blood cultures within the 1 hour timeframe. The reason for the variance with administration of antibiotics is the delay in completion of the prescription and the time taken to reconstitute the antibiotic medication.	A deep dive into sepsis is complete with actions in place to improve compliance. Two consultant sepsis clinical leads are supporting Emergency Department clinicians in the interim to embed the processes. Weekly oversight meetings are underway between the Deputy Chief Nurse for Patient Safety, Sepsis Clinical Leads and Emergency Department representatives to oversee progress. The Patient Safety Nurses will have a presence in the Emergency Department to support improvements. 'Think Sepsis Champions' are being identified across the Trust. Solutions to improve compliance for the administration of antibiotics have been identified with support from pharmacy.

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)?
Duty of Candour Red: <100% Green: 100%	CQC The Trust achieved 100% for Duty of Candour in month.		No variance, the Trust remains 100% compliant.	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 and a separate Duty of Candour Policy is in draft.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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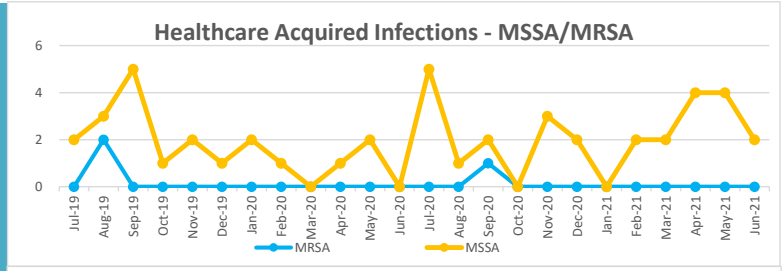
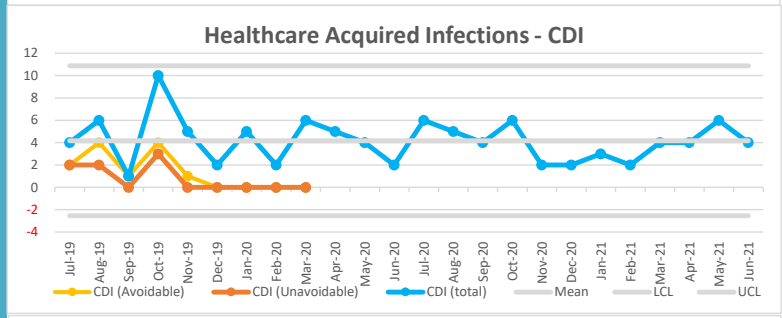
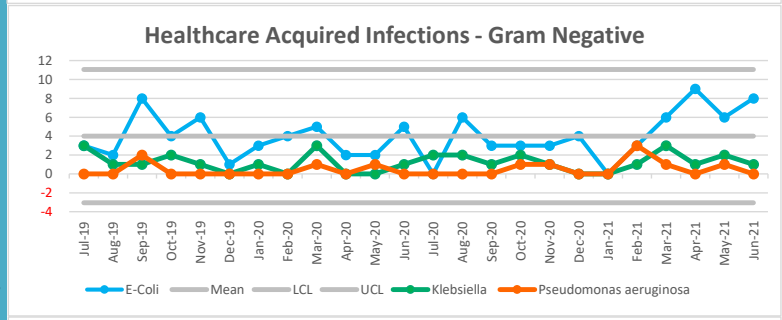
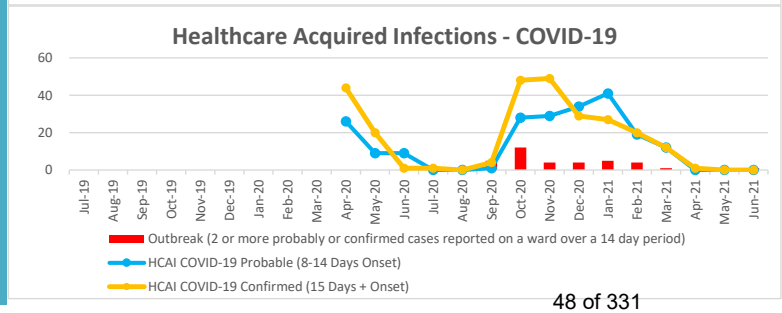
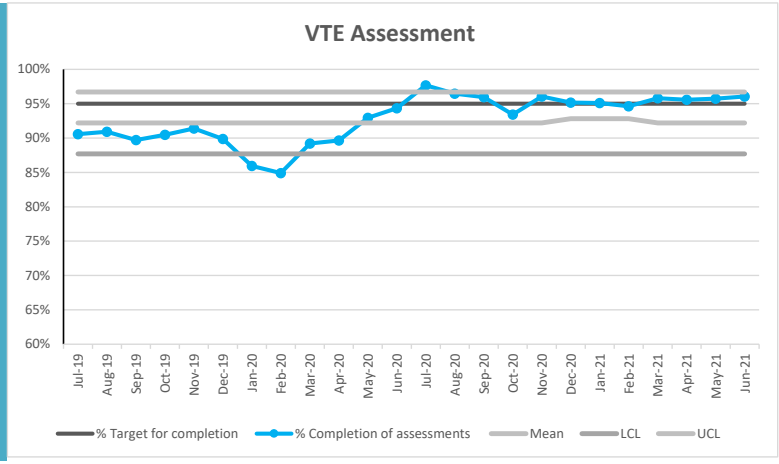
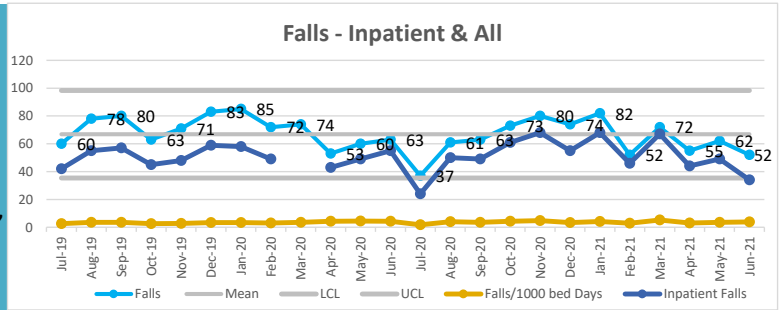
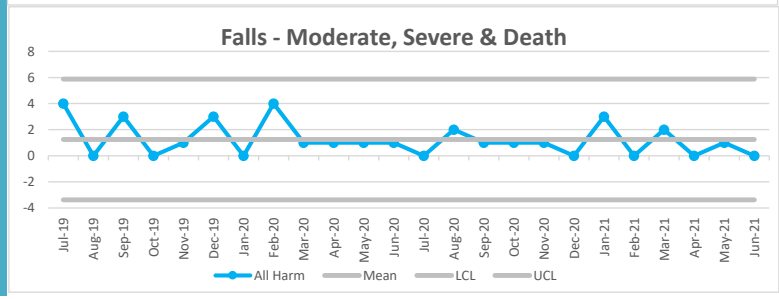
Quality Improvement - Trust Position

	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 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 June 2021, the following cases were reported: CDI – 4 cases - 14 YTD E-Coli – 8 cases - 23 cases YTD Klebsiella – 1 case - 4 cases YTD MRSA - nil cases MSSA – 2 cases - 10 YTD Pseudomonas aeruginosa - 1 case YTD Covid-19 15+ days - 3 cases. Only 1 case reported externally as the other patients were reported asymptomatic.		The change in the apportionment rule has increased the number of GNBSI cases apportioned to the Trust.	Action plans are in place for the prevention of all HCAIs. The GNBSI reduction Group is established with 7 wards engaged in phase 1. Robust processes are in place for COVID-19 admission, day 3 and day 5 testing with Infection Prevention and Control (IPC) guidance on isolation and personal protective equipment (PPE). Learning for COVID-19 outbreaks is being shared at CBU level and Trust wide.
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			Continuing global COVID-19 pandemic with high local prevalence per 100,000 / 7 day rate.	Learning for COVID-19 RCA investigations is being shared at CBU level with drill down to individual wards and Trust wide by Safety Huddle. Action plans will be put into place to address findings including: missed screening, length of stay, ward moves, environmental hygiene, IPC training compliance and PPE compliance. Robust processes are in place for COVID-19 admission, day 3 and day 5 testing with IPC guidance on isolation and personal protective equipment.

RR1275

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

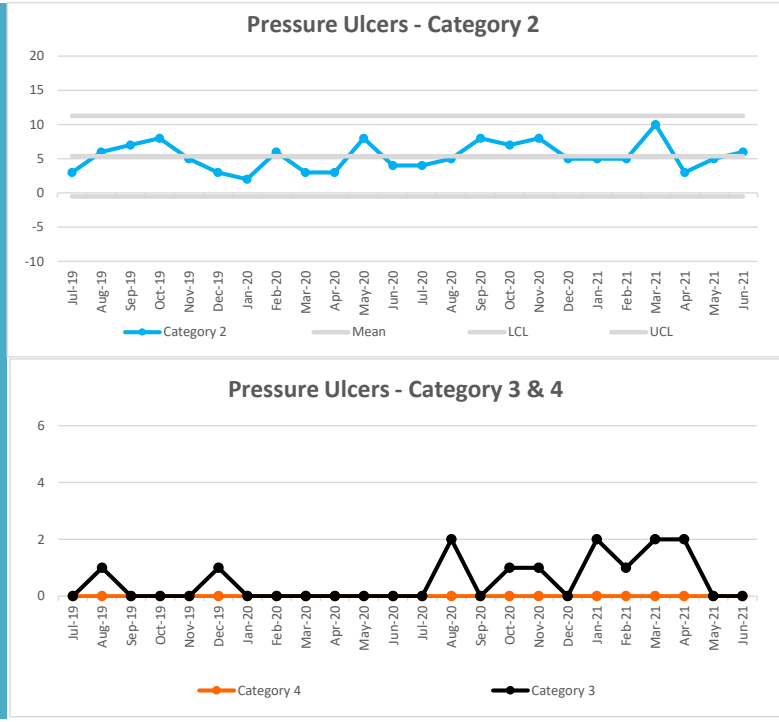
Quality Improvement - Trust Position

	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)?
VTE Assessment Red: <95% Green: 95% or above based on previous months' figures due to timescales for validation of data	The Trust achieved 95.30% for VTE assessments on average in Q1 2021/22.		The Trust achieved 96.04% for VTE assessments in June 2021. The quality standard has been achieved.	Work continues with the clinical teams to improve VTE compliance. Daily progress updates are escalated to clinicians and outstanding VTE assessments are communicated via the Trust Wide Safety Brief. A Clinical Data Capture (CDC) form within the Lorenzo Electronic Patient Record to document ward rounds is currently being piloted. This includes a prompt to complete a VTE risk assessment.
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	52 total falls were reported, 34 of those were inpatient falls, a reduction of 15 inpatient falls (30.00%) from last month. No falls which resulted in harm were reported.	 	Falls prevention remains a constant focus across the Trust. The number of falls remains within normal variation.	Weekly falls meetings reinforce preventative measures to address immediate issues. The Trust Wide Safety Brief highlights falls awareness and learning. The Falls Collaborative Quality Improvement Programme continues with 10 wards focussing on tests of change which has seen an overall reduction in falls on the innovation wards.

RR120

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

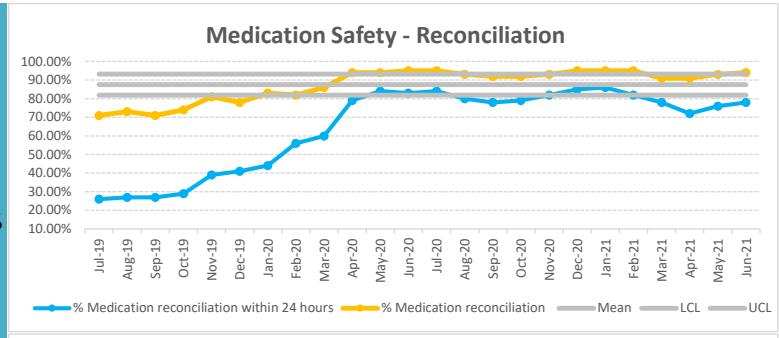
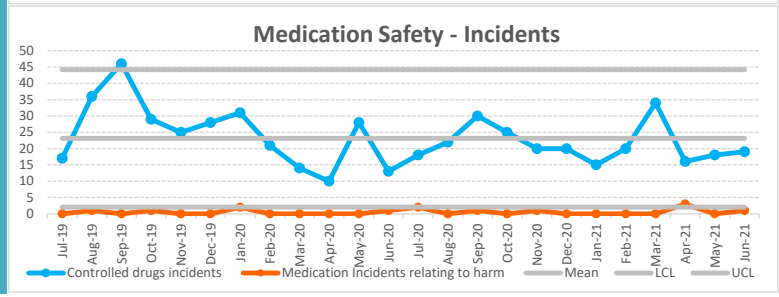
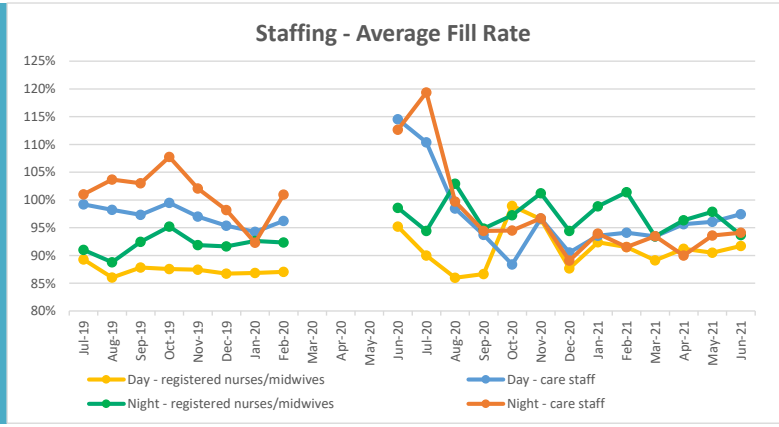
Quality Improvement - Trust Position

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)?
CQC There were 6 hospital acquired category 2 pressure ulcers reported in June and 0 category 3. This is a 20% increase (1) from the previous month	 	The reason for the increase in category 2 pressure ulcers is related to the use of devices and associated assessment. The increase in category 2 pressure ulcers is within expected variation.	3 of the pressure ulcers in June were reported from 1 area. Work is underway with the senior nursing team to address the learning requirements identified. The Quality Improvement Programme continues. All innovation wards have demonstrated a reduction in pressure ulcers. Weekly meetings continue with the clinical teams to support improvement in areas where an increase in pressure ulcers has been identified.

Pressure Ulcers
Based on 65 in 2019/20
Red: 4% reduction or below
Amber: 5%-9% reduction
Green: 10% reduction or above.

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

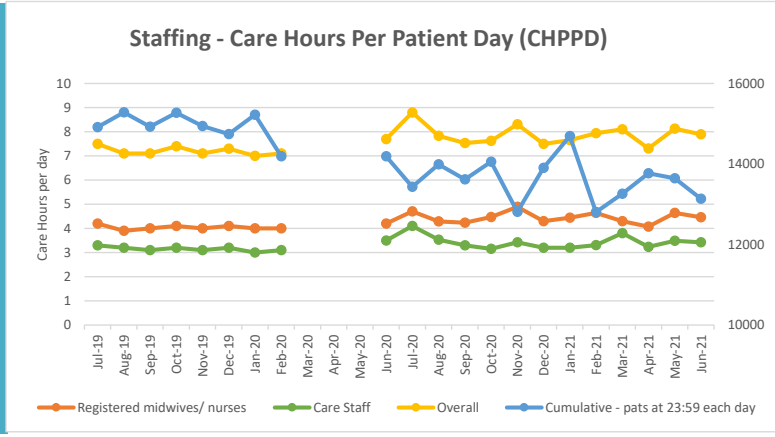
Quality Improvement - Trust Position

	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)?
Medication Safety Reconciliation within 24 hours Red: below 60% Amber: 60% - 79% Green: 80% or above	The Trust achieved 78.00% for medicines reconciliation within 24 hours and 94.00% for overall medicines reconciliation. There was 1 incident reporting harm. There were 19 controlled drug incidents.	 	Of the 19 controlled drug incidents reported, there were no trends identified in affected wards and the reported number of incidents remains within normal variation.	Pharmacy staffing remains below established levels, however recruitment is complete and staff will be in post mid-end September. This will impact positively by progressively improving reconciliation from the beginning of September with a full month benefit realised in November. All incidents are reviewed to identify learning and any need for safety communications. Pharmacy controlled drug audits are undertaken 3 monthly to identify themes and actions, tracked by the Medicines Governance Committee. The Deputy Chief Pharmacist (Clinical Services and Medicines safety) and the Deputy Chief Nurse (Patient Safety) have formed a focus group to drive improvements in controlled drug standards.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	In June 2021, the average staffing fill rates were: Day (Nurses/Midwife) 91.7% Day (Care Staff) 97.44% Night (Nurses/Midwife) 93.68% Night (Care Staff) 94.11%		13 of the 21 wards reported staffing levels over 90.00% in June 2021. Additional beds in use across the Trust and increased staff absence due to COVID-19 related reasons remains a driver for variation.	Staffing is reviewed twice daily by the senior nursing team and acuity and activity are monitored to ensure safe patient care at all times. All wards have senior nurse oversight by a Matron and Lead Nurse. The recruitment of 96 International Nurses along with full recruitment to Health Care Assistant vacancies ensures consistent fill rates.

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)?
RR115 RR1108 **In June 2021, the average CHPPD were:** **Nurse/Midwife: 4.5 hours** **Care Staff: 3.4 hours** **Overall: 7.9 hours**		**In June 2021, CHPPD was recorded at 7.9 in month, which is lower than the previous month which was 8.1, with a 2020/21 YTD figure of 7.9, against the national median rate of 9.1 and peer organisation rate of 8.3.**	**Ward staffing levels continue to be systematically reviewed, which includes planned versus actual staffing levels and overall staffing plans are on track.**

Staffing - Care Hours Per Patient Day (CHPPD)
Red: Below 6.0
Amber: 6.0 - 7.8
Green: 7.9 or More

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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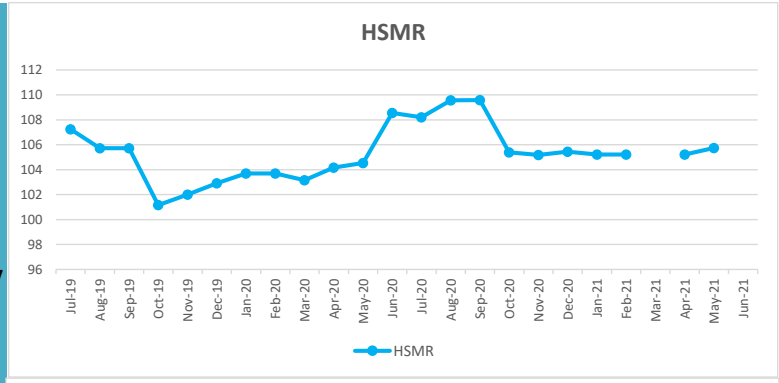
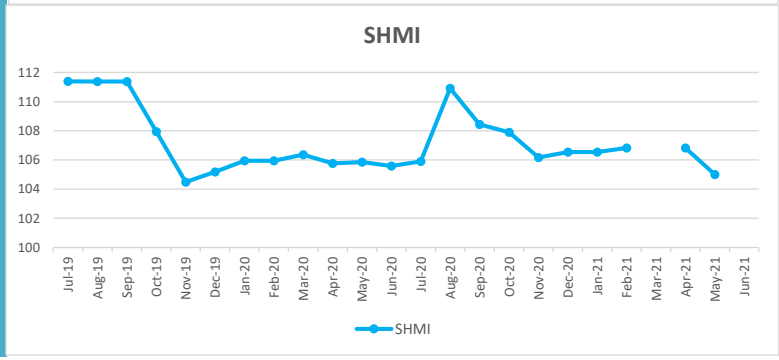
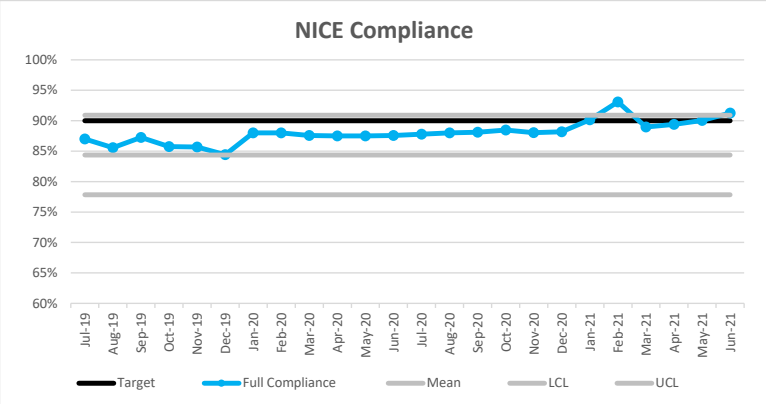
Quality Improvement - Trust Position

	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)?
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	CQC SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 105.74 for the latest reporting period. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 105.01 for the latest reporting period.	 	No variation. HSMR and SHMI remain within expected range.	Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning.

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)?
NICE Compliance Red: Below 75% Amber: 75% to 89% Green: 90% or Above	SOF The Trust achieved 91.25% in month.		Positive variation. NICE compliance has improved by 1.5% since May 2021.	Regular attendance by the governance team at CBU governance meetings and meeting with leads of those areas to offer additional support. Clear escalation processes are in place.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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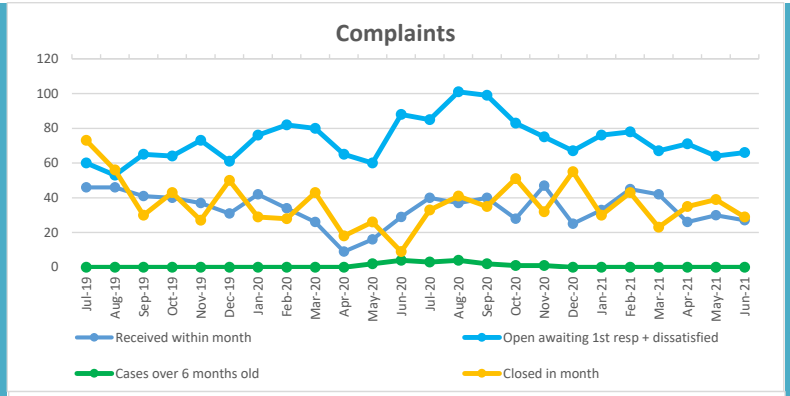
Quality Improvement - Trust Position

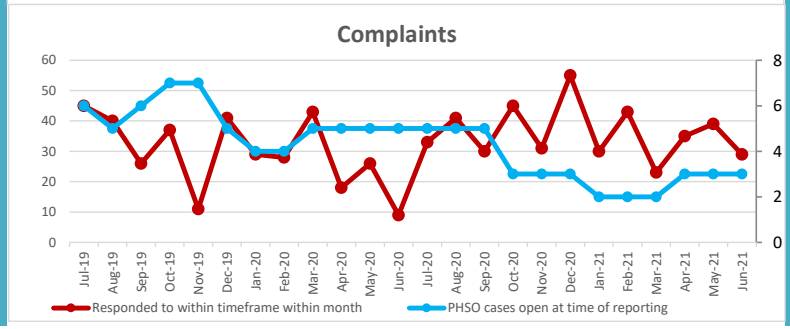
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

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.

In June 2021, 27 new complaints were received to the Trust. There were no dissatisfied complaints received.





Positive variance in performance as zero dissatisfied complaints. This is an improved position on the quality of complaints response. All other aspects of complaints are within trajectory.

To continue the improvement trajectory each Clinical Business Unit has a named lead for complaints. Resolution meetings for families/ patients will continue to be the first option to ensure efficient resolution.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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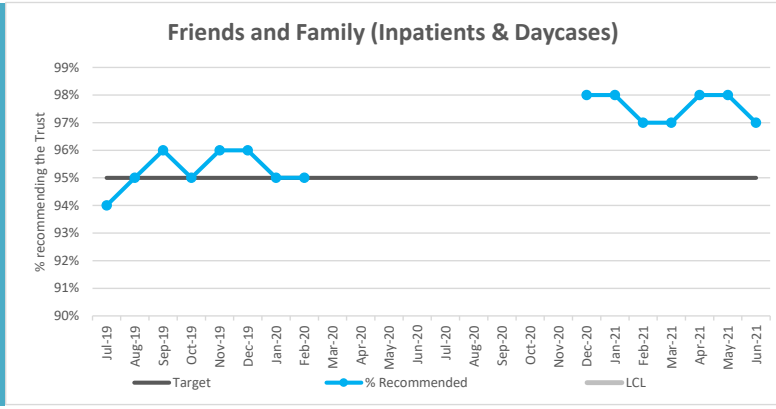
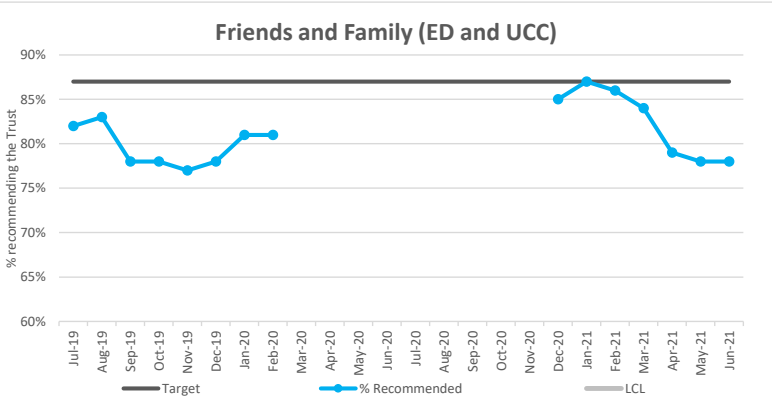
Quality Improvement - Trust Position

	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)?
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	SOF CQC S The Trust achieved 97.00% in month.		The Trust achieved an 97.00% recommendation rate in June 2021.	The Trust continues to be highly recommended through the FFT responses. Any variation is addressed locally and monitored through the Patient Experience Sub Committee.
Friends and Family (ED and UCC) Red: Less than 87% Green: 87% or more	SOF CQC S The Trust achieved 78.00% in month.		The Trust achieved 78.00% recommendation rate against a target of 87.00%	Alternative methods of gathering feedback within Urgent & Emergency Care have been implemented, such as online via IPads to increase the opportunity to capture real time or near real time feedback. Patient commentary through FFT relate directly to waiting times.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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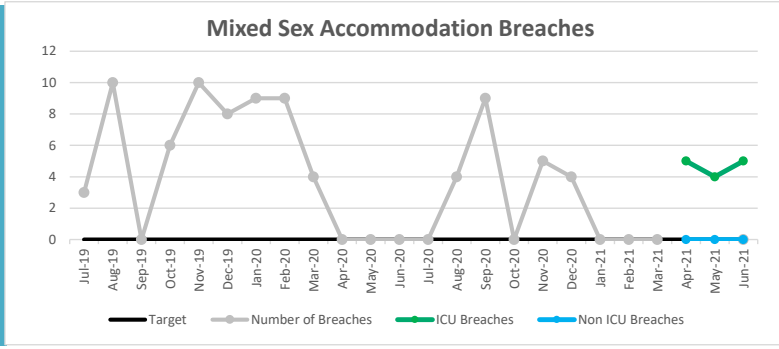
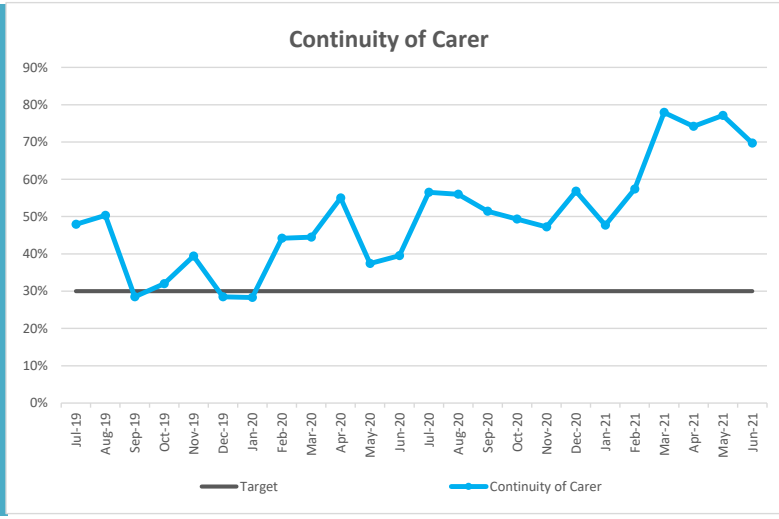
Quality Improvement - Trust Position

	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)?
Mixed Sex Accommodation Breaches (Non ITU Only) Red: 1 or more Green: Zero	SOF There were 5 mixed sex accommodation incidents during June 2021. All breaches occurred in Intensive Care Unit.		There were 5 mixed sex accommodation breaches reported in June 2021 in the ITU. There were zero breaches within any other ward area.	Patients are cohorted within the Intensive Care Unit, to minimise breaches and the installation of addition single rooms will prevent mixed sex accommodation breaches going forward. The sustainability plan post Operation Reset supports patient flow to ensure timely step down from the Intensive Care Unit.
Continuity of Carer Green: 51% or Above Amber: 35% - 50% Red: below 35%	In June 2021, 100% of Warrington women are booked onto such a pathway, if 'out of area' bookings are included the figure is 69.7% as we cannot provide the postnatal aspect of the pathway.		The Trust achieved 69.70% onto a CoC pathway (including intrapartum care) in June 2021. This is a reduction in total women on a CoC pathway due to an increased proportion of out of area women being booked for care at WHH.	New care new models have been developed by the Clinical Business Unit to enable the Trust to deliver 100% against the continuity of carer standard for in-area women. To meet the criteria of Better Births (which includes limits on team size and considerably lower caseload numbers than the traditional model of community midwifery), the requirement for additional staffing was identified and a business case was approved. Recruitment has been completed for these posts and start dates are being expedited.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Risk Register RR116
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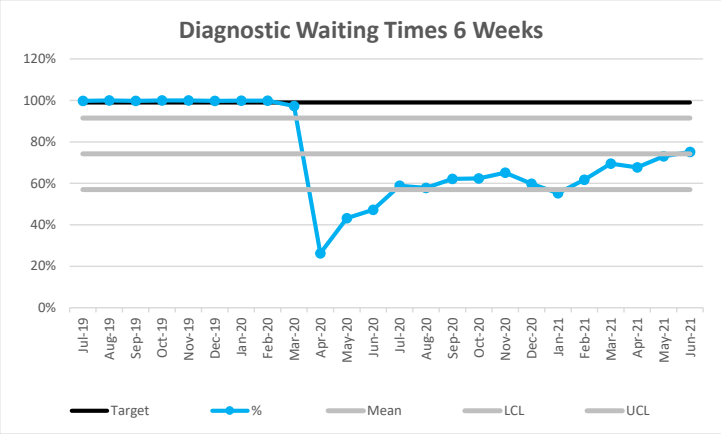
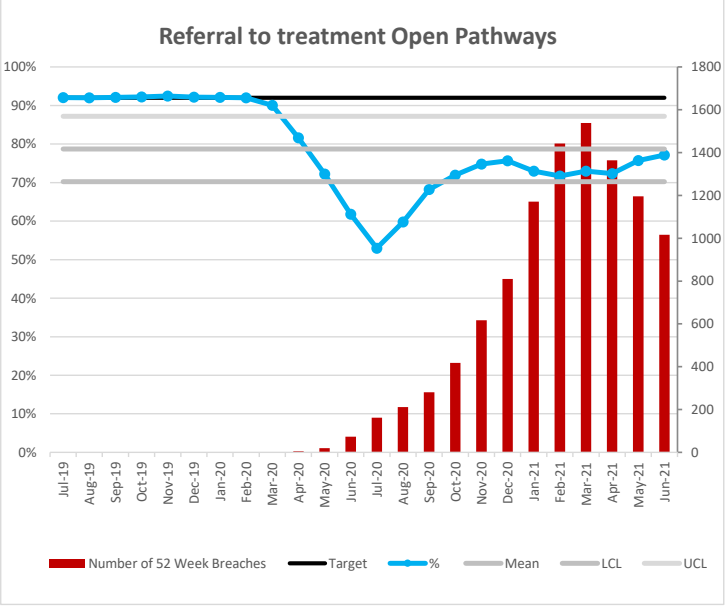
Care Quality Commission CQC

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)?
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	SOF CQC The Trust achieved 75.18% in month. RR1215 RR1125		The diagnostic standard was not achieved in July 2021, this was due to the impact of the COVID-19 pandemic. The position continues to improve in line with the recovery trajectory.	A recovery plan has now been agreed and patients are being clinically prioritised accordingly in line with national guidance. The recovery plan is demonstrating that the actions agreed are delivering recovery with fewer breaches recorded as services are brought back 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, Cystoscopy and CT.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or above RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red	SOF CQC The Trust achieved 77.15% in month. There were 1016, 52 week breaches in June 2021. RR1215 RR1125		The restoration of elective activity and clinical services has been impacted by Wave 2 and Wave 3. Elective activity for all priority group patients has been maintained on site and with support from the independent sector. The number of patients waiting 52 weeks + at the end of June was at 1016.	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 and Captain Sir Tom Moore Centre. • The Trust continues to utilise Independent Sector Capacity. • Restoration and recovery plans for 2021/22 have been drawn up in line with Operational Planning Guidance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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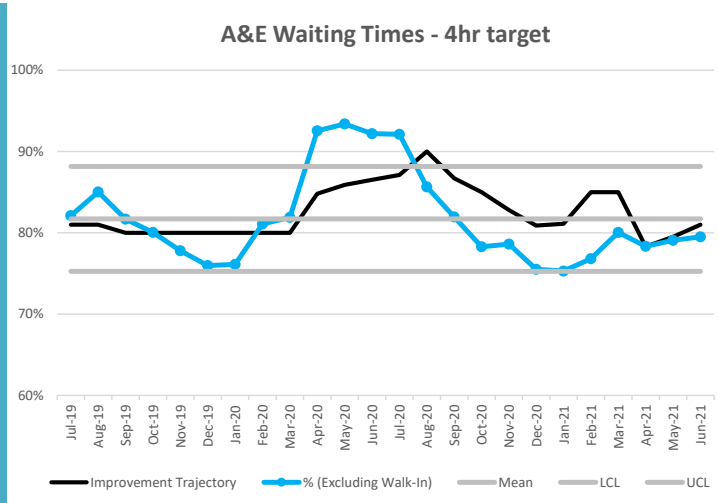
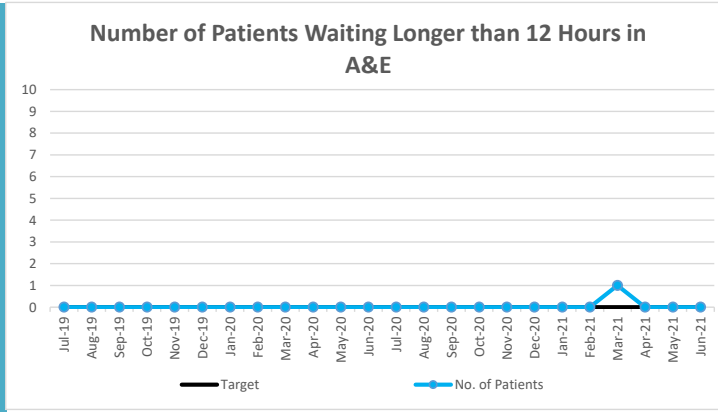
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Four Hour Standard - National Target Red: Less than 95% Green: 95% or Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory	SOF CQC The Trust achieved 79.50% excluding walk ins in month. RR224 RR1125		There was a slight improvement in performance from May to June to 79.50% (excluding Widnes Walk-in activity). This is attributable to the ongoing impact of the pandemic and a significant growth in Urgent Care attendances in ED. This trend is being seen across Cheshire and Mersey.	• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity to support flow. • The actions developed in response to the Royal College of Emergency Medicine (RCEM) guidance, Resetting Emergency Department Care, continue to be taken forward and monitored. • Additional beds remain open on the Halton site to support bed capacity and flow.
The number of patients who has experienced a wait in A&E longer than 12 hours from the decision to admit. Green = 0 Red = > 0	SOF There were 0 patients waiting longer than 12 hours in A&E in month.		The Trust has achieved the standard of not having any patients waiting longer than 12 hours in June from the decision to admit.	Maintain compliance against the 12 hour standard from the decision to admit.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

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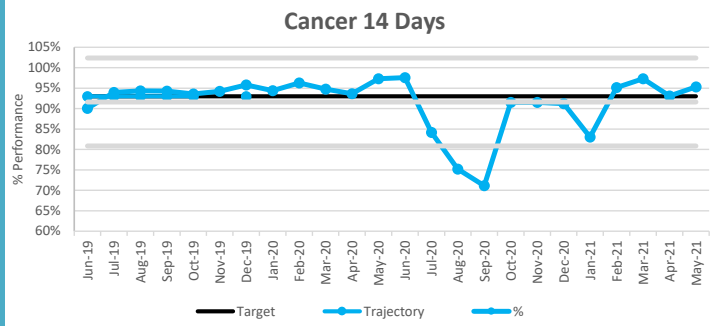
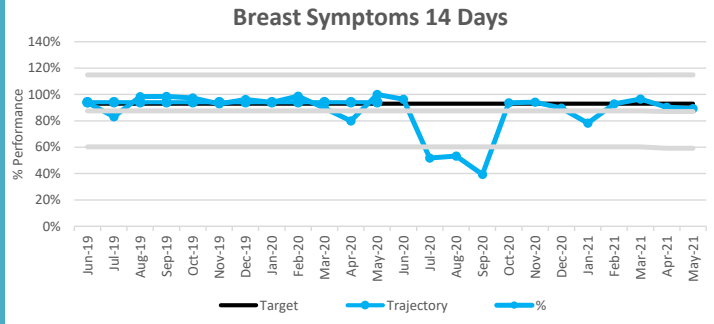
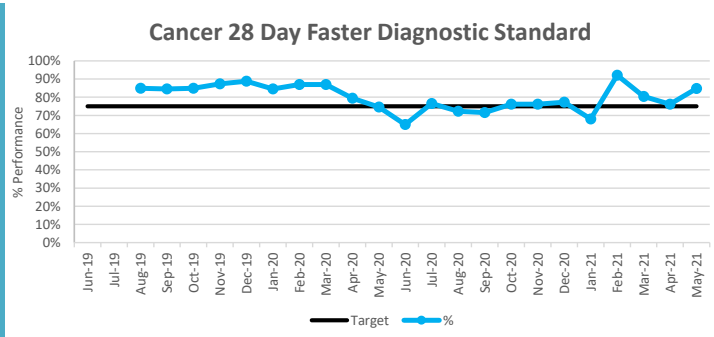
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 14 Days Red: Less than 93% Green: 93% or above SOF CQC **The Trust achieved 95.28% in May 2021.** RR1125		**The Trust did achieve the 2 week wait standard in May 2021. The position continues to be challenged by the availability of capacity due to COVID-19.**	**The Trust will continue to review capacity and clinical service restoration plans to support ongoing compliance against this standard.** **Performance against this standard is monitored via the Performance Review Group (PRG), the KPI sub-committee and the Clinical Services Recovery Oversight Group (CSOG).**
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above SOF CQC **The Trust achieved 89.39% in May 2021.** RR1125			
28 Day Faster Cancer Diagnosis Standard Red: Less than 75% Green: 75% or above **The Trust achieved 84.80% in May 2021.**		**The Trust continues to participate as the test site for the 28 day Faster Diagnosis standard as part of the clinical review of all cancer access standards. The Trust achieved the standard in May 2021 with 84.80% 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

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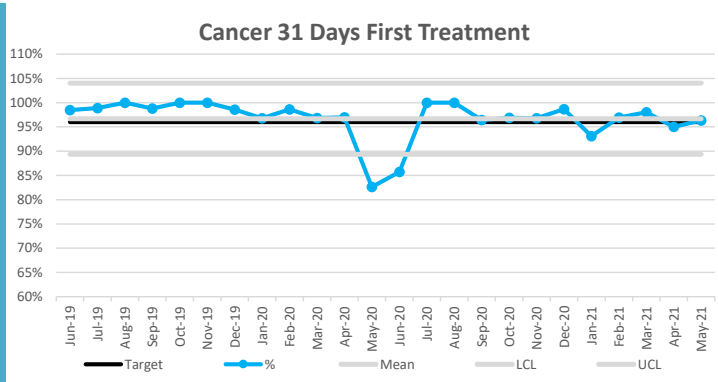
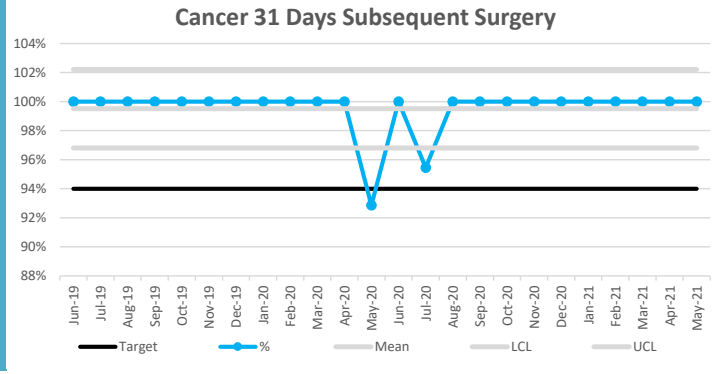
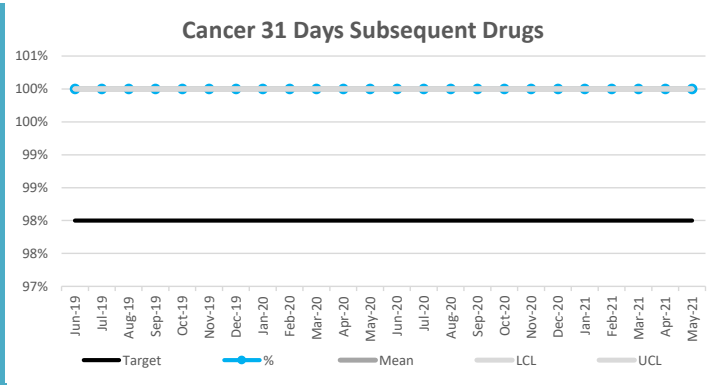
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above		The 31 day cancer target was achieved in May 2021 at 96.34% (First Treatment) and 100% (Surgery).	There remains a risk for performance due to the impact of the pandemic. Capacity is being reviewed in line with clinical service restoration plans.
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above			
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above		The Trust achieved 100% in May 2021.	Maintain compliance against the 31 day subsequent treatment (drug) standard.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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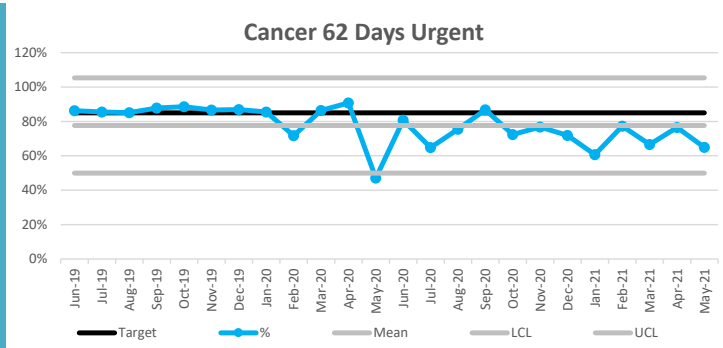
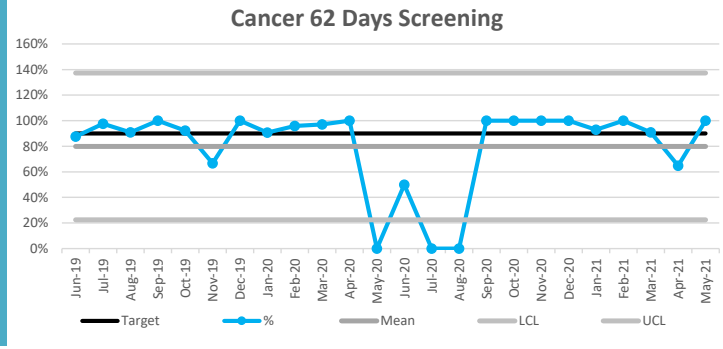
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	SOF CQC The Trust achieved 65.00% in May 2021. RR1125		The 62 day urgent target was not achieved in May 2021 at 65.00%. There still remains a number of patients around day 62 and this position is reflective of the number of patients who have already breached being treated. Trajectories for improvement have been submitted to Cheshire and Merseyside Cancer Alliance. The Trust did achieve the 62 day screening standard at 100%.	There remains a risk for performance due to the impact of the pandemic.
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	SOF CQC The Trust achieved 100% in May 2021. RR1125			

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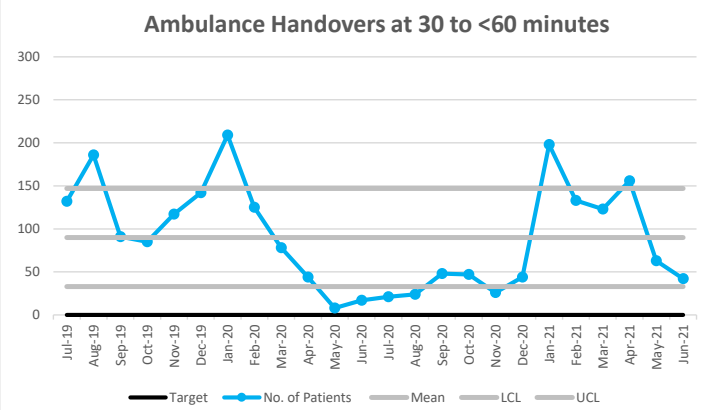
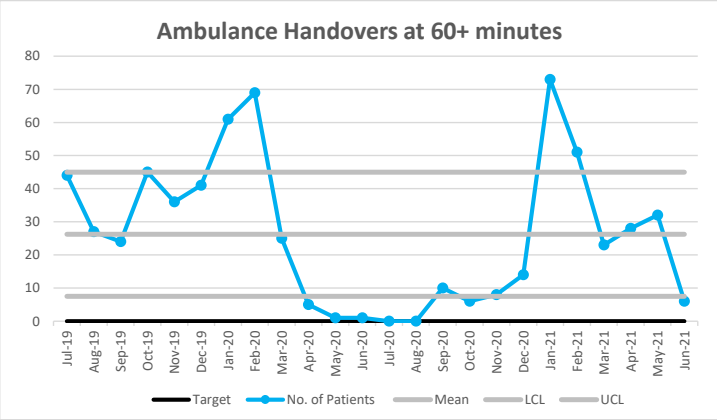
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Ambulance Handovers 30 to <60 minutes **Red: More than 0** **Green: 0** **There were 42 patients who experienced a delay in Ambulance Handovers between 30 to 60 minutes in month.**		**Handover performance has continued to improve following the improvement collaborative with the North West Ambulance Service (NWAS).**	**In May 2021, the Trust began a service improvement collaborative with NWAS to improve ambulance handover waiting times. The Trust will continue to work in partnership with the NWAS to identify and implement improvements.**
Ambulance Handovers at 60 minutes or more **Red: More than 0** **Green: 0** **There were 6 patients who experienced a delay in Ambulance Handovers over 60 minutes in month.**			

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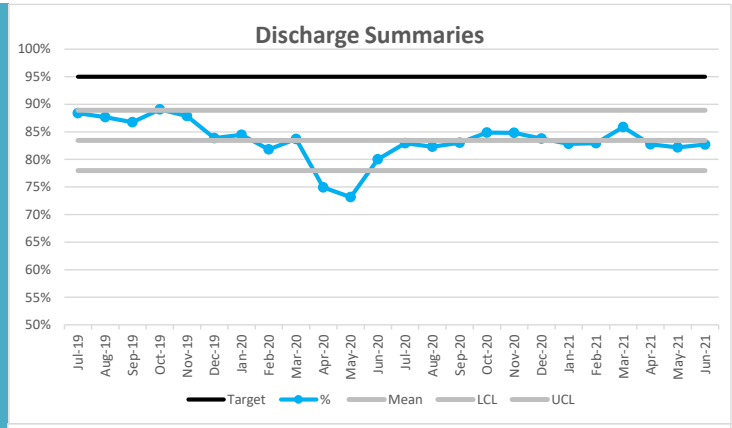
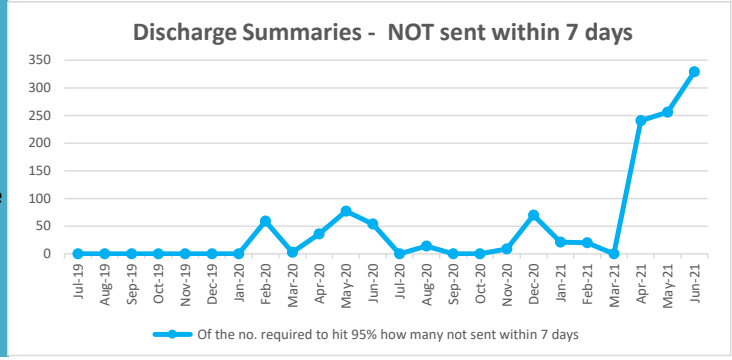
Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Discharge Summaries - % sent within 24hrs **Red: Less than 95%** **Green: 95% or above**	**The Trust achieved 82.71% in month.**		**There has been a sustained improvement in the number of discharge summaries sent within 24 hours. Performance is returning 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 (PRG) continues to monitor this standard to support improvements.**
Discharge Summaries - Number NOT sent within 7 days **Red: Above 0** **Green: 0**	**There were 329 discharge summaries not sent within 7 days required to meet the 95.00% threshold.**		**The significant deterioration in performance is being investigated at the time of writing this report.**	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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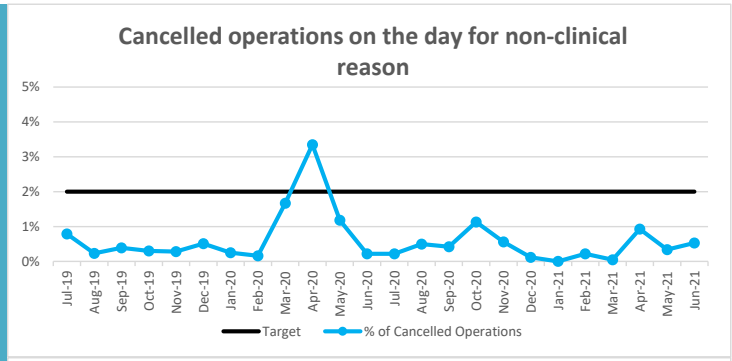
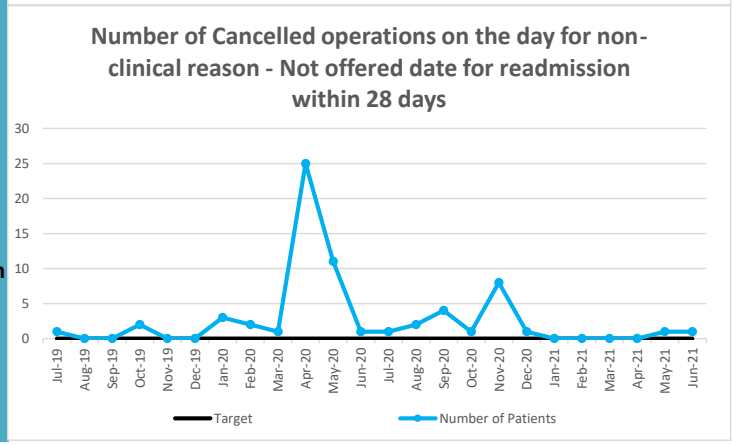
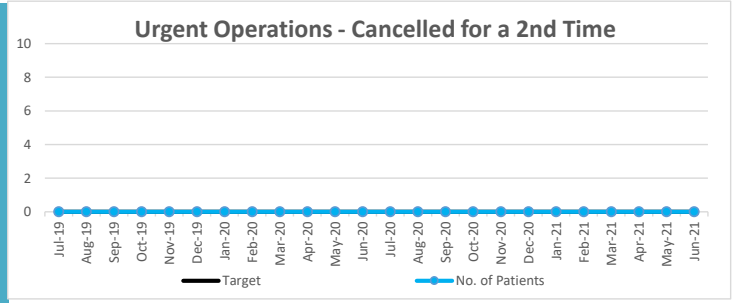
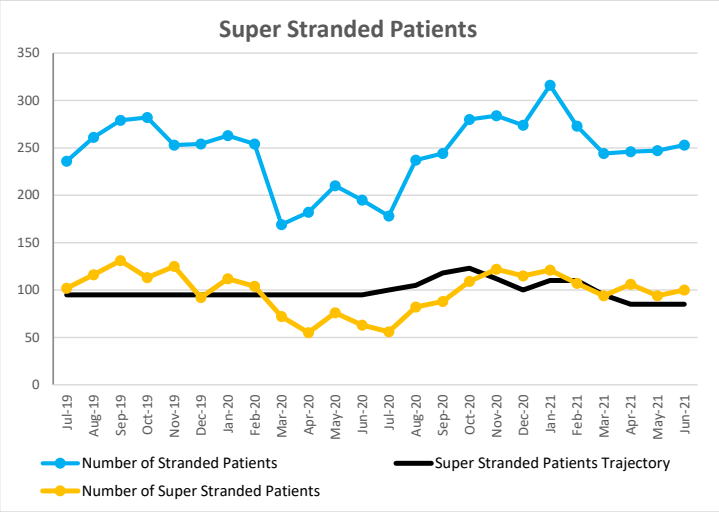
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancelled Operations on the day for a non-clinical reason Red: > 2% Green: < 2%	CQC 0.53% of operations were cancelled on the day for non clinical reasons in month.		Compliance against this standard remains below the monitored threshold of 2.00% (positive).	Recovery of elective activity continues to be monitored via the Clinical Services Recovery Oversight Group (CSOG).
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	There was 1 cancelled operation on the day for non clinical reasons in month, where the patient was not re-booked in within 28 days.		Compliance against this standard remains at the monitored threshold.	
Urgent Operations - Cancelled for a 2nd Time Green = 0 Red = > 0	There were 0 urgent operations cancelled for a second time in month.		This is an additional standard to enhance monitoring of cancelled operations. The Trust continues to maintain this standard.	Maintain the standard that no urgent operations are cancelled for a second time.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

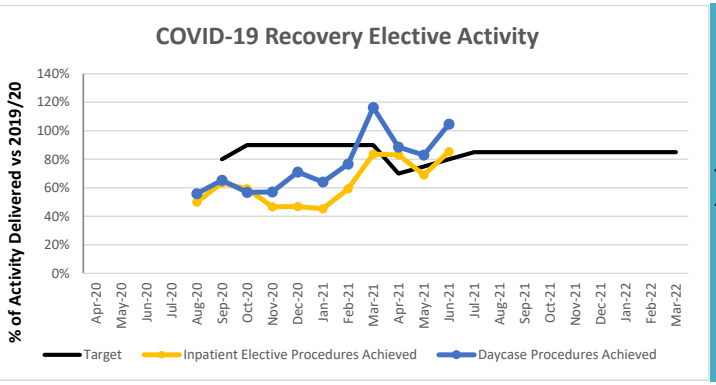
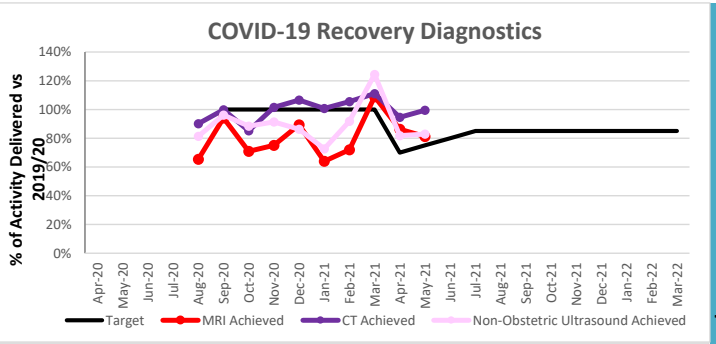
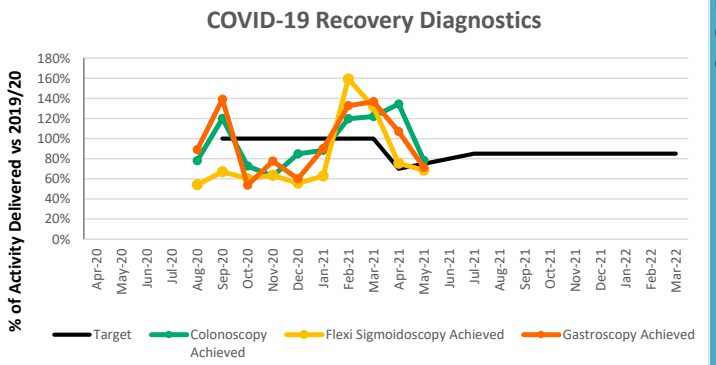
Access & Performance - Trust Position

	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 253 stranded and 100 super stranded patients at the end of June 2021.		The number of Stranded and Super Stranded patients on the last day of the month has increased slightly in June from the previous month.	The Trust is working in collaboration with partners from Local Authorities and community providers to ensure community capacity is available throughout the pandemic. The Trust has introduced "Focus on Flow" Length of Stay meetings on a daily basis to support timely discharge. Sustained improvement in LOS has been noted since Operation Reset in May focussing on internal ward MDT meetings and flow.

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)?
COVID-19 Recovery Elective Activity RED = Below Elective Recovery Target Green = Elective Recovery Target % activity is against activity in the same month in 2019/20	In June 2021, the Trust achieved the following % of activity against June 2019 (plan adjusted). This included 104.75% of Daycase Procedures and 85.33% of Inpatient Elective Procedures.		The Trust met the elective activity recovery trajectories for June.	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 Diagnostic Activity RED = Below Elective Recovery Target Green = Elective Recovery Target % activity is against activity in the same month in 2019/20	In June 2021, the Trust achieved the following % of activity against June 2019 (plan adjusted). This included: 87.68% of MRI 107.86% of CT 92.68% of Non Obstetric Ultrasound	 	The Trust met the diagnostic activity recovery trajectories for June. Data for Colonoscopy, Flexi Sigmoidoscopy and Gastroscopy is under review.	The Trust continues to restore clinical services in line with the national operating guidance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register RR116
Single Oversight Framework SOF
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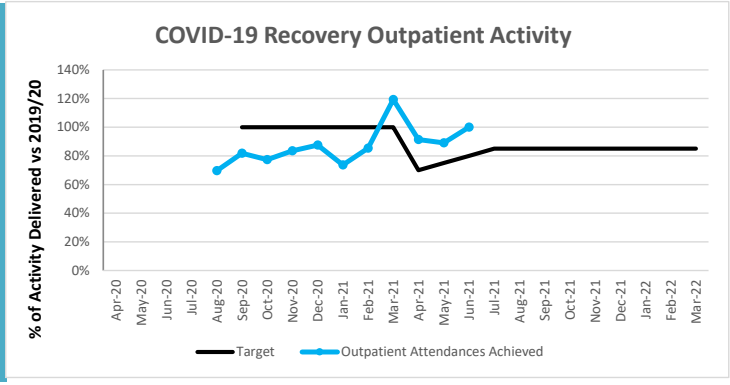
Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
COVID-19 Outpatient Activity **RED = Below Elective Recovery Target** **Green = Elective Recovery Target** **% activity is against activity in the same month in 2019/20**	**In June 2021, the Trust achieved 100.00% of Outpatient activity against June 2019 (plan adjusted)**	**The Trust met the Outpatient activity recovery trajectories for June.**	**The Trust continues to restore clinical services in line with the national operating guidance.**



Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance

Trend

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

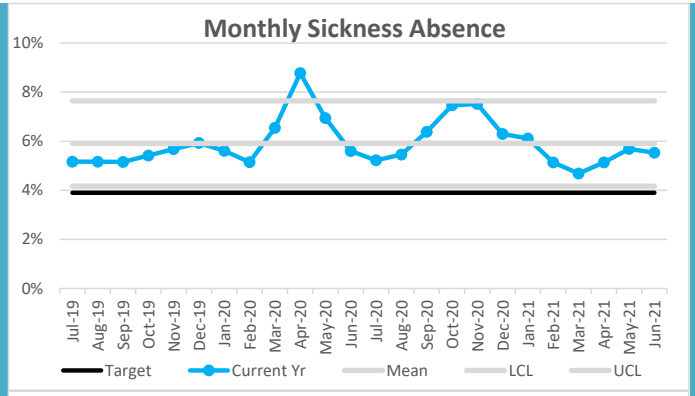
How are we going to improve the position (Short & Long Term)?

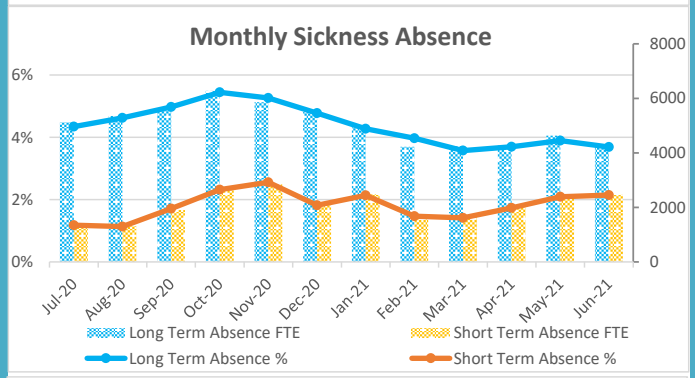
Sickness Absence

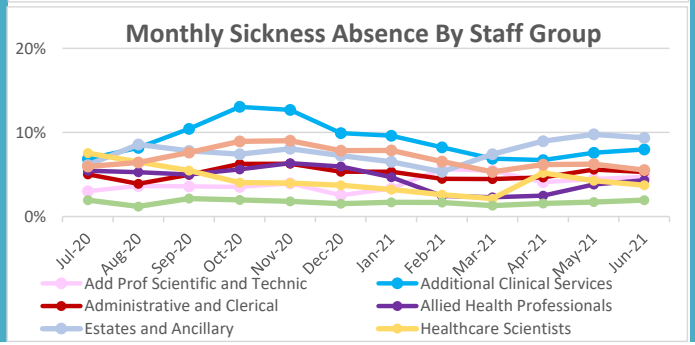
Red: Above 4.5%
Amber: 4.2% to 4.5%
Green: Below 4.2%

UoR SOF S RR200 RR1134 RR1108

The Trust's sickness absence rate was 5.83% in month.
SPC - There is evidence of special cause variation for sickness absence.







Sickness absence was 5.83% in June 2021, this compares to 5.90% in June 2020.

The majority of absence (3.69%) relates to long term absence.

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

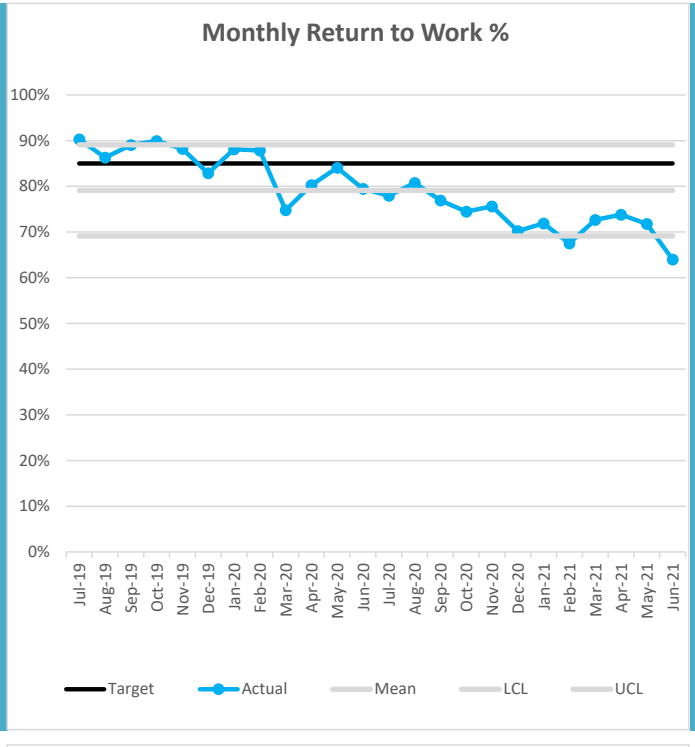
Estates & Ancillary (9.37%) and Additional Clinical Services (7.99%) Staff Groups have the highest sickness absence rates.

Please see narrative at the end of this Workforce section for detail around sickness absence actions.

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)

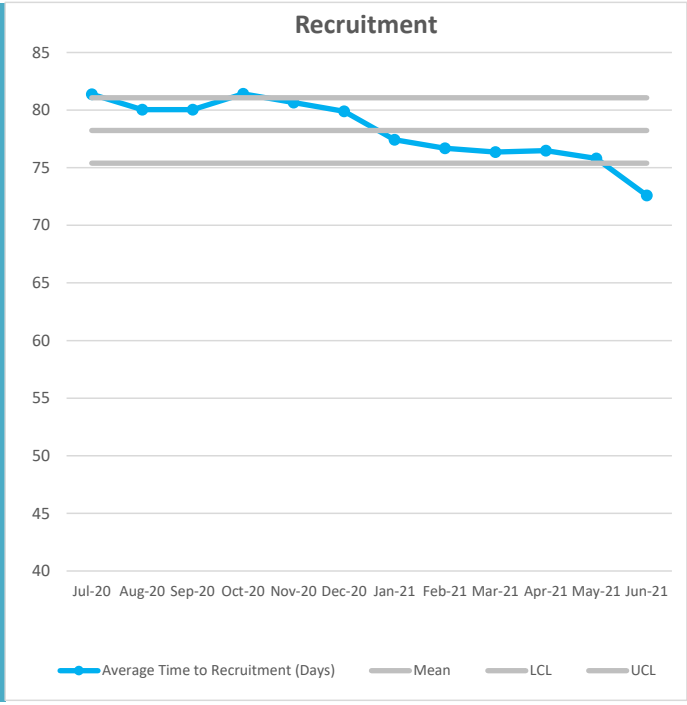
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%		Return to work interview compliance has reduced significantly due to pressures relating to COVID-19.	Return to work interviews remain a vital part of the support in place for our workforce. The reduction in compliance is in line with the findings of the Attendance Management Deep Dive and will form part of the recommendations (See Sickness Actions), as well as Workforce Recovery. The Operational People Committee (OPC) has requested plans and trajectories to demonstrate improving compliance. A bespoke training package has been developed by the HR Business Partner Team and is being rolled out across CBU's. This is one to one training where all elements of the process and recording are discussed. There has been significant uptake of this training which is ongoing. The issue is being raised at all CBU HR Meetings.

The Trust's return to work compliance was 64.00% in month.
SPC - There is evidence of special cause variation for Return to Work compliance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

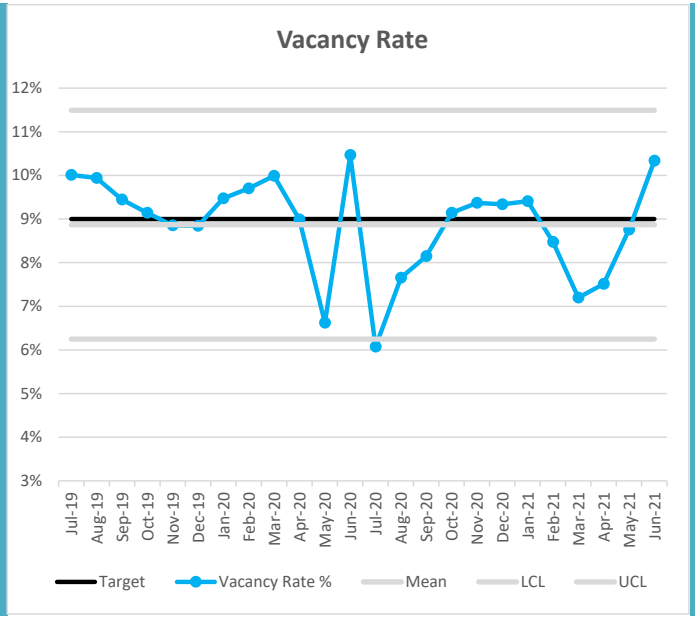
Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

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)?
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or below		Recruitment time to hire has continued to improve from October 2020 onwards, and is 73 days in June 2021. The average time to recruit calculation includes notices periods.	A review of time to hire has taken place and identified the following areas where recruitment time can be reduced: • Advert close to Interview • Pre-Employment Checks To maintain this improvement, the Recruitment team will further refine their communications to recruiting managers, to both manage expectations, but also support them to proactively consider their recruitment timeline. E-forms are in development for the candidates to complete, which will allow them to upload copies of their ID documents. Finally, the Trust has launched an Inclusive Recruitment review and associated action plan, this will have an indirect impact on time to hire through raising awareness and training.
The average number of working days to recruit is 73 days, 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) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR200)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR **The Trust vacancy rate was 10.34% in month. SPC - there is evidence of special cause variation for Vacancy Rates.**		**Vacancy rates has increased above the Trust target to 10.34% in June 2021. This is due to an increase in staff numbers.**	**The Trusts funded FTE (Full Time Equivalents) has increased in June 2021 to 4325 from 4268.**

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)
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)?

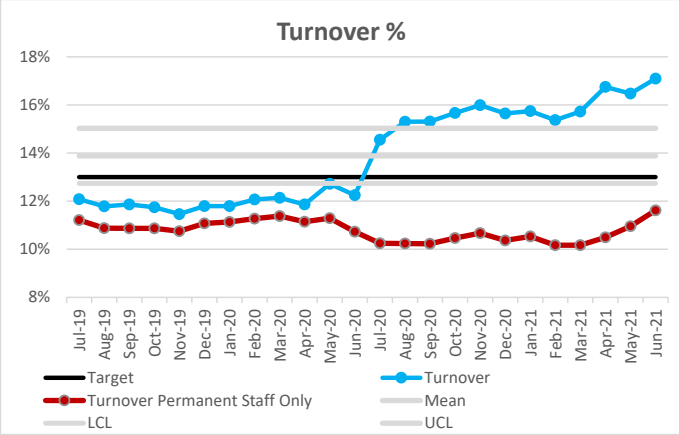
Turnover

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

CQC UoR

The Trust Turnover was 17.09% in month.
SPC - There is evidence of special cause variation for Turnover.

S SOF



Turnover in June 2021 is above target at 17.09% (adverse). Turnover of permanent staff is 11.62%. Retention in June 2021 is at 82.36%. Retention of permanent staff is 90.41%.
For permanent staff only, the Trust is performing better than target for both Turnover and Retention.

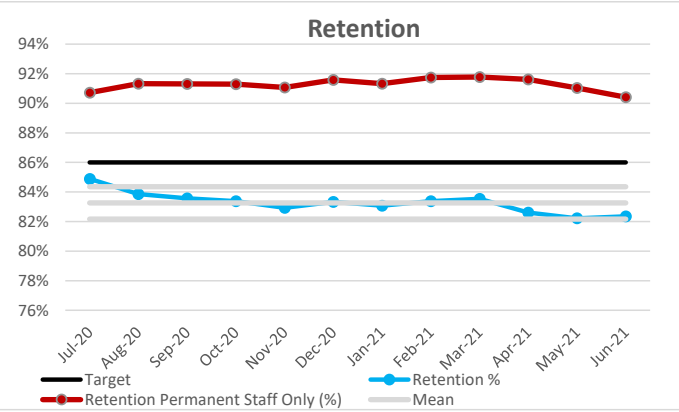
A range of work has been delivered and is on-going as part of the WHH People Strategy and the NHS People Plan to support retention of staff, including:
- **Compassionate Leadership Development Programmes**
- **Staff networks and celebrations of diversity**
- **Promotion of flexible working**
- **Review and marketing of the WHH offer to staff**
- **Team development**
- **Health and wellbeing offers**

Retention

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

UoR

Trust Retention was 82.36% 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)?

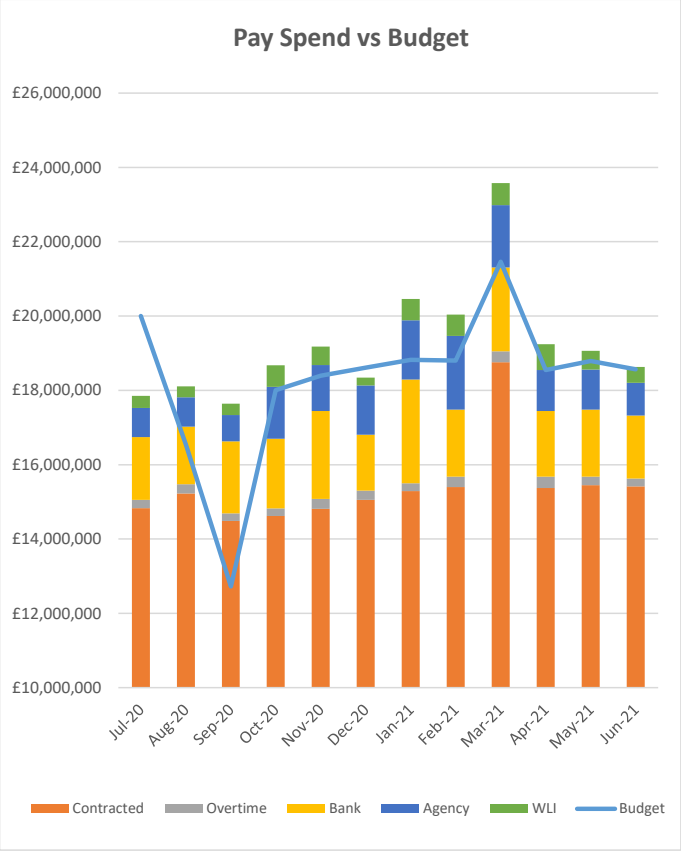
Pay

Red: Greater than Budget

Green: Less than Budget

UoR SOF RR199

Total pay spend in June 2021 was £18.63m against a budget of £18.56m.



The total pay spend is broken down into the following elements:

- **£15.4m Contracted Pay (i.e. substantive staff)**
- **£1.7m Bank Pay**
- **£0.9m Agency Pay**
- **£0.42m Waiting List Initiative (WLI) Pay**
- **£0.2m Overtime Pay**

Please note: the contracted position in March 2021 includes the annual leave accrual.

The additional controls and challenge around pay spend have been identified to support a reduction in premium pay including:

- **Enhanced ECF process for non-clinical vacancies;**
- **Expanded ECF process for agency temporary staffing pay spend;**
- **Introduction of the 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.

The current focus is Medical Bank/WLI rates/spend and the introduction of an equivalate ECF process/system for both bank and WLI expenditure.

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)

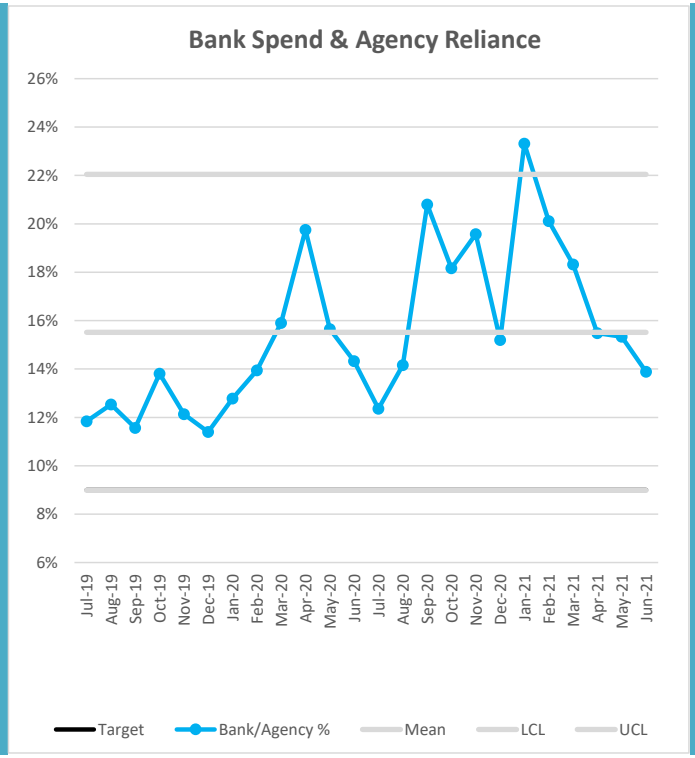
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Bank and Agency Reliance

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

UoR RR199

Bank and Agency Reliance was 13.89% in month. SPC - Bank/Agency reliance is within common cause (expected) variation.



Bank and Agency reliance peaked at 23.30% in January 2021 and there has been a continued reduction since. In June 2021, reliance is at 13.90%.

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 therefore removing the requirement for agency workers.
Compliance against processes is reported to the Finance and Sustainability Committee (FSC) and shows ongoing improvement.
In June 2021, 1.00% of bookings were advertised straight to agency, without an ECF in place. This is an improvement from 14.00% in August 2020.

The ongoing international Nurse recruitment, and the recruitment of the HCAs (where 40.00% of their bank bookings relate to filling a vacancy) will reduce bank and agency further – monitored within FSC.

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)

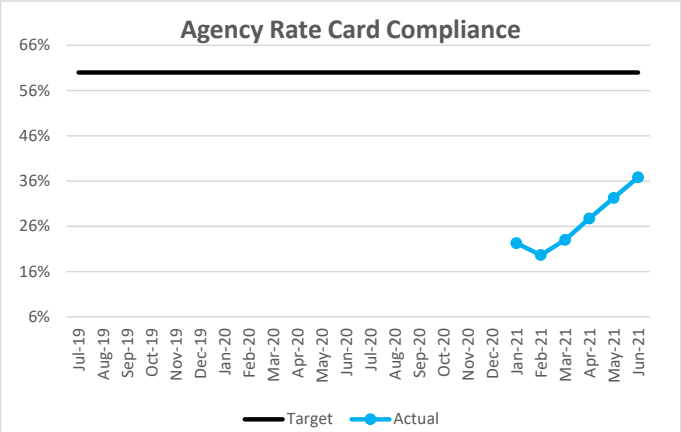
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Agency Rate Card Compliance

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

UoR

Agency Rate Card Compliance was 36.82% in month.

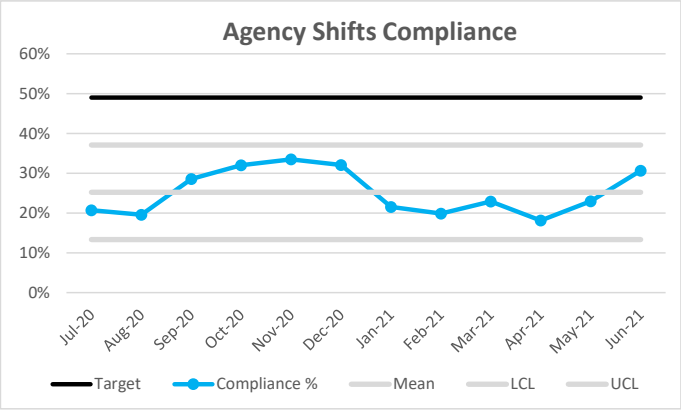


Agency Shifts Compliant with the Cap

Red: below 49%
Green: above 49%

UoR

30.63% of shifts were compliant with the NHSI Price Cap.
SPC - There is evidence of special cause variation within Agency Shift Compliance.



Compliance with the NHSEI rate card was 30.63%. In June 2021, non-compliance was highest amongst the following staff groups:
- **Medical and Dental: 100% above price cap**
- **Nursing and Midwifery: 76.00% above price cap**
- **Scientific, Therapeutic & Technical (AHPs): 56.00% above price cap**

Compliance with the Cheshire and Merseyside rate card was 36.82% in June 2021 and has been steadily increasing since February 2021.

The Central Bank and Agency Team continue to support CBUs in relation to; the booking of medical and dental staff, to negotiate rates down towards the Cheshire and Mersey Rate Card and the NHSI Price Cap compliance.

Neither rate cards have been amended throughout 2020 and 2021, to consider the response to COVID-19 or inflation. A recommendation to adjust the C&M rate card has been put forward to the Finance & Sustainability Committee in July 2021.

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)

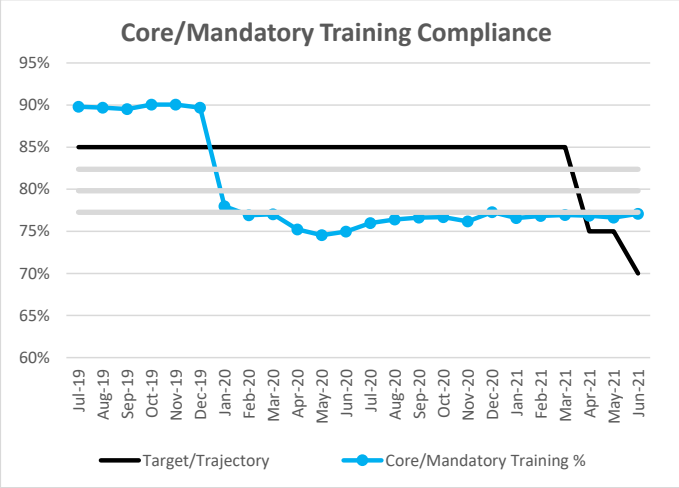
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Core/Mandatory Training

Red: Below Trajectory
Green: Trajectory

CQC

Core/Mandatory training compliance was 77.08% in month.
SPC - there is evidence of special cause variation.

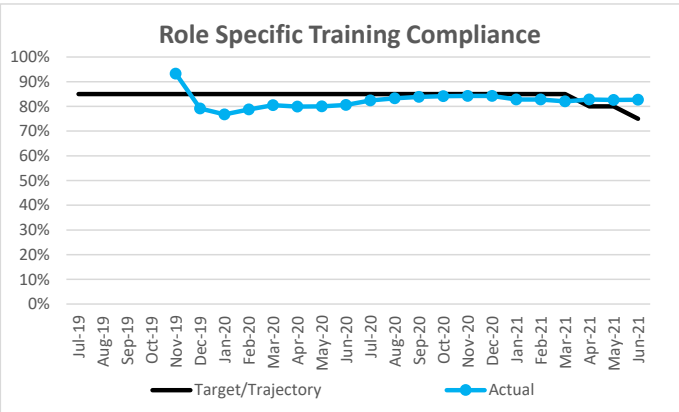


RR153

Role Specific Training

Red: Below Trajectory
Green: Trajectory

Role Specific Training compliance was 82.67% in month.



In June 2021, Mandatory Training compliance was 77.08% and Role Specific Training compliance was 82.67%.

Recognising the previous pause on compliance and ongoing workforce recovery for 2021/22, assurance for Mandatory Training, Role Specific Training and PDR compliance, will be provided using an improvement trajectory measure.

Mandatory training compliance is currently under review to separate out Safeguarding training from overall mandatory training compliance. Providing data for the face to face and e-learning aspects of this training outside of the overall mandatory training compliance reporting will enable focus on the aspects of this training that require compliance improvement which is impacting on the overall mandatory training compliance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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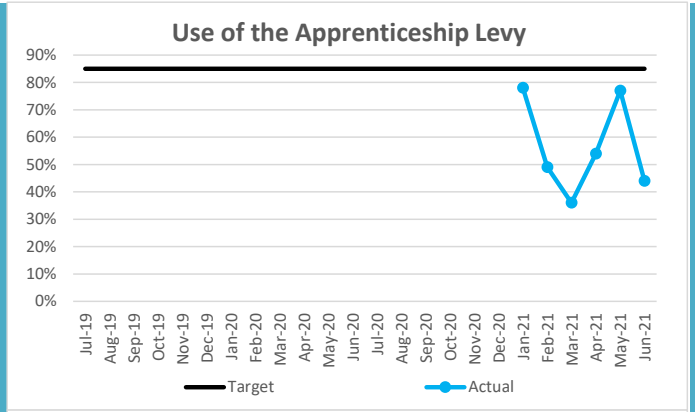
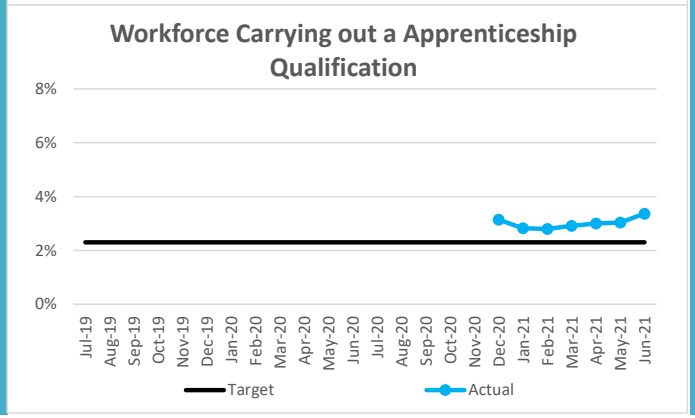
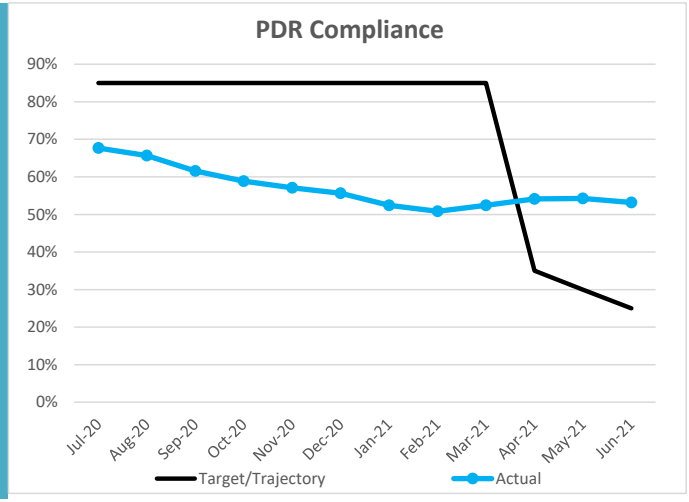
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

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	**Use of the Apprenticeship Levy was 44.00% in month.**		**Utilisation of the apprenticeship levy is below target in month at 44.00%. However, 3.4% of staff are carrying out a qualification, which is above target (positive).**	**Use of the levy continues to be challenged for new recruitment episodes and the uptake of formal training. Using the apprentice levy is regularly promoted.**
Workforce carrying out an Apprenticeship Qualification Red: below 1.5% Amber: 1.5% - 2.2% Green: 2.3% or above	**Percentage of the workforce carrying out a qualification was 3.37% in month.**			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
PDR Red: Below Trajectory Green: Trajectory		**In June 2021, PDR compliance was 53.18% which is above trajectory (positive).** **Recognising the previous pause in compliance and ongoing workforce recovery for 2021/22, assurance for Mandatory Training, Role Specific Training and PDR compliance, will be provided using an improvement trajectory measure.**	**PDR compliance continues to be monitored via the Workforce Recovery Steering Group.**
PDR compliance was 53.18% 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)?

Sickness Absence Actions

The HR and OD team is to set up a programme of work to focus on improving attendance which will:

- **Review the findings to the Attendance Management deep dive report that was presented in February 2021.**
- **Continue the work on exploring opportunities relating to an absence management system.**
- **Review 'Supported Early Return' pilot and roll out.**
- **Consider the work that is included as part of the NHSE/I deep dive review of absence which the Trust is participating.**
- **Continue the current focus on employee Health and Wellbeing.**
- **Continue focus and participation in LAMP testing of all staff.**
- **Focus on interventions for staff living in Halton and Warrington, working with local and community partners.**
- **Undertake a programme of engagement with line managers to promote education and understanding of the Occupational Health Service, strengthening links and joint working between line managers and the service.**

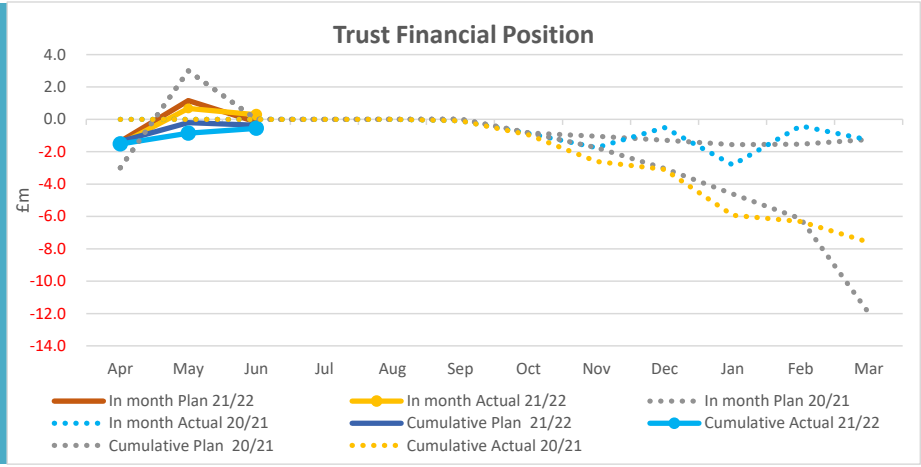
A comprehensive review of the Absence Management Policy is under way in partnership with Staff Side and Management Colleagues. The policy review is to be completed and new policy in place by no later than November 2021. Considering the following:

o Using the opportunity presented by the policy review to introduce a simpler process and embed Just Culture and Improving People Practices principles.
o Simplify management processes relating to Attendance Management, including but not limited to the Attendance Management Policy.
o Considering best practice and exemplary policies.
o The Trust is also introducing a Line Management Development Passport, inclusive of attendance management.
o Set expectations of line manager regarding people management practices.
o Introduce a new training approach for line managers to meet those expectations.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR SOF S **The Trust has recorded a deficit position of £0.6m as at 30 June.** RR134		**For the period ending 30 June 2021, the Trust has recorded a deficit position of £0.6m against a deficit plan of £0.4m. The position includes an overspend on COVID-19 partly offset with underspends in other areas of the organisation.**	**The Trust is applying national guidance as this emerges in relation to financial planning for H1 and H2.**

Trust Financial Position

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

System Financial Position

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

Warrington & Halton System reporting is currently on hold.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

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

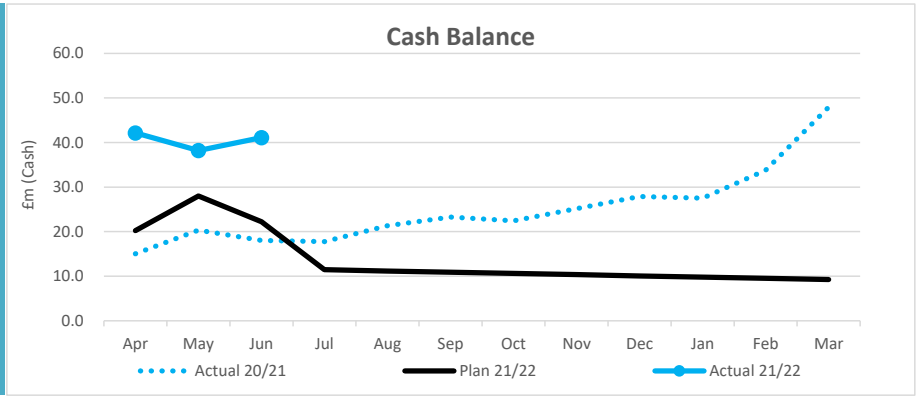
Cash Balance

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

UoR SOF

The current cash balance is £41.1m.

RR134



The current cash balance is £41.1m which is £18.9m better than the initial cash plan due to:
- **A delay in both creditor and capital creditor payments due to orders of goods and services being made later than originally anticipated.**
- **Cash has been received for the annual leave accrual which has not yet been incurred.**
- **An improvement in the year end deficit position due to central income and cash awards made in March 2021.**

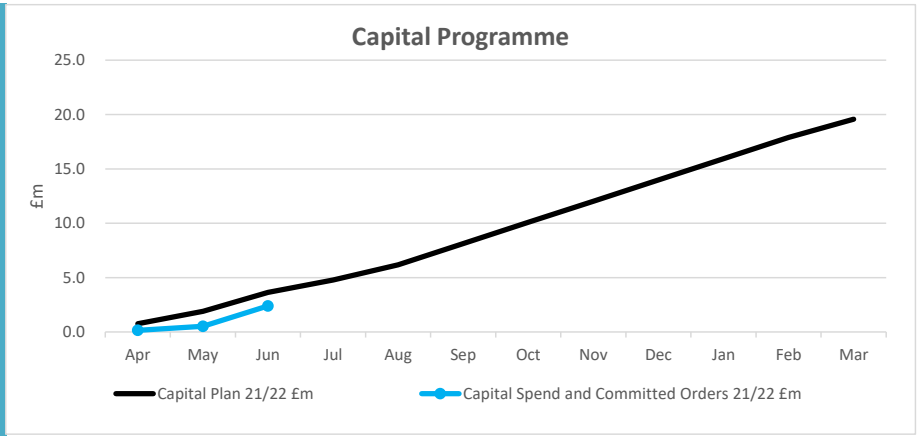
Capital Programme

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

UoR SOF

The actual capital spend in month 3 was £1.9m. In addition there are £0.7m committed orders on the system.

RR1176

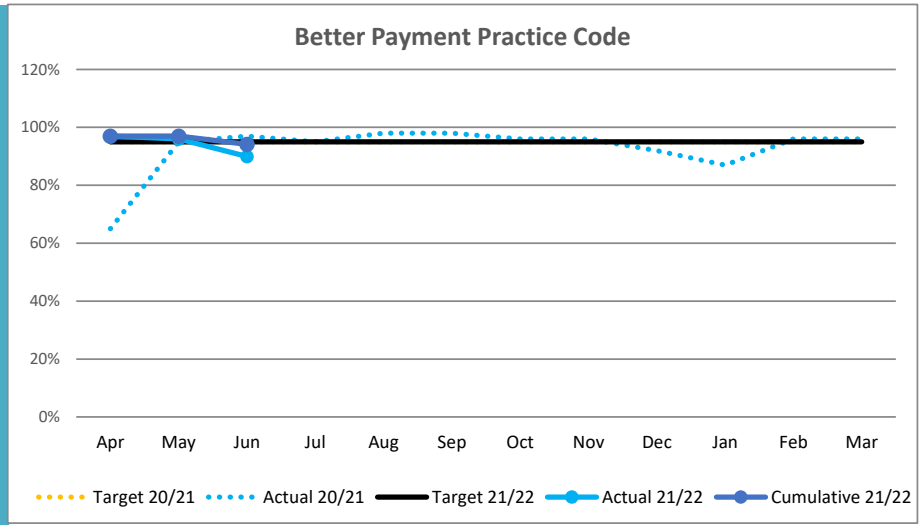


The Trust Board approved capital plan is £19.6m. The actual spend year to date is £2.4m which is £1.2m below the planned spend of £3.6m. However, the Trust has committed orders of £0.7m.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
In month, the Trust has paid 90.00% of suppliers within 30 days.		Performance of 90.00% is below the national standard of 95.00%.	Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments.

Better Payment Practice Code

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

Agency Spending

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

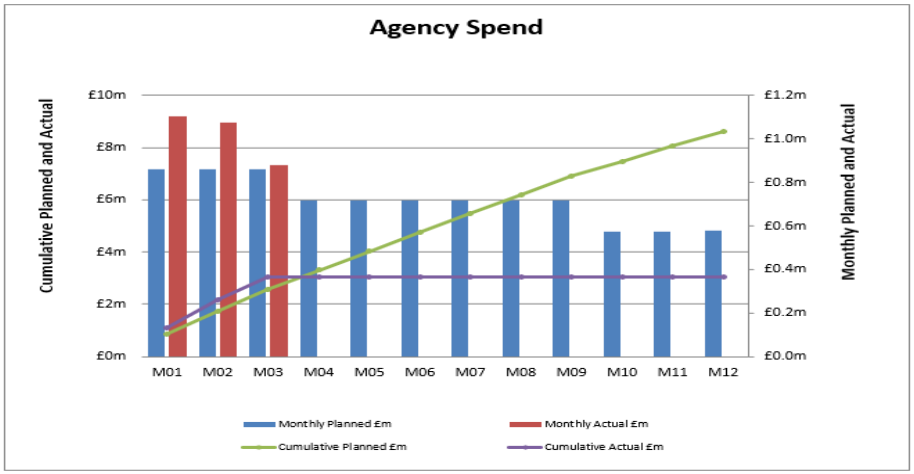
Trust Performance

UoR SOF

The actual agency spend in month is £0.9m.

RR199

Trend



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

The year to date spend of £3.1m is £0.5m above the plan of £2.6m.

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

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) | Use of Resources Assessment (UoR) | Risk Register (RR116) | Care Quality Commission (CQC) | Trust Strategy (S)

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
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		The year to date savings are £0.035m	CIP progress is reviewed on a weekly and monthly basis. Where possible, the Trust seeks to accelerate schemes and is reviewing additional areas to support further cost reductions.
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		There is no CIP target in Q1 2021/22. The Trust has a target of £4.8m for the year and schemes are being developed with CBU and Corporate Services to deliver the CIP.	To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT is being used. The CIP target was increased from £2.6m to £4.8m to provide more time to plan for efficiencies that may be required in H2. At 30 June, £1.5m CIP has been identified. Further work to increase identification of CIP schemes is underway across the Trust.
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	CBUs and Corporate Services have been given a CIP target and schemes are under development. There is no requirement to deliver CIP in Q1 2021/22 with a 1.00% target Q2 and 3.00% Q3 and Q4 totalling £4.8m for the full year.	UoR		

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.
Duty of Candour	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days. Duty of Candour must be completed within 10 working days.
Healthcare Acquired Infections (MRSA, CDI and Gram Negative)	Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to meticillin are termed meticillin susceptible Staphylococcus aureus (MSSA). MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. Clostridium difficule (c-diff) due to lapses in care; agreed threshold is <=44 cases per year. Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections. A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2024.
Healthcare Acquired Infections COVID-19 Hospital Onset and Outbreaks	Measurement of COVID-19 infections onset between 8-14 days and 15+ days of admission. Measurement of outbreaks on wards (2 or more probably or confirmed cases reported on a ward over a 14 day period).
VTE Assessment	Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month.
Total Falls & Harm Levels	Total number of falls per month and their relevant harm levels (Inc Staff Falls).
Pressure Ulcers	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.
Medication Safety	Overview of the current position in relation to medication, to include; medication reconciliation (overall and within 24 hours of admission), controlled drugs incidents and medication incidents relating to harm.
Staffing Average Fill Levels	Percentage of planned verses actual for registered and non-registered staff by day and night. Target of >90%. The data produced excludes CCU, ITU and Paediatrics.
Care Hours Per Patient Day (CHPPD)	Staffing Care Hours per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
HSMR Mortality Ratio	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.
SHMI Mortality Ratio	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
NICE Compliance	The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and

	Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world.
Complaints	Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe.
Friends and Family Test (Inpatient & Day Cases)	Percentage of Inpatients and day case patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?
Friends and Family (ED and UCC)	Percentage of AED (Accident and Emergency Department) patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?
CQC Insight Composite Score	The CQC Insight report measures a range of performance metrics and gives an overall score based on the Trust's performance against these indicators. This is the CQC Insight Composite Score.
Continuity of Carer	Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives. This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience.
Sepsis	Percentage of patients screened for Sepsis for emergency patients. Percentage of patients screened for Sepsis for all inpatients. Percentage of patients in an emergency setting receiving antibiotics within 1 hour of diagnosis. Percentage of patients in an inpatient setting receiving antibiotics within 1 hour of diagnosis.
Access & Performance	
Diagnostic Waiting Times – 6 weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks.
RTT Open Pathways and 52 week waits	Percentage of incomplete pathways waiting within 18 weeks. The national target is 92%.
Four hour A&E Target and STP Trajectory	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95%
A&E Waiting Times Over 12 Hours (Decision to Admit to Admission)	The number of patients who has experienced a wait in A&E longer than 12 hours from the decision to admit the patient to the patient being admitted as an inpatient to hospital.
Cancer 14 Days	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%.
Breast Symptoms – 14 Days	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%.
Cancer – 28 Day Faster Diagnostic Standard	All patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis. The national target is 75%.
Cancer 31 Days - First Treatment	All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%.
Cancer 31 Days - Subsequent Surgery	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%.

Cancer 31 Days - Subsequent Drug	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%.
Cancer 62 Days - Urgent	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory.
Cancer 62 Days – Screening	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%.
Ambulance Handovers 30 – 60 minutes	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system).
Ambulance Handovers – more than 60 minutes	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system).
Discharge Summaries – Sent within 24 hours	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge. This metric relates to Inpatient Discharges only.
Discharge Summaries – Not sent within 7 days	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge.
Cancelled operations on the day for non-clinical reasons	% of operations cancelled on the day or after admission for non-clinical reasons.
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
Urgent Operations – Cancelled for a 2nd Time	Number of urgent operations which have been cancelled for a 2nd time.
Super Stranded Patients	Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.
COVID-19 Recovery Elective Activity	% of Elective Activity (Inpatients & Day Cases) against the same period in 2019/20, monitored as part of 2021/22 Operational Planning Guidance.
COVID-19 Recovery Diagnostics	% of Diagnostic Activity against the same period in 2019/20, monitored as part of 2021/22 Operational Planning Guidance.
COVID-19 Recovery Outpatients	% of Outpatient Activity against the same period in 2019/20 monitored as part of 2021/22 Operational Planning Guidance.
Workforce	
Sickness Absence	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and peer average.
Return to Work	A review of the completed monthly return to work interviews.
Recruitment	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks.
Vacancy Rates	% of Trust vacancies against whole time equivalent.
Retention	Staff retention rate % over the last 12 months.
Turnover	A review of the turnover percentage over the last 12 months.
Bank & Agency Reliance	The Trust reliance on bank/agency staff against the peer average.
Agency Shifts Compliant with	% of agency shifts compliant with the Trust cap against peer average.

the Price Cap	
Agency Rate Card Compliance	% of agency shifts which comply with the Cheshire & Mersey rate card.
Pay Spend – Contracted and Non-Contracted	A review of Contracted and Non-Contacted pay against budget.
Core/Mandatory Training	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and Safeguarding.
Role Specific Training	A summary of role specific training compliance.
Use of Apprenticeship Levy	% of the apprenticeship levy being utilised.
Workforce carrying out an Apprenticeship Qualification	% of the workforce carrying out an apprenticeship qualification.
Performance & Development Review (PDR)	A summary of the PDR compliance rate.
Finance	
Trust Financial Position	The Trust operating surplus or deficit compared to plan.
System Financial Position	The system operating surplus or deficit compared to plan.
Cash Balance	The cash balance at month end compared to plan (excluding cash relating to the hosting of the Sustainability and Transformation Partnership).
Capital Programme	Capital expenditure compared to plan (The capital plan has been increased to £10.2m as a result of additional funding from the Department of Health, Health Education England for equipment and building enhancements).
Better Payment Practice Code	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
Use of Resources Rating	Use of Resources Rating compared to plan.
Agency Spending	Agency spend compared to agency ceiling.
Cost Improvement Programme – In Year Performance	Cost savings schemes deliver Year to Date (YTD) compared to plan.
Cost Improvement Programme – Plans in Progress (In Year)	Cost savings schemes in-year compared to plan.
Cost Improvement Programme – Plans in Progress (Recurrent)	Cost savings schemes recurrent compared to plan.

Appendix 4 - Statistical Process Control

What is SPC?

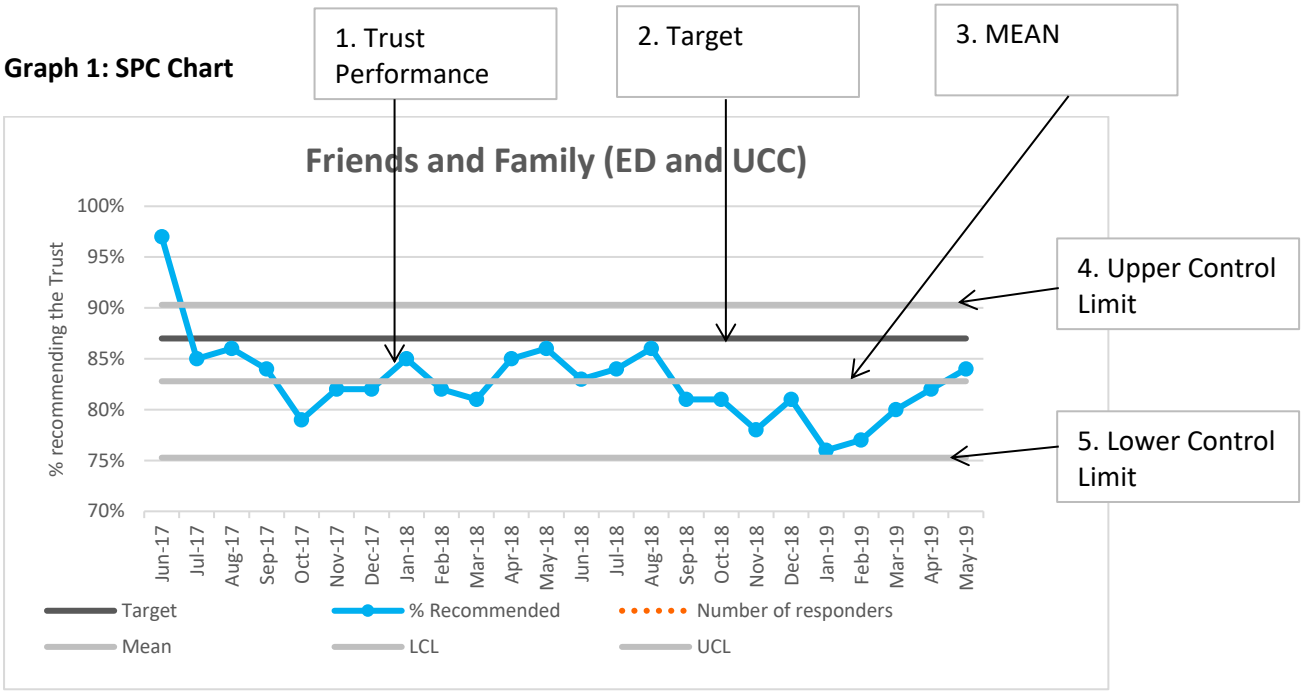
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

SPC Charts

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

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

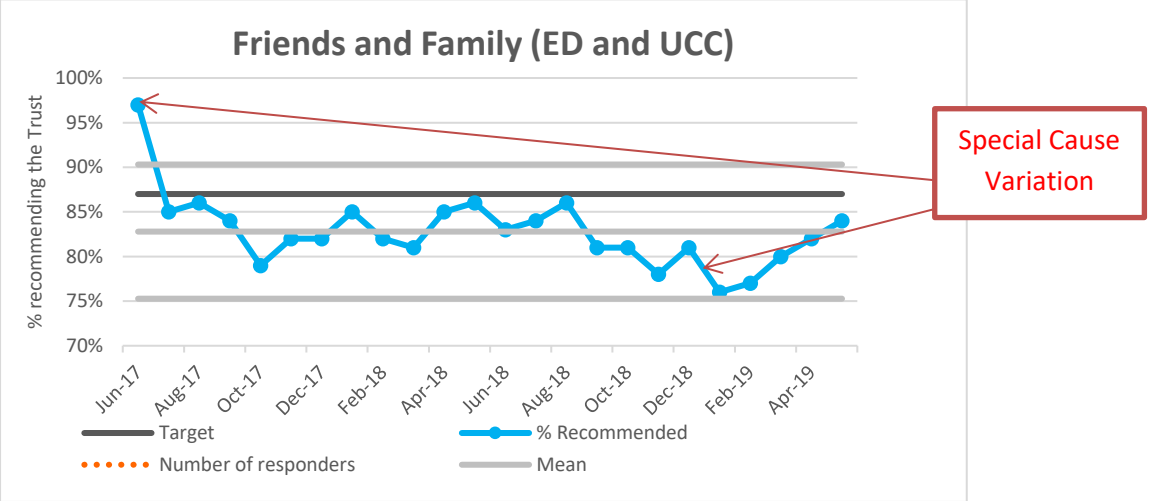
Graph 1: SPC Chart



Interpreting a SPC Chart

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

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



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

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

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

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

Appendix 5

Income Statement, Activity Summary and Use of Resources Ratings as at 30 June 2021

Income Statement	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income						
NHS Clinical Income						
Elective Spells	2,664	2,393	-271	7,386	6,345	-1,041
Elective Excess Bed Days	13	1	-13	37	14	-23
Non Elective Spells	5,886	6,061	175	17,857	17,732	-125
Non Elective Bed Days	179	112	-67	536	396	-140
Non Elective Excess Bed Days	147	71	-76	446	102	-344
Outpatient Attendances	3,400	3,803	402	9,288	9,615	327
Accident & Emergency Attendances	1,392	1,606	214	4,215	4,780	566
Other Activity	5,342	4,955	-387	17,306	18,164	858
COVID Top up Income (Liverpool CCG)	4,905	5,312	407	14,713	15,120	407
Sub total	**23,928**	**24,313**	**385**	**71,784**	**72,268**	**484**
Non NHS Clinical Income						
Private Patients	0	48	48	0	96	96
Non NHS Overseas Patients	3	0	-3	9	6	-3
Other non protected	81	73	-8	242	81	-161
Sub total	**84**	**121**	**37**	**251**	**184**	**-68**
Other Operating Income						
Training & Education	683	718	36	2,048	2,048	0
Donations and Grants	0	0	0	0	0	0
Miscellaneous Income	1,121	1,202	80	3,385	3,523	137
Sub total	**1,804**	**1,920**	**116**	**5,433**	**5,570**	**137**
Total Operating Income	**25,816**	**26,354**	**539**	**77,469**	**78,022**	**553**
Operating Expenses						
Employee Benefit Expenses	-18,565	-18,422	143	-55,905	-56,197	-292
Drugs	-1,242	-1,559	-317	-3,726	-4,458	-732
Clinical Supplies and Services	-1,876	-1,808	68	-5,629	-5,115	513
Non Clinical Supplies	-2,952	-2,914	38	-8,543	-8,792	-249
Depreciation and Amortisation	-914	-914	0	-2,742	-2,742	0
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	**-25,549**	**-25,617**	**-68**	**-76,545**	**-77,305**	**-761**
Operating Surplus / (Deficit)	**267**	**737**	**470**	**924**	**716**	**-208**
Non Operating Income and Expenses						
Profit / (Loss) on disposal of assets	0	4	4	0	10	10
Interest Income	0	0	0	0	0	0
Interest Expenses	0	0	0	0	0	0
PDC Dividends	-447	-469	-22	-1,341	-1,341	0
Total Non Operating Income and Expenses	**-447**	**-465**	**-18**	**-1,341**	**-1,330**	**10**
Surplus / (Deficit) - as per Accounts	**-180**	**272**	**452**	**-417**	**-614**	**-197**
Adjustments to Financial Performance						
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0	0	0
Less Donations & Grants Income	0	0	0	0	0	0
Add Depreciation on Donated & Granted Assets	16	19	3	48	55	7
Total Adjustments to Financial Performance	**16**	**19**	**3**	**48**	**55**	**7**
Adjusted Surplus / (Deficit) as per NHSI Return	**-164**	**291**	**455**	**-369**	**-559**	**-190**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	2,464	2,476	12	6,059	6,711	652
Elective Excess Bed Days	49	0	-49	136	32	-104
Non Elective Spells	3,200	2,563	-637	9,265	7,726	-1,539
Non Elective Bed Days	498	281	-217	1,494	1,103	-391
Non Elective Excess Bed Days	544	0	-544	1,649	380	-1,269
Outpatient Attendances	28,451	33,569	5,118	68,713	96,813	28,100
Accident & Emergency Attendances	9,671	10,965	1,294	29,337	31,762	2,425

Appendix 6 - Capital Plan Analysis as at 30 June 2021

Scheme	£000's	Approval Required	Approval Status
Warrington & Halton Breast Unit Relocation	1,200	Board paper	Submitted/Incomplete
MRI Estates	900	Board paper	Completed
Underspends from 20/21:			
Estates - Various all under £500k	900	CPG paperwork	
IT	100	CPG paperwork	
Medical Equipment - Various all under £500k	900	CPG paperwork	
2021/22			
Contingency - for urgent and emergency schemes through out the year:	1,000		
Modular Build - Carparking, Lighting and Pathways	30	Urgent Capital Requests	Completed
Damper Power Supply Units - Burtonwood Wing	9	Urgent Capital Requests	Submitted/Incomplete
Generator Repair - Halton Nightingale	24	Urgent Capital Requests	Submitted/Incomplete
Halton Air Conditioning - Pathology	8	Urgent Capital Requests	Completed
W&C Nurse Call	25	Urgent Capital Requests	Completed
Room 2 Detector	38	Urgent Capital Requests	Completed
Pharmacy Fridge	6	Urgent Capital Requests	Completed
Non Mandated:			
Shopping City	380	CPG paperwork	Completed
New Town	100	CPG paperwork	Completed
Sub A Statix Fire Protection	50	CPG paperwork	Completed
008 Network Switch Expansion	23	CPG paperwork	Outstanding
Backlog - Flooring Replacement Works	150	CPG paperwork	Completed
Breast Relocation Equipment - this is included in the £2.1m (Scheme 68872 above)	216	CPG paperwork	Outstanding
Other	441	CPG paperwork	Outstanding
SAN*	240	CPG paperwork	Completed
Urology Investigation Unit	870	Board Paper	Outstanding
	2,470		
SUB TOTAL			
Mandated schemes			
Call Alarms for all Anaesthetic & Recovery Rooms Halton Site	90	CPG paperwork	Submitted/Incomplete
IT Staffing	316	CPG paperwork	Completed
Essential power installation - Halton Pharmacy	9	CPG paperwork	Outstanding
Substation B at Warrington Replace 2no. Air Circuit Breakers and 1no. HV Ring Main Unit	-200	CPG paperwork	Outstanding
Electrical Infrastructure	200	CPG paperwork	Submitted/Incomplete
Fire - Relocate and replace medical gas AVSU's to clinical wards	20	CPG paperwork	Outstanding
Backlog - Croft Wing Electrical remedial works following fixed electrical testing of clinical areas	30	CPG paperwork	Outstanding
Backlog - Provide safe surface temperatures of radiators in patient clinical areas	10	CPG paperwork	Outstanding
Backlog - North Lodge Basement Electrical Installation Replacement	225	CPG paperwork	Outstanding
Backlog - Fire install of fire dampers 2nd phase	100	CPG paperwork	Submitted/Incomplete
Backlog - Catering Department remove or replace roof lantern	30	CPG paperwork	Outstanding
Fire - Replacement of obsolete 5000 series fire alarm panels and end of line devices	600	Board Paper	Submitted/Incomplete
Estates Capital Staffing for Design Team Works	177	CPG paperwork	Completed
Fire - Halton 30 minute Fire Compartmentation (Phase 2)	150	CPG paperwork	Outstanding
Appleton Wing Circulation Areas Fire Doors	200	CPG paperwork	Outstanding
Warrington and Halton Gas Meter Replacement	100	CPG paperwork	Outstanding
Backlog - All areas fixed installation wiring testing	100	CPG paperwork	Outstanding
6 Facet survey annual update	55	CPG paperwork	Completed
Backlog - Water Safety Compliance	50	CPG paperwork	Completed
Backlog - Annual Asbestos Management & Remedial	30	CPG paperwork	Completed
Backlog - HV (High Voltage) Maintenance annual	40	CPG paperwork	Completed
CMTC Replacement Emergency Lighting	150	CPG paperwork	Outstanding
SUB TOTAL	**2,700**		
Business Critical			
New Maternity system integration to Lorenzo	132	CPG paperwork	Outstanding
New Maternity system	100	CPG paperwork	Submitted/Incomplete
EPR Tactical Lorenzo 5 Year Extended Service	0	CPG paperwork	Outstanding
Phase 2 Structure - Digital Project Management and Benefits Management resource	0	CPG paperwork	Completed
005 Cisco Refresh (Phase 1)	192	CPG paperwork	Outstanding
006 Comms Cabinets (Phase 2) x 2 (one each site) (Network Cabinets)	90	CPG paperwork	Completed
007 IP Telephony	65	CPG paperwork	Outstanding
012 UPS - Main Server Room at Warrington	190	CPG paperwork	Outstanding
013 Data Warehouse Infrastructure Refresh	85	CPG paperwork	Submitted/Incomplete
014 Device Replacement (Tech Refresh)	55	CPG paperwork	Outstanding
EPMA 1-4	24	CPG paperwork	Completed
Health & Wellbeing Workplace	13	CPG paperwork	Outstanding
Cardiac Catheterisation Suite	800	Board Paper	Submitted/Incomplete
Radiology - Fluoroscopy Room	300	CPG paperwork	Submitted/Incomplete
Phase 2 Structure - Digital Project Management and Benefits Management resource	165	CPG paperwork	Outstanding
Lorenzo Theatres Licences	218	CPG paperwork	Outstanding
Chief Nurse Information Post (Digital Nurse)	31	CPG paperwork	Completed
Electronic Patient Record Procurement	243	CPG paperwork	Completed
Induction Bay	22	CPG paperwork	Outstanding
SUB TOTAL	**2,700**		
PDC Funded**			
Paeds (Children's Outpatients)	700	Board Paper	Submitted/Incomplete
ICU (B18)	1,000	Board Paper	Completed
Specimen Cabinet (Part of ICU (B18))	70	CPG paperwork	Submitted/Incomplete
ED Plaza	5,000	Board Paper	Completed
SUB TOTAL	**6,770**		
TOTAL	**19,640**		

* SAN originally included in the "Other" when capital programme signed off. Highlighted now as separte scheme.

** Guidance has been released around the 2021/22 emergency capital process. All applications need to be submitted by 30 November 2021.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/91 a**			
SUBJECT:	**Safe Staffing Assurance Report – April & May 2021**			
DATE OF MEETING:	28 July 2021			
AUTHOR(S):	Ellis Clarke, Lead Nurse for Nurse Staffing & Workforce Improvement			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.			
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	*		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper details ward staffing data for the months of April & May 2021. 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. Registered Nurse & Midwife sickness absence in the month of April was recorded at 6.14% showing a decrease from the February/March report which was recorded at 6.55%. Sickness data in May details a further decrease to 6.06%. In the month of April, it was noted that 11 of the 21 wards were below the 90% target during the day, with a similar position noted in May with 11 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 April was 7.7 and 8.1 in May, with a year to date rate 7.9. WHH have joined Wigan, Wrightington and Leigh NHS Trust to participate in a regional pilot for recruitment of international nurses. Following a successful business case, WHH have recruited 30 registered nurses to join the Trust between the months of February and April 2021. The Healthcare Assistant recruitment campaign was successful, and WHH reported zero vacancies in April, with a reserve list is available for turnover in the coming months. Due to turn over the HCA vacancy rate rose in May to 11, all of which have recruits in the pipeline.			
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/212/07/55
	Date of meeting	21 July 2021
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Safe Staffing Assurance Report – April & May 2021	AGENDA REF:	BM/21/07/91 a

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report – April & May 2021.

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

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

2. KEY ELEMENTS

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

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

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

Care Hours Per Patient Day

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 April and May 2021 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 April CHPPD was recorded at 7.7 and May recorded at 8.1 with a 2021/22 YTD figure of 7.9. This is in comparison to the national YTD figure of 8.1.

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

Table 1 – CHPPDD Data 2020/21

	Trust wide			
Month	**Cumulative count over the month of patients at 23:59 each day**	**Registered midwives/nurses**	**Care Staff**	**Overall**
Apr-21	13769	4.4	3.3	7.7
May-21	13645	4.6	3.5	8.1
YTD	27414	4.5	3.4	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 11 of the 21 wards in April and 11 out of 21 in May reported staffing levels under the 90% for registered nurses. Staffing is reviewed twice daily by the senior nursing team and staff are moved based on acuity and activity to ensure safe patient care at all times.

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

Maternity (ward C23) was stable at 92% & 91% for both months. Ward C23 use their responsive staffing plans in the unit to move staff to support if acuity requires additional staffing.

Vacancy Summary

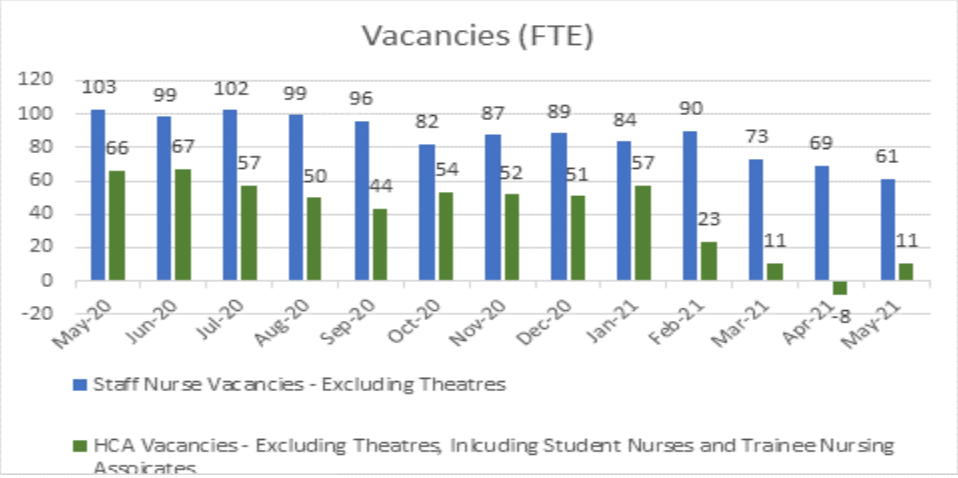
In April 2021 we had 69 registered nurse and zero health care assistant vacancies at WHTH, which requires reliance on temporary staffing to ensure safe staffing levels on the wards. In May using the same reporting method as April, the vacancy levels were 61 registered nurse and 11 health care assistant vacancies.

Recruitment and retention continue to be priorities for the senior nursing team. WHH are working in collaboration with Wigan, Wrightington and Leigh NHS Trust and Mid Cheshire NHS FT for recruitment of international nurses. The partnership includes HEE, recognising the need to address the urgent nursing workforce shortages across the region. This approach has utilised the 'toolkit' commissioned by the Department of Health and Social Care produced by NHS Employers (January 2020). A Task and Finish Group has now been initiated to implement this programme. The Trust has submitted a bid to NHSI/E in order to access funding to support the international nurse recruitment programme. Through the programme 96 international nurses have been recruited who will join the Trust between January and December 2021. See **Appendix Five** for the Progress Tracker

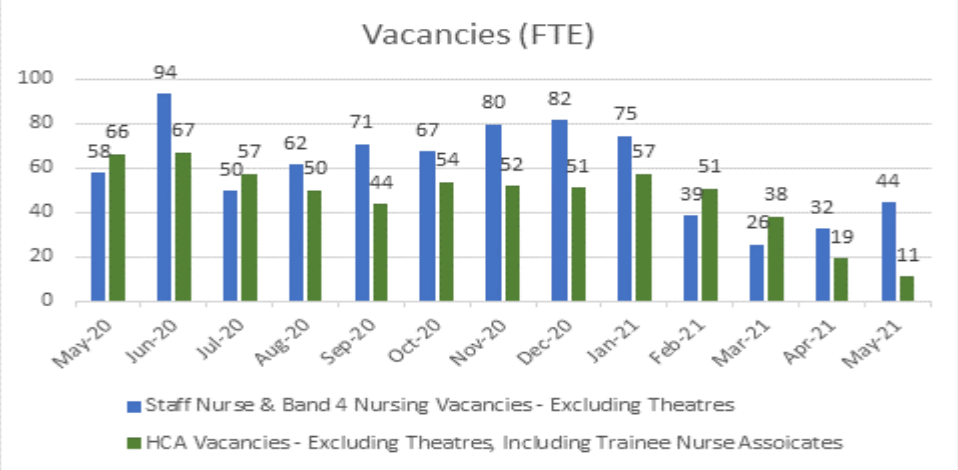
Recruiting to HCA vacancies has previously been a challenge for the Trust. However, the Trust received funding from NHSI to enhance HCA recruitment and pastoral support in the clinical areas. In April 2021 we had zero HCA vacancies following a successful campaign to fill all posts by the end of March 2021. There are 11 vacancies in May, recruitment to these posts is in progress.

Nurse Vacancy Review

The Lead Nurse of Staffing & Workforce Improvement led a recent review of nurse vacancies. This involved an accountant from Finance, HR Rep and a Matron/Lead Nurse from each CBU. There was concern that the number of vacancies that we were reporting was not reflected when it came to place our new recruits. The initial report showed 61 RN and 11 HCA vacancies in May.



During the review a number of wards reporting Band 5 vacancies had employed alternatives (either Registered Nurse Associates or Assistant Practitioners) at Band 4. The resultant over establishment meant that the actual number of vacancies was reduced to 44.



We have a number of RN recruits already placed who set to start in the next 2 months, so that figure on investigation is below 20.

The other key finding of the review was that there are several vacancies being held on wards/departments for staff in interim roles elsewhere. WHH have substantive staff working on wards B3 & K25 that are currently backfilled by temporary staff as detailed below. WHH also have 3 ward managers acting as Matrons, with their post being held as a vacancy in their 'home area'. Substantive staff for K25 have been recruited with more to follow, however the staff working on B3 are leading to vacant posts held elsewhere. We are investigating recruiting substantively into those posts with a plan to move staff into other vacancies as and when B3 closes.

Escalation Beds and Costs

In the months of April & May 2021 B3 has remained open and is currently being managed by the Unplanned Care Group. This area has had staffing support from the displaced staff from ward B1 after it closed in summer 2020. Cost associate with B3 are detailed below in table 2 and 3.

Table 1 – Cost associated with additional beds in April 2021

Apr-21			
No. Bed Days	**Additional Costs £**	**Notional Bed Day Cost £**	**Total Cost £**
638	144,221	0	144,221
638	**144,221**	**0**	**144,221**

Table 1 – Costs associated with additional beds in May 2021

May-21			
No. Bed Days	**Additional Costs £**	**Notional Bed Day Cost £**	**Total Cost £**
730	165,018	0	165,018
730	**165,018**	**0**	**165,018**

A number of additional beds were 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.

Sickness Absence – April & May 2021

During the month of April registered nurse and midwifery absence rates were recorded at 6.14% showing a decrease from the April/May report which was recorded at 5.4%. Sickness data in May details a slight decrease to 6.06%. The cost of bank/agency cover of qualified nursing sickness (at usual bank/agency fill rates) is £245,286 in April and £257,420 for May as detailed in the tables 4 and 5 below;

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

Contracted Nursing WTE (Band 5 to 7)	939.31
% Sickness	6.14%
WTE Equivalent of Sickness	57.67
NHSP Fill Rate	79%
WTE Covered by Temporary Staffing	45.56
Cost at Average NHSP Rates	***245,286***

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

Contracted Nursing WTE (Band 5 to 7)	939.34
% Sickness	6.06%
WTE Equivalent of Sickness	56.92
NHSP Fill Rate	84%
WTE Covered by Temporary Staffing	47.82
Cost at Average NHSP Rates	***257,420***

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

Clinically Extremely Vulnerable Nursing Staff

There are 63 Registered Nurses who have been classed as Clinically Extremely Vulnerable for COVID-19. These staff have to be moved from the higher risk areas at the Trust. HR keep a master record of these staff that is updated daily.

Of the 63: -

- 2 are working normal duties on site
- 17 are working as normal on site in low risk areas
- 5 are working on site with adjusted duties
- 15 are working normal duties from home
- 8 are working adjusted duties from home
- 2 are on Maternity Leave
- 1 has been redeployed to a different area
- 1 is awaiting redeployment

Midwifery Staffing Incidents

Following an increase in staffing related incidents in Maternity the Associate Chief Nurse worked with the team to improve the response. Red Flags specific to the Maternity area have now been introduced. When a Red Flag is raised the Matron will be alerted and will record their response within 1 hour. This is reflective of the process on the general wards. All staff have now been trained in the use of Red Flags and use of the system is expected to increase with time, again this reflects usage on general wards where the change from Datix to Red Flags took some time to embed.

Birth Rate Plus, the recognised Maternity acuity tool, is underway for data collection with the report to follow in July.

Paediatric Nurse Staffing Red Flags

In July the Paediatric wards will join the other wards in utilising the Red Flag system for reporting incidents associated with staffing. Currently issues associated with staffing are recorded on Datix and reported directly to the ward manager and Matron.

Appendix One

Monthly Safe Staffing Data – April 2021																			
		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1725.0	1357.0	1380.0	1436.8	79%	104%	1035.0	1195.9	1035.0	1081.0	116%	104%	968	2.6	2.6	0.1	0.0	7.8
DD	Ward A5 G	1035.0	885.5	1035.0	1125.5	86%	109%	690.0	690.0	1035.0	954.5	100%	92%	588	2.7	3.5	0.3	0.0	5.4
DD	Ward A5 E	690.0	724.5	690.0	430.5	105%	62%	690.0	655.5	690.0	241.5	95%	35%	153	9.0	4.4	0.0	0.0	6.5
MSK	Ward A6	1782.5	1506.5	1782.5	1564.0	85%	88%	1069.5	1058.0	1782.5	1679.0	99%	94%	1007	2.5	3.2	0.0	0.0	13.4
MSK	CMTC	1069.5	1150.0	713.0	966.0	108%	135%	713.0	690.0	713.0	322.0	97%	45%	210	8.8	6.1	0.0	0.0	5.8
W&C	C20	1063.5	995.5	713.9	655.5	94%	92%	713.0	713.0	0.0	0.0	100%	0%	465	3.7	1.4	0.0	0.2	14.9
W&C	Ward C23	1380.0	1265.0	690.0	598.0	92%	87%	690.0	586.5	690.0	644.0	85%	93%	401	4.6	3.1	0.0	0.0	5.3
W&C	Birth Suite	2070.0	1874.5	345.0	299.0	91%	87%	2070.0	1886.0	345.0	276.0	91%	80%	227	16.6	2.5	0.0	0.0	7.7
W&C	The Nest	690.0	586.5	345.0	310.5	85%	90%	690.0	598.0	345.0	299.0	87%	87%	27	43.9	22.6	0.0	0.0	19.1
W&C	Ward B11	2485.0	2219.0	850.0	792.5	89%	93%	1812.8	1800.8	312.0	312.0	99%	100%	324	12.4	3.4	0.8	0.0	66.4
W&C	NNU	1725.0	1261.0	345.0	519.0	73%	150%	1725.0	1092.5	345.0	379.5	63%	110%	358	6.6	2.5	0.0	0.0	16.6
UEC	Ward A1	2250.0	1997.0	2250.0	2495.0	89%	111%	1564.5	1286.9	1251.6	1043.0	82%	83%	1080	3.0	3.3	0.0	0.0	9.1
UEC	Ward A2	1380.0	1269.5	1667.5	1664.0	92%	100%	1035.0	1081.0	931.5	1092.5	104%	117%	900	2.6	3.1	0.0	0.0	6.3
UEC	ED	5250.0	5941.0	2625.0	2200.0	113%	84%	3441.9	4562.9	938.7	1481.1	133%	158%						
MC	ACCU	2415.0	2012.5	1035.0	1035.0	83%	100%	1725.0	1633.0	1035.0	1150.0	95%	111%	790	4.6	2.8	0.0	0.0	5.7
MC	ICU	4830.0	4761.0	1035.0	983.3	99%	95%	4830.0	5002.5	1035.0	908.5	104%	88%	507	19.3	3.7	0.0	0.0	7.4
MC	Ward A7	1725.0	1983.5	1380.0	1816.5	115%	132%	1380.0	1927.0	1035.0	1087.0	140%	105%	974	4.0	3.0	0.0	0.0	23.0
IM&C	Ward C21	1035.0	1058.0	1380.0	1295.5	102%	94%	690.0	690.0	1035.0	1173.0	100%	113%	748	2.3	3.3	0.0	0.0	7.0
IM&C	Ward B14	966.0	1015.0	1840.0	1531.5	105%	83%	690.0	692.0	1380.0	1126.9	100%	82%	720	2.4	3.7	0.0	0.0	5.8
IM&C	Ward B12	966.0	1000.5	2541.5	2064.3	104%	81%	690.0	690.0	1815.5	1667.5	100%	92%	630	2.7	5.9	0.0	0.0	6.1
IM&C	Ward B19	1311.0	1088.5	1725.0	1530.5	83%	89%	966.0	966.0	1380.0	1322.5	100%	96%	792	2.6	3.6	0.0	0.0	8.7
IM&C	Ward A8	1725.0	1379.5	1725.0	1161.5	80%	67%	1380.0	1299.5	1725.0	1184.5	94%	69%	900	3.0	2.6	0.0	0.0	6.2
IM&C	Ward A9	1725.0	1481.5	1725.0	1736.5	86%	101%	1035.0	1069.5	1725.0	1506.5	103%	87%	980	2.6	3.3	0.0	0.0	5.6
	Total	41293.5	38812.5	29818.4	28210.8	94%	95%	31325.7	31866.5	22579.8	20931.46	102%	93%	13749	4.4	3.3	0.0	0.0	6.1
		= above 100%			= above 90%			= above 80%			= below 80%								

Appendix Two

April 2021 - 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)

	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 A4	79%	104%	116%	104%	Vacancy - band 5 2.0wte recruiting international nurses Sickness rate - 8.63% (long term 7.50%) Action taken - All sickness managed as per policy
Ward A5 Gastro	86%	109%	100%	92%	Vacancy - zero Sickness rate - 1.77% Action taken - All sickness managed as per policy
Ward A5 Elective	105%	62%	95%	35%	Vacancy - band2 2.33 wte band 5 0.38 wte band 5 0.48 wte Sickness rate - 4.53% Action taken - All sickness managed as per policy . Green pathway area, so unable to backfill gaps caused by vacancy & sickness at present
Ward A6	85%	88%	99%	94%	Vacancy - band 6 = 1.25 WTE trauma coordinator post awaiting checks, band 5 = 2 WTE remaining with 2 RN commencing May 2021 , band 2 = 1 WTE Sickness rate - 7.14% Action taken - recruitment for vacant posts, sickness abscence policy followed for all staff, occupational health referrals completed and advice sought from HR for complex cases
CMTC	108%	135%	97%	45%	Vacancy - band 5 = 2 WTE with new starters already factored in international nurse commencing May 2021 and NQN commencing September 2021 , band 2 = o vacancies Sickness rate - 4.41% Action taken - recruitment for vacant posts, sickness abscence policy followed for all staff, occupational health referrals completed and advice sought from HR for complex cases
C20	94%	92%	100%	0%	Vacancy - 0 WTE RN, .40 WTE Band 2 Sickness rate - 4.43% Action taken - All sickness managed with policy HR & OH
Ward C23	92%	87%	85%	93%	Vacancy - 37.31% Out to recruitment Sickness rate - 1.57% Action taken - Actions in line with HR/OHWB

Birth Suite	91%	87%	91%	80%	Vacancy - 8.92% Out to recruitment Sickness rate - 6.21% Action taken - Actions in line with HR/OHWB
The Nest	85%	90%	87%	87%	Vacancy - 0% Sickness rate - 0% Action taken - No actions required
Ward B11	89%	93%	99%	100%	Vacancy - Fully established once new starters complete pre-employment checks Sickness rate - Long-term 5.57WTE (1 Band 4 WTE 1.57 Band 5 WTE 3 Band 6 WTE) Maternity leave 3WT (1 Band 2 WTE 1 Band 5 WTE 1 Band 6 WTE Action taken - Managed inline with trust attendance managemnet policy. HDU 8 days
NNU	73%	150%	63%	110%	1 band 8 3 band 6 vacancies. Longterm sickness managed as per policy.
Ward A1	89%	111%	82%	83%	Vacancy - 16.83% (taken from Lion) 1x Band 6 / 0.9 x Band 5/ 1 x Band 7 Nurse Educator Sickness rate - 5.90% Managed in line with policy Action taken - Ongoing recruitment, staffing discussed daily. WM filling shortfalls in staffing. Reliance on agency nurses
Ward A2	92%	100%	104%	117%	Vacancy - 13.96% (taken from Lion) Fully Established at all bands Sickness rate - 4.90% Managed in line with policy. Agency usage reducing Action taken - WM filling any shortfalls in staffing. Staffing discussed daily.
ED	113%	84%	133%	158%	Vacancy - 5.24% (taken from Lion) Band 7 x1/ band 6 x 4.58/ 5 x 6.18/ band 2 x 0.3 Sickness rate - 6.05% Managed inline with policy Action taken - Ongoing recruitment, engaging with NHSP for fill. WM fillling shortfalls in staffing. Use of NHSP
ACCU	83%	100%	95%	111%	Vacancy - 0 Sickness rate - 2.6% Action taken - 2 x International RN's starting May.
ICU	99%	95%	104%	88%	Vacancy - 7.7% allocation of international nurses Sickness rate - 3.8% OH/Wellbeing support Action taken -
Ward A7	115%	132%	140%	105%	Vacancy - 0.21 band 2 vacancy Sickness rate - 2.24% short term, 7.02% long term Action taken - allsickness managed in line with policy. Shifts out to NHSp to cover staff still currently medically suspended due to risk assessment
Ward C21	102%	94%	100%	113%	Vacancy - fully established Sickness rate - short term sickness Action taken - sickness managed as per policy with OH& HR support
Ward B14	105%	83%	100%	82%	Vacancy - no vacancy at band 5 band 2 2.0 wte awaiting start date Sickness rate - 2.77% maternity leave x2 hca's Action taken - CSWD supporting band

					2 vacancy sickness being managed in line with attendance policy
Ward B12	104%	81%	100%	92%	Vacancy - no vacancy at band 5 band 2 awaiting start date Sickness rate - LTS x1 awaiting redeployment x3 Action taken - sickness being managed as per policy with HR staff awaiting redelpoyment in process with HR as to suitable placment
Ward B19	83%	89%	100%	96%	Vacancy - international band 5 starting end of may Sickness rate - LTS AND Short term sickness being managed Action taken - HR/OH support as required
Ward A8	80%	67%	94%	69%	Vacancy - 2.0 wte international nurses in post and x2 awaiting start date Sickness rate - 13% being managed as per policy Action taken - HR/OH support as required
Ward A9	86%	101%	103%	87%	Vacancy - band 5 international x2 to start in May new startergoing through HR process Sickness rate - short term sickness no LTS Action taken - Sickness being managed as per policy CSWD in support recuritment on going
Total Fill Rate (%)	94%	95%	102%	93%	

Key	
	Above 100%
	90-100%
	80-90%
	Below 80%

Appendix three

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Monthly Safe Staffing Data – May 2021

		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1782.5	1477.5	1426.0	1489.3	83%	104%	1426.0	1380.0	1426.0	1449.0	97%	102%	1016	2.8	2.9	0.1	0.0	5.9
DD	Ward A5 G	1069.5	908.5	1069.5	1126.0	85%	105%	713.0	713.0	1069.5	1012.0	100%	95%	608	2.7	3.5	0.2	0.0	6.4
DD	Ward A5 E	1069.5	839.5	690.0	479.5	78%	69%	713.0	713.0	690.0	276.0	100%	40%	233	6.7	3.2	0.0	0.0	9.9
MSK	Ward A6	1782.5	1610.0	1782.5	1656.1	90%	93%	1069.5	1104.0	1782.5	1483.5	103%	83%	1007	2.7	3.1	0.0	0.0	5.8
MSK	CMTC	1069.5	1230.5	713.0	897.0	115%	126%	713.0	713.0	713.0	356.5	100%	50%	210	9.3	6.0	0.0	0.0	15.2
W&C	C20	966.0	958.5	644.0	615.5	99%	96%	713.0	713.0	0.0	161.5	100%	0%	458	3.6	1.7	0.0	0.2	5.5
W&C	Ward C23	1426.0	1242.0	713.0	690.0	87%	97%	713.0	621.0	713.0	655.5	87%	92%	642	2.9	2.1	0.0	0.0	5.0
W&C	Birth Suite	2139.0	1932.0	356.5	276.0	90%	77%	2139.0	2012.5	356.5	322.0	94%	90%	235	16.8	2.5	0.0	0.0	19.3
W&C	The Nest	713.0	644.0	356.5	287.5	90%	81%	713.0	632.5	356.5	322.0	89%	90%	20	63.8	30.5	0.0	0.0	94.3
W&C	Ward B11	2811.0	2509.5	912.5	902.5	89%	99%	1855.2	1843.2	322.4	322.4	99%	100%	312	14.0	3.9	1.3	0.0	19.2
W&C	NNU	1782.5	1277.5	356.5	276.0	72%	77%	1782.5	1161.5	356.5	322.0	65%	90%	215	11.3	2.8	0.0	0.0	14.1
UEC	Ward A1	2314.8	2190.6	2255.0	2229.0	95%	99%	1763.2	1572.0	1010.3	960.5	89%	95%	650	5.8	4.9	0.0	0.0	10.7
UEC	Ward A2	1438.0	1444.0	1608.5	1467.2	100%	91%	1139.4	1033.3	1105.0	1002.0	91%	91%	853	2.9	2.9	0.0	0.0	5.8
UEC	ED	7730.0	6761.0	2575.9	2129.7	87%	83%	5540.6	5164.7	2113.2	1679.0	93%	79%						
MC	ACCU	2495.5	2154.0	1069.5	1104.0	86%	103%	1782.5	1748.0	1069.5	1069.5	98%	100%	825	4.7	2.6	0.0	0.0	7.4
MC	ICU	4991.0	4686.3	1069.5	1040.8	94%	97%	4991.0	4726.5	1069.5	1023.5	95%	96%	500	18.8	4.1	0.0	0.0	23.0
MC	Ward A7	1782.5	1942.5	1426.0	1875.0	109%	131%	1426.0	1844.0	1069.5	1247.0	129%	117%	1026	3.7	3.0	0.0	0.0	6.7
IM&C	Ward C21	1069.5	1054.0	1426.0	1654.5	99%	116%	713.0	713.0	1069.5	1367.5	100%	128%	770	2.3	3.9	0.0	0.0	6.3
IM&C	Ward B14	1069.5	1103.8	1782.5	1612.5	103%	90%	713.0	713.0	1093.5	1368.5	100%	125%	744	2.4	4.0	0.0	0.0	6.5
IM&C	Ward B12	1069.5	1070.0	2725.5	2173.5	100%	80%	713.0	713.0	2012.5	1828.5	100%	91%	651	2.7	6.1	0.1	0.0	9.1
IM&C	Ward B19	1803.5	1098.8	1903.6	1636.8	61%	86%	1104.0	966.0	1512.5	1455.0	88%	96%	602	3.4	5.1	0.0	0.0	8.6
IM&C	Ward A8	1782.5	1575.5	1782.5	1414.5	88%	79%	1426.0	1345.5	1782.5	1150.0	94%	65%	1044	2.8	2.5	0.0	0.0	5.3
IM&C	Ward A9	1782.5	1621.5	1782.5	1853.5	91%	104%	1069.5	1782.5	1656.0	1657.0	167%	100%	1024	3.3	3.4	0.0	0.0	6.8
	Total	45939.83	41331.43	30427	28886.22	90%	95%	34931.35	33928.22	24349.37	22490.32	97%	92%	13645	4.6	3.5	0.1	0.0	8.2
		= above 100%			= above 90%			= above 80%			= below 80%								

Appendix 4

May 2021 - 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)

	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 A4	83%	104%	97%	102%	Vacancy - band 5 2.0wte recruiting international nurses uplift staffing budget agreed international nurses recruited cswd utilised Sickness rate - 11.65% (long term 9.05%%) Action taken - All sickness managed as per policy
Ward A4	83%	104%	97%	102%	Vacancy - band 5 2.0wte recruiting international nurses uplift staffing budget agreed international nurses recruited cswd utilised Sickness rate - 11.65% (long term 9.05%%) Action taken - All sickness managed as per policy
Ward A5 Gastro	85%	105%	100%	95%	Vacancy - nil Sickness rate - 2.97% all sickness manages as per policy Action taken -
Ward A5 Elective	78%	69%	100%	40%	Vacancy - band2 2.33 wte band 5 0.38 wte band 5 0.48 wte Sickness rate - 6% Action taken - All sickness managed as per policy
Ward A6	90%	93%	103%	83%	Vacancy - band 7 = 1 pending retirement out to advert, band 6 trauma coordinator now has start date, band 5 = 0 WTE international nurses commenced May 2021 and NQN commencing September 2021 , band 2 = o vacancies awaiting new starters Sickness rate - 3.95% ST and 5.38 % Lt Action taken - recruitment for vacant posts, sickness abscence policy followed for all staff, occupational health referrals completed and advice sought from HR for complex cases
CMTC	115%	126%	100%	50%	Vacancy - band 5 = 0 WTE NQN commencing September 2021 , band 2 = 0 vacancies Sickness rate - 1.14% ST and 2.58 % Lt Action taken - recruitment for vacant posts, sickness abscence policy followed for all staff, occupational health referrals completed and advice sought from HR for complex cases
Ward C20	99%	96%	100%	0%	Vacancy - 0 Sickness rate - ST 3.53 % LT 4.46 Action taken - Absecence managed with policy/HR and OH guidance

Ward C23	87%	97%	87%	92%	Vacancy - 0.0wte Sickness rate - 7.69% Action taken - Sickness absence managed in line with OH & HR policy
Delivery Suite	90%	77%	94%	90%	Vacancy - 0.0% Sickness rate - 5.3% Action taken - All managed with HR policy
The Nest	90%	81%	89%	90%	Vacancy - 0 Sickness rate - 0 Action taken - No concerns
Ward B11	89%	99%	99%	100%	Vacancy - Fully established once 3 WTE pre-employment checks. Sickness rate - Long term 4 WTE. Maternity Leave 3 WTE. Action taken - Sickness managed in line with trust attendance policy, 4WTE will have resumed by 3rd June. HDU 23 days.
NNU	72%	77%	65%	90%	Vacancy - 1x band 8a, 3x band 6 recruitment plan with CBU Sickness rate - 2 off sick, 2 long term and 2 maternity all full WTE Action taken - following trust policy and guidance
Ward A1	95%	99%	89%	95%	Vacancy - band 5 x 3.72 - new starters by september / band 4 x 5.42 (not actively recruiting) / Band 2 x 1 (CSWd to fill) Sickness rate - 5.93% Managed in line with policy Action taken -Reliance on agency/NHSP due to sickness. WM also filling shortfalls in staffing. Recruited into band 5 positions- fully established by September
Ward A2	100%	91%	91%	91%	Vacancy - Fully established Sickness rate - 11% Managed in line with policy Action taken - Use of NHSP/agency to fill gaps. WM also filling shortfalls in staffing.
	87%	83%	93%	79%	Vacancy - Band 6 x 2 / Band 5 x 9 / Band 2 x 5 - ongoing recruitment new starters awaiting dates for band 6 and 5 Sickness rate - 11.22% Managed in line with sickness Action taken - Ongoing recruitment. Use of agency/NHSP to fill shortfalls
ACCU	86%	103%	98%	100%	Vacancy - Band 6 - 0.87wte, band 5 - 1.52wte. 1.8wte RN mat leave, 1.0wte RN shielding, 2.92wte RN seconded to K25,0.92wte RN Seconded to nurse training, 0.92wte RN LTS. 0.31wte HCA LTS< 2.92wte HCA seconded to K25 Sickness rate - 4.12% managed in line with attendance policy. Action taken - 2.0wte International nurses recently recruited, 0.92wte HCA redeployed temporarily from B12, 1.0wte HCA recruited, awaiting start dates.
ICU	94%	97%	95%	96%	Vacancy - 8.26% starting dates/ names to all vacanies . managed as per policy/support in place Sickness rate - 4.99% Action taken - managed as per policy/support in place
Ward A7	109%	131%	129%	117%	Vacancy - band 2 vacancy 0.42 Sickness rate - band 6 1.0 wte long term sick, band 6 0.92

					maternity, band 2 1.0 wte long term sick, band 2 maternity 0.61 wte, band 2 med suspended 2.53 Action taken - all band 5 vacancy recruited to awaiting start dates, all sickness managed in line with policy, medically suspended awaiting updates re green areas of work available
Ward C21	99%	116%	100%	128%	Vacancy - fuly estblaished band 5 Sickness rate - 7.28% short and long term sickness Action taken - sickness being managed as per policy with OH & HR support CSWD in post to support
Ward B14	103%	90%	100%	125%	Vacancy - fully established band 5 band 2 vacancy 2.84wte start date to be confirmed Sickness rate - 2.77% short term no long term sickness Action taken - CSWD in support for vacancy
Ward B12	100%	80%	100%	91%	Vacancy - .57wte band 5 awaiting start date band 2 1.39wte awaiting start date Sickness rate - 8.78% long & short term sickness Action taken - long term being managed with OH & HR support short term being managed as per policy CSWD in post to support vacancy and looking at recruiting band 4
Ward B19	61%	86%	88%	96%	Vacancy - 0 Sickness rate - 2.77% Action taken - Recruited B5 RNs x 2
Ward A8	88%	79%	94%	65%	Vacancy - fully estblished band 5 &2 Sickness rate - 14.16% short and long term sickness Action taken - being managed as per policy with HR & OH support
Ward A9	91%	104%	167%	100%	Vacancy - band 5 international nurse to start June 2021 3.0 wte vacancy Band 2 x3 maternity leave Sickness rate - 5.47% long term sickness x1 and short term Action taken - Discussions with Hr to progress sickness short term being managed as per policy CSWD in post to support maternity leave
Total Fill Rate (%)	90%	95%	97%	92%	

Key	
	Above 100%
	90-100%
	80-90%
	Below 80%

Warrington and Halton Hospitals International Nurse Recruitment Summary – June 2021

Warrington and Halton Hospitals are part of two International Nurse recruitment collaborations to recruit a total on 96 nurses by October 2021. The collaborations are summarised below, with tables 1 and 2 outlining the progress tracker of arrivals and training updates for both collaboratives.

Wigan Wrightington and Leigh (WWL) – After a successful Business Case and agreement to recruit 30 nurses as part of this collaboration, all these nurses have now arrived in the Trust as of the 6th April 2021. Progress detailed below in table 1 below. WHH were also successful in receiving 47k in NHSI funding to support the recruitment of these 30 nurses.

Cheshire International Recruitment Collaborative (CIRC) – We have two Business Cases in this collaboration; the first is to recruit 36 nurses (cohort 3-6) in the collaboration which was support by 100k of funding from NHSI to establish the Cheshire collaborative. Following the release of further NHSI funding another Business Case was drafted to increase the number with the Cheshire collaboration by another 30 nurses (cohort 1-2). WHH were successful in receiving the additional funding providing the nurses arrive in the UK by the 30th April 2021.

All the nurses arrive at their accommodation at the Crewe University Campus, where they spend the first 2 weeks in quarantine and then commence their OSEC training (in their bubbles). Following the successful completion of their OSEC examination they can apply to be registered with the NMC. We have accommodation available for the nurses on the Halton site for the period that they are undertaking their clinical induction and local rental providers meet with them on day one of the induction to help secure them with accommodation in the Warrington area ready for them joining the ward teams.

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As of Friday, 30th April 2021 the UK Government has put a hold on all international recruitment from India due to the ongoing crisis of the Covid-19 pandemic in that country.

For WHH the effect of this will mean that there is a potential hold on the number of recruitments in Cohorts 3, 4 and 5

Cohort	Date of arrival	Number of recruits from India	Number from other countries
Cohort 3	21stMay 2021	5	7- Zimbabwe/ AUE/ Philippines
Cohort 4	23rd July 2021	6	5 – Philippines / Kuwait / Barbados **1- post to be filled**
Cohort 5	9th September 2021	6	4 – Jamaica / Philippines **2- post to be filled.**

Following a meeting with CIRC on the 4th May the plan is to try and bring forward nurses from the other nationalities, than India, that are in Cohorts 4 and 5, to fill Cohort 3. The Agency and Julie Mitchell will be working towards this. We are waiting on clarification and details from NHSi on the funding implications / support. We had a full day of interviews on the 12th May specifically for theatre staff to fill the gaps identified above and allow for a 10% drop out which has been recommended by the Agency. 9 nurses where interviewed by the theatre team and 3 where successful. We will have to watch the dropout rate due to the situation in India and the fact we have little slippage, but across CIRC there is capacity due to over recruitment.

Table 1 Progress Tracker for International Nurses Wigan Wrightington and Leigh (WWL)

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	Arrival (approx)	OSEC Training	OSEC Exam	Arrival to Trust	Booked in WHH accommodation until…	Notes
WWL Cohort 1	December 2020 - 9 nurses arrived in the UK	Commenced early Dec-20	03/02/2021	05/02/2021	04/03/2021	8 of the 9 successfully completed their OSEC Examination; one resit on the 12/02/2021 candidate was successful. All currently on the wards as of 1st March 2021 • Ward A9 x2 • Ward A8x 2 • Ward A5 x2 – moved to K25 due to skill mix on ward • A&E x2 • ICU x1
WWL Cohort 2	January 2021 -9 nurses arrived in the UK	Commenced early Jan-21	25/02/21 x 3 10/03/21x 1 11/03/21 x 4	15/03/2021	2/4/21	OSEC Examination on different dates due to arrivals and availability. All now out on wards from the 5/4/21 • ICU x 2 • Theatres x 3 • A7 x 1 • Ward A6 x2 2 from theatres moved to ICU at their request.
WWL Cohort 3	February 2021 -12 nurses arriving	Commencing in February/March	20/03/21 x 3 27/03/21 x 2 31/03/12 x 5	06/04/21	30/04/21	1 nurse arrived in the UK 27/4/21 awaiting OSCE date she will join Cohort 1 of MC for induction. On ward 26/4/21

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			09/04/21 x 1			Wards allocated: • A&E x1 • A1 x2 • A2x 2 • ICU x3 …….2 nurse to follow after OCSE • Theatre x 1 • A4 x 1

Table 2 Progress Tracker for International Nurses Cheshire and Merseyside Collaborative (CIRC)

	Arrival (approx)	OSEC Training	OSEC Exam	Arrival to Trust	Booked in WHH accommodation until…	Notes
CIRC Cohort 1	26th February 2021 - 13 nurses arrive in the UK	Commencing 08/03/2021	21/04/2021	24/04/21		100% OSCE pass On Wards W/C 17/05/21 Wards Allocated: • A7 x 2 • A6 x 2 • B19 x2 • B4 Day case Halton x1 • Neonate x 2 • A2 x1 • A3 x1 • A8 x1 • A&E x1
CIRC Cohort 2	26th March 2021 - 17 nurses arrive in the UK	05/04/2021	18/05/21 and 20/05/21	22/05/21		16 nurses passed OSCE first attempt. 1 nurse has re-sit 1/6/21 Ward Allocation:

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						• A9x1 • K25 x2 • A&E x1 • ICU x1 • Theatres x1 • B4 Halton x 2 • CMTC Ward x1 • A4 x1 • Endoscopy x2 • C21 x 2 • B12 x 1
The arrival of Cohort 1 and 2 nurses meet the terms of the NHSI funding (30 nurses in the UK by April 2021) which will secure the 210k funding to support the recruitment of these nurses. Weekly programme Board in place to monitor progress and action any changes during the COVID-19 Pandemic and possible delays.						
CIRC Cohort 3	21st May 2021 -8 nurses arrived in the UK	02/06/2021	13-15/07/2021	19/07/21		8 nurses have arrived in the UK - 4 nurses from India are postponed.
CIRC Cohort 4	23rd July 2021 – 12 + nurses arrive in the UK	02/08/2021	09/09/2021	TBC	23 July x 12	As per comments on page 1
CIRC Cohort 5	10TH September 2021 -12 + nurses arrive in the UK	20/09/2021	01/11/2021	TBC		As per comments on page 1
The arrival of the 36 nurses in cohort 3-5 will take place before the NSHI deadline of arrival (end of Nov 21) – all progress monitored at the weekly CIRC programme Board. 1/6/21 this deadline has been expended to December 31st, 2021 due the Covid situation in India.						

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 21/07/91 b	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	28 July 2021

Date of Meeting	1 June 2021
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/21/06/ 150	**Matters Arising**	QAC/21/05/120 CNST Process for approval of submission – submission approved virtually by QAC following May QAC including requested amendments. Submission approved at Trust Board 26.05.2021. Action closed.	The Committee noted the updates and received good assurance	**Trust Board 25.05.2021**
QAC/21/06/ 152	**Hot Topic - Antimicrobial Point Prevalence Audit**	The Committee received a comprehensive report and overview of main findings of the quarterly audit which reviews all patients in hospital over 1 or 2 days. Key matters highlighted were: - February 2021 - 532 patient records audited, 199 patients prescribed 290 antibiotics. - Consistent compliance since 2015 over 80%, internal compliance minimum target 90%, February 2021 compliance 88.2%, mainly due to not prescribing as formulary and accessibility to digital formulary. Digital solution to be explored. - Key themes for non-compliance included COVID 'side-effect', some inappropriate prescribing and initiation of particular medicines and duration of antibiotics. - Focus on omitted medicines and antibiotic prescribing. - During COVID, expenditure for antibiotics decreased by 44%, reinforcing importance of adherence to formularies.	The Committee noted the updates and received moderate assurance.	**Patient Safety & Clinical Effectivness & QAC (6 months)**

		- It was agreed that the audit would be shared at the Nursing & Midwifery Forum and Operation al Patient Safety Meeting to raise awareness. - It was agreed that in those areas of low compliance, it would be included as a standing item in CBU Governance Meetings		
QAC/21/06/153	**Moving to Outstanding (M2O)**	The Committee received the following update: - Maternity Mock Inspection undertaken by M2O Task and Finish Group. - Focus on M2O agenda, preparation for potential inspections of Maternity Services and ED. - Working with CQC on 'red flag' areas, primarily performance and sickness absence, oversight at Executives and monitoring at M2O Forum. - M2O plan is aligned with the CQC new strategy, will be more challenging to achieve Outstanding for all Trusts. No full inspections to be undertaken unless significant concerns raised by CQC. Expectation that all Maternity Services in England will be inspected within 2 years under umbrella of Ockenden. - WHH dashboard developed, oversight at M2O Group, anticipated only 1 or 2 core services will be inspected	The Committee reviewed and noted the comprehensive report and good assurance provided of monitoring processes in place.	**Trust Board 28.07.2021 QAC 03.08.2021**
QAC/21/06/154	**Deep Dive – Pressure Ulcers April 2020-May 2021.**	The Committee received a high-level summary of outcomes of the Pressure Ulcer (PU) review. Of particular note: - Total number of PUs for 2020-21 = 80 (21% increase.) - 50% increase in PUs reported for Cat3/unstageable for 2020-21 compared to 2019-20. - increase in incidences and mitigations in place include: o standardised training / C&M training programme to be introduced. o Quality Improvement metrics, targeted focus/teaching to support product choice to reduce number of heel PUs (42% of all PUs during the period); focussed work with ED, some PUs (11) likely to be present on admission; o Local audits to address inconsistencies of completion of documentation and share best practice. o Themes identified shared across teams, action plans in place for areas of higher risk, focussed work on A6; individualised improvement plans in place for other high-risk areas, monitored weekly. o To sustain improvement, senior oversight of action plans, measurement	The Committee noted the comprehensive report and elements of good assurance provided through internal monitoring and oversight of action plans with mitigations in place. Monitoring will continue via the IPR and further review by QAC if required.	

		of PU on admission included on Trust IPR, close working with Care Homes to be refocussed and reinforced, shadowing with TV team had commenced.		
QAC/21/06/159	**Maternity Safety Champion Report**	**Maternity Report and Ockenden Review update report** No issues escalated relating to Maternity Safety Champions and Ockenden Review The Committee particularly noted: Continuity of Care progress - 6 mixed risk teams in place in Warrington Community, four geographically based, one Team (River Pass) providing care in both in Halton and Warrington with focus on care for vulnerable families, including MH support, with translator support to inform women how to access support of they have any concerns during their pregnancy. Last mixed risk team launched February 2021, all teams to work closely with Warrington Council, GPs and 0-19 service to improve health inequalities and population health. - 77.9% March 2021, WHH women booked onto CoC pathway, 100% women living in Warrington on CoC pathway to date, positive feedback received from patients and staff. - Service to be reviewed for non-Warrington & Halton women not in WHH footprint. Saving Babies Lives (SBL) - Overview provided of the SBL which looks at risk factors for still-birth, neo-natal mortality, including pregnancies in the community to reduce variance. SBL elements (1) reduced smoking (CO2), (2) surveillance of fetal growth restriction; (3) reduced fetal movements; (4) fetal monitoring in labour, fifth element had been added reducing preterm birth. - Compliance across all Elements, compliance for Element 4 achieved 28 May 2021. - Improvements reported in a number of elements including CO2 monitoring, screening tool for early detection of fetal growth restriction, CTG competency and risk assessments for fetal monitoring during labour; focus on prediction, prevention and preparation in reduction of pre-term birth.	The Committee noted the updates and received good assurance.	**QAC 01.06.2021 Trust Board 28.07.2021**

		Maternity Monthly SI Report High level summary of Maternity Serious Incidents (SIs) was noted and the format will be reviewed for future meetings.		
QAC/21/06/ 156	**Quality Account 2020-21**	The Committee reviewed the Quality Account 2020-2021 and approved for submission to NHSE/I.		
QAC/21/06/ 157	**Quality Strategy 2021-2024**	The Committee approved the Quality Strategy in principle in advance of the proposed amendments. Amended Quality Strategy to be circulated to Trust Board for virtual ratification prior to national submission on 30 June and presented to July 2021 for formal ratification.		**Trust Board 28.07.2021**

The Committee received and noted the following
- Advanced Clinical Practice Strategy
- Medicines Management and Controlled Drugs Annual Report

The Committee received the High Level Briefing Reports from the following Sub Committees:
- Patient Safety and Clinical Effectiveness Sub Committee
- Safeguarding Sub Committee
- Complaints Quality Assurance Group
- Patient Experience Sub Committee
- Equality, Diversity & Inclusion Sub Committee

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 21/07/91 b	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	28 July 2021

Date of Meeting	6 July 2021
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Cliff Richards
Was the meeting quorate?	Meeting was cancelled due to operational pressures

The meeting was cancelled due to significant operational pressures. Subsequently, the follow Chair's actions were taken:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/21/07/ 177	**Strategic Risk Register & BAF**	All actions proposed in the report (detailed below) were supported via Chair's actions: • Escalation of three risks; • Reduce rating of three risks; • Amend the descriptions of two risks; • De-escalate three risks		**Trust Board 28.07.2021**
QAC/21/07/ 178	**Committee Chair's Annual Report to Board**	The Quality Assurance Committee Chair's Annual Report was approved via Chair's actions.		**Trust Board 28.07.2021**
QAC/21/07/ 179	**IPR Changes – Quality Indicators**	Proposed changes to the Trust IPR were approved by Chair's actions. The proposed new indicators outlined the Trust's performance in relation to Freedom of Information Requests (FOIs) and Trust ward moves/transfers between 10:00pm and 06:00am. There were also proposals of updates to sepsis indicators and pressure ulcers to provide clarity in relation to the Trust's performance against these standards.		

QAC/21/07/ 180a	**Nursing and Midwifery Strategy 2021-2024**	The Nursing and Midwifery Strategy 2021-2024 was approved by Chair's actions and will be shared with the Trust Board		**Trust Board 28.07.2021**
QAC/21/07/ 180	**Equality Diversity & Inclusion Committee Structure Review - Proposal**	Proposed changes to the Equality Diversity & Inclusion Committee Structure were approved by Chair's actions. The changes separate the Workforce and Patient work strands into two Sub Committees. The Workforce EDI Sub Committee will report to the Strategic People Committee and provide a Workforce High Level Briefing Report for assurance, and the Patient EDI Sub Committee will report directly to the Quality Assurance Committee.		**QAC 03.08.2021**
QAC/21/07/ 193	**Health and Safety Annual Report**	The Health & Safety Annual Report was approved via Chair's actions and will be shared with the Trust Board		**Trust Board 28.07.2021**
QAC/21/07/ 196	**Safeguarding Annual Report**	The Safeguarding Annual Report was approved via Chair's actions and will be shared with the Trust Board		**Trust Board 28.07.2021**

Items deferred to August meeting:

- Hot topic – Delirium
- Deep Dive – Sepsis
- High Level Briefing: IG & Corporate Records: 08.06.2021 and Data Security and Protection Deep Dive
- Health and Safety Benchmarking Exercise.
- Report against the Health and Safety Executive COVID-19 Spot Check Inspection Programme Findings
- Annual Review of the Patient Experience Strategy (2020-2023).

High Level Briefings deferred to August meeting:

- Patient Safety & Clinical Effectiveness Sub Committee: 29.06.2021
- Risk Review Group: 07.06.2021
- Infection Control Sub Committee: 17.06.2021
- Quality Academy Board: 15.06.2021
- Equality, Diversity and Inclusion Sub Committee: 11.06.2021

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/21/07/91		TRUST BOARD OF DIRECTORS	DATE OF MEETING	28 July 2021

Date of Meeting	21 July 2021
Name of Meeting + Chair	Strategic People Committee
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
SPC/21/07/39	**Matters Arising:**	**On-Call Harmonisation,** **Chief People Officer** On-Call Harmonisation to be reviewed at SPC meetings until such time as the work programme can be restarted **Moving to Outstanding** **Chief People Officer** Framework for 'People' elements of M2O action plan to be reported to future SPC meetings. **Local Induction for Temporary Medical Staff,** **Deputy Chief People Officer**	**Assurance** **On-Call Harmonisation** On-Call Harmonisation report provided an overview of the on-call harmonisation status and intended timescale to restart and resolve on-call harmonisation. The Committee approved the suggested timescales **Assurance** **Moving to Outstanding** M2O meeting has continued since 22/07/2020. Well Led Subgroup has been incorporated into the M2O meeting. **Assurance**	Complete Complete

		Query on the period of time a completed local induction lasts before expiry. **Overview of Staff Networks** **Chief People Officer** Overview of the work undertaken and progress of Networks	**Local Induction for Temporary Medical Staff,** Update provided about the current processes, SPC interested to see if compliance has increased – report on the agenda **Decision** **Overview of Staff Networks** Presentation going to Board in July 2021, further update to SPC requested in Jan 2022	Complete Complete
SPC/21/07/40	**Terms of Reference**	**SPC Terms of Reference Update** **Deputy Chief People Officer** SPC Terms of Reference updated to include the addition of COVID-19 Workforce Recovery Sub Group and amendment to ED&I Sub Committee, to Workforce ED&I Sub Committee.	**Decision** **SPC Terms of Reference** Changes to terms of reference noted and approved	Complete
SPC/21/07/41	**BAF & Risk Register – Workforce**	**BAF & Risk Register – Workforce** **Trust Secretary** Update of the Trust BAF & Risk Register for those relating to the workforce	**Assurance** **BAF & Risk Register** • **1124**, Provision of PPE, risk reduced from 15 to 10 • **1207**, Workplace Risk Assessments – suggested a review of the risk rating given all the support/guidance provided • **1134**, Provide adequate staffing caused by absence relating to COVID-19 – SPC noted the update	
SPC/21/07/42	**Committee Structure Review**	**ED&I Committee Structure Review** **Chief People Officer** The EDI Sub Committee priorities has driven an extensive work programme and following a review of the committee performance in June 2021 there has been a proposal to separate the Workforce and Patient work strands.	**Decision** **ED&I Committee Structure Review** SPC approved the separation of the Workforce and Patient work strands into 2 Sub Committees. The Workforce EDI Sub Committee will report to the Strategic People Committee and provide a Workforce High Level Briefing Report for assurance; and the Patient EDI Sub Committee will report directly to the Quality Assurance Committee. SPC requested a review in 6 months.	

				Jan-22
SPC/21/07/43 & 44	**Workforce Race Equality Standards (WRES) & Workforce Disability Equality Standards (WDES)**	**WRES and WDES** **Chief People Officer** The Trusts approach to the timely submission and production of the WRES and WDES was outlined to the committee.	**Decision** **WRES and WDES** Approach for WRES and WDES outlined to the committee and approved. The Trust's WDES/WRSE data is to be submitted to the national central government portal by 31st August 2021. An action plan is required to be uploaded to the Trust's website by 31st October 2021. The Trust's WDES and WRES data and action plan will be reported to SPC in September 2021 for approval.	Sept-21
SPC/21/07/45	**Facilities Time Off Annual Report**	**Facilities Time Off Annual Report,** **Chief People Officer** The Committee received a paper on Facilities Time Off, requesting SPC to approve the content, in time for submission by Sept-21.	**Decision** **Facilities Time Off Annual Report** As expected, following the previous 12 months facilities time has reduced. SPC noted the content and approved for publishing.	Complete
SPC/21/07/46	**Chief People Officer Report**	**Chief People Officer Report,** **Chief People Officer** The Chief People Officer updated the Committee on: • National Quarterly Pulse Survey (NQPS) • COVID-19 Workforce Risk Assessments • Clinically Extremely Vulnerable (CEV) Deep Dive • NHS Severance Payments • The Brathay Trust • Mandatory Training Update	**Assurance** **The National Quarterly Pulse Survey (NQPS)** replaces the Friends and Family Test and will be run 3 times a year, initial results due Aug-21 to be reported to SPC. **Assurance** **COVID-19 Workforce Risk Assessments** update and progress noted **Assurance**	Sept-21

			Clinically Extremely Vulnerable (CEV) deep dive outlined the good processes and systems in place, highlighted the costs associated with backfilling our CEV staff **Assurance** **NHS Severance Payments** update outlined the reversal of the severance payments £95k cap. To note the Trust has not made any severance payments whilst the cap was in place. **Assurance** **The Brathay Trust** is a staff offer from a psychological and wellbeing perspective, SPC were updated about the offer and target audience. **Decision & Assurance** **Mandatory Training Update** – reporting on Safeguarding Adults Levels (SGA) 1 to 3 suggested to be separated out from the overall CSFT compliance. SPC discussed the rationale for this decision, and due to the 3-year lead in time to complete SGA training, including it in the overall CSFT compliance, masks the overall compliance figures and separation also enables reporting to be developed against an agreed trajectory (to be agreed). Supported by SPC, requires approval at the Safeguarding Committee and Quality Assurance Committee. A further report requested at Sept-21 SPC, with reference to the proposed changes made on the IPR. SPC received reassurance plans in place for SGA Face to Face training, given the low compliance.	Sept-21
SPC/21/07/47	**WHH GMC National Trainee Survey Results 2020**	**Update on WHH GMC National Trainee Survey Results 2020** **Executive Medical Director**	**Assurance** 2020 NTS was undertaken during the COVID-19 pandemic and a total of 80 postgraduate medical trainees from	

		Update on WHH GMC National Trainee Survey Results 2020, National Trainee Survey Submission 2021 and the Trust GMC Refresh Reporting June 2021. In addition, acknowledgement of impact of COVID-19 pandemic and the response to support trainees.	WHHFT completed the survey which equates to a response rate of 42.1%. WHHFT results can be summarised as: • Positive trends in Foundation, GP and Medicine programmes. • Positive trends in Emergency Medicine and Pediatrics posts. • Results for Anesthetics and O&G suggest review of support and supervision of trainees • Many trainee groups reported feeling exhausted by the thought of the day ahead, although not as many reported feelings of tiredness by the end of the day. • Emergency Medicine and O&G did not perceive a culture of proactively reporting concerns. • Other specialties gave scores nearer the national average for a culture of proactively reporting concerns. The GMC NTS for 2021 closed on 15th May 2021 with much improved trainee response rates of 97.5% (159/163 trainees completed). Feedback is awaited. GMC NTS (2021) survey results to be summarised at Sept-21	Sept-21
SPC/21/07/51	**Local Induction Temporary Medical Staff**	**Local Induction Temporary Medical Staff – compliance progress report** **Executive Medical Director**	**Assurance** Content of the paper noted, demonstrating a clear methodology about the Trusts approach to Medical Locum Local Induction, which includes: • Local Induction form now only available electronically, and available on various devices	

			• Compliance dashboard available for all managers, updated on a weekly basis SPC recognised work to be done on improving compliance and therefore compliance report to return in Nov-21	Nov-21
SPC/21/07/57	**Guardian of Safeworking Q4 Report**	**Guardian of Safeworking Q4 Report** **Executive Medical Director**	**Assurance** The report summarised the monitoring of the safe implementation of the 2016 Junior Dr Contract. Issues regarding safe working hours, rota problems, educational or patient safety issues are recorded by Junior Doctors in the form of Exception Reporting via the Allocate System, which are then escalated to their responsible Educational Supervisors and monitored by the GSW. During Quarter 4 2020-21, 51 Exception Reports (ERs) were submitted – this represents a 50% rise since Q3, and approaches the average numbers seen pre-COVID. Over 90% of ERs relate to excess hours worked. • Continually monitored by SPC.	Sept-22

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/20/07/91 d i		TRUST BOARD OF DIRECTORS	DATE OF MEETING	28 July 2021

Date of Meeting	**23 June 2021**
Name of Meeting + Chair	**Finance and Sustainability Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
	May Meeting	The Committee noted the items reviewed in May when the Committee was cancelled. These items included MIAA recommendations, Capital, Performance and the MRI Capital Business case was supported to be presented at Board	The Committee **noted** the update	Board June 2021
	Matters arising - EPR	EPR negotiations relating to the Lorenzo contract are ongoing and the Trust awaits a further offer	The Committee **noted** the updates	FSC July 2021
FSC/21/06/85	Corporate Performance Report	The Committee considered and reviewed the report noting:- • 79.06% May A&E performance which is an improvement but below target. Increased attendance continues across Acute Trusts • RTT achieved 75.74% against the 92% standard. Previous month 72.32% • There were 1196 52-week breaches recorded - this number is well below the May trajectory of May 1765. • The diagnostic target was not achieved in May 2021 and the number of patients waiting increased which relates to the impact	The Committee **noted** the updates and received moderate assurance.	FSC July 2021

		of the COVID-19 pandemic. However, the number of breaches decreased by 603 again in May 21.		
FSC/21/06/86	Pay Assurance Report	The Committee considered and reviewed the report noting: - • HCA reviewing recruitment and vacancies • Clinically Extremely Vulnerable – some staff need to continue to work non-clinically or in green pathways. Currently 134 CEV staff with the majority either working from home (60) or on site (58) • Medical Bank rate card review to reduce flexibility is being undertaken to go to Medical cabinet before Executive Meeting • Off framework agency reduced usage with increased governance and sign off • NHSE/I – asked all NW to sign up to data sharing agreement • International nurse recruitment 59 with us and 39 in the substantive numbers • Extra duty payments review on target except for two areas, the rate card and the associated policy.	The Committee **noted** the update	FSC July 2021
FSC/21/06/87	COVID-19	The Committee noted the COVID-19 update, noting:- • The position for March, April and May • Current spend in year is £0.7m greater than budget due mostly to the impact of CEV staff • If ward B3 is not closed as planned on 2 July this will cause further pressures	The Committee **noted** the update	FSC July 2021
FSC/21/06/88	Indicative Financial Cost of Harm Annual Update Report	The Committee received and noted the annual report. The report includes the indicative financial cost to the Trust only. • This paper looks at the following areas where an indicative financial cost of harm can be calculated, these are: ○ Inpatient Falls ○ Healthcare Acquired Infections (MRSA, CDI, Ecoli) ○ Pressure Ulcers	The Committee **noted** the update to be presented to Board on 30 June 2021	Board June 2021

		• The total Indicative Financial Cost of Harm for 2020/21 was between £1.2m - £1.6m which is a comparable with 2019/20 indicative costs of between £1.3m - £1.6m.		
FSC/21/06/89	Additional Oversight of Capital	The Committee considered and reviewed the presentation noting: - • Current underspends against budget • Concerns for timelines for ED Plaza raised	The Committee **noted** the update	FSC July 2021
FSC/21/06/90	Costing Update	The Committee noted the update regarding national cost collection, Patient Level information Costing system and next steps for the Costing Steering Group	The Committee **noted** the update	FSC October 2021
FSC/21/06/91	Business Case Benefits realisation	The Committee considered and reviewed the report noting: - • Overdue reviews of the benefits from investment • The presentation given to the Executive Team and the ongoing review	The Committee **noted** the update	FSC July 2021
FSC/21/06/92	Business Case Progress Update	The Committee reviewed the paper noting: - • The schemes approved at budget setting and the progress on the production and approval of the detailed business cases for the scheme	The Committee **noted** the update	FSC July 2021
FSC/21/06/93	MIAA – Estates Capital	The Committee received an update on the MIAA recommendations from the capital estates review	The Committee **noted** the update	FSC July 2021
FSC/21/06/94	Medical Establishment	The Committee considered and reviewed the report noting: - • The work undertaken so far • The detailed information for each CBU • A further presentation will be considered by the Executive Team and then FSC in July, which will pull together all findings, conclusions and next steps The Committee thanked the team for the comprehensive update	The Committee **noted** the update	FSC and Board July 2021

FSC/21/06/95	Digital Services Board Report	The Committee considered and reviewed the report noting: - • Comprehensive report for May and June including assurance ratings • EPR procurement and Outline Business Case (OBC). Originally the programme was Paper to Electronic Patient Record (EPR) in 2015 now it is EPR to EPCMS (Electronic Patient Care Management System)	The Committee **noted** the update	FSC July 2021
FSC/21/06/96	Annual FSC Committee Effectiveness Outcomes	The Committee reviewed the responses noting a slight movement from strongly agree to agree.	The Committee **noted** the outcomes	FSC May 21
FSC/21/06/97	Capital Business Cases	The Committee considered the 2 capital business cases • Fire alarm replacement • B18 second year costs	The Committee **suppported** the Business cases for presenting at Board	Board June 21
FSC/21/06/98	Monthly Finance report incl: a) April 2021 and May 2021 b) Draft Capital Planning Group minutes (30.04.2021) c) CPG Terms of Reference d) FRG minutes (19.04.2021) e) CIP Target 2021-2022	The Committee considered the report and capital proposals. Key points to note included: • C&M £6.9m deficit at 31/5/21 mostly in CCGs with Providers £0.5m deficit. • WHH £0.6m worse than plan which would have increased to £1.2m without offset from under spends • Pay and productivity and use of WLI. Assurance needed to ensure the Trust is fully utilising job plans and sessions before WLI working • Capital delivered was £0.5m expenditure year to date, which was £1.5m below budget. A detailed forecast month by month has been requested for committee oversight. • Note emergency capital approvals • Changes to the capital programme highlighted for support to take to Board for Approval	The Committee **noted** the updates and received good assurance The Committee **supported** the changes to the capital plan to be presented to Board for approval and **noted** the emergency capital approvals The Committee **supported** the	FSC July 21 Trust Board June 21

		• Highlighting emergingnon pay pressures including drugs, which are subject to a review and will be reported in the next FSC meeting • CIP will be back on the FSC agenda from July, paper appended in this report, noted increase to the CIP to £4.8m anticipating increased requirement in H2 • Risks noted including B3 closure, ERF and achieving targets and gateways • The run rate will be a key focus for NHSE/I	increase in the CIP target	
FSC/21/06/99	Risk Register including	The Committee considered the Risk Register noting the following:- • Suggestion to increase the rating of risk 1372 EPR and add to the BAF • Proposal to close risk 1205 continuity care information • Corporate risk register 1132 Pandemic fraud covered by Fraud • Risk 1127 digital services reduced to a score of 8	The Committee **supported** the updates	FSC July 2021
FSC/21/06/100	Committee Chairs Annual Report to Board	The Committee considered the Committee Chairs Annual Report which was noted and will be presented to the Board	The Committee **noted** the report to be presented to Board on 30 June 2021	Board June 2021

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/20/xx/xx		TRUST BOARD OF DIRECTORS	DATE OF MEETING	21 July 2021

Date of Meeting	**21 July 2021**
Name of Meeting + Chair	**Finance and Sustainability Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
FSC/21/07/107	Corporate Performance Report	The Committee considered and reviewed the report noting:- • 79.5% June A&E performance which is an improvement but below target. Increased attendance continues across Acute Trusts nationally • Staffing issues and increased activity are a huge pressure currently • Working with the system pressure to alleviate the pressures • The 62 day cancer target was not achieved in June 2021 • DNA face to face is increasing	The Committee **noted** the updates and received moderate assurance.	FSC August 2021

FSC/21/07/108	Pay Assurance Report	The Committee considered and reviewed the report noting: - • Ongoing analysis on clinical support staff agency usage K25, skill mix review and turnover • Cost of shielding 26 WTE have come back and deployed at CEV in different roles • Medical bank rate card issue not complete due to an issue at medical cabinet relating to rates for WLIs • Cheshire and Mersey average rates have not been updated to reflect cost of living. This has been reviewed for consideration • International nurse recruitment continues with placement into the organisation	The Committee **noted** the update	FSC August 2021
FSC/21/07/109	ED Nursing Business Case	The Committee considered and reviewed the business case noting:- • The additional staffing areas increased capacity. • Budget has been ringfenced in budget setting and the paper if supported will go to Board for approval • No additional staffing costs will be required with the new ED Plaza	The Committee **supported** the Business case to be presented to Board for approval	Board July 2021
FSC/21/07/110	COVID-19	The Committee noted the COVID-19 update, noting:- • The position for Quarter 1 • Year to date expenditure is £2.45m which is £1m more than budget due mostly to the impact of isolating staff • Schemes due to be switched off 30 June 2021 are confirmed as stopped	The Committee **noted** the update	FSC August 2021
FSC/21/07/111	Additional Oversight of Capital	The Committee considered and reviewed the presentation noting: - • Current underspends against budget • Concerns for timelines for ED Plaza raised • MIAA Estates Capital recommendations complete • Considered capital changes (also in finance report)	The Committee **noted** the update and **escalate** the risk of timescales for ED Plaza	FSC August 2021
FSC/21/07/112	Business Case Benefits realisation	The Committee considered and reviewed the report noting: - • Overdue reviews of benefits realisation	The Committee **noted** the update	FSC August 2021

	and business case update	• Progress with outstanding business cases		
FSC/21/07/113	Digital Services Board Report	The Committee considered and reviewed the report noting: - • Comprehensive report from meeting on 12 July including assurance ratings • Discussed the items of limited assurance • Moderate assurance items reviewed • EPR costings for the contract have reduced on the assumption national funding is available for elements and VAT is reclaimable • Query relating to an issue in relation to the Ormis contract status. More information has been sought in this regard.	The Committee **noted** the update	FSC August 2021
FSC/21/07/114	Medical Establishment	The Committee considered and reviewed the presentation: - • 2019/20 The medical staffing budget pressure of £4.8m was presented and detailed by CBU • Noted it is important to know which residual pressures have been funded through budget setting and pressures that have not which would require business cases – this will need to be clarified for Board • Highlighted the funding already received for the 2019/20 & 2020/21 pressures • Noted why cost pressures exist • Noted opportunities to reduce cost pressures and improve productivity • Board to discuss the governance arrangements I relation to the actions and next steps • The information to decide on any investment is not in scope of this review	The Committee **noted** the update and supported to progress to Board	Board July 2021
FSC/21/07/115	Monthly Finance report incl: a) June 2021 b) Draft Capital Planning Group	The Committee considered the report and capital proposals. Key points to note included: • Deficit of £0.6m at end of June £0.2m worse than plan • Overspending on COVID offset by slippage on investment • Change to the thresholds for ERF funding from 85% to 95% and reduction in tariff payment from 120% to 100%	The Committee **noted** the updates and received good assurance The Committee **supported** the	FSC August 21

	minutes (25.06.2021) c) CPG Terms of Reference d) FRG minutes (19.05.2021)	• WHH is reliant on ERF funding to breakeven • Best, most likely, worse case for Trust submitted to C&MHCP, with forecast 'likely' remaining at break even • WLIs assurances will be sought from MIAA review • Capital noted and supported all items • CIP increased from £2.6m to £4.8m, £1.5m identified in year and £2m recurrently • CPG Terms of reference approved • Noted CPG and FRG minutes • ED Plaza Capital and EPR risks to be escalated to Board	changes to the capital plan to be presented to Board for approval and **noted** the emergency capital approvals and approved the updated CPG terms of reference The Committee **supported** the WLI MIAA Review	
FSC/21/07/116	EPR	The Committee considered the report noting:- • The affordability • Cash releasing benefits • Overview of the options • Support of accounting treatments from NHSE/I • Next step need support from Health and Care Partnership before procurement stage • Require assurance no risk of double counts with medical establishment review	The Committee **reviewed** and **supported** the report to be presented to Board for approval to go to procurement exercise stage	Board July 2021
FSC/21/07/117	Risk Register including	The Committee considered the Risk Register noting the following:- • Suggestion to increase the rating of risk 1372 EPR and add to the BAF • Proposal to close risk 1205 continuity care information • Corporate risk register 1132 Pandemic fraud covered by Fraud • Risk 1127 digital services reduced to a score of 8	The Committee **supported** the updates	FSC August 2021
FSC/21/07/118	Deloitte Report	The Committee considered the final report from the COVID expenditure review	The Committee **noted** the report	

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/07/91 (e) i		TRUST BOARD OF DIRECTORS	DATE OF MEETING	28th July 2021

Date of Meeting	**22nd May 2021**
Name of Meeting + Chair	**Clinical Recovery Oversight Committee (CROC) 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
CROC/21/05/41	Harm Profile update	• Overall following last week's meeting there has been a further reduction of 102 reviews completed, therefore an overall reduction of 906 reviews completed since 7th April 2021 (Figure 1). • 635 harm reviews have been completed an increase of 116 since last week. 271 of the 906 were patients already treated or with a TCI in next couple of weeks • No new harms identified in the 116 completed this week. • Focussed governance review continues for T&O and Urology trajectories continue to be monitored (Figure 5 and 6) • Additional validation support has now been identified to assist with the work and due to start on the 25th May 2021 with appropriate kit in place	The Committee **noted** the report.	CROC June 2021
CROC/21/05/02	Waiting List update	• The Trust received planning guidance relating to the response to the Covid-19 pandemic in March 2021 • The Trust received planning guidance relating to the response to the Covid-19 pandemic in March 2021	The Committee **noted** the report.	CROC June 2021

		• At the end of April 2021, the 52-week trajectory was met against the agreed trajectory. The number of breeches recorded was 1364 against a trajectory of 1806 • The Trust is not achieving the 18-week Referral to Treatment standard however we have agreed a trajectory for recovery and achieved 72% against a trajectory of 70.74% at the end of April 2021 • As of the 21st May Warrington and Halton (WHH) have a total 533 patients with a P2 code assigned to them and a trajectory for clearance of the backlog by the end of August 2021 • The May trajectory is on track for delivery currently at 533 against a trajectory of 476. VMD advised that the P2 backlog was down as at today to 240 against its May trajectory of 215. • Diagnostics – Clinical the diagnostic target was not achieved in April 2021 and the number of patients waiting increased which relates to the impact of the COVID-19 pandemic. However, the number of breeches has seen a slight increase by +47 again in April 21 • Outpatients - The guidance suggests that providers should deliver 100% of last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from May 2021. The trust as of the w/e 16th May is currently achieving 83% for NP and 93% for FU against a trajectory of 100%		
CROC/21/05/44	Recovery Completion Forecast Weekly C&M Activity Recovery Summary	• For assurance Presentation & Briefing Document • P2 pack for information but should note the risk of not comparing like with like in other Trusts. • DM reported that the Trust was on track at circa 90% which will achieve the restoration trajectory by the end of May 2021. • The stand	The Committee **noted** the update	CROC June 2021

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/07/91 (e) ii		TRUST BOARD OF DIRECTORS	DATE OF MEETING	28th July 2021

Date of Meeting	**8th June 2021**
Name of Meeting + Chair	**Clinical Recovery Oversight Committee (CROC) 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
CROC/21/06 /52	Harm Profile update	• Overall, there has been a further reduction of 66 reviews completed, therefore an overall reduction of 1080 reviews completed since 7th April 2021 (Figure 1). • 762 harm reviews have been completed an increase of 127 since last week. 318 of the 1080 were patients already treated or with a TCI in next couple of weeks. • No new harms identified. • Focussed governance review continues for T&O and Urology trajectories continue to be monitored (Figure 5 and 6). • A new trajectory has been developed for Max Fax (Figure 7). • Plan is to complete the work by the end of July 2021.	The Committee **noted** the report.	CROC June 2021
CROC/21/06 /53	Waiting List update	• Patients in the 104+ day's category; There are 9 against a trajectory of 30 (-21 under)	The Committee **noted** the report.	CROC June 2021

		• Patients in the 62+ day's category; 69 against a trajectory of 96 (-27 under). No harm has been identified in these cancer patients. • The trajectory has changed slightly at the request of the Cancer Alliance to reduce numbers to 55 by September 2021. • It was noted that an Outpatient Improvement Group has been set up by Hilary Stennings, Acting Director of Operations and Performance and Mark Jones, Radiology and Outpatients Clinical Business Unit Manager. o Delivery of Recovery Activity o Risk Stratification o Operational Issues (including ERS) o Workforce o Performance and KPIs (including cancellations) o Access Policy • At the end of May 2021, the 52-week trajectory was met and under trajectory by -446 however this has not yet been fully validated. The number of breeches recorded was 1316 against a trajectory of 1765 • The Trust is not achieving the 18-week Referral to Treatment standard however we have agreed a trajectory for recovery and achieved 75.66% against a trajectory of 71.23% at the end of May 2021 • The position as of the 5th June is that there are 250 backlog against an end of May trajectory of 215. Work is ongoing to bring this into line with the end of month expectation. • Diagnostics – Clinical Position as of 5th June 2021 is that there is a total waiting list of 5219. All patients waiting over 6 weeks are all triaged and classed as non-urgent and all cancer fast track and urgent patients are accommodated within 2 weeks apart from CT Colons which have a current wait of up to 4 weeks		

		• For MRI the Trust has a mobile van giving 58 days of extra capacity over the next 3 months to clear the patients waiting over 6 weeks		
CROC/2021/06/04	Risk Register Update	• Currently four risks on the BAF for which this Committee is a monitoring Committee: 1215, 1273, 1331 and 1332 and a further three risks on the Corporate Risk Register: 1125, 224 and 1135. • TA asked for assurance that the risk rating of Risk 224 of 15 is sufficient given the pressures currently in the Emergency Department (ED), MB endorsed this and suggested an increase in the rating.	The Committee **noted** the report.	CROC June 2021
CROC/21/05/44	Recovery Completion Forecast Weekly C&M Activity Recovery Summary	• Re P2 backlog, the Trust has closed the gap substantially from the last meeting of this Committee on 25th May 2021. DM reported that the Trust is compliant for the June 2021 reporting position.	The Committee **noted** the report.	CROC June 2021

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/07/91 (e) iii		TRUST BOARD OF DIRECTORS	DATE OF MEETING	28th July 2021

Date of Meeting	**22nd June 2021**
Name of Meeting + Chair	**Clinical Recovery Oversight Committee (CROC) 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
CROC/21/06/64	Harm Profile update	• Overall, there has been a further reduction of 78 reviews completed, therefore an overall reduction of 1232 reviews completed since 7th April 2021 (Figures 2&3). • No new harms identified. • Focussed governance review continues for T&O, Urology and Max Fax trajectories continue to be monitored (Figure 5, 6 and 7). • Plan is to complete the work by the end of July 2021.	The Committee **noted** the update	CROC July 2021
CROC/21/06/53	Waiting List update	RTT Breakdown May: • May Position 75.74% Performance an increase of 3.43% on Apr Position – Better than estimated Trajectory 71.23% • Total RTT Waiting list size 20299(this does not include ASI, RAS patients) lower than the submitted estimate 20732) Including ASI, RAS Total WL size 21215	The Committee **noted** the report.	CROC July 2021

		• 5 Specialties achieving standard of 92% - Cardiology, Rheumatology, Elderly Medicine Services (Geriatric) General Internal Medicine, Gastroenterology • All Specialties improved on the previous Month • Under 18 weeks increased by 924 on last • Over 18 weeks decreased by 607 on March submission • 52-week Breaches for May Month end 1196 against a submitted trajectory of 1765 • TC provided assurance that all 52-week waiters were being monitored for harm; P2 codes have been re-visited. • The P2 backlog continues to be slightly over trajectory, but reducing each month. The gap between trajectory and actual as improved to only 10 patients adrift being forecast for June achieving circa 207 against a plan of 197.		
CROC/21/06/66	Access to recovery fund	• JH advised that the Trust had increased it expected ERF to £3.9m in line with discussion with operational colleagues. Regionally, there is discussion regarding the national funding of £1bn and current estimations show that this will not be sufficient.	The Committee **noted** the update	CROC July 2021
CROC/21/06/70	Recovery Completion Forecast Weekly C&M Activity Recovery Summary	• Continued compliance against the recovery trajectories was noted for Elective, Cancer, outpatients. An improving position in relation to the P2 backlog was also noted.	The Committee **noted** the update	CROC July 2021

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 21/07/91 f i	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	28 July 2021

Date of Meeting	24 June 2021
Name of Meeting & Chair	Audit Committee (Year End), Chaired by Ian Jones
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
AC/21/06/50	**External Auditors Findings Report on 2020-21 Accounts IAS 260 Memorandum**	It was reported to the Committee that the Audit and testing had taken longer than anticipated, primarily due to current COVID challenges, overall level of challenge during the process, range of increased audit evidence required and new Auditors standards particularly related to estimates. The following were highlighted as part of the process of testing and auditing the annual accounts and annual report: - Auditors undertaking further testing relating to updated risk - accuracy of year end position. - **Unqualified Opinion** on final financial statement to be issued, some issues to be resolved in conclusion of the audit relating to uncertainties and misstatement (£2.6m) - Materiality – statement supported by the Audit Committee; some may go into next year. - Value for Money (VFM)– subject to wider scope. GT had attended a number of Committee Assurance meetings, had undertook interviews with CEO, COO, CFO & Deputy CEO and members of the Finance Team. VFM had not yet been completed; however, no significant weaknesses identified	**The Committee discussed the report and received good assurance**	**Audit Committee 19.08.2021**

		and no impact on Opinion provided today. - Extra Ordinary Audit Committee 7 July 2021 to be reconvened to receive final External Audit Report and VFM Conclusion in order to support laying of the Annual report before Parliament prior to the summer recess. - **Approved** Annual Accounts 2020-21 for submission to NHSE/I 30 June 2021. - **Approved** the Management Letter of Representation. - **Accepted** recommendations outlined and managed risk relating to journal testing. - **Reviewed and noted** External Audit Findings Report and External Auditors Unqualified Opinion relating to Financial Statements.		
AC/21/06/51	**Annual Report 2020-21**	The Annual Report was received by the Committee - **The Committee reviewed and approved the Annual report in principle subject to minor amendments highlighted.** The final Annual Report and Annual Accounts to be submitted for E-Laying to the Department of Health and Social Care by 9 July 2021. - **Post meeting note** final External Audit Report and VFM conclusion not to be approved until after 9 July, documents to be submitted to Department of Health and Social Care post summer recess.	**The Committee discussed and approved the report and received good assurance**	**Audit Committee 19.08.2021**
AC/21/06/52	**Final Annual Accounts**	The Final Accounts were received by the Committee and it was noted that there had been no significant amendments to the draft Annual Accounts presented to Audit Committee 29 April 2020. - External Auditors to issue final Audit Opinion Certificate and Audit Findings Report. Final submission of Annual Report and Accounts to DHSC by 9 July 2021.	**The Audit Committee reviewed and approved the 2020-21 Final Audited Annual Accounts and TAC Schedules and received good assurance**	
AC/21/06/55	**Code of Governance Compliance 2020-21**	The Committee received the Trust's declaration of annual compliance as part of the NHS Foundation Trust Code of Governance (the Code) under the principle of 'comply or explain'.	**The Audit Committee reviewed and approved the assurance report and approved declaration of compliance with the provisions of the Code in the Annual Report 2020-21 and received good**	

			assurance	
AC/21/06/56	**Compliance with Licence Annual Return – FT4 declaration**	The Committee received the Trust's Licence Annual Return – FT4 statement of compliance declaration. It was noted that the Trust does not consider itself to be in breach of is provider license and declares continued compliance, no material risks had been identified. Periodic monitoring will continue and any material changes report to the Audit Committee and the licence published on the Trust website.	**The Audit Committee noted good assurance provided of full compliance with the Trust Provider Licence conditions and Certificate of Compliance.**	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/92**	
SUBJECT:	**Moving to Outstanding**	
DATE OF MEETING:	28 July 2021	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	#145 a. Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	Following the completion of the CQC's post-inspection action plan, the Moving to Outstanding Steering Group has a refreshed focus that includes: • The 'Red Flags' report, linked to CQC's Insight Report • Oversight of CQC enquiries (0 received June 17 to date) • Oversight of the mock inspection programme • A Regulatory update • Details and plans for any compliance outliers for mandatory training • Progress updates on: o the CQC registration of 'Shopping City' o the RCEM action plan o progress towards ACSA accreditation o Use of Resources o the Moving to Outstanding Task and Finish Group This paper provides high-level updates across each of these areas.	

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

RECOMMENDATION:	The Board of Directors is asked to note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Moving to Outstanding**	**AGENDA REF:**	**BM/21/07/92**

1. BACKGROUND/CONTEXT

Following the completion of the CQC's post-inspection action plan, the Moving to Outstanding Steering Group has a refreshed focus that includes:

- The 'Red Flags' report, linked to CQC's Insight report
- Oversight of CQC enquiries (0 received June 17 to date)
- Oversight of the mock inspection programme
- A Regulatory Update
- Details and plans for any compliance outliers for mandatory training
- Progress updates on:
    - the CQC registration of 'Shopping City'
    - the RCEM action plan
    - progress towards ACSA accreditation
    - Use of Resources
    - the Moving to Outstanding Task and Finish Group

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

2. KEY ELEMENTS

Red flags report

Background

The CQC produce an Insight report which brings together in one place the information they hold about our services. The Insight report analyses and monitors 79 indicators across the Trust. The report is regularly reviewed and used to help CQC to decide what, where and when to inspect and provides analysis to support the evidence in their inspection reports.

Action taken

In order for the Trust to demonstrate a proactive approach, a process has been developed to comprehensively review the CQC Insight report to identify any indicators outlining variance.

A summary of information is collated and presented in the Red Flags report on a monthly basis to the Moving to Outstanding Steering Group to offer assurance around identified indicators.

CQC Enquiries

From 17 June 2021 the Trust has received 0 new enquiries.

Oversight of the mock inspection programme

- The initial mock inspection of maternity has been completed. An initial compliance action plan has been put in place, which is monitored at the Moving to Outstanding Steering Group. A more comprehensive action plan focusing on supporting the service moving to outstanding will be developed in August 2021 when the new Head of Midwifery commences in post.
- An unannounced inspection for Urgent and Emergency Care is scheduled (July 2021), which will be followed by an inspection of Outpatients (August 2021).

Shopping City CQC application

The Associate Director of Compliance and Quality has worked closely with the team to complete a draft application form. CQC have been contacted to arrange an initial pre-application meeting and we are currently awaiting a date for this.

Oversight of the RCEM action plan

There are 38 indicators in the RCEM report, from which the Trust had 119 individual actions. There are 3 Amber (on track) actions outstanding:

- IPC 06 – Nursing for Escalation areas – A business case is progressing to the Finance and Sustainability Committee.
- IPC09 – ED Plaza – A contractor has been identified.
- IPC 16 – Single Medical Clerking – The be implemented w/c 22 July 2021.

Oversight of progress towards ACSA accreditation

- The initial ACSA assessment was completed in March 2021. Positive feedback was received following the visit.
- The initial report from the Royal College was provided in May 2021, following which the Trust developed an action plan to address next steps. Assurance can be offered that all actions are on track.
- In July 2021 ACSA revised their standards. A revised action plan is being created. This will be reported through Moving to Outstanding in August 2021 and the Quality Assurance Committee in August 2021.

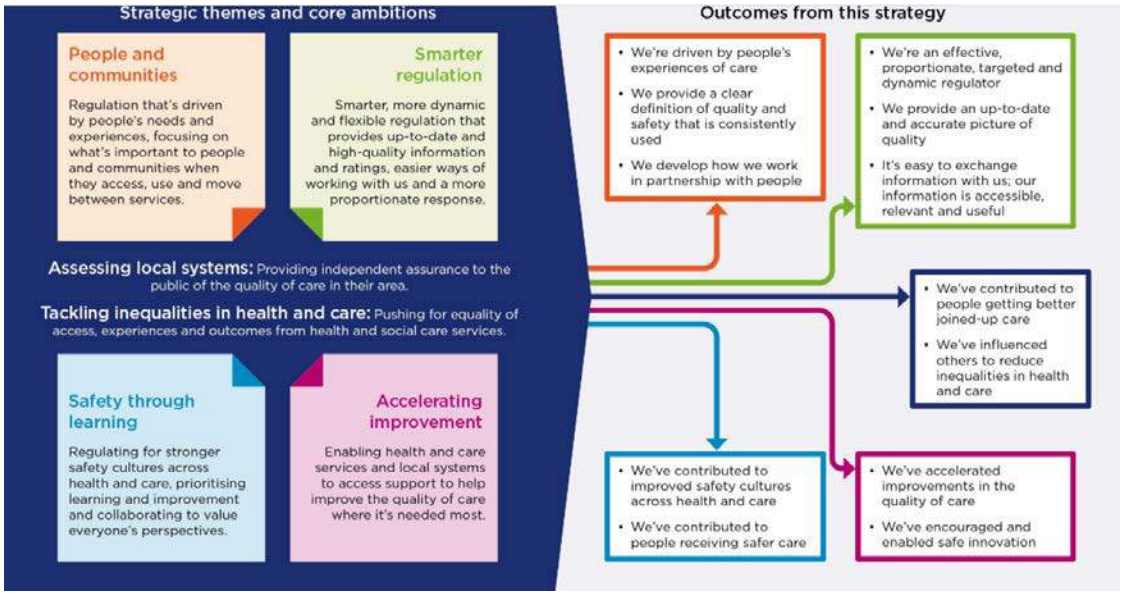
Updates on Use of Resources

Use of Resources assessments are currently suspended whilst the CQC and NHSI/E develop a revised framework. Internal work continues to be completed whilst further information relating to these frameworks is awaited.

Regulatory Update

CQC Strategy

On 27 May 2021 the CQC launched their new strategy. The CQC's new strategy has four strategic themes and two core ambitions, which run through the themes. Denoted below are the strategic themes, core ambitions and this is linked to outcomes:



Core service frameworks

The CQC are currently working to adapt the core service frameworks that the Trust's services are assessed with. This involves:

- retaining the five domains, Safe, Effective, Caring, Responsive and Well-Led;
- streamlining and adapting the KLOE to make them more accessible for patients and providers.
- revising rating characteristics to 'Quality Statements' linked to the regulations
- offering clear information outlining the evidence they will be looking at to assess each KLOE.

The above changes will benefit the Trust as currently there can be inconsistency in information requested to support a rating judgment. It will also enable us to actively monitor the content and quality of information likely to be requested, supporting improvements when required.

Engagement

The CQC have increased their engagement activity to include risk-based assessments Transitional Monitoring Assessments (TMA). These assessments involve submission of a comprehensive response. To date these have been undertaken for Maternity and Urgent and Emergency Care. A Trust-Wide assessment has also been undertaken. The Trust has received positive feedback for each Transitional Monitoring Assessment completed.

Provider Collaboration Reviews

The CQC have progressed their programme of provider collaboration reviews (PCRs). Each review has taken place at a different stage of the pandemic. This is not specific to WHH.

The urgent and emergency care PCR identified key challenges for systems looking forward to next winter and beyond. CQC have outlined that it is key that systems:

- Develop and build on relationships.

- Share important information.
- Understand staffing.
- Understand inequality.
- Embrace technology. Rapid advancement of new ways of working have presented an opportunity to improve people's access to care and their experience.

It is highly likely that there will be focus on these areas in subsequent Transitional Monitoring Assessments and provider collaboration reviews.

Our Outstanding Teams

At Moving to Outstanding we have introduced this new agenda item to enable services to share their outstanding practice. In July's meeting we launched this process and outlined some awards that teams have been shortlisted for:

For decision – attendance at Patient Safety Awards 2021 in Manchester 20 September 2021

1. **ICU**

Title: Warrington Covid Cooperative
Category: Deteriorating Patients and Rapid Response Initiative of the Year
Total Trusts shortlisted: 8

2. **ICU**

Title: Warrington Covid Cooperative
Category: Patient Safety Team of Year
Total Trusts shortlisted: 8

3. **Respiratory/ICU**

Title: Black Box Warrington
Category: Patient safety innovation of the year
Total Trusts shortlisted: 8

4. **Maternity**

Title: WHH Continuity of Carer Project
Category: Maternity and Midwifery Innovation of Year
Total Trusts shortlisted: 8

3. MONITORING/REPORTING ROUTES

A monthly report will be provided to the Quality Assurance Committee.

4. RECOMMENDATIONS

The Board of Directors are asked to receive the content of this paper.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/94**	
SUBJECT:	**COVID19 Overview Report**	
DATE OF MEETING:	28th July 2021	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#224** Failure to meet the emergency access standard, Caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to Trust reputation, financial impact and below expected Patient experience. **#1207** Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and	

	welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component. **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#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.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The COVID-19 pandemic has brought unprecedented challenge for all healthcare providers to ensure the timely delivery of safe care. At WHH, this has been underpinned by robust governance processes to ensure that decisions have been made collectively with appropriate oversight from Ward to Board. This paper will describe the Trust approach to the management of the pandemic with each wave (1-3) noted alongside phases referenced as 'gateways'. Each gateway will describe the work undertaken to provide assurance of safety throughout the pandemic for both patients and staff. This is evidenced through a number of modalities including: • Risk assessments. • Pathways. • Policies. • Standard Operating Procedures (SOPs). The Trust response to the COVID-19 pandemic has been underpinned by a robust governance framework ensuring that decisions have been made collectively across a range of senior disciplines including: • Medical Team • Nursing & Midwifery Team • Allied Health Professionals • Infection Prevention & Microbiology Teams

	• Operational Management Teams • Governance, legal and Statutory Teams • Occupational Health & Human Resources Teams • Finance & Procurement Teams • Palliative Care Team This has enabled timely escalation to the Strategic Oversight Group as necessary.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	**To note**	Decision
RECOMMENDATION:	The Board of Directors are asked to note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	COVID19 Overview Report	AGENDA REF:	BM/21/07/94

1. Background

The COVID-19 pandemic has brought unprecedented challenge for all healthcare providers to ensure the timely delivery of safe care. This has been underpinned by robust governance processes to ensure that decisions have been made collectively with appropriate oversight from Ward to Board.

This paper will describe the Trust approach to the management of the pandemic with each wave (1-3) noted alongside phases referenced as 'gateways'.

Each gateway will describe the work undertaken to provide assurance of safety throughout the pandemic for both patients and staff. This is evidenced through a number of modalities including:

- Risk assessments.
- Pathways.
- Policies.
- Standard Operating Procedures (SOPs).

The Trust response to the COVID19 pandemic has been underpinned by a robust governance framework ensuring that decisions have been made collectively across a range of senior disciplines including:

- Medical Team
- Nursing Team
- Infection Prevention
- Operational Management
- Governance, legal and Statutory
- Human Resources
- Procurement
- Palliative Care

This has enabled timely escalation to the Strategic Oversight Group as necessary.

2. Identification of Waves

2.1 Identification of Waves

At the time of writing this paper there have been three waves of COVID19 with signs of a fourth wave pending. Due to the vaccination programme this is unlikely to have the same effect as waves 1-3.

Table 1 details the dates assigned for waves 1, 2 and 3 and the peak number of COVID-19 positive **inpatients** at Warrington and Halton Hospitals NHS Foundation Trust (WHH). The first confirmed COVID19 inpatient was admitted on the 12th March 2020. The first Covid inpatient death occurred on 19th March 2020.

Table 1

Covid 19 Wave	Month and Duration	Peak Number of Covid 19 inpatients
Wave 1	March- 12th May 2020	124
Wave 2	September – November 9th November 2020	179
Wave 3	December – February 19th January 2021	243

2.2 Initial Considerations of WHH Response

2.2.1 Governance

Throughout the COVID19 pandemic, WHH has consistently applied a robust governance decision making framework encompassing a variety of cells. This has ensured that decisions have been made collectively by the senior team across a variety of disciplines / cells as noted previously. These cells have all reported daily through the Tactical Group (chaired by the Chief Operating Officer) with appropriate matters escalated to the daily Strategic Executive Oversight Group (Executive team), representing a silver and gold command structure.

The COVID-19 Tactical Group has been responsible for the following:

- Overseeing the Trust response to COVID-19.
- Monitoring community SARS-CoV2 numbers.
- Reviewing and managing Clinical Pathways and ensuring safe and effective services for patients, with efficient ratification of documents.
- Overseeing Business Continuity Planning across all CBUs and services.
- Management of incidents and formulating / communicating escalation plans.
- Reviewing and managing patient flow safely, effectively and efficiently.
- Continual review of staffing complexities.
- Receiving, logging, reviewing and implementing the latest NHSE & Public Health England (PHE) guidance.
- Reviewing stock of Personal Protective Equipment (PPE) and other relevant supplies to ensure safety of staff and patients. This includes medicines and consumables.

- Supporting the establishment of the Elective Recovery Board.
- The planning and delivery of wellbeing for staff throughout the pandemic.
- Coordination and completion of daily SitReps, with which the Trust are fully compliant.
- Governance in relation to service changes including the recovery of services with accompanied PPE forecasting documents to ensure adequate PPE provision at all times.
- An Incident Management Team and control room was established from the beginning of the pandemic to coordinate the Trust response to COVID19.

2.2.2 Capacity Arrangements: ED Footprint

WHH ensured that processes were in place to facilitate the appropriate and safe triage of patients to reduce the risk of COVID-19 transmission upon entry to the hospital. This included the introduction of assessment pods to optimise the timely delivery of care and review of patients. This meant expanding and flexing the Emergency Department (ED) footprint with careful Infection Prevention and Control (IPC) measures and appropriate staff training. This was discussed and agreed with all appropriate documentation in place via the Tactical Group.

In accordance with national guidance theatre capacity was reviewed with cubicles being utilised to isolate patients, expansion into theatre recovery and further escalation of the bedbase utilising theatre pods. This flexed as necessary to ensure adequate provision of high level care beds throughout the pandemic. WHH also utilised off framework nursing agencies where necessary to ensure patient safety employing staff with the appropriate skill mix. This of course incurred additional but necessary cost with all appropriate governance processes followed.

2.2.3 Fit Testing and PPE Provision

Prior to the COVID-19 pandemic WHH had an existing Fit Testing service for staff with training provided by an accredited Fit2Fit company. The provision of staff to undertake fit testing was enhanced in January 2020 with additional resource provided by the Patient Safety and Health and Safety team. A process was ratified at the Tactical Group to ensure that where fit testing had failed other appropriate alternatives were available, ensuring compliance with Public Health England standards. Throughout the pandemic WHH has only used appropriate equipment, all of which were approved by British standards. The availability of equipment and PPE has been overseen daily by the procurement department throughout the pandemic with continual updates provided through the Tactical Group. A system of mutual aid was also agreed across Cheshire and Mersey, providing additional assurance of access to appropriate equipment if required. This was further supported in wave 2 with a PPE central store for the monitoring of equipment.

3.0 Covid-19 Response Timeline

3.1 Wave1: Gateway 1ST March 2020 – May 2020

Table 2: Inpatient Covid Status March – 31st April 2020. Please note outbreak numbers also include staff cases.

	Number of COVID related deaths (inpatient)	Tier status	Peak inpatient number	Outbreaks
March 2020	19	National lockdown 23rd March 2020	28	No national definition

	Number of COVID related deaths (inpatient)	Tier status	Peak inpatient number	Outbreaks
April 2020	70	National lockdown	124	No national definition

On 3rd March 2020 NHSE/I declared a level 4 incident and on the 16th March 2020 speciality guidance was released to direct the delivery of speciality service. A further document released on the 17th March 2020 instructing a rapid repurposing of clinical services, staffing and capacity was issued. WHH responded efficiently and safely to the national guidance which formed the basis of the Trusts operational response to COVID19.

On 23rd March 2020 a national lockdown was instructed and patient visiting restrictions were put in place from 27th March 2020 as per national guidance. The Trust has maintained compliance with visiting restrictions throughout the pandemic with exceptions made for patients in extreme circumstances such as those approaching the end of their life or patients with specific mental health requirements. Where visiting has been agreed this has been managed and overseen appropriately from a risk and safety perspective.

Wave 1 noted a rapid increase in the number of inpatients and by 12th April 2020 a peak of 124 inpatients was noted.

At the beginning of April 2020 escalation of COVID19 patients had already occurred on wards: A7, A8, A4 and A5. A5 was identified as the designated end of life/ palliative care ward, thus helping to optimise patient experience and dignity in death during this challenging period.

In the first instance the Intensive Care Unit (ICU) had utilised cubicles to isolate COVID-19 patients before expanding into Theatre Recovery on the 9th April 2020, in response to the increased number of patients requiring high level care. Further escalation into theatre pods was then enacted.

Following the peak in mid-April, the number of COVID-19 inpatients reduced and continued to steadily decline until 9th September 2020, marking the beginning of the second wave and gateway 2. NHSE/I notified Trusts of work to be undertaken and part of the recovery plan in

April 2020 and WHH responded to this promptly in May 2020. This referenced the 'recovery phase whereby the Tactical Group was reduced and replaced with Recovery Board temporarily (Tactical twice weekly, recovery three times per week), chaired by the Chief Operating Officer. This was further supported by a service change and recovery proforma detailing all changes to services, ratified at the Tactical Group. This period represents wave 1, gateway 2 with the following undertaken:

- All NHS local systems and organisations working with regional colleagues were asked to fully step up non-Covid-19 urgent services over a six week period.
- Elective activity was restored in accordance with the Phase 2 (gateway 2) response with each CBU presenting their recovery plans to the Recovery Board.
- Advice was communicated around Restarting Planned Surgery by the Royal College of Anaesthetists, Association of Anaesthetists, Intensive Care Society and the Faculty of Intensive Care Medicine.
- The ongoing and consistent application of PHE/NHS Infection Prevention and Control guidance in all NHS organisations, with appropriate cohorting of Covid/non-Covid patients was adhered to.
- In response to the global PPE shortage, Department of Health and Social Care (DHSC) and the Cabinet Office together with the Department for Business, Energy and Industrial Strategy (BEIS - for UK manufacture) and the Department of International Trade (DIT) continued to expand the sourcing and procurement of HSE/PHE: recommended PPE for the NHS, social care and other affected sectors of the UK economy.
- Testing of all non-elective inpatients at the point of admission and the introduction of pre-admission testing of all elective patients was initiated.
- Asymptomatic staff testing was voluntary and all discharges to care homes were tested within 72 hrs of discharge
- Staff testing was expanded resulting in increased testing capacity to include asymptomatic staff, guided by PHE and clinical advice.
- In a letter received from NHSE/I on 17th March 2020 all NHS organisations were advised to continue to assess staff who may be at increased risk of contracting COVID19 and to ensure that appropriate risk assessments were in place. This was actioned and included:
- Pregnant women
- NHS returnees
- Black and ethnic minority staff
- Staff with underlying health conditions.

Adjustments were made accordingly following the completion of risk assessments. This was further supported by the WHH agile working policy and increased provision of IT equipment.

During wave 1 the Trust has evidenced compliance with all NHSE/I, PHE and HSE requirements. This is referenced across a number of documents detailed within this report. Some of these SOPs can be seen in **appendix 1** though the list is not exhaustive. This has included work relating to the following:

- Prompt screening for SARS-CoV2
- Efficient and safe capacity expansion
- Development of Cheshire and Mersey mutual aid agreement
- Collaborative decision making through governance framework
- Health and Safety risk assessments
- Work force risk assessments
- Environmental and Infection Prevention measures
- Estates work, assessments and monitoring arrangements including Oxygen
- Introduction of the Health and Wellbeing hub, staff counselling service and Wingman Lounge provided by furloughed pilots.
- Redeployment hub
- Family Liaison team protocol to support communication between patients, their loved ones and clinical teams as required.
- Chief Executive daily message
- Following national guidance, amendments were made to the pre-employment check process to support quicker recruitment. This included:

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

The Trust has been fully compliant throughout the pandemic with all PHE reporting requirements. This is evidenced through:

- The daily COVID19 SITREP process
- Daily reporting through PHE using the COVID19 Hospitalisations in England Surveillance System (CHESS) was established in wave 1 of the pandemic in accordance with national guidance. The report submitted details of all respiratory and COVID19 reported conditions.
- The COVID19 Patient Notification System (COVID19 deceased patient tool) was established to report COVID19 related deaths using a national toolkit to NHSE/I, PHE,CCG,CQC, North West ICC.

The major incident protocol was not utilised in wave 1 but processes were put in place should it have been required, led by the Chief Operating Officer.

3.2 Recovery: Wave 1; Gateway 2: May – September 2020

Table 3: Inpatient Covid Status May – August 2020

	Number of COVID related deaths (inpatient)	Tier status	Peak inpatient number	Outbreaks
May 20	34	National lockdown	91	No national definition

	Number of COVID related deaths (inpatient)	Tier status	Peak inpatient number	Outbreaks
June 20	10	National lockdown eased 23rd June 2020	47	1 Inpatient (C21)

	Number of COVID related deaths (inpatient)	Tier status	Peak inpatient number	Outbreaks
July 20	3	n/a	18	Nil outbreaks

	Number of COVID related deaths (inpatient)	Tier status	Peak inpatient number	Outbreaks
August 20	3	n/a	9	Nil outbreaks

In June 2020 it was announced that face masks must be worn on Trust premises at all times unless there was a medical reason to mitigate the use of a face mask. This was to be implemented on the 15th June 2020. WHH proactively implemented this on the 12th June 2020 prior to the national implementation date.

On 19 June 2020 the Chief Medical Officers and the Government's Joint Biosecurity Centre downgraded the UK's overall Covid alert level from four to three, signifying that the virus remained in general circulation with localised outbreaks likely to occur. This was followed on 23rd June 2020 with the Prime Minister announcing the easing of the first national lockdown.

During this time WHH expanded the work on the Trust environmental safety plan which has continually been updated throughout the pandemic and 'Staying Covid Secure in 2020' advice was issued to all corporate and clinical teams. There were updates on staff shielding in

response to falling community rates of COVID-19 and staff continued to work flexibly in accordance with the agile working policy. Staff were provided with equipment to enable them to work from home.

During this time as part of recovery work the Recovery Board agreed the re-opening of elective theatres and throughout the pandemic WHH has worked with external providers including the private sector e.g. SPIRE to optimise maintenance of elective work. The elective programme was rigorously monitored through Recovery Board and the Planned Care Group. At the time of writing this report there are plans in place to ensure appropriate waiting list management with clear governance processes in place to identify any potential harm to patients. This is reported through the Quality Assurance Committee, the Clinical Oversight Group, Trust Board and Clinical Oversight Recovery Committee which is led by a Non Executive Director. This information is also shared with the Clinical Commissioning Group.

On 17th July 2020 the Government set out next steps including the role of the new Test and Trace programme in providing advance notice of any expected surge in Covid demand, helping to manage local and regional public health mitigation measures to prevent national resurgence.

A Staff symptoms screening SOP for non-clinical and clinical areas was established as part of the risk assessment and COVID secure focus. Thermometers were procured and a screening process was established in all clinical areas. The screening process was set up for non-clinical areas with the use of thermometers to follow. An equipment request form was issued via NHSE and the Trust established a response to the equipment available. This equipment was received in August 2020. During this time the Trust was a pilot site for NHS 111-FIRST and a project team was established.

Workforce COVID19 Risk Assessments were in place from the beginning of the pandemic but in July 2020 a new COVID19 Workforce Risk Assessment Tool was launched. This electronic tool enabled all members of staff to undertake a self-assessment and request a risk assessment from their manager where required. The implementation of the tool was supported by guidance, virtual training and regular reporting.

A letter was shared by NHSE on 31st July 2020 with all Trusts. This detailed the reduced incident level from 4 (national) to 3 (regional). This was initiated from the 1st August 2020. NHS organisations were asked to retain their Emergency Preparedness Resilience Response (EPRR) incident coordination centres with support and oversight of Regional Directors and their teams. The letter detailed three priorities:

1. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter.

2. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

3. Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

A debrief with a review of the first wave of the pandemic and gateway 1 and 2 of the response was carried out on 3rd August 2020 with the people plan forming a significant part of the gateway 3 response.

Recovery Board continued to take place twice weekly and there were no Tactical meetings. Assurance around limiting crowding in ED was completed. Work towards completing the gateway 3 response continued. Other aspects undertaken in this time included (this list is not exhaustive).

- Clinically extremely vulnerable staff were advised that they could return to work providing appropriate risk assessments were carried out.
- The access policy was updated and waiting list details were shared and reviewed via the Recovery Board.
- National guidance around the removal of children and young people from the shielding list was communicated.
- NICE guidance for elective treatment was implemented.
- Infection Prevention guidance was updated, summarised and shared.
- Face to face mandatory training sessions were paused in accordance with national guidance and recommenced in June 2020 for following sessions:

    - Resuscitation
    - Safeguarding
    - Acute Illness Management System
    - Moving and Handling – Level 2
    - Information Governance

- 3RD June 2020 - Weekly meetings with the Black, Asian and Minority Ethnic (BAME) network chair.
- 6th July2020 100% compliance with risk assessments for substantive BAME staff
- 22nd July Introduction of the LGBTQA+ staff network

3.3 Wave 2, Gateway 1: September 2020 – November 2020

Table 3: Inpatient Covid Status September – November 2020

	Number of COVID related deaths (inpatient)	Tier status	Peak inpatient number	Outbreaks
September 2020	4 (+1 in ED)	n/a	33	5 outbreaks

				2 Inpatient (ACCU, A6,) 3 Staff (Discharge Planning Team, Endoscopy Halton, CSTM Theatre staff)

	Number of COVID related deaths (inpatient)	**Tier status**	**Peak inpatient number**	**Outbreaks**
October 2020	48 (+1 in ED)	Tier 3 23/10/21	144	12 Outbreaks 6 Inpatient (A4, A9, ACCU, B14, C21; B19) 6 Staff (Breast Screening, Discharge planning Team, AMU, ED Nursing, IM&C CBU office, IT Office)

	Number of COVID related deaths (inpatient)	**Tier status**	**Peak inpatient number**	**Outbreaks**
November 2020	67	National lockdown	179	8 Outbreaks 4 Inpatient (A2, A4, A6, K25) 4 Staff Pathology Laboratory staff, Rheumatology Team, IT Office, Waiting list team)

Tactical Board was re-established in September 2020 following an increase in the number of community prevalence cases and predicted surge pressures. Recovery Board continued until mid-September, before being replaced by daily Tactical meetings in entirety as in wave 1.

In order to meet the challenges presented by the surge, plans for further expansion of critical care were submitted and approved at the Tactical Group and Strategic Oversight Group in September 2020. Again the information detailed below is not exhaustive, but measures undertaken in September 2020 include:

- Completion and submission of the phase 3 return.
- The SIREN study was implemented with participants across CBUs, to understand whether prior infection with SARS-CoV2 protects against future infection with the same virus. This is ongoing.
- Patient visiting good practice guidance was shared through the Cheshire and Mersey network and a risk assessment was implemented to support safe visiting. The Trust has remained fully compliant with all guidance.
- The staff testing process was updated.
- Cheshire and Merseyside Gold Command communicated the Wave 2 considerations and some early modelling information.
- Dementia wellbeing in the COVID pandemic advice was communicated by NHSE.
- EPRR annual assurance was submitted.
- Flu vaccination guidance was shared including the vaccination of inpatients.
- NHSE requested the completion of the Readiness for increase in hospital admissions for COVID19 template. This was undertaken.
- Advice was shared with staff including a Top Ten Key messages, this captured key COVID-secure messaging and learning from outbreaks.
- COVID- 19 escalation planning for wave 2 was initiated at the end of September 2020.
- Trajectories of recovery of waiting lists were shared. Highest risk patient letters were approved and sent out.
- The site access plan was finalised and implemented.
- The framework for reintroducing maternity visitors was communicated by NHSE and the Trust responded accordingly.
- System resilience planning took place with WHH input into the system winter plan.
- Updates to the environmental safety plan occurred.
- Advice for shielding staff working in clinical areas was updated.
- Learning from Covid evaluation completed with the support of the Advancing Quality Alliance (AQUA).

October 2020

- Clinical validation of surgical waiting lists: framework and support tools communicated by NHSE on 1st October 2020, along with the National Elective Clinical Validation Programme - Exemption Process commenced.
- An updated FFP3 strategy was communicated through Tactical Board.

- Guidance on ICU and winter consumables were reviewed in preparation for the predicted surge and winter pressures.
- Test and trace Information for people working in healthcare was released and communicated.
- The ICU team reviewed the escalation plan determining escalation into Theatre Recovery and Theatre Pods to support surge pressures. It was determined that the unit would care for patients with COVID and the Theatre pods would support non-COVID ICU patients. Theatre Recovery would support Level 2 COVID patients if ICU was escalated to full capacity.
- A review of staff rest areas took place with a number of locations identified to allow for social distancing on breaks. All break areas across the Trust, corridors, stairwells etc have been risk assessed since the beginning of the pandemic with regular daily senior spot checks undertaken daily.
- The asymptomatic testing pilot was coordinated by the Finance Team and involved the testing of asymptomatic patient facing staff for green pathway patients.
- The Winter Plan for Critically ill Children in the North West Management of Capacity and Demand Pressures for Winter 2020/21 and COVID19 Potential Surge were shared through the regional network.
- The COVID19 visitors trigger tool was released by NHSE, along with updated advice on visiting. Visitor guidance was updated nationally and locally.
- The Redeployment Hub was re-established to support the surge pressures.
- Weekend exemption reporting occurred with NW Trusts completing additional weekend situation reports for 11 weeks, with returns before 9am on Saturday and Sunday.
- The Gold Command daily data collection reviewing cancellations started on 23d October 2020.
- The Palliative Care referral process was recirculated to support surge and the associated impacts of this.
- IPC shared a Checklist and Monitoring Tool for the Management of suspected and known COVID19 cases.
- COVID19 Escalation occurred into C21 and K25, beyond A7, A8 and A9.
- Additional staff communication was shared around car sharing, social distancing on breaks and reassessing environments to ensure COVID-secure.
- On 11th October 2020 Ward B3 was opened as an escalation area to support surge pressures.
- Draft ward escalation plans to support surge were created by Clinicians, identifying the appropriate pathways and medical cover to support escalation. Emergency management SOP and discharge processes were updated to support this escalation.
- The Trust Full Capacity Protocol was enacted on 22nd October 2020.

- NHS Nightingale North West was reopened on 26th October 2020 with the appropriate admission criteria established.

3.4 Wave 2; Gateway 2

The second nationwide lockdown was announced on 31st October 2020. On 4th November 2020 NHSE announced the return to Incident Level 4. The following was initiated:

- Asymptomatic testing using the Lateral Flow Testing (LFT), with patient facing staff being issued LFT home testing kits and agreeing to test twice weekly.
- On 2nd November 2020 Increased admissions prompted the instruction for the reduction in urgent elective activity through the Cheshire and Merseyside Gold Command.
- A ward escalation plan was developed to support up to 240 COVID19 patients.
- There was additional guidance shared to support Clinically Extremely Vulnerable staff.
- The internal winter plan was devised with priorities shared at Tactical Board.
- The COVID19 visitors trigger tool was updated by NHSE.
- National guidance 'Your COVID-recovery' released.
- Learning Disability Emergency Department Care Pathway COVID update shared by NHSE.
- The clinical prioritisation programme update was shared at Tactical Board on 11.11.20.
- Initial plans to develop a Continuous Positive Airway Pressure unit on ward A7 were communicated through Tactical Board.
- Version 1 of the Urgent and Emergency Care, Royal College of Emergency Medicine action plan was shared at Tactical Board on 11.11.20.
- The Danish mink variant was detected, and a triage process was identified on 12.11.20.
- COVID Oximetry work commenced with the initiation of oximetry at home on 12.11.20.
- The vaccination team was established, and deployment information was received.
- Flu vaccination uptake reminders occurred.
- Guidance from NHSE around Wave 2 Service Protection support guide for Specialised Services was released.
- De-escalation of COVID19 wards started to occur by 20th November 2020 with reduced pressure of COVID19 inpatient numbers.
- The IPC Board Assurance was updated and shared on 23.11.20.
- The trial of Tocilizumab was supported by Pharmacy, along with and update to the Recovery Trial SOP.

- The instruction for admission, day 3 and day 5 screening was initiated by NHSE on 17th November 2020 with which the Trust was compliant. The Trust had initiated day 2 screening ahead of the release of this guidance on 16th November 2020.

3.5 Wave 3, Gateway 3: December 2020 - February 2020

Table 4: Inpatient Covid Status December – February 2020

	Number of COVID related deaths (inpatient)	Tier status	Peak inpatient number	Outbreaks
December 20	55	Tier 2 2/12/20 Tier 3 23/12/20	150	3 Outbreaks 3 Inpatient (A5, A8, B3)

	Number of COVID related deaths (inpatient)	Tier status	Peak inpatient number	Outbreaks
January 21	97	National Lockdown implemented 4th January 2021	243	5 Outbreaks Inpatient (A2, A4, A6, B12, K25)

	Number of COVID related deaths (inpatient)	Tier status	Peak inpatient number	Outbreaks
February 21	42 (to 24/02)	National lockdown	223	4 Outbreaks (B14, B18, B3/B4/ A5GU)

The easing of the second national lockdown on 2nd December 2020 was announced. Warrington remained at Tier 3 when the national restrictions were lifted and Halton at Tier 2. Actions during this time included:

- The vaccination programme commenced with the use of the Pfizer BioNTech vaccine and groups were prioritised in accordance with the cohorting identified by the JVCI. A range of SOPs were approved to support the operational, logistical and clinical processes associated with the vaccination programme.
- New COVID19 variants were discovered in parts of London and the South East.
- Clinically Extremely Vulnerable advice was updated to support this group of staff through the tier system.

- The Home for Christmas campaign was implemented on 10th December 2020, before the launch of Where Best Next? following the Christmas period.
- Prioritisation letters for the waiting lists were approved through Tactical group.
- The wards were de-escalated in the reverse order of the October / November 2020 escalation plan – K25, C21, A9, A8 and A7 were utilised for COVID19 capacity.
- Cheshire and Merseyside Gold Command shared some modelling to support preparation for a third wave. The operational managers reviewed escalation plans in Intensive Care and on the wards to plan for this.
- Additional advice to support pregnant women was released by NHSE.
- NHSE communicated additional funding availability to support winter workforce pressures.
- The self-isolation policy was reviewed by the Planned Care Team and Microbiology. This was approved through the Tactical Group.
- The mortuary refurbishment commenced mid-December 2020 with mitigation to utilise space at the Halton site.
- Updates to the Acute Sitrep and reporting processes were communicated by NHSE.
- All business-as-usual reporting occurred over the Christmas period and a detailed Christmas Plan was communicated for assurance of staffing and operational teams.
- NHSE communicated operational priorities for winter and 2021-22 on 23rd December 2020.
- Lateral Flow guidance for ED and Maternity was issued with subsequent action plans being implemented in departments.
- The Trust received guidance on the LAMP testing for staff to replace LFT home testing in the Local community rates peaked on 12th January 2021. On 15th January 2021 the Trust experienced a peak of 243 COVID19 inpatients.
- The Prime Minister announced the third national lockdown on 4th January 2021.
- Staff redeployment was reviewed to support the increased demand on Intensive Care and COVID19 escalation wards at the start of January 2020.
- Ward escalation followed the previous plan, with A7, A8, A9, C21 and K25 established for escalation. Reconfiguration of surgical wards meant B18 was also available for ward escalation.
- National updates on patient visiting were communicated by NHSE, with no significant changes to current practices.
- Oxygen issues emerged with alarms triggered due to the increased use of oxygen in wave 3. The SOP to support the safe deployment of oxygen was devised and there was increase monitoring of the flow of oxygen through Tactical group meetings. Mutual aid supported the increased demand on CPAP and NIV machines.
- Paediatric ED relocated to B11 to ensure adequate assessment space for surge pressured in ED.
- Medical student deployment was extended.

- The Oxford Astra Zeneca Vaccine was deployed for patient and staff vaccinations.
- Inpatient vaccinations commenced on both the Warrington and Halton sites.
- Enhanced Respiratory Care Ward - A7 was stepped up as additional ICU / HDU. support with patients receiving CPAP and NIV on the ward.
- The COVID Virtual ward was established.

In February 2021 the number of COVID-19 admissions continued to decline. This was reflected in the reduction in community rates. De-escalation occurred in the reverse escalation order, with C21, B18, K25, A9 de-escalated by mid-February 2021. Intensive Care de-escalation involved decanting COVID19 patients from Theatre Recovery back into ICU, using the back of ICU for non-COVID patients with non-COVID patients remaining in the Theatre pod. National guidance on shielding was updated on 16th February 2021 and Trustwide communication associated with the changing guidance was shared:

- NHSE updated guidance around hospital discharge and support care funding.
- LFT was adopted as point of care testing in ED and Maternity.
- Amendments to the patient screening SOP were implemented indicating;
  - Additional screening days added. All non-elective patients to have initial screening on admission and then again on day 3 and then on day 5 of admission regardless of their symptoms (if the admission screen result were negative).
  - Elective patients to have a repeat test at Day 3 of admission if initial screening was negative.
  - All patient's elective or non-elective if staying in-patients beyond 7 days required repeat screening on a weekly basis if previous screen results were negative. This was a locally determined action. As noted above in November 2020 WHH was compliant with all screening requirements and in 2021 the Abbott ID kit was provided – a rapid point of care molecular test delivering positive results within 5 minutes and negative results within 15.
  - Whilst challenging from an operational perspective staffed worked to ensure that patients in ED were not transferred until 2 negative screens were obtained. This has been supported by the more recent introduction of the Abbott ID NOW test.
  - The POCU was set up to support the sustainability of the elective programme on the Warrington site.
  - Works on A5 were initiated to support the elective green pathway.
  - 24 hour Microbiology support was re-established on 20th February 2021.

4.0 Risk Management

The management of risk has been crucial for healthcare providers. Throughout the pandemic WHH has continued to proactively review Trustwide risk ensuring appropriate escalation and oversight. This has seen a number of additional risks added to risk registers at CBU level, Corporate Risk Register and the Strategic Risk Register. The Assurance Framework was reviewed by MIAA during the pandemic reporting that processes were in place to update the

Assurance Framework were robust and clearly reflected the impact of COVID-19 on the organisation. The review added that the Assurance Framework was structured to meet the NHS requirements, is visibly used in the organisation and clearly reflects the risks discussed by the Board. An overarching risk noted as Risk ID 1215 was also added to the Strategic Risk Register. During the height of the pandemic, the Strategic Risk Register included 12 risks specifically related to COVID19 A specific Covid risk register was also devised and held within the governance department. All of these risk registers are discussed and scrutinised at the monthly Risk Review meeting, chaired by the Chief Nurse, Deputy Chief Executive. Reports providing updates on the Corporate and Strategic Risk Register have also been provided throughout the pandemic to the Patient Safety and Clinical Effectiveness Sub Committee and Quality Assurance Committee (QaC). During the pandemic QaC has taken place monthly rather than bi monthly. As part of the Covid 19 response and national requirement WHH also have an IPC BAF which is monitored via the Infection Control Sub-Committee and Quality Assurance Committee. This was shared with CQC who commended this piece of work.

5.0 Health and Safety

Health and Safety has been fundamental throughout the pandemic to ensure that the Trust has actioned measures accordingly ensuring compliance with the standards set by the Health and Safety Executive (HSE). This has been achieved. WHH sadly reported one staff member who passed away during the pandemic and an investigation was undertaken as expected. This was shared with the HSE with no action to take forward. Health and Safety have completed and supported all risk assessments across the Trust including HR, Estates, Operational requirements and governance requirements. These are logged as evidence within the governance department and across CBUs underpinning a number of documents presented at assurance committees:

- Environmental action plan
- Health and Safety Report
- Legal Paper
- Nosocomial paper
- Numerous standard operating procedures
- Meeting minutes from:
    - Tactical Group
    - Recovery Board
    - Strategic Oversight Group
    - Patient Safety and Clinical Effectiveness Sub Committee
    - Risk Review Group
    - Health and Safety Sub Committee
    - Infection Prevention Silver Command
    - Covid Learning exercise, wave 1 (Appendix 1)
    - Service Change Proforma log

- Silver COVID19 Group

6.0 Summary

WHH have undertaken a huge amount of work to provide assurance of compliance throughout the pandemic in accordance with national, regional and local requirements, thus ensuring the safety of both staff and patients. This is well evidenced within a number of documents all of which have been discussed and reviewed at relevant assurance committees. This includes reports, risk management, risk assessments, standard operating procedures and policies, some of which are noted below with SOPs and policies referenced in Appendix 1.

Reports:

- Environmental Plan
- Health and Safety Executive Paper
- Board PPE Paper
- Nosocomial paper with Learning
- Mortality and Nosocomial paper
- Health and Safety Annual Plan
- COVID, Corporate, Strategic Risk Register and IPC BAF
- Staff risk assessments
- Oxygen risk assessments
- Estates risk assessments
- Nosocomial paper
- Service Change Proformas
- Policies
- Standard Operating Procedures all of which were ratified via the Tactical Group – detailed in **Appendix 1**
- A learning capture was also undertaken during wave 1 with the support of Aqua which is attached in **Appendix 2**

7.0 Recommendations

The Board of Directors are asked to receive and note the report.

Appendix 1

Ratification of Standard Operating Procedures

Month	Standard Operating Procedures
April 2020	Medicines Policy - Proposed Policy Changes during COVID19 Escalation SOP for Health Care Workers SOP for Resuscitation of adults

	Visiting the dying and care after death SOP for Isolation of Vulnerable Patients and Infection during COVID19 Oxygen and NEWS guidance Contact a patient SOP Standard Operating Procedure for the Deployment of Oxygen Concentrators During COVID19 Pandemic Operation Shield SOP Discharging SARS-CoV2 Positive Patients / Stepping Down Infection Control Precautions while in the Hospital Clinical ethics committee TOR and escalation process RIDDOR and COVID19 - Safe Operating Procedure Updated SOP for Management of COVID19 Patient Placement During COVID19 Pandemic Testing Healthcare workers for COVID19 Estates Use of high flow Oxygen therapy devices Vulnerable Patients Update SOP for Isolation of Vulnerable Patients Caring for people at high risk during Covid 19 Criteria for Admission for Suspected COVID Patients from 08th April 2020 Clinical guide for the management of surge Nightingale Hospital North West Reusable Personal Protective Equipment Decontamination and Maintenance SOP
May 2020	A report was produced by AQUA summarising the response to the first wave of the pandemic. Waiting list process COVID19 Medical Care Recovery Plan V 1.0 SOP for Fit Testing of Respiratory Protective Equipment using the Qualitative (taste) Method Use of black box risk assessment Pilot Testing of Asymptomatic Staff Service recovery for Endoscopic procedures in Halton Theatre and Spire during COVID 19 Cancer pathways Laparoscopic Surgery Patient Placement during COVID19 Pandemic Service Change Protocol v2 Prescribing of paracetamol for staff in staff accommodation self-isolating Operating framework for urgent and planned services in hospital settings during COVID19 Respiratory Follow Up of Patients with COVID19 Pneumonia SOP for Testing Healthcare workers V7 WHH SOP NHS On Loan Equipment 2.docTrack and Trace of Loaned Medical Devices during COVID19 V.1 Testing Healthcare workers for COVID19 Staff Antibody SOP V1.1 Revised Elective Surgery during COVID19 Pandemic SOP Women's and Children's CBU COVID19 Recovery Plan v1.0 Recovery board action plan ~ Halton Elective Centre

	Recovery Board Action plan DD.docx RCEM - COVID 19 Action Plan Service recovery for Endoscopic procedures in Halton Theatre and Spire through COVID 19 v3 Individual Risk Assessment Elective Surgery During COVID19 Pandemic SOP
June 2020	COVID Recovery Plan Check in Meeting Manager's Guidance WHH SOP Paediatric Immunisation Clinic for low risk children during Covid Restarting urgent elective surgery in Warrington theatres, using Elective Surgery SOP Patient Placement During COVID19 Pandemic Ward Configuration Financial Process for COVID19 with appendices
July 2020	Pharmacy SOP recovery CAU WHH SOP CAU Admission Avoidance Appointment - SOP_ (2) Remdesivir Covid 19 Patient Information Leaflet for your surgery or procedure (002) Quantative FIT testing using Accutfit 9000 Surgical PPE Updating visiting guidance SARS Antibody testing for patients COVID19 Patient antibody testing PPE Room SOP COVID19 SOP - staff Clinical screening - non swabbing(2) C0649 Waiting List Validation programme DPA Template between Trust and NECS COVID19 Swabbing Paper Briefing Paper. Impact of COVID 19 and Recovery Phase on Medical Education and Training
August 2020	Surgical PPEv3 SIREN Study ICB Swabbing Surgical PPE v1.6 Dental Transition to Recovery SOP 28 August 2020 C0703_COVID19 Urgent dental care SOP 28 August 2020 Hospital_Discharge_Policy COVID19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020 Patient Placement During COVID19 Pandemic V2.4 Self-isolation policy v1 ID 33 - Updated version - Elective Paediatric Surgery SOP.docx
September 2020	Corticosteroid guidelines Chest Pain SOP

	Intermediate care Swabbing Elective procedure self-isolation Insertion of naso gastric tubes Healthcare workers return from shielding Testing and advice for healthcare workers Virtual MDT SOP Corticosteroids in COVID -19 PACU SOP Elective paediatric surgery low prevalence Elective paediatric surgery high prevalence Standard Operating Procedure for Management of Novel Coronavirus (COVID19) in Adults and Children version 14092020 A4 WHH SOP exclusion 03.8.2020 Transfer of Covid-patient
October 2020	Treatment escalation plans and communication Staff clinical screening - non swabbing Remdesivir SOP Combined HFNO Ward Admissions SOP Local Anaesthetic Administration SOP V2 Ward Admissions SOPv2 Healthcare workers return from shielding v2
November 2020	Version 4 WHH Pharmacy SOP Recovery Clinical Trial 26-11-2020 SOP Conscious Proning WHH SOP Safety Huddle and Briefing COVID19 Patient Screening SOP 2.1 NOV 2020 SOP for Testing and advice for Healthcare workers using LFD - OH additions - 18.11.2020 SOP for Remote Working
December 2020	Tactical - SOP for Testing and advice for Healthcare workers relating to COVID19 V10 • SOP Ordering Pfizer BioNtech Covid- 19 Vaccines • SOP Monitoring Freezer Temperature • SOP IT support for receipt of COVID vaccines sites • SOP Covid Vaccines Clinic Appointments • SOP Covid Vaccines in OPD • SOP Mortuary Refurbishment OOH Temp Failure at WHH • SOP Covid -19 vaccines governance • SOP MS35 Reciept of Standard bulk deliveries into pharmacy • SOP Moving PFizer BioNtech Covid -19 Vaccine • SOP Issuing, Checking, delivering supplies of Vaccines • SOP Mortuary Refurbishment Site Manager at WHH • COVID19 Patient Screening SOP 2.3 Dec 2020

	• WHH OPD SOP
January 2021	Tocilizumab ICU SOP B18 SOP V4 Jan 2021 COVID19 Service Changes Process SOP (V6) SOP forever hearts Lateral Flow Testing in ED SOP Enhanced Respiratory Care Unit SOP wave 3 updated staffing.docx V04 SOP Oxygen Cylinders WHH SOP Inpatient Vaccinations 3.0docx AstraZeneca COVID19 vaccine administration in OPD SOP January 2021 v2.0 SOP for the monitoring of oxygen usage on wards A9 and A5 x WHH SOP C-19 vaccination pregnancy and breast feeding 17Jan 20 C0995_COVID19 Waste Management Guidance SOP version 4 Final C1037 COVID vaccine deployment SOP community-based care workers 14 January 2021 Paediatric B11PED SOP Jan 2021 CPAP Black box SOP FINAL approved wave 3 Combined HFNO SOP Version 2 with weaning guides Jan 2021 C1042_SOP discharge COVID19 virtual ward_13Jan WHH SOP Ophthalmic Day ward – CSTM Anti-Coagulation Vaccination Centre SOP SOP TOE (covid update) Tactical - SOP for Testing and advice for Healthcare workers relating to COVID19 V11 Patient Initiated Follow Ups SOP
February 2021	COVID Virtual Ward SOP Jan 2021 v 2 final RECOVERY Trial Pharmacy SOP V5.0 Tocilizumab and Sarilumab ICU SOP V2 SOP - Internal process for Oxford AstraZeneca Referrals SOP - Internal process for booking cohorts of non-WHH staff for COVID19 vaccinations SOP - Referral of patients from PCN and Pharmacy Sites for COVID19 Vaccinations MS 38 Packing of Cool Box SOP updated by DM COVID19 Patient Screening SOP v3 FEB 2021 (3) POCU SOP Feb 2021 SOP Orthodontics Oral Surgery Transition to Recovery Feb 2021

Appendix 2 – AquA Report on the first phase of the response to COVID19

Headlines on capturing learning fro

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/21/07/95	
SUBJECT:	**NHSE/I System Oversight Framework Update**	
DATE OF MEETING:	28th July 2021	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer and Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1273 Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. #1289 Failure to deliver planned elective procedures caused by the Trust's decision to pause some elective procedures in order to ensure safe staffing and critical care capacity during the COVID-19 pandemic, resulting in potential delays to treatment and possible subsequent risk of clinical harm #115 Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. #134 Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	A briefing on the draft NHSE/I System Oversight Framework consultation was delivered to the Trust Board in April 2021. The final framework was published by NHSE/I in June 2021. The basis of the framework has not changed since the consultation. This paper outlines the published oversight metrics and the next steps for implementation.	

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

RECOMMENDATION:	The Board of Directors is asked to: 1. Note the introduction of the published System Oversight Framework and support the next steps.

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

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

NHSE/I System Oversight Framework (Update)

Launched in June 2021

Trust Board – 28th July 2021

NHSE System Oversight Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- A briefing on draft NHSE/I System Oversight Framework Consultation was delivered to the Trust Board in April 2021 (Appendix 1).
- The final framework was published by NHSE/I in June 2021. The basis of the framework has not changed since the consultation.
- The System Oversight Framework sets out how the Trust will be overseen by NHSE/I and then by the ICS as it develops throughout 2021/22.
- The main differences from the previous oversight framework are:
  - There is an emphasis on system performance and an expectation of collaboration.
  - ICSs will eventually replace NHSE/I to provide oversight of PLACE and over individual Trusts
  - Replacement of Segment 4 Special Measures with a Recovery Support Programme
  - Updated Oversight Metrics
- The Oversight Metrics have now been published (Appendix 2) and the metrics applicable to the Trust are outlined in Appendix 3.

Next Steps/Implementation

- The Trust is awaiting next steps from the ICS/NHSE around how oversight will be managed locally. The framework notes this will happen over the course of 2021/22.
- The Trust will be placed in Segment 2 initially.
- The ICS/Trust will need to understand from NHSE/I what they feel are the areas the Trust needs to improve and what the support requirements are.
- The ICS to agree MOU with NHSE/I including; financial governance and effective management of resources arrangements, quality governance arrangements with escalation, the role of PLACE based partnerships and provider collaboratives to deliver NHS priorities, the roles of ICS and NHSE/I in the oversight structures and local strategic priorities.
- The new oversight metrics will be mapped to understand internally how the metrics are monitored and if necessary updates to IPR/other reporting mechanisms will take place.
- Changes to indicators/reporting will be presented to the relevant committees in August/September.

Recommendation

The Trust Board is asked to:

- Note the introduction of the published System Oversight Framework and support the next steps.

Appendix 1 – System Oversight Framework Briefing Presentation (Consultation) April 2021, Updated June 2021 for the published framework.

Introduction

- Replaces the current NHSE Oversight Framework
- Emphasis on “System” level oversight with accountability at both system and organisational level (Providers and CCGs) with a move towards the ICS (as it develops) taking the oversight role from NHSE/I for PLACE and individual organisations.
- Reflects the vision set out in the; NHS Long Term Plan, Integrating Care Next Steps Paper, Integration and Innovation Paper and the 2021/22 NHS Operational Planning Guidance.
- Provides clarity to ICS/Organisations around how NHSE/I will monitor performance and sets expectations on working together to maintain and improve quality of care and describes how support needs to improve outcomes will be delivered.

Changes from the NHSI Oversight Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Describes in detail the relationship between NHSE/I and ICSs and how they will work together to improve oversight.
- Takes into account proposed legislation including ICS NHS Bodies and how the role of ICSs will develop over time.
- Single set of oversight metrics for ICSs, Providers and CCGs
- Replacement of “Special Measures” with a “Recovery Support Programme” which will be nationally led by a Service Improvement Director.
- Segmentation remains in place with each ICS/Organisation being placed into a segment e.g. Segment 1 (greater autonomy) – Segment 4 (recovery support programme).

Purpose & Principles

- Alignment of priorities of the ICSs and the Organisations which are part of it.
- Objectivity used to identify where ICSs/Organisations may require support to deliver priorities and when/how NHSE will intervene in serious cases.
- Where possible NHSE/I will work with/through ICSs
- Greater emphasis on system performance and quality of care outcomes
- Accountability matched with improvement support with greater autonomy for successful and high performing ICSs/Organisations with evidence of collective working and delivery of NHS priorities.
- Expectation of greater collaborative working. Failure to do so may be treated as a breach of governance conditions and potentially subject to enforcement action.

The role of Integrated Care Systems (ICS)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Integrated Care Next Steps Paper	2021/22 Operational Planning Guidance	ICS Development
• Improving Population/Outcomes • Tacking unequal outcomes and access • Enhancing Productivity/Value • Helping the NHS support broader social/economical development	• Collective Management of Resources & Performance at System, Place and Organisational level	• ICSs increasing involved in oversight in partnership with NHSE/I • ICS/NHSE/I to progress as the ICS develops. • Development of locally appropriate approaches to oversight.

Approach to Oversight

Warrington and Halton Teaching Hospitals NHS Foundation Trust

5 National Themes

- Quality of Care, Access & Outcomes
- Finance & Use of Resources
- Preventing Ill Health & Reducing Inequalities
- Leadership
- People

1 Local Theme (agreed with ICS)

- Locally agreed at PLACE, agreed with ICS reflecting challenges and collaboration.

3 Step Oversight Cycle **<Segmentation>**

Single set of oversight metrics will be used to flag potential issues and prompt further investigation of support needs with ICS, PLACE or individual Trusts.

Monitoring

- Oversight arrangements will be flexible in response to COVID-19 and other unexpected issues.
- NHSE/I will monitor and gather insight across the 6 themes.
- Annual Plans, Surveys, Reports, Regular Finance/Operational Information, Risk/Issues, Metrics, Other Information.
- In Year, Monthly, Annual and By Exception
- Current & Historical Performance – evidence of improving clinical variation.
- Expectation for ICSs/Organisations to engage with NHSE/I regional teams on issues outside of monitoring which could materially impact quality and performance.
- NHSE/I statutory powers and responsibilities remain unchanged.

Monitoring

- Robust quality governance arrangements; share intelligence, monitor quality measures and outcomes, identify and manage risks to quality, working in collaboration where issues can’t be resolve locally, PLACE based solutions and ongoing quality improvement.
- NHSE/I review meetings at ICSs level and/or PLACE and by exception with individual organisations. Leadership and culture at organisational and system level form core part of oversight conversations.
- Local PLACE/Organisation meetings by ICSs (with support from NHSE regional teams) in the delivery of governance arrangements across the ICS including financial governance arrangements, collaboration and local strategic priorities.
- New approach to CCG assessment based on performance against metrics, key lines of enquiry based on the five national themes and assessment of collaboration in quality outcomes.

Monitoring – Review Meetings

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	ICS	Place*	Individual organisations/collaboratives
Scope	• Performance against national requirements including the NHS Long Term Plan deliverables at ICS level across the five national themes of the NHS System Oversight Framework • Delivery against ICS 'local priorities' set out in ICS strategic plans and its local people plan • Extent to which system partners are working effectively together to deliver and improve	• Performance against national requirements including the NHS Long Term Plan deliverables at place and organisation level across the themes of the NHS System Oversight Framework • Delivery against place and organisation level priorities set out in ICS plans including primary/community care and population health • Any emerging organisational health issues that may need addressing • Extent to which place-based partners are working effectively together to deliver and improve	• Oversight of and support to: – individual organisations that span multiple ICSs, or have significant funding flows from outside an ICS, eg ambulance trusts and specialist trusts – collaboratives that span multiple places, including for the delivery of specialised services • Linked to NHS England statutory duty to annually assess CCGs • Occur by exception only for other organisations, with scope determined by the specific issues identified in discussion between the NHS England and NHS Improvement regional team and ICS leadership
Roles and participation	• **Led by NHS England and NHS Improvement regional team** with: – ICS leadership team – CEOs and AO(s) from system providers and commissioner(s)	• **Typically led by ICS** (with NHS England and NHS Improvement role linked to ICS maturity) with: – provider and commissioner leadership team – place-based system leaders as appropriate	• **NHS England and NHS Improvement, ICS and organisational teams as relevant** for cross ICS, provider collaborative and exceptional meetings • CCG leadership team, chair and governing body members for CCG assessment-related meetings
Frequency of review meetings	• The default frequency for these meetings will vary according to the governance arrangements agreed between the regional team and ICS, but should be at least quarterly • Regional team will engage more frequently where there are material concerns	• Determined in discussion between the regional teams and ICS based on local system architecture and governance arrangements • Regional and/or system team will engage more frequently where necessary, including focused meetings around specific themes (eg quality, finance) and/or with a subset of organisations	• Frequency determined based on need through discussion between NHS England and NHS Improvement regional team and ICS and organisational leadership • Annual meeting linked to CCG assessment process. CCGs are also expected to complete a mid-year self-assessment

Segmentation & Support Levels

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- ICSs, Trusts & CCGs will all be allocated to a support segment (1-4) – phased implementation starting with ICS/Trust which qualify for S3 & S4.
- Support Levels are not determined by the segment the Trust is in.
- S1 has the greatest level of autonomy, S4 requires the highest level of support – Recovery Support Programme.
- Replacement of “Special Measures” support level (quality & finance) with a “Recovery Support Programme” for Segment 4.
- All ICSs/Trusts/CCGs placed in Segment 2 by default unless they meet the criteria for another segment.
- Segmentation decisions and support requirements are based on objective criteria/judgement Inc. views of system leaders. Additional factors will be considered if a ICS/Organisation meets the eligibility criteria for a segment.

Segments & Support Requirements

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Segment description			Scale and nature of support needs
	ICS	CCG	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver the ICS four fundamental purposes is well developed	Consistently high performing across the six oversight themes Streamlined commissioning arrangements are in place or on track to be achieved	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and overall ICS priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective, self-standing ICS Plans that have the support of system partners in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England and NHS Improvement universal support offer (eg GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in building the capability and capacity required to deliver on the ICS four fundamental purposes	Significant support needs against one or more of the six oversight themes No agreed plans to achieve streamlined commissioning arrangements by April 2022	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)	Bespoke mandated support through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

Segmentation Approach

Warrington and Halton Teaching Hospitals NHS Foundation Trust

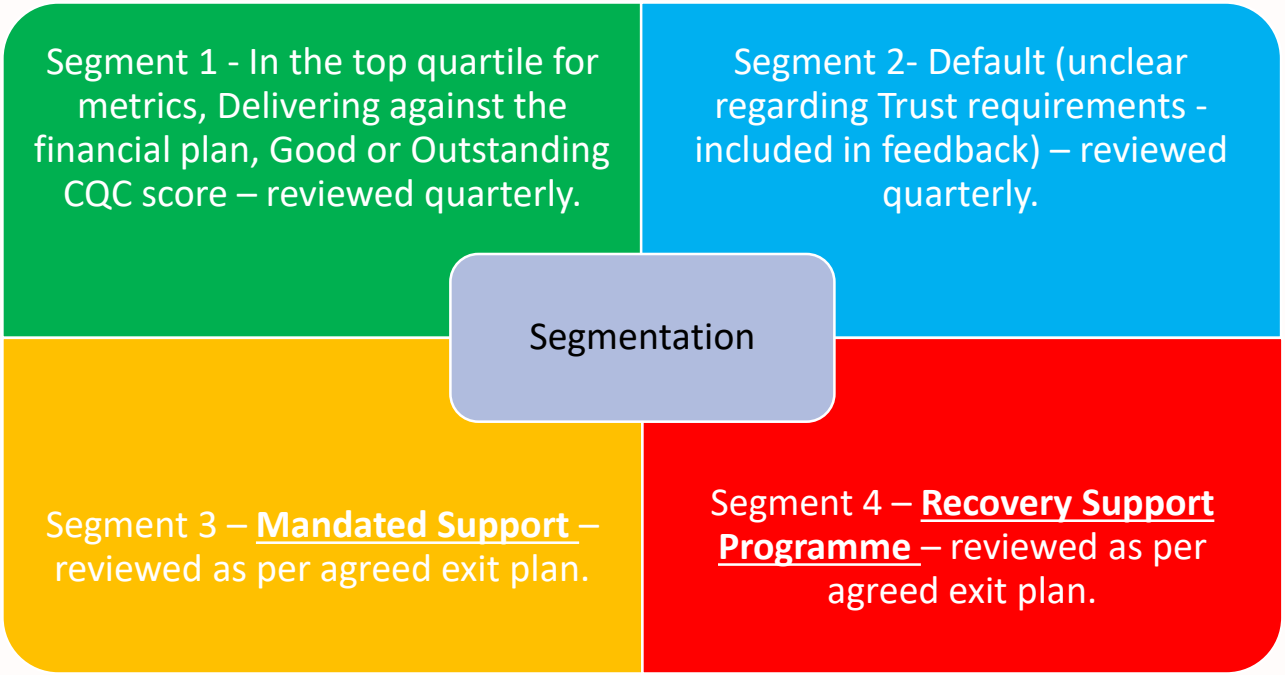
	Eligibility criteria	Additional considerations
1	• Performance against the oversight themes typically in the top quartile nationally based on the relevant oversight metrics *and* • On agreed financial plan and forecasting delivery against full year envelope *and* • CQC 'Good' or 'Outstanding' overall and for well-led (trusts)	*For ICSs and/or CCGs:* • Success in tackling variation across the system and reducing health inequalities • Whether the ICS consistently demonstrates that it has built the capability and capacity required to deliver on the four fundamental purposes of an ICS • Whether the CCG has achieved streamlined commissioning arrangements aligned to the ICS boundary, or is on track to fully achieve these against an agreed plan. *For trusts:* • Evidence of established improvement capability and capacity • The degree to which the trust plays a strong, active leadership role in supporting and driving place-based priorities, provider collaboration and overall ICS priorities.
2	This is the default segment that all ICSs, trusts and CCGs will be allocated to unless the criteria for moving into another segment are met	
3	• Performance against multiple oversight themes in the bottom quartile nationally based on the relevant oversight metrics *or* • A dramatic drop in performance, or sustained very poor (bottom decile) performance against one or more areas *or* • An underlying deficit that is in the bottom quartile nationally and/or a negative variance against the financial plan and/or not forecasting to meet plan at year end *or*	*For all:* • Existence of other material concerns about a system's and/or organisation's governance, leadership, performance and improvement capability arising from intelligence gathered by or provided to NHS England and NHS Improvement (eg delivery against the national and local transformation agenda) • Evidence of capability and capacity to address the issues without additional support, eg where there is clarity on key issues with an existing improvement plan and a recent track record of delivery against plan and/or of agreed recovery actions • There are other exceptional mitigating circumstances *For ICSs:* • Evidence of collaborative and inclusive system leadership across the ICS, eg where the system is not in financial balance, whether it has been able to collectively agree credible plans for meeting the system envelope

Segmentation Approach

	Eligibility criteria	Additional considerations
	• A CQC rating of 'Requires Improvement' overall and for well-led (trusts) *or* • No agreed plans to achieve streamlined commissioning arrangements aligned to ICS boundaries by April 2022 (CCGs)	• Clarity and coherence of system ways of working and governance arrangements *For trusts:* • Whether the trust is working effectively with system partners to address the problems
4	In addition to the segment 3 criteria: • Longstanding and/or complex issues that are preventing agreed levels of improvement for ICSs, trusts or CCGs in SOF segment 3 *or* • A catastrophic failure in leadership or governance that risks damaging the reputation of the NHS *or* • A significant underlying deficit and/or significant actual or forecast gap to the financial plan *or* • CQC recommendation (trust)	

Changes to the ICSs/Trusts Segments

Warrington and Halton Teaching Hospitals NHS Foundation Trust



ICSs/Organisations are not automatically placed in a segment even if they meet the eligibility criteria alone. Other factors will be taken into consideration e.g. success in tacking variation, consistently demonstrate leadership capability/capacity.

Segment 3 – Mandated Support

- Criteria – Negative variance against financial plan, bottom quartile or sustained poor performance in metrics, dramatic drop in performance, CQC RI overall or in well led domain or concern around governance/leadership.
- Co-ordinated by regional NHSE/I teams in conjunction with ICSs. Enforcement action requiring ICSs/Organisations to undertake specific actions.
- Consideration around if the ICS/Organisation is working collaboratively to address the issue, mitigating circumstances and if there is capability/capacity to resolve the issue.
- NHSE/I will communicate the decision to place the ICS/Organisation in S3 and will work with them to develop/deliver mandatory support package and agreed exit criteria/timescale.
- Additional interventions may include; enhanced monitoring/scrutiny, NHSE/I advisory role in senior appointments, financial controls, additional reporting requirements.

Segment 4 – Recovery Support Programme (RSP)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Criteria – longstanding complex issues preventing agreed improvement actions, actual/forecast significant gap against financial plan, catastrophic failure in leadership or governance or upon recommendation by CQC (generally “Inadequate” organisations).
- Co-ordinated by the NHSE/I national team with oversight from a System Improvement Director.
- NHSE/I will communicate the decision to place the ICS/Organisation in S4 with a formal public announcement via press release and will work with them to develop/deliver mandatory support package and agreed exit criteria/timescale.
- Additional interventions may include; governance review, improvement programmes, deficit drivers review, financial turnaround/recovery, intensive support for people/workforce practices, challenge meetings, board vacancies appointed as directed by NHSE/I, NHSE/I board appointed advisors, enhanced reporting.
- Additional financial controls could include peer review expenditure controls, reduced capital approval limits, NHSE/I control of finances, additional grip and control measures.

Segment 4 – Recovery Support Programme (RSP)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- The new RSP will be system orientated, focus on underlying drivers, nationally led by service improvement director with MDT support.
- Local system partners expected to support individual organisations which are placed in the RSP.
- The Service Improvement Director will co-ordinate support and develop and agree an exit plan with ICSs/Organisations (usually exit within 12 months).
- NHSE/I will review capability of ICSs/Organisations leadership and if necessary make changes to ensure Exec Team/Board can make the required improvements.
- Exit from RSP to be decided by NHSE/I System Oversight Committee based on agreed exit criteria.

Conclusion

The main developments in the new System Oversight Framework are:

- Greater emphasis on the system and role of the ICS.
- Replacement of Intensive Support with the Recovery Support Programme led by Service Improvement Director (Segment 4)
- 6 Themes, 5 National with 1 Local Theme
- New oversight metrics now published.
- NHSE/I to continue to work with ICSs, Commissioners and Providers throughout 2021/22 to further develop approach and oversight with an updated framework for 2022/23. The updated framework will outline ICSs role in more detail once formal legislation has been enacted.
- NHSE/I statutory responsibilities will remain the same in 2021/22 and the accountabilities of individual organisations also remain unchanged.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 2 – Segmentation Criteria

	Segment description			Scale and nature of support needs
	ICS	CCG	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver the ICS four fundamental purposes is well developed	Consistently high performing across the six oversight themes Streamlined commissioning arrangements are in place or on track to be achieved	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and overall ICS priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	This is the 'default' segment unless an ICS, trust or CCG triggers the criteria for moving into another segment. While ICSs in this segment will still be on a development journey, they will demonstrate many of the characteristics of an effective, self-standing ICS. Where performance is challenged at system, place or organisation level, plans that have the support of system partners will be in place to address this.			Flexible support delivered through peer support, clinical networks, the NHS England and NHS Improvement universal support offer (eg GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in building the capability and capacity required to deliver on the ICS four fundamental purposes	Significant support needs against one or more of the six oversight themes No agreed plans to achieve streamlined commissioning arrangements by April 2022	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)	Bespoke mandated support through regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

Appendix 2 – System Oversight Framework Metrics

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
Quality, access and outcomes	Primary and community services including new community services response times	All general practices to be delivering at, or above, pre-pandemic appointment levels, including through consolidating and maximising the use of digital consultation methods and technology	Access to general practice – number of available appointments	✓		✓
			Proportion of the population with access to online GP consultations	✓		✓
		Maximising dental activity and targeting capacity to minimise deterioration in oral health and reduce health inequalities	Dental activity	✓		✓
		Transforming community services and improving discharge	2-hour urgent response activity	✓	✓	✓
			Discharges by 5pm	✓	✓	✓
			Delayed transfers of care per 100,000 population	✓		✓
	Restoration of elective and cancer services*	Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services	Elective activity levels	✓	✓	✓
			Overall size of the waiting list	✓	✓	✓
			Patients waiting more than 52 weeks to start consultant-led treatment	✓	✓	✓
		Restore full operation of all cancer services	Cancer referral treatment levels	✓	✓	✓
			People waiting longer than 62 days	✓	✓	✓
			% meeting faster diagnosis standard	✓	✓	✓

Appendix 2 – System Oversight Framework Metrics

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
		Maximise diagnostic activity focused on patients of highest clinical priority	Diagnostic activity levels	✓	✓	✓
	Improve cancer outcomes: early diagnosis and survival		Proportion of people who survive cancer for at least 1 year after diagnosis	✓		✓
			Proportion of cancers diagnosed at stages 1 or 2	✓		✓
	Outpatient reform: avoidance of up to a third of outpatient appointments	Embed outpatient transformation	Advice and guidance and patient initiated follow-up activity levels	✓	✓	✓
	Implementation of agreed waiting times		% of all outpatient activity delivered remotely via telephone or video consultation	✓	✓	✓
			UEC performance measure*	✓	✓	✓
			30-minute ambulance breaches	✓	✓	✓
			Ambulance response times		✓	
	Maternal and children's health**	Continue delivery of the maternity transformation measures set out in the NHS Long Term Plan	% women on continuity of care pathway		✓	
			Number of stillbirths per 1,000 total births			✓

Appendix 2 – System Oversight Framework Metrics

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
		Implement the five elements of the Saving Babies' Lives care bundle	Number of neonatal deaths per 1,000 live births			✓
	Emergency care: on agreed trajectory for same day emergency care (SDEC) and integrated urgent care services (IUC)	Maximise the use of booked time slots in A&E	% of patients referred to an emergency department by NHS 111 that receive a booked time slot to attend	✓		✓
		Increase % of patients seen and treated on the same day or within 12 hours if this spans to midnight	% of zero-day length of stay admissions (as a proportion of total)		✓	✓
		Reduce avoidable A&E attendances by directing patients to more appropriate urgent care settings	% of unheralded patients attending EDs	✓		✓
	Mental health	Meet the MHIS and use the investment to grow the workforce and deliver transformation of care	Delivery of the mental health investment standard	✓		✓
		Deliver the mental health ambitions outlined in the NHS Long Term Plan, expanding and transforming core mental health services	NHS Long Term Plan metrics for mental health	✓	✓	✓
	Learning disability and autism: reducing	Continue to reduce reliance on inpatient care (adults and children)	Reliance on specialist inpatient care for adults/children with a learning disability and/or autism			✓

Appendix 2 – System Oversight Framework Metrics

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
	inpatient rate and increasing learning disability physical health checks	Make progress on the delivery of annual health checks for people with a learning disability	Number of people with a learning disability on the GP register receiving an annual health check	✓		✓
	People will get more control over their own health by rolling out NHS personalised care model across the country	Systems should continue and, where possible, accelerate the delivery of existing requirements, including personalised health budgets, wheelchairs for children, social prescribing referrals and personalised care and support plans	Number of personalised care interventions	✓		✓
			Personal health budgets	✓		✓
			Social prescribing unique patient referrals	✓		✓
	Delivering safe, high quality care overall		Summary hospital-level mortality indicator		✓	
			Overall CQC rating (provision of high-quality care)		✓	
			Acting to improve safety (safety culture theme in NHS Staff survey)		✓	
			Patient experience of GP services	✓		✓
			Potential under-reporting of patient safety incidents		✓	
			National Patient Safety Alerts not completed by deadline		✓	

Appendix 2 – System Oversight Framework Metrics

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
			Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia infection rate		✓	
			Clostridium difficile infection rate		✓	
			E. coli bloodstream infections	✓	✓	✓
			Venous thromboembolism (VTE) risk assessment		✓	
			Antimicrobial resistance: appropriate prescribing of antibiotics and broad-spectrum antibiotics in primary care	✓		✓
Preventing ill health and reducing inequalities	**Screening and vaccination programmes meet base levels in the public health agreement or national goals**	First COVID-19 vaccination dose offered to all adults by the end of July	% of adults vaccinated			✓
		Maximise efforts to recover immunisation services that were paused or had reduced uptake due to the COVID-19 pandemic	Population vaccination coverage – MMR for two doses (5 year olds) to reach the optimal standard nationally (95%)	✓		✓
		Flu vaccination	Number of people receiving flu vaccination	✓	✓	✓
		Restore of NHS bowel cancer screening programme	Bowel screening coverage, aged 60–74, screened in last 30 months	✓		✓
		Restore the national breast screening service back to the key performance indicator threshold	Breast screening coverage, females aged 50–70, screened in last 36 months	✓		✓

Appendix 2 – System Oversight Framework Metrics

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
		Restore cervical screening	Cervical screening coverage, females aged 25-64, attending screening within target period	✓		✓
	Improvements for people with conditions such as diabetes, CVD and obesity	Improved uptake of the NHS diabetes prevention programme	Number of people supported through the NHS Diabetes Prevention programme	✓		✓
			Diabetes patients that have achieved all the NICE-recommended treatment targets (adults and children)	✓		✓
		Make progress against the NHS Long Term Plan high impact actions to support stroke, cardiac and respiratory care	Number of people with CVD treated for cardiac high risk conditions	✓		✓
			Number of people receiving mechanical thrombectomy	✓		✓
		Increase referrals to NHS digital weight management services	Number of referrals to NHS digital weight management services	✓		✓
	Reducing inequalities	Restoring NHS services inclusively	Ethnicity and most deprived quintile proportions across service restoration and NHS Long Term Plan metrics	✓	✓	✓
		Accelerating preventative programmes	COVID-19 vaccination uptake for black and minority ethnic groups and the most deprived quintile compared to the national average			✓
		Ensuring datasets are complete and timely	Proportions of patient activities with an ethnicity code	✓	✓	✓
	Leadership		Quality of leadership†	✓	✓	✓

Appendix 2 – System Oversight Framework Metrics

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
Leadership and capability			Aggregate score for NHS Staff Survey questions that measure perception of leadership culture††	✓	✓	✓
People	People Promise	Supporting the health and wellbeing of staff and taking action on recruitment and retention	People promise index††	✓	✓	✓
	Looking after our people		Health and wellbeing index††	✓	✓	✓
			Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (a) managers, (b) other colleagues, (c) patients/ service users, their relatives or other members of the public in the last 12 months	✓	✓	✓
			Proportion of people who report that in the last three months they have come to work despite not feeling well enough to perform their duties	✓	✓	✓
			Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns	✓	✓	✓
			% of jobs advertised as flexible	✓	✓	✓
			Staff retention rate (all staff)	✓	✓	✓

Appendix 2 – System Oversight Framework Metrics

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
			Sickness absence (working days lost to sickness)	✓	✓	✓
			Proportion of staff who say they have a positive experience of engagement	✓	✓	✓
			Number of people working in the NHS who have had a 'flu vaccination	✓	✓	✓
	Belonging in the NHS		Proportion of staff in senior leadership roles who are (a) from a BME background, (b) women	✓	✓	✓
			Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	✓	✓	✓
	Growing for the future		Number of registered nurses employed by the NHS (WTE)			✓
			Number of doctors working in general practice (WTE)	✓		✓
			Additional primary care WTE through ARRS	✓		✓
			Number of healthcare support workers employed by the NHS			✓
			Mental health workforce growth	✓		✓

Appendix 2 – System Oversight Framework Metrics

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
Finance and use of resources	**The NHS will return to financial balance: NHS in overall financial balance each year**	Systems to manage within financial envelopes	Performance against financial plan	✓	✓	✓
			Underlying financial position	✓	✓	✓
			Run rate expenditure	✓	✓	✓
			Overall trend in reported financial position	✓	✓	✓

Note: This list may be updated in year to reflect planning guidance for the second half of the year.

* A response to the consultation to the UEC clinically-led review of standards will be published in due course.

** We will also monitor delivery against the other priorities set out in the planning guidance, including progress against implementing the immediate and essential actions from the Ockenden report.

† Based on CQC leadership rating for trusts and GP practices, and NHS England and NHS Improvement assessment for CCGs and ICSs.

†† Metric under development.

Appendix 3 – System Oversight Framework Metrics (relevant to the Trust)

2021/22 Planning Guidance Deliverable	Metric	Directorate
Restoration of elective and cancer services	Elective activity levels	Operations
	Overall size of the waiting list	Operations
	Patients waiting more than 52 weeks to start consultant-led treatment.	Operations – currently reported on the IPR.
	Cancer referral treatment levels	Operations – currently reported on the IPR.
	People waiting longer than 62 days.	Operations – currently reported on the IPR.
	% meeting faster diagnosis standard	Operations – currently reported on the IPR.
	Diagnostic activity levels	Operations
Outpatient reform: avoidance of up to a third of outpatient appointments	Advice and guidance and patient initiated follow-up activity levels	Operations
Implementation of agreed waiting times	% of all outpatient activity delivered remotely via telephone or video consultation	Operations
	UEC performance measure*	Operations - Currently under development by NHSE/I
	30-minute ambulance breaches	Operations – currently reported on the IPR.
Maternal and children's health**	% women on continuity of care pathway	Nursing/Governance – currently reported on the IPR.
Emergency care: on agreed trajectory for same day emergency care (SDEC) and integrated urgent care services (IUC)	% of zero-day length of stay admissions (as a proportion of total)	Operations
Delivering safe, high quality care overall	Summary hospital-level mortality indicator	Nursing/Governance – currently reported on the IPR.
	Overall CQC rating (provision of high-quality care)	All – Trust CQC Rating
	Acting to improve safety (safety culture theme in NHS Staff survey)	Nursing/Governance
	Potential under-reporting of patient safety incidents	Nursing/Governance

Appendix 3 – System Oversight Framework Metrics (relevant to the Trust)

	National Patient Safety Alerts not completed by deadline	Nursing/Governance
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Nursing/Governance – currently reported on the IPR.
	Clostridium difficile infection rate	Nursing/Governance – currently reported on the IPR.
	E. coli bloodstream infections	Nursing/Governance – currently reported on the IPR.
	Venous thromboembolism (VTE) risk assessment	Nursing/Governance – currently reported on the IPR.
Screening and vaccination programmes meet base levels in the public health agreement or national goals	Number of people receiving flu vaccination	Nursing Governance – need to understand if this metric is relevant to the Trust
Restoring NHS services inclusively	Ethnicity and most deprived quintile proportions across service restoration and NHS Long Term Plan metrics.	Operations
Ensuring datasets are complete and timely	Proportions of patient activities with an ethnicity code	Operations
Leadership	Quality of leadership† (based on CQC Leadership Rating)	All – CQC Rating
	Aggregate score for NHS Staff Survey questions that measure perception of leadership culture††	All
People Promise	People promise index††	Metric Under Development by NHSE/I
Looking after our people (A1)	Health and wellbeing index††	Metric Under Development by NHSE/I
	Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (a) managers, (b) other colleagues, (c) patients/ service users, their relatives or other members of the public in the last 12 months	People – Staff Survey
	Proportion of people who report that in the last three months they have come to work despite not feeling well enough to perform their duties	People – Staff Survey

Appendix 3 – System Oversight Framework Metrics (relevant to the Trust)

	Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns	People – Staff Survey
	% of jobs advertised as flexible	People
	Staff retention rate (all staff)	People – currently reported on the IPR.
	Sickness absence (working days lost to sickness)	People – currently reported on the IPR.
	Proportion of staff who say they have a positive experience of engagement	People – staff survey.
	Number of people working in the NHS who have had a 'flu vaccination	People
Belonging in the NHS (A2)	Proportion of staff in senior leadership roles who are (a) from a BME background, (b) women	People
	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.	People – Staff Survey
The NHS will return to financial balance: NHS in overall financial balance each year	Performance against financial plan	Finance – currently reported on the IPR
	Underlying financial position	Finance
	Run rate expenditure	Finance
	Overall trend in reported financial position	Finance

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/21/07/96	
SUBJECT:	**Use of Resource Assessment (UoRA) Update – Q1 2021/22**	
DATE OF MEETING:	28th July 2021	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer and Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1273 Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. #1289 Failure to deliver planned elective procedures caused by the Trust's decision to pause some elective procedures in order to ensure safe staffing and critical care capacity during the COVID-19 pandemic, resulting in potential delays to treatment and possible subsequent risk of clinical harm #115 Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. #134 Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust continues to progress improvement in its Use of Resources both internally and in collaboration with system wide partners, however COVID-19 has impacted progress. This paper outlines the current status of the Use of Resources Dashboard, however it should be noted that many of the indicators have not been updated on the Model Hospital.	

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

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

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

REPORT TO THE BOARD OF DIRECTORS

SUBJECT	Use of Resource Assessment (UoRA) Update – Q1 2021/22	AGENDA REF:	BM/21/07/96

1. BACKGROUND/CONTEXT

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

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

2. KEY ELEMENTS

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

There has been no movement in the UoRA Model Hospital Indicators in Quarter 1.

National Corporate Benchmarking

The national corporate benchmarking exercise is taking place in Quarter 2 2021/22 (having been paused in 2020/21). This will provide the Trust with an up to date position in relation to costs of corporate services and how the Trust benchmarks against the national and peer medians based on 2020/21 data. The final report is expected to be issued in Q3 2021/22.

Self-Assessments

Each KLOE lead has produced a UoRA "Self-Assessment" which outlines the actions taken to improve in each area, the impact on investment from capital and revenue business cases, outstanding practice areas and future improvement actions. This is then presented to the wider UoRA group each month on a rolling programme.

3. RECOMMENDATIONS

The Board of Directors is asked to:

1. Note the contents of this report.

Andrea McGee
Chief Finance Officer and Deputy Chief Executive
21st July 2021

Appendix 1 – Benchmarking Performance against the National Median

KLOE Indicator	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22
KLOE 1 - Clinical												
Pre-Procedure Elective Bed Days	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21
Pre-Procedure Non-Elective Bed Days	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21
Emergency Readmission (30 Days)	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21
Did Not Attend (DNA) Rate	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21
KLOE 2 - People												
Staff Retention Rate	June 2018	September 2018	December 2018	December 2018	December 2018	December 2018	March 2020	March 2020	June 2020	Sept 2020	December 2020	March 2021
Sickness Absence Rate	May 2018	August 2018	November 2018	November 2018	June 2019	October 2019	March 2020	March 2020	June 2020	Sept 2020	January 2021	March 2021
Pay Costs per Weighted Activity Unit	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	This indicator has been moved to a "Legacy" area of the model hospital and is no longer being updated.					
Medical Costs per WAU	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2019/20	2019/20
Nurses Cost Per WAU	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2019/20	2019/20
AHP Cost per WAU (community adjusted)	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2019/20
KLOE 3 – Clinical Support Services												
Top 10 Medicines - Percentage Delivery of Savings	March 2018	March 2018	March 2018	March 2018	September 2019	November 2019	March 2020	March 2020	August 2020	November 2020	February 2021	May 2021
Pathology - Overall Costs Per Test	Q4 2017/18	Q4 2017/18	Q2 2018/19	Q2 2018/19	Q4 2018/19	Q2 2019/20	Q3 2019/20	Q3 2019/20	Q3 2019/20	Q1 2020/21	Q3 2020/21	Q4 2020/21
Non-Pay Costs per WAU	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	This indicator has been moved to a "Legacy" area of the model hospital and is no longer being updated.					
Finance Costs per £100m Turnover	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19
Human Resource Costs per £100m Turnover	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19
Procurement Process Efficiency and Price Performance Score Clinics	Q4 2016/17	Q4 2017/18	Q3 2018/19	Q3 2018/19	Q4 2018/19	Q4 2018/19	Q4 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q2 2019/20	Q2 2019/20
Estates Costs Per Square Meter	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19
KLOE 5 - Finance												

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

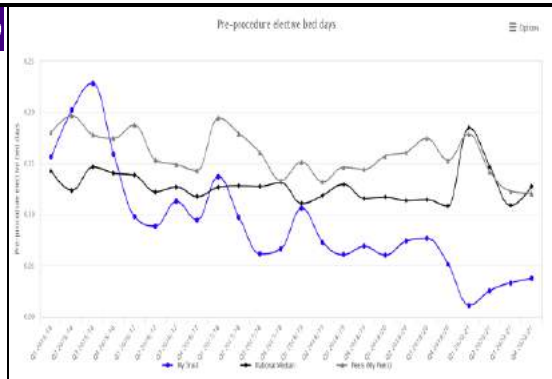
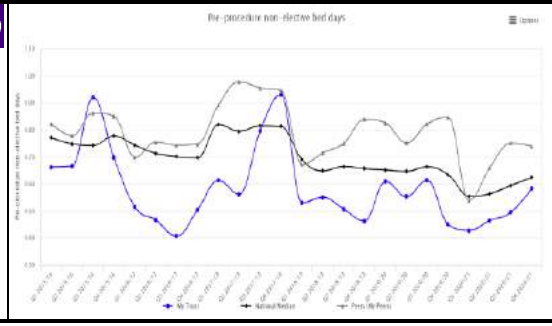
Green on the Model Hospital (Better than the National Median)
Red on the Model Hospital (Worse than the National Median)
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q1 2021/22

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

KLOE 1: Clinical/Operational

KLOE Operational Lead: Hilary Stennings

Pre Procedure Elective Bed Days - The number of bed days between the elective admission date and the date that the procedure taken place.	**National Median: 0.13 days** **Q4 2020/21** **Peer Median: 0.12 days** **Target: Maintain** **Best Quartile: 0.06 days** **WHH Position:** **0.04 days** **Ranking:** **3/10 Peer Group** **Quartile:** **1 (Best)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		**The Trust is performing in the best quartile for this metric and is performing better than the national and peer medians.** The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme supported the reduction in theatre cancellations and in improving productivity and efficiency. Further improvements have been made during the pandemic, however this is likely due to the reduction in the elective programme. The Trust would expect to see a slight rise in the number of bed days. However, the Trust was performing better than the national median prior to the pandemic.
Pre Procedure Non Elective Bed Days - The number of bed days between an emergency admission date and the date the procedure taken place.	**National Median: 0.62 days** **Q4 2020/21** **Peer Median: 0.74 days** **Target: Maintain** **Best Quartile: 0.45 days** **WHH Position:** **0.58 days** **Ranking:** **04/10 Peer Group** **Quartile:** **2 (2nd Best)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		**The Trust is performing better than the national and peer medians**. The Trust continually reviews opportunities to improve efficiency around emergency and non elective procedures. The surgical transformation programme supported the reduction in theatre cancellations and in improving productivity and efficiency. Further improvements have been made during the pandemic, however this is likely due to the reduction in non elective activity. The Trust would expect to see a rise in the number of bed days. However, the Trust was performing better than the national median prior to the pandemic.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

Trust Position

National Median

Peer Median

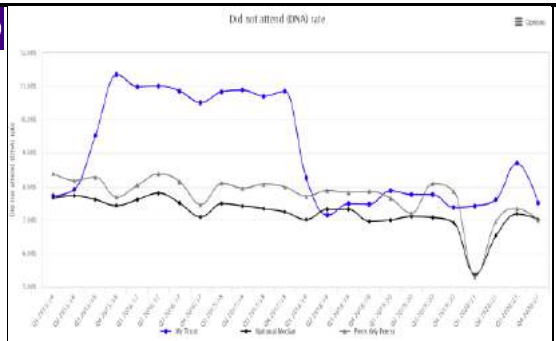
Key

Green on the Model Hospital (Better than the National Median)

Red on the Model Hospital (Worse than the National Median)

Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q1 2021/22

Action/ Recommendation	Benchmarking/Progress		Trend	Narrative - Warranted/Unwarranted & Justifiable
Did Not Attend Rate - Rate of patients not attending their outpatient appointment	**National Median: 7.02%** **Peer Median: 7.00%** **Best Quartile: 5.87%** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q4 2020/21** **Target: National Median** **7.51%** **07/09 Peer Group** **3 (2nd Worse)**		**The Trust is performing slightly worse than the national and peer medians, although improvement has been seen this quarter.** The Trust reintroduced a text reminder service which has resulted in a significant improvement in the DNA (Did Not Attend) rate. Further improvements have been made to the text message reminder and a communications campaign has been launched (Don't Let Me Down). During the pandemic, the use of virtual and telephone appointments has been rapidly expanded. It is anticipated the Trust will see further improvements during future reporting periods as a result. The Trust has established the Outpatient Recovery Improvement Group incorporating 5 workstreams; Risk Stratification, Workforce, Performance & KPIs, Operational and Access Policy. DNA performance is monitored through the Performance & KPI workstream. The Access policy and the DNA policy are being reviewed and individual CBUs are monitoring frequent DNAs to ensure that these patients are clinically reviewed for potential discharge. Patient initiated follow ups are also being used as a trial to reduce DNAs.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

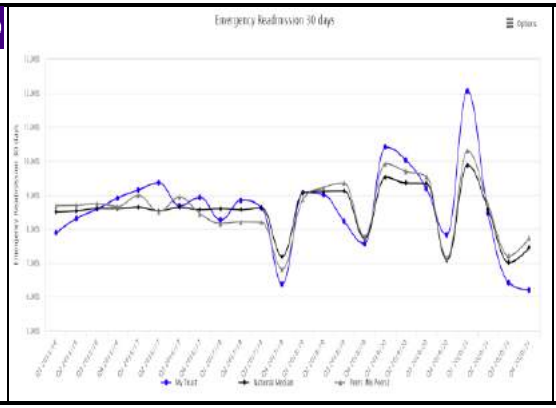
Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

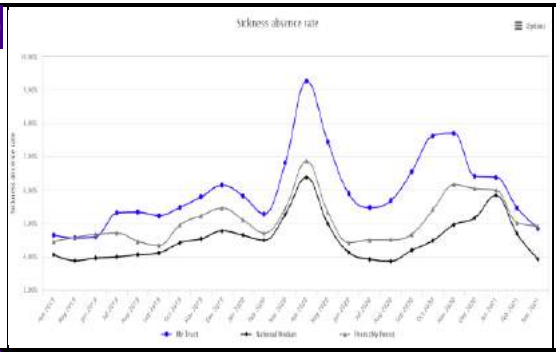
Green on the Model Hospital (Better than the National Median)
Red on the Model Hospital (Worse than the National Median)
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q1 2021/22

Action/ Recommendation	Benchmarking/Progress		Trend	Narrative - Warranted/Unwarranted & Justifiable
Emergency Readmission Rates (30 Days) - This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay. Admissions for cancer and obstetrics are excluded as they may be part of the patient's care plan.	**National Median: 7.46%** **Peer Median: 7.74%** **Best Quartile: 6.23%** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q4 2020/21** **Target: Maintain** **6.20%** **3/10 Peer Group** **1 (Best)**		**The Trust is performing better than national and peer medians and is in the best quartile for this metric.** Every effort is made when discharging patients to ensure that the discharge is appropriate. Readmissions are reviewed by the clinical directors to understand any inappropriate discharges and to ensure lessons are learned. The Trust is fully engaged with GIRFT (Getting It Right First Time) and continues to use intelligence to make improvements in efficiencies and the quality of services.

KLOE 2: People

KLOE Operational Lead: Carl Roberts

Staff Sickness - Percentage of staff FTE sick days.	**National Median: 3.92%** **Peer Median: 4.92%** **Best Quartile: 3.28%** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: Trust Board, SPC** **Source: HSCIC - NHS Digital iView Stability Index**	**March 2021** **Target: 4.2%** **4.81%** **5/10 Peer Group** **4 (Worse)**		**The Trust is performing worse than the national medians but better than the peer median.** Significant strategic and operational work has been undertaken to improve this position. The position includes COVID-19 and Non COVID-19 related sickness but does not include shielding/medical suspensions as a result of COVID-19. The Trust Board requested a deep dive review into sickness absence in November 2020 which took place during Q4. The HR team is working with services to implement a number of recommendations.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

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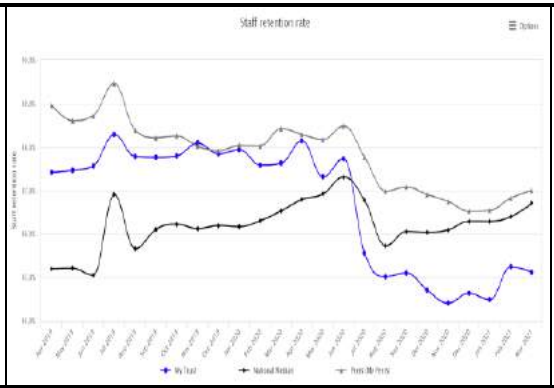
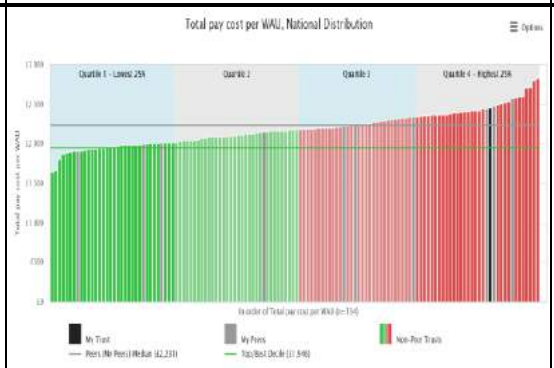
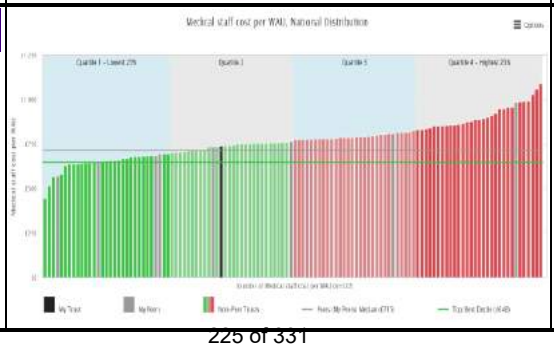
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q1 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Staff Retention Rate - The percentage of staff that remained stable over 12 months period.	**National Median: 86.7%** **March 2021** **Peer Median: 87.0%** **Target: National Median** **Best Quartile: 89.2%** **WHH Position:** **85.10%** **Ranking:** **9/10 Peer Group** **Quartile:** **3 (2nd Worse)** **Monitoring: SPC** **Source: HSCIC - NHS Digital iView Stability Index**		**The Trust is performing worse than the national and peer median.** The Trust has previously performed well in regards to staff retention and turnover which has demonstrated the success of the work undertaken in line with the NHSE/I nursing retention programme. However, performance has been impacted by the significant number of temporary staff who supported the Trust during the pandemic and whom have now left their post. This indicator is a rolling 12 month period and performance is expected to improve as the Trust returns to normal operations. For example retention of permanently contracted staff in May 2021 was 91.44%
Pay Costs per Weighted Activity Unit - This metric shows the amount the trust spends on pay per WAU across all areas of NHS clinical activity. **This Metric is no longer being updated on the model hospital.**	**National Median: £2180** **2017/18** **Peer Median: £2312** **Target: £2312** **Best Quartile: £2014** **WHH Position:** **£2,455** **Ranking:** **9/11 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: Trust Board, SPC (From March 2019), FSC, TOB** **Source: Trust consolidated annual accounts and reference cost data**		**The Trusts pay costs per WAU are worse than the national and peer median.** This metric is no longer being updated on the model hospital. The Trust continues to explore ways to reduce pay costs whilst continuing to provide an excellent standard of patient care.
Substantive Medical Costs per WAU - This metric shows the amount the trust spend on pay for medical staff per WAU across all areas of NHS clinical activity.	**National Median: £772** **2019/20** **Peer Median: £715** **Target: Maintain** **Best Quartile: £696** **WHH Position:** **£739** **Ranking:** **6/10 Peer Groups** **Quartile:** **2 (2nd Best)** **Monitoring: SPC** **Source: ESR, Trust consolidated annual accounts and reference cost**		**The Trusts medical pay costs per WAU are better than the national median**. However, vacancies within this workforce will have contributed to this position. As the Trust seeks to recruit to these vacant posts, the Trust may see costs per WAU increase, however this will lead to improvement in other areas such as agency/locum spend. There maybe additional requests for posts in line with the medical staffing review, which will impact this position.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

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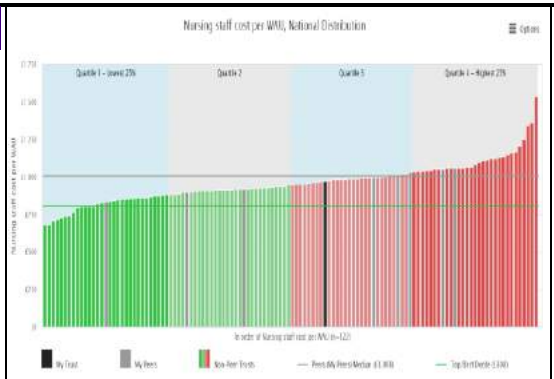
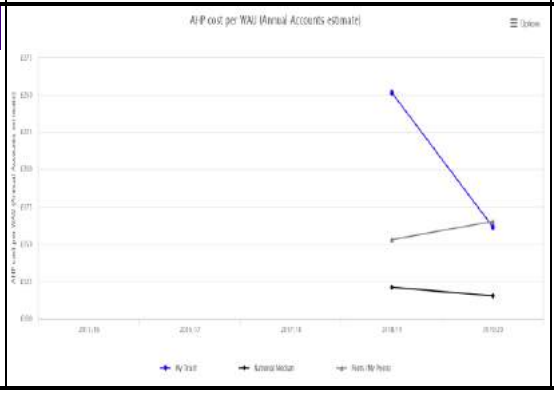
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q1 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Substantive Nursing Cost Per WAU - Total pay costs for nursing staff, adjusted for the % of Trust expenditure reported in reference costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median: £949** **2019/20** **Peer Median: £1008** **Target: National Median** **Best Quartile: £883** **WHH Position:** **£985** **Ranking:** **4/11 Peer Group** **Quartile:** **3 (2nd Worse)** **Monitoring: SPC** **Source: ESR, Trust consolidated annual accounts and reference cost**		**The Trusts Nursing Costs per WAU are worse than the national but better than the peer median.** The Trust has addressed vacancies and continues to recruit to nursing posts to reduce agency costs. The Trust has recruited a number of International Nurses (59 are working on the Wards, 0 are on the Trusts Induction, 9 are studying towards their OSCE and 17 are currently going through the pre-employment clearances) as of June 2021. The Trust has also addressed vacancies within the Healthcare Assistant staff group from 63 vacancies in January 2021 to 0 in March 2021. As of June 2021 there are 11 vacancies due to natural turnover.
Substantive AHP Cost per WAU Total pay costs for Allied Health Professionals, adjusted for the % of trust expenditure reported in Reference Costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median: £115** **2019/20** **Peer Median: £165** **Target: National Median** **Best Quartile: £98** **WHH Position:** **£161** **Ranking:** **05/ 09 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: SPC** **Source: ESR, Trust consolidated annual accounts and reference cost**		**The Trusts AHP Costs per WAU are worse than the national and but better peer medians.** This indicator includes costs for staffing who are outsourced via Service Level Agreements to other Trusts but does not include the associated income.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

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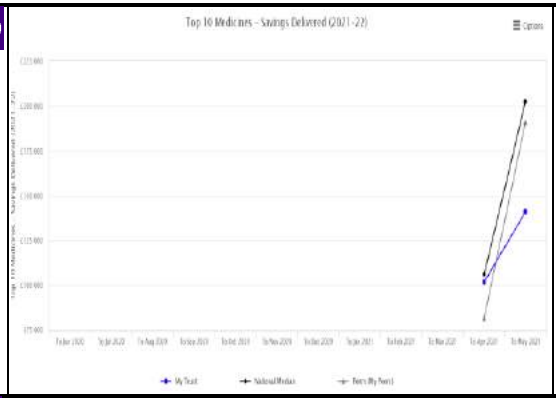
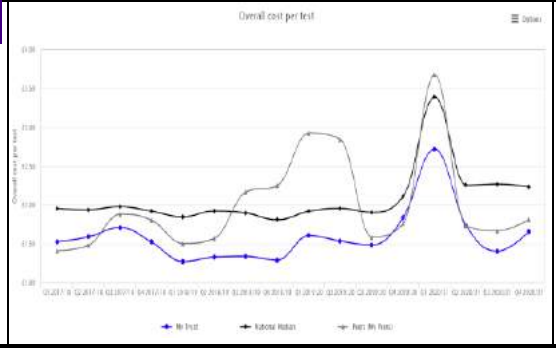
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q1 2021/22

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

KLOE 3: Clinical Support

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

Top 10 Medicines - Percentage Delivery of Savings (Pharmacy)	**Benchmark: £62k** **May 2021** **Peer Median: £191k** **Target: Benchmark** **Best Quartile: N/A** **WHH Position:** **£141k** **Ranking:** **Quartile:** **N/A** **Monitoring: Medicines Governance Committee** **Source: Rx-Info Define© (processed by Model Hospital)**		**The Trust is performing better than the national benchmark.** The Trust is exceeding the national benchmark and has achieved savings of £141k as of May 2021. Medicines optimisation remains a prioritised workstream. Processes continue to be aligned between the Trust, CCGs/ICS and the Pan Mersey Area Prescribing Committee. Collaboration is ongoing to ensure opportunities for further improvements are identified. The Trust is participating in a QIPP (Quality, Innovation, Productivity and Prevention) workstream within the health economy to improve sub-optimal prescribing and identify where joint working could produce improvements.
Pathology - Cost Per Test - The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items.	**National Median: £2.24** **Q4 2020/21** **Peer Median: £1.81** **Target: Maintain** **Best Quartile: £1.78** **WHH Position:** **£1.66** **Ranking:** **1/4 Peer Group** **Quartile:** **1 (Best)** **Monitoring: Pathology Business Meeting** **Source: NHSI Q Pathology Data Collection 19/20**		**The Trust is performing better than the national and peer medians.** Overall the Trust's pathology service is efficient with the use of streamlined processes, technology and procurement opportunities. The cost per test has risen as a result of the COVID-19, as the number of tests performed has reduced. This is in line with the National and Peer medians. Data collections have now resumed and the Trust has submitted up to date data including the annual position for 2019/20 and Q4 2020/21.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

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National Median	
Peer Median	

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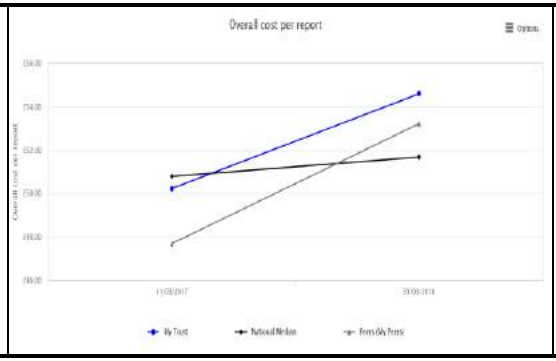
Not RAG Rated on the Model Hospital

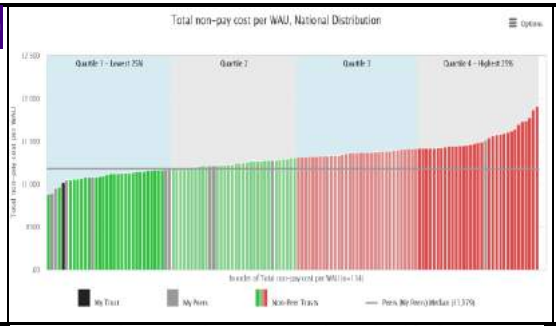
Use of Resources Assessment Dashboard - Q1 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Imaging - Cost Per Report - Total cost of reporting one image, irrespective of modality	**National Median: £51.67** March 2018 **Peer Median: £53.21** Target: **Best Quartile: £41.48** **WHH Position:** £54.59 **Ranking:** 7/11 Peer Group **Quartile:** 3 (2nd Worse) **Monitoring:** **Source: NHS Imaging Productivity Data Collection (Annual)**		**The Trust Imaging Cost Per Report are higher than the peer and national medians.** This metric has not updated since March 2018. Within this position, the Trust outsourced ultrasound services, cardiac MRI, and vascular ultrasound. The Trust also outsourced reporting due to pension changes, however the Trust has now brought a number of these services back in house which will improve the position. This will be reflected during future reporting periods.

KLOE 4: Corporate Services

Finance
Procurement
HR & OD
Estates & Facilities

KLOE Operational Lead: Jane Hurst
KLOE Operational Lead: Alison Parker
KLOE Operational Lead: Carl Roberts
KLOE Operational Lead: Ian Wright

Non Pay Costs per WAU - This metric show the amount the trust spends on non-pay per WAU across all areas of NHS clinical activity. **This Metric is no longer being updated on the model hospital.**	**National Median: £1307** 2017/18 **Peer Median: £1200** **Target: Maintain** **Best Quartile: £1172** **WHH Position:** £1,027 **Ranking:** 3/11 Peer Group **Quartile:** 1 (Best) **Monitoring: FSC** **Source: HSCIC - NHS Digital iView Stability Index**		**The Trusts non pay costs per WAU are better than the national and peer medians.** The Trust continues to review opportunities to reduce non-pay costs whilst maintaining quality. This indicator is no longer being updated on the model hospital.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

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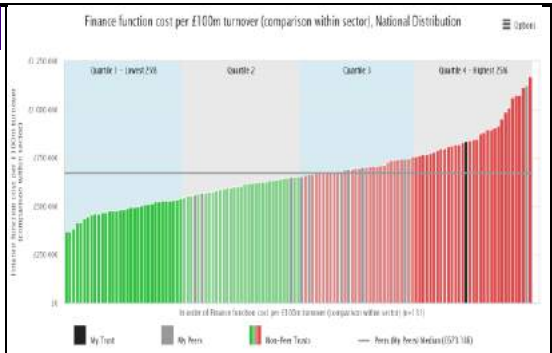
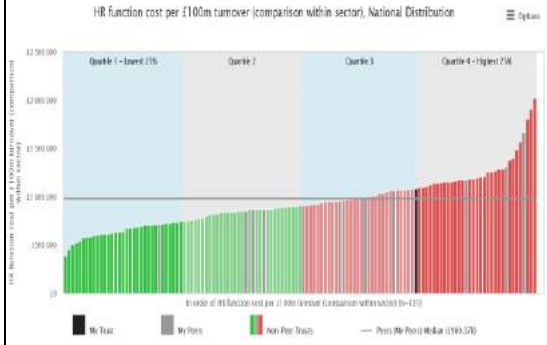
Use of Resources Assessment Dashboard - Q1 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Finance Costs per £100m Income - Total finance cost divided by trust turnover multiplied by a £100m	**National Median: £653k** 2018/19 **Peer Median: £673k** **Target: Benchmark** **Best Quartile: £541k** **WHH Position:** **£838k** **Ranking:** **10/11 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: FSC** **Source: Trust consolidated annual accounts and NHSI improvement 18/19 data collection template**		**The Trusts Finance costs per £100m income are higher than the national and peer medians based on national benchmarking data.** This indicator has not been updated since 2018/19, no national benchmarking has taken place for 2019/20. There has been minimal change to the Trust Finance team and therefore the Trust expects to score similar in the next benchmarking exercise. Previously there has been an issue in the allocation of the SBS contract and how it impacts on the data, this will be reviewed again. The benchmarking exercise for 2020/21 has commenced and will be reported back in Q3 2021/22.
Human Resource Costs per £100m Income - HR is made up of a number of sub compartments taken into consideration when considering total HR costs per £100m turnover.	**National Median: £911k** 2018/19 **Peer Median: £980k** **Target: Benchmark** **Best Quartile: £745k** **WHH Position:** **£1.09m** **Ranking:** **8/11 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: SPC** **Source: Trust consolidated annual accounts and NHSI improvement 18/19 data collection template**		**The Trusts HR costs per £100m income is worse than the national median based on the national benchmarking data.** This indicator has not been updated since 2018/19, no national benchmarking has taken place for 2019/20. The Trust has seen a reduction in HR costs per £100m income in 2018/19 from £1.2m to £1.1m which brings the Trust to just above the national median. Payroll costs have reduced in 2018/19 from £114k to £97k and this is below the national median with core payroll in the national best quartile. HR costs per FTE are lower than the national and peer medians, with the exception of Medical Staffing & Education each sub-function is also below the national median based on this. The Trust is undertaking collaboration with Bridgewater Community Healthcare NHS Foundation Trust and the North West Ambulance Service for the provision of Mandatory Training and ESR Support.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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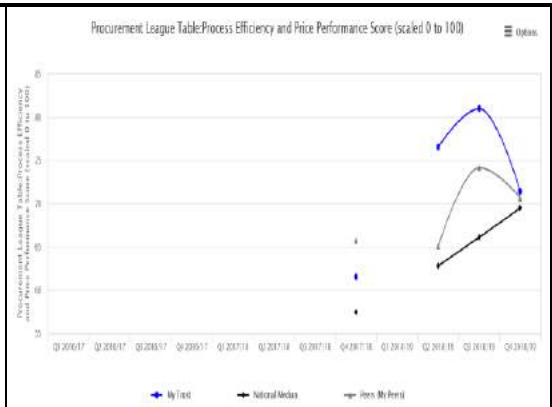
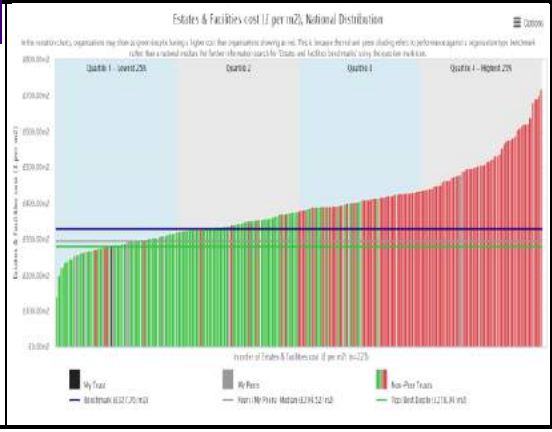
Use of Resources Assessment Dashboard - Q1 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Procurement Process Efficiency and Price Performance Score - This measure provides an overall view of how efficient and how effective an NHS Provider is in it's procurement process and price performance, respectively, when compared to other NHS providers.	**National Median: 56** **Q2 2019/20** **Peer Median: 44.7** **Target: 72** **Best Quartile: 72** **WHH Position:** **61** **Ranking:** **4/11 Peer Group** **Quartile:** **3 (2nd Best)** **Source: Purchase Price Index and Benchmark (PPIB) tool**		**The Trust is performing better the national and peer median for the Procurement Process Score.** Pre COVID-19 the Trust was engaged to move to Edge for Health which will be revisited in Q2 2021/22. This will further improve the Electronic Transfer of Order and Invoices metric and therefore contribute to the Procurement League Table ranked position.
Estates & Facilities Costs (£ per m2) - The total estates and facilities running costs is the total cost of running the estate in an NHS trust including, staff and overhead costs. In-house and out-sourced costs, including PFI costs, will be included.	**National Median: £327** **2019/20** **Peer Median: £294** **Target: Maintain** **Best Quartile: £319** **WHH Position:** **£283** **Ranking:** **3/10 Peer Group** **Quartile:** **1 (Best)** **Monitoring: Estates and Facilities Operational Group** **Source: ERIC 2018-19 Total Estates and Facilities Running Costs**		**The Trust Estates and Facilities costs are better than the national and peer medians.** The Trust has invested year on year to reduce backlog maintenance. The Trust has had the opportunity in 2020/21 to significantly invest in backlog maintenance and this should be reflected in 2021/22 data. It is anticipated that cost per m2 will rise for 2020/21 due to the increase spend relating to COVID-19, however this will be a similar position for all Trusts.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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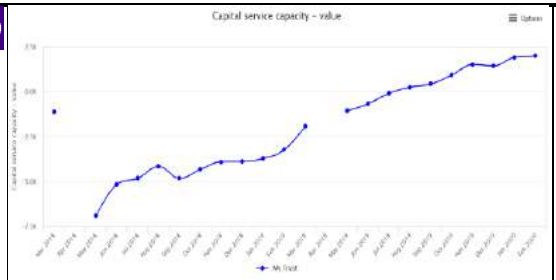
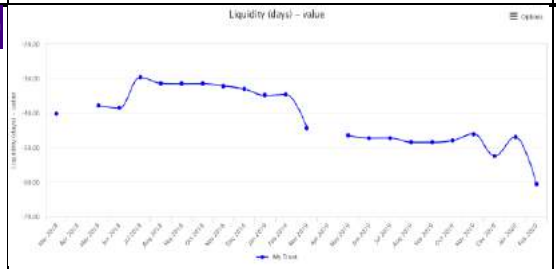
Use of Resources Assessment Dashboard - Q1 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
KLOE 5: Finance			**KLOE Operational Lead: Jane Hurst**
Capital Services Capacity - The degree to which the provider's generated income covers its financial obligations	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 1.99 (February 2019) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		Use of Resource (Finance) reporting has been suspended since March 2020, therefore the information on the model hospital is out of date. The Finance position has significantly changed since April 2020 due to the COVID-19 pandemic under the new financial regime. For 2021/22 months 1-6 (known as H1), the Trust has a target of breakeven. The Trust continues to respond to developments and awaits next steps.
Income & Expenditure Margin - The income and expenditure surplus or deficit, divided by total revenue.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital -0.85% (February 2019) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		For 2020/21, the Trust delivered a deficit of £11.3m with an adjusted deficit of £6.8m. The forecast for 2021/22 is breakeven for H1. The Trust is working with the system to deliver a breakeven position.
Liquidity (Days) - Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital -66.53 (February 2019) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		The Trust liquidity days are 21 as of M3 2021/22. This is positive and means that the Trust can promptly pay suppliers. As at M3, the cumulative Trust performance against the Better Practice Payment Code was 94%

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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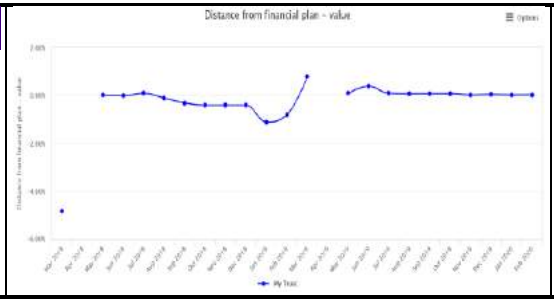
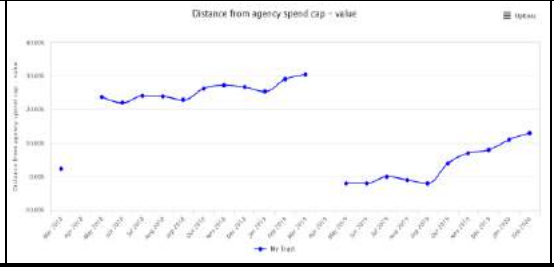
Use of Resources Assessment Dashboard - Q1 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Distance from Financial Plan - Year-to-date actual I&E margin in comparison to year-to-date plan I&E margin. I&E margin calculated on a control total basis. Measure is in percentage points.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 0.04% (February 2019) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		As at month 3 the Trust is off plan with a cumulative plan of £0.4m deficit and actual £0.6m deficit. This is mainly due to the ongoing COVID-19 costs.
Agency Spend - Cap Value - The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 13.00% (February 2019) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		There is no agency cap for 2021/22, however the Trust continues to closely monitor agency spending for both business as usual and COVID-19 requirements. The agency costs are £3.1m as at month 3, of which £1.04m relates to COVID-19.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q1 2021/22

KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
Clinical/ Operational - Operational Efficiency	**Hilary Stennings**	**Operational Efficiency** • Deep Dive Reviews • Theatre Transformation • A&E Improvements • Maternity Improvements • Ward Reconfiguration – programme to increase the number of beds on the Warrington site by 18 resulting in improvements in flow, patient experience and care. • Re-designing the Community ECG pathway – redesign of ECG pathway providing ECG in community settings. • Hospital Handover Improvement Project – project to review ambulance handover times and improve flow in ED. • Operation Reset – programme of work to improve discharges, improving flow, ensuring patients are at the most appropriate point of care. **DNA Rate** • DNA - Communications Campaign "Don't let us down" • Review of alternative appointment methods. • Use of Technology – optimisation of text message reminder service. **Emergency Readmissions – 30 Days** • Improvements in Discharge Planning. **COVID-19** • Virtual COVID-19 Ward - early supported discharge by monitoring COVID-19 patients at home. • Investment in Diagnostics Equipment - CT/MR £4.5m, X-ray Room in A&E £0.4m. This will support patient flow and COVID-19 recovery.	• Progression of collaboration opportunities through mutual aid/SLAs to maximise use of assets e.g. Walton Centre Pain service and support recovery. • Virtual Enhanced Care – review and re-design of processes to improve patient care/experience. Expanding the use of virtual clinics, all CBUs are creating SOPs where appropriate. • Patient Transport Services – reprocurement of patient transport services including capacity/demand management. • ED plaza development - phase 1 (ED Ambulatory Assessment Service) to be delivered 2021/22. • COVID-19 Recovery – recovery programme for the Trust to achieve the elective activity and outpatients - on track to deliver trajectories. • Breast Service Reconfiguration – the Trust is in the process of a consultation for the reconfiguration of breast screening and surgery - building work to be handed over for completion in Q2 2020/21. This will improve patient experience and improve efficiency. • DNA - Patient Initiated follow up is live in T&O with plans in place for Cardiology, Ophthalmology and Rheumatology.
People - Sickness	**Carl Roberts**	**Sickness Programme of Work:** In order to improve sickness absence and also in response to COVID-19 related sickness, the Trust has implemented a number of initiatives including: COVID-19 nursing advice line, Occupation health call centre, Enhanced 7 day occupational health service, Enhanced health & wellbeing options, Mental Health wellbeing drop in sessions, Facilitated conversations within impacted clinical areas, Face to Face on site counselling, Alternative therapies, Additional support for BAME staff, A real-time workforce information hub, Support for shielding staff, Processes around antigen and antibody testing, Self-compassion at work programme, Bringing teams together bespoke development package and the Launch of the Disabled Staff Network. • Working with other Trusts across the North West to improve sickness absence - utilising lessons learned and how these can be applied in the future with analysis/deep dive reviews.	**Sickness:** The Trust undertook a deep dive review into sickness absence and attendance management following a request by the Trust Board in November 2020. Recommendations which are in the process of being implemented are: • Continued focus on employee Health and Wellbeing. • Focus on interventions for staff living in Halton and Warrington, working with local community partners. • Review 'Supported Early Return' pilot and roll out Trust wide. • Undertake a full and thorough review Attendance Management Policy. • Undertake a programme of engagement and training with line managers to promote education and understanding of the Occupational Health Service, strengthening links and joint working between line managers and the service.

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KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
People - Retention	**Carl Roberts**	**Retention:** Improving work/life balance by reviewing policies/procedures and promotion of offerings, Support for staff to pursue career progression, Develop and empower line managers to retain staff, Development of recruitment and retention champions, Improvement of retire and return options and pre-retirement courses, Launch of new PDR framework and the Introduction of the flexible working actions set out within the NHS People Plan.	**Retention:** • A line manager development programme is being implemented. • Launch of a kindness, civility and respect campaign - in progress. • Embed a programme of Workforce Recovery to maintain the current focus on employee Health and Wellbeing, this is being lead by the Workforce Recovery Steering Group. Bespoke programmes are being developed for ED, Theatres and ITU.
People - Staff Costs per WAU	**Carl Roberts**	**Staff Costs per WAU:** Ongoing development of workforce plans which will flex as required, Review of vacancies in hard to recruit roles and understand what can be done differently, Monthly deep dives supported by NHS professionals, Enhanced ECF processes for non-clinical vacancies, Expanded ECF processes for temporary staffing, Implementation of the Cheshire & Mersey rate card, Implementation of consistent hourly rates for Medical staff, Introduction of patchwork medical bank system, Review of all long term locums by the COO and Review and action of pay elements within NHSI/E Grip and control checklist. • Recruitment of International Nurses - the Trust embarked on a programme to recruit 96 International Nurses to support the Nursing workforce and fill the vacancies. The programme consists of working with both WWL NHS Trust and Mid Cheshire Hospitals NHS Trust to support the 96 Nurses through their OSCE (Objective Structured Clinical Examination) to enable them to receive their NMC Registration. The Trust has embedded a comprehensive induction which includes a supernumerary period on the wards. The Trust has recruited a number of International Nurses (59 are working on the Wards, 0 are on the Trusts Induction, 9 are studying towards their OSCE and 17 are currently going through the pre-employment clearances) as of June 2021. The Trust has also addressed vacancies within the Healthcare Assistant staff group from 63 vacancies in January 2021 to 0 in March 2021 as of June 2021 there are 11 vacancies due to turnover.	**Staff Costs per WAU:** • Analyse the established medical model and the proposed effective establishment within the context of RCP Safe Medical Staffing Guide. • Identify the gaps within the Medical Workforce based on the analysis, developing innovative solutions to fill the gaps. • Expansion of the International Recruitment Programme so it covers Medics, AHPs, Operating Department Practitioners and Nurses. • Implementation of a refined WHH Medical Bank Rate Card. • Setup of a Temporary Staffing Review group to assess high vacancies/high temporary staffing spend and develop actions to address, review to see if this can be incorporated into a existing forum. • Deep dive review undertaken to understand nursing vacancies across the wards - the outcome of the review shows that there are a small number of nursing posts which have not got a candidate recruited to with the majority of vacancies recruited to and are in the employment checks/notice period.

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Clinical Support - Pharmacy	**Diane Matthew**	**Savings on Medicines:** The Trust delivered £1.7m of savings on medicines in 2019/20 and £1.7m in 2020/21 which was better than the national benchmark in both years. **Pharmacy Efficiencies:** 7-day clinical pharmacy services are now embedded across the Trust, with the service intelligently deployed based upon targeted medicines reconciliation data across the bed-base daily. This has resulted in medicines reconciliation rates (completed within 48 hours) increasing to 92%, from a baseline of 44% in 2018. **Missed Dose Report:** Introduction of daily electronic report highlighting any missed medicine administration slots, alerting clinical pharmacy and wider teams for further investigation and action. **Critical Care Service Resilience:** Throughout the COVID-19 pandemic, the pool of clinical pharmacists and technicians trained and proficient in critical care has been increased, with a robust, integrated clinical pharmacy service provided 7 days per week. Enhanced specialist service provision remains on-going, with work to support the wider B18 reconfiguration. **Blueteq Utilisation:** With the exception of ophthalmology, all clinical areas that utilise high-cost medicines across the Trust have implemented the Blueteq electronic approval system to ensure adequate funding and commissioning arrangements are in place for the use of these medicines.	• **Savings on Medicines:** Further action and focus on: Homecare services, Blueteq implementation and Biosimilar switching. • **Job Planning:** Undertake internal review of job plans within pharmacy establishment. • **GP Connect:** Implementation of GP connect, enabling the Trust to see a list of medication prescribed by the GP with links into the Trust EPR, reducing the chance of selection errors when prescribing medication in hospital which also improves safety. • **e-Exchange:** Increase integration and use of e-Exchange facility into clinical pharmacy activities, to better access and utilise relevant patient information. • **ePMA:** The Trust continues to implement ePMA with the last 2 specialities scheduled for go live: Neonates to be scoped by the end of 2021/22 with plans for ITU in Q2 2021/22. • **ePMA Phase 4:** Integration with JAC system (Stock Control) contingent upon JAC upgrade to be released in Q2 2021/22 with a go live by Q3 2021/22. • **VAT Changes:** The Trust is awaiting guidance around the potential VAT charge changes between primary and secondary care services which has the potential to result in significant cost savings and may impact the Trust's approach to delivering pharmacy and medicines-related services in the future. • **Missed Dose Report:** Analysis and reviews to be conducted with specific targeted actions being developed - Q4 2021/22. • **Clinical Research Network:** Exploring options around how pharmacy resource can be shared across the research network to deliver clinical trials.
Clinical Support - Radiology	**Mark Jones**	**Radiology Efficiencies:** • The Trust no longer outsources Vascular Ultrasound at a cost saving of £140K per year. • The department had reduced Ultrasound outsourcing by approx. 30%. However the Trusts recovery plans and infection prevention and control guidelines has impacted this position. • The department continues to minimise external reporting services, however due to COVID-19 recovery, the Trust has had to increase its external reporting capacity. There has been a increase in MDT and rapid incident reviews requiring consultant attendance which has reduced the Trusts reporting capacity. • Lung cancer easy diagnosis – the pilot has been completed and this is now being rolled out so that patients who require CT scans for a lung cancer diagnosis have the x-ray first then CT within 2 days if required. • Trial of hot reporting completed by reporting radiographers. This provides a report for the ED clinicians within 1 hour which increases flow in the ED department with a more accurate diagnosis. • Maintenance – the department has worked with the Trusts procurement team to reprocure the maintenance contract for X-ray equipment with a saving of £200k annually.	**Radiology Efficiencies:** • The Trust has installed a new MRI machine which will mean the Trust is able to repatriate cardiac MRI and reduce the use of outsourced mobile MRI – this is due to be operational from June 2021, however these has been a delay to the build to the end of August 2021. These works have reduced the capacity of the department due the encroachment of the working area. • Cheshire & Mersey ICS is carrying out a review of how data is recorded and reported across the network to ensure like for like comparisons. This has been paused due to COVID-19.

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Clinical Support - Pathology	**Neil Gaskell**	**Pathology Network:** The overarching business case was agreed by the network and organisations to rationalise pathology services across Cheshire & Mersey. A Project Initiation Document (PID) and Project Plan have been developed and signed off. **Implementation of NPEX:** As part of COVID-19 response in Q1 (2020/21), the Trust received funding to implement NPEX which supports joint working across the Network with electronic requests, removing the requirement for manual intervention. The Trust is looking how NPEX can be used to expand out of area tests connected to NPEX whist there is a review from the Pathology network on the repatriation of out of area referred work. **Pathology Procurement:** The Trust continues to look for opportunities to reduce costs by utilising procurement processes. For example the Trust has switched providers for HBA1C diabetes tests reducing the contract price from 77p to 32p per test with overall savings of c£45k. The network is reviewing potential procurement savings of c£44m influenceable spend, consolidating into 1 maintenance contract with a potential of c£7m savings across the network over the next 6/7 years due to the alignment of contracts. **Collaborative Working:** The Pathology Team is working in collaboration with 2 other Trusts and the Cancer Alliance to deliver FIT Testing as part of the national pilot. Due to COVID-19, this has been extended to provide tests for patients awaiting endoscopy which reduces the overall risk whilst providing additional income via a service level agreements. **COVID-19:** The Trust has supported the regional response to COVID-19 and has developed a web form for patients who require anti-body testing. In addition, a simple e-booking system for patients who need vaccinations, swabs or blood tests has been developed. The pathology team has implemented a point of care rapid test in the A&E department which allows the department to carry out their own initial screening, which had reduced the pressure on the pathology lab, however due to the delta variant, duplicate testing has been implemented to ensure patient safety and reduce the infection control risk.	**Pathology Network:** The Trust continues to work with the Pathology Network and specifically with STHK around the future of pathology services across Cheshire & Mersey. A number of options are being explored. A second review of the PID (WHH & STHK) has taken place and we are awaiting a response. A number of risks have been identified around Finance, Logistics and Operations. Further detail has been requested from the network to understand how these risks can be mitigated. Process mapping of the current service is underway. **Digital Pathology:** The Pathology Network has funded the implementation of a digital Pathology solution that allows the scanning and visualisation of microscopic tissue slides for diagnosis. The solution works similarly to tried and tested PACS technology and has been developed by Philips. The network is looking at using the Trust system (Molis) for Cellular Pathology as it is more digitally mature than other LIMS in C&M. A bid has been submitted by the network and the outcome is awaited. **Pathology Efficiency & Quality:** • The Trust will pilot the phlebotomy and transfusion application in ED (anticipated Q2 2021/22), this will improve patient safety by taking the sample at bedside using the electronic identification system which matches the patient request to the wrist band reducing the risk of taking the wrong blood from the wrong patient and therefore issuing the wrong results. Future options around efficiencies relating to the Phlebotomy application will be explored. • The Pathology Team will carry out a review of cost per test and benchmark against the actual costs. • The Trust has engage with Simplybook and Halton CCG to electronically book patient appointments for Phlebotomy which will reduce paper and improvement patient experience and referrals. • E-Task management system – the Trust utilises its e task management system out of ours to inform acute clinical areas of critical abnormal pathology results. This utilises a interfaces between the Trust pathology systems and e-task management providing real-time alerts which improves efficiency and patient safety. Currently this is only used in Acute services out of hours, however future options to expand in other areas.

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Corporate - Estates	**Ian Wright**	**Strategic Cost Reduction** • The Estates & Facilities team conducts rolling reviews of costs and identifies opportunities to reduce costs through procurement and standardisation. The Trust continues to explore collaboration opportunities. The Trust continuously benchmarks estates and facilities efficiency through ERIC returns and the Model Hospital and implements action plans around the results of PLACE assessments. ERIC returns were submitted in June 2021 (for 2020/21) and it is anticipated the report will be received in Q3 2021/22. • Investment in backlog maintenance in 2020/21 to improve the critical risk infrastructure. Impact on critical infrastructure risk costs as a result of backlog maintenance spend will be recognised in Q3 2021/22 when NHSE report is received by the Trust. • Energy Saving Schemes: Procurement of an energy infrastructure upgrade (CHP) which saved; carbon, energy, money and future investment (savings of £140k in 2019/20 on the contract cost). The Carbon Energy Fund (CEF) provided replacement of 4000 halogen bulbs with more cost effective LED lighting. All new capital developments are now fitted with energy saving lightbulbs. **COVID-19** • Significant effort to support the Trust during the COVID-19 response. This includes additional requests e.g. screens, laundry, capital spending, security transfers of COVID-19 patients. • Establishment of a furniture swap in order to reduce expenditure on new furniture, anticipated return in Q4 2021/22. • Streamlined capital project process to improve the response times whilst also including stakeholders in the design process.	**Strategic Cost Reduction:** • Explore and develop further collaboration opportunities (impacted by COVID-19). • Review of Facilities Management Contracts at Cheshire & Mersey Level (Energy, Linen, Post and Decontamination). A plan has been developed for a collaborative approach across C&M as current contracts expire. Opportunities to tender collaboratively to reduce costs. C&M are currently evaluating clinical and domestic waste contracts through the collaboration at scale board, anticipated completion in Q2 2021/22. • Progression/Expansion of agile working to reduce floor space (this has been accelerated by COVID-19, however due to social distancing requirements, the ability to remove desks has been affected). **Energy Saving Schemes:** • Internal replacement of emergency lighting to improve efficiency. • Cost neutral proposal for electric car charging points - in progress. • Capital spend on projects that will reduce critical infrastructure risk and long term estates maintenance costs. **Collaboration & Sustainability:** • Monitoring of critical infrastructure risk and how this has had an impact on estates maintenance costs. • Development and publication of the Trust's Green Plan. • The Trust has commissioned a deep dive in the CHP contract to ensure the Trust is gaining value of money and expert advice.

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KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
Corporate - Procurement	**Alison Parker**	**Procurement Service Collaborative** • The Trust is providing procurement services on behalf of Mersey Care (now incorporating North West Boroughs) and Bridgewater via Service Level Agreements. • Bridgewater has an approved Procurement Strategy and Procurement Policy. • Mersey Care has a draft Procurement Strategy and Procurement Policy pending approval. • A highlight report has been developed for Chief Finance Officers detailing collaborative procurement progress and opportunities. • An ICS Task & Finish Group has been established for the delivery of the ICS Based Procurement plan. • Further work is being undertaken to develop a collaborative contract register • The Trust implemented the Cheshire & Mersey agency rate card (with estimated savings of £0.8m) in November 2019. A new SRO needs to be identified at ICS level from the HR Network to develop the next phase of this project (benchmarking and adherence to rate metrics). • The Trust has re-engaged with Category Tower 10 – Food as procurement lead to develop a C&M wide strategy for the purchase of food. • The Trust as re-engages with Supply Chain Co-ordination Ltd (SCCL) to develop a C&M wide savings strategy presented to the C&M Procurement Committee in July. **Procurement Efficiency** • The Trust is fully engaged with SCS (Spend Comparison Service) participating in training, webinars and events. Further training is taking place as new members of staff are appointed to the team. • E-Catalogue Transactions - regular reviews of items used which are suitable for cataloguing with analysis of non-pay spend and usage establishing catalogues where appropriate. • The Trust went live with "Punch Out" in November 2019 which improves the loading of the NHS Supply Chain catalogues and streamlines processes. • The Trust has implemented additional monitoring and weekly review meeting to oversee the capital programme. The Trust will be recruiting a Procurement Manager for Capital and Projects to provide additional support to the capital programme and leading procurement on some larger procurement initiatives. **COVID-19** • The Trust took the lead on the COVID-19 Response Procurement Group supported by MIAA, facilitating mutual aid, driving the PPE agenda with a structured to move to a 7- day service. • The Trust represented C&M organisations on the NW PPE forum established in response to COVID-19.	**Procurement Efficiency** • Development of high-level ICS Procurement Plan to deliverable actions. PTOM Steering Group in place to develop plans. • Re-engage with SBS regarding the implementation of Edge for Health. This has been placed on hold by SBS, the Trust is awaiting next steps. • Re-commence data analytics re the Spend Comparison Service, a plan has been developed. • Re-engage on C&M Wide Medical Locum Project re standardised rate, card, performance management and adherence to rates. • Re-engage on the development of a strategy for the Category Tower 10 (Food) to deliver potential savings of c£0.8m. This has commenced, currently awaiting a strategy from Foodbuy. • The Trust has re-engaged with Supply Chain Co-ordination Limited (SCCL) to develop a C&M wide strategy for the delivery of savings from the category towers which will be presented to the C&M procurement committee in July 2021. • The ICS Task & Finish Group is seeking support and funding for the appointment of a substantive ICS Procurement Lead which is a key requirement of the ICS Procurement Action plan alongside the implementation of a Data Analytics Platform.

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KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
Finance	**Jane Hurst**	**Financial Planning, Sustainability & Controls:** • Strengthening of Treasury Management processes. • Close monitoring of COVID-19 Capital and Revenue spend with new governance processes implemented. Positive report received from external audit of COVID-19 spend. • Close monitoring of COVID-19 vaccination hub spend. • Improvement of Better Payment Practice Performance to 90% cumulatively in 2020/21. • Delivered CIP in 2020/21. • Delivered financial position in 2020/21.	**Financial Planning, Sustainability & Controls** • The Trust will continue to monitor and assess emerging guidance to ensure compliance. Financial performance is closely monitored and variation from plan is addressed in a timely manner. • Increased monitoring of COVID-19 schemes due to cease. • Increased scrutiny and governance on capital schemes over £0.5m. • The Trust is working with the system to deliver a breakeven position in 2021/22. • Delivery of CIP of £4.8m in 2021/22 and monitoring of Quality Impact Assessments. • Delivery of £19.6m Capital Programme in 2021/22. • Monitoring and delivery of activity to achieve Elective Recovery Fund. The plan assumes £3.9m. • Secure funding for ED Plaza and Paediatric capital schemes. • Increased monitoring of cashflow. • Increased review investment proposals and benefits realisation. • Increase scrutiny and governance over retrospective wavers. • Training for non-finance colleagues regarding Finance and Procurement. • Action plan to achieve level 3 Future Focused Finance accreditation.

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REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/97**				
SUBJECT:	**Health and Wellbeing Stocktake and Wellbeing Guardian Update**				
DATE OF MEETING:	28th July 2021				
AUTHOR(S):	Rebecca Patel, Associate Chief People Officer				
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People Officer				
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.				
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	X			
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.				
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1207** Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.				
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an overview of the Wellbeing Guardian role and the Principles that the Guardian will work towards in order to provide assurance to the Board on the work that is undertaken operationally by the HROD directorate to keep the workforce healthy, happy and motivated during workforce recovery In addition, the paper provides an overview of a self-assessment taken against the national Health and Wellbeing Framework and the Greater Manchester Health and Wellbeing Framework to provide assurance on the areas that the organisation are delivering well against and the identifies areas for improvement. The paper sets out the self-assessment results which demonstrate that the organisation is clear on our commitment to the health and wellbeing of our workforce but areas for improvement include interactions with line managers, which aligns with our annual NHS staff survey results and the physical infrastructure available regarding rest areas and catering facilities.				
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision	

RECOMMENDATION:	Trust Board are asked to note the stocktake utilising both national and local frameworks and endorse the actions identified as prioritised for improvement.	
PREVIOUSLY CONSIDERED BY:	**Committee**	N/A
	Agenda Ref.	N/A
	Date of meeting	N/A
	Summary of Outcome	N/A
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Health and Wellbeing Stocktake and Wellbeing Guardian Update	AGENDA REF:	BM/21/07/97

1. BACKGROUND/CONTEXT

The NHS People Plan[1], published in July 2020 provides NHS organisations with key actions to implement within their workforce. One of the key objectives relates to "looking after our people", which has been especially pertinent not just during the pandemic but as the organisation transitions through its recovery phase.

As part of the key objective of "Looking After Our People", the NHS People Promise shown in **diagram one** has been developed to demonstrate what our workforce should be able to say about their experience of working in the NHS and our organisation. This an ambition to ensure that all colleagues, line managers and central bodies work together to make these ambitions a reality for all.

Diagram One: The NHS People Promise

A recommendation in the People Plan to support this People Promise and in particular, the "We are safe and healthy" element of the People Promise is that every NHS organisation should appoint a Wellbeing Guardian who is a senior leader to question decisions or challenge behaviour on the health and wellbeing impact on our workforce. The role aims to build on pre-existing internal resources of the organisation to increase advocacy and ownership of the mental and physical health of our workforce.

NHSEI have outlined nine key board principles that a Wellbeing Guardian should support which are identified in **table one**. Dr Cliff Richards is the organisation's appointed Wellbeing Guardian with a wealth of experience, knowledge and expertise on the importance of a healthy, motivated and engaged workforce looking at all of the determinants of health through a population health lens. The Wellbeing Guardian focus will be on the provision of the wellbeing of the entire workforce which includes the organisation's substantive workforce, volunteers, bank and agency members of staff.

[1] NHS England » We are the NHS: People Plan for 2020/21 – action for us all

Table One: Wellbeing Guardian Principles

Number	Principle
1.	The mental health and wellbeing of NHS Staff and those learning in the NHS should not be compromised by the work they do for the NHS
2.	The Wellbeing Guardian will ensure that where there is an individual or team exposure to a clinical event that is particularly distressing, time is made available to check the wellbeing impact on those NHS Staff and learners
3.	The Wellbeing Guardian will ensure that wellbeing check-in meetings will be provided to all new staff on appointment and to all learners on placement in the NHS
4.	All NHS staff and those learning in the NHS will have ready access to a self-referral, proactive and confidential Occupational Health service that promotes and protects wellbeing
5.	The death by suicide of any member of staff or learner working in an NHS organisation will be independently examined and findings reported through the Wellbeing Guardian to the board
6.	The NHS will ensure that all staff and learners have an environment that is safe and supportive of their mental wellbeing
7.	The NHS will ensure that the cultural and spiritual needs of its staff and those learning in the NHS are protected and will ensure equitable and appropriate wellbeing support for overseas staff and learners who are working in the NHS
8.	The NHS will ensure the wellbeing and make the necessary adjustments for the nine groups protected under the Equality Act (2010)
9.	The Wellbeing Guardian working with system leaders and regulators will ensure that wellbeing given equal weight in organisational performance assessment

These principles will provide the framework for the Wellbeing Guardian to gain assurance on the work that is undertaken operationally by the HROD directorate to keep the workforce healthy and happy during the pandemic, during workforce recovery and as the organisation transitions into the new business as usual.

2. KEY ELEMENTS

2.1 Gap Analysis of Health and Wellbeing offer within WHH

The approach to the delivery of supporting the workforce from a health and wellbeing perspective has been on the basis of evidence and best practice from sectors such as our Armed Forces, academics in the field of population health and learning from other countries in relation to the response to the pandemic. Health and wellbeing for individuals and our collective workforce have many different components, from the mental wellbeing of an individual to the physical infrastructure which may support an individual within work to have adequate rest and nutrition facilities. All interventions and offers regarding health and wellbeing look at the needs of the "whole person" undertaking a population health perspective and recognising that there will be key themes according to different protected characteristics and locality.

In order to understand and identify the organisation's baseline position in relation to health and wellbeing a gap analysis and stocktake has been undertaken utilising the following tools:

1) National Health and Wellbeing Framework (produced by NHSEI)
2) Greater Manchester Health and Wellbeing Framework

Both frameworks focus on the organisation self-assessing against a set criteria to provide a robust overview of the areas that the organisation are performing well against and the areas for improvement. All offers and interventions have also been mapped against Cheshire and Merseyside Health and Care Partnership's strategy "Improving Health and Wellbeing in Cheshire and Merseyside"[2], in particular the objective of improving population health and care and tackling unequal outcomes and access.

2.1.1 National Health and Wellbeing Framework

The national health and wellbeing framework have been developed by NHSEI and focuses on organisational enablers and health interventions as identified in **table two**, with key themes for the organisation to assess ourselves against.

Table two: National Health and Wellbeing Framework Self-Assessment Topics

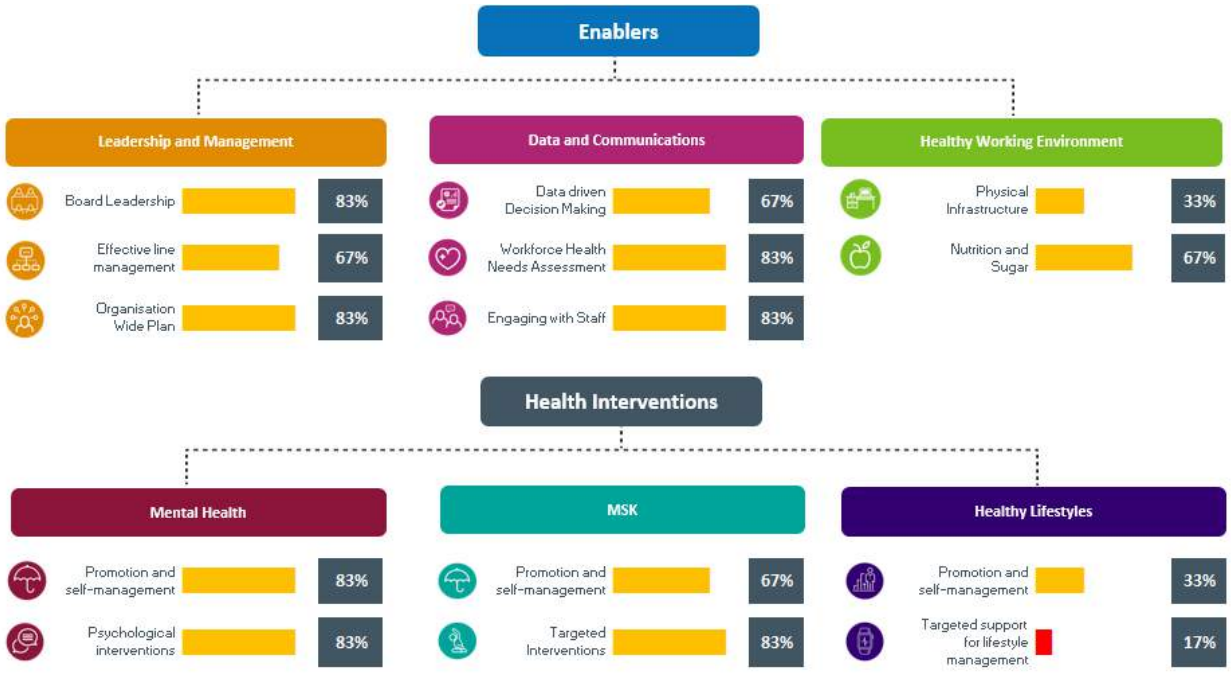
ORGANISATIONAL ENABLERS	**Leadership and Management**	
	Topic	**Self-assessment criteria**
	Board leadership: Boards engaged with the staff health and wellbeing agenda and responsible for advancing it forward	• Board accountability • Vision and Strategy • Resourcing
	Effective line management: Line managers include staff health and wellbeing in their line management responsibilities	• Essential Structures • Supporting good line management • Managing sickness absence
	Organisation-wide plan: Staff health and wellbeing plan led in multi-disciplinary way with significant input from Occupational Health, Human Resources and operational management	• Health and Wellbeing plan • Health and Wellbeing lead • Integrated teams
	Data and Communication	
	Data driven decision making: Decisions related to staff health and wellbeing are informed by effective use of data	• Workforce Challenges • Reporting • Review
	Workforce health needs assessment: The organisation understands the health and wellbeing needs of individuals and groups of staff. Staff feel comfortable disclosing health and wellbeing needs. Data and feedback is collected and analysed to identify issues, trends, opportunities and risks	• Information gathering • Culture of disclosure • Needs based plan
	Engaging with staff: The organisation has an effective way of communicating messages about health and wellbeing with staff, with the aim of changing behaviour and increasing uptake. The organisation regularly engages with staff on matters related to their health and wellbeing	• Engagement plan • Board and managers as champions • Targeted engagement

[2] Improving Health and Wellbeing in Cheshire and Merseyside: Strategy-Document-Final-Version-April-2021.pdf (cheshireandmerseysidepartnership.co.uk)

HEALTH INTERVENTIONS	**Healthy Working Environment**	
	Physical infrastructure: Provide a physical and cultural environment that enables and actively promotes health and wellbeing at work	• Facilities to promote active lifestyles • Break, rest and food preparation • Wellbeing promoting culture
	Nutrition and sugar: Staff should have access to healthy food and drink at work. Healthier food and drink options should be provided and promoted wherever food is sold on NHS premises. These options should be available to patients, visitors and staff, including the night shift workforce	• Food and drink nutrition • Tendering for new suppliers • Staff access to nutritious food
	Mental Health	
	Prevention and self-management: Working practices and conditions that are identified as contributing to poor mental health are proactively managed. Workplace support is available for staff to maintain good mental health and manage mental health conditions in the workplace	• Supportive environment • Training • Access to interventions
	Psychological interventions: Staff have access to clinically sound psychological interventions when necessary	• Psychological support • Referral pathway • Evaluation
	Musculoskeletal	
	Promotion and self-management: Workplace support is available for staff to maintain good musculoskeletal health and manage any conditions in the workplace. A culture of self-care should be promoted. Working practices and conditions identified as contributing to poor musculoskeletal (MSK) health and injury are proactively managed	• Supportive working environment • Training • Access to interventions
	Targeted Interventions: Where necessary staff have access to clinically sound and timely physiotherapy	• Access to physiotherapy • Referral pathway • Evaluation
	Healthy Lifestyles	
	Prevention and self-management: The workplace and rewarding work can support good health and wellbeing. Workplace support should be available for staff to maintain good health and manage conditions in the workplace. This may cover health and health related issues such as: smoking, sleep, alcohol/drug misuse, debt, physical activity and obesity	• Supportive working environment • Training • Access to interventions
	Targeted support for lifestyle management: Where necessary staff have access to clinically sound and timely workplace support and/or signposting to relevant external support and advice. This could include weight loss programmes and smoking cessation support in the workplace. The board and senior management lead by example as role models	• Targeted interventions • Referral pathway • Evaluation

Diagram two illustrates the position as at June 2021 for the organisation's self-assessment against the national Health and Wellbeing framework.

Diagram Two: WHH self-assessment results against national Health and Wellbeing framework



The self-assessment illustrates that the organisation is strong across the board in relation to leadership and management. In particular, board leadership and organisation wide plan are higher scores in comparison with effective line management. This is due to the fact that the self-assessment asks questions in relation to organisational commitment to health and wellbeing, which scores highly as evidenced by the annual Staff survey 2020 score which scored 6.5 (higher than the Acute Trust score average across England), whether there is budget and investment in relation to health and wellbeing and that there is a dedicated lead for health and wellbeing across the organisation which is evidenced in the Wellbeing Guardian position on the board, and the Head of OD, Learning and Culture and Head of Occupational Health within the HROD directorate.

From a data and communication perspective, these scores are consistent with the leadership and management theme. From the "date driven decision-making theme", this focuses on the use of data in order to develop interventions aligned to workforce need. This is a key component of our approach to workforce recovery, based on best practice and evidence and the needs of our workforce. As our workforce programme is an evolving approach it is likely that this score will be improved aligned to our recovery programme.

In terms of a healthy working environment, it is recognised that the organisation has particular challenges on the Warrington site in relation to physical infrastructure for staff facilities and the framework requires the organisation to self-assess ourselves against other elements of a healthy working environment including physical equipment available for members of staff. Although, the organisation through the benefits platform Vivup has access to discounted gym membership or exercise classes this is not necessarily as embedded within our site. The theme of nutrition and sugar

focuses on access to a range of nutritious food that is healthy and promotes healthy lifestyles, this will be further enhanced through the upgraded provision of foot outlets at the main site at Warrington hospital. From a Halton perspective, the restaurant provides a range of options in line with NHS Guidelines to encourage healthy eating wherever possible.

The health and wellbeing offer across the organisation is particularly strong in relation to mental wellbeing which is reflected in the mental health self-assessment scores from both a promotion perspective and also bespoke interventions that are available for individuals and teams. The organisation participated in a research project in partnership with Unilever's Data Good team and the makers of an app called Talk It Out which focuses on enabling individuals to understand their subconscious thoughts, emotions and reactions to build resilience in their professional and working lives, the early results are promising and due to be released at the beginning of August 2021.

From an Musculoskeletal perspective (MSK), staff do have access to an onsite physiotherapy service delivered by the Occupational Health and Wellbeing team and there are further plans to develop additional sessions for line managers to support colleagues' MSK health as MSK remains in the top three reasons for sickness absence.

The organisation has a responsibility to create the culture and environment where staff feel supported and healthy in work. The self-assessment has highlighted that an area for improvement is in relation to the organisation's physical wellbeing offer to staff which is currently being scoped in partnership with local voluntary sector organisations. Although the staff engagement and wellbeing and mental wellbeing hub teams promote campaigns aligned to public health methodology on behaviour change and encouraging people to think about their physical activity, this will need to translate into bespoke interventions similar to the mental health and MSK offer. There are national programmes currently in development by NHSEI to address this particular element of health and wellbeing.

2.1.2 Greater Manchester Health and Wellbeing Framework

The Greater Manchester Health and Wellbeing Framework was developed as part of a system wide project across health and social care organisations in 2017. The framework was commissioned by the City of Manchester's Health and Wellbeing Board on behalf of the health and social care economy in the region and, similarly to the national health and wellbeing framework asks organisations to assess themselves against a set criteria which is highlighted in **table three**.

Table Three: Greater Manchester Health and Wellbeing Framework

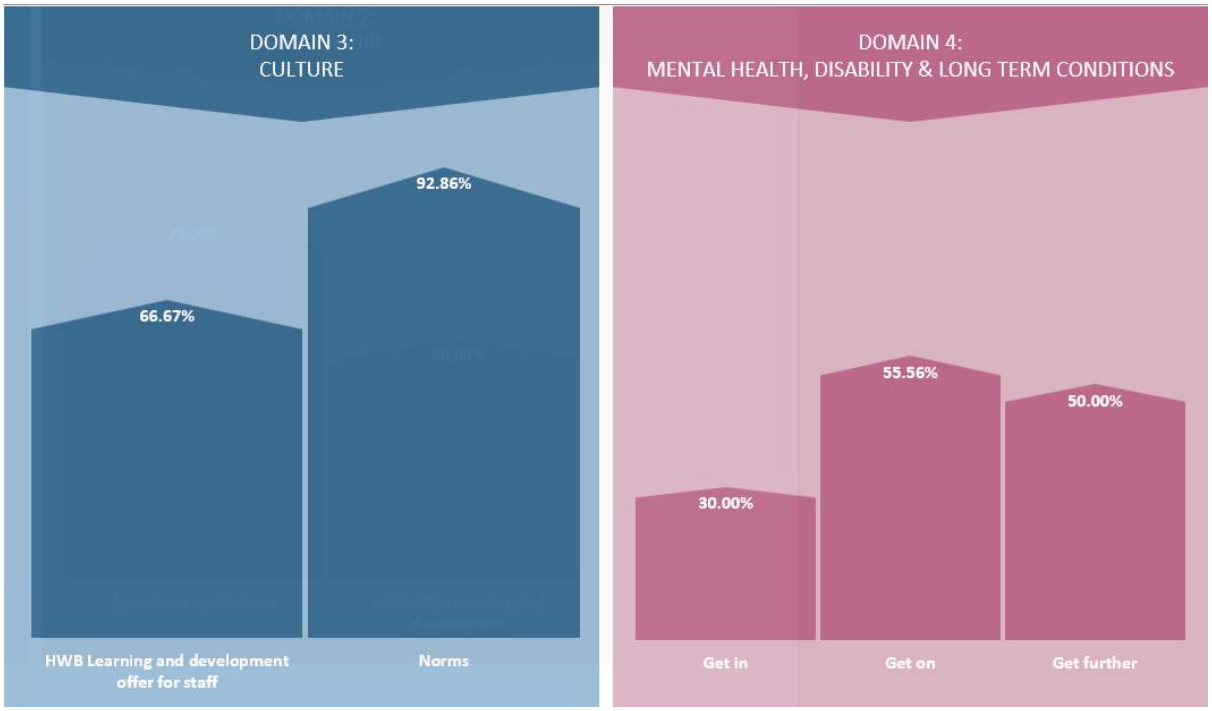
Domain	Goal	Self-assessment criteria
1: Good health for all	Ill health is prevented, and good health is sustained and improved for everyone	• Organisational commitment to health and wellbeing • Health and wellbeing services • Health and wellbeing workshops and support groups • Environment • Policies

2: Leadership	Leaders and managers in the organisation demonstrate support for health and wellbeing and role model health and wellbeing behaviours	• Leadership behaviours • Leadership learning and development
3: Culture	The way we things around here is supportive of health and wellbeing	• Health and wellbeing learning and development offer for staff • Health and wellbeing norms
4: Mental Health, Disability and Long-Term Conditions	We support people with any physical or mental impairment that has an impact on their ability to work, to get in work, stay in work and flourish in work	• Get In • Get On • Get Further

Diagram three and Diagram Four illustrates the position as at June 2021 for the organisation's self-assessment against the Greater Manchester Health and Wellbeing framework.

Diagram Three: GM HWB Framework – Domains 1 and 2

Diagram Four: GM HWB Framework - Domains 3 and 4



Domain one focuses on good health for all and creating the environment and infrastructure to support health and wellbeing within the workplace, it is clear to see that the organisation is excelling in its commitment to health and wellbeing, which is also reflected in the annual staff survey results from 2020, as well as the creation of policies which focus on health and wellbeing through our staff retention approach, flexible working approach aligned to the NHS People Plan, Dignity at Work approach and equality, diversity and inclusion to name a few. The areas for improvement in relation to this goal focuses on very specific health and wellbeing services, workshops and support groups, examples of which are below:

- MOT Health screening checks – which is undertaken by primary care services
- On-site physical activity classes or facilities
- Weight loss classes
- Awareness around Diabetes, financial fitness and work-life balance workshops

The second domain, similar to the national Health and Wellbeing Framework focuses on leadership and in particular behaviours that enable a supportive environment and the learning and development opportunities which enable line managers and leaders to be equipped to support their staff. The organisation performs well in the self-assessment in relation to leadership behaviours which focuses on board support of health and wellbeing initiatives, role modelling behaviour and providing opportunities for line managers to have conversations about health and wellbeing which is articulated in the check-in conversation approach the organisation has undertaken. The learning and development element of this domain focuses on the opportunities that line managers have to equip themselves with understanding on the health and wellbeing and associated Equality, diversity and inclusion agenda.

Domain three focuses on the culture of the organisation and the goal of “the way we do things is supportive of health and wellbeing”. The organisation scores highly on the theme of “norms” which

focuses on creating a psychologically safe environment which has been aided by the developed of our mental wellbeing offer and the Halton and Warrington wellbeing hubs, the addition of the organisation's values of "Kind" and "Inclusive" also helps to engender an organisation which is supportive of the workforce. From a learning and development perspective, there is a focus on enabling a coaching culture and support for managers on courageous conversations and supporting the workforce to remain healthy and well in the workplace which is currently delivered by the organisation's HR and OD directorate.

The third and final domain of the GM Health and Wellbeing framework focuses on mental health, disability and long-term conditions under three themes as illustrated below:

1) Get In – people with long term conditions are supported to get into work
2) Get On – people with long term conditions are supported at work
3) Get Further – people with long term conditions are supported to flourish at work

The self-assessment results demonstrate that the organisation has some improvements to make in relation to enabling individuals to be supported into work. Our widening participation approach with bespoke schemes in partnership with voluntary sector providers and also local job centres supports our local communities. In addition, the HROD directorate is currently reviewing recruitment processes in line with an inclusive recruitment approach which support some of the ambitions set out in this framework. The organisation self-assessed scores fare slightly better in the "get on" and "get further" themes which focus on the embedding of reasonable adjustments to awareness and line management support regarding disability and other related long-term conditions.

2.1.3 Identified areas for improvement

The self-assessment against each of the health and wellbeing frameworks demonstrate a significant gap in relation to the provision of physical activity opportunities to encourage healthy lifestyles, as well as the facilities to support these activities. In addition, some of the suggested workshops from the Greater Manchester Health and Wellbeing Framework will be explore as part of the workforce recovery programme to ensure that there is a suite of options available to our workforce to support a healthy and productive work environment at both the Warrington and Halton sites.

2.2 Investment in Health and Wellbeing

One of the key successes in relation to the organisation's approach to support the workforce's health and wellbeing has been the investment into this agenda both from a physical staffing and resources perspective. The provision of health and wellbeing activity during the pandemic and more recently as part of our workforce recovery efforts can be split into areas which were delivered by the HROD directorate and the Staff Welfare investment, led by the transformation and strategy team during the heightened waves of the pandemic. In total over £200k has been invested in areas focusing on staff wellbeing for during and beyond the pandemic.

Diagram five provides an overview of the Staff Welfare offer during the pandemic which focused on areas such as securing delivery of hot meals to staff, providing accommodation and the provision of childcare in partnership with the Peace Centre.

Diagram Five: Staff Welfare Offer during the COVID-19 pandemic

Diagram six highlights the investment from Charitable Funds focused on staff health, wellbeing and training which includes investment in Psychological and Mental Health First Aid training.

Diagram Six: Charitable Funding Investment

Staff Health & Wellbeing & Training £210k

- Refurb of kitchen at CANtreat chemo unit £35k
- Sanctuary Hub £33k
- Clinical ED training suite equipment £27.6k
- Wingman lounge supplies £22k
- Thank you awards, badges and cupcakes £20k
- Staff Emergency Welfare - Covid wave 2 £20k
- Staff relaxation areas £16.8k
- Human factors training 10k
- Mental health support for staff £8.6k
- Complimentary pamper sessions £6k
- Nightingale leadership programme £5k
- Investment in BAME Network £3.6k
- Fruit for flu campaign £1.4k
- Theatres area equipment £0.7k

In addition, to charitable funding, the organisation has committed further investment from the COVID-19 revenue stream as illustrated in **table four**.

Table Four: COVID-19 and Staff Wellbeing investment

Scheme	Level of Investment
Occupational Health COVID-19 Response Service	£500,000 (1st April 2021 – 31st March 2022)
X2 B5 Staff Counsellors aligned to mental wellbeing hub	£152,000 (August 2020 – August 2022)
Temporary marquee facility implemented as part of staff rest areas in Cherry Tree Courtyard	£10,080 (1st January – 30th July 2021 extension)

The initial investment has enabled the organisation to build an infrastructure and a lasting legacy around health and wellbeing, but it is important that this investment is seen as sustainable, to support the organisation through recovery and continue to enable an environment where we look after our people, and where we are safe and healthy as identified in the NHS People Plan and the NHS People Promise.

3. RECOMMENDATIONS

The Board are asked to note the overview of the Wellbeing Guardian and the assurance that will be provided to this position on the Board, the stocktake undertaken via self-assessment against national and local health and wellbeing frameworks including the areas for improvement which will be undertaken as key priorities for the staff engagement and wellbeing function within the HROD Directorate moving forwards.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/98**	
SUBJECT:	**Trust Engagement Dashboard Q4 and Q1 2021-22**	
DATE OF MEETING:	28th July 2021	
AUTHOR(S):	Pat McLaren, Director of Communications & Engagement	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications & Engagement	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X X X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***		
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Engagement Dashboard is for the period Jan – Jun 2021 inclusive (Q4 and Q1) and addresses: • Level of success in managing the Trust's reputation in the media and across digital and social platforms • Our engagement with patients, staff and public via our social media channels • The Trust's website and levels engagement with this key platform • Patient enquiries via our website • Patient/public feedback on the independent platforms (recent addition of GOOGLE) **Media** 1. **Covid-19 data from our hospitals** remains a key item of interest among our local and regional media. We continue to publish key Covid-19 stats on our website at 1pm daily which are reported on weekly in local outlets. 2. **Media sentiment** continued neutral, ie where media reported on Covid statistics, however the Trust pressed ahead with key projects which drew media attention such as the opening of the clinical research centre at Halton, the arrival of our first cohort of international nurses, proposed new health hub at Runcorn Shopping City, reinstatement of car parking charges and the opening of our new stroke unit garden. **Social Media** 1. **Twitter** – Followers continue to climb steadily to 12.5K with engagements in the period reaching 890K 2. **Facebook** reach in the period rose to 1.1m – to note that Facebook and Twitter channels were extensively used to promote Public Health England Covid-19 messaging	

	3. **Instagram** – a new metric on the dashboard this platform is extensively used by younger users and we are working on building a following on this medium **Website** 1. **Website visits** reached an all time high in January at 70K settling to around 50K per month – this is double that which we used to achieve with our previous platform. This version is highly accessible and mobile enabled, nearly 60% of visitors arrived by mobile phone. 2. **Patient/visitor enquiries** through the website totalled 1,842 for the period – we are planning to introduce a 'Chat Bot' to support visitors to find the information they require through a single search term. As well as offering a significantly better visitor experience, it will also reduce pressure on scarce resources. **Patient Feedback** 1. There were 45 patient reviews on the three main external channels: NHS Choices, Care Opinion and I Want Great Care of which 7 were negative. 2. **Healthwatch** continues to collect ratings on healthcare services in each borough, Halton Hospital is at 5* from 61 reviews, RUCC is at 4.5* from 8 reviews and Warrington Hospital is at 3* based on 15 reviews 3. **Google Reviews** We have begun to collate Google reviews, an increasingly popular ratings system and which are present when the user searches for an organisation or establishment. Warrington Hospital is at 3.4* where users most often mention A&E and Car Park in their reviews. Halton General is at 3.9* with users most often mentioning 'professional, nurse, treatment and triage' Both CMTC and CSTM now showing with 4 and 4.9* respectively – insufficient ratings to review comments.

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

RECOMMENDATION:		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

WHH Engagement Dashboard

Half year dashboard

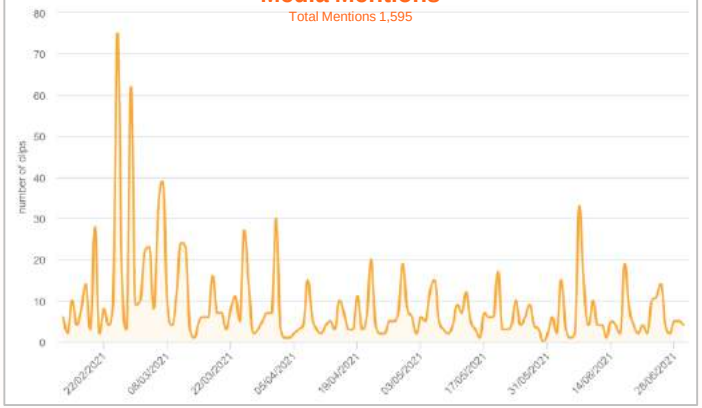
January 2021 – June 2021

Media Dashboard

Warrington and Halton Teaching Hospitals NHS Foundation Trust

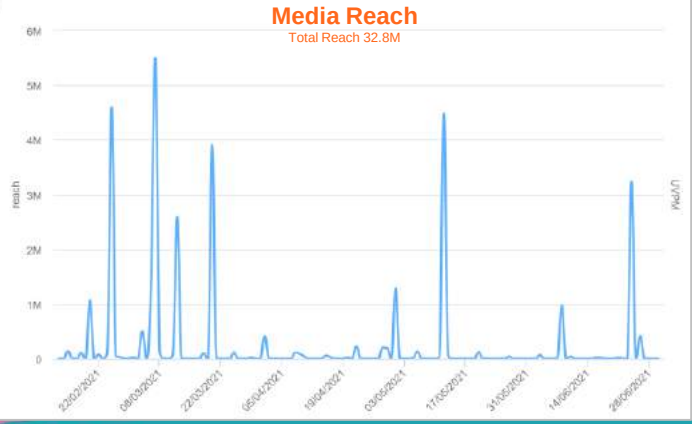
Media Mentions

Total Mentions 1,595



Media Reach

Total Reach 32.8M



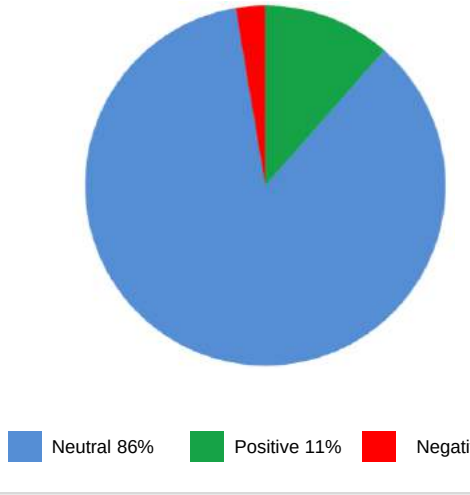
Top Outlets

OUTLET	NUMBER OF CLIPS	REACH
Sky News	92	15,228,000
Warrington Guardian	383	15,228,000
Cheshire Live	30	4,726,350
Warrington Worldwide	166	1,958,800
Runcorn & Widnes World	35	385,525
Runcorn & Widnes Weekly News	26	76,844

Top Articles

HEADLINES	OUTLET	REACH
Charlotte Dawson celebrates vale...	Daily Mail - MailO	23,912,681
Charlotte Dawson's baby son is sp...	Daily Star	2,707,483
Dad delivered baby at home afte...	Manchester Eveni	1,808,899
Charlotte Dawson celebrates 'first...	Daily Mail	938,327

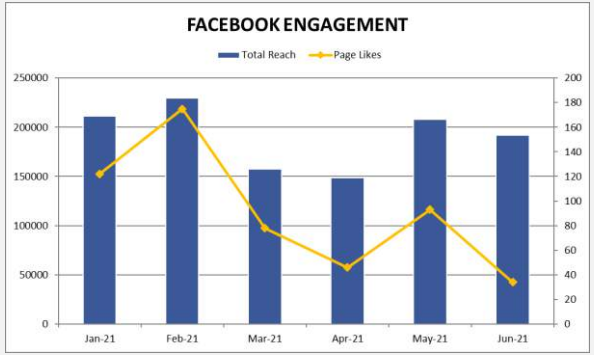
Media Coverage Sentiment by mention

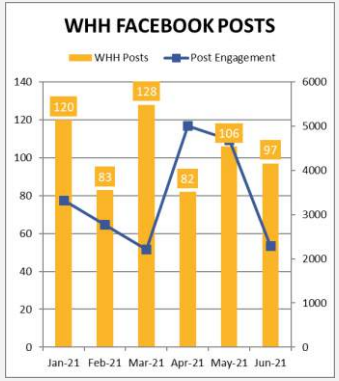


WHH Social Media

Warrington and Halton Teaching Hospitals NHS Foundation Trust

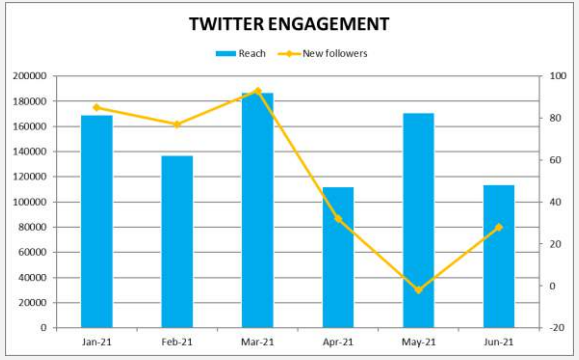
FACEBOOK
Total Reach 1.1M

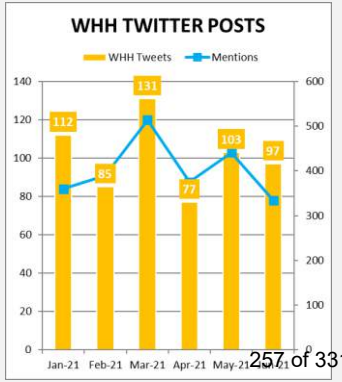




TOP POSTS
50K REACH

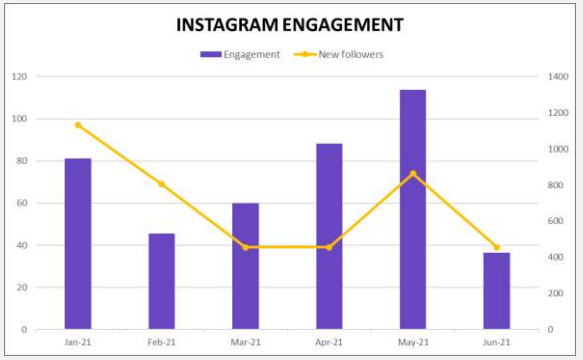
TWITTER
Total Reach 890K

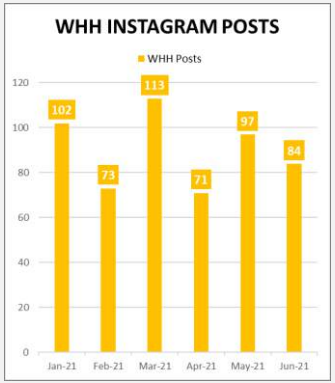




TOP TWEET
15K IMPRESSIONS

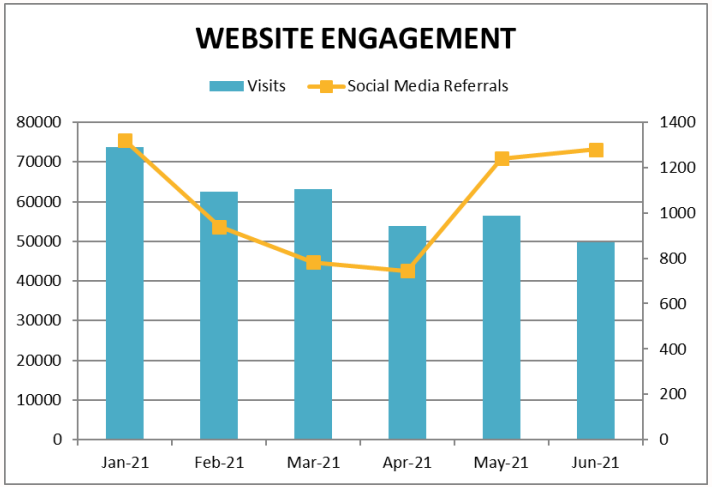
INSTAGRAM
Total Engagement 4.9K

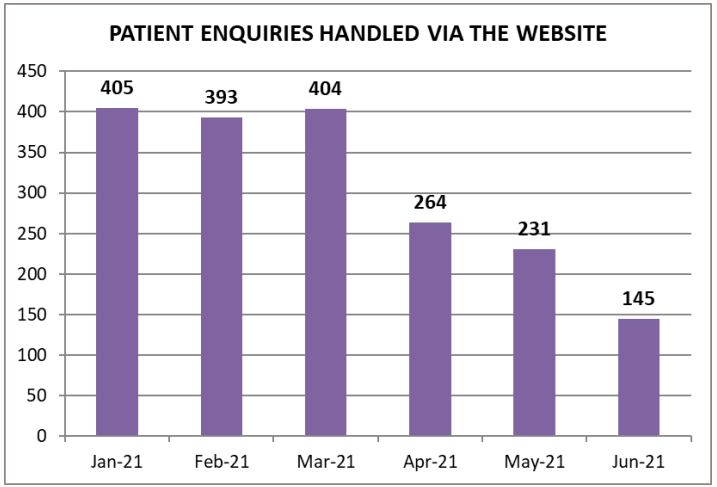


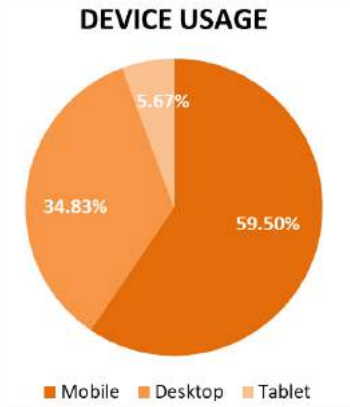


TOP POST
1.6K REACH

WHH Website





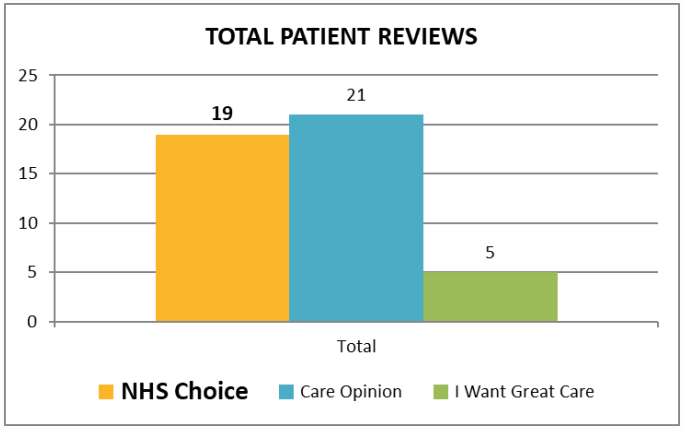


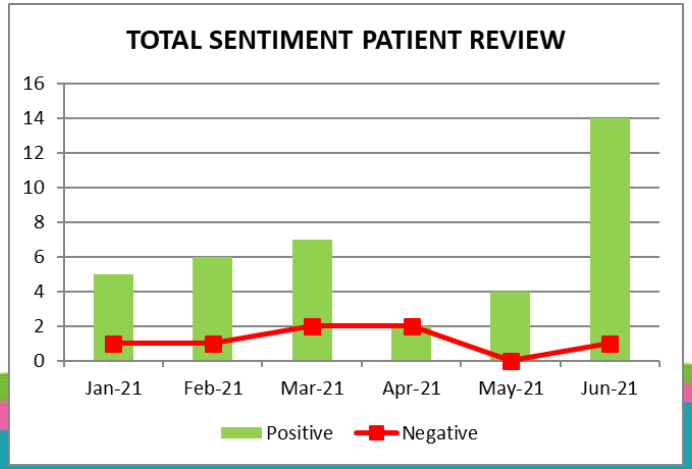
Total website sessions: 359,414 ↑62% from the same period last year

Total patient enquiries handled: 1,842 ↑18% from the same period last year

Patient Experience - Third party website feedback

Warrington and Halton Teaching Hospitals NHS Foundation Trust



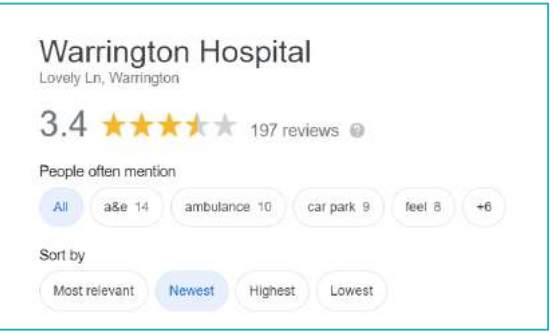


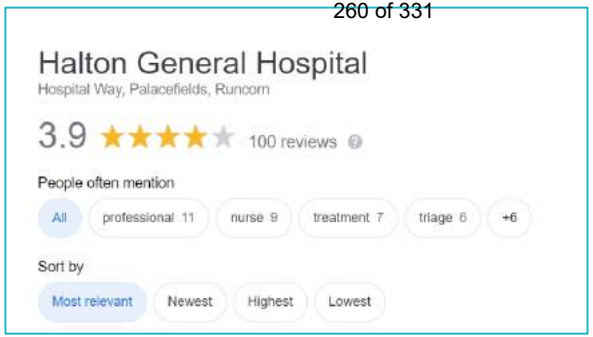
"Staff run off their feet, day and night, but they still gave excellent care and time for every individual patients needs, going above and beyond. Hospital kept very clean. PATIENTS behaviour at times can be unacceptable, even racist, but staff still remain professional and caring despite. STAFF are truly amazing"

"Just been to A&E fantastic staff all sorted within one hour treated and on my way back home thanks to all the staff stay safe thank you"

"I attended the UCC at Halton for the first time yesterday. Reception was considerate to the privacy of my information and my waiting time was minimal. The nurse who examined me was very softly spoken and put me at ease straight away. She explained I would need a referral to Warrington and again was supportive and caring. Great staff and environment, even down to the temperature of the examination room. Parking was easy and I was very grateful that it was free as I had rushed out of work and had no money"

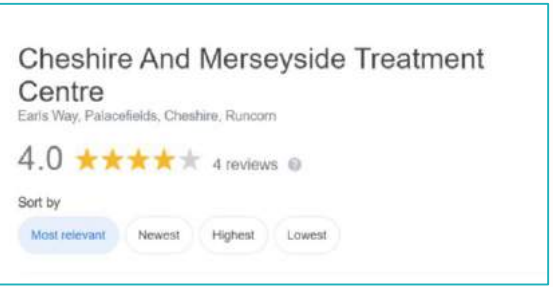
Google Reviews





NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

healthwatch Warrington



Warrington Hospital
Lovely Lane, Warrington, WA5 1QG
01925 635911
www.warringtonandhaltonhospitals.nhs.uk

healthwatch Halton

Halton General Hospital
Feedback Rating
Based on 61 reviews

Runcorn NHS Urgent Care Centre
Feedback Rating
Based on 8 reviews

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/99**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	28th July 2021	
AUTHOR(S):	John Culshaw, Trust Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Since the last meeting: • Three new risks have been added to the BAF; • The ratings of three risks has been reduced and it is proposed to increase the rating of one further risk. • The descriptions of two risks on the BAF have been amended and it is proposed to amend the description of one further risk. • Four risk has been de-escalated from the BAF since the last meeting. Notable updates to existing risks are also included in the paper.	
PURPOSE: ***(please select as appropriate)***	Information	Approval ✓	To note	Decision
RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC 21/07/177		
	Date of meeting	06.07.2021		
	Summary of Outcome	Amendments were approved by Chair's actions		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework and Strategic Risk Register report	AGENDA REF:	BM/21/07/99

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 **three** new risks have been added to the BAF.

Following discussion at the Clinical Recovery Oversight Committee (CROC) on 8th June 2021, and agreement by the Quality Assurance Committee via Chair's actions on 6th July 2021; risk **#224** (detailed below) was escalated.

ID	Risk description	Rating (initial)	Rating (Current)	Risk Register	Executive Lead	Monitoring Committee
224	Failure to meet the emergency access standard, Caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to Trust reputation, financial impact and below expected Patient experience.	16	16	BAF	Dan Moore	Quality Assurance Committee

Following discussion at the Risk Review Group on 7th June 2021, and agreement by the Quality Assurance Committee via Chair's actions on 6th July 2021; risk **#1233** (detailed below) was added to the BAF.

ID	Risk description	Rating (initial)	Rating (Current)	Risk Register	Executive Lead	Monitoring Committee
1233	Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base.	16	16	BAF	Alex Crowe	Quality Assurance Committee

Following discussion at the Risk Review Group on 7th June 2021 and support from the Finance & Sustainability Committee on 23rd June 2021, it was agreed by the Quality Assurance Committee via Chair's actions to add risk **#1372** (detailed below) to the BAF

ID	Risk description	Rating (initial)	Rating (Proposed)	Risk Register	Executive Lead	Monitoring Committee
1372	FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case	12	16	BAF	Alex Crowe	Finance & Sustainability Committee

2.2 Amendment to Risk Ratings

Since the last meeting, the ratings of **3** risks have been reduced.

Following discussion at the Risk Review Group on 7th June 2021, at the Patient Safety & Clinical Effectiveness Committee on 29th June 2021, and following agreement by the Quality Assurance Committee via Chair's actions on 6th July 2021; as the number of COVID-19 positive patients in the Community and the Trust had reduced, it was agreed to reduce the ratings of risks #1331 and #1332 (detailed below) from the rating of 15 to a rating of 10.

ID	Risk description	Rating (current)	Rating (Proposed)	Risk Register	Executive Lead	Monitoring Committee
1331	Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the increase in critically unwell COVID-19 positive patients resulting in potential harm.	15	10	BAF	Dan Moore	Quality Assurance Committee

ID	Risk description	Rating (current)	Rating (Proposed)	Risk Register	Executive Lead	Monitoring Committee
1332	Failure to provide a suitable patient environment caused by the rapid creation and opening of additional capacity/wards resulting in potential harm	15	10	BAF	Dan Moore	Quality Assurance Committee

For the same reasons, it was also agreed to reduce the rating of risk **#1124** (detailed below) from 15 to 10.

ID	Risk description	Rating (Current)	Rating (Proposed)	Risk Register	Executive Lead	Monitoring Committee
1124	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff	15	10	BAF	Kimberley Salmon-Jamieson	Quality Assurance Committee

Proposed risk rating amendment

Further to the escalation of risk **#224** as described in section 2.1, the Trust Board is asked to consider the proposal to increase the current rating of 16 to 25 to reflect the significant pressure currently experienced.

2.3 Amendments to descriptions

It was agreed by the Quality Assurance Committee via Chair's actions to amendmend the descriptions of **two** of the risks on the BAF in order to best describe the current situation.

It was agreed to amend the description of risk **#1108:**

FROM:

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

TO:

Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team

It was agreed to amend the description of risk **#1289:**

FROM:

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

TO:

Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm

Proposed risk descripton amendment

Furthermore, the Trust Board is asked to consider and amendment to amend the title of risk **#224** as described below in order to reflect the potential impact on staff wellbeing:

Current: *Failure to meet the emergency access standard, caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to Trust reputation, financial impact and below expected Patient experience.*

Proposed: *Failure to meet the emergency access standard, caused by system demands and pressures resulting in potential risks to the quality of care and patient safety, staff health and wellbeing, Trust reputation, financial impact and below expected Patient experience.*

2.4 De-escalation of Risks

Following discussion at the Risk Review Group on 7th June 2021, and agreement by the Quality Assurance Committee via Chair's actions on 6th July 2021, risks **#1331**, **#1332** & **#1124** as described in section 2.2, were de-escalated to the Corporate Risk Register for continued monitoring.

Moreover, following the completion of all the actions of risk **#1205** (detailed below), it was also agreed close the risk.

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
1205	FAILURE TO send accurate continuity of care information medication and / or allergies information from the Lorenzo EPR to external stakeholder. E.g. GPsCAUSED 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	20	10	BAF	Alex Crowe	Finance & Sustainability Committee

	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 *****				

2.5 Existing Risks - Updates

Detailed below are the updates that have been made to the risks since the last meeting.

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
1273	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.	• Trust working with ECIST on improving flow and implementation of national discharge policy	No impact on risk rating
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.	• Bioquell Pods now in place in ED.	No impact on risk rating
1275	Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks	• Process for assurance of 3 and 5 day swabs in place • Bioquell Pods now in place in ED • Trust completed learning from Nosocomial outbreaks sessions. • COVID-19 quality metrics in place	No impact on risk rating
115	Failure to provide adequate staffing levels in some specialities and wards, caused by inability to fill vacancies, sickness, resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	• Care Hours Per Patient Day (CHPPD) currently 7.1 (Year to date position 7.9) • Trust has intensified the HCA recruitment and achieved 0 vacancies by April 21 • In May 21 we have 88 wte band 5 vacancies. • There are currently 7 Health Care Assistant vacancies within the Trust. All vacancies are subject to further recruitment. • There are currently 88 wte registered nurse vacancies within the Trust.	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update 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.	• Achieved 2020/21 Control Total. • Deloitte Audited completed. Positive report received with one overclaim reported (£112k). Draft report to be received by the Finance & Sustainability Committee. • Executive review of COVID-19 costs completed and supported as part of budget setting. • Clinical Review Oversight Committee (CROC) established to provide oversight and assurance on recovery performance. • Submitted plan of breakeven for H1 which assumes ERF funding of 2.5m • Unqualified audit opinion (2020/21) • Deloitte Audited completed. Positive report received with one overclaim reported (£112k). Final report to be received by the Finance & Sustainability Committee in July 2021 and Audit Committee in August 2021 <u>Assurance Gaps</u> • Uncertainty of the Trust allocation from the Cheshire & Merseyside Health & Care Partnership • Cheshire & Merseyside system is required to break-even • ERF Funding is not guaranteed and is non-recurrent • PDC Capital still to be confirmed • ERF subject to system performance and achievement of five gateways.	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	• The COVID-19 nursing advice line continues to be funded until March 2022, to provide a range of advice and guidance to the workforce. • The OH call centre continues to be funded until March 2022, which enables all calls to be answered and triaged by a team of administrators. • Work to support workforce recovery continues including health, wellbeing, leadership, teams, HR and resourcing with some tailored support being provided to some departments such as ITU and A&E. • Central log in HR Department to capture all clinically extremely vulnerable staff – process in place for on-going updates. A Covid Secure SOP was written to support the safe return of CEV to work or to agree working from home arrangements as	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		appropriate to a completed Risk Assessment signed off by Occupational Health professionals. Covid Secure areas under regular review by Microbiologist via Tactical Group. • Trust continues to be challenged by high sickness absence rates nationally the North West has higher sickness absence rates. Trust has conducted a deep dive into their data and also participated in a NHSE/I deep dive to understand the challenged faced. Improving attendance programme to commence in August 2021 incorporating the data findings and recommendations of both deep dives. • Overall absence rate is 5.82% for May 2021 and is therefore reducing. May 2020's absence rate was 7.94%. • Participation in LAMP testing. Due to low update a comprehensive communication and engagement plan has been deployed in order to increase compliance. • COVID vaccine programme continues with good uptake from across the workforce, with monitoring arrangements in place. • 67 of our 96 international Nurses are now in the country. • 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 July 2021.	
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	• The use of automatic patching software to rollout security updates to devices. • Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links. • 5 servers 2008 R2 unable to install security patches: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system & Winscribe dictation system (all issues resolved). • Office 2010 being used while end of life due to the N365 deployment plan (100% migrated).	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	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.	• Administrator accounts still have access to the Internet & email, although only used when required. <u>Assurance & Control Gaps</u> • Mostly achieving of mandated compliance with DSPT, incorporating CE+ (to be confirmed post MIAA audit results) • Not been able to fully recruit to the Digital Service restructure in terms of cyber. Majority of post filled by end of June 21 • No dedicated logging tool to pull all key logs together and provide useable alerts. MIAA to review processes and tools (May 21) • Using no longer supported Exchange 2010 email system for mail archive • Using SharePoint 2010 for the Hub • Remote devices bypassing the proxy Lack of process to check antivirus alerts in console. MIAA to review processes and tools (May 21) • No controls in place for Bluetooth connectivity.	
1207	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	• The Trust COVID-19 Workforce Risk Assessment Tool was developed by the HR and OD Team and launched in July 2020. The electronic tool enables all members of staff to undertake a self-assessment and followed by a risk assessment with their line manager where required. The implementation of the tool was supported by guidance, virtual training and regular reporting. Trust compliance as at 7th July 2021 • Have you offered a Risk Assessment to all staff? - Yes • What % of all your staff have you Risk Assessed? - 94.3% • What % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary? - 97.5% • What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary? - 95.9%	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• Reports of any outstanding self-assessment and risk-assessments are provided to managers on a daily basis and numbers of outstanding assessments by CBU / Department are escalated to Tactical Meeting. In addition, the HR Team proactively make contact with any managers where there are outstanding assessments. HR continue to support managers to complete the risk assessments. At 7th July 2021: • 196 staff members yet to complete self-assessment • 16 Management Risk Assessments (required when an individual identifies as having a COVID Vulnerability) have been outstanding for over 3 months • 36 Management Risk Assessments have been outstanding for less than 3 months	
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 Paediatric ED reconfiguration commenced in November 2020. This will increase the Paediatric ED Urgent Care footprint allowing for a better segregated flow of paediatric patients to support Covid-19. Completed and opened in May 2021. Due to fully complete in February 2022	No impact on risk rating
1108	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by Covid, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team	• NICE staffing red flags linked to Safecare implemented at beginning of June 2021 • Midwifery management team strengthened – Two matrons in acting posts until end September 2021 • Birth suite Manager appointed and in post 9th June 2021 • Interview for permanent posts 27th June 2021	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
1274	Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.	• Internal review of Clinically Extremely Vulnerable (CEV) completed to expedite return to work and ensure staff safety.	No impact on risk rating
1290	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices, technology products and services, clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.	• The Procurement Department is implementing processes to monitor prices to determine if there has been any financial impact upon exit from the EU. To date there are no significant price increases; for the period January to March 2021 there has been a net price impact of £621. This work will continue for Q1 and Q2 of 2021/22. • Should a UK data adequacy decision not be reached before 30th June 2021, alternative data transfer mechanisms will need to be put in place to enable personal health data to continue to flow legally from the EU to the UK. The European Commission has published its draft data adequacy decisions. These recognise the UK's high data protection standards and set out that the UK should be found 'adequate'. On 6th May 2021 the IG Manager will attend a webinar on EU-UK transfers of data in order to keep abreast of developments. • An assurance exercise based on the EU settlement scheme was submitted to NHSE in May 20212, indicating no significant risks. • Daily SitRep reporting was stepped down on 08/06/21 as per communication from NHSE. • The Digital department has reviewed all the Trust key IT systems and data flows. To date no issues have been identified which will impact upon data flows. A time limited 'bridging mechanism' has been agreed which will allow personal data to	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		continue to flow as it does now from the EEA whilst EU adequacy decisions for the UK are discussed. A UK data adequacy decision was reached in June 2021 enabling personal health data to continue to flow legally from the EU to the UK. • Assurance letters and communication regarding the EU settlement scheme have been circulated as a reminder about the settlement scheme. An assurance exercise based on the EU settlement scheme was submitted to NHSE in May 2021, indicating no significant risks. • Processes developed by UEC and Finance to ensure chargeable patients are managed appropriately. From the Chargeable Patients point of view, there are no risks to financial procedures, patients or staff. Additional processes and a dashboard have been shared for assurance purposes.	

3 RECOMMENDATIONS

The Board is asked to discuss and approve the changes and updates to the Board Assurance Framework.

Board Assurance Framework

Board Assurance Framework

The Board Assurance Framework (BAF) focusses on the key strategic risks i.e. those that may affect the achievement of the Trust's Strategic Objectives

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
1215	Daniel Moore	Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm	1	25 (5x5)	6 (3x2)	TBC	Quality Assurance Committee
1273	Daniel Moore	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.	1	25 (5x5)	5 (5x1)	TBC	Quality Assurance Committee
1272	Kimberley Salmon-Jamieson	Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident.	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
1275	Kimberley Salmon-Jamieson	Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
1289	Daniel Moore	Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
115	Kimberley Salmon-Jamieson	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	1	20 (5x4)	12 (4x3)	TBC	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

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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	Alex Crowe	FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	1	20 (5x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1079	Kimberley Salmon-Jamieson	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.	1	20(4x5)	2 (1x2)	TBC	Quality Assurance Committee
224	Daniel Moore	Failure to meet the emergency access standard, Caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to Trust reputation, financial impact and below expected Patient experience.	1	16 (4x4)	8 (2x4)	TBC	Clinical Recovery Oversight 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

Board Assurance Framework

1372	Alex Crowe	FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case	3	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1233	Alex Crowe	Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base.	1	16 (4x4)	6 (2x3)	TBC	Quality Assurance Committee
125	Daniel Moore	Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	1	16 (4x4)	4 (4x1)	TBC	Trust Operations Board
1108	Kimberley Salmon-Jamieson	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team	1	16 (4x4)	4 (4x1)	TBC	Quality Assurance Committee
145	Simon Constable	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	3	15 (3x5)	8 (4x2)	TBC	Trust Operations Board
1274	Kimberley Salmon-Jamieson	Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing;	1	15 (3x5)	5 (5x1)	TBC	Quality Assurance Committee

Board Assurance Framework

		potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.					
1290	Andrea McGee	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.	3	12 (3x4)	4 (1x4)	TBC	Finance & Sustainability Committee

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

Board Assurance Framework

Risk ID:	1215	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to deliver the capacity required caused by the on-going COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm			**Initial:**	25 (5x5)
				Current:	25 (5x5)
				Target:	6 (3x2)

Assurance Details:

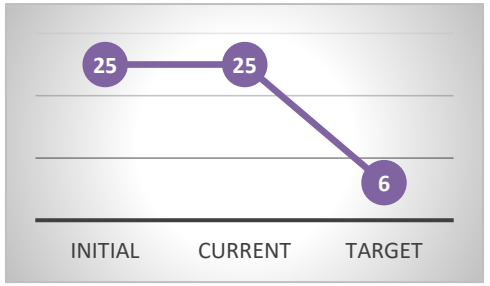
- Operational Planning Guidance submission – 23rd April 2021
- Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery
- Operational planning to be monitored by Gold Command on a daily basis, by Cheshire & Merseyside elective restoration meeting weekly and the Clinical Recovery Oversight Committee (CROC) & Clinical Services Oversight Group (CSOG). This relates to elective surgical activity.
- 2021/22 Operational Planning Guidance received in April 2021 outlining planning requirement for the first 6 months.

Radiology

- New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance.
- Department has been supported by the Trust through £380K recurrent funding to recruit additional staff. Advert out 11th June 2020. Recruiting 4 Radiographers, 2 Sonographers, 2 Healthcare Assistants.
- Additional staff will support additional capacity through extended working days across all scanners – currently unable to achieve this due to Covid-19 demands.
- Additional CT capacity (15 exams per week) will be provided mid-July 2020 via use of mobile CT scanner supported by the National Imaging Team Covid-19 Response initiative.
- All outstanding requests are clinically reviewed by Senior Consultant Radiologists as per local SOP. Exams are deferred in line with clinical priority. Cancer and Urgent patients are being imaged as per pre-Covid-19 as per national guidance.
- Those deferred patients are sent a letter informing of delay, and to contact their Doctor if any concern. The referrer of delayed patients are also sent a letter informing of delay, but this referrer letter includes a direct telephone number to the Senior Radiology Consultants, and also an email address should there be a concern with delaying. Any exams that are highlighted from referrers as not suitable for delay are appointed on the next available appointment.
- This delay process has been discussed via Medical Cabinet and agreed as most appropriate process.
- This clinical review and delay process is ongoing daily.
- Improvement against all modalities for numbers waiting more than 6 weeks noted in April performance.
- CT Business case approved to increase CT capacity and support expediting recovery.

Unplanned care

- The emergency department has been reconfigured to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics in line with Royal College of Emergency Medicine (RCEM) guidance.
- Minor injuries is provided in an area in close proximity but separate to the main emergency department. This has provided an opportunity to use the old minors department as Majors 2 to support management of surge demand and avoidance of corridor care.
- New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance.
- In patient capacity is reviewed with the patient flow and CBU teams daily to ensure that there is adequate capacity for all patient groups to be admitted.
- 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.



Board Assurance Framework

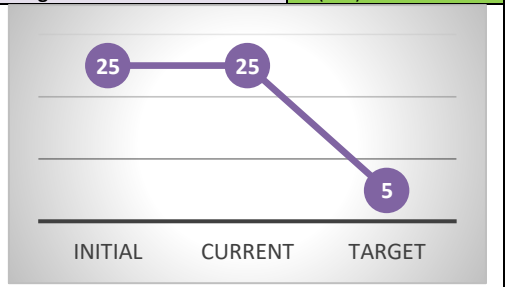
	• Waiting lists are reviewed through the performance review group weekly – outpatients and diagnostics. • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • NHS 111 First pilot went live on 8th September 2020 to reduce attendances to the emergency department and to support the planning of activity in a more streamlined way to reduce overcrowding and risk of nosocomial infection. • Business Case for ED Plaza Scheme approved in 2021/22 Capital Plan • Reconfiguration of Paediatric ED as per phase 1 of the ED Plaza business case commend in December 2020 and is due to be completed in January 2021 which will support an increase in paediatric capacity and further support compliance against RCEM guidance e.g. segregated flows. • Phase 2 ED Plaza commenced in February 2021. • Deployment of Bioquell Pods in ICU in January 2021 to support flow and IPC compliance. This will help reduce instances of have to escalate capacity to the Main Theatre at the Warrington site. Planned Care • All elective patients have been clinically reviewed and categorised in line with national guidance. • Suspected cancer, cancer and clinically urgent patients are treated as a priority. • Theatre capacity has been reviewed and additional capacity is now available with the de-escalation of the theatre PODs • The Halton site is being developed as a covid secure site and will be run as an Elective Centre. • Elective Surgery Standard Operating Procedure (SOP) in place • Capacity identified and being utilised at spire Healthcare • Clinical Services Oversight Group (CSOG) established • Clinical Recovery Oversight Committee (CROC) established • Clean/green pathways have been developed for those priority 2 patients (cancer & urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward 5 on the Warrington site. This pathway is set to commence w/c 8th February and replaces the B18 pathway. • A separate pathway has been developed for Emergency surgery and future plans and bed base has been agreed as part of the ward reconfiguration process. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Workforce plans are continually reviewed to ensure that all wards and teams are staffed safely. • Waiting lists are reviewed through the performance review group weekly • Weekly theatre scheduling to ensure listing of patients in line with national guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021 • Continued use of the independent sector (Spire Cheshire) under new contract in 2021/22 with support from the CCG. • Participation in national clinical validation exercise commenced in November 2020 to support and inform patient waiting time status and support safe management of waiting lists.	
Assurance Gaps:	Radiology 1. Harm may be caused due to the incompleteness of clinical information on a referral. This may also be compounded by the referrer incorrectly entering the wrong priority code on the referral. • It is thought that the letter to the referrer will highlight the exam has been delayed and that the provision of a direct link to the Radiology Consultant team by phone/email will allow these cases to be expedited where appropriate. 2. Harm may be caused by the delay of a routine examination where there is an unlikley serious pathological finding present. • 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.	

Board Assurance Framework

	2. Expansion of the emergency department is required to ensure any increase in demand can be accomodated in line with RCEM guidance 3. Referrals do not include adequate information to triage and prioritise patietns appropriately • Regular meetings and communication with the CCG and GP's to inform them with recovery progress within the organisation and to highlight/address any identified problems 4. Reduction in face to face primary care appointments having a negative impact on increased attendances. 5. Capacity challenge with social workers to keep on top of demand and necessary patient assessments. 6. Estates work required to increase general ICU Capacity & ICU cubicle capacity e.g. Installation of Bioquell cubicles Planned Care 1. Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility. • This is being progressed with the support of the estates and capital planning team. 2. Waiting list do not include adequate information to triage and prioritise patients appropriately • Regular meetings and communication with the waiting list and scheduling teams and inform them of recovery plans and to highlight/address any identified problems 3. New framework for ISP will not include all specialties currently being undertaken. This will increase waiting list pressure for those specialties on this site.

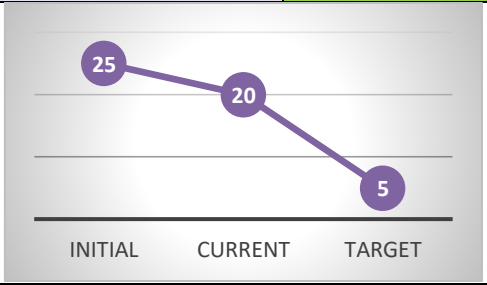
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
ED Plaza building works	Completion of ED Plaza building works	Complete Building work	Sharon Kilkenny	31/03/2020	Phase 1 completed
Install of Bioquell Cubicles	Install of Bioquell Cubicles	Complete Installation	Sharon Kilkenny	28/02/2021	Installation in ICU Complete Jan 2021
Build ED Plaza	Completion of ED Plaza building works	Complete Building work	Sharon Kilkenny	31/02/22	

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. Daily system pressures meeting that reviews hospital and wider system bed capacity to support safe and timely discharge of patients from hospital to support flows Trust participates in Mid-Mersey Operational Group which supports Out of Hospital Cell discussions in relation to system discharge planning. The number of discharge delays in relation to Super Stranded patients is reported daily in the Executive Summary and reviewed so that Executive Directors can support and escalate pathway delays. 'Where's best next' event initiated in January 2021 with system partners to support safe discharge of patients with long lengths of stay to create capacity through December and January expected winter pressures and support wave 3. Scheme issued by the Government to support indemnity concerns of care homes in relation to caring for COVID-19 patients. It will support the system in the creation of COVID-19 designated setting capacity. New 'Discharge to Assess' process has gone live to reduce the length of stay for a cohort of patients who would otherwise be assessed in hospital can be assessed in a transitional care bed. Progressing the procurement of a new software programme which will be able to accurately track and share system delays with partners. By improving information, it will enable quicker and more effective decisions on discharges. Established Patient Flows Oversight Group (PSOG) to develop and support pathways relating to discharge efficiency. Trust working with ECIST on improving flow and implementation of national discharge policy				
Assurance Gaps:	Delays in discharge caused by adherence to Covid-19 infection control pathways and the patient's Covid-19 status. Intermediate Care and other community capacity impacted and restricted by Covid-19 e.g. Care Home and other facility closures due to outbreaks. Access to community capacity impacted by Covid-19 as a result of staff sickness Internal staff shortages to help support discharge planning. Restricted as a result of Covid-19 sickness and self-isolation High number of patients in Warrington awaiting social work assessment, causing a delay in discharges from the acute site in to care homes and intermediate care capacity				

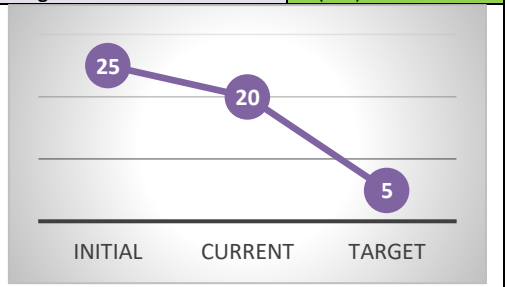
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Risk ID:	1272	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 meters apart, resulting in reduced capacity to admit patients and a potential subsequent major incident.			**Initial:**	25 (5x5)
				Current:	20 (4x5)
				Target:	5 (5x1)
Assurance Details:	The Trust has in place a full environmental plan. The Trust has used a risk assessment approach to identify compliance or challenges in meeting the 2-metre requirement. Risk assessments have been completed on each Ward. Clear curtains are in place all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. Collapsible screens in some areas 8 weeks environmental visit rota in place, supported by the Health & Safety Team and senior clinical nursing staff Expected deployment of Bioquell Pods in ED & ICU in March/April 2021 Bioquell Pods now in place in ICU Bioquell Pods now in place in ED.				
Assurance Gaps:	Individual Ward risk assessments identify challenges in meeting the 2 metre requirement.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
An environmental inspection plan to be set up to ensure there is monitoring of social distancing.	Clear curtains are in place on all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. Bioquell Pods are now in place in ICU. As the number of COVID positive patients has reduced and the nosocomial outbreaks has also reduced, it was agreed at QAC on the 4th May 2021 to reduced the risk from 25 to 20. The situation needs to be continually monitored and therefore the action will remain open and reviewed each month.	Health and Safety to develop and implement an environmental inspection programme in all clinical areas.	Kennah, Ali	30.06.2021	
All wards and departments to have up to date risk assessments in place.	All wards and departments to have up to date risk assessments in place.	Review risk assessments	Wynn, Helen	30.09.2021	

Board Assurance Framework

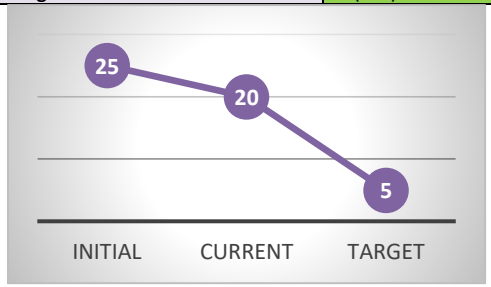
Risk ID:	1275	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks			**Initial:**	25 (5x5)
				Current:	20 (4x5)
				Target:	5 (5x1)
Assurance Details:	Restricted site access is in place to reduce the risk of COVID19 transmission. COVID19 incidents are monitored daily. Risk assessments are in place in all Wards/Departments and rest rooms. Mask stations and santiser is in place at all entrances and designated points throughout the Trust. Agile working policy is in place Information technology infrastructure is in place to support remote working. Risk assessment in place to support safe visiting where appropriate. PPE is monitored daily. Providing and maintaining a clean environment that facilitates the prevention and control of infections. Daily communications through TWSB to staff reinforcing social distancing measures Environmental Safety Action plan in place reviewed via Silver IC bi-weekly meeting Outbreak meetings held with lessons learned shared across the Trust Signage and written information in place to support social distancing practices Retractable screens between beds spaces in ED PPE audits completed weekly on wards PPE Champions in place Clear curtains are in place all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. Process for assurance of 3 and 5 day swabs in place Bioquell Pods now in place in ICU Bioquell Pods now in place in ED Trust completed learning from Nosocomial outbreaks sessions. COVID-19 quality metrics in place				
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.	Findings from inspections. Findings will be fed back to the Deputy Chief Nurse and reported to Silver Command each Monday. Health and Safety inspections continue on an 8 week programme.	Health and Safety inspections to be carried out.	Kennah, Ali	30.09.2021	

Board Assurance Framework

1289	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm			**Initial:**	25 (5x5)
			Current:	20 (4x5)
			Target:	5 (5x1)

Confirmed continued use of the private sector (Spire Cheshire) in 2021/22. Under new contracting arrangements.
Waiting lists monitored and measured weekly
Post Anaesthetic Care Unit (PACU) remains open and operational
Continue to undertake harm review process and triangulate with waiting list process and Priority 2 patients
Continue to specifically focus on and monitor patients waiting greater than 52 weeks
Continue to ensure urgent cancers are prioritised in line with national guidance
Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site.
ED is set to install Bioquell Pods in April 2021
B18 footprint development to support improved Respiratory & Critical response to peaks in the pandemic is underway and set to complete in June 2021.
Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee.
Safe staffing levels reviewed daily. If necessary this may mean a review of clinical services to support the release of staff on a temporary basis.
The re-start of the Warrington site green pathway commenced w/c 8th February in the newly established ward A5 elective footprint. At present this supports cancer and other green pathways on the Warrington site
Clinical Recovery Oversight Committee (CROC) established
Clinical Services Oversight Group (CSOG) established



Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop plan for Ward 18 Footprint to support alternative critical care escalation.	Develop plan for Ward 18 Footprint	Kilkenny, Sharon	28/02/2021	28/02/2021
Complete the B18 development	Complete the B18 development	Kilkenny, Sharon	30/06/2021	

Board Assurance Framework

Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first 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. Students who were redeployed to the Trust during the COVID 19 pandemic have been offered substantive posts
- International Nurse Business Case has been approved for 96 Registered Nurses – we have set up a task and finish group to implement this. We have recruited 73 HCAs since February 2020 with rolling HCA recruitment programme in place
- National staffing guidance has been utilised to inform new staffing models
- Care Hours Per Patient Day (CHPPD) currently 7.1 (Year to date position 7.9)

<u>Recruitment Assurances</u>

- Rolling advert for B5 Nurses
- 12 month recruitment plan in place taking into consideration social distancing restrictions
- Developing WHH recruitment campaign
- Career advice events in local schools and colleges
- Production of monthly and bi-annual staffing reports received by the Trust Board
- Trust has intensified the HCA recruitment and achieved 0 vacancies by April 21. NHSI funding support received to achieve this aim. Weekly monitoring on progress and reporting to NHSI in place
- International Nurses Business cases – 30 Nurses recruited in partnership with Wigan, Wrightington & Leigh all arrived by the end of March 21. 18 joined the Trust in March 2021, with the others currently undertaking OSCE training and local induction.
- The Trust has joined the Mid Cheshire Collaborative after an additional successful business case, 30 nurses arriving in March and April 21 – a further 36 Nurses to be recruited after April 2021.
- The Trust will be recruiting 96 International Nurses by Oct 21.
- In May 21 we have 88 wte band 5 vacancies.

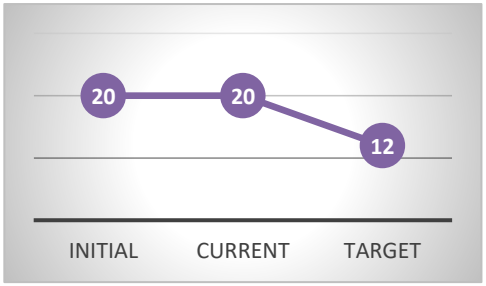
HCA

There are currently 7 Health Care Assistant vacancies within the Trust. All vacancies are subject to further recruitment.

Working up a process with NHSP and HR to ensure all HCA's are automatically recruited by NHSP.

RN Recruitment

There are currently 88 wte registered nurse vacancies within the Trust.

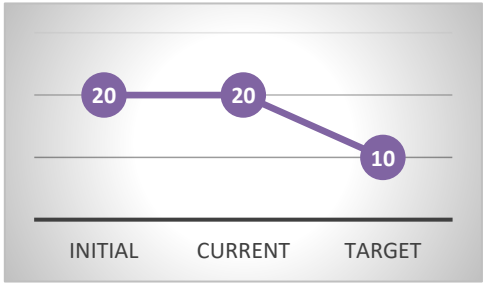


Board Assurance Framework

	60 International Nurses recruited and are joining the Trust between March – May 21 and 31 students due to qualify in Sept who have been offered positions. Retention Assurances • 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 10.25% • International nurses have started to join WHH in March 21. 18 have commenced on the wards with a further 8 starting their induction in the Trust in April 21. COVID-19 Assurances • Implemented a graduated and planned nurse staffing response to the COVID-19 Pandemic. • Revised staffing models for the expansion of critical care capacity, acute and supportive respiratory wards • Strengthened daily staffing meetings chaired by the Associate Chief Nurse for senior oversight • Increased use of temporary staffing through NHSP and off framework agencies – close monitoring arrangements in place • Implementation of NHSP incentive scheme for staff to improve fill rates – update monitored weekly • Nursing Times Workforce Award winners in November 2021 – Best Recruitment Experience During COVID-19 Pandemic Response • As the number of COVID patients in March 21 reduce the staffing plans are being revised and the number of agency staff is starting to reduce.	
Assurance Gaps:	Increase staffing pressure due to ongoing use of temporary winter ward for which there is no funded establishment Recruitment Gaps • 73.41 RN Vacancies in March 21 Retention Gaps • 10.25% nursing turnover	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

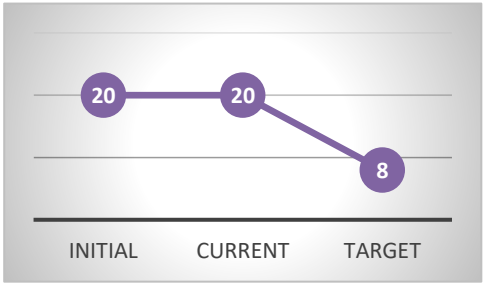
Risk ID:	134	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Financial Sustainability a) Failure to sustain financial viability, caused 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 future loans will be required which would raise the 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 2020/21 Control Total. • Unqualified audit opinion (2020/21) •Corporate Trustee Charities Commission Checklist, reporting annually through Board •Monitoring of charitable funds income, assessment of return on investment and controls on overhead ratios via quarterly financial reports •Regular updates to Executive Team, FSC and Trust Board •Financial Resources Group (FRG)that reports to FSC • Workshop undertaken with - Exec, CBU, Corporate to review 2021/22 cost pressures • 2021 cost pressures supported by Trust Board. Business cases being developed to secure required levels of funding. •Trust Board approval of 2021/22 Capital Plan including the requirement for PDC as part of the final programme •Completed MIAA Governance Checklist received by Audit Committee •H1 Expenditure Budgets approved by the Trust Board on 31st March 2021 •Capital Plan approved by Trust Board on 31st March 2021 (£19.75m) •c£34m cash support secured in the form of PDC in March 2021 <u>COVID-19</u> • Governance process in place to ensure all additional costs are being approved and monitored – re-introduced for Wave 2 & Wave 3 • Reporting to NHSE/I • Regular attendance to regional and national conference calls • Circulate latest guidance from MIAA Counter Fraud team • Ensure governance and processes in place including checks in place for all expenditure in particular procurement, contracts, payroll and HR. • Highlighted the different methods of fraud/ scam in operation to all staff and share it as widely through Trust • Receiving Charitable donations that will support sustainability of Trust Charity • Monthly Report to Exec & F&SC on COVID Pay Costs • Deloitte Audited completed. Positive report received with one overclaim reported (£112k). Final report to be received by the Finance & Sustainability Committee in July 2021 and Audit Committee in August 2021 • Participating in exercise to understand run rate for 2020/21 to support funding envelopes for 2021/22 • Executive review of COVID-19 costs completed and supported as part of budget setting. • Clinical Review Oversight Committee (CROC) established to provide oversight and assurance on recovery performance.				

Board Assurance Framework

	• Submitted plan of breakeven for H1 which assumes ERF funding of 2.5m	
Assurance Gaps:	• Inability to develop a strategic plan to deliver a break-even position over the next 5 to 10 years • Non-recurrent and unidentified CIP presents a risk to in-year and future year financial position. • Failure to fully comply with emerging national employment litigation resulting in additional pay costs or the trust receiving potential claims. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Risk that capital needs exceed capital funding resources available. • Hospital Infrastructure Programme (HIP) announcement. WHH not included in with phase 1 or phase 2 funding allocation. • Need to determine the future run rate which is currently uncertain in order to mitigate risks. • Increased threat of fraud during COVID-19 global pandemic • Uncertainty of the Trust allocation from the Cheshire & Merseyside Health & Care Partnership • Cheshire & Merseyside system is required to break-even • ERF Funding is not guaranteed and is non-recurrent & subject to system performance and achievement of five gateways. • PDC Capital still to be confirmed	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Submit requested Workforce & CIP information to NW Intensive Support Director	Cheshire and Merseyside Health & Care Partnership in receipt of Tier 1 Intensive Support – Information requested by NHSE/I on workforce & CIP	Submit requested Workforce & CIP information to NW Intensive Support Director	Andrea McGee	30/03/2020	Paused
Monitor all COVID-19 requests	COVID-19 Revenue	All covid expenditure to be reported to Execs and only extended following approval (Currently undertaken monthly)	McGee, Andrea	31/03/2022	

Board Assurance Framework

Risk ID:	1134	**Executive Lead:**	Cloney, Michelle	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain			**Initial:**	20 (4x5)
				Current:	15 (3x5)
				Target:	8 (4x2)
Assurance Details:	• The COVID-19 nursing advice line continues to be funded until March 2022 , to provide a range of advice and guidance to the workforce. • The OH call centre continues to be funded until March 2022, which enables all calls to be answered and triaged by a team of administrators. • The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff) • Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical. • An enhanced wellbeing offer continues , linked to learning from Wuhan, Italy and the British Psychological Society. • A specialist extranet page is in place which includes all national wellbeing offers, and links to discounts for our NHS staff during this period of time. • Mental health wellbeing drop in sessions continue across both Warrington and Halton sites, with a specific wellbeing email address created for any enquiries to the wellbeing hub. • Facilitated conversations are available to staff working on COVID-19 wards. • Face to face counselling is available on-site. • Telephone counselling is available to Trust staff. • Alternative therapies such as relaxation therapy is available. • Additional support put in place for Black, Asian and Minority Ethnic staff including a specific risk assessment • Guidance on risk assessments for various groups of staff has been issued to managers with clear expectation on completion. • Following national guidance, amendments have been made to the pre-employment check process to support speedier recruitment • The Workforce Information Hub has supported the 'real time' reporting of absence, to enable a clear picture of current staffing. • A Temporary Workforce Redeployment Hub continues to be established to support staffing levels by identifying staff who are available for redeployment and match them with demand. This hub has increased its capacity as the Trust moved into wave 3 in December 2020. • A deep dive review of all Clincally Extremely Vulnerable Staff was undertaken to ensure that staff were supported back into work and that resource was utilised apporporiately. • Retirement Policy has been temproarily updated to allow a shorter break (24 hours) in service. • All Trust staff were afforded the opporunity to carry over any untaken annual leave from 19/20 providing that they were unnable to take it due to the covid response. • Work to support workforce recovery continues including health, wellbeing, leadership, teams, HR and resourcing with some tailored support being provided to some departments such as ITU and A&E. • Central log in HR Department to capture all clinically extremely vulnerable staff – process in place for on-going updates. A Covid Secure SOP was written to support the safe return of CEV to work or to agree working from home arrangements as appropriate to a completed Risk Assessment signed off by Occupational Health professionals. Covid Secure areas under regular review by Microbiologist via Tactical Group. • Electronic system continues to be available to support the COVID-19 Workforce Risk Assessment Tool in line with Risk Reduction Framework • Regular reporting on compliance with risk assessment requirements is in place and reported at Tactical on a weekly basis.				

Board Assurance Framework

	• Regular training on COVID-19 Workforce Risk Assessment is in place. • Trust continues to be challenged by high sickness absence rates nationally the North West has higher sickness absence rates. Trust has conducted a deep dive into their data and also participated in a NHSE/I deep dive to understand the challenged faced. Improving attendance programme to commence in August 2021 incorporating the data findings and recommendations of both deep dives. • Overall absence rate is 5.82% for May 2021 and is therefore reducing. May 2020's absence rate was 7.94%. • Extensive communications via Trust Safety Huddle and global emails to promote use of PPE, social distancing and compliance with environmental risk assessments restricting numbers within confined staff areas. • Participation in LAMP testing. Due to low update a comprehensive communication and engagement plan has been deployed in order to increase compliance. • Occupational Health opening times have been extended since 4 January 2021. • COVID vaccine programme continues with good uptake from across the workforce, with monitoring arrangements in place. • COVID-19 Workforce Recovery Steering Group commenced. • Supported by funding from NHSI there has been a big push to fill our HCA vacancies, we currently reporting 11 FTE vacancies (31/05/2021) • Extension of existing temporary changes to terms and conditions to support the covid response e.g. special leave, retirement, overtime until 30.06.2021. • In April 2021 overall vacancy rate is 7.51% compared to a peak in Jun 2020 of 10.5%. • 67 of our 96 international Nurses are now in the country. • Therefore, as vacancies and sickness absence reduced it is expected our bank and agency reliance reduce and within May 2021 reliance on bank and agency staff reduced for the fourth month in a row and is now 15.3% compared to a peak of 23.3% in Jan 2021.	
Assurance Gaps:	• Unable to control staff selecting to use national track and trace system for swabbing rather than local service. Therefore, staff will receive results and instructions from national Trace and Trace service and any contacts in the workplace could be instructed to self-isolate. Escalated to National & Regional Teams • Awaiting National Update from NHSE/I to concern raised about local management of staff self-isolating following symptoms & swabbing versus National Trace and Trace advice. No National or Regional solution to date. • National Policy on sickness absence monitoring and payments are being negotiated nationally - unable to influence outcome. May increase gaps in provision due to additional sickness absence allowances and associated pay arrangements. Negotiations ongoing. National Guidance expected in July 2021. • Continued lack of national/regional clarity of the management of long covid in the context of the National agreement.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Following an overall reduction in absences, review the trends of each category of COVID-related absence and re-assess risk score.	Review Recent Absence Trends	• Data analysis and recommendation relating to risk score	Robert, Carl	31/05/2021	

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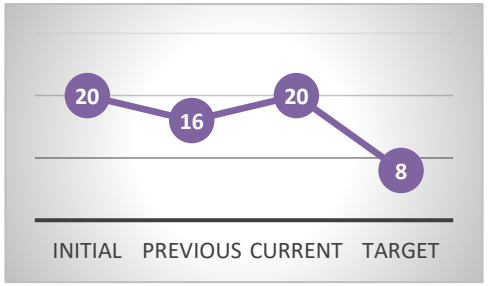
Risk ID:	1114	**Executive Lead:**	Crowe, Alex	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	FAILURE TO provide essential, optimised digital services in a timely 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). • ITHealth Assurance Dashboard is live, monthly external penetration testing is now in place using NHS Digital's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. (March 2021) **Controls:** • **Digital Operations Governance** including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard. • Active membership of the **Sustainability Transformation Partnership Cyber Group.** • **Digital Change Management** regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions. • **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training. • **Cyber Training** for the Trust Exec Board • Secured annual capital investment to increase Digital skills and capacity. • Digital Board support for profiling of a 7 Year Capital investment based upon asset replacement cycle and strategic roadmap (to deliver the approved Digital Strategy (January 2020)) • The use of automatic patching software to rollout security updates to devices. • Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links. • 5 servers 2008 R2 unable to install security patches: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system & Winscribe dictation system (all issues resolved). • Office 2010 being used while end of life due to the N365 deployment plan (100% migrated)				
Assurance Gaps:	**Gaps In Assurance:**				

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	• Mostly achieving of mandated compliance with DSPT, incorporating CE+ (to be confirmed post MIAA audit results) **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Outcome of the Phishing exercise by NHS Digital, too many people clicked on the link. Next steps for staff awareness to be agreed. • Current performance of Lorenzo and whether migration to the cloud will provide any benefit. • Not been able to fully recruit to the Digital Service restructure in terms of cyber. Majority of post filled by end of June 21. • 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). • Not all Windows Server 2003 server will be migrated to Windows Server 2016 before the N365 agreement starts. (1 out of 77 servers are at risk of not being migrated in time. The system at risk is Medicorr.) • No local-based firewalls in use while on site, dependant on the site boundary firewalls • Using generic logins staff usernames and passwords are stored in browser when selecting "remember me" • No dedicated logging tool to pull all key logs together and provide useable alerts. MIAA to review processes and tools (May 21) •Using no longer supported Exchange 2010 email system for mail archive • Using SharePoint 2010 for the Hub •Remote devices bypassing the proxy • Lack of process to check antivirus alerts in console. MIAA to review processes and tools (May 21) • Administrator accounts still have access to the Internet & email, although only used when required. • No controls in place for Bluetooth connectivity.

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) [Progress has been slow as core members were trying to provide an automated "bot" style document suite. This was too ambitious, and the group decided to scale it down to templates only. MIAA have writing the templates. The workstream are currently reviewing	Deacon, Stephen	28/02/2022	

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		these documents for the 5th review and providing feedback and will be approved by the May C&M STP Cyber Group. Once approved Digital Compliance would rewrite the local documentation and seek approval from the Information Governance and Records Sub Committee.]			
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system). [Delivers: Best Practice]	Migrate all 2003 and 2008 servers to 2016.	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to Windows Server 2016 • Extend Support for Windows Server 2008 until Feb 2022 [Status April 21] Total Completed % Complete 2003 Servers 22 16 72.5% 2008 Servers 79 55 68.8% [Status May 21] Total Completed % Complete 2003 Servers 22 17 77.3% 2008 Servers 80 56 70.0% [Status June 21] Total Completed % Complete 2003 Servers 22 17 77.3% 2008 Servers 80 57 71.3% NB: Windows Server 2003 is out of support; however, Windows Server 2008 is still in support until March 22. [All simple migrations have been completed by IT Services. A report was presented at the October's Digital Board, providing progress made in the decommissioning of Windows 2003/2008 servers, the timetable for decommissioning the remaining servers and the mitigations identified for those servers which are unlikely to be decommissioned before 31st December 2020. The only server at risk is the	Deacon, Stephen	31/03/2022	

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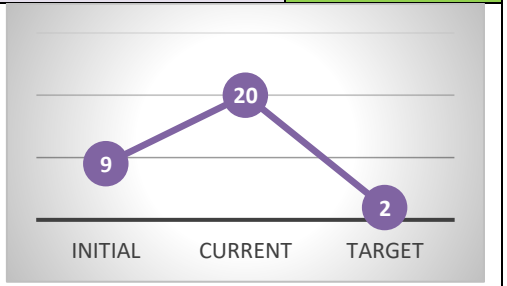
		Medicorr Server. As part of the DSPT requirements we have asked for an update action plan.]			
Deliver fit for purpose Lorenzo EPR Performance and agility of changes to deliver the paperless strategy. [Delivers: Optimisation / Timeliness]	Work with supplier to assure EPR performance	• Work with EPR supplier to safely migrate Lorenzo to the modern cloud solution. The date is subject to national contract changes that our out of our control.	O'Brien, Emma	31/08/2021	
Implementation of the revised staff structure	Implementation of the revised staff structure	[Phase 1 Consultation complete. Process to now to get the staff in place. Contractors are covering the gaps]	Deacon, Stephen	30/09/2021	
From the review of the first phishing exercise, provide a comms strategy and send it out to the users. Once finished rerun the phishing exercise next year.	Lessons learnt from previous phishing exercise and rerun phishing exercise	Lessons learnt from previous phishing exercise rerun phishing exercise • Produce a comms plan and send out comms to all staff • Arrange a rerun the phishing exercise • Examine the results and publish at the April IGRSC [Engaged with Templar (NHS Digital) and agreed September for the next phase of the phishing exercise]	Deacon, Stephen	30/09/2021	
Migrate the last 9 endpoints devices to Windows 10	Migrate the last 9 endpoints devices to Windows 10	The below endpoint devices can be replaced: 1x Catering Menu Mark – This can now finally be replaced with Windows 10. 1x ED Whiteboard PC – This can be replaced as we have the kit to do it. 1x Lung Function PC – This was a computer provided by the supplier of the Lung Function machine, but they have said it is our asset to do what we want and we can replace it. 1x Laptop in Medical Engineering – Unsure why this is still in use. Endpoint devices more complicated to migrate: 1x Dexa Scanner computer – This cannot be replaced at the moment, however, a new dexa scanner has been procured, just waiting on delivery and installation. 1x Ophthalmology Fundus imaging computer – This cannot be	Waterfield, Tracie	30/09/2021	

Board Assurance Framework

		upgraded/replaced as the Fundus camera is not Windows 10 compatible. Conversations on going with the department around replacement camera or removing use of the system altogether. 2x Pathology computers – These are running some sort of Pathology system on them; one is a live and one is a backup. 1x Pathology Cognos client – This is some sort of information reporting system used in Pathology. They have supposedly purchased a replacement, just not implemented it yet. [As part of the DSPT requirements we have asked for an update action plan.]			

Board Assurance Framework

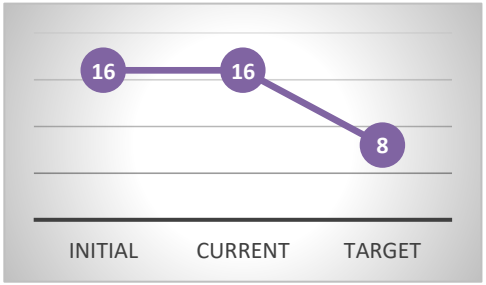
Risk ID:	1079	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.			**Initial:**	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. Presentation provided by prospective suppliers on 18th December 2020 Decision on supplier expected by 31st January 2021 EPR Strategic Outline Case supported by the Trust Board in December 2020 Temporary fix for CTG archiving agreed and fitted in December 2020 with review in January & February 2021 Following completion of supplier decision making process, implementation due to complete in September 2021				
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.				

Board Assurance Framework

	Ineffective use of midwifery time- midwives continuing to report excessive additional effort to correct omissions and inaccuracies, impacting upon carer/woman relationship and data quality, and leading to concerns that the current situation may impact the Trust's aspirations to achieve outstanding status.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Implementation of new EPR system	New EPR is fully in use and all training completed	Implementation plan Training of staff on new EPR.	Arya, Dr Rita	30/11/2021	

Board Assurance Framework

Risk ID:	224	**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 meet the emergency access standard, Caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to Trust reputation, financial impact and below expected Patient experience.			**Initial:**	16(4x4)
				Current:	16(4x4)
				Target:	8 (2 x 4)
Assurance Details:	•Regular Trust Wide Capacity meetings led by the Senior Site Manager for the day •Systemwide relationships including social care, community, mental health and CCGs •Discharge Lounge/Patient Flow Team/Silver Command •Red to Green - Discharge Planning •ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing •Controller •Private Ambulance Transport to complement patient providers out of hours •FAU/Hub operational from June 2018 - Now operating 5 days per week. •Discharge Lounge opened 26th November 2018 •Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance. •System actions agreed supporting the Winter Plan •Further development of Rapid Response to avoid admission •Increase IMC provided by the system such as the opening of the Lilycross site •Increase IMC at home •Regular monitored at the Mid Mersey A&E Board •Trust is working with ECIST on a number of Long Length of Stay & Flow improvement projects •ECIST is supporting effective deployment of the national discharge policy •Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. •The Trust participates at the system & regional UEC improvement meeting on each Wednesday •Redeveloped ED 'at a glance' dashboard •Trust implemented NHS 111 first successfully in August 2020 allowing for directly bookable ED appointments •Board approval of capital plan to build new £5m purpose built acute Medical Ambulatory Care area aka ED Plaza •Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings •Integrated discharge Team now in place •Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients •ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised. •Respiratory Ambulatory Care Facility agreed by CCG •Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved •Collaborative working with Orthopaedics in management ok MSK Minor injuries via Minor's Stream •Reinstated CAU 24/7 •Upgrade to Minor's resulting in Oxygen points in all cubicles •Non-Elective flow activity now above 2019/20 activity levels for type 1 & 3 •Operation Re-set undertaken at the end of May 2021 to support flow and discharge				
Assurance Gaps:	• Robust WHHFT PAN receipt, review and act process for all PANs.				

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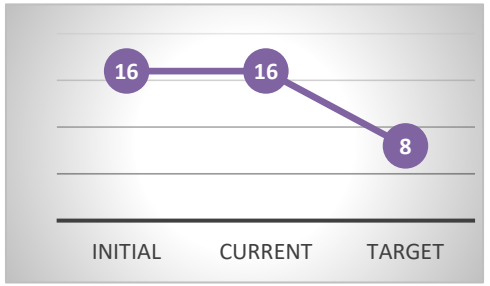
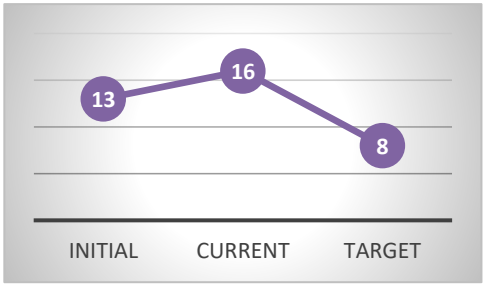
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Escalation of breaches	Escalation of risk of breach and capacity status	Breaches continue to be escalated.	Field-Delaney, Sheila	30/07/2021	
Monitor frequency of occurrence	Monitor frequency and severity of risk. Staff have been advised to datix incident. Governance manager will link to risk and monitor for potential harm	Staff to continue to datix incident	Field-Delaney, Sheila	30/07/2021	

Board Assurance Framework

Risk ID:	1207	**Executive Lead:**	Michelle Cloney, Chief People Officer	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.			**Initial:**	16 (4 x 4)
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.			**Current:**	16 (4 x 4)
				Target:	8 (2 x 4)
Assurance Details:	The Trust COVID-19 Workforce Risk Assessment Tool was developed by the HR and OD Team and launched in July 2020. The electronic tool enables all members of staff to undertake a self-assessment and followed by a risk assessment with their line manager where required. The implementation of the tool was supported by guidance, virtual training and regular reporting. Trust compliance as at 7th July 2021 Have you offered a Risk Assessment to all staff? - **Yes** What % of all your staff have you Risk Assessed? - **94.3%** What % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary? - **97.5%** What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary? - **95.9%** Reports of any outstanding self-assessment and risk-assessments are provided to managers on a daily basis and numbers of outstanding assessments by CBU / Department are escalated to Tactical Meeting. In addition, the HR Team proactively make contact with any managers where there are outstanding assessments. HR continue to support managers to complete the risk assessments.				
Assurance Gaps:	At 7th July 2021: •196 staff members yet to complete self-assessment •16 Management Risk Assessments (required when an individual identifies as having a COVID Vulnerability) have been outstanding for over 3 months •36 Management Risk Assessments have been outstanding for less than 3 months				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Managers must complete all outstanding risk assessments and any new risk assessments that are triggered.	Completion of risk assessments.	• Completion of risk assessments.	Deborah Smith, Deputy Director of HR and OD	30/08/2021	
To encourage the completion of the Self-Risk Assessments	Completion of Self-Risk assessments.	• Further communication to staff re the importance of completing Self-Risk Assessments • Completion of Self-Risk assessments.	To encourage the completion of the Self-Risk Assessments	30/08/2021	

Board Assurance Framework

Risk ID:	1372	**Executive Lead:**	Alex Crowe	**Rating**
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.			
Risk Description:	FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case			**Initial:** 12 (3 x 4) **Current:** 16 (4 x 4) **Target:** 8 (2 x 4)
Assurance Details:	Assurance: • Trust Board approved Strategic Outline Case has moved the project to the Outline Business Case stage • EPR Project Board (and escalation/assurance through Digital and Trust Boards) • Regular, documented conference call with NHSE, NHSX and NHSD • Noted support of the Health Care Partnership Digital Board • Commissioning support of expert third party for development of business cases • EPR SRO and CIO to meet Chief Finance Officer and Trust Chair to agree expectations to assure the support of the Trust Board Controls: • Approved business case for a new 3 – 5 year Lorenzo contract in support of time required to complete the procurement and deployment • Trust financial modelling includes 3 – 5 year Lorenzo costs • DXC working with Trust to migrate Lorenzo to AWS platform in spring 2021 to improve baseline performance • Trust performance Task & Finish group has introduced measures such as auto desktop reboots and Tech Refresh continues to assure all desktops are less than 5 years old •Implementation of approved Principle CCIO and Associate CCIOs to support the business case production •Pre-procurement market engagement with supply chain, against a pre-agreed discussion framework, to inform further costs and benefits opportunities for OBC			
Assurance Gaps:	Gaps In Assurance: • Checkpoint meeting with senior stakeholders to review the potential affordability Gaps In Controls: • Financial modelling of realistic collaboration options to provide genuine 5, 10 and 15 year options to control whole life costs • Identification of further realistic cash releasing benefits • Deployment of dedicated Maternity EPR and thus avoidance of the associated risks • Approved business case for deployment of Lorenzo Theatres • Contracts for tactical solution not yet signed as offer from Dedalus does not matched approved Business Case.			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Complete OBC	Complete OBC approval planned July Trust Board.	Complete OBC approval planned July Trust Board.	Deacon, Stephen	30/07/2021	
Sign off PID for the maternity project	Sign off PID for the maternity project	Sign off PID for the maternity project	Deacon, Stephen	30/07/2021	
External review of OBC	External review of OBC	External review of OBC	Deacon, Stephen	31/07/2021	
Signing of tactical agreement	Signing of tactical agreement	Signing of tactical agreement	Deacon, Stephen	30/09/2021	
Phase 1 – Maternity go live	Phase 1 – Maternity go live	Phase 1 – Maternity go live	Deacon, Stephen	31/03/2022	
Phase 2 – Maternity go live	Phase 2 – Maternity go live	Phase 2 – Maternity go live	Deacon, Stephen	30/09/2022	

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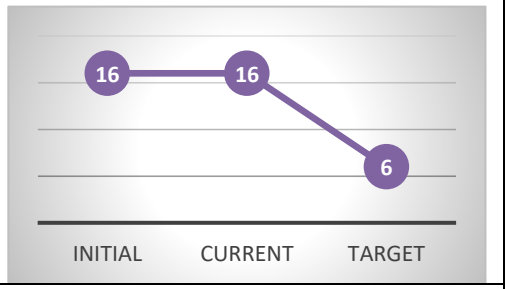
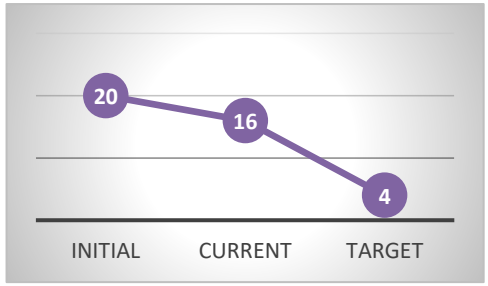
Risk ID:	1233	**Executive Lead:**	Alex Crowe	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base.			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	6 (2 x 3)
Assurance Details:	A surgical ambulatory nurse co-ordinator is supporting surgical emergency admission patients. An admission avoidance clinic is set up but cannot be utilised as we have no where to bring patients back to when CAU is bedded. Regular CAU steering group in place and will continue to review situation.				
Assurance Gaps:	Due to demands on CAU we are limited to the number of surgical patients that can be brought back daily. During bed pressures CAU is likely to be a bedded area which further limits the availability for the surgeons to review any admission avoidance patients. Surgical patients who would usually go to CAU are having to wait in a crowded ED. Surgeons are struggling to find assessment areas in ED to treat patients.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Appointment of 2nd Surgical Ambulatory Nurse	Currently we have one Ambulatory coordinator. Nursing team to review if 2nd Nurse is required.	Senior nursing team to review ambulatory nurse coordinator post and appoint 2nd nurse to ensure 7 day service.	Blackwell, Emma	01/10/2021	
Surgical Hot Clinics	Arrange for surgical hot clinics to take place weekly to avoid patients attending CAU.	Find alternative location for hot clinics to be established. Arrange medical and nursing cover for hot clinics.	Blackwell, Emma	01/10/2021	

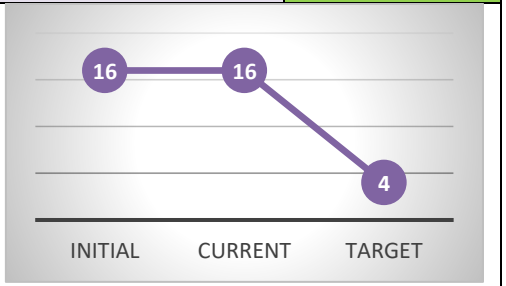
Board Assurance Framework

Risk ID:	125	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide a safe, secure, fit for purpose hospitals and environment caused by the age and condition of the WHH estate and limited availble resource resulting in a risk to meeting compliance targets, staff and patient safety, increased backlog costs, increased critical infrastructure risk and increased revenue and capital spend.			**Initial:**	20 (5x4)
				Current:	16 (4x4)
				Target:	4 (4x1)
Assurance Details:	Controls: 2018 C&M H&CP Estates strategy – updated annually Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out Capital Planning Group and associated capital funding allocation process Planned Maintenance Program Reactive maintenance regime Annual asbestos survey - asbestos management survey makes an assessment of the condition of any materials present and determine the likelihood of any fibres being released. Annual PLACE assessments Assurance: External estates compliance audit carried out in November 2019 which has in formed a number of remedial actions to improve compliance across the estate Monthly Estates compliance audit Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers Fire Safety Group – monitors fire safety issues across the trust and provides assurance to Cheshire fire and rescue service on Fire Safety Management PLACE assessment action plan and monitoring - Capital Planning Group – determine how the trust capital is spent Use of resources group – monitors how cost effective and value for money estates and facilities are in relation to a number of national and regional benchmarks New hospitals for Warrington and Halton groups – providing a platform to address the critical infrastructure and backlog risk 20-21 capital programme approved which includes £2.27m to address backlog maintenance Business Case for ED Plaza Scheme approved: Phase 1 Paediatric ED reconfiguration commencing in November 2020. This will increase the Paediatric ED Urgent Care footprint allowing for a better segregated flow of paediatric patients to support Covid-19. Completed and opened in May 2021. Due to fully complete in February 2022 Commencement of Phase 2 (although approved) reliant on capital funding in 2021/22 which is now confirmed. Progress will now be made against the scheme with indicative construction completion date of January 2022. Critical Infrastructure Capital Funding to support schemes with critical and high levels of backlog maintenance approved Cancer Alliance funding of £0.5m for endoscopy enabling work at Halton to improve the environment Phase 1 of CT Buildings work complete Additional staff rest areas deployed to support social distancing and reduce staff nosocomial infection during rest and break times during the Covid-19 pandemic.				
Assurance Gaps:	Estates staffing - reduced staffing numbers since 2011 has impacted on ability to carry out elements of essential maintenance – review to be undertaken in 2021 Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome Cost pressures – unfunded elements of maintenance in I&E budget Use of Resources - benchmarking against backlog maintenance and critical infrastructure risk are below national medium Threat to the delivery of capital schemes due to the pandemic e.g. manufacturing delays, additional costs of construction relating to IPC guidelines and the unavailability of an appropriately skilled workforce.				

Board Assurance Framework

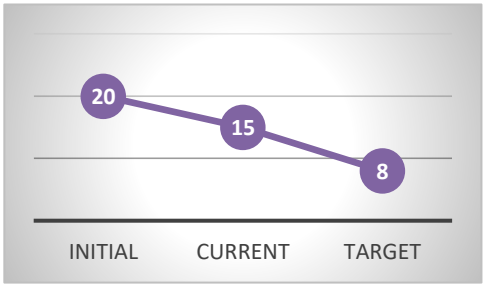
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Complete Premises Assurance Model by April 2021	Set up working group with Estates and Finance team to complete the documentation and file the evidence required to complete the PAM)	By completing, analysing and actioning any gaps in compliance	Boyd, Desmond	31/03/2021	

Board Assurance Framework

Risk ID:	1108	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.			
Risk Description:	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.			**Initial:** 16 (4x4) **Current:** 16 (4x4) **Target:** 4 (4x1)
Assurance Details:	Provided listening events and 1:1 meetings for all staff. This has resulted in accumulated feedback to identify key themes to be addressed. Review of all processes. Interim Head of Midwifery in post New CBU manager appointed and in post. Appointment of 9.2 WTE midwives. Daily staff meetings taking place to intensively monitor staffing. NHSP and agency staff are being used to back fill shifts where possible. Nursing staff utilised for C23 when it is not possible for a midwife to fill the post. When short staffed on C23, an extra maternity support worker is asked to work. NICE staffing red flags linked to Safecare implemented at beginning of June 2021 Midwifery management team strengthened – Two matrons in acting posts until end September 2021 All additional 9.2 WTE Midwives in post. Midwives redeployed across the unit as appropriate 1:1 care rate currently @ 92% Birth suite Manager appointed and in post 9th June 2021 Additional 3 Band 7 Birth suite Co-ordinators appointed 1st Feb 2021 2021. Interview for permanent posts 27th June 2021 Birthrate plus full review funded by Local Maternity System to be carried out by 31st Dec 2021 3 X Interim managers extended until 30th June 2021 Board approved 6 recurrent additional band 7 WTE midwife posts and 1.58 band 6 WTE in March 2021 to support the roll out of the Continuity of Carer model – recruitment on going Daily staffing meeting and redeployment of staff to maintain safe staffing levels			
Assurance Gaps:	Potential for uncertainty across the services as a result of COVID-19 pandemic Short term sickness 1 matron in maternity - 1 matron has stepped down			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
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	30/09/2021	
Band 6 and 7 midwife posts out to recruitment. To continue to closely monitor vacancy rates so that the vacancies can be appointed to in timely manner	Designated matron leading on recruitment.	Interviews for band 7 uplift posts planned for end June 2021. Advert for Band 6 posts awaiting closing date prior to interviews being arranged.	Gould, Debby	30/09/2021	

Board Assurance Framework

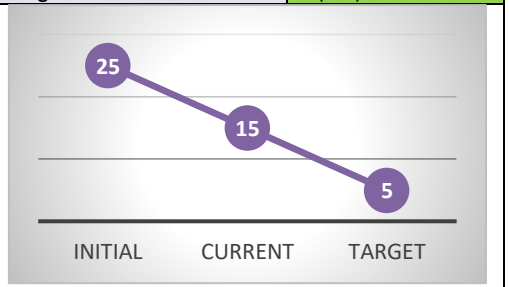
Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Influence within Cheshire & Merseyside a. Failure to deliver our strategic 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:** **Current:** **Target:**	20 (5x4) 15 (5x3) 8 (4x2)
Assurance Details:	The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the C&M Health and Care Partnership plans. The Trust has developed effective clinical networking and integrated partnership arrangements. Some examples include: - The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. - Council and CCG in both Warrington & Halton supportive of development of new hospitals. Agreement with key stakeholders to progress single programme and proceed with OBC development. - Agreement of sustainability contract with Warrington CCG and subsequently Warrington & HaltonSystem Financial Recovery Plan - 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. - 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 Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. - Letter written to Government from senior stakeholders requesting funding as part of HIP - Additional phase of HIP funding announced with the opportunity for investments in 8 additional new hospital developments. The Trust stated its intention to bid via a competitive process which is likely to take place in spring 2021. - Positive meeting the Medical Director and Director of Strategy at Alder Hey confirming their intention to work with the Trust to repatriate WHH patients. – currently paused due to the COVID -19 pandemic				

Board Assurance Framework

	- 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 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. Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services to commence form September 2021. - 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. £22.1m funding approved for the Town investment plan, including £3.1m for the Health & Wellbeing Hub and £1m for the Health & Social Care Academy. - The Trust is leading the development of the detailed plan for the Health & Wellbeing Hub. - Strategy refresh completed and approved at Trust Board to confirm 2020/21 priorities. Town Deal plan for Runcorn due submitted in January 2021, including £3m for Health Education Hub in Runcorn. - In February 2021 the Government White Paper, "Integration and Innovation: working together to improve health and social care for all - The Department of Health and Social Care's legislative proposals for a Health and Care Bill" was published. - The Trust Board agreed in March 2021 that a transaction between BCH and WHH is no longer required, given that the White Paper enables an acceleration of place-based integration including all commissioners and providers. - The Trust has been awarded Social Value Award status recognising the contribution to the outcomes of local populations. It is one of only two organisations in Cheshire & Merseyside to receive the award.	
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 within organisation prioritised	

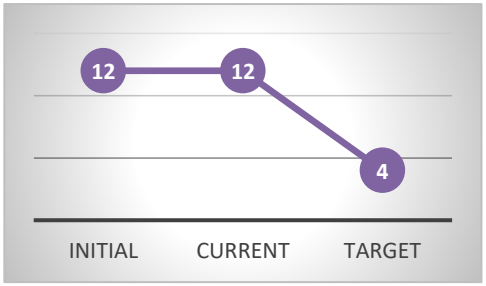
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Progress plans for new hospitals to be best placed to secure funding when available	Develop SOCs and OBCs	Develop SOCs and OBCs	Lucy Gardner	SOCs – April 2020 OBCs – Q4 2021/22 Warrington Q3 2021/22 Halton	SOCs – March 2020
Retain contact and relationship with Alder Hey	Retain contact and relationship with Alder Hey	Regular meetings with Alderhey Director of Strategy	Lucy Gardner	30/06/2021	
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	30/06/2021	

Board Assurance Framework

Risk ID:	1274	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.			**Initial:**	25 (5x5)
				Current:	15 (3x5)
				Target:	5 (5x1)
Assurance Details:	Plan in place to carry out Asymptomatic testing of staff. There is a high-level rationale for testing due to the level of community transmission in the North West as well as nosocomial infection rates. Staff are being tested over a ten-day period. All staff to wear face masks in both non-clinical and clinical areas. Use of effective messaging and communication. Risk stratification in place so there is no service level disruption to provision. Staff groups have been split to ensure only 5 members of staff from each service are tested at any one time. Lateral flow self-testing twice weekly in place – 1.8% positivity rate Loop-mediated Isothermal Amplification (LAMP) testing introduced. LAMP testing commenced in ED/ICU LAMP testing to commence in Wards A7/A8 by the end of March 2021 Internal review of Clinically Extremely Vulnerable (CEV) completed to expedite return to work and ensure staff safety.				
Assurance Gaps:	Potential for unsafe staffing levels. Requirement to improve uptake of LAMP testing across the organisation				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Improve compliance with uptake of LAMP testing across the Trust	Campaign to increase awareness	Campaign to increase awareness	Rylett, Louise	31/08/2021	

Board Assurance Framework

Risk ID:	1290	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices, technology products and services, clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.			**Initial:**	12(3x4)
				Current:	12 (3x4)
				Target:	4 (1x4)
Assurance Details:	• The Brexit Sub Group has been stepped up with key leads for the associated work streams (Procurement, Pharmacy, EPRR, Finance, Communications, HR and Information). • The Procurement Department has undertaken a review of all suppliers as part of the national self-assessment exercise which was completed as C&M HCP system. Whilst this piece of work has been completed with no apparent adverse impact the Procurement Department continues to monitor fulfilment of orders to adopt a process of early investigation where supply appears to be disrupted. In addition, the Procurement Department is implementing processes to monitor prices to determine if there has been any financial impact upon exit from the EU. To date there are no significant price increases; for the period January to March 2021 there has been a net price impact of £621. This work will continue for Q1 and Q2 of 2021/22. • The Pharmacy department has contacted the Regional Procurement Pharmacist who has advised that there will be monitoring of medicines purchases and usage centrally to manage medicines continuity. Issues / concerns / actions required will be communicated via regular updates to the Chief Pharmacist network. To date there have been no medicines supply issues linked to the end of the EU transition period. • Service level business continuity plans continue to be refreshed. • The majority of Pathology consumable suppliers are being checked by DHSC for supply assurances. Suppliers not on this list have been identified to procurement and are being address through the procurement department. • The Digital department has reviewed all the Trust key IT systems and data flows. To date no issues have been identified which will impact upon data flows. A time limited 'bridging mechanism' has been agreed which will allow personal data to continue to flow as it does now from the EEA whilst EU adequacy decisions for the UK are discussed. A UK data adequacy decision was reached in June 2021 enabling personal health data to continue to flow legally from the EU to the UK. • Nationally, lessons in supplies and medicines have been captured from the COVID-19 period and there has been assurances made around national supplies of PPE and consumables. • Assurance letters and communication regarding the EU settlement scheme have been circulated as a reminder about the settlement scheme. An assurance exercise based on the EU settlement scheme was submitted to NHSE in May 2021, indicating no significant risks. • Re-instigated the Brexit Sub-Group on 9th September 2020 and the group continues to meet bi-monthly. • In December 2020 NHSE/I completed an assurance exercise with NHS Trusts to ensure EU Exit SRO and EU Exit Team in place. • Processes developed by UEC and Finance to ensure chargeable patients are managed appropriately. From the Chargeable Patients point of view, there are no risks to financial procedures, patients or staff. Additional processes and a dashboard have been shared for assurance purposes. • Daily SitRep reporting was stepped down on 08/06/21 as per communication from NHSE. • Single point of contact in place for operational response, aligned with the regional Level 3 incident expectations; • An EU Exit deal was established on 24th December 2020. The impacts of the terms of this deal and the implications on the supply of medicines and consumables are under review nationally and locally. The Brexit Subgroup continues to meet to monitor the implications of the established deal.				
Assurance Gaps:	Continued national uncertainty on the terms of the EU exit. Trusts being requested not to stockpile supplies. Potential price increases to supplies. Winter pressures, COVID-19 pressures and increase demand on Workforce and UEC.				

Board Assurance Framework

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Reinstate Brexit Sub Group	Reinstate Brexit Sub Group	Reinstate Brexit Sub Group	Andrea McGee	01/02/2021	09/09/2020

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/100**	
SUBJECT:	**2020/21 SIRO (Senior Information Risk Owner) Report**	
DATE OF MEETING:	28 July 2021	
AUTHOR(S):	Mark Ashton, Information Governance and Corporate Records Manager	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	
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 assurance report is provided on behalf of the Senior Information Risk Owner who has executive responsibility for information risk and information assets. In order to demonstrate compliance with the NHS Digital Data Security and Protection Toolkit standards, and to ensure the Board is adequately briefed on information risks, it is necessary to provide a report detailing identified information risks and progress against the Data Security and Protection Toolkit standards more generally. The report outlines the self-assessed performance, informed by MIAA review, against the standards in the Data Security and Protection Toolkit. The Trust continues to perform well against the standards, continuously working to reduce risk and improve processes. The report includes a view on the standards which the Trust is unable to currently comply with, based on tighter national guidance aimed at raising the bar in the NHS in the area of Information Governance and Cyber Security. The proposed June 2021 DSPT submission to NHS Digital will reflect this position.	

	The Senior Information Risk Owner is required to act as an advocate for information risk on the Trust Board and is responsible for providing appropriate Information Governance content for inclusion in the Quality Account Statement and the Annual Report.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note ✓	Decision
RECOMMENDATION:	The Board is asked to: Note and approve the contents of the report; Receive assurance that SIRO responsibilities are being fulfilled effectively.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 31-Law Enforcement			

REPORT TO BOARD OF DIRECTORS

SUBJECT	SIRO Report	AGENDA REF:	BM/21/07/100

1. BACKGROUND/CONTEXT

The objective of the SIRO report is to inform the Board of progress against the Data Security and Protection Work programme for the period 2020/21. It contains a quantitative and qualitative analysis (using information obtained from the Datix risk and incident system, CareCERT dashboard, ITHealth Assurance Dashboard, Data Security and Protection Toolkit, MIAA audit reports, and the minutes of the Information Governance And Records Sub-Committee).

Organisations that have access to NHS patient information must provide assurances that best practice data security and protection mechanisms are in place. The report includes a summary of key outstanding issues and clarifies the planned actions to resolve these.

The purpose of the report is to ensure that the Board understands how the strategic business goals of the organisation may be impacted by information risks and the steps being taken to mitigate those risks. The Trust's Senior Information Risk Owner position is currently held on an interim basis by the Executive Medical Director. The SIRO position will become a key element of the new Chief Information Officer's role on commencement of employment with the Trust in August 2021. The SIRO is responsible for the provision of assurance to the Board that information risks are adequately managed.

2. KEY ELEMENTS

The assurance section of the report is divided into six distinct areas. The relevance of each section is described below.

- **Information Governance Framework**

In line with the requirements of Assertion 1 within the Data Security and Protection (DSP) Toolkit the Trust must demonstrate that there are clear lines of responsibility and accountability to named individuals for data security. It must also demonstrate that data security direction is set at Board level and is translated into effective organisation practices.

The Information Governance (IG) Framework describes the structure in place to manage the burgeoning data security agenda and the key staff involved in that process.

- **Information Risk Analysis**

The Trust must demonstrate that robust processes are in place to understand and manage identified and significant risks to sensitive information and services. The information risk analysis element of this report describes the arrangements in place to manage such risks.

- **Data Security and Protection Toolkit Performance**

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool which allows the Trust to measure its performance against the National Data Guardian's 10 data security standards. Annual submission of a baseline and final DSPT assessment to NHS Digital is a mandatory requirement.

The DSPT performance section of this report articulates the current compliance position, areas of weakness, and the proposed June 2021 DSPT submission.

- **Cyber Security Arrangements**

Cyber threats are now ever-present, and the Trust works with NHS Digital, in conjunction with the National Cyber-Security Centre, to deploy specialist products, manage cyber risk and to repel cyber-attacks. In line with Assertion 6 of the DSP Toolkit the Trust must have robust arrangements in place to identify and resist cyber-attacks. In addition, the Trust must demonstrate that it is responsive to security advice and alerts provided by NHS Digital.

This section of the report describes the arrangements in place to protect the Trust's IT infrastructure and information systems from cyber-attack.

- **Externally Reported Data Security Incidents**

In line with Assertion 6 of the DSP Toolkit the Trust must have a procedure in place to ensure that data security and protection incidents are managed and reported appropriately.

This section of the report contains detail related to 2020/21 data security incidents deemed of the requisite severity for reporting via the DSP Toolkit incident reporting tool. In some cases, incidents will have been escalated to the Information Commissioner's Office, the Department of Health and Social Care and NHS England.

- **The Role of the SIRO & the Trust's Caldicott Guardian**

In line with DSP Toolkit Assertion 1, the Trust must have a Board-level individual who has overall accountability for the security of networks and information systems. This individual is known as the Senior Information Risk Owner.

In addition to the SIRO all NHS organisations must have a Caldicott Guardian. The Caldicott Guardian is responsible for protecting the confidentiality of health and care information and making sure it is used properly.

This section of the report explains how both the SIRO and Caldicott Guardian fulfil their roles and demonstrates that they are active and participating in the Trust's data security and protection agenda.

3. SUMMARY OF ASSURANCE

3.1 Information Governance Framework

The Trust's DSP annual work plan (cycle of business) details the standing agenda items which are included at each meeting of the Information Governance and Records Sub-Committee (IGRSC). The cycle of business for 2021/22 was reviewed and approved in April 2021.

The (IGRSC) meets on a bi-monthly basis and is chaired by the Trust's SIRO (the CIO undertook this role in 2020/21) and is attended by the Caldicott Guardian (Medical Director). Meetings of the IGRSC continued throughout the Covid-19 emergency and all meetings were quorate.

Key Information Governance staff members are:

- SIRO (Chief Information Officer)
- Caldicott Guardian (Medical Director)

- Head of Digital Compliance-Stephen Deacon
- Information Governance and Corporate Records Manager/DPO-Mark Ashton

The role of SIRO has been filled on an interim basis by the Medical Director since March 2021. This will continue until the commencement of employment of the Chief Information Officer appointed in 2021.

The Information Governance and Records Sub-Committee reports directly to the Quality Assurance Committee and its core members include:

- SIRO (CIO)
- Caldicott Guardian (Medical Director)
- Deputy CIO
- Head of Digital Compliance
- Information Governance and Corporate Records Manager
- Medical Records Manager
- Head of Enterprise Solutions
- Lead Nurse for Nurse Staffing & Workforce Improvement (Clinical Safety Officer)
- RA (Smartcard) Lead
- Information Asset Owners (key systems)

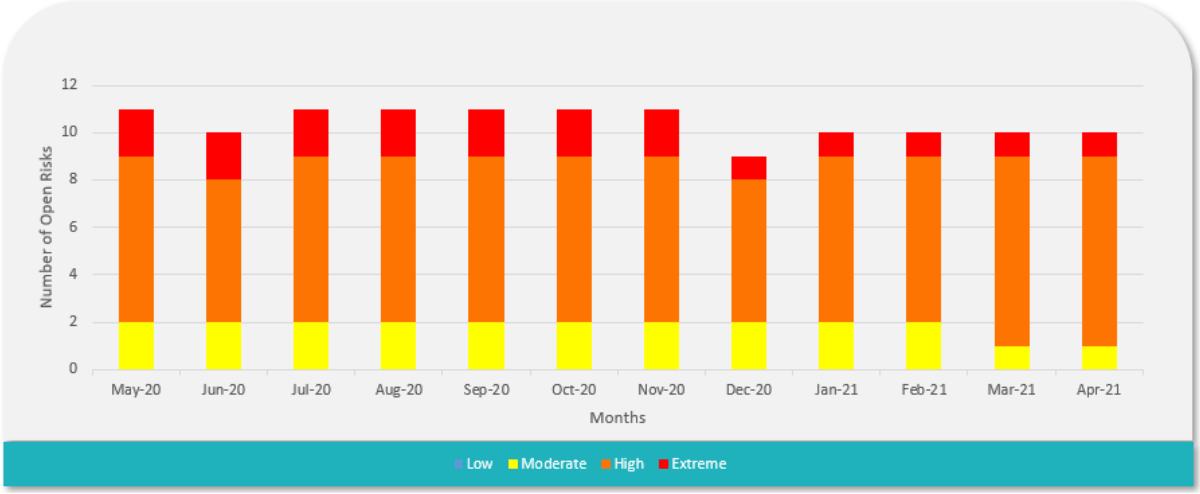
In addition to the IGRSC's bi-monthly reporting obligations to the Quality Assurance Committee the Audit Committee will be provided with Information Governance related audits conducted by Mersey Internal Audit Agency. Most notably this will include the annual Data Security and Protection Toolkit Assurance Review.

3.2 Information Risk Analysis

The Head of Digital Compliance manages data security risks within the Datix risk/incident system. The Digital Services risk management process ensures that risk management is structured according to Trust policy and risks are regularly reviewed at the Digital Services Risk Review meeting. The Digital Services Risk Review Group meets on a monthly basis. Digital Services are also represented at the Trust's Risk Review Group to review risks each quarter.

Digital Services risks and mitigating actions are scrutinised by the Trust's Risk Review Group. All Information Governance/Cyber risks are also included as a standing agenda item at the IGRSC. Risk information is then escalated to the Quality Assurance Committee.

The below graph indicates Digital Services Risk trends over the previous 12-month period with the sum total of risks and scoring remaining constant during 2021/22. We have seen a trend in fewer extreme and a slight rise in moderate risks since December 20. 4 risks were closed, and 4 new risks were added to the Digital Services risk register in the last 12 months.



The Cyber/IG-based risks are:

Risk Description	Outstanding Actions	Rating
FAILURE TO deliver essential Digital services (cyber-attack) **CAUSED BY** a successfully executed Cyber Attack, resulting in loss of access to data and vital IT systems **RESULTING IN** potential patient harm, loss in productivity, damage to the Trust reputation and possible income losses and	• Migrate Server 2003/2008 servers • Standardised policies and procedures across the C&M STP using the core documentation from standard of ISO 27001 and the DSPT • Lessons learnt from previous phishing exercise and rerun phishing exercise • Mitigate 5 2008 servers not patching	12

regulatory fines of up to 4% of the Trusts annual turnover.	• Migrate the last 9 endpoints devices to Windows 10	
FAILURE TO prevent unauthorised access to electronic person identifiable data **CAUSED BY** smartcard and password sharing **RESULTING IN** invalidation of electronic clinical systems audit trail data and a breach of confidentially.	• Recommence ward audits post to maintain improved standards • Review the potential use of virtual smartcards to mitigate the bad practice of leaving smartcards in smartcard readers	9
FAILURE TO secure paper medical records in clinical areas **CAUSED BY** poor housekeeping **RESULTING IN** potential breaches of confidentiality	• Recommence ward audits post to maintain improved standards	6
FAILURE TO implement the requisite NIS Directive (Networks and Information Systems) policies, procedures and processes **CAUSED BY** lack of resources and monies **RESULTING IN** potential unplanned downtime for systems without resilience, possible income losses, interruption to service, patient harm and regulatory fines of up to 4% of the Trusts annual turnover.	• MIAA IT Service Continuity & Resilience Review • Increase Storage Area Network (SAN) Space • Liaise with NHS D to move CIS to the cloud.	12
FAILURE TO implement best practice information governance and information security policies and procedures **CAUSED BY** increased competing priorities due to an outdated IM&T workforce plan **RESULTING IN** ineffective information governance advice and guidance to reduce information breaches.	• IT Dept restructure to increase resources targeted at Information Governance. IT Services are currently recruiting and have contractors in place covering gaps identified	12

3.3 Data Security and Protection Toolkit (DSPT) Performance

Launched in 2018, the DSP Toolkit is the means by which the Trust can assess its level of compliance with the National Data Guardian's 10 standards and NHS Digital's guidance for GDPR compliance. The Trust must undertake assessments against the NHS Digital Data Security and Protection Toolkit on an annual basis. This requirement is documented within Information Standards Notice Amd 71/2020 published under section 250 of the Health and Social Care Act 2012.

Subject to ongoing development, the DSPT currently comprises 44 assertions which break down into a number of evidence items dependant on the category type of the NHS organisation. There are four category types within the current DSPT:

- Category 1-NHS Trusts
- Category 2-CCGs, CSUs, and ALBs
- Category 3-Others
- Category 4-GPs

There are a total of 149 evidence items specified for NHS Trusts (category 1). 110 of these items are mandatory and the evidence items are divided into 10 domains which mirror the National Data Guardian's 10 security standards. These are:

- Personal Confidential Data
- Staff Responsibilities
- Training
- Managing Data Access
- Process Reviews
- Responding to Incidents
- Continuity Planning
- Unsupported Systems
- IT Protection
- Accountable Suppliers

The Trust's 2020/21 Data Security and Protection Toolkit assessment was carried out by Mersey Internal Audit Agency and consisted of two phases. The first phase, conducted in March 2021, consisted of a readiness review which was designed to assess the Trust's preparedness for the DSPT final submission which must be made by 30th June 2021. An assessment is then carried out by MIAA of available evidence and, dependent upon the results of the assessment, the Trust is then able to revise the final self-assessment made to NHS Digital.

The outcome of the readiness assessment is included in the table below.

Area	Rating	Rationale
Base Line Completed		This review was carried out prior to the submission date for the baseline assessment. However, it was evidenced that the SIRO and Caldicott Guardian had been provided with an assessment report for sign off with a further report to be provided retrospectively to the Information Governance and Records Sub Committee on April 13th, 2021.
Base Line Subject to Review		The governance structure demonstrated to monitor the Trust's DSPT submission was clear and ensured oversight at Executive and Non-Executive level. Reports were provided to the IG and Records Sub Committee, chaired by the SIRO and attended by the Caldicott Guardian, which in turn reports to the Quality Assurance Committee (QAC). Information is also provided to the Digital Board and escalated through both the Finance and Sustainability Committee and QAC.
Wider-Risks Reported		Risks were managed using the Trust's Datix system. There was a generic risk relating to DSPT non-compliance which was managed at a local level, through discussions with the senior leadership team, and reported to the Risk Review Group and escalated to the Digital Board, chaired by the SIRO and attended by the Caldicott Guardian. However, the Trust should look to include more details around the areas of concern that they have highlighted from their assessment document.
Action Plan In Place		The Trust were able to provide the DSPT assessment that was given to the SIRO and Caldicott Guardian to enable sign off for the baseline submission with areas of concern clearly highlighted as a priority. However, the document provided was not an action plan of all assertions, as only the six deemed high priority were extracted into an action plan. It was identified through this review that updates given in the assessment document needed to reflect plans to achieve the June submission rather than current status.

On the basis of the findings of the readiness assessment the scope of the Trust's action plan was widened and actions were added for all DSPT requirements. The baseline was also completed and submitted to NHS Digital.

The second phase of the 2021 IG assurance audit process, consisting of a progress review, commenced in April. The finalised report will include the following ratings:

- MIAA's confidence level in the veracity of the DSPT self-assessment carried out
- MIAA risk rating of the WHH data security and data protection control environment

The MIAA DSPT review will be conducted in line with the assessment methodology for independent assessment and internal audit providers published by NHS Digital in September 2020. It should be noted that some of the new assessment methodology steps contained within *'Strengthening Assurance: DSPT Independent Assessment Framework*' exceed what is asked in the DSP Toolkit. Therefore, we have seen a reduced position on assurance compared with the 2019/20 position.

June 2021 DSPT Submission

The submission of a DSPT assessment to NHS Digital must take place by June 30th, 2021. It is proposed that the Trust submits an action plan to NHSD to outline areas for improvement in relation to the following DSPT standards.

DSPT Evidence Item	Action Required	Owner(s)
3.2.1 (Mandatory) Have at least 95% of all staff, completed their annual Data Security Awareness Training?	Maintain Data Security and Protection Training in all staff groups at 95% in-year levels. Training to be offered via various platforms in 2021 including MS Teams in order to increase levels of staff trained.	M. Ashton (in conjunction with Education)
4.2.3 (Mandatory) Logs are retained for a sufficient period, reviewed regularly and can be searched to identify malicious activity **4.4.1 (Mandatory)** Has the Head of IT, or equivalent, confirmed that IT administrator activities are logged and those logs are only accessible to appropriate personnel?	Liaise with companies specialising in bespoke products to retain logs. WHH ability to retain all the requisite logs does not currently exist. WHH does retain local logs (firewall, Anti-Virus, etc) but this alone is not sufficient to satisfy this standard. The system needed to satisfy this standard (LogPoint) may cost circa 50k per annum. There is currently a moratorium on the purchase of new IT systems until MIAA have conducted a review of tools currently available to Digital Services which is due in August 2021. If a system is purchased to store such logs it is possible that a resource would be required to interrogate and interpret the logs retained.	S. Deacon (in conjunction with Digital Services technical team) S. Deacon (in conjunction with Digital Services technical team)

4.1.2 (Mandatory) Does the organisation understand who has access to personal and confidential data through your systems, including any systems which do not support individual logins?	System Level Security Policies are required for each system present on the Trusts' IT systems asset register. An approach whereby key systems are prioritised has been agreed for this standard.	S. Deacon/M. Ashton (in conjunction with Information Asset Owners)
4.4.3 (Mandatory) The organisation does not allow users with wide ranging or extensive system privilege to use their highly privileged accounts for high-risk functions, in particular reading email and web browsing. **4.4.5** You record and store all privileged user sessions for offline analysis and investigation.	Whilst technicians use their admin accounts to perform technical duties access to the Internet is a fundamental requirement. The DSPT technical standards task and finish group will be consulted to ascertain whether implementing controls on admin accounts is possible. As per 4.2.3 & 4.4.1 a company has been engaged in order to scope the work required.	S. Deacon (in conjunction with Digital Services technical team) S. Deacon (in conjunction with Digital Services technical team)
4.5.6 Do you have high-strength passwords defined in policy and enforced technically for all users of internet-facing authentication services?	90-day password policy enforcement was suspended at the start of the Covid-19 pandemic. The agreement of the Medical Director/Caldicott Guardian is required to re-implement this control.	S. Deacon (in conjunction with IGCRSC members)
6.2.6 (Mandatory) Connections to malicious websites on the Internet are prevented.	Whilst connection to malicious websites are prevented for devices connecting to the Internet within the Trust this is not the case for remote devices. A bespoke product will be required in order to block malicious websites on remote devices. Funding for such a product is currently being discussed. The bespoke product required is £21.7k and this one-off payment will be funded through capital.	S. Deacon (in conjunction with Digital Services technical team)

8.1.3 (Mandatory) Devices that are running out-of-date unsupported software and no longer receive security updates (patches) are removed from the network, or the software in question is uninstalled. Where this is not possible, the device should be isolated and have limited connectivity to the network, and the risk assessed, documented, accepted and signed off by the SIRO. **8.1.4** The organisation ensures that software that is no longer within support or receiving security updates is uninstalled. Where this is impractical, the endpoint should be isolated and have limited connectivity to the network.	Unsupported software in use is highlighted within the Digital Services' ITHealth Assurance Dashboard. A server migration plan will be authored by 17/08/21. At this point the work required to migrate 2008 servers housing products such as The Hub, Exchange, Symphony and Meditech will be better understood. 9 devices are still running Windows 7 operating system. A number of these devices cannot be decommissioned due to their use in running other systems which are not compatible with later versions of Windows. As above. Mitigation for this standard would be limited connectivity to the network. The ITHealth system can show software in use but this information will need to be interpreted by the Digital Services' Deployment Team.	S. Deacon/ M. Ashton (in conjunction with Digital Services technical team) S. Deacon/ M. Ashton (in conjunction with Digital Services technical team)
8.4.2 (Mandatory) All infrastructure is running operating systems and software packages that are patched regularly, and as a minimum in vendor support.	As per 8.1.3 & associated migration plans. As per 8.1.4 the information available in the ITHealth system will need to be interpreted by the Deployment Team.	S. Deacon/ M. Ashton (in conjunction with Digital Services technical team)
9.7.6 (Mandatory) Do all of your desktop and laptop computers have personal firewalls (or equivalent) enabled and configured to	Remote devices are protected with personal firewalls. On-site devices are protected by two boundary firewalls. Agreement on deployment of local firewalls to be reached with Digital	S. Deacon (in conjunction with Digital Services technical team)

block unapproved connections by default?	Services technical team at DSPT task and finish group. The deployment of local Firewalls would need to be trialled as the consequences of deployment are not fully understood.	
10.1.2 Contracts with all third parties that handle personal information are compliant with ICO guidance. **10.2.2 (Mandatory)** Your organisation determines, as part of its risk assessment, whether the supplier certification is sufficient assurance. **10.2.3** Percentage of suppliers with data security contract clauses in place.	Where data processors are identified supplementary detail is added to contracts. Information Governance and Corporate Records Manager to liaise with procurement to refine processes to identify such companies/individuals. See 10.1.2	M. Ashton (in conjunction with Procurement)
10.2.4 (Mandatory) Where services are outsourced (for example by use of cloud infrastructure or services), the organisation understands and accurately records which security related responsibilities remain with the organisation and which are the supplier's responsibility. **10.2.5** All suppliers that process or have access to health or care personal confidential	See 10.1.2 See 10.1.2	M. Ashton (in conjunction with Procurement)

information have completed a Data Security and Protection Toolkit, or equivalent.		

11 of the DSPT standards in the above table are mandatory standards. There are risks present against all mandatory standards that the completion of actions required for compliance may not be possible. Mandatory training targets, log retention and the eradication of unsupported software present particular challenges. On that basis the risk of not complying with all mandatory DSPT requirements in 2021/22 is extant.

3.4 Cyber Security Arrangements

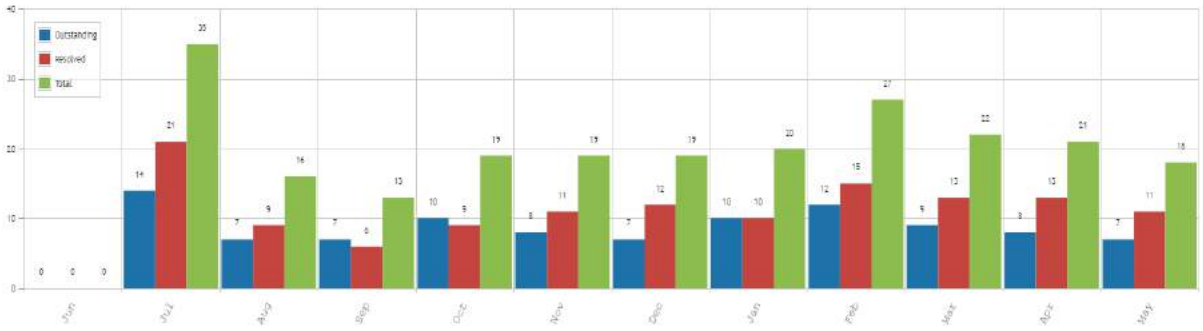
3.4.1 CareCERT Alerts

All Trusts are required to act upon any critical and high security cyber alerts issued by NHS Digital. Such Cyber Security Bulletins are called CareCERT alerts and organisations are required to confirm that they have taken the requisite action, or have sought support from NHS Digital, if they are unable to do so. Any issues are escalated to the SIRO.

The Trust has procured the ITHealth Assurance Dashboard Solution which consolidates all areas of WHH cyber security into a single, real-time view including our status in respect of WHH responses to the NHSD issued security CareCERT alerts. The ITHealth Assurance Dashboard gives complete visibility of what is happening within the Trust's network. It significantly increases our understanding of the security risks we face, and levels of compliance at both a local and national NHS Digital level. Most importantly it provides the IT Team with confidence in the assurance provided to the Board on the security of our IT infrastructure and any risks identified. 81% of mandatory cyber-related requirements contained on the DSP Toolkit can be satisfied by the use of the IT Health Assurance Dashboard.

The below tracker details the CareCERTS issued and actioned. The Green bar indicates all CareCERTS issued. The red bar indicates actions completed by the Trust., and the blue bar indicates outstanding actions since June 2020. Numbers of outstanding actions do fluctuate dependent upon cyber threat levels. Of the outstanding careCERT's 4 are high risk, each having a small number of devices that need the updates. We are working with the company to ensure these are resolved within the next few weeks. With other mitigations in place, including Anti-virus, Advanced Threat Protection and two boundary firewalls, the risk is low.

CareCERTS security alerts issued are prioritised according to their severity level. When a high level CareCERT alert is received the Trust has 48 hours to respond and 14 days to action and close the alert. Since June 2020 the Trust has received 8 high severity CareCERT alerts and has closed 100% of these with only one being closed outside the requisite 14 day period as mitigations were put in place to ensure the downtime to ED and wards was kept to a minimum whilst our virtual environment was patched.



3.4.2 Desktop and Server Operating System Patching

Windows updates allow for fixes to known flaws in Microsoft products and operating systems. The fixes, known as patches, are modifications to software and hardware to help improve performance, reliability, and security. There is a patching regime operated routinely on a monthly basis. The patching for both desktop and servers is automated by the use of automated patching software. All critical security patching is up-to-date with the exception of unsupported software.

3.4.3 Migration from Unsupported Operating Systems and Applications

All software will eventually become out of date, after which point, ideally, it should not be used. Using obsolete software compounds two related problems:

- Software will no longer receive security updates from its developers, increasing the likelihood that exploitable vulnerabilities will become known by attackers.
- Latest security mitigations are not present in older software, increasing the impact of vulnerabilities, making exploitation more likely to succeed, and making detection of any exploitation more difficult.

The Trust have migrated 99% of desktop machines from unsupported Windows 7 to the latest Windows 10 operating system. The Trust have migrated 72% of the unsupported Windows Servers to Windows Server 2016 and extended support for Windows 2008 whilst the migration trajectory is resolved. The Trust has completed 93% of the Office 2010 to Office 365 migration. It is anticipated that the remaining devices will be migrated by mid-2021.

3.4.4 Server Migration Status-May 2021

2003 Servers

Total	Completed	% Complete	Migration Completion Due Date
22	**17**	**77.3%**	**July 21**

***** 2003 servers are currently unsupported and not receiving security patches.

2008 Servers

Total	Completed	% Complete	Migration Completion Due Date
79	**56**	**70.0%**	**February 22**

***** 2008 servers are currently supported and will receive security patches until March 2022

Servers awaiting migration fall into the category of being more problematic to migrate for several reasons. This can be attributable to systems held on servers requiring often complex data migration work to migrate data into new versions of systems which are compatible with newer server operating systems. Alternatively, funding may be required to procure a new system as systems currently used will not function on a server with a new operating system.

3.4.5 External Security Rating (Bitsight)

The Trust uses an external software system which calculates a security score and benchmarks the Trust against other organisations within the Healthcare/Wellness industry in 20 major security risk categories. The below graphic details our security rating trend over the last year. The Trust is in the upper range of the security score with a rating of 780 (Advanced) which places the Trust within the top 10% of benchmarked healthcare organisations. Cyber security-based projects over the last year have increased the Trust's rating to levels last seen in May 2020. These projects include:

- Extending NHS digital's secure boundary to our Internet connection
- Migrating away from unsupported systems
- Tightening security on our outward facing network hardware

3.4.6 Monthly Network Penetration Tests

The Digital Services team have engaged a company to perform network penetration tests on a monthly basis. Such tests enable the Trust to identify the security vulnerabilities and flaws that are currently present on our network which enables the Trust to understand the level of security risk and priorities mitigations plans to resolve the security vulnerabilities and flaws.

Vulnerabilities identified during network penetration tests are escalated to both Digital Board and the Information Governance and Records Sub-Committee. Reporting of these vulnerabilities includes a severity score and proposed actions for resolution.

3.4.7 NHS Secure Boundary

The NHS Secure Boundary provides additional firewall security which effectively allows WHH to control what passes in and out of our digital estate. This augments the security already deployed by the Trust.

In January 2021 the Trust extended the NHS Secure Boundary service to our Internet connection. This strengthens the Trust's cyber-security defences. Use of the NHS Secure Boundary enables NHS Digital to scan for potential threats in real time, detecting and neutralising them to help the Trust increase their security protection against cyber-related attacks.

3.5 Externally Reported Data Security Incidents

The table below contains details of data security and protection incidents reported to the Information Commissioner's Office in the 2020/21 financial year. This information is also included in the annual governance statement contained within the Trust's annual report.

Incidents are reported via the Data Security and Protection Toolkit incident reporting system and escalated to the ICO if they satisfy the requisite severity criteria. The ICO has taken no further action against the Trust in relation to incidents reported during the 2020/21 period.

Data security and protection incidents are routinely reviewed at the Information Governance and Records Sub-Committee. A bi-monthly report is produced from the Datix system and included as part of the annual work plan at each meeting of the IGRSC. The Information Governance and Corporate Records Manager liaises with the ICO to provide all the information required to conclude each incident within the timescales requested by the ICO.

ICO Reportable Incidents 2020/21

NHS Digital Reference	Date Reported	Detail	Information Commissioner's Office Decision
20161	22/06/2020	Appointment letter sent to data subject's previous address	No further ICO action taken

20361	03/07/2020	Data subject received correspondence relating to another data subject	No ICO action taken
20485	13/07/2020	Letter sent to an incorrect address	Breach notification obligation did not apply No further ICO action taken
20755	04/08/2020	Patient discharged with correct records and additional records relating to incorrect data subject	No further ICO action taken
21128	03/09/2020	Letter sent to an incorrect address	No further ICO action taken
21657	14/10/2020	Test results letter sent to the biological Mother of a child in Foster care	No further ICO action taken
21849	28/10/2020	Unauthorised access made to records contained on electronic clinical systems by staff member	Investigation conducted by ICO investigations team No further ICO action taken
22031	12/11/2020	CCTV footage released as part of a subject access request contained images of a third-party	No further ICO action taken
23126	24/02/2021	Maternity notes destroyed in error. Confidentiality of notes not compromised but they are unavailable for use	No further ICO action taken

23154	26/02/2021	One set of notes cannot be located. The notes in question are not the property of Warrington and Halton Teaching Hospital Foundation Trust	No further ICO taken

3.6 The Role of the SIRO and the Trust's Caldicott Guardian

SIRO

All NHS Trusts must have a Board-level individual who has supports implementation of international and government standards for information management and security.

SIRO Responsibilities:

- Accountable for information security
- Drives corporate policy on information security
- Champions information security at Board level

Caldicott Guardian

The Caldicott Guardian is responsible for protecting the confidentiality of health and care information and making sure it is used properly.

Caldicott Guardian Responsibilities:

- Supports work on information sharing and advises on confidentiality issues
- Actively involved in development of data security and protection frameworks to attain the highest possible standards of the protection of person identifiable information
- Advocate for the data security and protection agenda at Board level

Both the SIRO and Caldicott Guardian are actively involved in the work of the Trusts Information Governance and Records Sub-Committee. The Information Governance and Corporate Records Sub-Committee's objective is to support the Information Governance and corporate records agenda, and to provide the Quality Assurance Committee with the assurance that effective Information Governance best practice mechanisms are in place within the organisation.

The table below provides examples of SIRO and Caldicott Guardian activity to support the data security and protection agenda.

Data Protection Impact Assessments are completed for new / amended processing use cases of Personal Information and signed off	• SIRO and CG actively involved in approving DPIAs for new systems and processes.
IG skills and knowledge are kept up to date	• CG has attended meetings of the UK Caldicott Guardian Council. • CG and SIRO attended GCHQ Certified Board Cyber Security Training in 2020. This was provided as part of NHS Digital's Cyber Security Support Model (CSSM). • Both SIRO and Board level Cyber Security training will be refreshed during Autumn 2021.
The Board is informed of confidentiality concerns	• SIRO and CG attend the IGCRSC and scrutinises reports provided to the QAC. Confidentiality incidents report is a standing agenda item at IGCRSC. • SIRO and CG are routinely informed of incidents escalated via the DSP Toolkit incident reporting system and of incidents escalated to ICO.
Arrangements for confidentiality and data protection are monitored	• Confidentiality audits conducted provided to IGCRSC attended by SIRO and CG. • Confidentiality audits performed in clinical areas to support CQC KLoE 6 evidence provision provided to SIRO and CG. • Approval of Information Sharing agreements entered into is sought from CG and records kept of approved ISAs.
Staff are provided with clear guidelines and procedures	• Alerts, guidance and policies issued are approved by SIRO and CG as core members of the IGCRSC.
Identified improvements to confidentiality processes are implemented	• Lessons learned from IG incidents scrutinised by CG and SIRO at IGCRS and escalated to Quality Assurance Committee. • Actions identified to improve confidentiality processes in audits undertaken approved by CG.

4. RECOMMENDATIONS

The Board is asked to:

Note and approve the contents of the report;
Receive assurance that SIRO responsibilities are being fulfilled effectively.

Trust Board

DATES 2021-2022

All meetings to be held in the Trust Conference Room

Date of Meeting	Agenda Settings	Deadline For Receipt of Papers	Papers Due Out
2021			
Wednesday 27 January	Thursday 7 January	Monday 18 January	**Wednesday 20 January**
Wednesday 31 March	Thursday 10 March	Monday 22 March	**Wednesday 24 March**
Wednesday 26 May	Thursday 6 May	Monday 17 May	**Wednesday 19 May**
Wednesday 28 July	Thursday 8 July	Monday 19 July	**Wednesday 21 July**
Wednesday 29 September	Thursday 9 September	Monday 20 September	**Wednesday 22 September**
Wednesday 24 November	Thursday 4 November	Monday 15 November	**Wednesday 17 November**
2022			
Wednesday 26 January	Thursday 6 January (EXECS)	Monday 17 January	**Wednesday 19 January**
Wednesday 30 March	Thursday 10 March (EXECS)	Monday 21 March	**Wednesday 23 March**