WHH Board of Directors Meeting Part 1

Wednesday 26 MAY 2021
10.00am-12.15pm
Via MS Teams

Warrington and Halton Teaching Hospitals NHS Foundation Trust
Agenda for a meeting of the Board of Directors held in public (Part 1)

Wednesday 26 May 2021 time 10.00am -12.15pm

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/21/05	ITEM	PRESENTER	PURPOSE	TIME	
BM/21/05/	Patient Story Maternity	Debbie Gould Professional Midwifery Adviser / Head of Midwifery (Interim) Deborah Carter Project Director Women and Children's Services		10.00	Verb
BM/21/05/ 62	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	10.15	Verb
BM/21/05/ 63 PAGE 7	Minutes of the previous meeting held on 31 March 2021	Steve McGuirk, Chairman	Decision	10:17	Encl
BM/21/05/ 64 PAGE 19	Actions & Matters Arising	Steve McGuirk, Chairman	Assurance	10:20	Encl
BM/21/05/ 65 PAGE 21	Chief Executive's Report	Simon Constable, Chief Executive	Assurance	10:25	Encl
BM/21/05/ 66	Chairman's Report	Steve McGuirk, Chairman	Information	10:35	Verb

Quality People Sustainability

BM/21/05/ 67 PAGE 30	COVID-19 Performance Summary Report and Situation Report – *to follow*	Simon Constable, Chief Executive	Assurance	10:40	Enc
BM/21/05/ 68 PAGE 54	Integrated Performance Dashboard M1 and Assurance Committee Reports	All Executive Directors	To note for assurance	10:50	Enc
(a i) PAGE 117	- Quality and Performance Dashboard including o Monthly Nurse Staffing Report February & March 2021	Daniel Moore Chief Operating Officer Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO			Enc
(b) PAGE139	- Key Issues report Quality and Assurance Committee (06.04.2021 and 04.05.2021)	Margaret Bamforth Committee Chair			Enc
	- People Dashboard	Michelle Cloney Chief People Officer			
	- Sustainability Dashboard	Andrea McGee Chief Finance Officer & Deputy CEO			Enc
(c) PAGE149	- Key Issues Finance and Sustainability Committee (21.04.2021) - Committee Chairs Q&A's (19.05.2021)	Terry Atherton Committee Chair			
(d) PAGE160	- Key Issues Audit Committee (29.04.2021)	Ian Jones Committee Chair			Enc
(e) PAGE163	- Key Issues Clinical Recovery Oversight Committee (14.04.2021, 27.04.2021 & 13.05.2021)	Terry Atherton Committee Chair			

Quality

BM/21/05/69 PAGE 175	Moving to Outstanding (M2O) Update	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	To note for assurance	11.25	Enc
BM/21/05/70 PAGE 178	Maternity Serious Incident Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	To note for assurance	11.30	Enc

Sustainability

BM/21/05/71 PAGE 183	Use of Resources Assessment (UoRA) Q4 update report	Andrea McGee Chief Finance Officer & Deputy CEO	To note for assurance	11.40	Enc
BM/21/05 72	H1 Plan	Andrea McGee Chief Finance Officer & Deputy CEO	To note for assurance	11.45	PPT

GOVERNANCE

BM/21/05 73 PAGE 204	Strategic Risk Register & BAF	John Culshaw Trust Secretary	To note	11.55	Enc

MATTERS FOR APPROVAL

	ITEM	Lead (s)				
	Quality Priorities 2021-22	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee	12.00	Enc
			Agenda Ref.	QAC/21/04/95		
			Date of meeting	06.04.2021		
			Summary of Outcome	**Approved**		
BM/21/05 75	CNST Maternity Incentive Scheme evidence of compliance. Virtual approval on 19.05.2021	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/21/05/120		
			Date of meeting	04.05.2021		
			Summary of Outcome	Noted		
BM/21/0 76	Clinical Recovery Oversight Committee Cycle of Business	John Culshaw Trust Secretary	Committee	Clinical Recovery Oversight Committee		Enc
			Agenda Ref.	CROC/21/04/14		
			Date of meeting	27 April 2021		
			Summary	**Approved**		
BM/21/0 77	Compliance with NHS Provider Licence Annual Return - Gernal Condition (G6 (3)) and Continuity of Service Condition CoS7	John Culshaw Trust Secretary	Committee	N/A		Enc
			Agenda Ref.			
			Date of meeting			
			Summary			

MATTERS FOR NOTING FOR ASSURANCE

	ITEM	Lead (s)				
BM/21/07/78	Annual Complaints Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee	12.05	Enc
			Agenda Ref.	QAC/21/05/145		
			Date of meeting	04.05.2021		
			Summary of Outcome	**Noted**		

BM/21/05 79	**Learning from Experience Q4**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	QAC/21/05/126		
			Date of meeting	04.05.2021		
			Summary of Outcome	**Noted**		
BM/21/05/ 80	**Infection Prevention and Control Board Assurance Framework Compliance Bi-Monthly Report**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	QAC/21/05/132		
			Date of meeting	04.05.2021		
			Summary of Outcome	**Noted**		
BM/21/05/ 81	**Infection Prevention and Control (DIPC) Q4 Report**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	QAC/21/05/131		
			Date of meeting	04.05.2021		
			Summary of Outcome	**Noted**		
BM/21/07/ 82	**Quality Strategy Annual Update report**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	QAC/21/04/95		
			Date of meeting	06.04.2021		
			Summary of Outcome	**Noted**		
BM/21/05/ 84	**Mortality Review Q4 Report**	**Alex Crowe Executive Medical Director**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	QAC/21/05/130		
			Date of meeting	04.05.2021		
			Summary of Outcome	**Noted**		

	Any Other Business	**Steve McGuirk, Chairman**	**N/A**	**12.10**	**Ver**
	Date of next meeting: Wednesday 28 JULY 2021, Trust Conference Room				

Conflicts of Interest

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

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

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

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

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

Interests fall into the following categories:

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

GLOSSARY OF TERMS

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

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Warrington and Halton Teaching Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 31 March 2021, 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
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse & Deputy CEO and Director of Infection Prevention & Control (DIPC)
Anita Wainwright (AW)	Non-Executive Director
In Attendance	
Michelle Cloney (MC)	Chief People Officer
Lucy Gardner (LG)	Director of Strategy & Partnerships
John Culshaw (JC)	Trust Secretary
Paula Gunner	Senior Executive Assistant
Apologies	Pat McLaren, Director of Communications & Engagement
Observing N Holding, Lead Governor Members of the public (4)	P Bradshaw, S Fitzpatrick, T Martin, C Fitzpatrick, C Jenkins, C McKenzie, A Robinson Public Governors, D Birtwistle Staff Governor, T Cooper

BM/21/03/25	**Welcome, Apologies & Declarations of Interest** The Chairman welcomed all to the meeting. No declarations made in relation to the agenda. The agenda had been streamlined to focus on key pertinent issues ensuring governance process and evidence remains robust whilst not constraining discussions. Chairman reminded colleagues of the current period of pre-local election purdah.
BM/21/03/26	**Minutes of the meeting held 27 January 2021** P7 5th paragraph Nosocomial and P8 Ockenden report the items have been amended as per comments by KSJ and SMcG. With this amendment the minutes of 27 January 2021 were agreed as an accurate record.
BM/21/03/27	**Actions and Matters Arising. Action log and updates noted and recorded.** There were no matters arising for discussion.
BM/21/03/28	**Chief Executive's report** The report was taken as read, the CEO highlighted: – 48 COVID-19 patients are in the Trust this is a slight improvement but still remains high compared with other Acute Trusts in Cheshire & Merseyside but going in the right direction. – There have been no deaths with COVID-19 in the last 7 days which is positive. – To date the Trust has given 25,288 COVID-19 vaccinations and 90.4% of staff have been

	given their 1st dose of vaccine with 60% given their 2nd dose. – Warrington and Halton Teaching Hospitals NHS FT has the highest uptake of vaccinations of all Trusts in the North West. Questions were invited. CR asked about the Clinical Research Unit at the Halton Hospital and that the CRN were not supportive of this. SC explained that it was the Innovation Agency who could not support the Trust with the Clinical Research Unit, the Cheshire & Merseyside Clinical Research Network (NWCRN) have been very supportive of the setting up of the unit at Halton Hospital which will be used for the next trials of vaccines. The NWCRN also provided £200k of funding to ensure B1 could be made fit for purpose to house the Clinical Research Unit. SC advised the Board that he has been asked to take up the role of Deputy Chair on the NWCRN MB asked about the uptake of the Trust's Ethnic Minority staff. LG answered that the uptake is at 89% which is high, and the Trust is sharing good practice with other organisations. AW commented that this is the moment to thank the BAME Network for their presentation to Strategic People Committee and for their support of the vaccination programme and education network. LG advised that thanks to Suresh and the work he has undertaken to promote vaccination and this promotion material is being used NHSE/I and Warrington. **The Board noted the report.**
BM/21/03/29	**Chairman's Report** The Chair continues with internal and external meetings including with Non-Executives (NED) with NED Assurance Committee meetings, 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. Chairman had Chaired the recent C&M Health & Care Partnership Board. The Chair reported that there had been 2 good session with the Governors taking place over the last few weeks the first session which included KSJ, AC and DM and provided assurance and detail on the working taking place at the Trust on Clinical Harm and Waiting Lists. The second session was with regards to the Government white paper on Integrated Care Systems with Dr Andrew Davies, Clinical Chief Officer, Warrington and Halton CCG. Consultants Interviews have taken place with 3 – 4 appointments which now shows the standing of the hospitals in were it sits in the grand scheme of things to be able to recruit to these posts. The Chair appraised the Board of the support provided from the Sikh Community in Warrington providing meals over Friday, Saturday and Sunday to Trust staff especially ITU for the last year. Chairman presented a certificate and thanked the Sikh Community for their support. Chairman briefly appraised the Board of the NED recruitment process which is moving forward and will confirm at the next Board the name of the company who has been chosen

	to take the process forward for the Trust. **The Board noted the update**
BM/21/03/30	**COVID-19 Performance Summary and Situation Report** The CEO referred to the situation report and Elective Recovery plans. All data is submitted through Emergency Planning Resilience Reporting to NHSE/I and provides headline figures and outcomes data from a regional, national and local perspective. SC highlighted: The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily COVID-19 Executive Summary which outlines key information pertinent to the command and control of the situation. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where possible. This is the tenth iteration of this report which is part of the continuing development of understanding of demand, capacity and outcomes that will determine future strategic planning. Data up to 27th March 2021 is included. SC commented that there is a huge amount of data which is required to be reconciled prior to leaving the Trust and SC thanked Louise Ainsworth and her team or their part in the data collection and for not missing a single day through the pandemic in the submitting reports. CR commented on the last sentence of the report it states 'The Executive Team will continue to monitor this data and will take immediate action as appropriate where concerns are noted in any area' and asked how the Executive would do this and is there a parallel document which contains COVID-19 actions and responses. SC explained that the actions are captured in an action log of all decision which are made at COVNED and Strategic Executive Oversight Group which is (Executive Gold meetings). KSJ explained that all the actions /decision around COVID-19 are being pulled into one Governance legal paper. MB noted the leap in activity in the graph around Warrington A&E and Halton UC which has put A&E under considerable pressure. DM explained that NHS111 has been used by patients and has redirected them to more appropriate services than A&E it should be noted that patients who require A&E are able to book slots through the NHS111 service. DM advised that as of 1st April PC24 will be working in A&E undertaking a clinical assessment service and they will re-direct patients from A&E to more appropriate setting if necessary. KSJ explained that the Trust Nosocomial infection as benchmarked across Cheshire & Merseyside is 15.28%. St Helens & Knowsley Teaching Hospitals NHS Trust are at 7.22% which lower than any other acute Trust in the Cheshire & Merseyside area. KSJ has spoken to the Chief Nurse at St Helens to compare the process being used for nosocomial infections on both sites and we are both doing the same things. TA commented that it was likely due to the St Helen's estate being new and having more side rooms than the rest of the acute Trusts having older estates. CR commented that nosocomial infections and the pandemic should be included in the discussion regarding a new build hospital to include more side rooms and larger bed spaces. KSJ explained that 33 beds would have had to be taken out of the Trust to ensure 2m spacing between beds due to the pandemic or if 2metres cannot be maintained a full risk

	assessment has been undertaken. KSJ advised that although this indicator had moved from amber to red, the unit follows a staffing escalation process, unit leads advise the unit is safely staffed and sickness is mitigated by Children's and Paediatrics staff supporting to do this as well as NHSP staff. • **The Board noted the report.**
BM/21/03/31 ***BM/21/03/31 (a)*** ***BM/21/03/31 (a) ii***	**IPR Dashboard and IPR Key Issues** The CEO introduced the report and invited questions to focus on key issues within the IPR, Committee Assurance Reports, relevant to each Portfolio area <u>Quality Assurance Committee</u> MB – raised the 4-hour performance and the high numbers of patients arriving in A&E it has been a difficult few months for staff and to be able to achieve the standard. DM provided the detail behind the Trust not achieving its 4-hour target explaining the following:- – Wave 1 attendees to A&E – 124 per day – Wave 2 attendees to A&E – 180 per day – Wave 3 attendees to A&E – 240 per day The Trust was regularly working on 95% occupancy which affects urgent care flow through A&E and impacts the bed base and A&E still operating without CDU. DM also detailed the long length of stay patients and the work ongoing with system partners to reduce these number along with super stranded patients. The increase in Category 2 Pressure Ulcers were also discussed KSJ explained that this is under review as the pressure ulcers incidences have been in Wards A5, A6 , A8, A9 and ICU which is due to proning COVID-19 patients on these wards and is something which has been seen nationally. The RCA's will be reviewed to see if staffing has been an element in this. KSJ advised the Trust Board that a new mattress contract has been signed and there will be access to mattresses in a timely manner out of hours. No other questions/comments were raised in relation to the IPR. The Board noted the content of the report. <u>Nurse Staffing Report (12.20 & 01.21)</u> KSJ advised the Board that sickness absence rates were recorded at 8.93% in December 2020 and 7.65% in January 2021 for nursing and midwifery staff, December was consistent with October & November. In the month of December 2020, it was noted that 15 of the 21 wards were below the 90% target during the day, with a similar position noted in January 2021 with 14 of the 20 wards below the 90% target. In order to ensure safe staffing levels, mitigation and responsive plans were implemented daily to ensure that the safe delivery of patient care. CHPPD in December 2020 was 7.5 and 7.6 in January 2021, with a year to date rate 7.8.

	WHH have joined Wigan, Wrightington and Leigh NHS Trust to participate in a regional pilot for recruitment of international nurses. Following a successful business case, we have recruited 30 registered nurses to join the Trust between the months of February and April 2021. Trust Board asked to receive the contents of this report as discussed and received at the Strategic People Committee. No other questions/comments were raised in relation to the IPR.
BM/21/03/31 (b)	<u>Quality Assurance Committee (QAC) Assurance Report 01.02.2021 & 02.03.2021</u> Further to the matters below that the Committee wishes to bring to the attention of the Board, the Committee would also like to highlight the high quality of the reports that have provided assurance. The Committee recognises the considerable operational pressures during the third wave of the pandemic and wishes to commend those that have contributed to the work of the Committee during this difficult time. No further questions / matters escalated. **<u>People Dashboard</u>** MC presented the people dashboard to the Trust Board highlighting the following: - Sickness Absence – The Trust's sickness absence was 5.47% in February, an improvement from 6.40% in January, against a target of less than 4.20%. - Return to Work Compliance – interview compliance was 52.20% in February, a deterioration from 62.12% in January, against a target of 85.00%. - Recruitment – the average time to recruit was 77 days over the last 12 months as of February, the same as January against a target of less than 65 days. - Bank/Agency Reliance – The Trust's reliance was 19.15% in February, an improvement from 21.44% in January, against a target of less than 9.00%. - Agency Shifts Compliant with the Cap – 19.86% of agency shifts were compliant with the cap in February, a deterioration from 21.52% in January, against a target of 49.00%. - Agency Rate Card Compliance – 19.65% of agency shifts were compliant with the rate card in February, a deterioration from 22.31% in January, against a target of 60.00%. - Monthly Pay Spend – monthly Trust pay spend was £1.3m above budget in February, reduced from £1.6m above budget in January. - PDR Compliance – The Trust's PDR compliance was 52.11% in February, a deterioration from 54.94% in January, against a target of 85.00%. - One indicator has moved from Amber to Red in month which is the % use of the Apprenticeship Levy at 49.00% in February from 78.00% in January against a target of 85.00%. - One indicator has moved from amber to green in month which is vacancy rates in February this was 8.44% and has improved to 9.41% in January against a target of less than 9.00%. AW commented that the presentation provided on LGBTQ and BAME at the last Strategic People Committee was excellent and will provide the presentation to COVNED.
BM/21/03/31 (c)	<u>Strategic People Committee (SPC) 24.03.2021</u> no further questions / matters escalated.

	Sustainability Dashboard – AMcG highlighted the following proposals for the Board to consider and approve, in respect of the Capital Programme, all which had been discussed and supported at the Finance and Sustainability Committee (FS) on 23rd March 2021. - Approve the expenditure and funding arrangements regarding the COVID-19 vaccine service. - Note the capital schemes approved as an emergency by the Chief Finance Officer & Deputy Chief Executive. - Note the capital schemes approved by the Finance & Sustainability Committee within its delegated limit in Table 3. - Note the increase in the underspend / contingency in Table 4 due to the availability of alternative funding streams, underspends and potential non delivery of goods by 31 March 2021. Current forecast c£1.9m under spend. SC commented that within the environment of COVID-19 the Trust has done its best endeavours with finances. AMcG explained that the Trusts COVID-19 expenditure has been audited by MIAA and it has found that the Trust has robust measure in place with regards to the COVID-19 expenditure. TA echoed AMcG that the processes put in place and monitored by the Finance & Sustainability Committee are robust and the Board can take assurance from this. **The Board noted and approved the requests as above.**
BM/21/03/31 (d)	Finance & Sustainability Committee (FSC) 17.02.2021 & 24.03.2021 No further matters escalated or questions raised.
BM/21/03/31 (e)	Audit Committee (AC) 25.02.2021 The Trust Secretary asked to seek delegated authority from the Trust Board for Audit Committee to approve the Final Annual Report & Accounts 15 June 2021. No further questions / matters escalated. • **The Board approved delegated authority to the Audit Committee to approve the Final Accounts** The Annual Key Performance Indicator Review for 2021/22 has taken place and discussed with the Executive Team and Operational Leads to ascertain requirements for new indicators the 2021/22 Draft NHS standard contract has also been reviewed to understand the changes which may affect performance monitoring the indicators to be removed are set om the paper along with the indicators to be updated. • **The Board approved the recommended changes to the Key Performance Indicators on the IPR for 2021/22**
BM/21/03/ 32	**WHH Maternity Services – Compliance with Ockenden** The report was taken as read, KSJ highlighted key points to note which provided an update to Ockenden, the Trust's current position and background to NHSE/I request in December 2020. • Update on the Trust response to the Ockenden report ('Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust' on 11th December 2020). • Update on Maternity Safety Champion Roles and Responsibilities • Update on progress against the CNST Safety Actions

	• High-level summary of Serious Incidents AW thanked senior management on Maternity services work. MB referred to Neonatal staffing being low and are there plans in place to mitigate this. KSJ advised that although this has moved from amber to red, the unit is safely staffed and sickness is mitigated by Children's and Paediatrics staff supporting to do this. A discussion took place about the Trust Maternity Safety Champion and that Board level Safety Champions must work collaboratively together and with their Trust Maternity Obstetric and Midwifery Safety Champions to address and escalate locally identified issues. • This will include an Executive Director with specific responsibility for maternity services: • A Non-Executive Director who has oversight of maternity services: It was suggested that there needs to be a defined job description with accountability. • **The Board noted the report and assurance provided relating to: WHH Maternity Services – Compliance with Ockenden.**
BM/21/03/33	**Spinal Services Update** DM provided a presentation to the Trust Board which details the Spinal Service Update and the start of the new service from 1st July 2021. • **The Board noted the report and assurance provided.**
BM/21/03/35	**Annual Capital Programme 2021-2022** AMcG presented the capital programme to the Board as follows: – 2020/21 capital underspend forecast circa £1.9m – Informed Health & Care Partnership capital required 2021/22 – Early indication from Cheshire & Mersey shows that capital plans exceed envelope by circa £70m – Conversation with CMHCP 22/3/21 requesting voluntary reduction in capital - request response by 26/3/21 – Once the capital envelopes are agreed per Trust, applications for PDC to support the programme will be required. – Final plans are to be submitted to the HCP on 6th April 2021 – The Trust Board is asked to approve (subject to NHSE/I support) :- – the suggested capital schemes for 2021/22 – the request for additional capital funding AMcG advised that the mandated schemes are schemes by statute or legislation and is legally enforceable by governing body such as CQC, Fire & Rescue etc. The critical schemes are critical to service delivery for health and safety of patient, staff or visitors. AMcG explained that all the high-risk capital schemes in appendix 3 have been highlighted as urgent CQC requirements or are critical. The ED Plaza scheme was discussed and also the car park and IJ suggested that with the car park the previous estimate was £8m this is now £10m the business cases for these big

	schemes need to be written robustly and managed correctly with Board oversight The schemes delivered this year 2020/21 are: – PACU – MRI – NEST – ICU • **The Board noted, reviewed and discussed the information which had been presented and supported by Finance and Sustainability Committee on 24 March 2021 and approved the Capital Schemes for 2021/22.**
BM/21/03/37	**BAME Assembly Strategic Priorities and WHH Response** MC presented a paper which updates the Trust Board on The Vision, Mission and published priority areas for the NW BAME Assembly and also the submission of a Trust response detailing the work to eliminate race discrimination and a commitment from the Trust to becoming an Anti-Racist Organisation. MC also explained that a letter had been received which requested each NHS organisation in the North West prepare and submit by 22nd December the following information: - How you are planning to share the statement with your staff and engage them in conversations about racism and inequalities. - How you plan to link with the Assembly and its members, to support the development of your response to our statement - How you plan to build on the work already done in your own organisation – and by others – on promoting the health and wellbeing of your staff and the outcomes from the risk assessments carried out so far, particularly in relation to the roll out of the COVID vaccination programme. The Trust submitted a response as required and was informed that the intention following submission to NHSE/I was for all submissions to be collated and reported to the BAME Assembly in January 2021. Feedback would then be provided to each Trust on areas of good practice as well as areas of improvement this feedback has not been received. The Board discussed the paper at length and the next steps with the assurance to the Board will be provided through Strategic People Committee TA commented that the letter of 19th March 2021 from Bill McCarthy Regional Director NHSE/I referred to a reduction in inequalities and this would be welcomed going forward. SMcG commented that this is a helpful paper. **The Board noted the report and approve the ambition for the Trust to eliminate race discrimination and update of NW BAME Assembly ambition for NW Trust to be Anti-Racist organisation.**
BM/21/03/38	**National Staff Opinion Survey** MC presented the 2020 staff survey took place between September and November 2020

	and added that it is worth noting that the survey took place during the second wave of the COVID-19 pandemic which was not happening at that time across all parts of the country. In the 2020 staff survey, the organisation's response rate was 36%. It should be noted that the CBU managers are involved locally to promote the uptake of the survey and due to the pandemic they could not do that. AW commented that she agreed with MC's comments and this was discussed at Strategic People Committee (SPC) and it understandable that the response rates would not be as high during a pandemic Despite the context in which the survey was undertaken, the results show areas of improvement and also results above the national average. The organisation is better than the average score in 8 areas and in line with the average score in 2 areas. The results show two areas of statistically significant improvement when compared with the previous year: • Health and Wellbeing • Safe Environment – Violence The results also show two areas of statistically significant decline: • Immediate Managers • Team Work In relation to Immediate Managers, the thematic results demonstrate an overall reduction, which could be attributable to a range of factors such as staff not working in their substantive roles currently, a change in line management due to the response to the COVID-19 pandemic or having to shield at home due to an on-going medical concern. The national average results for this theme have also declined. The Trust's results do show an increase of 0.9% in comparison to 2019 in staff feeling that their immediate manager asks for their opinion before making decisions that affect their work. There is work to be done in relation to staff feeling that clear feedback is given on their work which has decreased by 4% and is slightly less than the national Acute Trust average. The number of staff who feel that line managers take a positive interest in their health and wellbeing has also decreased, against a national average increase in relation to this question and also against a significant increase for the Trust overall in relation to the Health and Wellbeing theme. KSJ commented that she would welcome development / support for line managers and junior managers. MC explained that line manager development is being discussed and is an area which requires investment along with the Team-building. AW agreed and said this is a tough job and this piece of work will come back to SPC for further discussion. • **The Board noted the report and assurance provided relating to: National Staff Opinion Survey**
BM/21/03/39	**Strategic Risk Register and Board Assurance Framework (BAF)** The report was taken as read and JC highlighted the following for the Board to review and consider the following proposals for the BAF since the last meeting and the rationale: Since the last meeting:

	Risk 1126 *Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.* COVID-19 demand has significantly reduced from c243 patients to c130 patients. Monitoring over a number of weeks indicates an average 30-35% usage. As the number of COVID-19 patients reduce, the expected use of O2 should also reduce. This risk has reduced from 25 to 15 and will reduce further. Also included in the report were notable updates to existing risks #1124; #1215; #1272 #1273; #1274; #1289; #115; #134; #1114; #1079; #1207; #1108; #1290. **The Board approved:** • **The amendment of to risk 1126 as above.**
BM/21/03/40	**Clinical Oversight Recovery Committee (CROC) Terms of Reference** JC presented the report, background and context. The COVID-19 pandemic had significantly impacted NHS services in Warrington and Halton, putting pressure on all health and social care services. The Finance and Sustainability Committee on 24 March 2021 had considered, discussed and supported the proposal to establish the Clinical Recovery Oversight Committee (CROC) to be accountable to the Trust Board for providing oversight, assurance and triangulation in relation to: • Referral to Treatment (RTT) • Patient Cancer Pathways • Diagnostics including Endoscopy and Outpatients • Progress of clinical harm reviews (CHR) The Chair suggested that a review in 6 months rather than 12 months. Also where it states members must send deputies this was asked to be taken out of the ToR for NEDs as they do not have deputies. TA noted that there are three NEDs on the committee and this will allow for 2 NEDS to be able to attend at anyone time. **The Board approved:** • **Reviewed, noted and discussed the proposal** • **Approved the establishment of the CROC and its Terms of Reference with the amendments described above.**
BM/21/03/41	**Partnership Agreement with University of Chester** The agreement was taken as read and LG highlighted section 7 of the agreement which states "The University will be represented by a Non-Executive Director on the Trust Board. This will be a reciprocal arrangement with the Trust being represented at University by a Council and Board member" it was agreed that the representative from the Trust Board would be discussed outside of this meeting. **The Board approved Partnership Agreement with University of Chester.**
MATTERS FOR APPROVAL/RATIFICATION	
BM/21/03/42	**Performance Assurance Framework (PAF) and Integrated Performance Indicator Review (IPR) 2021-2022** The Board **ratified** the which had been approved at the Finance and Sustainability

	Committee on 24 March 2021.
BM/21/03/43	**Trust Board Cycle of Business 2021-2022** The Board **approved** the 2021-2022 Cycle of Business.
BM/21/03/44	**Cycles of Business 2021-2022** The Board **approved** the Cycles of Business of Audit Committee, Finance & Sustainability Committee and Strategic People Committee which had been approved at the respective Committees on 25 February 2021 and 24 March 2021 respectively.
BM/21/03/45	**Strategic People Committee (SPC) Chairs Annual Report 2020-2021** The Board **approved** the SPC Chairs Annual Report 2021- which had been approved at the SPC on 24 March 2021.
BM/21/03/46	**Annual Review of Scheme of Reservation and Delegation (SORD) and Standing Financial Instructions (SFIs)** The Board **ratified** this been approved at the on 8 January 2021.
BM/21/03/47	**Delegation of Authority for Annual Report 2021-2022** The Board **approved** delegated authority to the Audit Committee (June 2021)
BM/21/03/48	**Amendment to the Constitution – for ratification** The Board **approved** this.
MATTERS FOR NOTING FOR ASSURANCE	
BM/21/03/49	**Learning from Experience Q2 Report** This report had been reviewed and discussed at the Quality Assurance Committee on 2 March 2021. **The Board noted the report.**
BM/21/03/50	**DIPC Q3 Report** This report had been reviewed and discussed at the Quality Assurance Committee on 2 March 2021. **The Board noted the report.**
BM/21/03/51	**Maternity Monthly SI Report** This report had been reviewed and discussed at the Quality Assurance Committee on 2 March 2021 and provided detail of the number of SIs reported at WHH in the last 12 months with learning identified. **The Board noted the report**
BM/21/03/52	**Hospital Volunteer Report** This report had been reviewed and discussed at the Strategic People Committee on 20 January 2021. **The Board noted the report.**
BM/21/03/53	**Moving to Outstanding (M2O)** This report had been reviewed and discussed at the Quality Assurance Committee on 2 March 2021. **The Board noted the report.**
BM/21/03/54	**Safe Staffing 6 month Report** This report had been reviewed and discussed at the Quality Assurance Committee on 2 March 2021. **The Board noted the report.**
BM/21/03/55	**Infection Prevention and Control BAF Bi-monthly Report** This report had been reviewed and discussed at the Quality Assurance Committee on 2 March 2021. **The Board noted the report.**
BM/21/03/56	**Freedom To Speak Up Bi-Annual Report** This report had been reviewed and discussed at the Strategic People Committee on 24

	March 2021. **The Board noted the report.**
BM/21/03/57	**Mortality Q3 Report** This report had been reviewed and discussed at the Quality Assurance Committee on 2 March 2021. **The Board noted the report.**
BM/21/03/58	**Digital Update report** The Board reviewed and noted report.
	Any Other Business There was no other business raised for discussion the meeting closed
	Next meeting to be held: Wednesday 26 May 2021

Signed …… Date ……

Chairman ……..

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE	BM/21/05/64	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	26 May 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
BM/18/07/57	26.05.2020	Junior Doctor/Trainee Engagement update Trello)	6 mth update presentation.	**Executive Medical Director + CCIO**	**Paused nationally 2020, date TBC**		14.01.2019. Deferred to March 27.03.2019. Deferred to future BTO 29.05.2019. Update to September Board to include results from GMC survey. 06.09.2019. Deferred to November Board due to deferred HEE visit. 18.11.2019. Deferred to January Board due to HEE visit. 13.01.2020 Date of HEE visit still to be confirmed. 9.03.2020 HEE visits cancelled on 3 occasions. HEE visit confirmed for 22.5.2020. Verbal update to May Board 27.05.2020 Visit cancelled. HEE visits paused due to COVID, future date to be confirmed 29.07.2020. Visit confirmed for Autumn 2020. 30.09.2020. Virtual HHE GMC	

							assessment anticipated Nov/Dec 2020. 25.11.2020 Notification of potential visit in February 2021.	
BM/20/11/117c	25.11.2020	People IPR - Attendance Management Policy	Review of shared learning from the C&M Symposium	**Chief People Officer**	**Paused**		C&M symposium paused due to pandemic	
BM/20/11/118	25.11.2020	M2O Report – Hospital Food National Review	Board sample of patient menu at a future Board meeting.	**Chief Nurse & Deputy CEO**	**Paused**		On hold due to Pandemic	

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/20/11/117ac	25.11.2020	Nurse Staffing challenges	Dedicated session be held with Trust Board on Nurse Staffing by the Chief Nurse.	**Chief Nurse & Deputy CEO**	**28.04.2021**	**28.04.2021**	Session held	

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/21/05/65**			
SUBJECT:	**Chief Executive's Briefing**			
DATE OF MEETING:	26th May 2021			
AUTHOR(S):	Simon Constable, Chief Executive			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***				✓ ✓ ✓
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/21/05/65

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 31st March 2021, some of which are not covered elsewhere on the agenda for this meeting.

2) KEY ISSUES

2.1 Current COVID-19 Situation Report

As at the time of writing we have a total of 2 inpatients with COVID-19 at WHH. This is a low COVID-19 demand that we have not seen since August of last year.

In terms of community prevalence, in the latest 7 days fully published (9th May – 15th May) in Warrington there were 10 cases per 100,000 people (the average area in England had 13); 10 new cases were reported in that week, with no change from the previous week. In Halton, there were 14 cases per 100,000 people; 18 new cases in that week, down 2 compared with the previous week.

The latest R number for the North West, last updated on Friday 14th May, is at 0.8 – 1.1, the same as England as a whole.

Since March, we have performed over 97656 COVID-19 tests and 5419 have been positive in total. We have discharged a total of 1995 patients with COVID-19 to continue their recovery at home. Sadly, a total of 499 patients with COVID-19 have died in our care.

2.2 WHH COVID-19 Vaccination Programme

Our vaccination programme continues to deliver an average of 272 vaccinations per day. At the time of writing, we have performed over 40709 COVID-19 vaccinations. We have also vaccinated 91.26% of WHH staff – the second highest trust in England. Second doses have now been given to 84.48% of staff.

Our WHH Neighbourhood Champion Scheme for vaccination for those within the JCVI recommended groups has continued. It works very well in terms of bringing people forward for vaccination, sponsored by members of staff, so that we continue to make best use of our capacity. DNA rates are very low. We have not wasted any vaccine through a lack of people to vaccinate.

We have also implemented the reduction of dosing interval from 12 weeks to 8 weeks in line with JCVI guidance for those in the priority groups 1 to 9.

2.3 WHH Mission, Vision, Values and Objectives

In the last year WHH has faced many challenges requiring new levels of partnership, fortitude, innovation, stamina, patience, commitment, kindness, compassion and inclusion. Whilst we and our patients, their families, our volunteers and wider community continue to

work through the COVID-19 pandemic we recognise that WHH is almost certainly a very different organisation to that at the beginning of 2020.

Although of course we still have many things to work on, arguably we are emerging as a stronger and more self-confident organisation with ever greater ambition, as a team, to do even better for our patients, each other and the communities we serve.

As part of looking at our COVID-19 legacy it became clear that our vision, values and objectives needed to better reflect the new and wider needs of all staff, our patients, volunteers and our communities. Words such as 'kindness' and 'inclusive' kept coming up in the feedback we had. As a large organisation (and employer) in both Halton and Warrington boroughs, we have much to offer our communities as they too emerge from the pandemic and its economic and emotional consequences to begin recovery. This includes apprenticeships, work experience and employment opportunities, training and development, volunteering, community support and inclusion as well as economic regeneration through more local procurement, estate development and diversification.

Together, our vision, mission, values and objectives provide the direction for everything that happens at WHH. They keep us focused on where we are going and what we are trying to achieve. They define our core values and how we are expected to behave in everything we do. Our improved, and indeed simplified vision, values and objectives come with a fresh modern new look as we face the future.

2.4 Operation Reset

The last few weeks has seen urgent and emergency care under real pressure across Cheshire and Merseyside, and we have felt this particularly acutely at WHH. Emergency Department attendances at Warrington have reached record levels and we have regularly been seeing approximately 100 attendances at our Halton Urgent Treatment Centre. Whilst attendances and admissions have been high, our discharges have not kept pace and as a result we are in a poor position with regards to patient flow. Our super-stranded position of patients with a length of stay greater than 21 days was at 100 on Monday 17th May 2021. Although this is not the worst level it has been it is still a significant demand for us to manage effectively.

On Monday 17th May 2021 we launched Operation Reset until 28th May. Operation Reset is all about implementing, embedding and refreshing all that we know that works in terms of patient flow and have a whole organisational focus in doing so. There is enhanced support across the urgent and emergency care pathway to support caring for our patients in the right place at the right time, whilst continuing our restoration and recovery work for COVID-19 and our elective patients. There will be a daily focus and theme areas from across the system, internal and external, and with all members of the team involved. There will only be essential meetings and email traffic should be reduced where possible. The normal bed/site management structure will remain but additionally there will be three checkpoints every day - 8am, 12pm & 4pm. A Command and Control centre has been setup in the Trust Conference Room, with the real-time escalation and management of issues and the daily measurement of success with clear goals and feedback.

Operation Reset is about the concerted trust-wide application of a bundle of supporting schemes to support patient flow in a better way.

The aims are:

- Maximise community bed base availability
- Keep Assessment Areas unblocked for ambulatory/same-day emergency care activity
- Maintain empty beds on AMU
- Maximise capacity on B3 at Halton

This will support us to achieve:

- Reduced occupancy levels
- Super-stranded of <75
- Embedding good practice
- Clear corridors and reduce crowding in ED

At the time of writing, Operation Reset has already had a positive impact on achieving the above aims. The challenge will be creating a lasting legacy of doing this in a sustainable way with the required level of performance improvement with the 4 hour standard for our emergency patients.

2.5 Overview of Trust Performance

As stated above, there have been significant and sustained operational challenges of achieving the 4 hour standard for the non-elective pathway and a deterioration in performance as a result. Operation Reset is part of our strategy to regain the initiative here

despite the increase in demand. However, WHH 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. 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.

The Trust has been set a draft control total for the first half of the year (H1) and this has submitted a plan to Cheshire and Merseyside Health and Care Partnership (CMHCP) to deliver this. Further information is awaited from the CMHCP to confirm final income allocations and control totals. We are working with all trusts across Cheshire and Merseyside to support a breakeven position.

Once again we have an ambitious capital plan of £19.6m for 2021/22 including:

- Completing the £5m ED Assessment Plaza
- Urology investigation unit
- Cardiac Catheterisation Suite
- Paediatric Outpatients
- Completing the MRI, ICU beds and Breast Service reconfiguration started in 2020/21

Total staff absence, including COVID-19 related-absence approximates 6% and remains the most challenging 'People' metric at the current time.

2.6 COVID-19 Vaccine Research

We opened our Halton Clinical Research Unit in March and our first study was started in April. This is a COVID-19 vaccine study on behalf of the French biotechnology company Valneva. We are one of two sites in the North West Coast (WHH and Blackpool). We have recruited just short of 140 participants so far (out of a target of 160) and are optimistic about being on target for completion. It is more difficult to recruit at this stage of the national COVID-19 vaccination programme roll out as lots of people are now being invited to be vaccinated anyway. However, what we have done so far is a phenomenal achievement and a reflection of the hard work of so many in getting this started. Our next study is already being planned and our Halton CRU has lots of potential for research from both our own staff and external partners across the North West Coast.

2.7 Our 'Black Boxes' fly to India

On 5th May a British Airways flight from London Heathrow took 38 of our famous black boxes/CPAP machines to India, where they will be used in the western state of Gujarat. A further 22 were sent to southern India. We have been working with charities and the Indian High Commission to do this, and I am grateful to many colleagues, especially Dr Saagar Patel and Suresh Arni Sukumaran for making it happen. These repurposed sleep apnea/CPAP machines were a 'game changer' for WHH in wave 1 of the pandemic. Since then we have been lucky enough to have lots of new equipment and we have not needed them, so it is absolutely right that we hand them over to our Indian colleagues to make very good use of them.

2.8 Experience of Care Week

We marked Experience of Care Week as an international initiative running from 26th April to 30th April. The week focused on celebrating great patient experience by putting a spotlight on good ideas and recognising the staff making changes for the better across health and social care. This week also celebrated a time for learning, thinking differently and taking stock of all the incredible work of the past 12 months.

This year's themes for learning are:

• Co-Production – by hearing the voice of people's experiences of using a service as a patient, carer, family member or the team who deliver care and turn this experience into action by working together to develop the service that meets the needs of all.

• Carers – unpaid carers play a vital role in providing physical and emotional support for patients; it is important that they experience great care so they can support their loved ones.

• Health Inequalities – are the preventable and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies. Health inequalities determine the risk of individuals getting ill, ability to prevent sickness or the opportunity to take action and access treatment when ill health occurs.

• Allied Health Professionals – who provide a vital role in providing patient care and contributing to the patient and families' experiences of care. COVID-19 witnessed a large percentage of AHPs redeployed into different roles across the Trust where "co-production" was at the heart of our patients care.

2.9 Warrington Guardian Lockdown Heroes Awards

The Warrington Guardian has honoured members of our whole community who went above and beyond over the past 12 months. The awards were held on 30th April in association with Warrington Borough Council and WHH – in recognition of the support and efforts of our amazing local community for our hospitals during the pandemic. The virtual event was hosted by TV medic Dr Hilary Jones and celebrated NHS staff, shop workers, volunteers and young people.

Congratulations go to all who took part, collectively summing up the spirit of 2020 and how our whole community has come together. There was a lovely (genuine) surprise for me at the end too for which I am extremely grateful and honoured.

NHS Hero:	Winner - Mel Thompson, Ward Manager A7 Highly Commended - Lee Caiger, Paediatrics Commended - Allen Hornby, ICU lead nurse Commended - Olivia King, Midwife
Team of the Year:	Winner - Intensive Care Unit; Highly Commended - Specialist Palliative Care Unit
Community Champions:	Winner: Sikh Community (for all those thousands and thousands of meals they cooked for us)

2.10 Special Days/Weeks for professional groups

Since our last Board meeting in March, 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:

Stress Awareness Month – April 2021
Experience of Care Week – 26th to 30th April 2021
Deaf Awareness Week – 3rd to 9th May 2021
International Day of the Midwife – 5th May 2021
Mental Health Awareness Week – 10th to 16th May 2021
International Nurses Day – 12th May 2021
Operating Department Practictioner Day – 14th May 2021

2.11 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 dialogue with all four of our local Westminster MPs – Derek Twigg MP (Halton), Mike Amesbury MP (Weaver Vale), Charlotte Nichols MP (Warrington North) and Andy Carter MP (Warrington South). I have been updating them on the WHH situation; similarly they have asked questions on behalf of their constituents. All of our senior stakeholders are active participants and members of our New Hospitals Strategic Oversight Group.

2.12 Employee Recognition

During the COVID-19 pandemic the WHH employee recognition scheme (*Employee of the Month and Team of the Month)* has been temporarily suspended. There is a small backlog of 20 nominations for the last year which we will address. A brand new scheme - *You Made a Difference* - will be launched in June 2021.

Chief Executive Award (May 2021): Dr Diane Matthew

Dr Diane Matthew is our Chief Pharmacist and has been recognised for her exceptional professional pharmacy leadership throughout the whole pandemic, most recently with respect to the COVID-19 vaccination programme. The latter has required her high standards and absolute attention to detail.

Chief Executive Award (May 2021): Lesley Mills

Lesley Mills is our Consulant Nurse in Diabetes. She has played a key role in bringing the diabetes community across the country together throughout the pandemic and raising standards of care. More recently, she has been an important clinical leader within the COVID-19 vaccination programme.

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

I have also specifically recognised the work of the following members of staff:

- Judith Burgess, Associate Chief Nurse - Unplanned Care
- Judith Collier, Sister, ACCU
- Dr Chew Tan, Consultant Physician - Digestive Diseases
- Lucy Gardner, Director of Strategy & Partnerships
- Sharon Kilkenny, Associate Director of Operations
- Sue Sergison, Midwife
- Dr Colin Wong, Consultant Paediatrician - Women's & Children's Health
- Debby Gould, Professional Midwifery Advisor -Women's & Children's Health
- Deborah Carter, Project Director - Women's & Children's Health
- Angela Myklestad, Orthotist
- Emily Spicer, Student Nurse – Ward A5
- Annette Jeffrey, Ward Clerk - CSTMB
- Marcia Harris, Housekeeper – CSTMB
- Dr Mithun Murthy, Consultant Physician – Ward A7
- Mel Thompson, Ward Manager - Ward A7
- Ellen Quinn, Ward Manager - Ward B19
- Kath Norman, Staff Nurse - Ward AMU/A1
- Emily Mills, Staff Nurse - Ward ACCU/A3

2.13 Signed under Seal

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

- Intermediate building contract for the Breast Unit at Halton

3 MEETINGS ATTENDED/ATTENDING

The following is a summary of key external stakeholder meetings I have attended in April 2021 and May 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 (Quarterly)
- NHSE/I COVID-19 System Leadership (Biweekly)
- C&M CEO Provider Group Calls (Weekly)
- C&M Medical Directors Clinical Prioritisation & Mutual Aid meeting (Weekly)
- NHS 111 Oversight Group (Bimonthly)
- Update calls with our local MPs: Andy Carter MP, Charlotte Nichols MP, Derek Twigg MP, Mike Amesbury MP
- Steve Broomhead, Chief Executive, Warrington Borough Council
- David Parr, Chief Executive, Halton Borough Council
- Dr Andy Davies, Clinical Chief Officer, NHS Warrington and Halton CCG
- Colin Scales, Chief Executive, Bridgewater Community Health NHSFT

- C&M Hospital Cell (Weekly)
- C&M Gold Command (Twice weekly)

4) RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Report to the Board of Directors

AGENDA REFERENCE:	**BM/21/05/67**		
SUBJECT:	**COVID-19 Performance Summary and Situation Report**		
DATE OF MEETING:	26th May 2021		
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance		
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive		
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first 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)***	#1135 Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision. #1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #115 Failure to provide adequate staffing levels in some specialities and wards. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #1126 Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.		
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily COVID-19 Executive Summary which outlines key information pertinent to the command and control of the situation. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where possible. This is the 12th iteration of this report which is part of the continuing development and understanding of demand, capacity and outcomes that will determine future strategic planning. Data up to 22nd May 2021 is included.		
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS

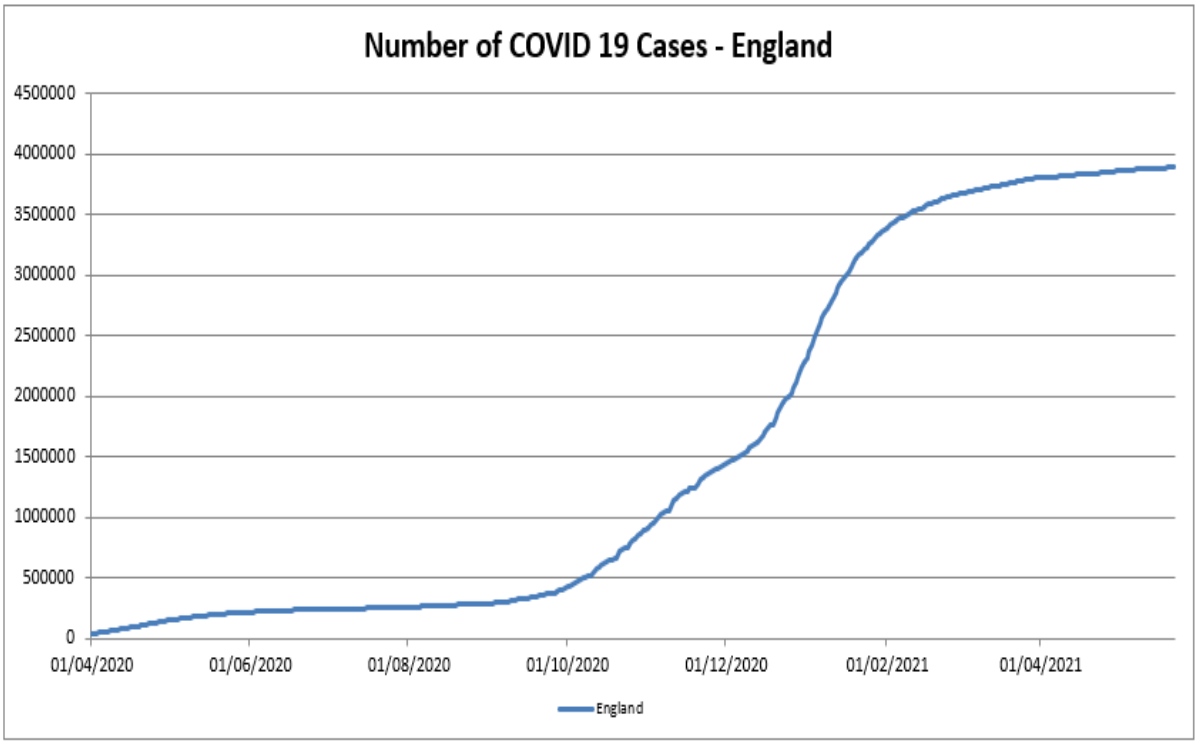
SUBJECT	COVID-19 Performance Summary and Situation Report	AGENDA REF:	BM/21/05/67

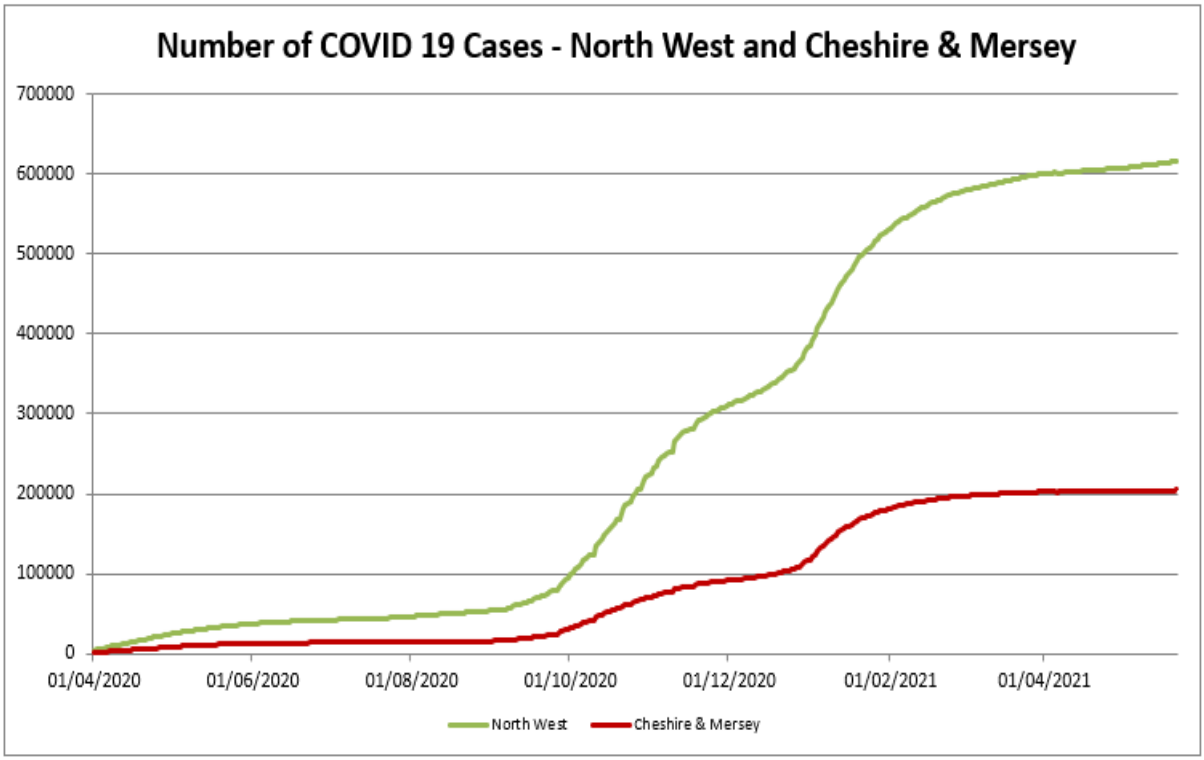
1. BACKGROUND/CONTEXT

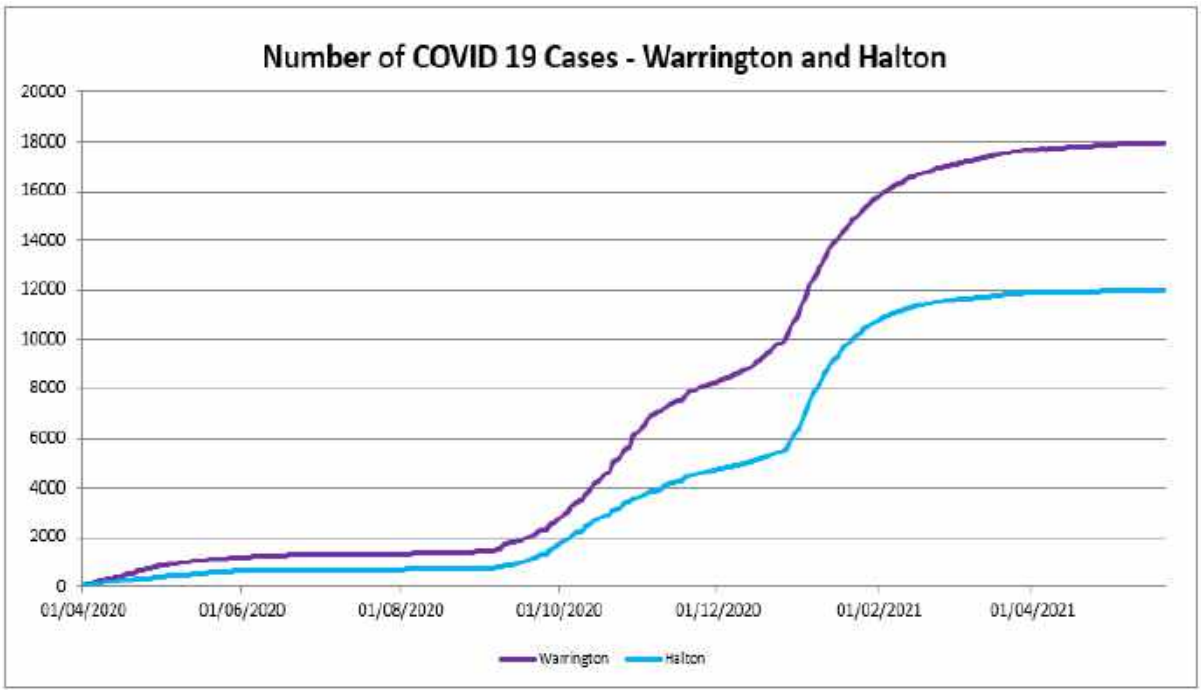
The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily COVID-19 Executive Summary which outlines key information pertinent to the command and control of the situation. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where possible. This is the 12th iteration of this report which is part of the continuing development and understanding of demand, capacity and outcomes that will determine future strategic planning. Data up to 22nd May 2021 is included.

2. KEY ELEMENTS

2.1 Number of Reported Cases

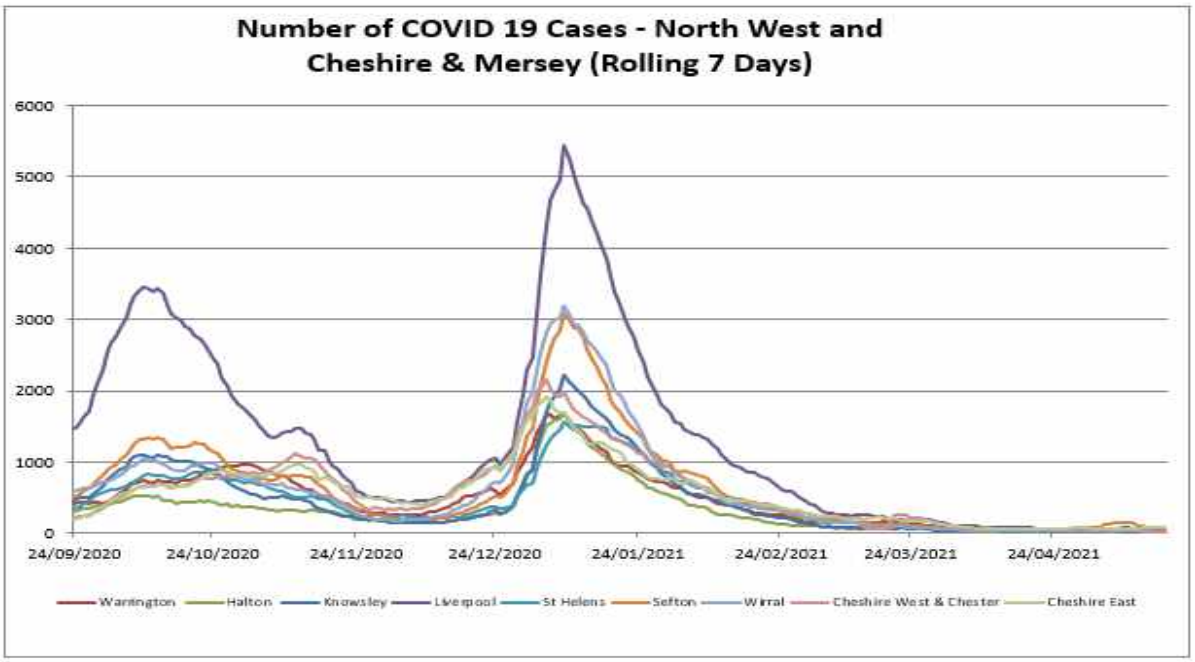


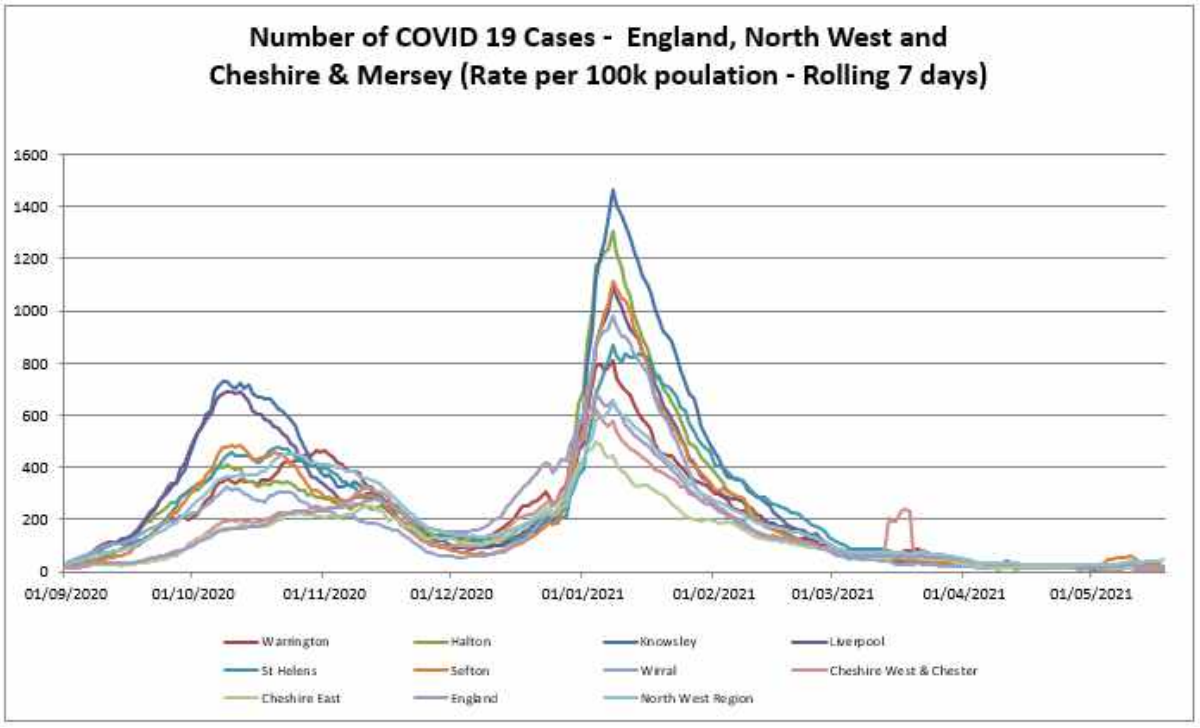




Narrative: As of 22/05/2021, there were 17,939 cases (from 17,834 on 24/04/2021) of confirmed COVID-19 reported in Warrington and 12,003 (from 11,933 on 24/04/2021) cases reported in Halton. The Trend is in line with the England, Cheshire & Mersey and the North West positions.
Source: https://coronavirus.data.gov.uk/

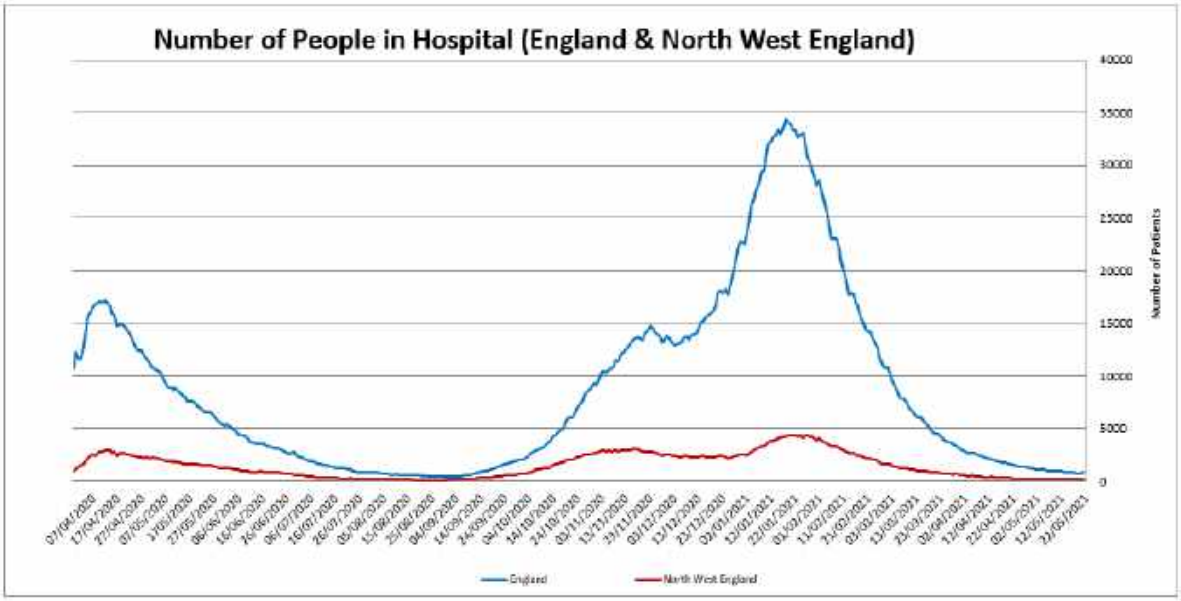
2.2 Infection Rates in the Community (per 100k population – Rolling 7 days)

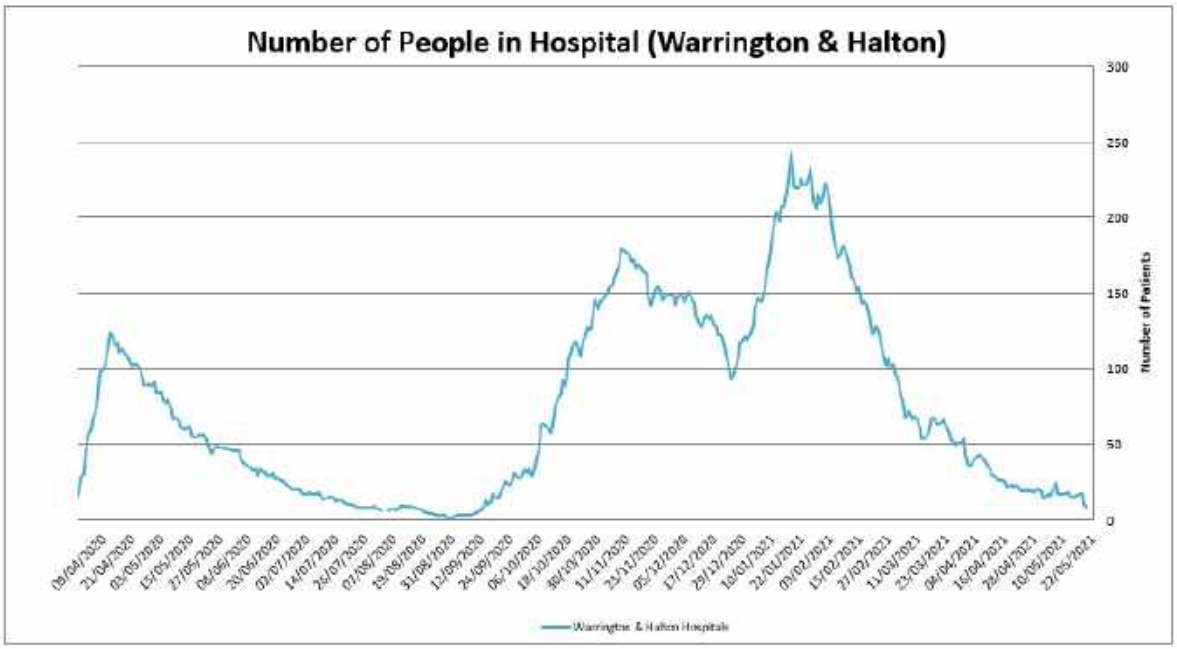




Narrative: The graphs show the infection count and rates per 100k population over a rolling 7 day period. This is a fairer comparison than total number of cases due to the different populations. The data continues to show a significant declined in the number of infections since the peak on 08/01/2021. As at 18/05/2021 (the latest data period for this indicator) Warrington had 8.6 cases per 100k population and Halton had 10.8 cases per 100k population which is lower than the North West position (44.8 cases/100k population) and the England position (21.3 cases/100k population).
Source: https://coronavirus.data.gov.uk/

2.3 Number of People in Hospital

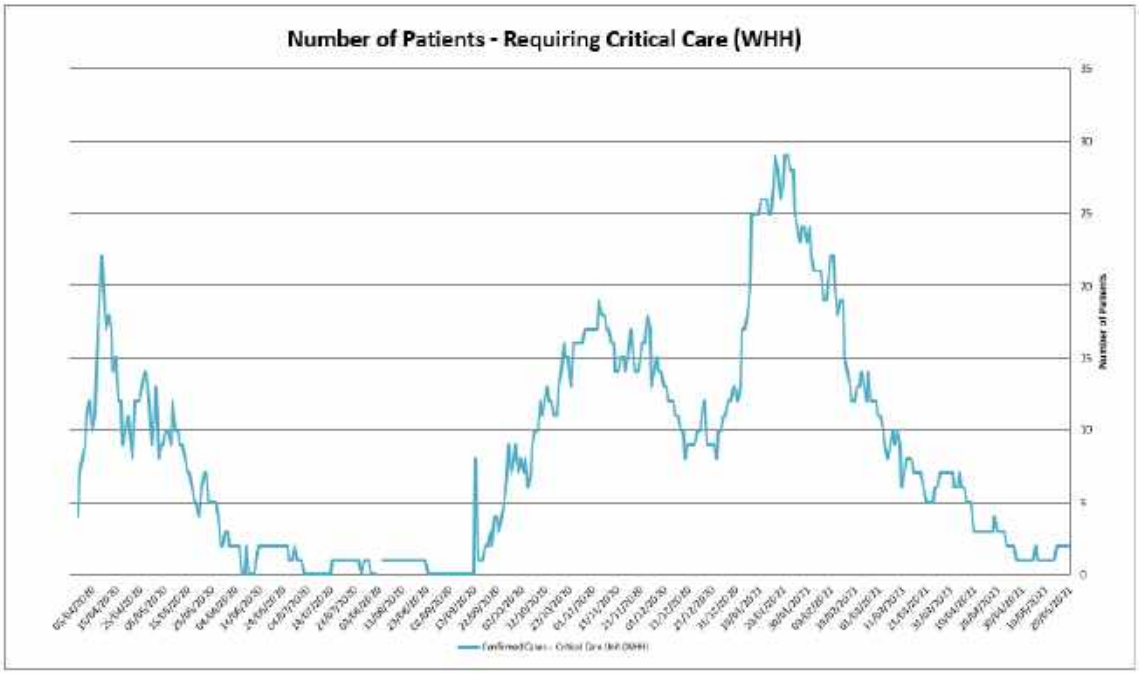




Narrative: As 22/05/2021, there were 7 inpatients being treated by the Trust with confirmed COVID-19 (from 19 on 24/04/2021). The peak of the 3rd wave was on 18/01/2021 with 243 inpatients receiving treatment, this was followed by a period of small peaks and waves. The number of inpatients has continued to decline since early February.

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

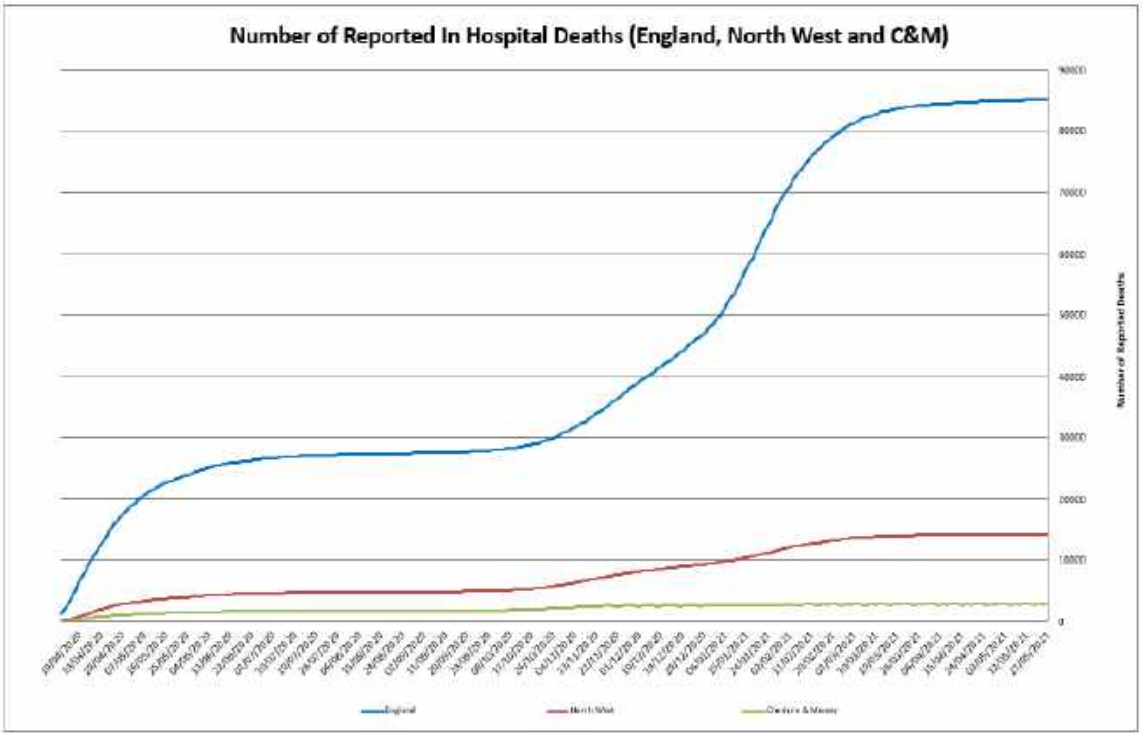
2.4 Number of Patients Requiring Critical Care

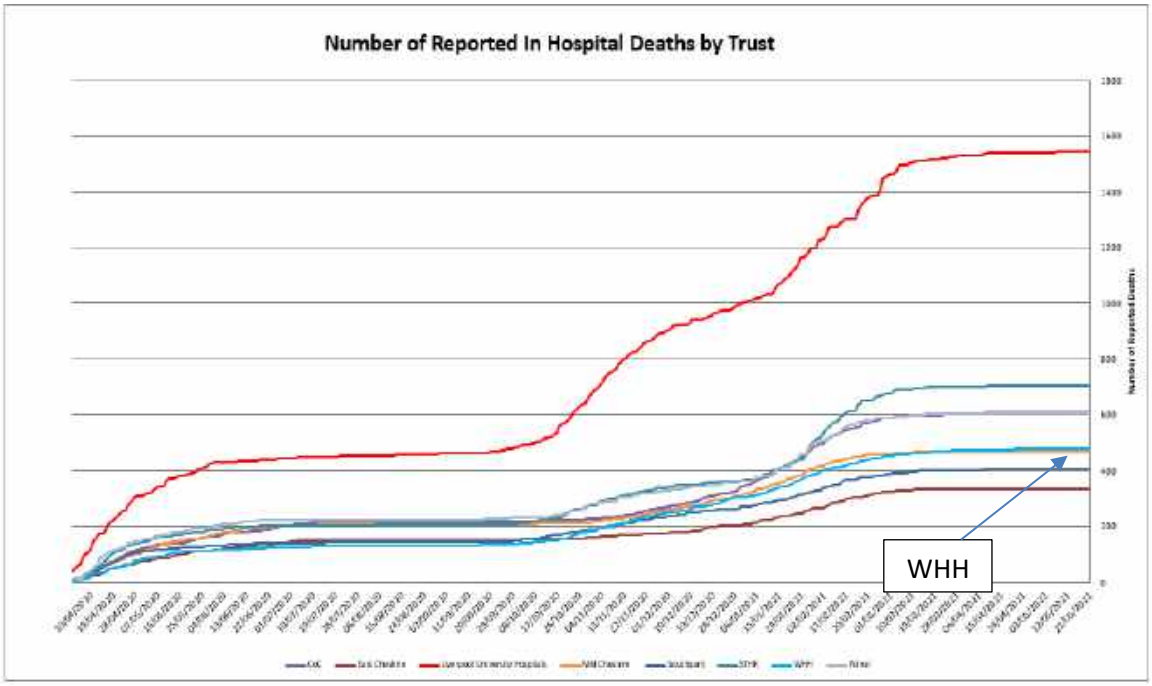


Narrative: As of 22/05/2021, there was 1 inpatient with confirmed COVID-19 (from 2 confirmed cases 24/04/2021). The peak of the 3rd Wave came on 22/01/2021 with 29 patients in critical care.

Source: Trust Data (Warrington & Halton).

2.5.1 Number of In-Hospital Deaths





Narrative: As of 22/05/2021, the Trust had reported 497 deaths of inpatients with confirmed COVID-19 (from 496 on 24/04/2021). The trend is in line with the North West and Cheshire & Mersey positions.

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

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

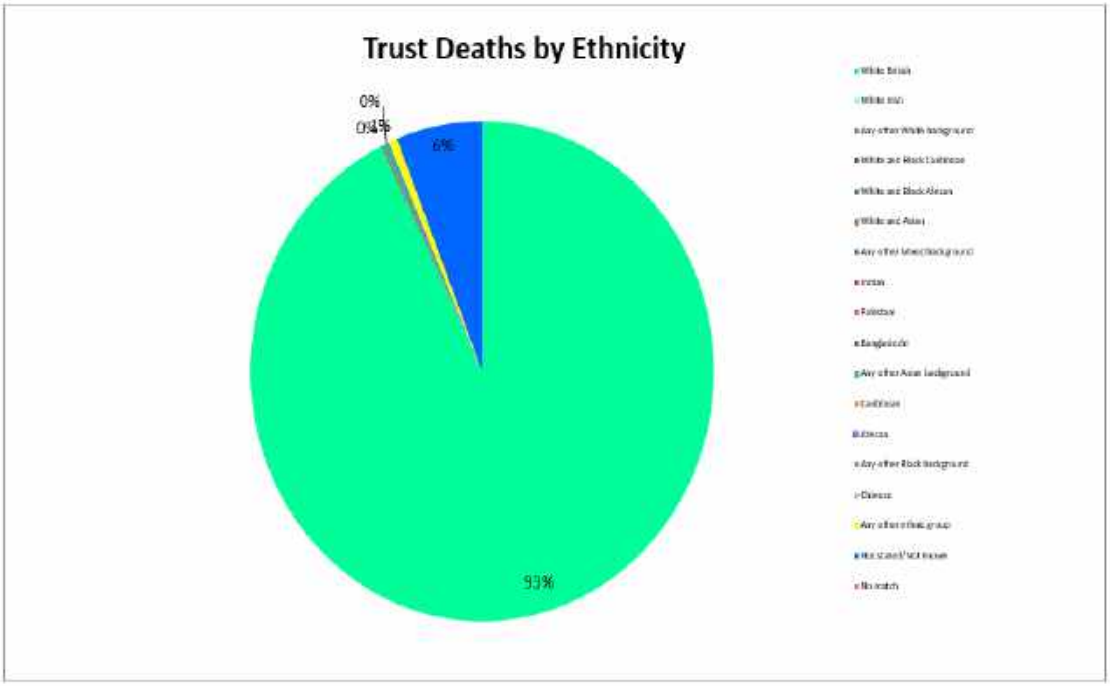
2.5.2 Crude Mortality

	2020	2021
April (All Deaths)	144	64
April (Non COVID)	61	55
April (COVID)	83	9
% COVID Deaths (of all deaths)	57.60%	14.10%
Discharges	2916	4858
Crude Mortality (deaths divided by deaths+discharges)	4.9%	1.3%

	Wave 1 Apr-Aug 2020	Wave 2 Sept-Dec 2020	Wave 3 Jan 2021 -Present
All Deaths	405	402	434
Non-COVID	272	228	248
COVID	133	174	186
% COVID Deaths (of all deaths)	32.8%	43.3%	42.9%
Discharges	19326	17240	20527
Crude Mortality (deaths divided by deaths+discharges)	2.1%	2.3%	2.1%
Crude Mortality COVID-19 (COVID-19 deaths divided by COVID-19 deaths+ COVID-19 discharges)	25.2%	20.2%	16.8%

Narrative: Crude mortality in April 2021 was 1.3% compared with 4.9% in April 2020. Crude mortality was 2.1% in wave 1 and 2.3% in wave 2 and 2.1% in wave 3 (to date) with Crude mortality for COVID-19 patients 25.2% in wave 1, 20.2% in wave 2 and 16.8% in wave 3 (to date).
Source: Trust Data.

2.5.3 Number of In Hospital Deaths (Ethnicity)



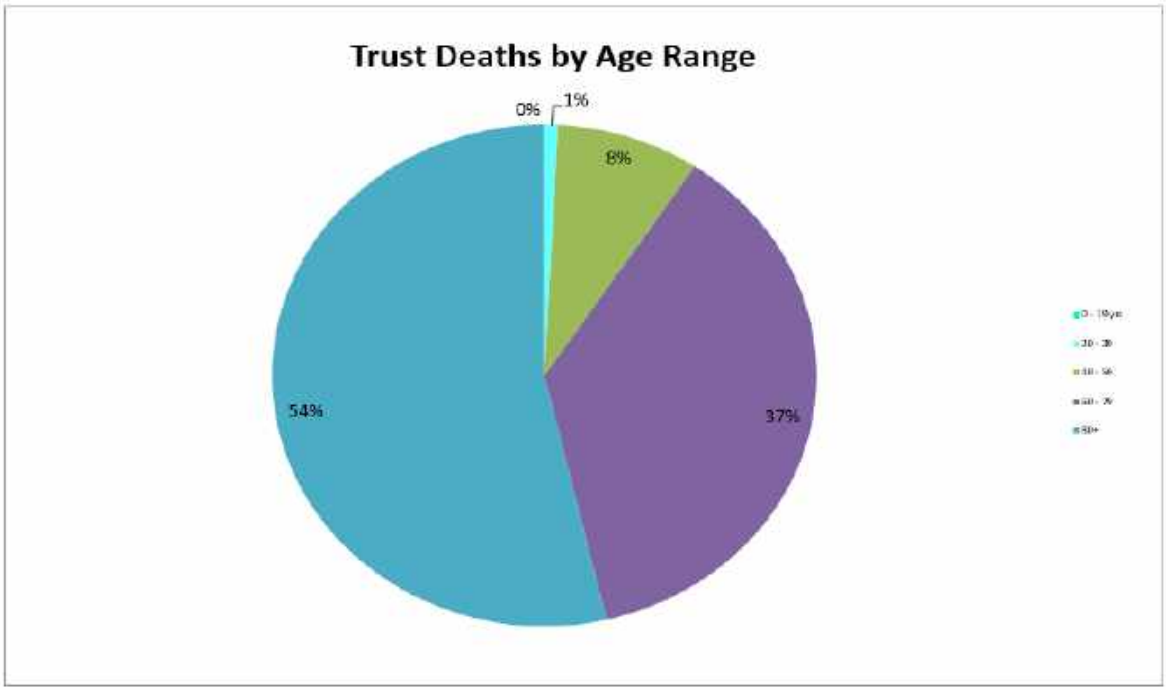
Narrative: As of 22/05/2021, 93% of reported deaths were patients who identified as “White British”, with 6% patients’ ethnicity “Not Stated/Not Known”, <1% patients’ ethnicity stated as “Any Other Ethnic Group”, <1% patients stated as “Asian” or “Asian British” and <1% patient identified as “White Any Other Background”. The proportion of White British patient deaths is greater than

the national position, however this is as expected when comparing the population of Warrington (96.00% White British) & Halton (98.00% White British).

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

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

2.5.4 Number of In Hospital Deaths (Age Range)

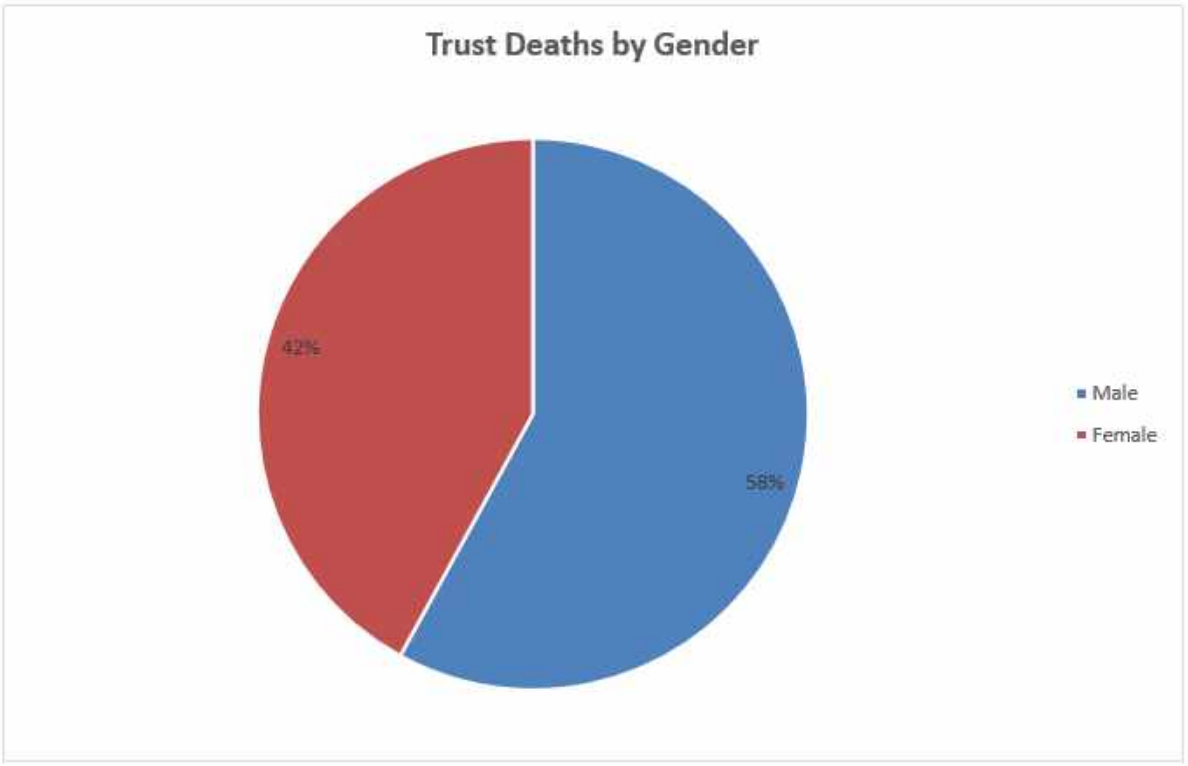


Narrative: As at 22/05/2021, 91.0% of COVID-19 related deaths were inpatients over the age of 60, which is line with the national position. The average age of death was 78 years.

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

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

2.5.5 Number of In Hospital Deaths (Gender)

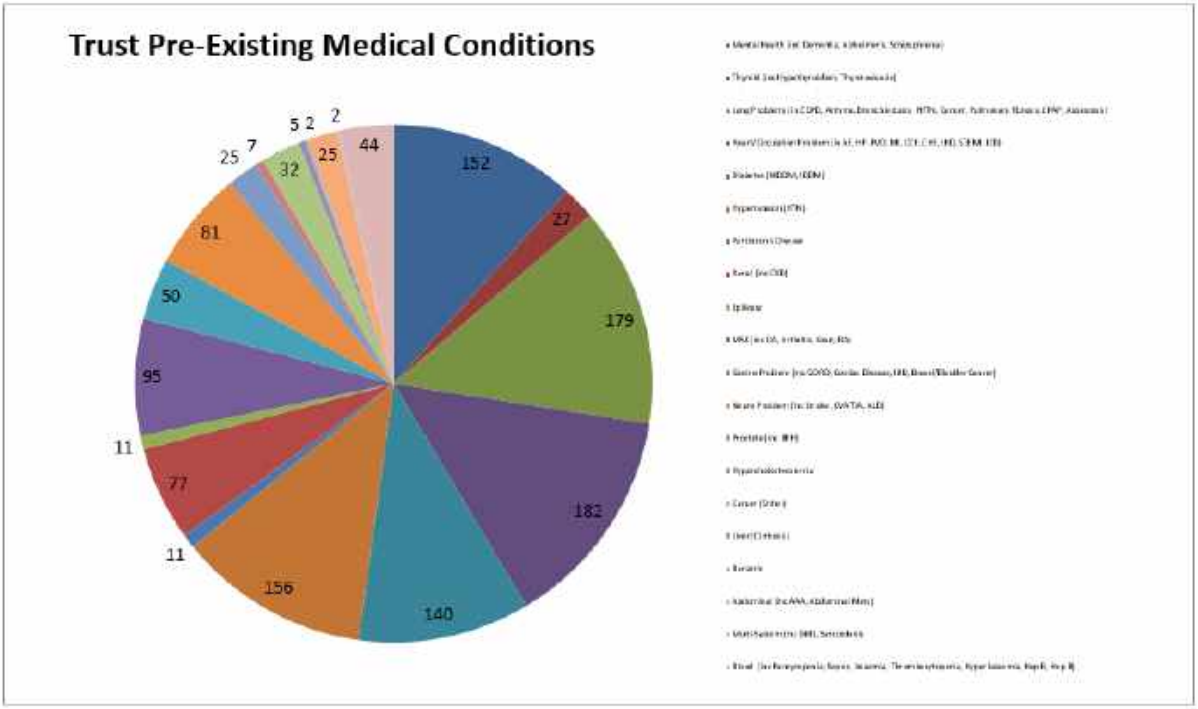


Narrative: As at 22/05/2021, 58% of COVID-19 deaths were male patients and 42% of deaths were female patients.

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

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

2.5.6 In Hospital Deaths - Pre-Existing Medical Conditions



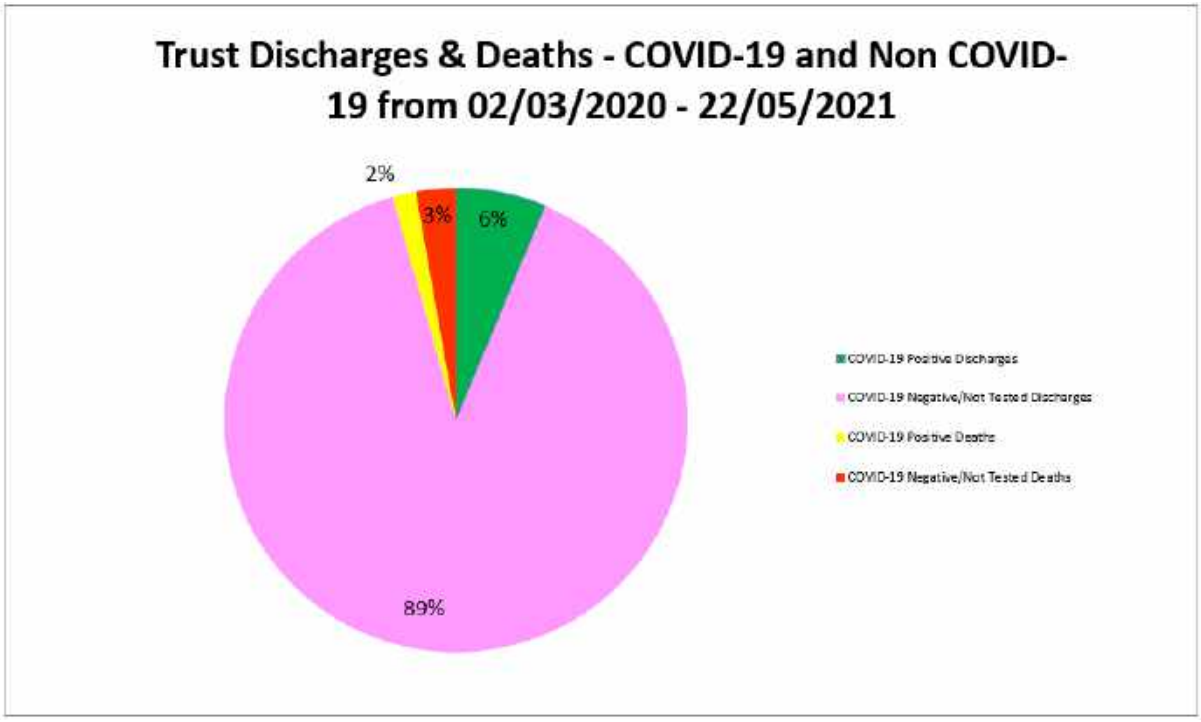
Narrative: As at 22/05/2021, 88% of Trust inpatients who have died as a result of COVID-19 had a pre-existing medical condition recorded. The most common of these were Heart and Lung conditions in additional diabetes and organic mental health conditions such as Dementia and Alzheimer's.

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

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

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

2.6 Trust Outcomes

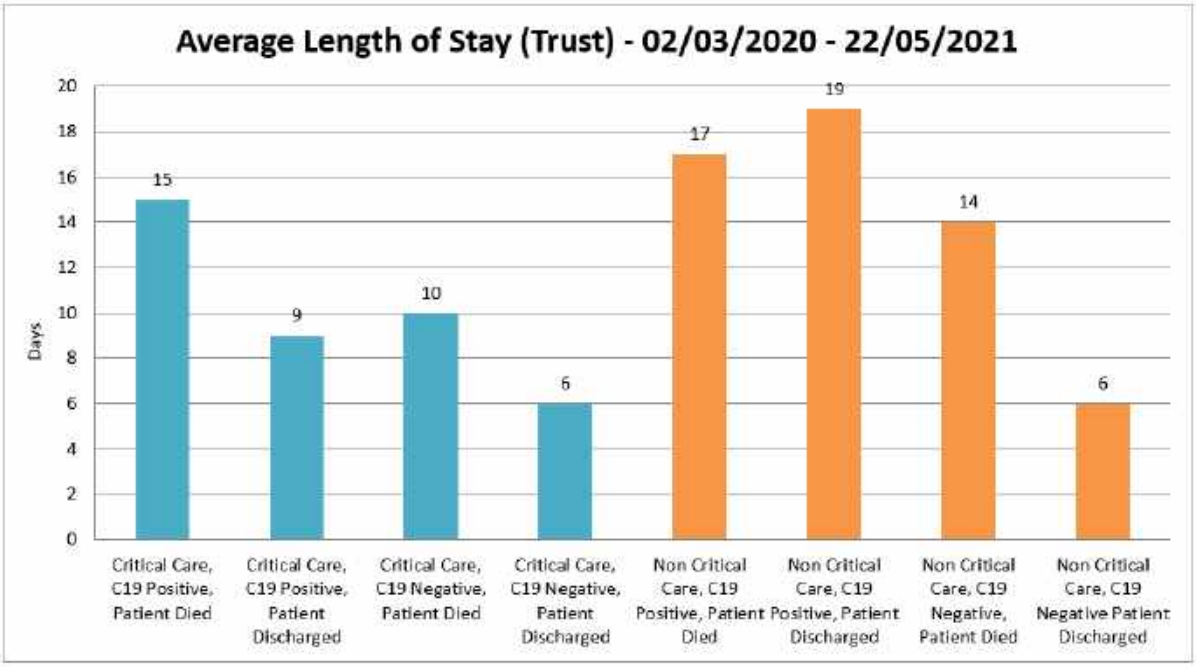


Narrative:

- Between 02/03/2020 – 22/05/2021, the Trust treated 30,019 inpatients (any patient with at least 1-night stay).
- 2,384 (7.94%) inpatients had tested positive for COVID-19.
- 95.58% of all patients were discharged from hospital (COVID-19 and Non COVID-19).
- There was a total of 1,326 inpatients (all causes) who have died; this represents 4.41% of all inpatients.
- 497 inpatient deaths were related to COVID-19 which represented 1.65% of all inpatients.
- 93 patients who have died and who had tested positive for COVID-19 were admitted from a care home, 3.90% of all COVID-19 positive inpatients.

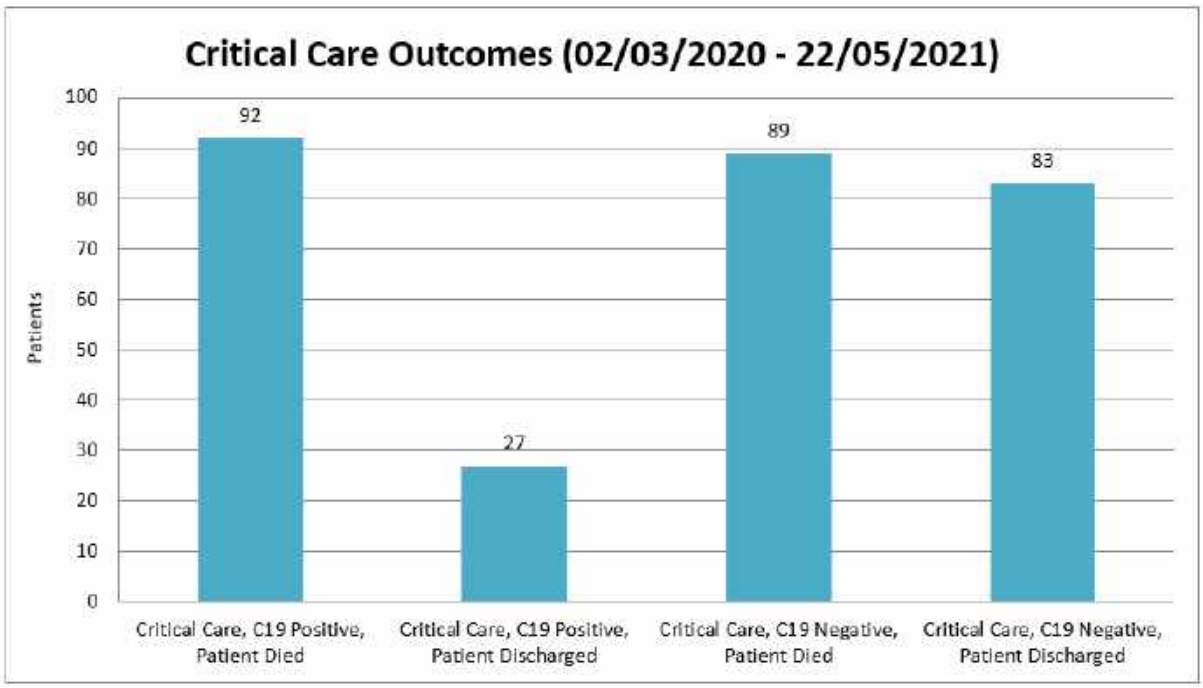
Source: Trust Data

2.6.1 Average Length of Stay



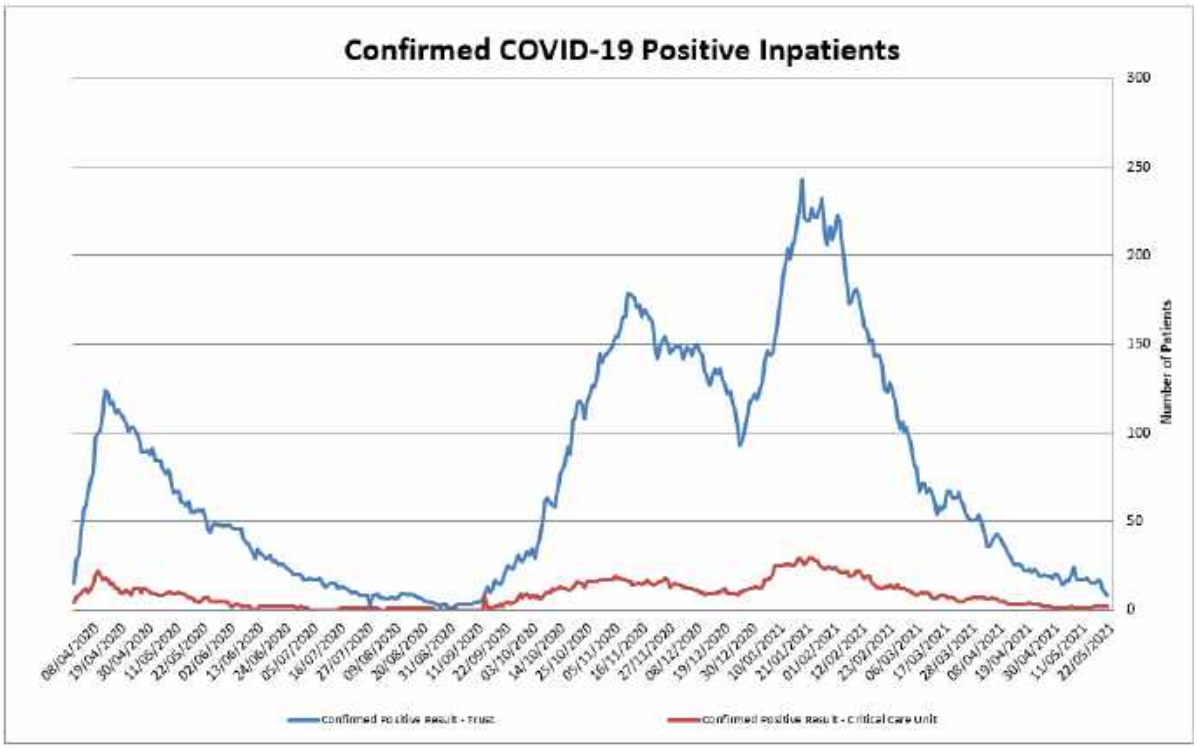
Narrative: From 02/03/2020 – 22/05/2021, the average length of stay for patients who had tested positive for COVID-19 was 13 days in critical care and 19 days in non-critical care.
Source: Trust Data

2.6.2 Critical Care Outcomes



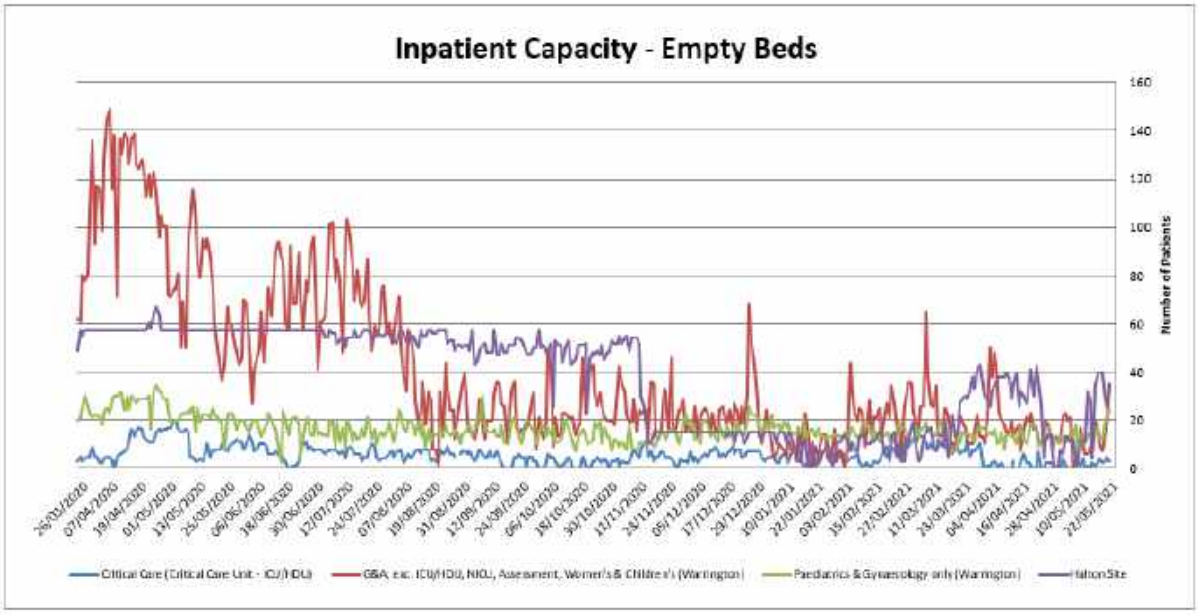
Narrative: From 02/03/2020 – 22/05/2021, there were 181 critical care inpatient deaths (92 COVID-19, 89 Non-COVID-19) and 110 critical care inpatient discharges (27 COVID-19, 83 Non-COVID-19).
Source: Trust Data

2.7 Confirmed Positive COVID-19 Patients



Narrative: As of 22/05/2021, there were 7 patients who have had a COVID-19 positive test at some point during their admission with 1 patient in critical care.

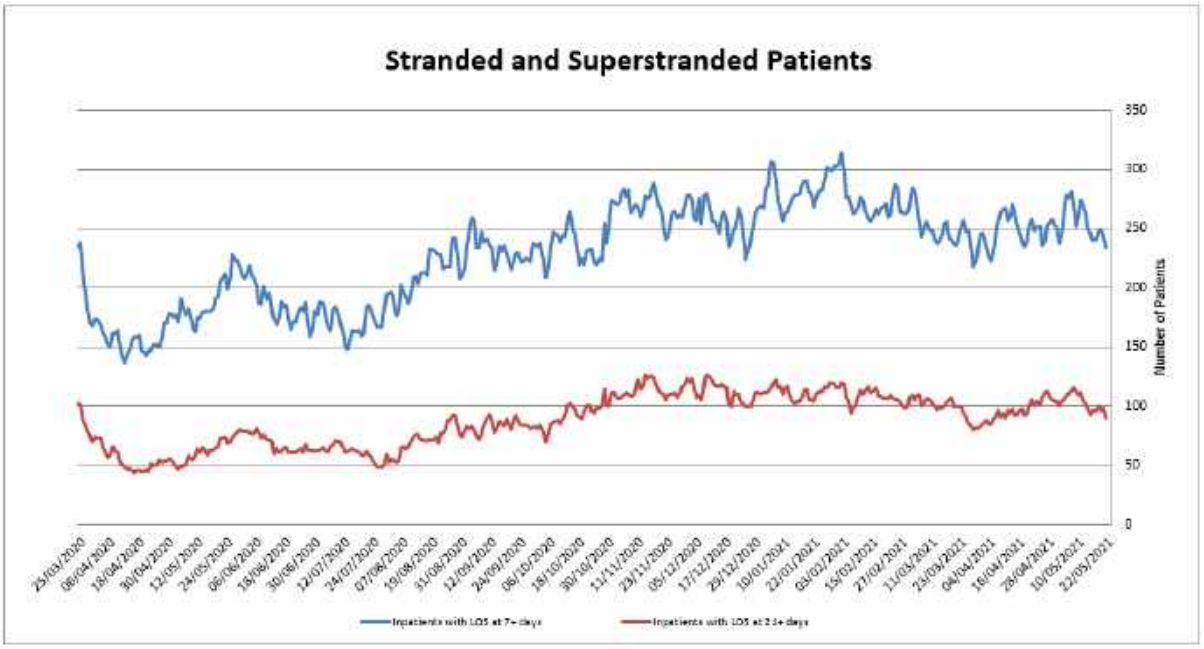
2.8 Capacity/Empty Beds



Narrative: There has been 8 days since the last report on 24/04/2021 where there has been no critical care beds available.

Source: Trust Data

2.9 Stranded/Super Stranded Patients

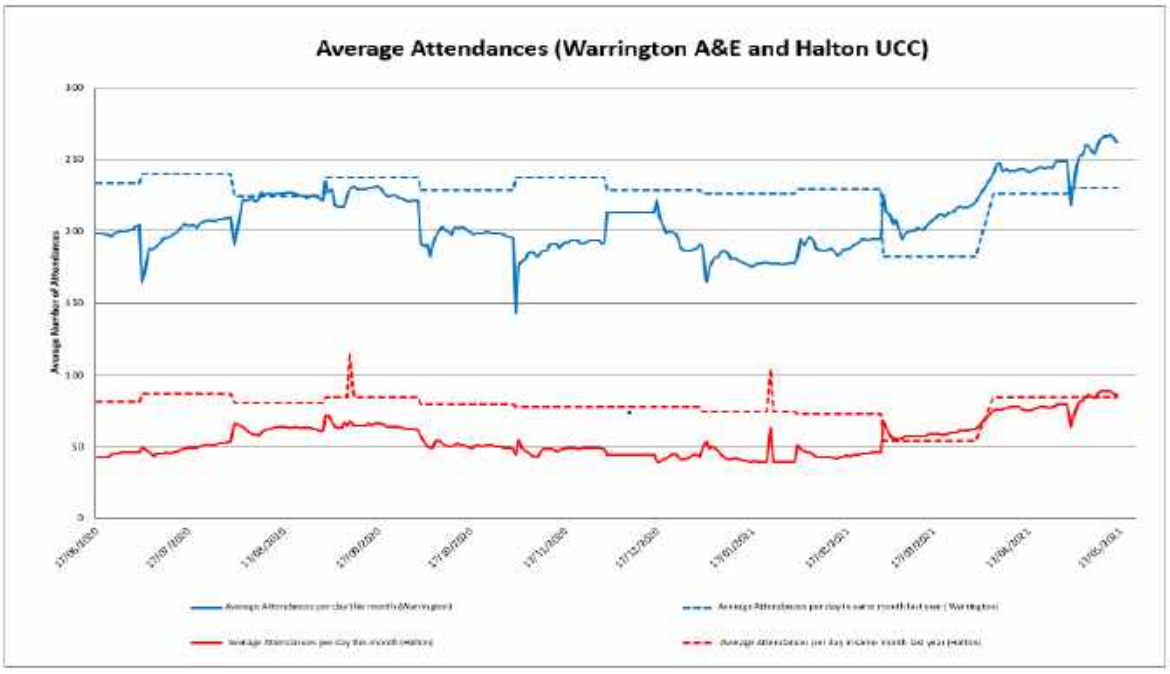


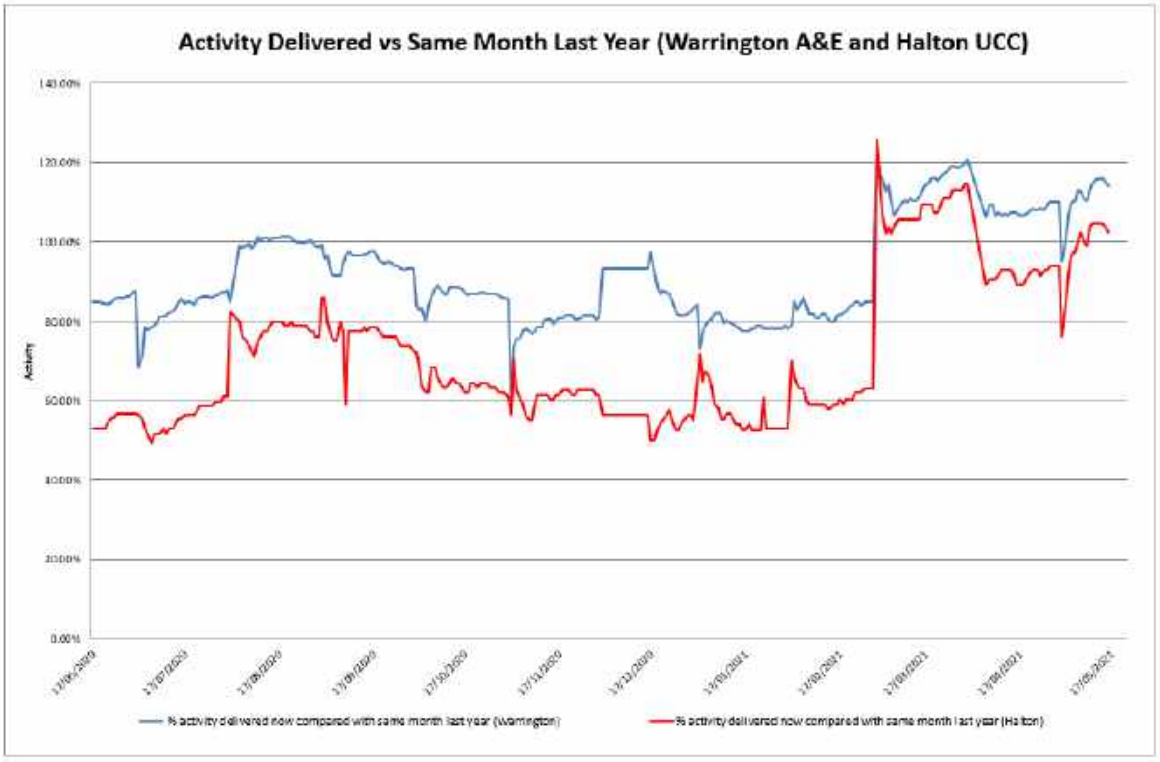
Narrative: On 22/05/2021, there were 216 Stranded and 85 Super Stranded patients in the hospital.
Source: Trust Data

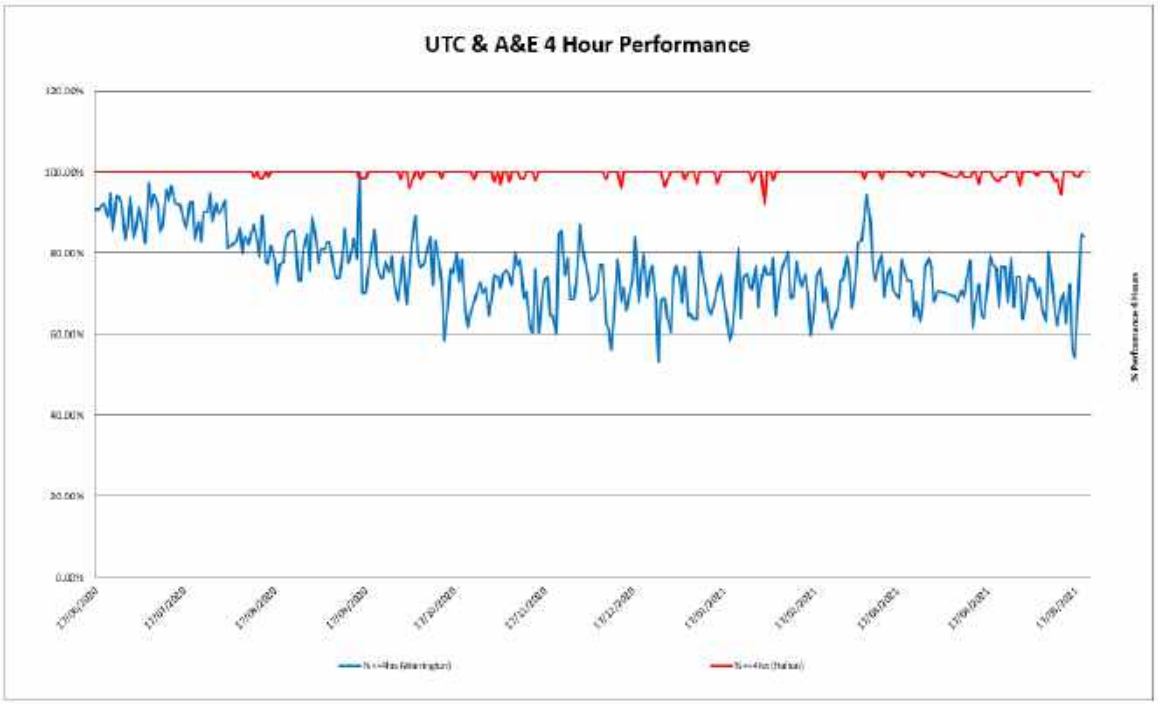
2.10 Staff Sickness

Narrative: Data was unavailable in month.

2.11 Urgent Care



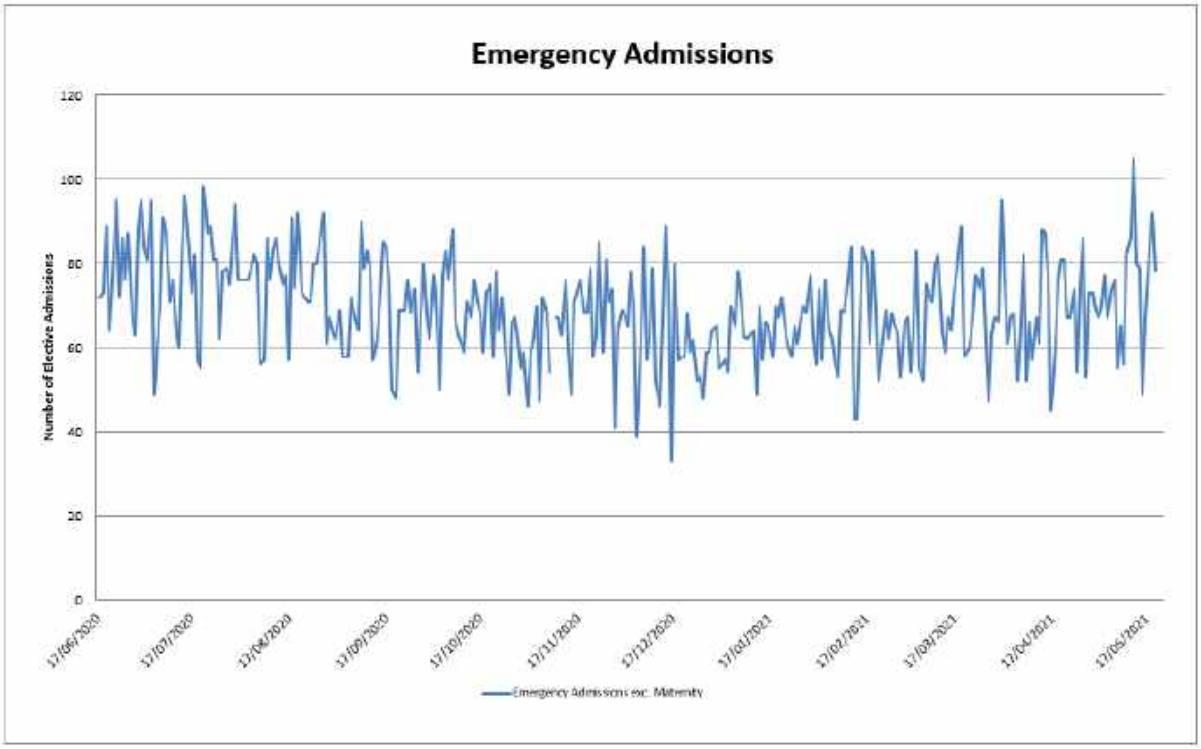




Narrative: Activity in April 2021 in Warrington A&E has averaged 121% of activity in April 2019. Activity in April 2021 at the Halton UTC has averaged 129% of activity in April 2019.

Source: Trust Data

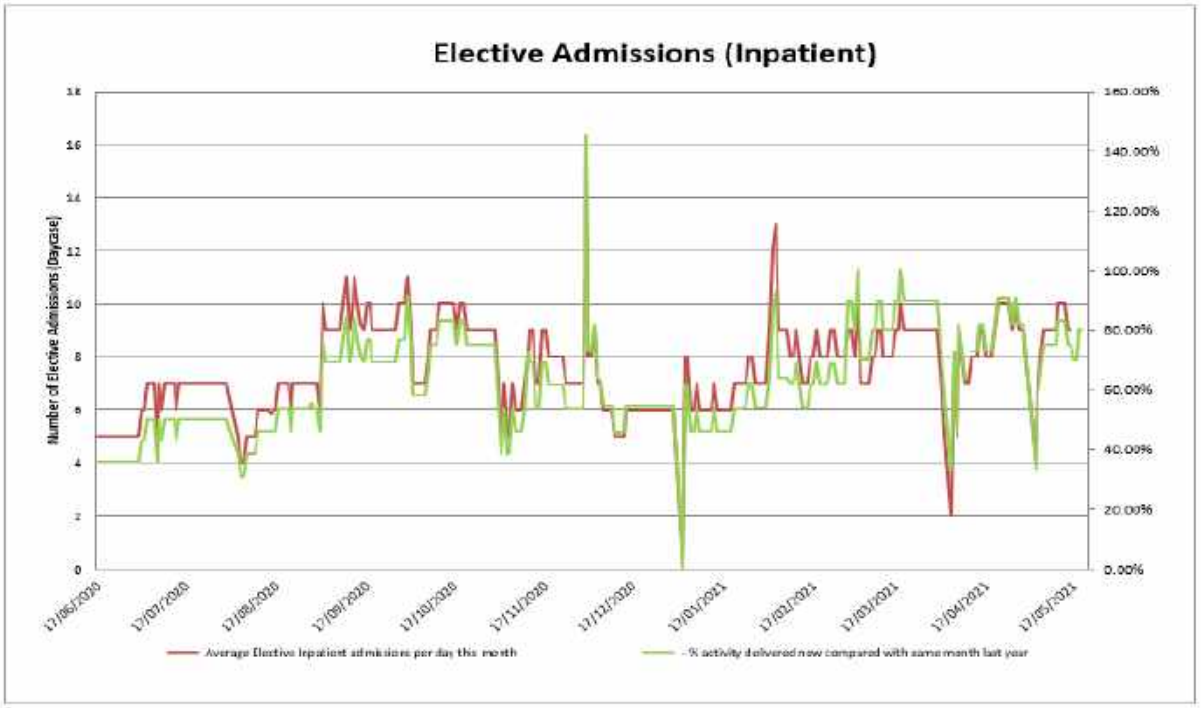
2.12 Emergency Admissions

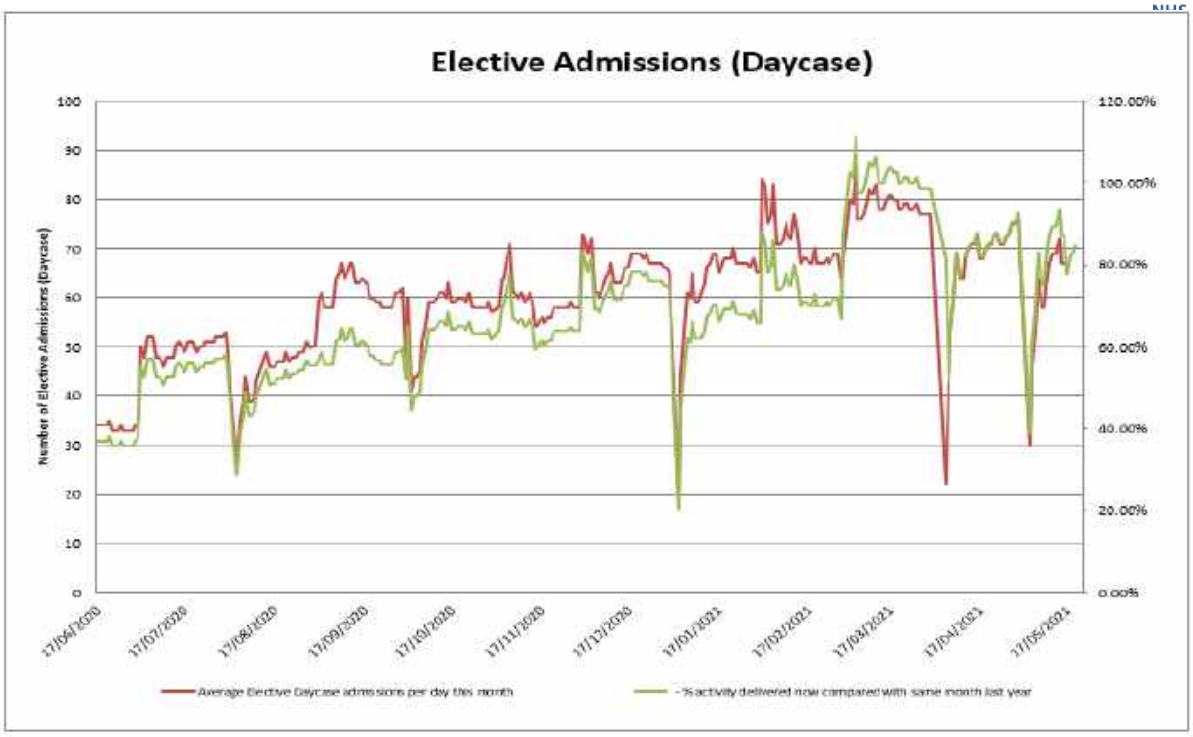


Narrative: The average number of emergency admissions in April 2021 was 80.14% of the average number of emergency admissions in April 2019.

Source: Trust Data

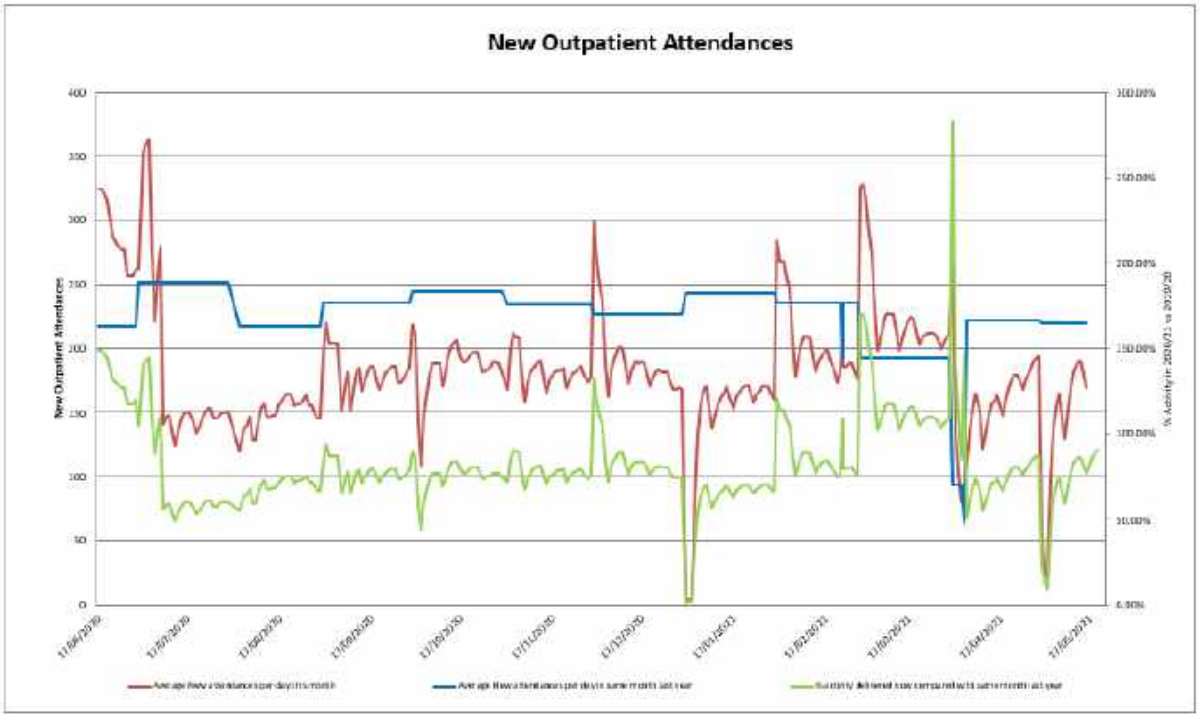
2.13 Elective Admissions

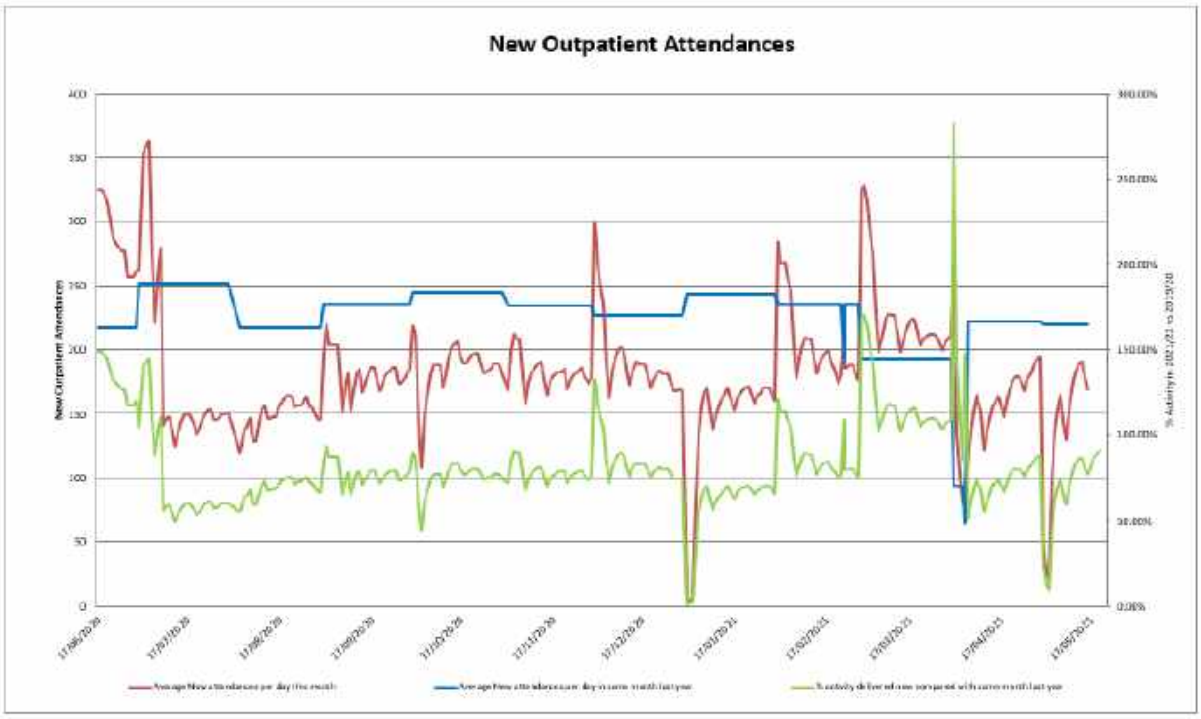


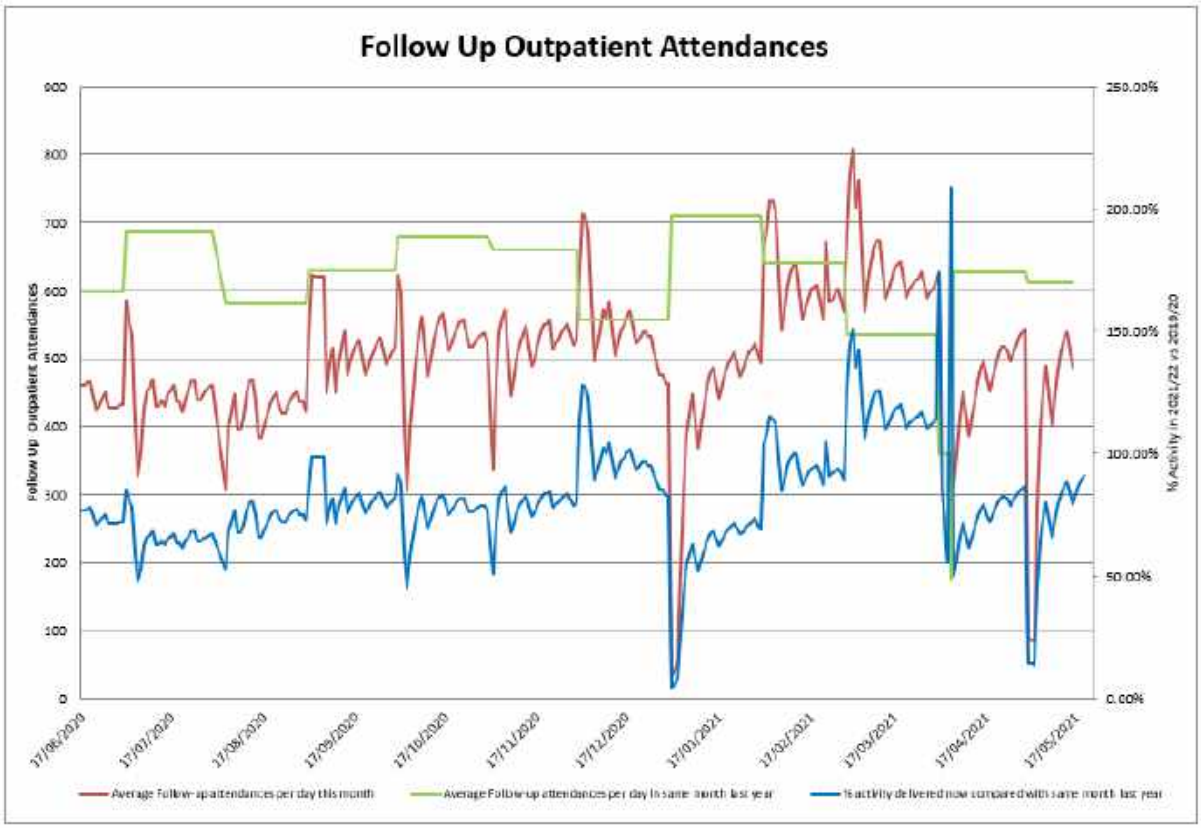


Narrative: The average number of elective inpatient admissions in April 2021 was 77% of the average number of elective inpatient admissions in April 2019.
The average number of elective daycase admissions in April 2021 was 83% of the average number of elective daycase admissions in April 2019.
Source: Trust Data

2.14 Outpatient Attendances







Narrative: The average number of new outpatient attendances in April 2021 was 86% of the average number of new outpatient attendances in April 2019.

The average number of follow up outpatient attendances in April 2021 was 82% of the average number of follow up outpatient attendances in April 2019.

Source: Trust Data

2.15 Nosocomial Infection

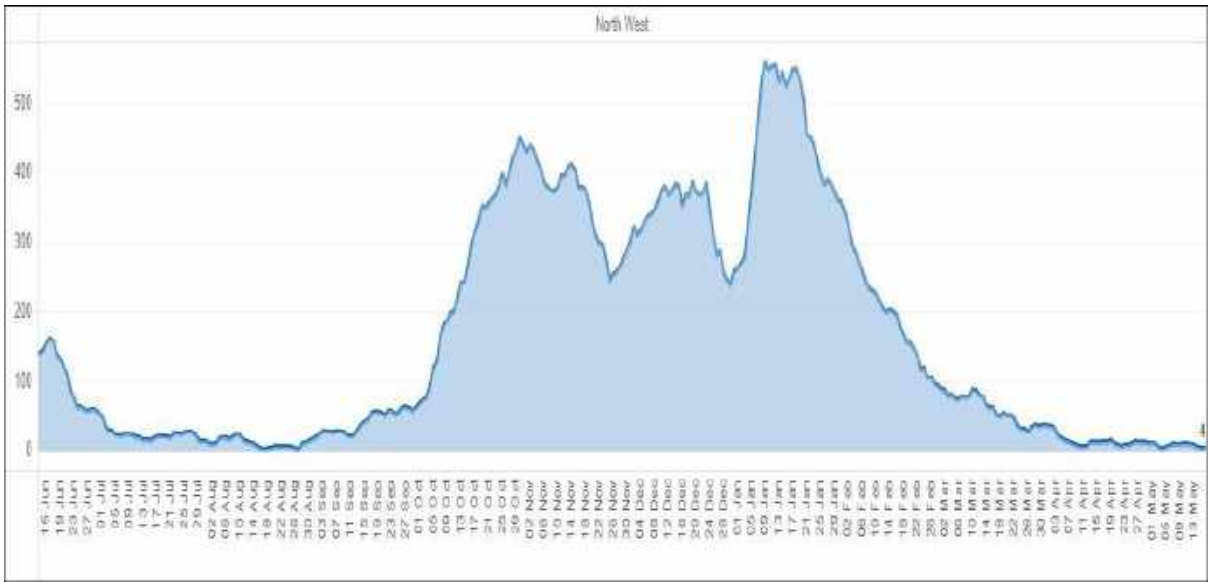
Nosocomial infections are defined as:

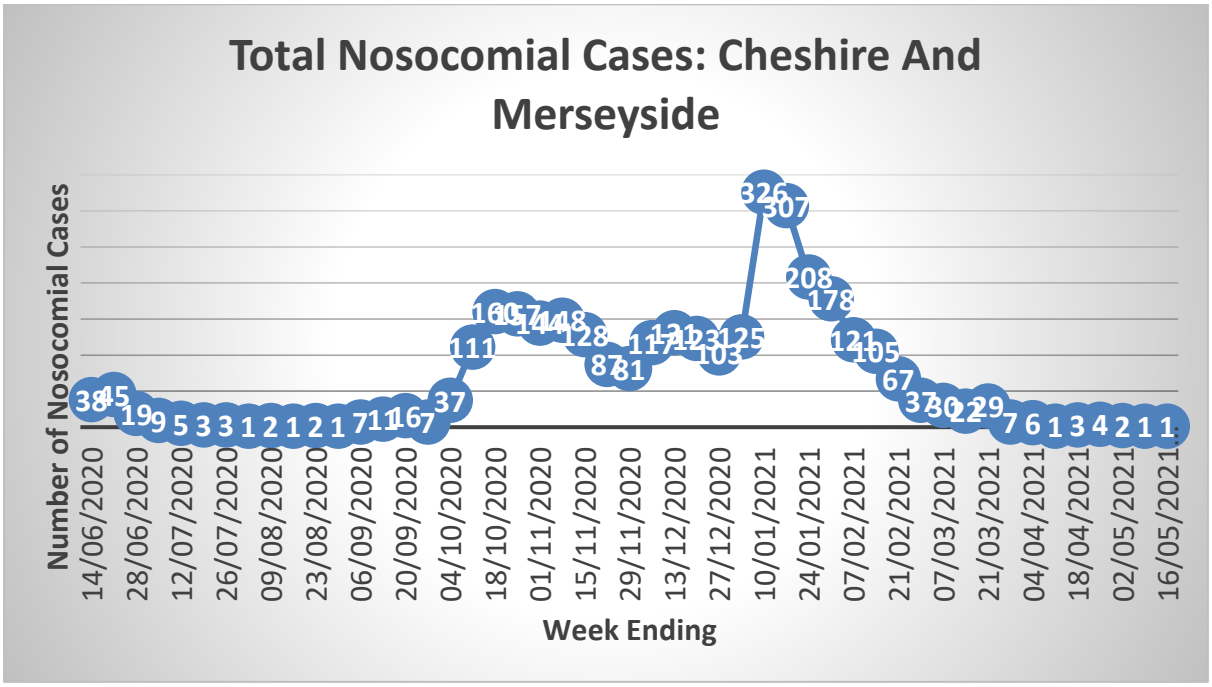
- Length of Stay at the Time of Positive COVID Sample 0-2 Days – Community Acquired
- Length of Stay at the Time of Positive COVID Sample 3-7 Days – Hospital Onset Indeterminable Hospital Associated
- Length of Stay at the Time of Positive COVID Sample 8-14 Days – Hospital Onset Probable Hospital Acquired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

Cheshire & Mersey Benchmarking for Cumulative Nosocomial Infection Rates w/e 16th May 2021

Cumulative Total Since Recording started until latest data available	Sum of Total Nosocomial Cases	Sum of Total Number of Covid Inpatients	Cumulative % Rate
Cheshire And Merseyside STP	**3302**	**22341**	**14.78%**
Countess of Chester Hospitals	381	2200	**17.31%**
Warrington & Halton Hospitals	355	2355	**15.07%**
Liverpool University Hospitals	878	6523	**13.46%**
Southport And Ormskirk	270	1843	**14.65%**
Mid Cheshire Hospitals	343	2095	**16.37%**
Wirral University Hospitals	304	2143	**14.18%**
East Cheshire Hospital	200	1338	**14.97%**
St Helens And Knowsley Teaching Hospitals	190	2640	**7.19%**

Narrative: The Trust is performing in line with peer Trust and in line with Cheshire & Mersey nosocomial rates of 15.07%.




Total Nosocomial Cases: Cheshire And Merseyside
Number of Nosocomial Cases
Week Ending
14/06/2020
28/06/2020
12/07/2020
26/07/2020
09/08/2020
23/08/2020
06/09/2020
20/09/2020
04/10/2020
18/10/2020
01/11/2020
15/11/2020
29/11/2020
13/12/2020
27/12/2020
10/01/2021
24/01/2021
07/02/2021
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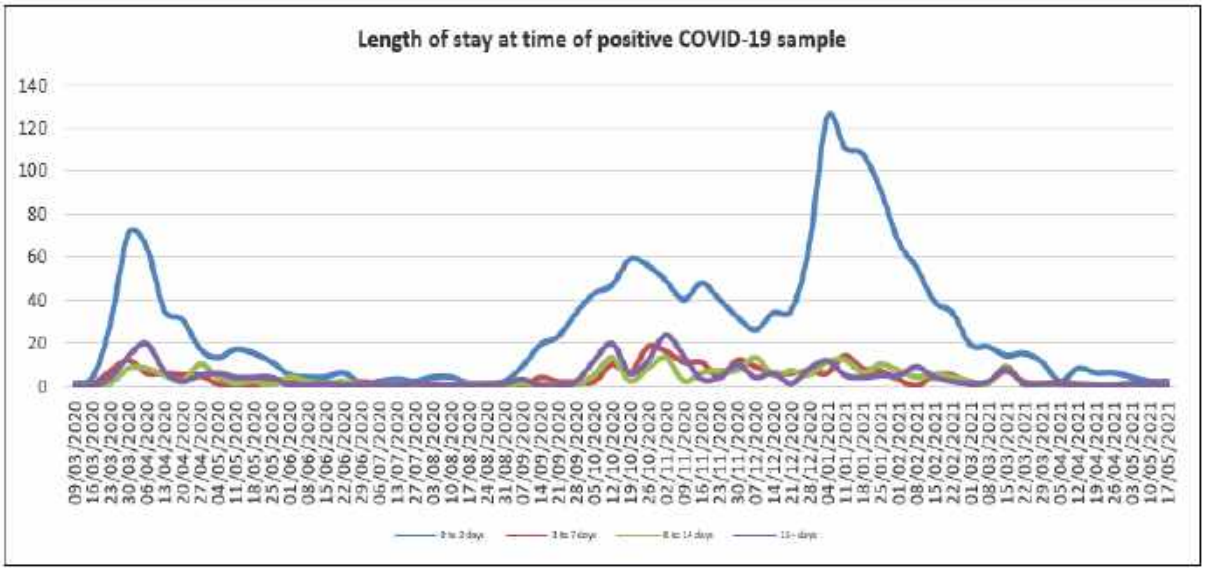
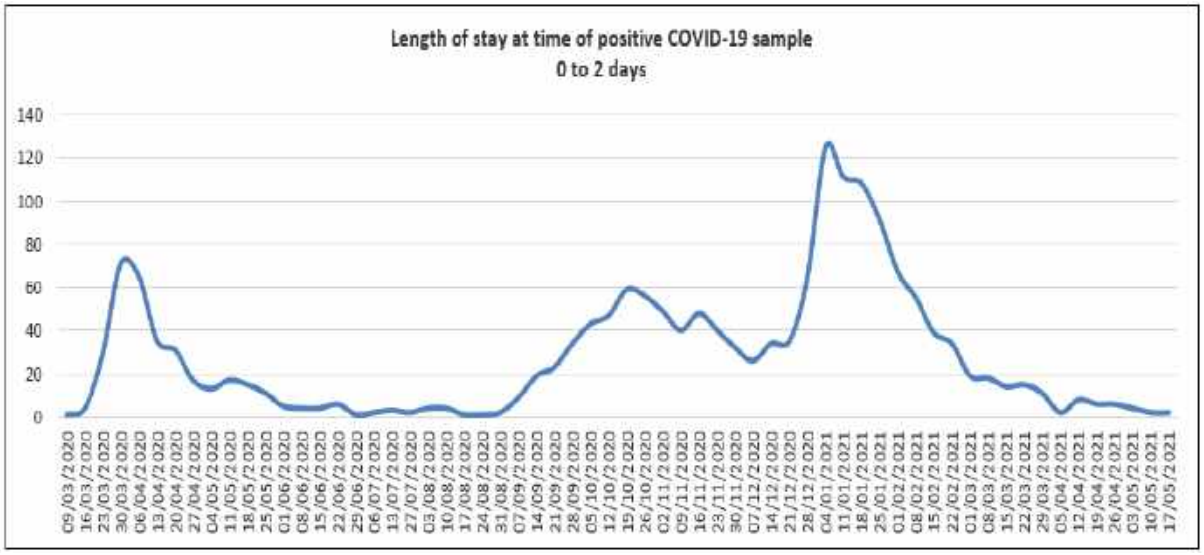
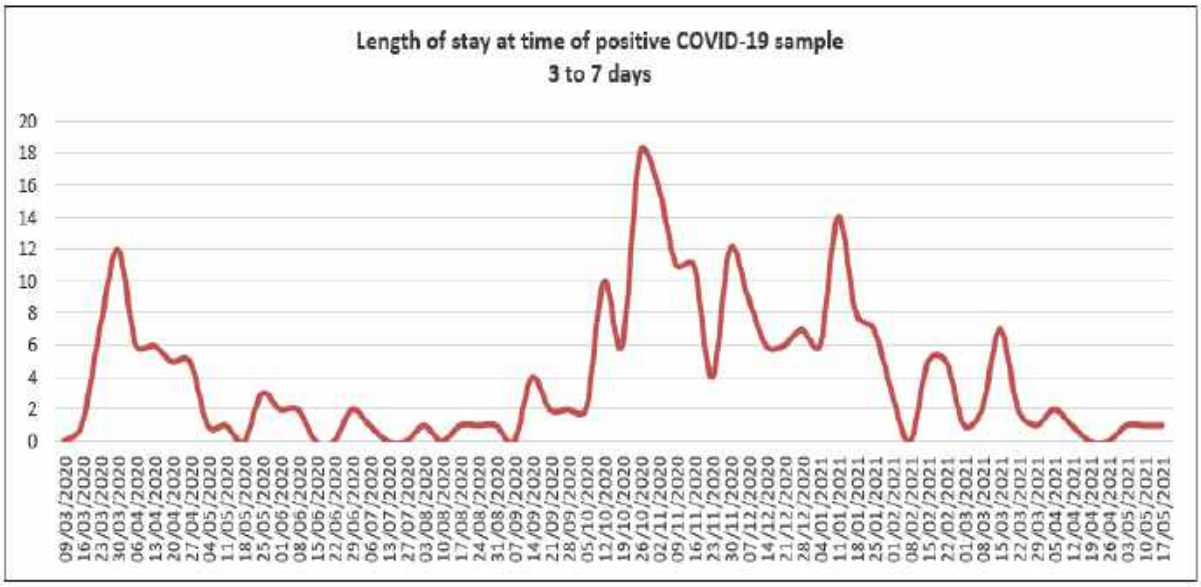
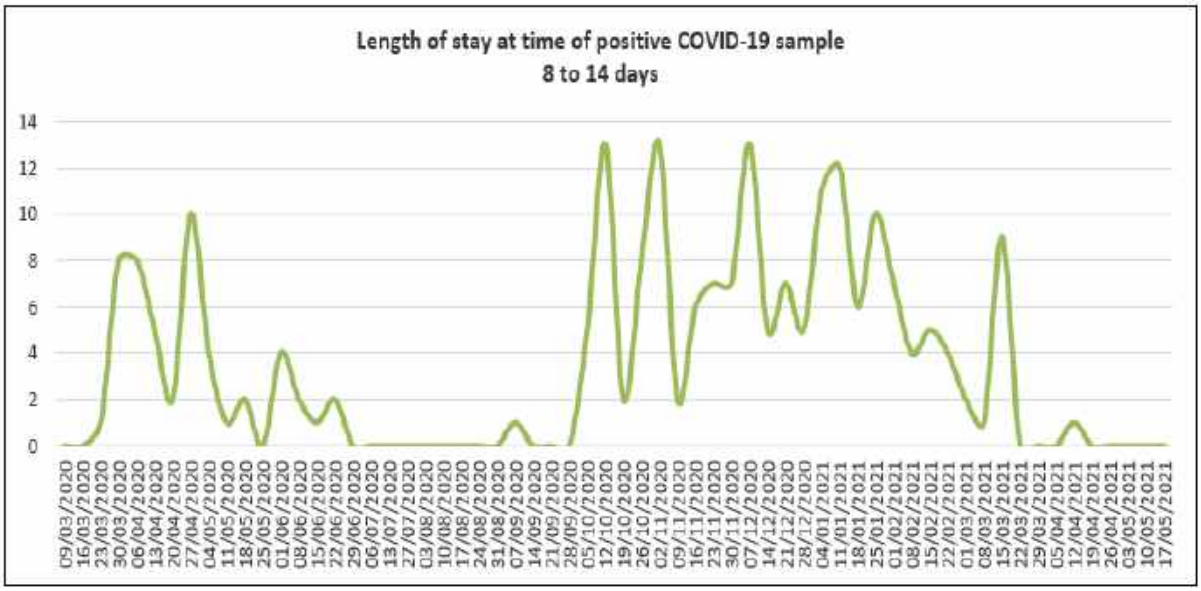
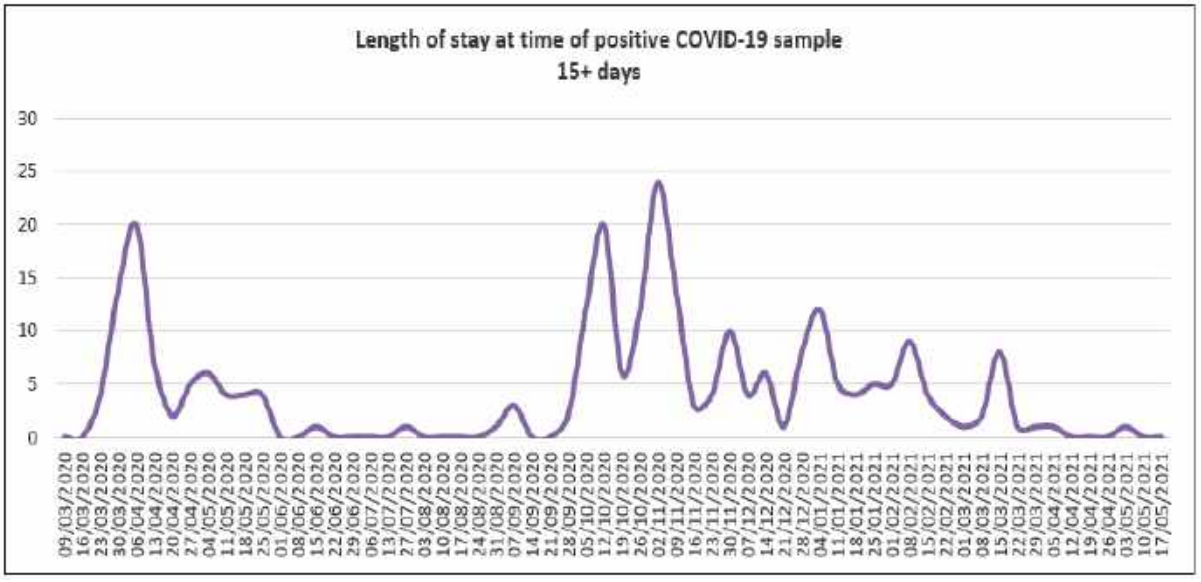
18/04/2021
02/05/2021
16/05/2021


Length of stay at time of positive COVID-19 sample


Length of stay at time of positive COVID-19 sample
0 to 2 days


Length of stay at time of positive COVID-19 sample
3 to 7 days


Length of stay at time of positive COVID-19 sample
8 to 14 days

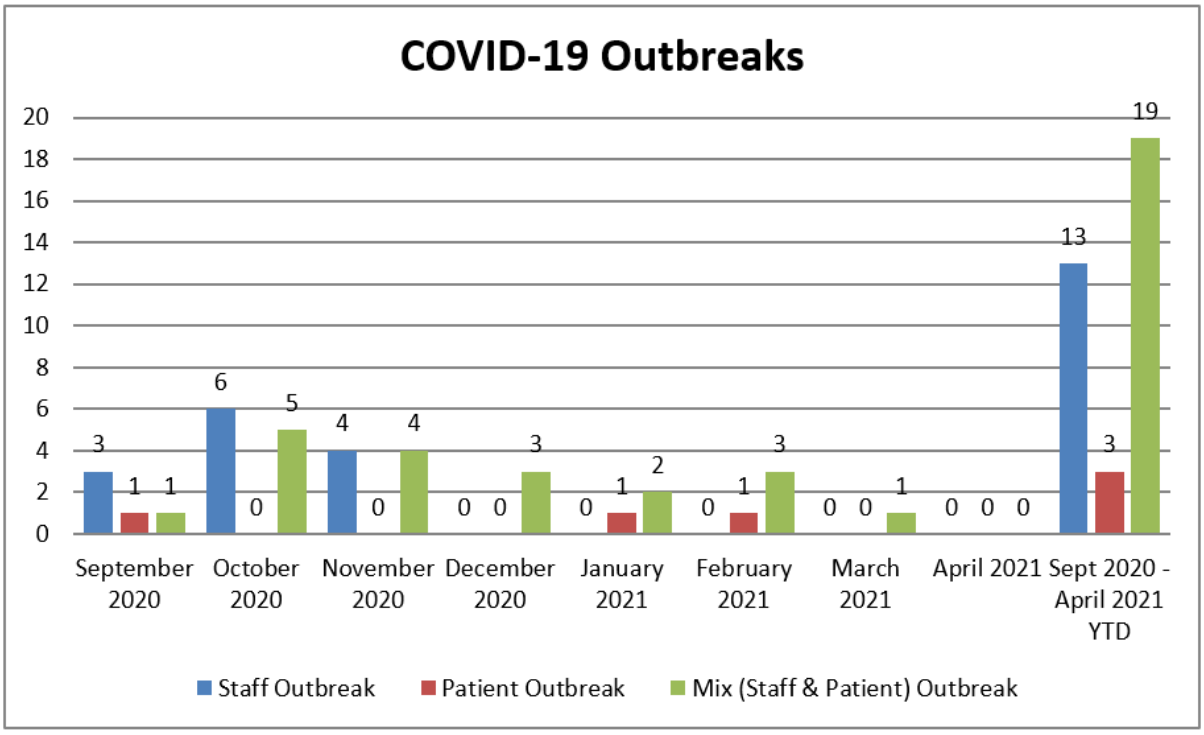

Length of stay at time of positive COVID-19 sample
15+ days

Narrative: The graphs show that the majority of the positive tests come within 2 days of admission or between 3-7 days of admission which suggest these infections were probably picked up in the community and brought into hospital. However, in the last 7 days, 0 infections were detected within 8-14 days or 15 days +

Source: Trust Data

2.16 Outbreaks

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



Narrative: In April 2021, there were no outbreaks recorded in the Trust.

Source: Trust Data

3. CONCLUSION

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

4. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/21/05/68	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	26th May 2021	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Andrea McGee - Chief Finance Officer and Deputy Chief Executive Dan Moore - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	x
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#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 April as follows: Red: 28 (from 27 in March) Amber: 5 (from 7 in March) Green: 37 (from 33 in March) Not RAG Rated: 4 (from 5 in March)	

	The total number of indicators on the IPR has increased from 72 to 74 in line with the annual review approved by the Trust Board. As a result of the COVID-19 pandemic, the Trust has not met the RTT 18 week, RTT 52 week, Diagnostics 6-week 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, the Trust is working with system partners to address. During the COVID-19 pandemic measures of assurance for both quality and safety have remained in place. This report will provide a summary of performance against quality KPIs for the reporting period April 2021. 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 draft control total for H1 of c£7m deficit and has submitted a plan to the Cheshire and Merseyside Health and Care Partnership (CMHCP) to deliver this. Further information is awaited from the CMHCP to confirm final income allocations and control totals. For the period ending 30 April 2021 performance is £1.5m deficit against a planned £1.4m deficit, a £0.1m adverse variance. There are a number of risks that have emerged in month 1 that have been offset by under spends and if these are not managed, they pose a risk to the delivery of the plan. A national Elective Recovery Fund (ERF) has been set up in 2021/22, with £1bn available for recovery. The Trust has estimated that c£2.6m could be awarded to the local system from this fund relating to the Trust's performance subject to the delivery of the performance trajectories that the Trust has submitted and delivery of the minimum performance levels required across the Cheshire and Merseyside system. Elective recovery in April was better than plan. Activity plans are being reviewed before the final submission to CMHCP in May. This could increase the expected ERF allocated to the system should the trajectory be delivered.

	Cash is greater than plan at £42.2m against a plan of £20.0m. This is due to a number of reasons: 1. A delay in capital creditor payments due to orders of goods and services being made later than originally anticipated. 2. Cash has been received for the annual leave accrual which has not yet been incurred. 3. An improvement in the year end deficit position due to central income and cash awards made in March 2021. Further to a number of increases in the cash received in March from NHSE/I, a new cash flow forecast is being developed and will be shared with NHSE/I.			
PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the capital scheme approved as an emergency by the Chief Finance Officer & Deputy Chief Executive. 2. Note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**			
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	**AGENDA REF:**	BM/21/05/68

1. BACKGROUND/CONTEXT

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

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

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

Table 1: RAG Rating Movement

	March	April
Red	27	28
Amber	7	5
Green	33	37
Not RAG Rated	5	4
Total:	72	74

The total number of indicators on the IPR has increased from 72 to 74 in line with the annual review approved by the Trust Board.

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

There are 2 indicators which cannot be RAG rated in month as the data is not available or not reportable. These are:

Finance

- Use of Resource Rating – UoR rating is not currently reportable. The Trust is awaiting further guidance from NHSE/I.
- System Financial Position – system reporting across the Warrington & Halton system is currently on hold.

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

Quality

Quality KPIs

There are 4 Quality indicators rated Red in April, an increase from 3 in March.

The 1 indicator rated Red in March, which has remained rated Red in April is as follows:

- Friends and Family Test (ED) – the Trust achieved 79.00% in April, a deterioration from 84.00% in March, against a target of 87.00%.

There are 4 new indicators in the Quality section of the IPR for 2021/22. 3 of these indicators have been RAG rated Red in April as follows:

- Sepsis % Screening for Emergency Patients – the Trust achieved 55.00% in April, against a target of 90.00%.
- Sepsis % Screening for Inpatients – the Trust achieved 75.00% in April, against a target of 90.00%.
- Sepsis % Emergency Patients Administered Antibiotics Within 1 Hour – the Trust achieved 73.00% in April, against a target of 90.00%.

A focussed improvement plan is in place with oversight from the Deputy Chief Nurse, Patient Safety and Clinical Education.

There are 2 indicators which have moved from Red to Green in month, due to the annual reset of the thresholds for the RAG ratings:

- Healthcare Acquired Infections (MRSA) – this indicator has been reset for 2021/22 following the reporting of 1 case of MRSA in 2020/21 (September).
- Pressure Ulcers – the threshold for pressure ulcers has reset for 2021/22. The Trust reported 3 category 2 pressure ulcers and 2 category 3 pressure ulcers in April.

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

- Care Hours Per Patient Day – the Trust achieved 7.3 in April, a deterioration from 8.1 in March, against a target of 7.9.

VTE assessment compliance is reported as a quarterly position and is therefore not RAG rated in month. This indicator was rated Green for Q4 2020/21.

Access and Performance

Access and Performance KPIs

There are 11 Access and Performance indicators rated Red in April, the same as in March. 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 10 indicators which were rated Red in March and remain rated Red in April are as follows:

- Diagnostic 6 Week Target – the Trust achieved 67.66% in April, a deterioration from 69.55% in March, against a target of 99.00%.

- Referral to Treatment Open Pathways – the Trust achieved 72.32% in April, a deterioration from 72.93% in March, against a target of 92.00%.
- Referral to Treatment 52+ Week Waiting – there were 1,364 patients waiting over 52 weeks in April, an improvement from 1,544 patients in March, against a target of 0. RTT and Diagnostic performance is as a result of the reduction in the elective programme, suspension of services and the associated backlog during the initial phases of the pandemic. The Trust has robust recovery plans with clinical prioritisation.
- A&E Waiting Times 4-hour National Target – the Trust achieved 78.33% (excluding Widnes Walk ins) in April, a deterioration from March's position of 80.05%, against a target of 95.00%.
- A&E Improvement Trajectory – the Trust did not achieve the improvement trajectory of 85.00% in April.
- Cancer 62 Days Urgent - the Trust achieved 66.67% in March, a deterioration from 77.23% in February, against a target of 85.00%.
- Ambulance Handovers 30 – 60 minutes – there were 156 patients who experienced a delayed handover in April, a deterioration from 123 patients in March.
- Ambulance Handovers 60 minutes plus - there were 28 patients who experienced a delayed handover in April, a deterioration from 23 patients in March.
- Discharge Summaries % sent within 24 hours – the Trust achieved 83.43% in April, a deterioration from 86.10% in March, against a target of 95.00%.
- Super Stranded Patients – there were 106 super stranded patients at the end of April, a deterioration from 94 patients at the end of March, against a trajectory of 96 patients.

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

- A&E Waiting Time Over 12 hours – there were no patients waiting longer than 12 hours in A&E in April, there was 1 patient waiting over 12 hours in March against a target of 0.

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

- Discharge Summaries Not Sent Within 7 Days – there were 264 discharge summaries not sent within 7 days to meet the 95.00% threshold in April, a deterioration from 0 in March, against a target of 0. The change in logic in reporting for this indicator was approved by the Trust Board in line with the internal audit recommendation has impacted the position.

Please note that performance reporting against the COVID-19 Recovery KPIs has been updated in line with 2021/22 Operational Planning Guidance to reflect performance against the Trust's plan which is based on 2019/20 activity adjusted.

PEOPLE

Workforce KPIs

There are 8 Workforce indicators rated Red in April, an improvement from 10 in March.

The 8 indicators which were rated Red in March and remain rated Red April are as follows:

- Sickness Absence – The Trust's sickness absence was 5.21% in April, a deterioration from 4.94% in March, against a target of less than 4.20%.
- Return to Work Compliance – interview compliance was 58.61% in April, a deterioration from 64.96% in March, against a target of 85.00%.
- Recruitment – the average time to recruit was 77 days over the last 12 months as of April, an increase from 76 days in March, against a target of less than 65 days.
- Turnover – staff turnover was 16.70% in April, a deterioration from 15.70% in March, against a target of less than 13.00%. However, when excluding temporary staff, the position is 10.50% in April 2021. An additional line has been included on the graph in Appendix 2 which highlights permanent staff turnover.
- Bank/Agency Reliance – The Trust's reliance was 15.48% in April, an improvement from 18.55% in March, against a target of less than 9.00%.
- Agency Shifts Compliant with the Cap – 18.12% of agency shifts were compliant with the cap in April, a deterioration from 22.93% in March, against a target of 49.00%.
- Agency Rate Card Compliance – 27.72% of agency shifts were compliant with the rate card in April, an improvement from 23.00% in March, against a target of 60.00%.
- Monthly Pay Spend – monthly Trust pay spend was £0.7m above budget in April, reduced from £2.1m above budget in March.

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

- % Use of the Apprentership Levy – the Trust achieved 54.00% in April, an improvement from 36.00% in March, against a target of 85.00%.

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

- Core/Mandatory Training – the Trust achieved 78.14% in April, an improvement from 76.96% in March, against a recovery trajectory (in April 2021) of 75.00%.
- Role Specific Training - the Trust achieved 83.56% in April, an improvement from 83.13% in March, against a recovery trajectory (in April 2021) of 80.00%.

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

- PDR Compliance – the Trust achieved 52.39% in April, an improvement from 51.03% in March, against a recovery trajectory (in April 2021) of 35.00%.

Movements for Core/Mandatory Training, Role Specific Training and PDR compliance are due to changes agreed by the Trust Board in April around recovery trajectories for these indicators.

Please note: An issue has been identified with turnover and retention reporting which has now been rectified on the dashboards with updated performance. This data included

permanent and temporary staff. A number of temporary staff were excluded from the KPI which showed the Trust position was better than it was. Additional data has now been included on the dashboard demonstrating the turnover and retention of permanent staff.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 5 Finance & Sustainability indicators rated Red in April, including indicators for CIP which were not required in 2020/21.

The 3 indicators which were rated Red in March and remain rated Red in April are as follows:

- Trust operating surplus / (deficit) – The year to date position is a deficit of £1.5m against a deficit plan of £1.4m.
- Capital Programme – The actual spend year to date is £0.15m which is £0.61m below the planned spend of £0.76m. However, the Trust has committed orders of £1.4m.
- Agency Spending – The agency spend in April was £1.1m which is £0.24m above plan. It should be noted £0.5m relates to COVID-19.

The additional Red indicators relate to CIP which was not required due to COVID-19 in 2020/21, these are:

- Cost savings schemes in-year compared to plan.
- Cost savings schemes recurrent compared to plan.

A CIP target of 1.00%, £2.6m for 2021/22 has been set and distributed across the Trust. Plans are currently being developed. There is no requirement to deliver CIP in Quarter 1 2021/22.

The teams have started to develop CIP schemes and all CBUs and corporate services have been given targets. The Trust delivered a minimal CIP in April, 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**.

During April, £0.9m of COVID-19 costs were incurred which is £0.5m higher than planned due to ITU staffing needs and shielding pressures. These were partly offset by underspends in other areas of the organisation.

Cash

Cash is greater than plan at £42.2m against a plan of £20.0m. This is due to a number of reasons:

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

Further to a number of increases in the cash received in March from NHSE/I, a new cash flow forecast is being developed and will be shared with NHSE/I.

Capital Programme

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

Table 2 - Capital plan and spend year to date

Capital	Annual Plan	Plan To Date	Expenditure to Date*	Variance
	£000	£000	£000	£000
Trust Funded	12,900	759	149	610
PDC Funded:**				
ED Plaza	5,000	0	0	0
Paeds	700	0	0	0
ICU	1,000	0	0	0
Total Approved Capital Programme	**19,600**	**759**	**149**	**610**

*In addition to the expenditure, there are also committed orders of £1.4m.

** Guidance has been released around the 2021/22 emergency capital process. All applications need to be submitted by 30 November 2021. The Trust intends to apply in June 2021, depending on the revised cash plan.

Additional monitoring of schemes in excess of £0.5m is taking place through the Executive Team, the Finance & Sustainability Committee and the Trust Board and these are highlighted in **Table 3.**

Table 3 – Schemes over £0.5m

Scheme	£000	Status
Warrington & Halton Breast Unit Relocation	1,200	Scheme in progress estimated completion by July 2021 (CSTM) and October 2021 (Bath Street).
MRI Estates	900	Scheme in progress estimated completion by August 2021.
Urology Investigation Unit	870	Pending approval process, expected in May 2021. Estimated completion by February 2022.
Fire - Replacement of obsolete 5000 series fire alarm panels and end of line devices	600	Pending approval process, expected in June 2021. Estimated completion by January 2022.
Cardiac Catheterisation Suite	800	Pending approval process, expected in May 2021. Estimated completion by September 2021.
Paediatric Outpatients	700	Pending approval process, expected in May 2021. Estimated completion by February 2022.
ICU	1,000	Scheme in progress, estimated completion by June 2021.
ED Plaza	5,000	Scheme in progress estimated completion by February 2022.
Shopping Centre	630	£380k was supported in March 2021 by the Trust Board. An updated case is in progress for approval, expected in June 2021. Estimated delivery by September 2021.

The Trust Board is asked to note the following emergency capital scheme approved by the Chief Finance Officer & Deputy Chief Executive:

- Clinical Doors and Screens - £10k in April 2021.

The Trust Board is asked to:

1. Note the capital scheme approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.

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. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

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

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the capital scheme approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.
2. Note the contents of this report.

Key

Improvement in Performance	↑
Deterioration in Performance	↓
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating May 2020 – April 2021

	KPI	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21
	QUALITY												
1	Incidents	↑	↓	↑	↑	↓	↓	↑	↓	↔	↑	↑	↔
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 patients.												
22	Sepsis - % screening for all inpatients.												
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 May 2020 – April 2021

	KPI	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 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 May 2020 – April 2021

	KPI	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 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 May 2020 – April 2021

	KPI	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 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)**	-	-	-	-	-	-	-	-	-	-	-	

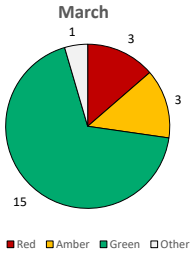
*RAG rating is based on previous month's validated position for these indicators.

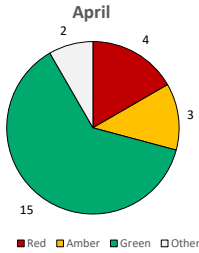
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Integrated Dashboard - April 2021

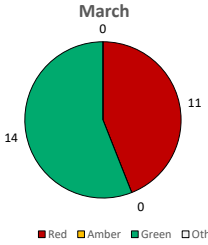
Appendix 2

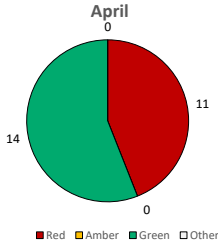
Quality Improvement



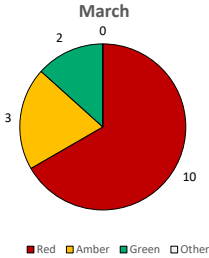


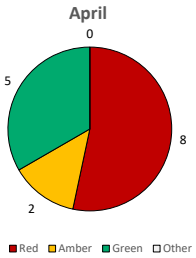
Access & Performance



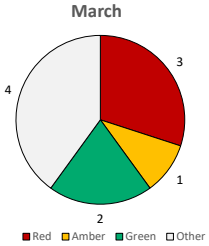


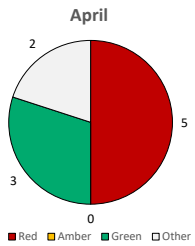
Workforce





Finance





Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

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

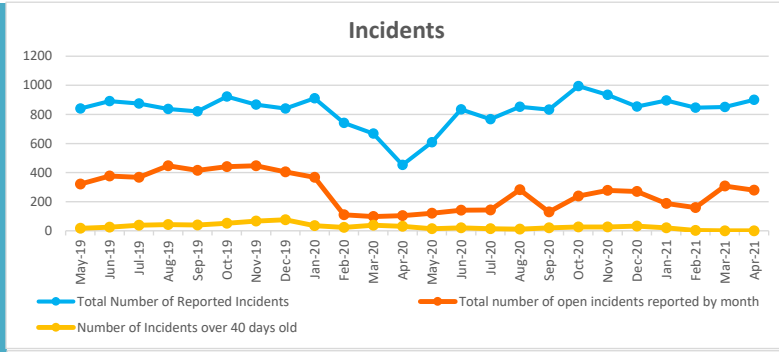
Patient Safety

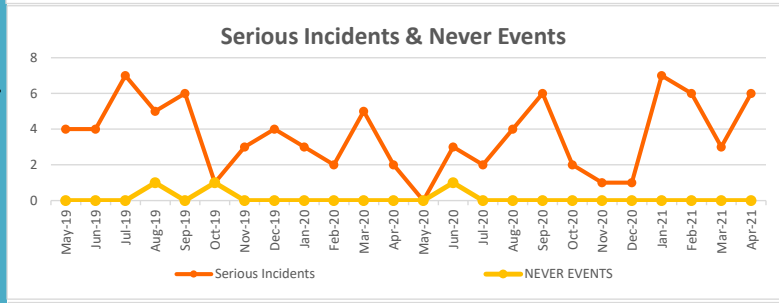
SOF CQC

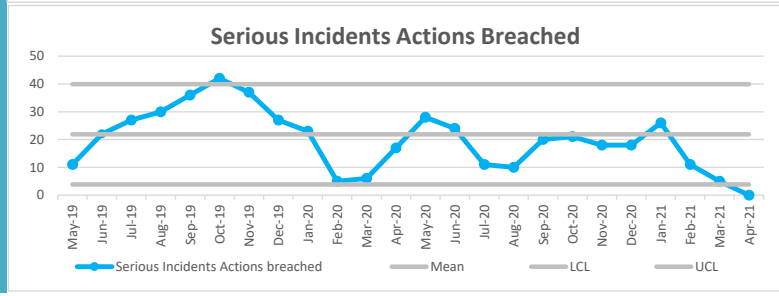
Incidents

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

There were 0 incidents over 40 days old open in April 2021.







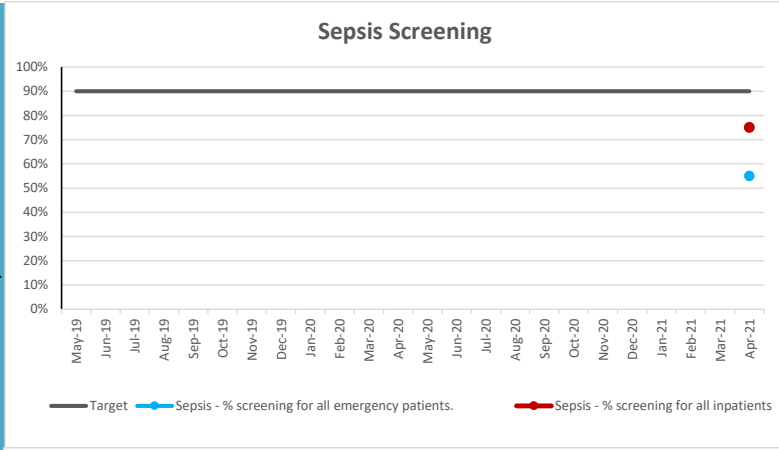
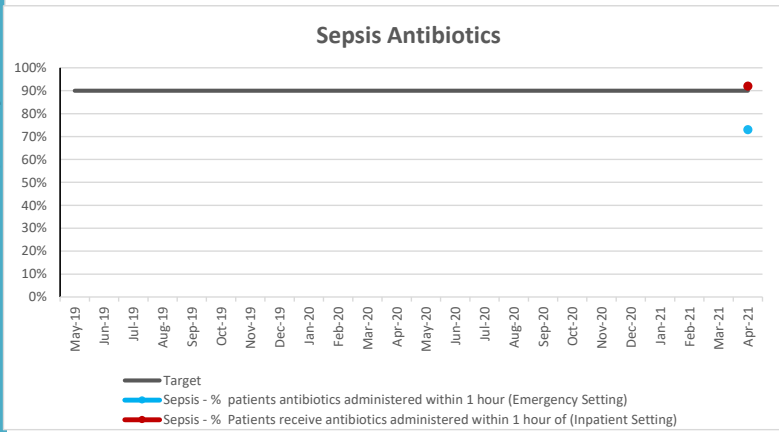
There were 6 Serious Incidents reported in April 2021: 3 for Integrated Medicine, 2 for Surgical Specialties and 1 for Urgent and Emergency Care. This is statistically average and in line with national reporting trends. Incident reporting levels have positively increased following the pandemic.

There is a significantly improved picture in the number of incidents open over 40 days when compared to last year reporting N=30. The overdue incidents, level of harm and incidents reported is monitored daily by the Head of Clinical Effectiveness. NRLS (National Reporting & Learning System) reporting shows a positive reporting culture and remains as expected for the number of incidents reported compared to number of bed days.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

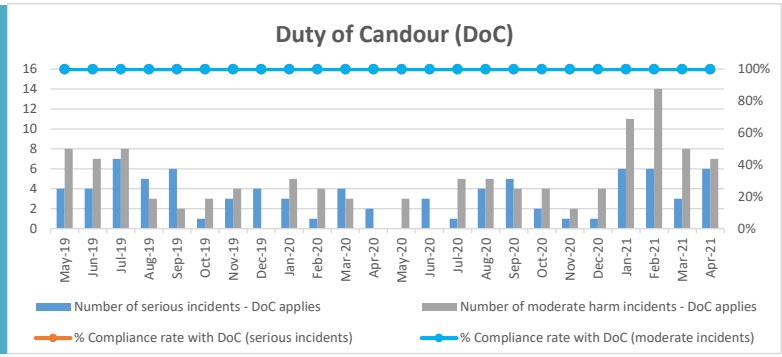
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
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: • 55.00% screening within 1 hour for all emergency patients. • 75.00% screening for all inpatients within an hour. • 73.00% of emergency patients with red flag for Sepsis, administered anti-biotics within 1 hour. • 92.00% of inpatients have antibiotics administered within 1 hour of a diagnosis of Sepsis.	 	55.00% of emergency patients were screened within 1 hour. The remainder of patents were screened and received antibiotics outside of the 1 hour national standard. This is mirrored on the inpatient wards. The variance is due to blood cultures not being obtained in a timely manner. The surge of patients experienced in ED as the COVID-19 pandemic numbers reduce resulted in difficulty in achieving full screening within 1 hour.	Sepsis was escalated back onto the Trust IPR due to the recognised improvement work required across ED and on patient wards. A deep dive is underway and will be presented to Quality Assurance Committee in July. There was a focussed quality improvement event in ED which incorporated a 'Sepsis Awareness Week'. Recognition of Sepsis and reinforcement of screening and blood culture training/refreshers for both nursing and medical team. Twice weekly Trust wide training e-learning sessions are available, The ED team is working with NWAS to ensure clearer communication of a patient arriving with suspected Sepsis is in place. An improvement action plan for ED is in place with oversight from the Deputy Chief Nurse for Patient Safety.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Duty of Candour Red: <100% Green: 100%	CQC The Trust achieved 100% for Duty of Candour in month.		Compliance with Duty of Candour remains in line with Trust policy at 100% compliance.	Weekly scrutiny and monitoring is in place by the newly appointed Patient Safety Manager and Head of Clinical Effectiveness to ensure that DOC remains at 100% and the interaction with families and patients is meaningful.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

Healthcare Acquired Infections

MRSA
Red: 1 or more
Green: 0

Healthcare Acquired Infections

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

Healthcare Acquired Infections - Gram Negative

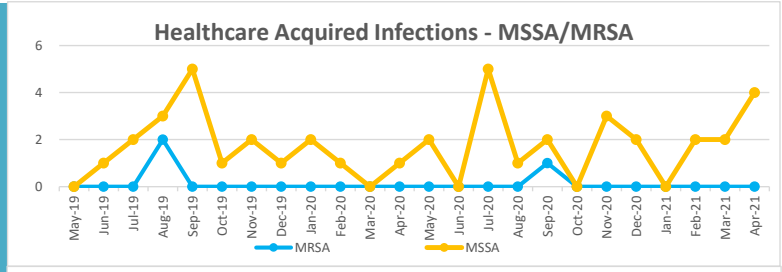
E-Coli
Red: 47+ per annum
Green: Less than 47 per annum
Pseudomonas aeruginosa & Klebsillea - No Threshold Set

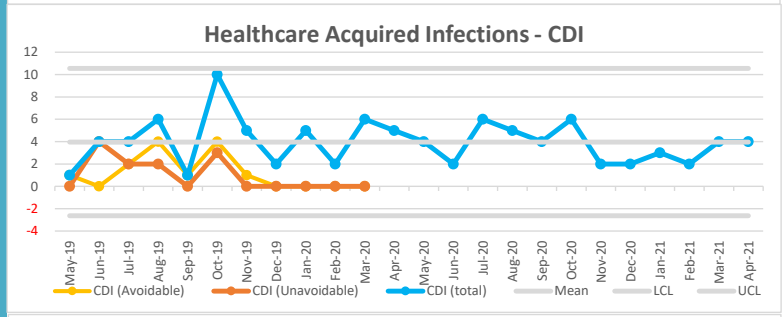
Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks

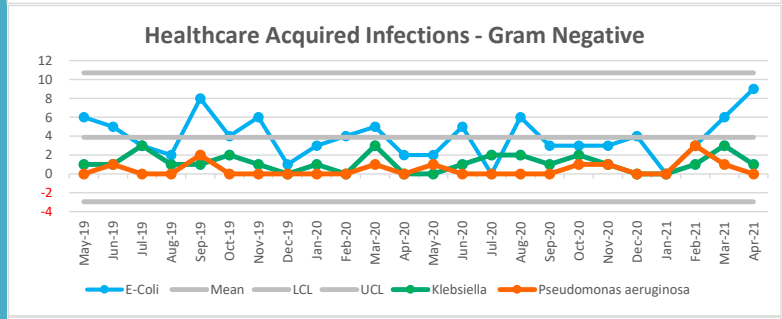
Trust Performance

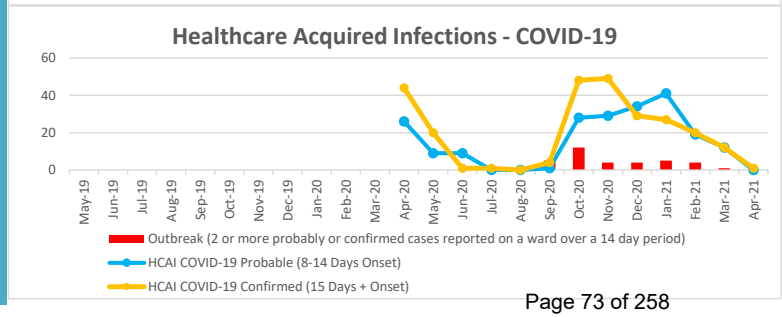
Healthcare Acquired Infection (HCAI) objectives have not been published nationally by NHSE/I for Gram Negative bloodstream infection reduction or C. difficile. The current RAG rating is based on 2019/20 thresholds. In April 2021, the following cases were reported:
MRSA - nil cases
MSSA – 4 cases
CDI – 4 cases
E-Coli – 9 cases
Klebsiella – 1 case
Pseudomonas aeruginosa - nil cases

Trend









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

The change in the apportionment rule has increased the number of E. coli cases.

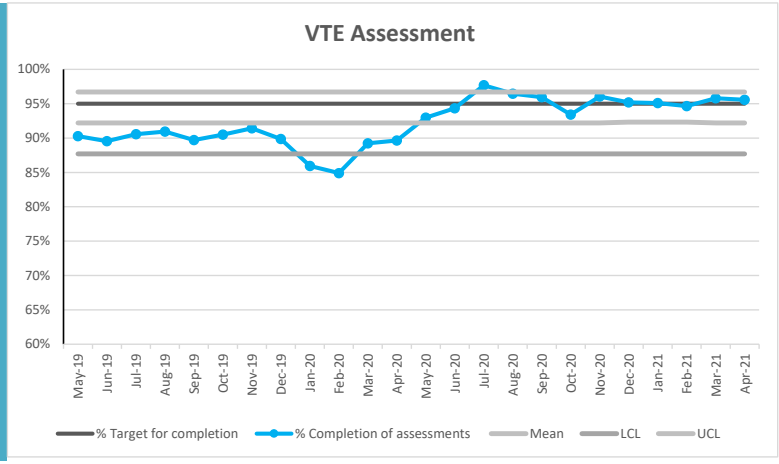
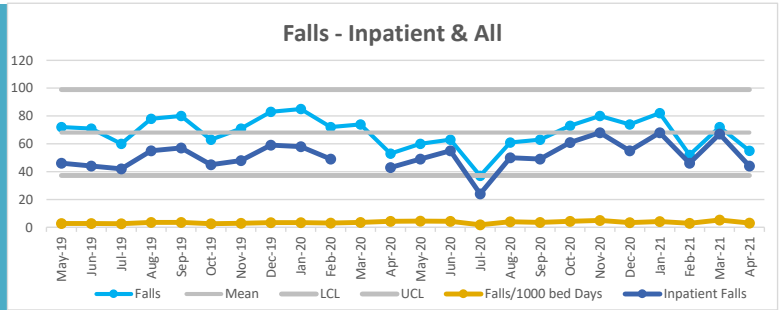
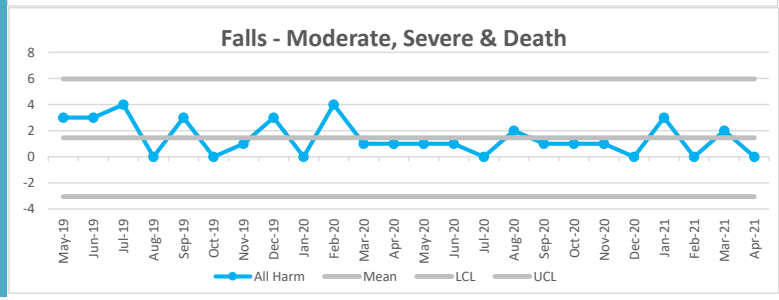
How are we going to improve the position (Short & Long Term)?

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.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework (SOF) | Risk Register (RR118)
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 95.17% for VTE assessments on average in Q4 2020/21.		The Trust achieved 95.58% for VTE assessments in April 2021. This is above the quarterly target in month. An average for this indicator is reported quarterly in relation to the National Trajectory of meeting the 95.00% target for VTE. Year to date the Trust has achieved 95.58%.	Focused work, "check and challenge" is taking place with clinical teams to improve VTE electronic risk assessment compliance. Daily progress updates are escalated to clinicians, supported by the Associate Medical Director to ensure completion of risk assessments. Outstanding VTE assessments are communicated via the Trust Wide Safety Brief. A Clinical Data Capture (CDC) form on Lorenzo to document ward rounds is 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	There were a total of 55 falls in April 2021; of which 44 were inpatient falls. There were 2 reported falls with harm. This is an 18.00% reduction in falls from the previous month.	 	The themes identified from harm falls were; the inability to fulfil enhanced care demands, Inappropriate selection of preventative measures was noted in the choice of alarm used and the inconsistent completion of nursing care plans.	The Falls Collaborative Quality Improvement Programme has commenced on wards A5/A1/A9/B12/A2/B19 with a plan to have 9 wards on board by the end of May and an on track trajectory is in place for the wards across the rest of the Trust. Tests of change are happening in clinical areas with regular support sessions from the Quality Improvement team every 2 weeks which includes ward visits to discuss progress with the teams. Wards with a higher incidence of falls have been included in the first phase. No harm falls were noted across innovation wards for April 2021. Weekly falls meetings continue to learn and share themes. Reinforced safety messages across the Trust via the Trust Wide Safety Brief with daily review of early learning continues.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

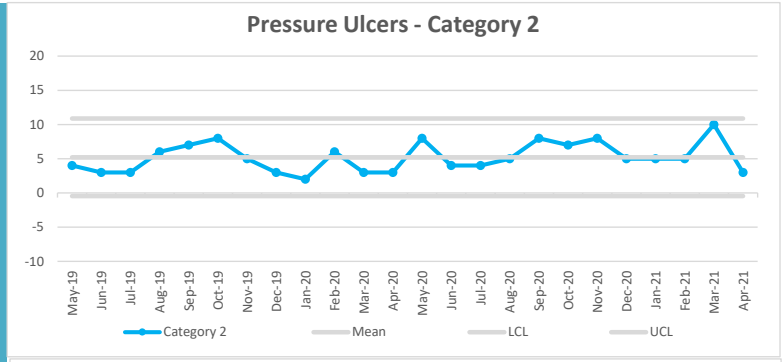
Quality Improvement - Trust Position

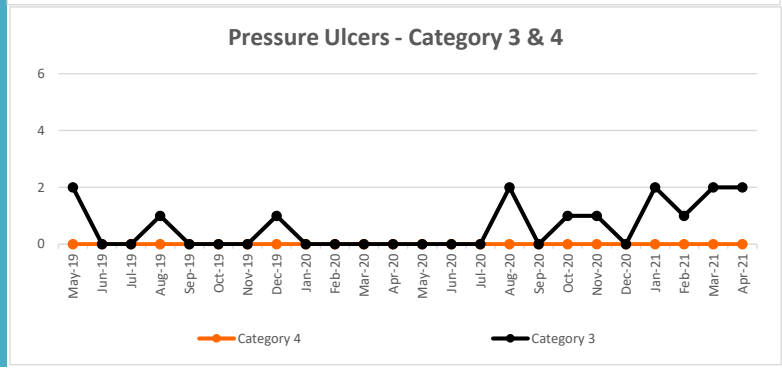
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

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

CQC

There were 3 hospital acquired Category 2 pressure ulcers and 2 Category 3 pressure ulcers reported in April 2021. This is a 70.00% reduction in category 2 pressure ulcers compared to March 2021.





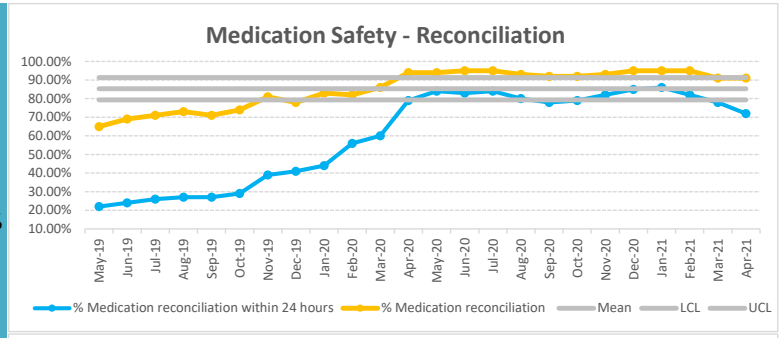
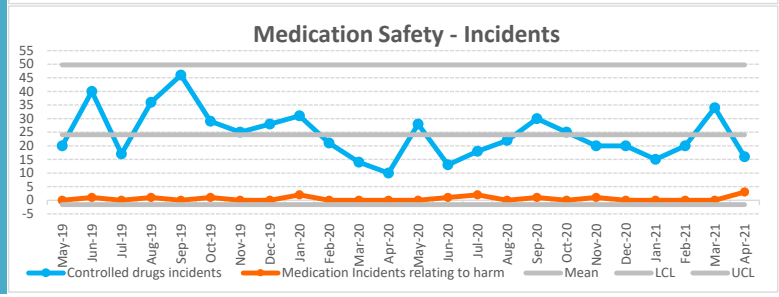
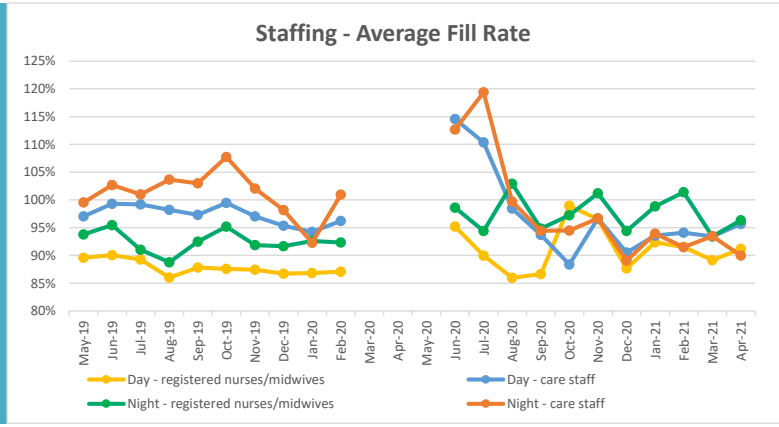
One of the category 3 pressure ulcers reported in April developed as a result of an orthopaedic device in situ with inconsistent checks to skin. The remainder are noted to be related to the lack of risk assessment and preventative measures to avoid heel pressure ulcers. A thematic review has been undertaken for the increase in pressure ulcers in 2020/21 and found the COVID-19 pandemic had a negative impact with 5 pressure ulcers occurring directly as a result of proning in ICU and a high numbers of those patients with pressure ulcers positive for COVID-19 or end of life, increasing their risk factors. There were also 9 pressure ulcers reported that were likely to have been present on admission.

Nurses from wards that have had higher incidence of pressure ulcers have been released to shadow the Tissue Viability Nurse Team. Weekly monitoring of action plans continues with the Deputy Chief Nurse for Patient Safety. The Quality Improvement Programme has commenced. The increased presence of the Senior Nursing and the Tissue Viability Team in higher risk areas continues. All areas have updated their twice daily safety brief to ensure the themes found from pressure ulcer RCA's are shared daily. As a result of increased pressure ulcers related to anti-embolic stockings, an alternative stocking has been evaluated and will be implemented across the Trust. Going forward, pressure ulcers that are present on admission will be reported on the Trust IPR.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework (SOF) | Risk Register (RR115 / RR1108)
Care Quality Commission (CQC) | Trust Strategy (S)

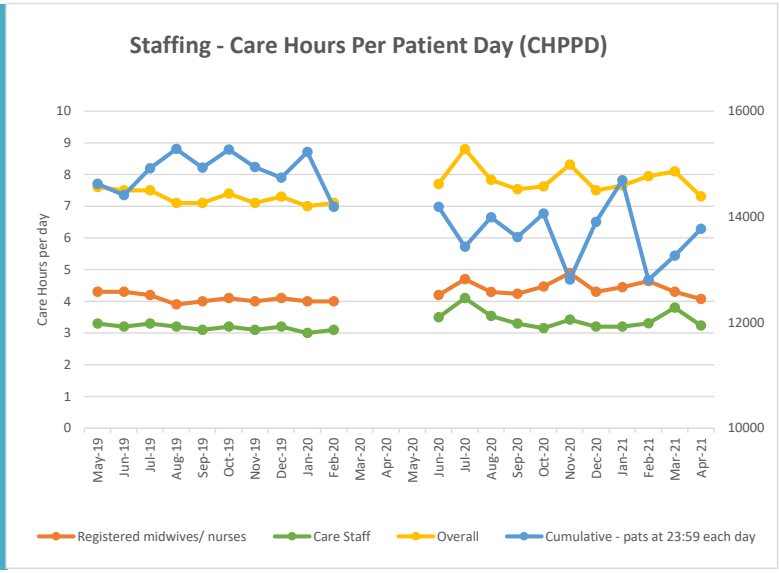
Quality Improvement - Trust Position

	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 72.00% for medicines reconciliation within 24 hours and 91.00% for overall medicines reconciliation. There were 3 incidents reporting harm. There were 16 controlled drug incidents.	 	The pharmacy department experienced several staffing pressures in April and this was also impacted by the 4 day bank holiday. In April, there was an increase in admissions and discharges which has impacted the position.	In the short term staffing overtime at weekends has been utilised, however a review of staffing to provide a consistent service in the emergency department 7 days per week as well as a weekend service in women's & children's and pre-op is required. 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. A monthly ward controlled drug check report is presented to the Operational Safety Group.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	In month the average staffing fill rates were: Day (Nurses/Midwife) 91.20% Day (Care Staff) 95.65% Night (Nurses/Midwife) 96.35% Night (Care Staff) 89.98%		11 of the 21 wards reported staffing levels under 90.00% in April 2021 for registered nurses in the day. On night shifts, this reduced to 5 wards out of the 21. HCA fill rates on days reported 9 wards out 21 under the 90.00% fill rate and 8 wards on nights. The fill rate percentage has shown an improvement this month as shift fill is improved through bank and agency. Additional beds in use across the Trust and increased staff absence due to COVID-19 related reasons remain a factor.	Staffing is reviewed twice daily by the senior nursing team and staff are moved based on acuity and activity to ensure safe patient care at all times. All wards have senior nurse oversight by a Matron and Lead Nurse, who will remain on the ward to support if required.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework (SOF) | Risk Register (RR1116)
Care Quality Commission (CQC) | Trust Strategy (S)

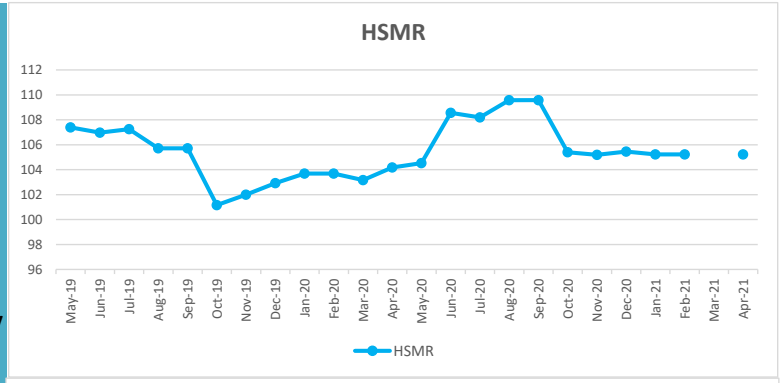
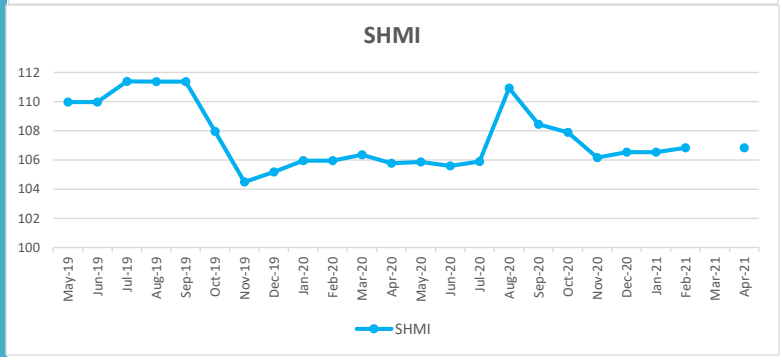
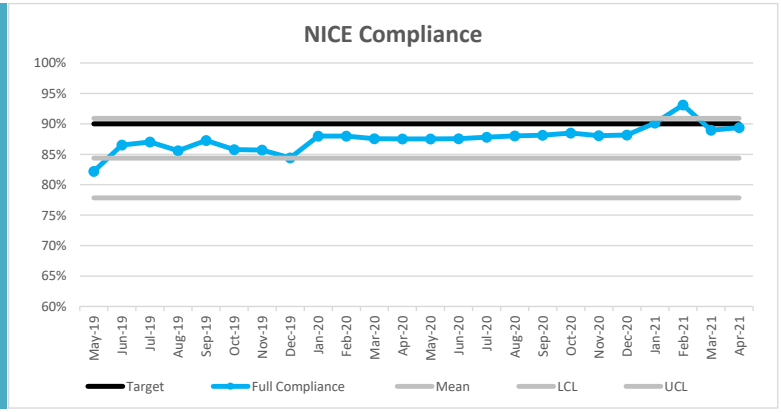
Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Staffing - Care Hours Per Patient Day (CHPPD) Red: Below 6.0 Amber: 6.0 - 7.8 Green: 7.9 or More	RR115 RR1108 **In month, the average CHPPD were:** **Nurse/Midwife: 4.1 hours** **Care Staff: 3.2 hours** **Overall: 7.3 hours**		**In April 2021, CHPPD was recorded at 7.3 in month, which is a reduction from the previous month of 8.1, with a 2020/21 position of 7.8, against the national median rate of 9.1 and peer median rate of 8.3.**	**Ward staffing levels continue to be systematically reviewed, which includes Planned vs. Actual staffing levels. These are reported monthly as part of the Unify submission and any ward that falls below 90.00% provides mitigation to ensure safe, high quality care is consistently being delivered in those areas.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected 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 105.22. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 106.83.	 	HSMR and SHMI remain within expected range.	Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning. The Trust's Mortality Lead post has now been recruited to in order to support with the learning from deaths agenda.
NICE Compliance Red: Below 75% Amber: 75% to 89% Green: 90% or Above	SOF The Trust achieved 89.39% in month		The Trust has increased compliance against partial compliant NICE guidance and is now just under the 90.00% target.	Compliance has marginally reduced when compared to March 2021 due to a number of baseline assessments requiring further information. This work is now complete with compliance expected to return to 90.00% next month.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

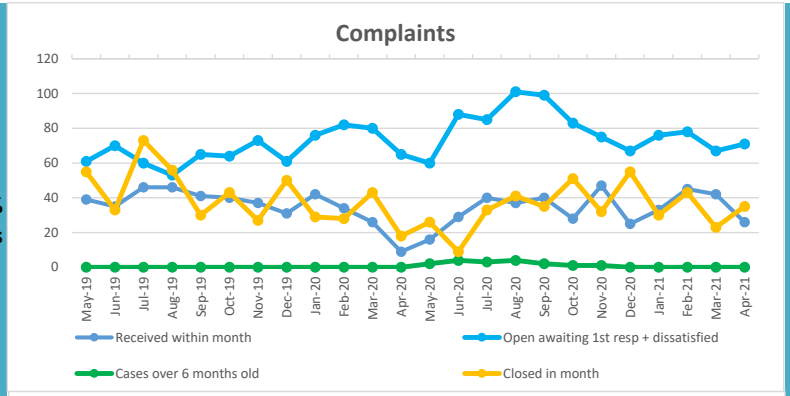
Quality Improvement - Trust Position

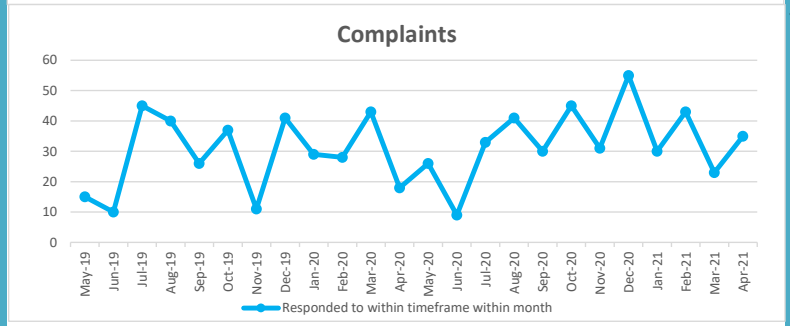
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Patient 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 April, there was a 84.60% decrease of new complaints into the Trust (48 in March 2021 vs 26 in April 2021). The Trust has maintained the timely closure of complaints, closing 100% within timeframe. There were 72 open complaints, with no complaints open over 6 months old.





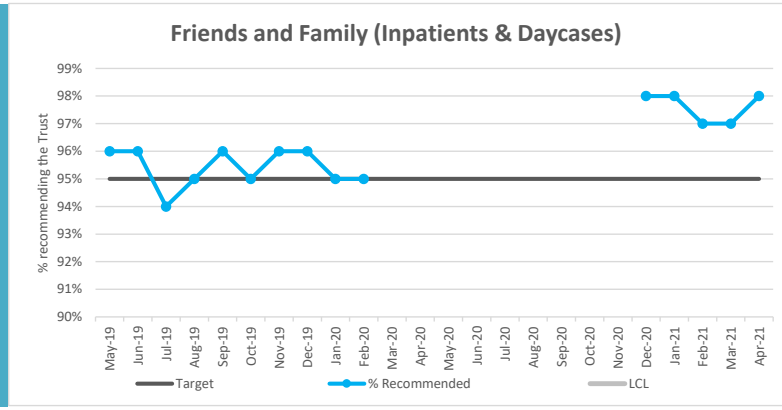
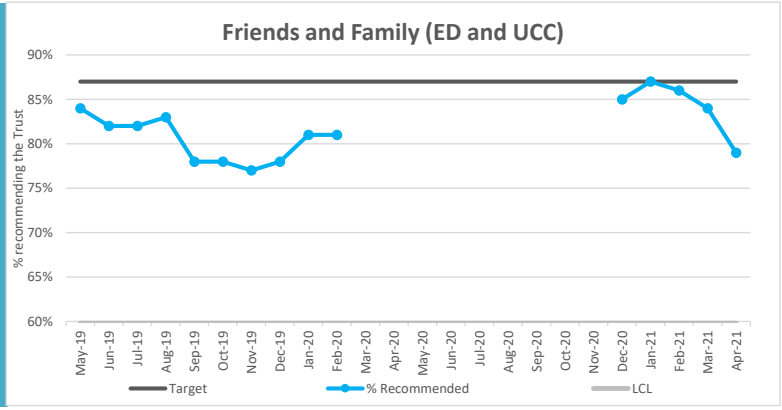
During April 2021, 35 complaints were closed, a 52.00% increase from March 2021. All complaints were closed within the required timeframes.

The complaints service continues to be overseen by the Associate Director of Governance and Compliance. Daily complaints progress reports and weekly performance reports are reviewed by the Associate Director of Governance and Compliance with escalation as appropriate to the Deputy Director of Governance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

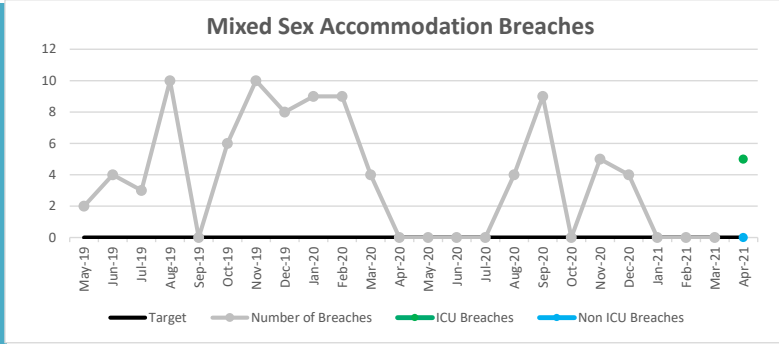
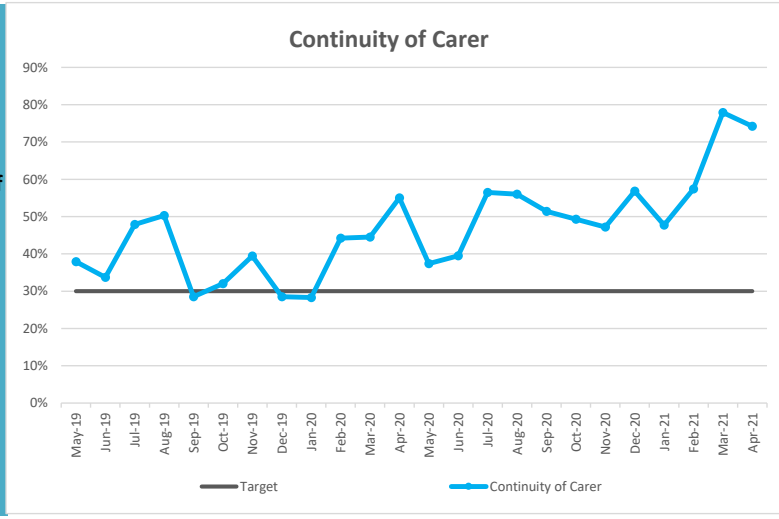
Quality Improvement - Trust Position

	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)?
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	SOF CQC S The Trust achieved 98.00% in month.		The Trust has met the standard set of 95.00% recommendation rate. The Trust recommenced FFT surveys is in line with national guidance. The Trust achieved 98.00% recommendation rate in April 2021.	Clinical Business Units provide a high level briefing paper to the Patient Experience Sub-Committee monthly, detailing FFT recommendation rates and FFT feedback responses. Recommendation rates continue to be monitored through Quality Metric reports.
Friends and Family (ED and UCC) Red: Less than 87% Green: 87% or more	SOF CQC S The Trust achieved 79.00% in month.		The Trust achieved 79.00% 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 chance of real time or near real time feedback. Thematic review of feedback identifies long waiting times as a root cause. Operation "reset" patient flow improvement programme is in place from 17th May for two weeks. Patient experience in ED has been identified as area for a Governor walkround in June 2021.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

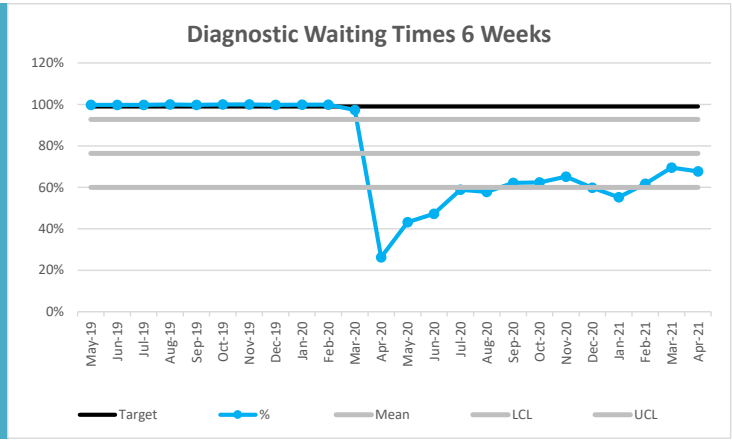
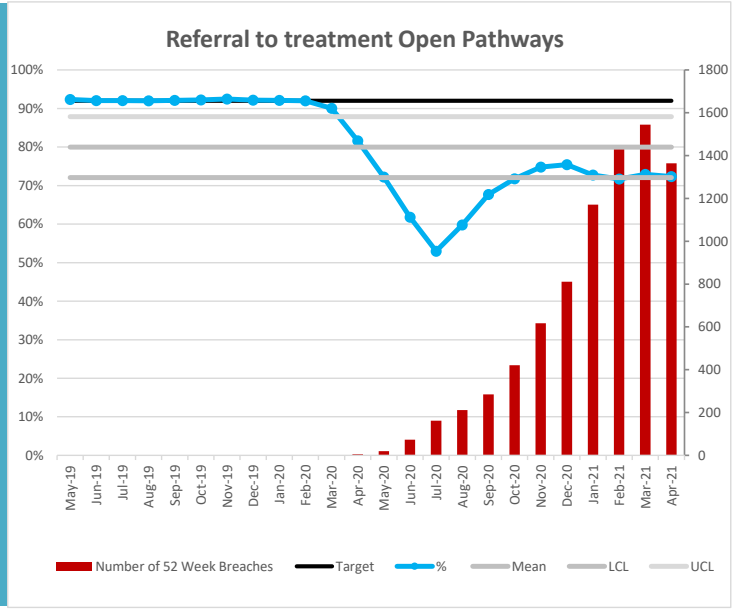
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Mixed Sex Accommodation Breaches (Non ITU Only) Red: 1 or more Green: Zero	SOF There were 5 mixed sex accommodation incidents during April 2021. All breaches occurred in ITU.		There were 5 mixed sex accommodation breaches reported in April 2021. All of these occurred within the Critical Care Unit.	Patients are cohorted to minimise breaches and step down is expedited as soon as is practicable. Operation "reset" patient flow improvement programme is in place from 17th May for two weeks.
Continuity of Carer Green: 51% or Above Amber: 35% - 50% Red: below 35%	In April 2021, 100% of Warrington women were booked onto a continuity of care pathway, if 'out of area' bookings are included the figure is 74.20% as the Trust cannot provide the postnatal aspect of the pathway.		The Trust achieved 74.20% of all women booked onto a Continuity of Care pathway (including intrapartum care) in April 2021.	New care new models have been developed by the CBU 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 in April 2021.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

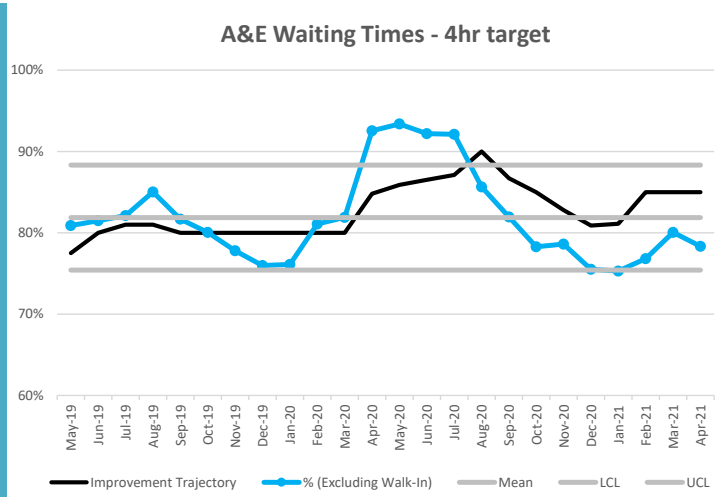
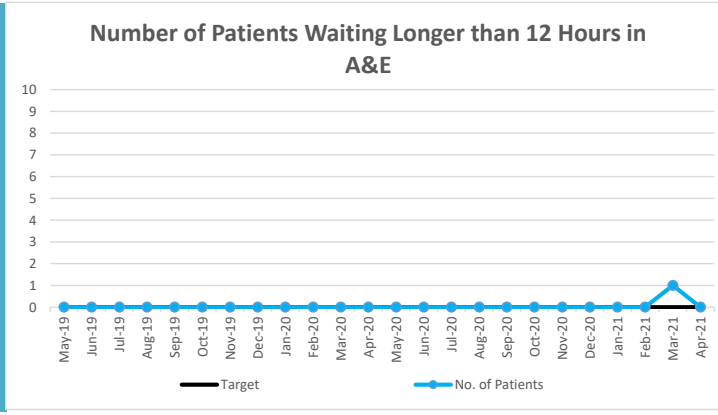
Key:
Risk Register
Single Oversight Framework
Care Quality Commission

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Diagnostic Waiting Times 6 Weeks **Red: Less than 99%** **Green: 99% or above**		**The diagnostic standard was not achieved in April 2021, this was due to the impact of the COVID-19 pandemic. The position worsened slightly compared to the previous month.**	**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**		**The restoration of elective activity and clinical services has continued to be impacted by Wave 2 and Wave 3. Elective activity for P1 and P2 patients has been maintained on site and with support from the independent sector. The number of patients waiting 52 weeks + at the end of February was at 1364.**	**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

Access & Performance - Trust Position

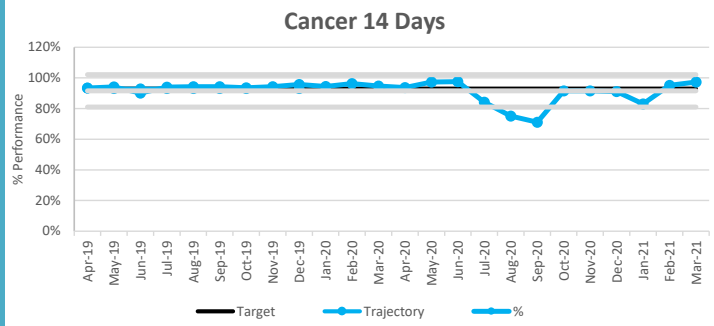
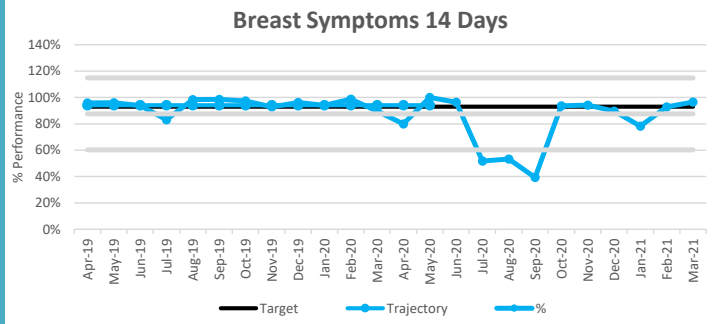
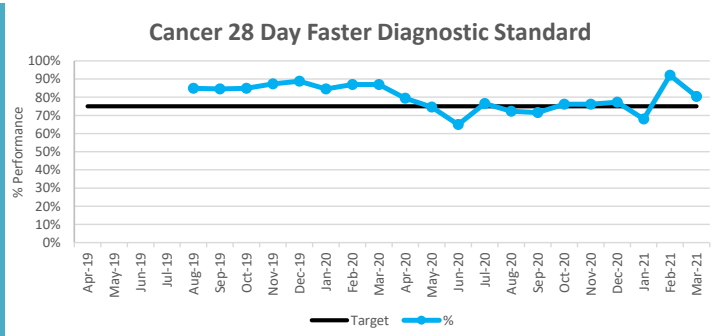
Key:
Risk Register
Single Oversight Framework
Care Quality Commission

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Four Hour Standard - National Target Red: Less than 95% Green: 95% or **Four Hour Standard Waiting Times - STP Trajectory** Red: Less than trajectory SOF CQC The Trust achieved 78.33% excluding walk ins in month. RR224 RR1125		There was a slight worsening in performance from March to April to 78.33% (excluding Widnes Walk-in activity). This is attributable to the ongoing impact of the pandemic and a significant growth in Urgent Care attends at ED. This trend is being seen across Cheshire and Mersey. Additionally, the ED footprint remains impacted by the pausing of the ED plaza works following instruction from NHSE/I and the need to segregate flows in line with RCEM guidance.	• 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 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 from the decision to admit in April 2021.	Maintain compliance against the 12 hour standard from the decision to admit.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

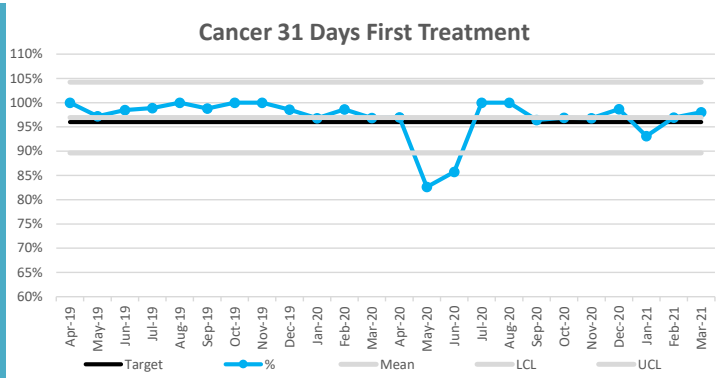
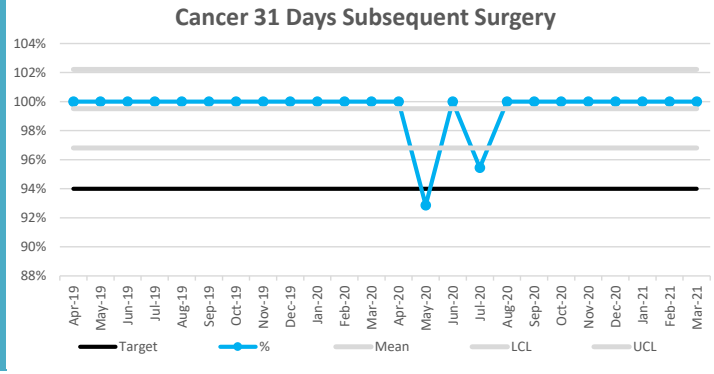
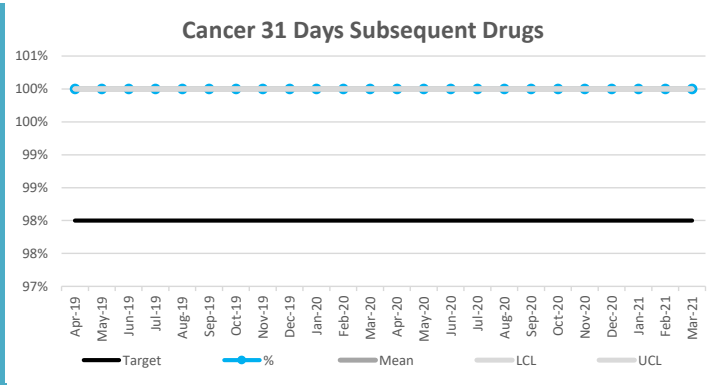
Key:
Risk Register
Single Oversight Framework
Care Quality Commission

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 14 Days Red: Less than 93% Green: 93% or above SOF CQC RR1125 **The Trust achieved 97.30% in March 2021.**		**The Trust did achieve the 2 week wait standard in March 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.**
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above SOF CQC RR1125 **The Trust achieved 96.55% in March 2021.**			
28 Day Faster Cancer Diagnosis Standard Red: Less than 75% Green: 75% or above **The Trust achieved 80.40% in March 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 March 2021 with 80.40% against a target of 75.00%.**	**Continue to maintain improvement against the FDS clinical review of standards pilot.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

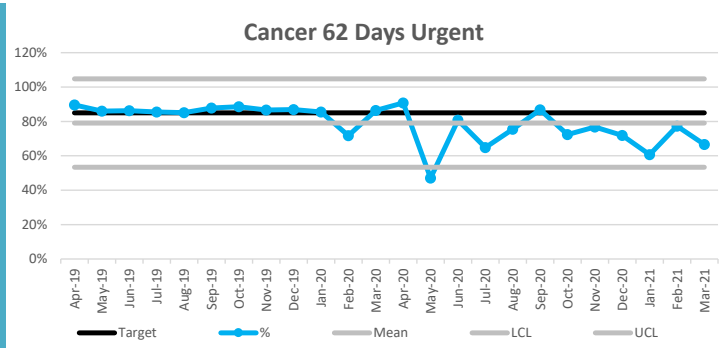
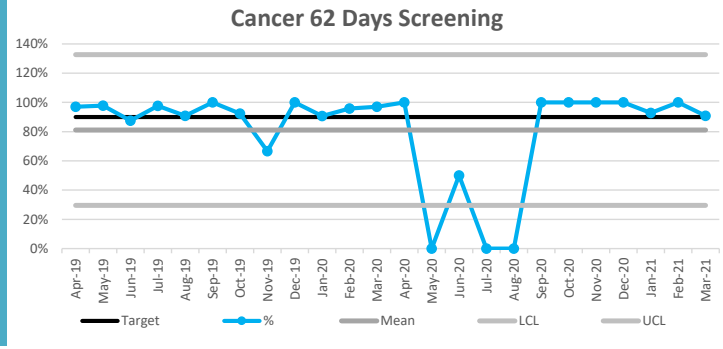
Key:
Risk Register
Single Oversight Framework
Care Quality Commission

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	**The Trust achieved 98.00% in March 2021.**		**The 31 day cancer target was achieved in March 2021 at 98.00% (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	**The Trust achieved 100% in March 2021.**			
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	**The Trust achieved 100% in March 2021.**		**The Trust achieved 100% in March 2021.**	**Maintain compliance against the 31 day subsequent treatment (drug) standard.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

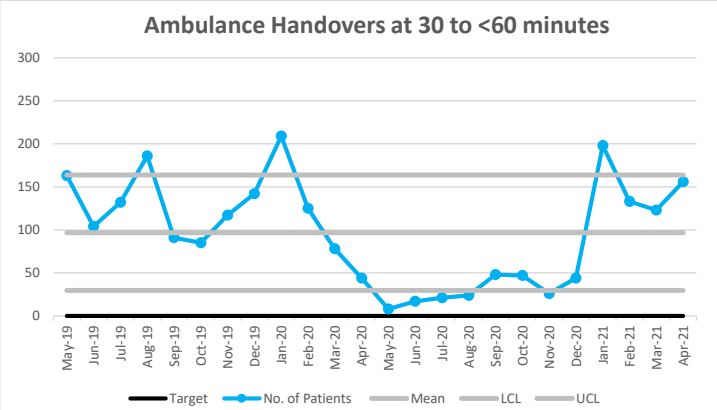
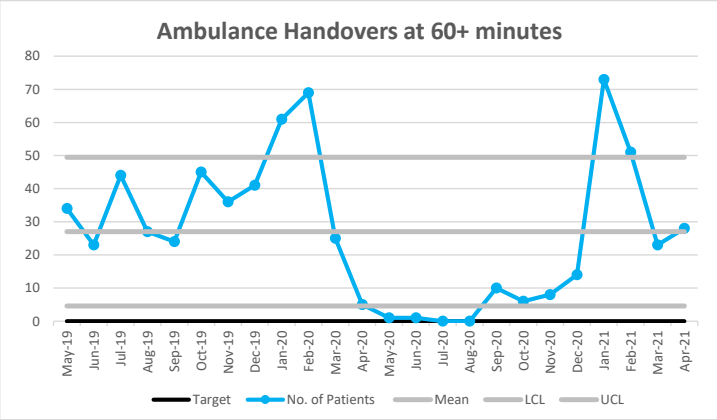
Key:
Risk Register
Single Oversight Framework
Care Quality Commission

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above The Trust achieved 66.67% in March 2021. RR1125		The 62 day urgent target was not achieved in March 2021 at 66.67%. There still remains a number of patients about 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 90.91%.	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 The Trust achieved 90.91% in March 2021. RR1125			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

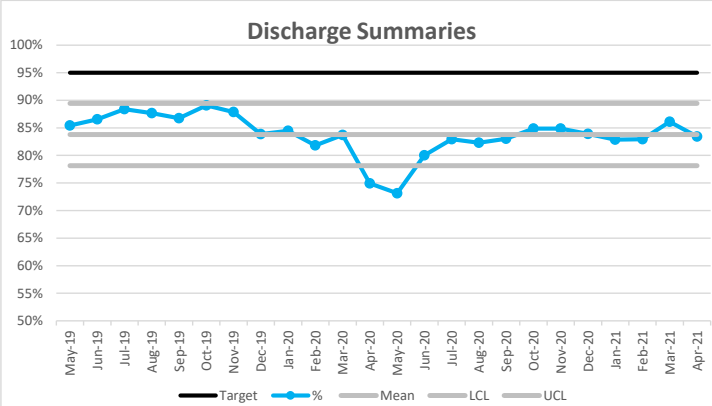
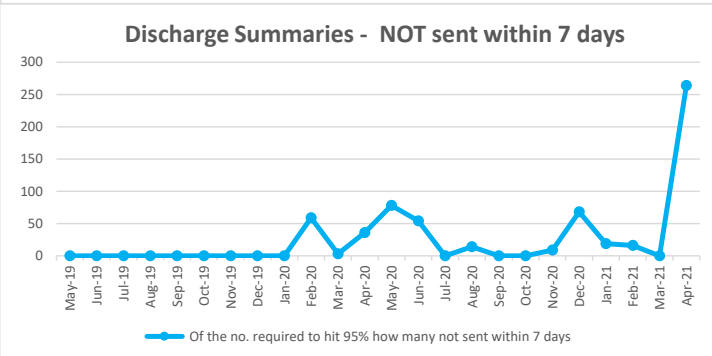
Access & Performance - Trust Position

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)?
Ambulance Handovers 30 to <60 minutes **Red: More than 0** **Green: 0** **There were 156 patients who experienced a delay in Ambulance Handovers between 30 to 60 minutes in month.**		**Handover performance remains challenged as a consequence of a significant rise of ED and Ambulance attends.**	**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 North West Ambulance Service to identify and implement improvements.**
Ambulance Handovers at 60 minutes or more **Red: More than 0** **Green: 0** **There were 28 patients who experienced a delay in Ambulance Handovers over 60 minutes in month.**			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register
Single Oversight Framework
Care Quality Commission

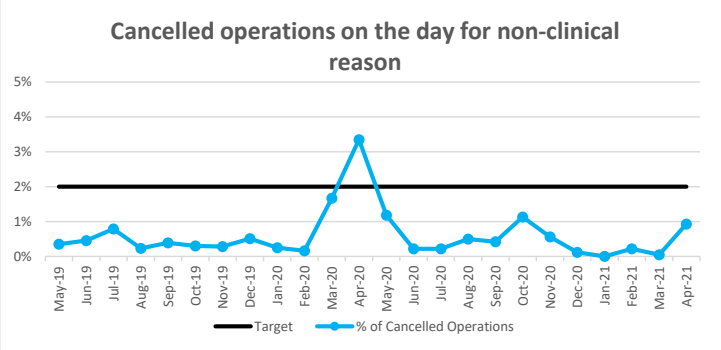
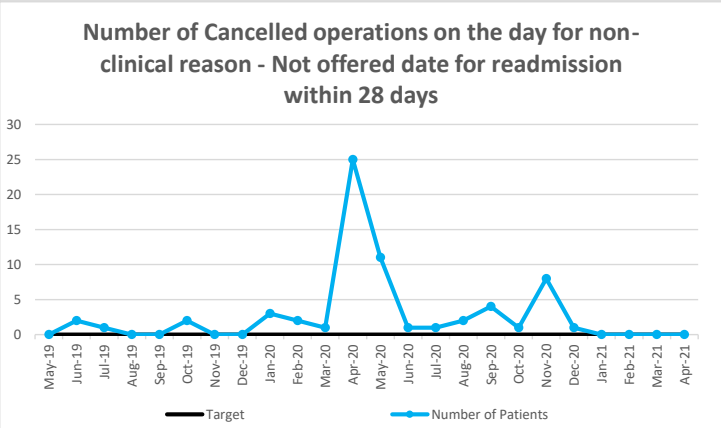
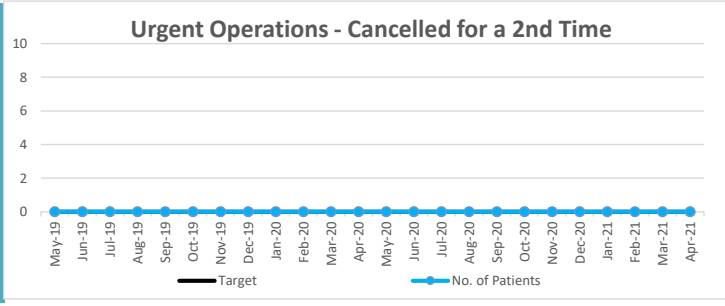
Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Discharge Summaries - % sent within 24hrs **Red: Less than 95%** **Green: 95% or above**	**The Trust achieved 83.43% 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 264 discharge summaries not sent within 7 days required to meet the 95.00% threshold.**		**The significant deterioration in performance in April is being investigated at the time of writing this report.**	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register
Single Oversight Framework
Care Quality Commission

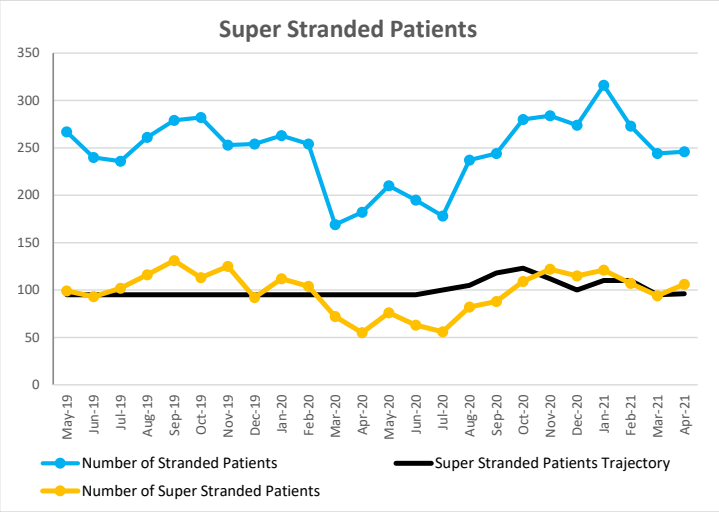
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancelled Operations on the day for a non-clinical reason Red: > 2% Green: < 2%	1.07% 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.
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	There was 0 cancelled operation on the day for non clinical reasons in month, where the patient was not re-booked in within 28 days.		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
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Super Stranded Patients Green: Meeting Trajectory Red: Missing Trajectory	There were 246 stranded and 106 super stranded patients at the end of April 2021.		The number of Stranded and Super Stranded patients on the last day of the month increased in April 2021.	The Trust is working in collaboration with partners from Local Authorities and community providers to ensure community capacity is available throughout the pandemic. The Trust has introduced "Focus on Flow" Length of Stay meetings on a daily basis to support timely discharge.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

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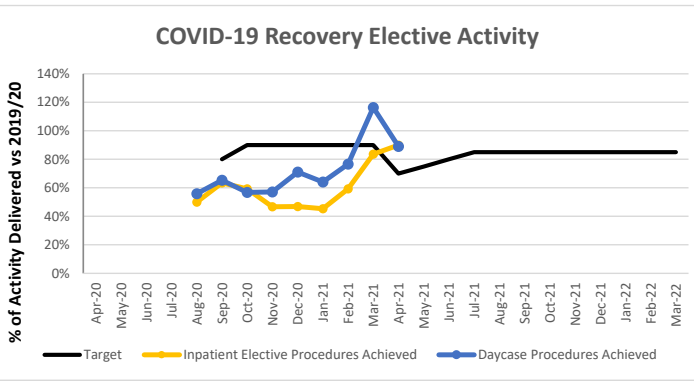
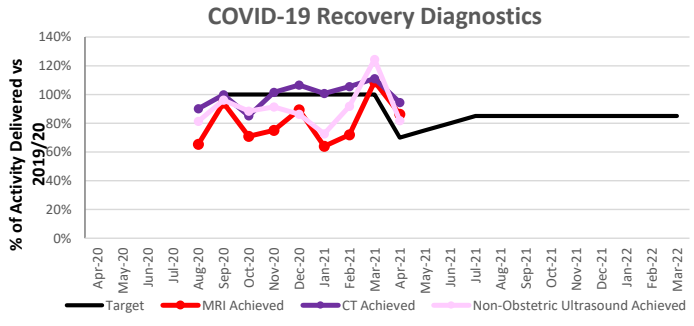
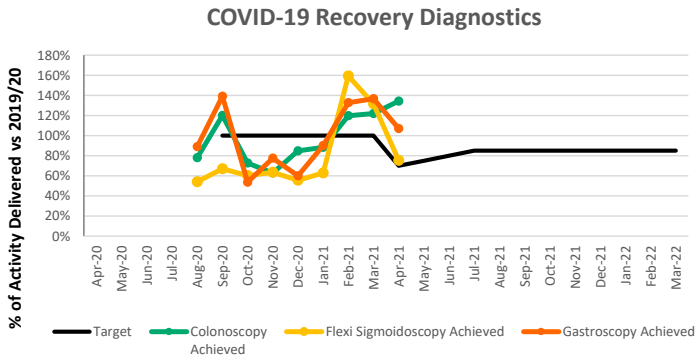
Risk Register
Single Oversight Framework
Care Quality Commission

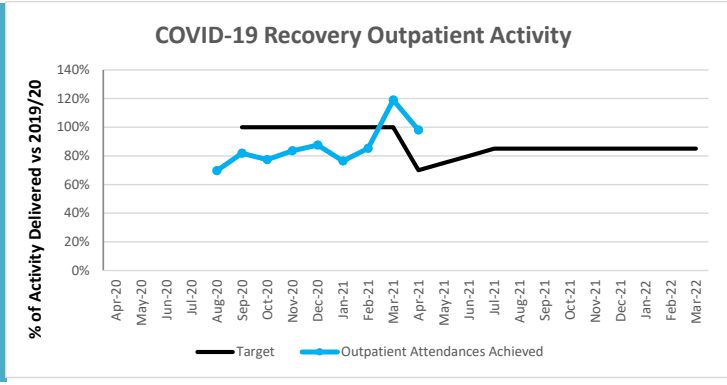
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
COVID-19 Recovery Elective Activity RED = Below Elective Recovery Target Green = Elective Recovery Target % activity is against activity in the same month in 2019/20	In April 2021, the Trust achieved the following % of activity against April 2019 (plan adjusted). This included 89.00% of Daycase Procedures and 90.00% of Inpatient Elective Procedures.		The Trust met the elective activity recovery trajectories for April.	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 April 2021, the Trust achieved the following % of activity against April 2019 (plan adjusted). This included: 86.28% of MRI 94.50% of CT 81.82% of Non Obstetric Ultrasound 134.34% of Colonoscopy 75.47% of Flexi Sigmoidoscopy 106.96% of Gastroscopy	 	The Trust met the diagnostic activity recovery trajectories for April.	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 | Single Oversight Framework | Care Quality Commission

Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
COVID-19 Outpatient Activity RED = Below Elective Recovery Target Green = Elective Recovery Target % activity is against activity in the same month in 2019/20	In April 2021, the Trust achieved 98.00% of Outpatient activity against April 2020 (plan adjusted)	The Trust met the Outpatient activity recovery trajectories for April.	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?

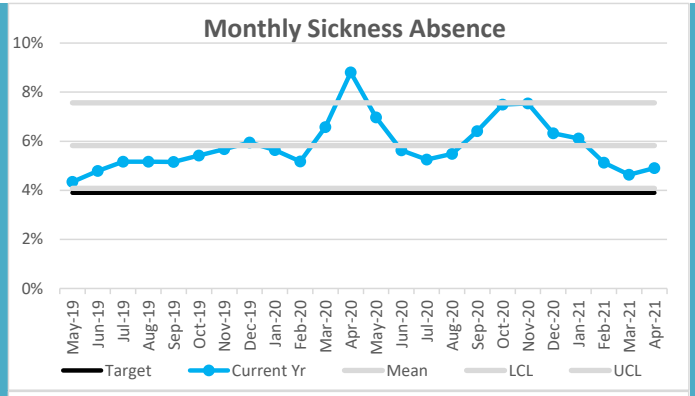
How are we going to improve the position (Short & Long Term)?

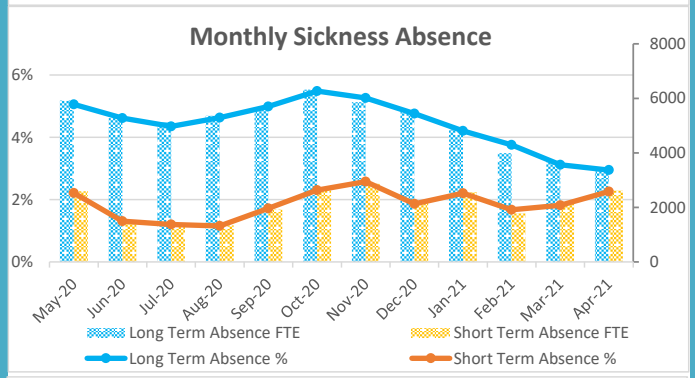
Sickness Absence

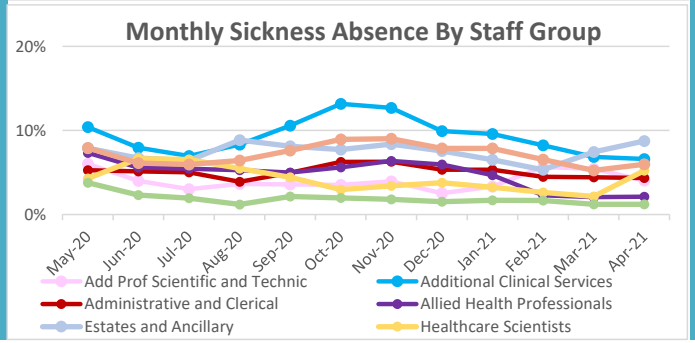
Red: Above 4.5%
Amber: 4.2% to 4.5%
Green: Below 4.2%

UoR SOF S RR200 RR1134 RR1108

The Trust's sickness absence was 5.21% in month.
SPC - There is evidence of special cause variation for sickness absence.







Sickness absence is 5.21% in April 2021.

0.60% relates to COVID-19 sickness absence and 4.60% relates to non-COVID-19 sickness absence.

The majority of absences (2.95%) relates to long term absences although this has continued to decline steadily from October 2020.

Sickness absence in April 2020 was 9.10%.

Anxiety, Stress and Depression are the most common reasons for sickness absence, followed by Chest and Respiratory problems.

Both the Estates & Ancillary and Healthcare Scientists Staff Groups sickness absence have increased significantly in April 2021.

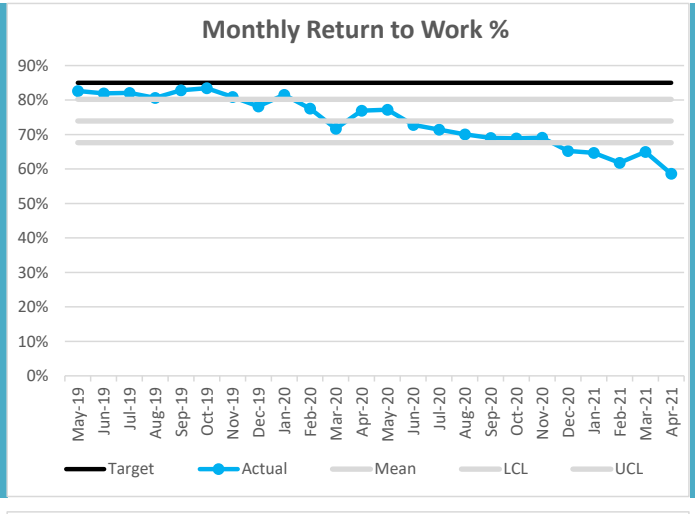
This increase has been driven by an increase in long-term sickness absence related to anxiety/stress/depression. The need for additional support within these staff groups is currently being reviewed.

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

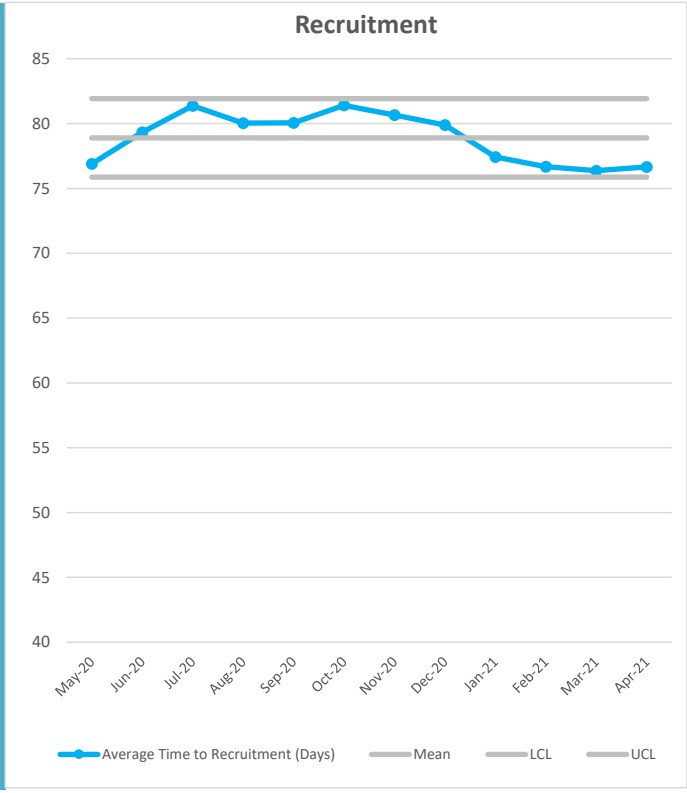
Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

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%	The Trust's return to work compliance was 58.61% in month. SPC - There is evidence of special cause variation for Return to Work compliance.	 Return to work interview compliance has reduced significantly due to pressures relating to COVID-19.	Return to work interviews remain a vital part of the support in place for our workforce. The reduction in compliance is in line with the findings of the Attendance Management Deep Dive and will form part of the recommendations as well as Workforce Recovery. The HR Business Partners continue to support to the CBUs to improve their compliance through the monthly meetings.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

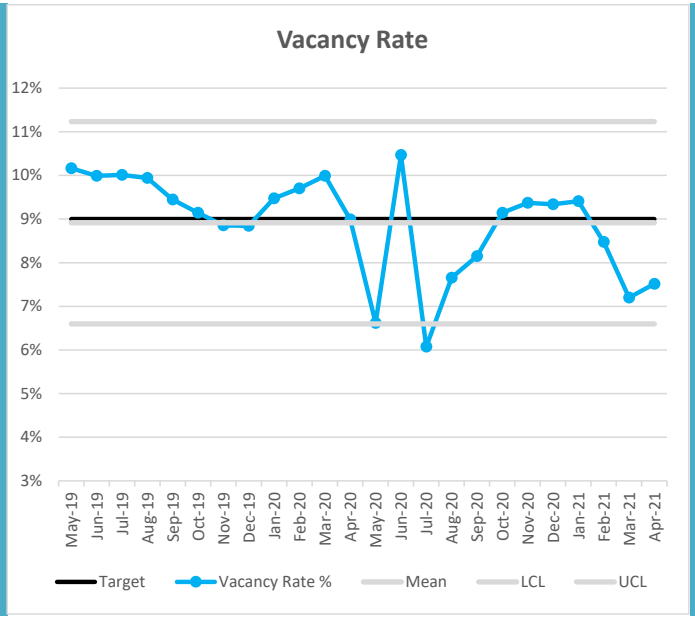
Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

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. However the Trust has seen a slight increase to 77 days in April 2021. This includes notices periods.	A review of the 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 improve on this, 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. Secondly, an e-form is in development for the candidates to complete which will allow them to upload copies of their ID documents. The Trust has previously made several amendments to keep time to hire to a minimum includes: • Inductions are now weekly providing much more flexibility with start dates. • Managing expectations of both the candidates and recruiting managers through improved communications • Contractual change letters and contracts are now emailed using the information supplied on the contractual change form (ECF).
The average number of working days to recruit is 77 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)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR The Trust vacancy rate was 7.51% in month. SPC - there is evidence of special cause variation for Vacancy Rates.		Vacancy rate remain below the Trust target (positive) at 7.51% in April 2021. In March 2020, the Trusts vacancy rate was 10.00%, the increase in recruitment activity over last 12 months due to COVID-19 for both permanent and temporary positions has enabled to Trust to remain below Trust target (9.00%) since February 2021.	The Trust has recruited 987 staff (728 FTE) compared to 821 (630 FTE) in the previous 12 months, a significant increase. Part of this increase in workforce includes 60 international nurses since November 2020 who are at various stages of their journey with WHH either in quarantine, currently training or out on the wards. A further 36 nurses are either to be appointed or are going through pre-employment clearances. The Trusts HCA recruitment drive between January 2021 and April 2021, resulted in the recruitment of 48 HCAs. Pastoral and educational support for both the International Nurses and HCAs has been increased to support the retention of these new recruits.

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)?

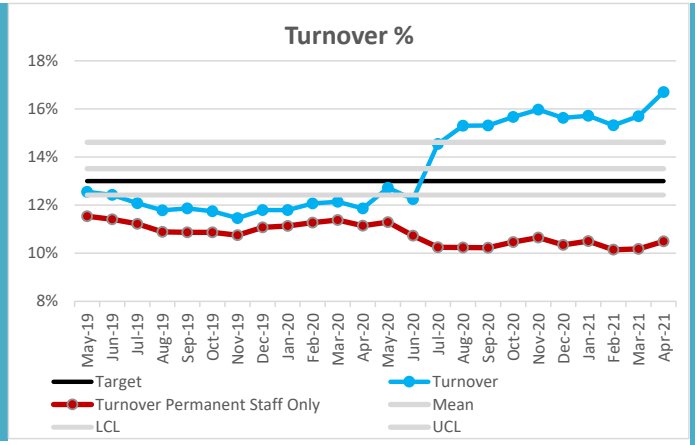
Turnover

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

CQC UoR

Trust Turnover was 16.70% in month.
SPC - There is evidence of special cause variation for Turnover.

S SOF

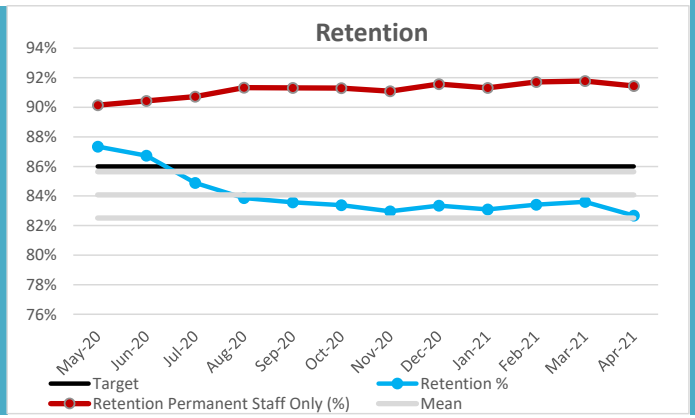


Retention

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

UoR

Trust Retention was 82.68% in month.
SPC - There is evidence of special cause variation for Retention.



Turnover in April 2021 and is above target at 16.70% (adverse). Turnover of Permanent staff is 10.50%. Retention in April 2021 is at 82.50%. Retention of Permanent staff is 91.40%.
Please note: there has been an error in the reporting of turnover, due to the exclusion of a number of temporary staff. This has been corrected for the previous 12 months.

For permanent staff only, the Trust is better than target for both Turnover and Retention. However due to the response to COVID-19 the Trust engaged 270 fixed term temporary staff whom have both joined and left the Trust since January 2020. This has impacted overall performance against the target.
This is demonstrated by both our turnover and retention of permanent staff surpassing the Trust targets.

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

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

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)?

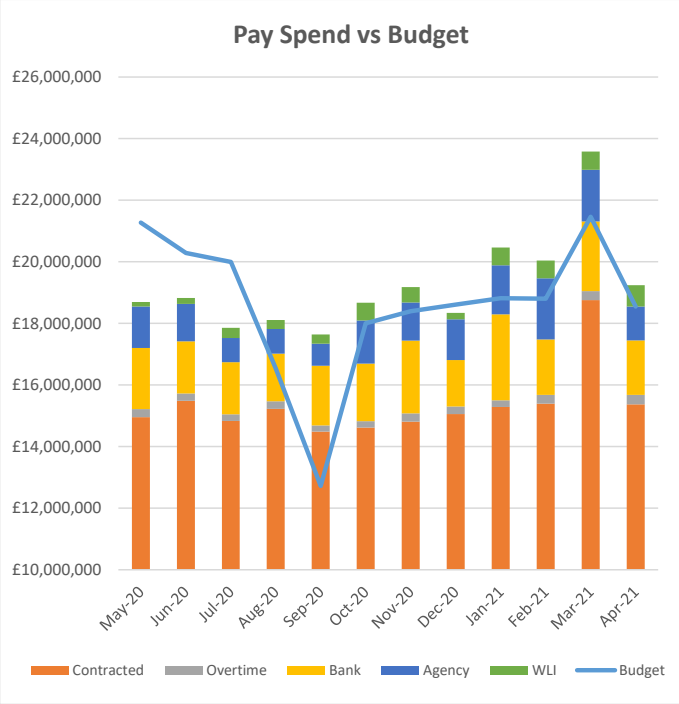
Pay

Red: Greater than Budget

Green: Less than Budget

UoR SOF RR199

Total pay spend in April 2021 was £19.24m against a budget of £18.55m.



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

- **£15.4m Contracted Pay (i.e. substantive staff)**
- **£1.8m Bank Pay**
- **£1.1m Agency Pay**
- **£0.69m Waiting List Initiative (WLI) Pay**
- **£0.3m Overtime Pay**

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

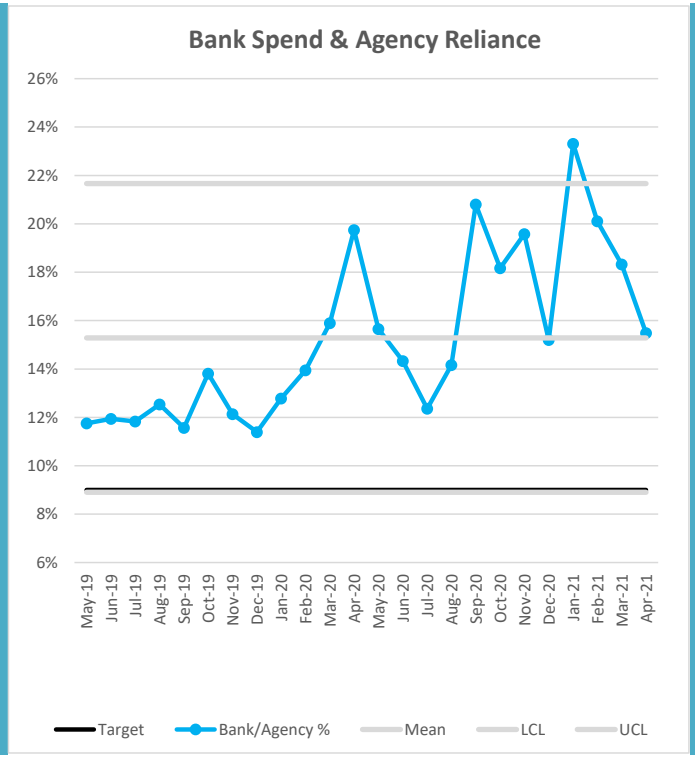
- **Enhanced ECF process for non-clinical vacancies;**
- **Expanded ECF process for agency temporary staffing pay spend;**
- **Introduction of Patchwork Medical Bank system;**
- **Introduction of +Us Medical Agency System;**
- **Introduction of central bank and agency team**

Through the Finance and Sustainability committee, compliance against our processes and rate cards is being monitored. This has enabled the Trust to identify where additional support from the central bank and agency team is required.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

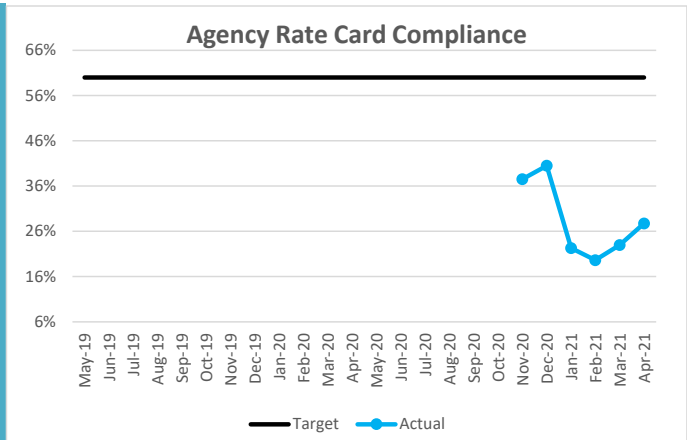
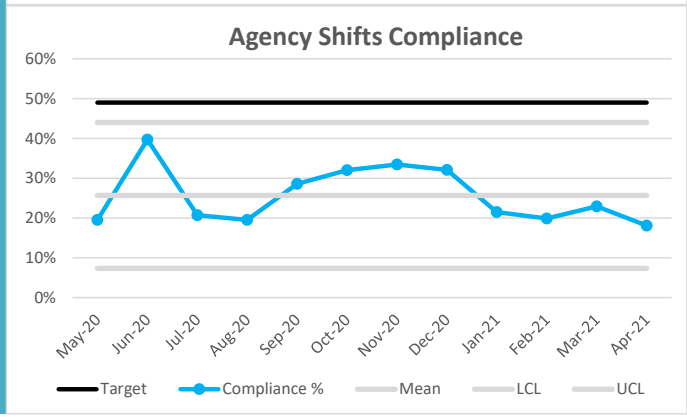
Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

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 15.48% in month. SPC - Bank/Agency reliance is within common cause (expected) variation.**		**Bank and Agency reliance peaked at 23.3% in January 2021 and although there has been a reduction in April 2021, reliance remains high at 15.48%.**	**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 and shows on-going improvement: In April 2021 0.00% of bookings were advertised straight to agency, with an approved 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) should reduce bank and agency reliance further.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR **Agency Rate Card Compliance was 27.72% in month.**		**Compliance with the NHSEI cap was 18.12%. In April 2021, non-compliance was highest amongst the following staff groups:** **• Medical and Dental: 100% above price cap.** **• Nursing and Midwifery: 88.00% above price cap.** **• Scientific, Therapeutic & Technical (AHPs): 33.00% above price cap.** **Compliance with the Cheshire and Merseyside rate card was 27.72% in April 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 and to negotiate rates down towards the Cheshire and Mersey Rate Card and the NHSI Price Cap compliance.** **Neither rate cards or caps have been amended throughout 2020 and 2021, to consider the response to COVID-19 or inflation. The Trust will perform a review and recommend adjustments.**
UoR **18.12% of shifts were compliant with the NHSI Price Cap.** **SPC - There is evidence of special cause variation within Agency Shift Compliance.**			

Agency Rate Card Compliance

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

Agency Shifts Compliant with the Cap

Red: below 49%
Green: above 49%

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)

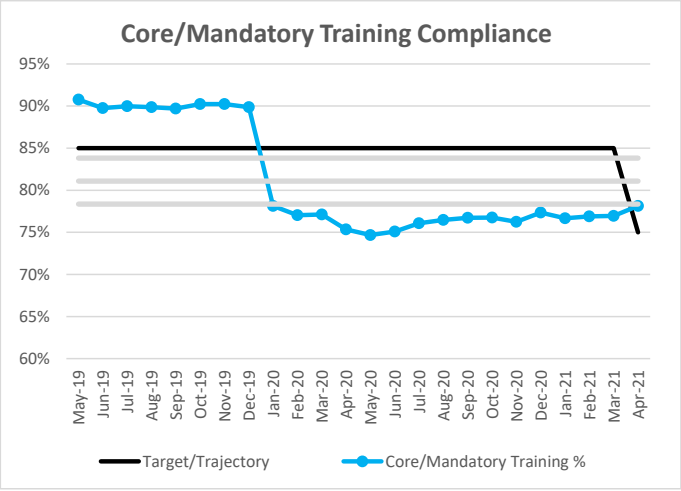
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Core/Mandatory Training

Red: Below Trajectory
Green: Trajectory

CQC

Core/Mandatory training compliance was 78.14% in month.
SPC - there is evidence of special cause variation.



In April 2021, Mandatory Training compliance was 78.14% and Role Specific Training compliance was 83.56%.

In line with National Guidance from NHS Employers (March 2020) and NHSE/I Guidance (January 2021), the Strategic Executive Oversight Group (SEOG) agreed a temporary pause on completion of Mandatory Training and Role Specific Training renewals for existing staff and a temporary pause on PDR completion for new and existing staff, where staff are unable to complete these due to the on-going COVID-19 response.

Recognising the pause 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.

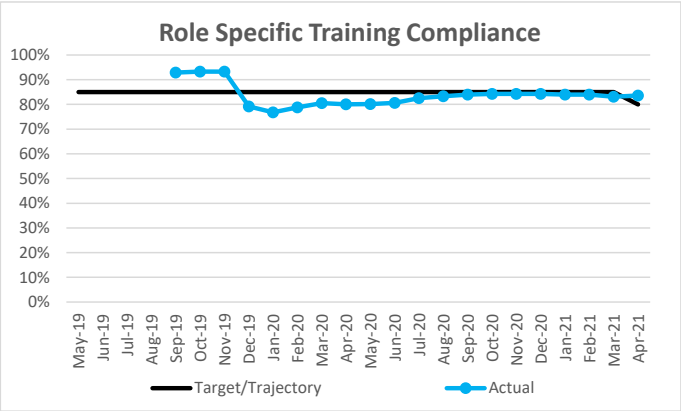
This improvement trajectory will set out a pathway to support organisational compliance of 85.00% by 31st March 2022.

Role Specific Training

Red: Below Trajectory
Green: Trajectory

RR153

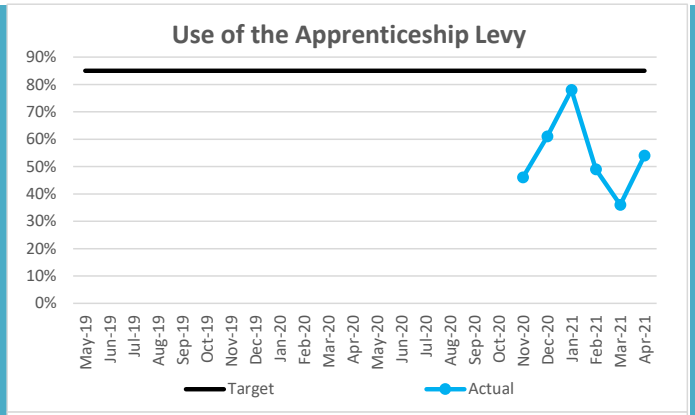
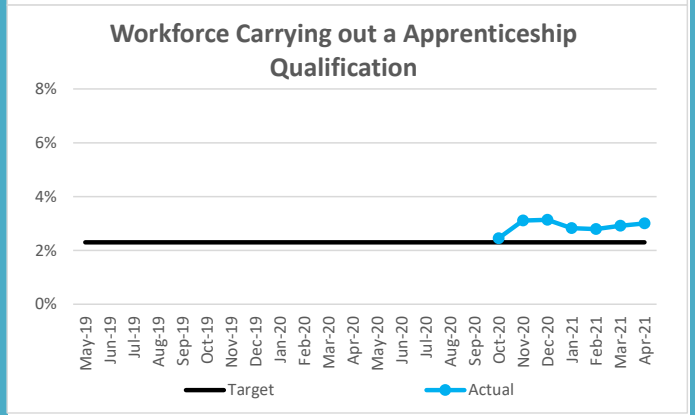
Role Specific Training compliance was 83.56% in month.



Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

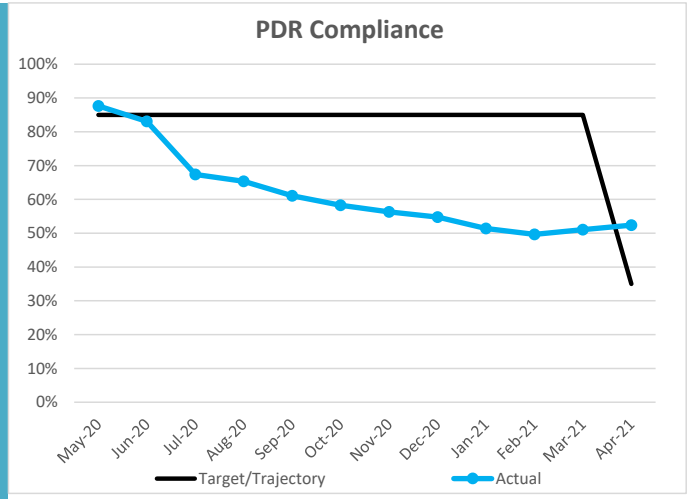
Key:
Single Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR200)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Use of Apprenticeship Levy Red: below 50% Amber: 50-84% Green: 85% or above		Utilisation of the apprenticeship levy is below target in month, although 3.00% 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. A proportion of the HCAs recently recruited, will be completing their apprenticeship, supporting their development.
Workforce carrying out an Apprenticeship Qualification Red: below 1.5% Amber: 1.5% - 2.2% Green: 2.3% or above			
Use of the Apprenticeship Levy was 54.00% in month.			
Percentage of the workforce carrying out a qualification was 3.00% 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)?
PDR Red: Below Trajectory Green: Trajectory PDR compliance was 52.39% in month.		In February 2021 PDR compliance was 52.39%. In line with National Guidance from NHS Employers (March 2020) and NHSE/I Guidance (January 2021), the Strategic Executive Oversight Group (SEOG) agreed a temporary pause on completion of Mandatory Training and Role Specific Training renewals for existing staff and a temporary pause on PDR completion for new and existing staff, where staff are unable to complete these due to the on-going COVID-19 response.	Recognising the pause 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. This improvement trajectory will set out a pathway to support organisational compliance of 85% by 31st March 2022.

Sickness Absence Actions

The Recommendations from the Attendance Management Deep Dive were approved by the Strategic People Committee in March 2021. These recommendations were:

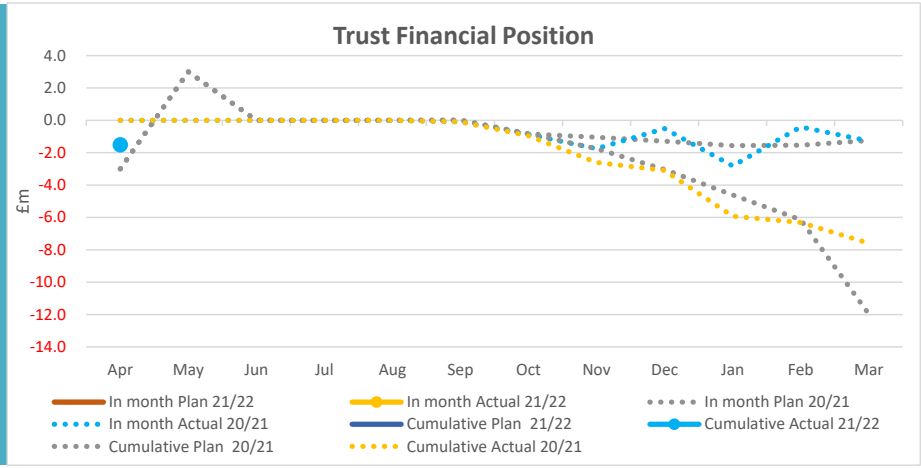
- **Continue the current focus on employee Health and Wellbeing and the approach that has been in place since the appointment of the Head of Engagement and Wellbeing and the response to the COVID-19 pandemic.**
- **Focus on interventions for staff living in Halton and Warrington, working with local and community partners.**
- **Review 'Supported Early Return' pilot and roll out, prioritising specific the staff groups.**
- **Undertake a full and thorough review Attendance Management Policy, including liaison with organisations outside of the NHS.**
- **Using the opportunity presented by the policy review to introduce a simpler process and embed Just Culture principles.**
- **Continue the work on exploring opportunities relating to an absence management system.**
- **Simplify management processes relating to Attendance Management, including but not limited to the Attendance Management Policy.**
- **Set expectations of line manager regarding people management practices.**
- **Introduce a new training approach for line managers to meet those expectations.**
- **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 task and finish group as been established to drive these recommendations forward.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
The Trust has recorded a deficit position of £1.5m as at 30 April.		For the period ending 30 April 2021 the Trust has recorded a deficit position of £1.5m against a deficit plan of £1.4m. The position includes an overspend on COVID-19 partly offset with underspends in other areas of the organisation.	The Trust is applying national guidance as this emerges in relation to financial planning for 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) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR1176)

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)?

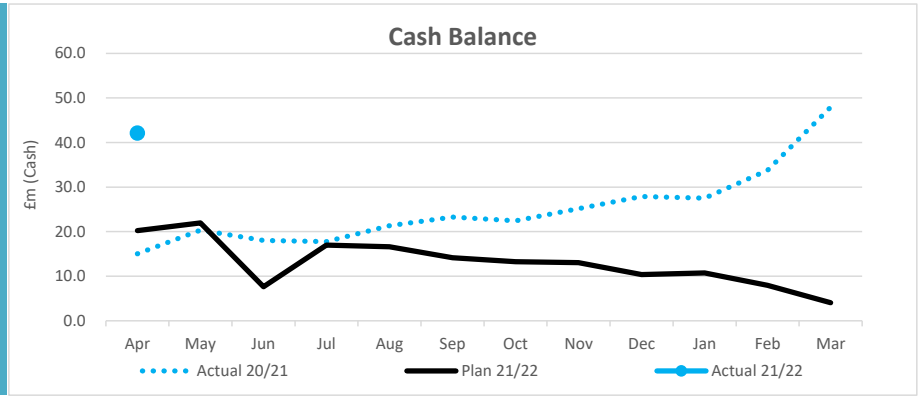
Cash Balance

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 £42.2m.

RR134



The current cash balance is £42.2m which is £22.00m better than the initial cash plan.

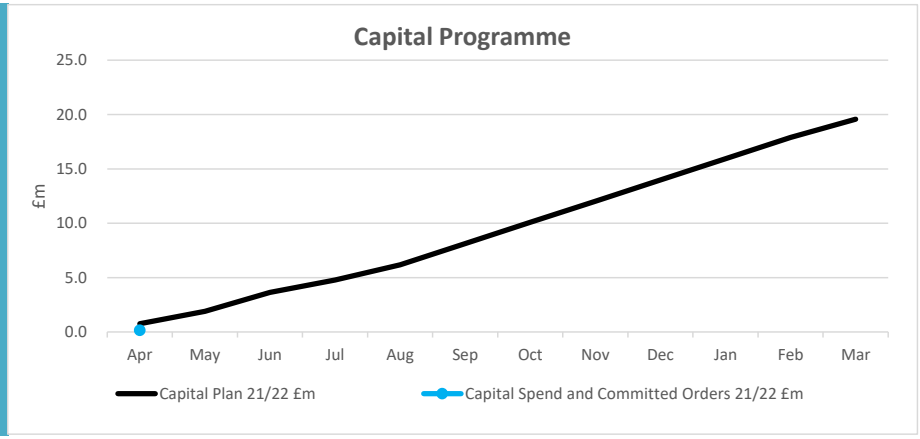
Capital Programme

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 1 was £0.15m. In addition there are £1.4m committed orders on the system.

RR1176

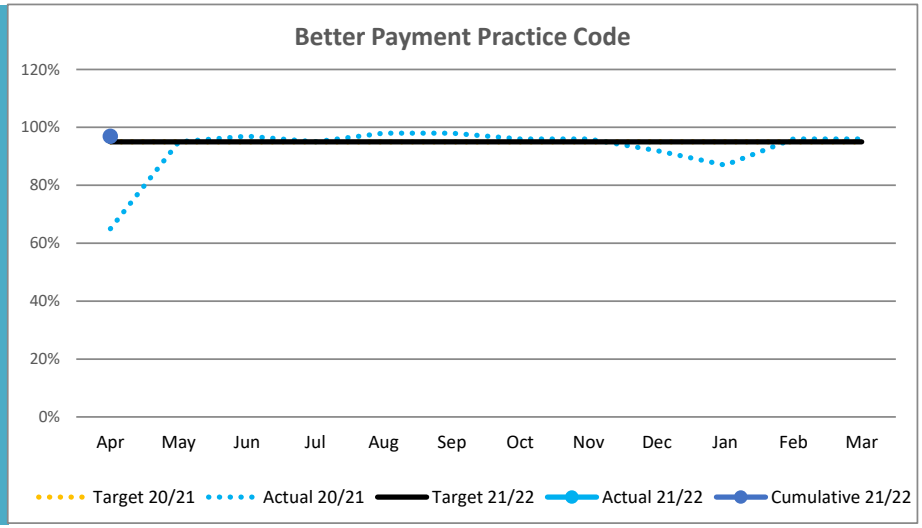


The Trust Board approved capital plan is £19.6m. The actual spend year to date is £0.15m which is £0.61m below the planned spend of £0.76m. However, the Trust has committed orders of £1.4m.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register
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 97.00% of suppliers within 30 days.		**Performance of 97.00% is above 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

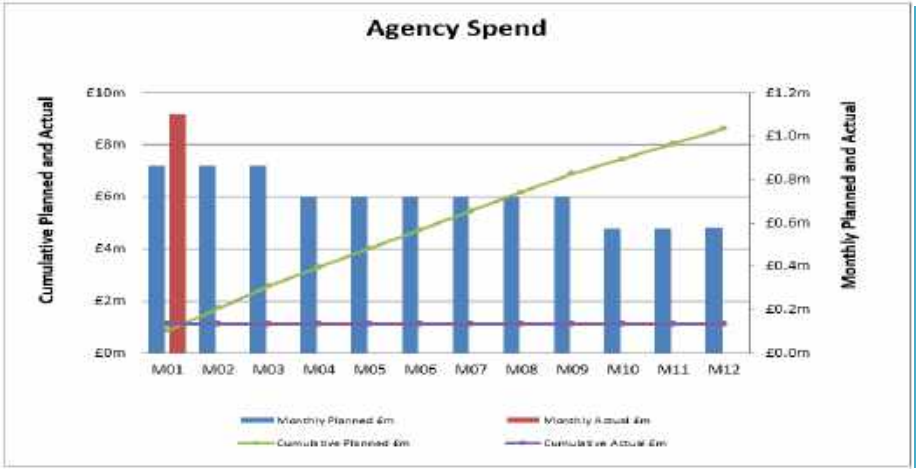
The Use of Resources Rating is not currently being reported. The Trust is awaiting further guidance from NHSE/I.

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR11b)
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 **The actual agency spend in month is £1.1m.** RR199		**The spend of £1.1m is £0.24m above the plan of £0.86m. £0.5m relates to COVID-19.**	**The Trust continues to monitor and report the use and spend on agency as well as the use of efficient models to reduce costs. The Trust is part of a Cheshire & Mersey collaborative that has established a standard rate card across all staff groups and specialties to reduce rates and is enhancing processes and controls to ensure appropriate and best use of agency staff.**

Agency Spending

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register
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 monthly savings are £0.003m.		**The monthly savings are £0.003m.**	**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			
	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 (£2.6m) for the remainder of the year.		**There is no CIP target in Q1 2021/22. The Trust has a target of £2.6m 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 schemes utilising all tools and benchmarking information available such as Model Hospital, GIRFT, NHSI support.**
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	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?

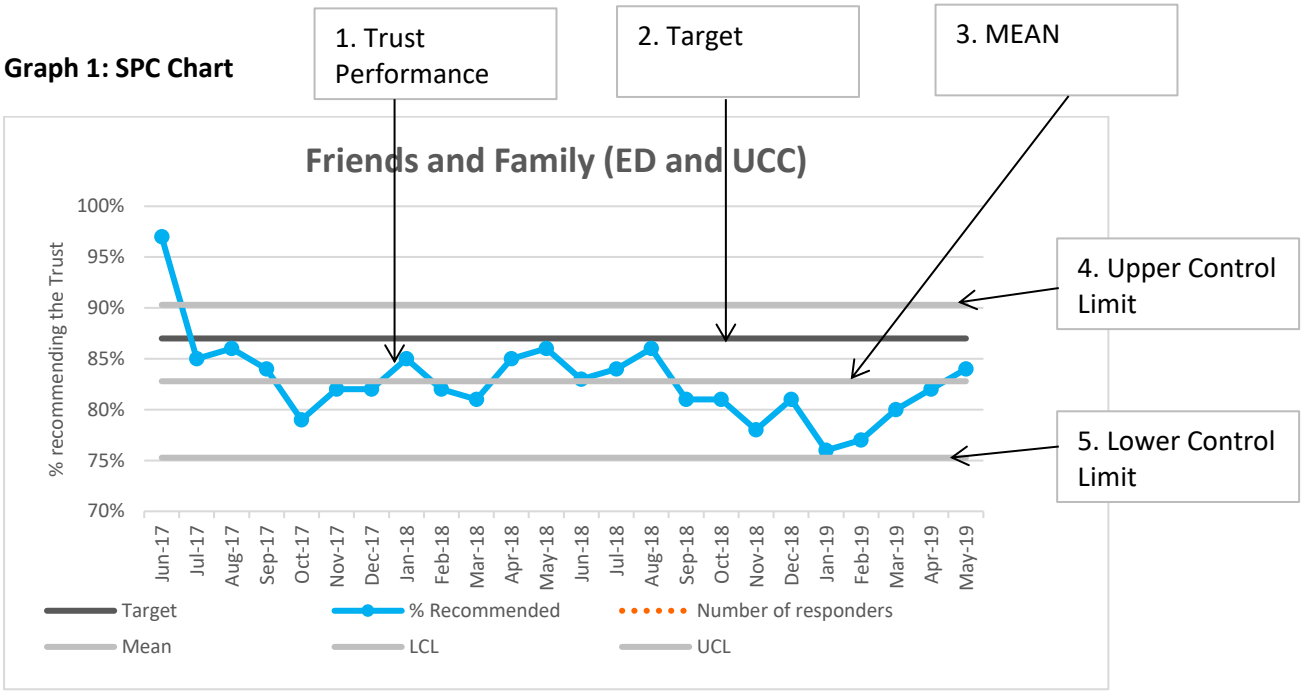
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

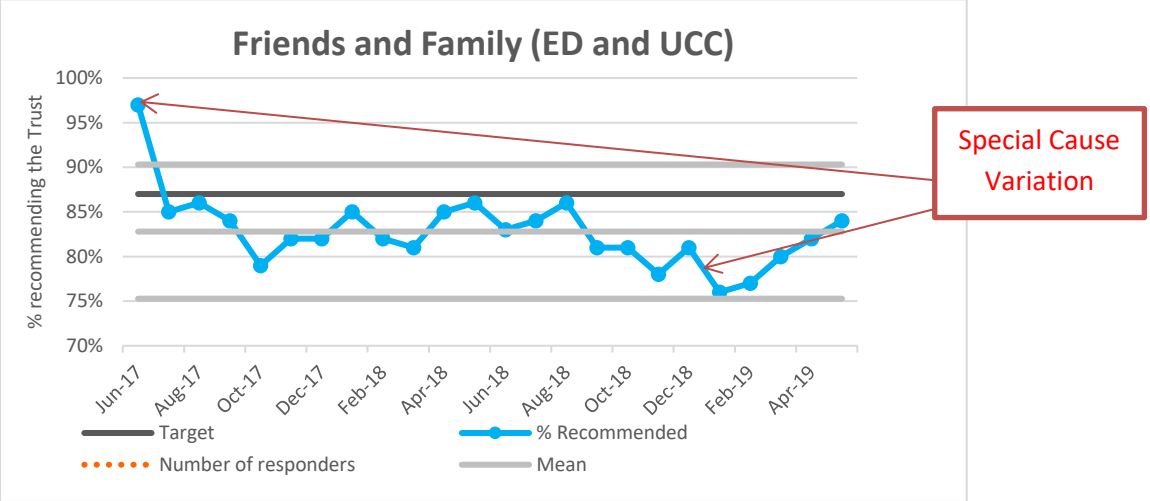
Graph 1: SPC Chart



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 30th April 2021

Income Statement	Month		
	Budget £000	Actual £000	Variance £000
Operating Income			
NHS Clinical Income			
Elective Spells	2,550	2,069	-481
Elective Excess Bed Days	13	0	-13
Non Elective Spells	5,987	5,619	-367
Non Elective Bed Days	0	112	112
Non Elective Excess Bed Days	150	0	-150
Outpatient Attendances	3,066	2,744	-322
Accident & Emergency Attendances	1,411	1,530	118
Other Activity	5,796	7,017	1,221
COVID Top up Income (Liverpool CCG)	3,863	3,772	-91
Sub total	**22,836**	**22,863**	**28**
Non NHS Clinical Income			
Private Patients	0	29	29
Non NHS Overseas Patients	3	6	3
Other non protected	81	52	-29
Sub total	**84**	**86**	**3**
Other Operating Income			
Training & Education	640	640	0
Donations and Grants	0	0	0
Miscellaneous Income	809	1,108	299
Sub total	**1,449**	**1,748**	**299**
Total Operating Income	**24,369**	**24,698**	**329**
Operating Expenses			
Employee Benefit Expenses	-18,550	-18,938	-388
Drugs	-1,242	-1,506	-264
Clinical Supplies and Services	-1,834	-1,538	296
Non Clinical Supplies	-2,735	-2,887	-151
Depreciation and Amortisation	-937	-937	0
Net Impairments (DEL)	0	0	0
Net Impairments (AME)	0	0	0
Restructuring Costs	0	0	0
Total Operating Expenses	**-25,298**	**-25,804**	**-507**
Operating Surplus / (Deficit)	**-929**	**-1,107**	**-178**
Non Operating Income and Expenses			
Profit / (Loss) on disposal of assets	0	0	0
Interest Income	0	0	0
Interest Expenses	0	0	0
PDC Dividends	-436	-436	0
Total Non Operating Income and Expenses	**-436**	**-436**	**0**
Surplus / (Deficit) - as per Accounts	**-1,365**	**-1,543**	**-178**
Adjustments to Financial Performance			
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0
Less Donations & Grants Income	0	0	0
Add Depreciation on Donated & Granted Assets	0	18	18
Total Adjustments to Financial Performance	**0**	**18**	**18**
Adjusted Surplus / (Deficit) as per NHSI Return	**-1,365**	**-1,525**	**-160**

Activity Summary	Planned	Actual	Variance
Elective Spells	2,677	2,465	-212
Elective Excess Bed Days	47	0	-47
Non Elective Spells	3,614	2,408	-1,206
Non Elective Bed Days	0	311	311
Non Elective Excess Bed Days	553	0	-553
Outpatient Attendances	27,891	25,899	-1,992
Accident & Emergency Attendances	9,364	9,848	484

Appendix 6 - Capital Plan Analysis as at 30 April 2021

Scheme	31 March 2021 £000's	Revised 30 April 2021 For Approval £000's	Approval Status	Expected start date	Expected finish date
Warrington & Halton Breast Unit Relocation	1,200	1,200	Started	Commenced	Oct-21
MRI Estates	900	900	Completed	Commenced	Aug-21
Underspends from 20/21:					
Carry forward	1,900	1,672	CPG Paperwork received 20/21 or Required		
2021/22					
Contingency - for urgent and emergency schemes through out the year	1,000	1,000	Urgent Capital requests		
Non Mandated:					
Shopping City Health and Wellbeing Hub	380	608	CPG 30/04/2021	01/06/2021	30/09/2021
New Town	100	100	CPG 30/04/2021	01/05/2021	31/03/2022
Sub A Statix Fire Protection	50	50	CPG Paperwork Required		
008 Network Switch Expansion	23	23	CPG Paperwork Required		
Backlog - Flooring Replacement Works	150	150	CPG Paperwork Required		
Breast Relocation Equipment	216	216	CPG Paperwork Required	Commenced	01/07/2021
Other *	681	441	CPG Paperwork Required		
SAN *		240	Completed	May-21	Jul-21
Urology	870	870	Started	Jun-21	Feb-22
	2,470	**2,698**			
SUB TOTAL					
Mandated schemes					
Call Alarms for all Anaesthetic & Recovery Rooms Halton Site	90	90	CPG Paperwork Required		
IT Staffing	316	316	CPG 30/04/2021	Apr-21	Mar-22
Essential power installation - Halton Pharmacy	9	9	CPG Paperwork Required		
Substation B at Warrington Replace 2no. Air Circuit Breakers and 1no. HV Ring Main Unit	200	200	CPG Paperwork Required		
Fire - Relocate and replace medical gas AVSU's to clinical wards	20	20	CPG Paperwork Required		
Backlog - Croft Wing Electrical remedial works following fixed electrical testing of clinical areas	30	30	CPG Paperwork Required		
Backlog - Provide safe surface temperatures of radiators in patient clinical areas	10	10	CPG Paperwork Required		
Backlog - North Lodge Basement Electrical Installation Replacement	225	225	CPG Paperwork Required		
Backlog - Fire install of fire dampers 2nd phase	100	100	Started	Aug-21	Dec-21
Backlog - Catering Department remove or replace roof lantern	30	30	CPG Paperwork Required		
Fire - Replacement of obsolete 5000 series fire alarm panels and end of line devices	600	600	Started	Jul-21	Jan-22
Estates Capital Staffing for Design Team Works	177	177	CPG Paperwork Required		
Fire - Halton 30 minute Fire Compartmentation (Phase 2)	150	150	Started	May-21	Oct-21
Appleton Wing Circulation Areas Fire Doors	200	200	CPG Paperwork Required		
Warrington and Halton Gas Meter Replacement	100	100	CPG Paperwork Required		
Backlog - All areas fixed installation wiring testing	100	100	CPG Paperwork Required		
6 Facet survey annual update	55	55	CPG Paperwork Required		
Backlog - Water Safety Compliance	50	50	CPG Paperwork Required		
Backlog - Annual Asbestos Management & Remedial	30	30	CPG Paperwork Required		
Backlog - HV (High Voltage) Maintenance annual	40	40	CPG Paperwork Required		
CMTC Replacement Emergency Lighting	150	150	CPG Paperwork Required		
SUB TOTAL	**2,682**	**2,682**			
Business Critical					
New Maternity system integration to Lorenzo	132	132	CPG 30/04/2021	Aug-21	Mar-22
New Maternity system	100	100	CPG 30/04/2021	Apr-21	Mar-22
005 Cisco Refresh (Phase 1)	192	192	Completed	Oct-21	Mar-22
006 Comms Cabinets (Phase 2) x 2 (one each site)	90	90	Paperwork submitted awaiting approval	Sep-21	Dec-21
007 IP Telephony	65	65	Completed	Jul-21	Sep-21
012 UPS - Main Server Room at Warrington	190	190	Paper work to be submitted May 21	TBC	TBC
013 Data Warehouse Infrastructure Refresh	85	85	Paper work to be submitted May 21	Oct-21	Jan-22
014 Device Replacement (Tech Refresh)	55	55	Completed	Apr-21	Mar-22
EPMA 1-4	24	24	Submit paper work in May 21	TBC	TBC
Health & Wellbeing Workplace	13	13	CPG Paperwork Required		
Cardiac Catheterisation Suite	800	800	Started	01/08/2021	15/09/2021
Radiology - Fluoroscopy Room	300	300	CPG Paperwork Required	01/08/2021	15/09/2021
Phase 2 Structure - Digital Project Management and Benefits Management resource	165	165	CPG 30/04/2021	Jul-21	Mar-22
Lorenzo Theatres Licences	218	218	Subject to new Lorenzo contract	TBC	TBC
Chief Nurse Information Post	31	31	Requested further information		
Electronic Patient Record Procurement	243	243	CPG 30/04/2021	Apr-21	Mar-22
Induction Bay	22	22	CPG Paperwork Required		
SUB TOTAL	**2,725**	**2,725**			
PDC Funded **					
Paeds	700	700	Started	Aug-21	Feb-22
ICU	1,000	1,000	Started	Mar-21	Jun-21
ED Plaza	5,000	5,000	Completed	Aug-21	Feb-22
SUB TOTAL	**6,700**	**6,700**			
TOTAL	**19,577**	**19,577**			

* 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. The Trust intends to apply in June 2021, depending on the revised cash plan.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/05/68 a**			
SUBJECT:	**Safe Staffing Assurance Report – February & March 2021**			
DATE OF MEETING:	26th May 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 February & March 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 February was recorded at 6.55% showing a decrease from the December/January report which was recorded at 7.65%. Sickness data in March details a further decrease to 5.4%. In the month of February it was noted that 11 of the 21 wards were below the 90% target during the day, with a similar position noted in March 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 February was 7.9 and 8.1 in March, with a year to date rate 7.8. WHH have joined Wigan, Wrightington and Leigh NHS Trust to participate in a regional pilot for recruitment of international nurses. Following a successful business case we have recruited 30 registered nurses to join the Trust between the months of February and April 2021. The Healthcare Assistant recruitment campaign was successful and we will be reporting zero vacancies in April, with a reserve list is available for turnover in the coming months.			
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/21/05/52
	Date of meeting	19 May 2021
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Safe Staffing Assurance Report – February & March 2021	AGENDA REF:	BM/21/05/68 a

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report – February & March 2021.

The purpose of this report is to provide assurance with regard to the nursing and midwifery ward staffing levels during the months of February & March 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 October and November 2020 ward staffing data continued to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels.

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

Care Hours Per Patient Day

The Trust currently collects and reports CHPPD data on a monthly basis. CHPPD is the total time spent on direct patient care based on the number of occupied beds at midnight. The October and November 2020 Trust wide staffing data was analysed and cross-referenced, with ward level data for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (Clinical Effectiveness).

Table 1 illustrates the monthly CHPPD data. In the month of February CHPPD was recorded at 7.9 and March recorded at 8.1 with a 2020/21 YTD figure of 7.8. This is in comparison to the national YTD figure of 8.1.

During the COVID-19 Trust response the Trust was not required to submit staffing data to Unify as part of the pause of some activities, therefore the data has resumed collection in June 2020. During the pause staffing reviews were undertaken three times per day with responsive and robust plans in place

to ensure that all wards were adequately staffed. Staff data continued to be recorded on Gold Command and in E-roster.

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

Table 1 – CHPPDD Data 2020/21

	Trust wide			
Month	**Cumulative count over the month of patients at 23:59 each day**	**Registered midwives/nurses**	**Care Staff**	**Overall**
Jun-20	14189	4.2	3.5	7.7
Jul-20	13433	4.7	4.1	8.8
Aug-20	13990	4.2	3.5	7.8
Sep-20	13616	4.2	3.3	7.5
Oct-20	14058	4.5	3.2	7.6
Nov-20	13774	4.5	3.2	7.7
Dec-20	13902	4.3	3.2	7.5
Jan-21	14691	4.4	3.2	7.6
Feb-21	12805	4.6	3.3	7.9
Mar-21	13262	4.3	3.8	8.1
YTD	137720	4.4	3.4	7.8

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 February and 10 out of 20 in March 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.

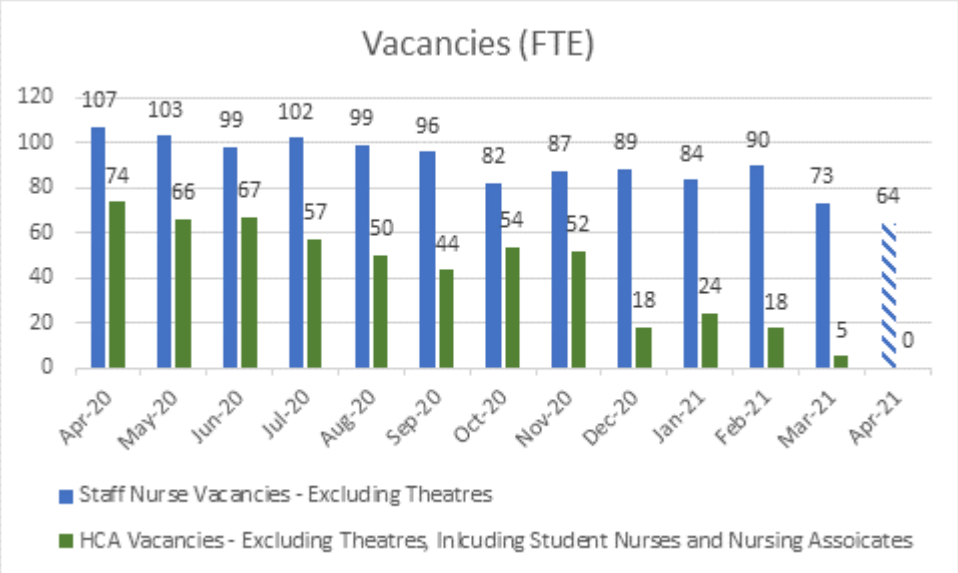
In order to ensure safe staffing levels, mitigation and responsive plans continue to be put in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates continue to be monitored month on month.

Maternity (ward C23) was stable at 90% 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 December 2020 we had 89 registered nurse and 65 health care assistant vacancies at WHH, as seen in chart 1, which requires reliance on temporary staffing to ensure safe staffing levels on the wards. In January we have maintained the vacancy levels with 84 registered nurse and 71 health care assistant vacancies – an improvement for RN but extra HCA.

Chart 1 - Registered Nurse and Health Care Assistant vacancies 2020-2021



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

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

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

Recruiting to HCA vacancies remains a challenge for the Trust and although we have recruited 103 HCA staff since February 2020. The Trust has recently received funding from NHSI to enhance HCA recruitment and pastoral support in the clinical areas, progress against this will be reported monthly to the Workforce Group. In April 2021 we will be reporting zero HCA vacancies following a successful

campaign to fill all posts by the end of March 2021. Following the campaign we now have a waiting list of potential HCAs to fill any turnover in the coming months.

Escalation Beds and Costs

In the months of February & March 2021 there were two additional wards open, K25 and B3 both of which are currently being managed by the Unplanned Care Group. These areas have had staffing support from the recently displaced staff from ward B1 after it closed in the summer months. Cost associate with these wards are detailed below in table 2 and 3.

Table 1 – Cost associated with additional beds in February 2021

Feb-21			
No. Bed Days	**Additional Costs £**	**Notional Bed Day Cost £**	**Total Cost £**
543	122,746	0	122,746
478	108,053	0	108,053
1021	**230,799**	**0**	**230,799**

Table 1 – Costs associated with additional beds in March 2021

Mar-21			
No. Bed Days	**Additional Costs £**	**Notional Bed Day Cost £**	**Total Cost £**
527	119,129	0	119,129
558	126,137	0	126,137
1085	**245,266**	**0**	**245,266**

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

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

Sickness Absence – February & March 2021

During the month of February registered nurse and midwifery absence rates were recorded at 6.55% showing a decrease from the December/January report which was recorded at 7.65%. Sickness data in March details a further decrease to 5.4%. The cost of bank/agency cover of qualified nursing sickness (at usual bank/agency fill rates) is £247,906 in February and £205,552 for March as detailed in the tables 4 and 5 below;

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

	Feb-21
Contracted Nursing WTE (Band 5 to 7)	925.05
% Sickness	6.55%
WTE Equivalent of Sickness	60.59
NHSP Fill Rate	76%
WTE Covered by Temporary Staffing	46.05

Cost at Average NHSP Rates	***247,906***

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

	Mar-21
Contracted Nursing WTE (Band 5 to 7)	930.35
% Sickness	5.40%
WTE Equivalent of Sickness	50.24
NHSP Fill Rate	76%
WTE Covered by Temporary Staffing	38.18
Cost at Average NHSP Rates	***205,552***

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

Moving to Oustanding – Use of Resources Assessment
See Appendix six for the summary

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. WHTH is slightly above the national median but better than the peer median.

Nursing Staffing Costs Per WaU – this has increased from 2018/19 to 2019/20 which will be as a result of posts being recruited to. The importance of considering this and the other staffing metrics in relation to wider metrics such as Care Hours Per Patient Day are important and professional leads need to be involved in providing narrative. It is also expected that costs per WAU may increase as productivity decreases as a result of the pandemic, however this will be the same for other organisations.

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

Patient Harm by Ward
In February we have reported 5 category 2 pressure ulcers on Wards 2 on A1, 3 on A6, 1 on ICU & 1 on A9. There have been 0 patient falls with moderate or major harm reported in February.

In March we have reported 7 category 2 pressure ulcers; 2 on Ward A6, 2 on A8 and 1 on Wards CAU, A2, B14 & B19. There was 1 patient fall with moderate harm reported in March on A7.

Infection Incidents
In both February & March the Trust did not report any cases of MRSA bacteraemia.

Midwifery Staffing Incidents

Following an increase in staffing related incidents in Maternity the Associate Chief Nurse is working with the team to improve the response. We have introduced Red Flags specific to the the Maternity area. 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.

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

Appendix One

Monthly Safe Staffing Data – Feb 21																			
		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1334.0	1173.0	1173.0	1282.5	88%	109%	839.5	897.0	966.0	943.0	107%	98%	667	3.1	3.3	0.2	0.0	6.6
DD	Ward A5	1610.0	1173.0	1288.0	1052.3	73%	82%	1288.0	1161.4	1288.0	862.0	90%	67%	710	3.3	2.7	0.1	0.0	6.1
DD	Ward B18	690.0	690.0	690.0	690.0	100%	100%	690.0	690.0	690.0	690.0	100%	100%	488	2.8	2.8	0.0	0.0	5.7
MSK	Ward A6	1782.5	1253.5	1782.5	1437.0	70%	81%	1069.5	1062.0	1782.5	1336.0	99%	75%	891	2.6	3.1	0.0	0.0	5.7
MSK	CMTC	1069.5	885.5	713.0	546.5	83%	77%	713.0	713.0	713.0	287.5	100%	40%	175	9.1	4.8	0.0	0.0	13.9
W&C	C20	1069.5	996.5	713.9	685.5	93%	96%	713.0	713.0	0.0	253.5	100%	0%	478	3.6	2.0	0.0	0.2	5.7
W&C	Ward C23	1288.0	1161.5	644.0	621.0	90%	96%	644.0	609.5	644.0	632.5	95%	98%	223	7.9	5.6	0.0	0.0	13.6
W&C	Birth Suite	1932.0	1752.5	345.0	310.5	91%	90%	1932.0	2079.5	345.0	290.5	108%	84%	211	18.2	2.8	0.0	0.0	21.0
W&C	The Nest	644.0	644.0	322.0	310.5	100%	96%	644.0	609.5	0.0	0.0	95%	0%	19	66.0	16.3	0.0	0.0	82.3
W&C	Ward B11	2508.5	2457.0	771.0	746.0	98%	97%	1674.0	1684.0	291.2	260.0	101%	89%	253	16.4	4.0	1.1	0.0	21.5
W&C	NNU	1610.0	1207.5	322.0	409.5	75%	127%	1610.0	1012.0	322.0	398.0	63%	124%	204	10.9	4.0	0.0	0.0	14.8
UEC	Ward A1	2100.0	1787.5	2100.0	2312.5	85%	110%	1460.2	1293.9	1168.2	861.8	89%	74%	900	3.4	3.5	0.0	0.0	7.0
UEC	Ward A2	1288.0	1023.5	1610.0	1432.5	79%	89%	966.0	1023.5	966.0	1012.0	106%	105%	840	2.4	2.9	0.0	0.0	5.3
UEC	ED	4900.0	6452.0	2450.0	1590.5	132%	65%	3212.4	4590.8	876.1	1481.6	143%	169%	n/a					
MC	ACCU	2254.0	1945.5	966.0	977.5	86%	101%	1610.0	1593.0	966.0	966.0	99%	100%	691	5.1	2.8	0.0	0.0	7.9
MC	ICU	4508.0	4973.8	966.0	839.5	110%	87%	4508.0	4835.8	966.0	799.3	107%	83%	639	15.4	2.6	0.0	0.0	17.9
MC	Ward A7	1610.0	1989.5	1288.0	1601.0	124%	124%	1288.0	1823.0	966.0	1294.0	142%	134%	811	4.7	3.6	0.0	0.0	8.3
IM&C	Ward C21	1035.0	890.0	1322.5	1306.5	86%	99%	713.0	809.5	1000.5	1014.5	114%	101%	669	2.5	3.5	0.0	0.0	6.2
IM&C	Ward B14	966.0	966.0	1610.0	1372.0	100%	85%	644.0	644.0	966.0	1000.5	100%	104%	672	2.4	3.5	0.0	0.0	6.0
IM&C	Ward B12	966.0	937.5	2254.0	1952.0	97%	87%	644.0	644.0	1610.0	1518.0	100%	94%	588	2.7	5.9	0.0	0.0	8.8
IM&C	Ward B19	1288.0	1007.5	1610.0	1451.0	78%	90%	966.0	966.0	1288.0	1230.5	100%	96%	784	2.5	3.4	0.0	0.0	5.9
IM&C	Ward A8	1610.0	1460.5	1610.0	1337.5	91%	83%	1610.0	1426.0	1610.0	1173.0	89%	73%	952	3.0	2.6	0.0	0.2	5.8
IM&C	Ward A9	1610.0	1442.5	1610.0	1520.0	90%	94%	966.0	1281.5	1276.5	1318.0	133%	103%	940	2.9	3.0	0.0	0.0	5.9
Total		39673.0	38269.8	28160.9	25783.8	96%	92%	30404.6	32161.9	20701.0	19622.2	106%	95%	12805	5.5	3.5	0.0	0.0	9.1
		= above 100%			= above 90%			= above 80%			= below 80%								

Appendix Two

February 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)

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

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
Ward A4	88%	109%	107%	98%	Vacancy - nil Sickness rate - 5.56% Action taken -
Ward A5	73%	82%	90%	67%	Vacancy - band 1.72 wte Sickness rate - 12.96% mangaed by using NHSP and reallocation of staff Action taken - All sickness managed in line as per policy
Ward B18	100%	100%	100%	100%	Vacancy - 1.2 band 2 wte Sickness rate - 6.89% Action taken - Long term sickness managed in ine as per policy
Ward A6	70%	81%	99%	75%	Vacancy - band 6 = 1.25 WTE trauma coordinator post, band 5 = 4 WTE remaining with 3 RN commencing april 2021 , band 2 = 1 WTE Sickness rate - 9.8% 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	83%	77%	100%	40%	Vacancy - band 5 = 3 WTE with new starters already factored in commencing April and September 2021 , band 2 = 2.3 Sickness rate - 11% 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	93%	96%	100%	0%	Vacancy - 0 Sickness rate - 4.47% Action taken - ward manager in number and long term sickness managed through trust attendance managemnet policy
Ward C23	90%	96%	95%	98%	Vacancy - 0.0% Sickness rate - 5.23% Action taken - All sickness absence managed in line with HR/OHWB
Birth Suite	91%	90%	108%	84%	Vacancy - 0.0% Sickness rate - 7.99% Action taken - All managed with HR policy

The Nest	100%	96%	95%	0%	Vacancy - 0.0% Sickness rate - 0.0% Action taken - No concerns
Ward B11	98%	97%	101%	89%	Vacancy - Filled pending pre-employment checks / references Sickness rate - 5 WTE Maternity Leave 2 WTE HDU 11 days Action taken - Following successful recruitment X 4 Band 5 and x 1 Band 6 recruited Long-term sickness Managed through the Trust Atendance Policy
NNU	75%	127%	63%	124%	long term sickness. Vacancies out to recruitment. Band 4 HCA students
Ward A1	85%	110%	89%	74%	Vacancy - Band 5 2.72wte/ Band 4 3.82wte/ ongoing recruitment Sickness rate - 9.68% Managed in line with policy Action taken - Ward Manager filling shortfalls in staffing. Use of agancy and bank
Ward A2	79%	89%	106%	105%	Vacancy - band 4 1.12 / Band 5 0.25 Sickness rate - 4.48% managed in line with policy Action taken - Ward manager filling in shortfalls in staffing. Use of agency and bank to support
ED	132%	65%	143%	169%	Vacancy - Band 6 3.78wte / Band 5 1.98wte Sickness rate - 7.71% Managed in line with policy Action taken - Use of agency and bank to fill shortfalls
ACCU	86%	101%	99%	100%	Vacancy - Sickness rate - 1.0 RN sick, 1.0 RN sheilding, 0.8 RN mat leave, 1.92 RN seconded K25, 0.92 RNA seconded, 0.31 band 2 lts Action taken - use of agency and bank to fill shortfalls
ICU	110%	87%	107%	83%	Vacancy - 4.3% Sickness rate - 5.5% Action taken - International recruitment will fill all vacancies in the next 3 months
Ward A7	124%	124%	142%	134%	Vacancy - band 5 4.61, band 2 3.31 Sickness rate - band 6 1.92, band 6 sheilding 1.84, band 2 maternity 0.61, band 2 sheilding 2.53 Action taken - use of agency and nhsp to fill shortfalls, recruitment in progress
Ward C21	86%	99%	114%	101%	Vacancy - 0.39 B5 0.45 B2 2.64 B4 Sickness rate - Actiontaken - Sickness absence managed in line with policy
Ward B14	100%	85%	100%	104%	Vacancy - no vacancy at band 5 band 2 3.wte vacancy Sickness rate - x1 LTS progressing with HR & short term being managed as per attendance policy Action taken - CSWD in post to supprt Band 2 vacancy recruitment on going
Ward B12	97%	87%	100%	94%	Vacancy - 1.65WTE Vacancy Band 5 2.11wte Band 2 Sickness rate - LTS x2 shielding staff x3 Action taken - recruitment onm going for Band 2's awaiting start date for Band 5 LTS being progressed at attendance policy with HR

Ward B19	78%	90%	100%	96%	Vacancy - 1.6 RN wte , 5.4 wte HCA. plan to recruit from trust wide recruitment process for band 2 HCAs by the end of March 2021. advert for RNA band 4 Sickness rate - 4.0 wte RNs and 2.0 wte band 2 redeployed, 1 WTE RN shielding working from home Action taken - supported with redeployment from ward B1 staff, use of NHSP and agency to backfill, supported by CBU,
Ward A8	91%	83%	89%	73%	Vacancy - 4.8 RN wte , 5.4 wte HCA. Sickness rate -, 1.0 wte RNs LTS, 1 WTE RN working from home, 5 WTE Band 2 HCAs long term sickness, 2.0 WTE RNs redeployed due to risk assessments and 2.0 wte band 2 redeployed, Action taken - use of NHSP and agency to backfill, supported by CBU, CSWD to commence post in Jan 2021, recruitment plans in place
Ward A9	90%	94%	133%	103%	Vacancy - 5.0wte x2 new recruits starting 1st March awaiting start date for x2 Band 5's Band 2 vacancy 4.42wte Sickness rate - x 3 staff Sheidling x2 maternity leave STS x2 Action taken - recuritment ongoing in CBU Sickness managed as per policy
Total Fill Rate (%)	96%	92%	106%	95%	

Monthly Safe Staffing Data – Mar 21

		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1782.5	1293.8	1426.0	1418.3	73%	99%	1069.5	1082.0	1081.0	1104.0	101%	102%	924	2.6	2.7	0.2	0.0	5.5
DD	Ward A5	1069.5	724.5	1069.5	1173.0	68%	110%	713.0	724.5	1069.5	805.0	102%	75%	195.5	7.4	10.1	0.7	0.0	18.4
DD	Ward B18	690.0	874.0	690.0	378.0	127%	55%	713.0	713.0	690.0	207.0	100%	30%	222	7.1	2.6	0.0	0.0	9.8
MSK	Ward A6	1782.5	1437.5	1782.5	1793.5	81%	101%	1069.5	1115.5	1782.5	1575.5	104%	88%	891	2.9	3.8	0.0	0.0	6.7
MSK	CMTC	1069.5	1058.0	713.0	770.5	99%	108%	713.0	713.0	713.0	299.0	100%	42%	175	10.1	6.1	0.0	0.0	16.2
W&C	C20	1069.5	998.5	713.9	696.5	93%	98%	713.0	713.0	0.0	263.5	100%	0%	465	3.7	2.1	0.0	0.3	6.3
W&C	Ward C23	1426.0	1281.0	713.0	540.5	90%	76%	713.0	655.5	713.0	690.0	92%	97%	326	5.9	3.8	0.0	0.0	9.7
W&C	Birth Suite	2139.0	2110.5	356.5	333.5	99%	94%	2139.0	2079.5	356.5	287.5	97%	81%	300	14.0	2.1	0.0	0.0	16.0
W&C	The Nest	713.0	655.5	356.5	322.0	92%	90%	713.0	586.5	356.5	322.0	82%	90%	15	82.8	42.9	0.0	0.0	125.7
W&C	Ward B11	2798.0	2750.5	835.0	802.5	98%	96%	1920.0	1962.4	322.4	322.4	102%	100%	278	17.0	4.0	0.9	0.0	21.9
W&C	NNU	1782.5	1304.0	356.5	491.0	73%	138%	1782.5	1138.5	356.5	379.5	64%	106%	367	6.7	2.4	0.0	0.0	9.0
UEC	Ward A1	2325.0	1877.5	2325.0	2696.0	81%	116%	1616.0	1251.0	1293.0	1155.0	77%	89%	1116	2.8	3.5	0.0	0.0	6.3
UEC	Ward A2	1426.0	1377.0	1782.0	1750.0	97%	98%	1069.5	1035.0	1069.0	1178.0	97%	110%	930	2.6	3.1	0.0	0.0	5.7
UEC	ED	5425.0	6490.5	2712.5	2116.5	120%	78%	3556.6	5056.6	970.0	1512.4	142%	156%	0					
MC	ACCU	2495.5	1905.0	1069.5	1143.0	76%	107%	1782.5	1690.5	1069.5	1138.5	95%	106%	799	4.5	2.9	0.0	0.0	7.4
MC	ICU	4991.0	5221.0	1069.5	994.8	105%	93%	4991.0	5129.0	1069.5	1012.0	103%	95%	503	20.6	4.0	0.0	0.0	24.6
MC	Ward A7	2552.6	1998.4	2206.7	1948.1	78%	88%	2225.2	2048.2	2172.8	1265.0	92%	58%	618	6.5	5.2	0.0	0.0	11.7
IM&C	Ward C21	1069.5	999.0	1426.0	1424.8	93%	100%	713.0	713.0	1069.5	1166.5	100%	109%	775	2.2	3.3	0.0	0.0	5.7
IM&C	Ward B14	1069.5	1077.0	1782.5	1622.0	101%	91%	713.0	713.0	1069.5	1046.5	100%	98%	744	2.4	3.6	0.0	0.0	6.0
IM&C	Ward B12	1069.5	1058.0	2495.5	1955.0	99%	78%	713.0	713.0	1782.5	1748.0	100%	98%	651	2.7	5.7	0.0	0.0	8.6
IM&C	Ward B19	1426.0	1119.5	1782.5	1638.5	79%	92%	1069.5	1058.0	1426.0	1242.0	99%	87%	868	2.5	3.3	0.0	0.0	5.8
IM&C	Ward A8	1782.5	1547.5	1782.5	1219.0	87%	68%	1426.0	1253.5	1782.5	1207.5	88%	68%	1054	2.7	2.3	0.0	0.0	5.0
IM&C	Ward A9	1782.5	1483.5	1782.5	1535.0	83%	86%	1069.5	1138.5	1782.5	1495.0	106%	84%	1045	2.5	2.9	0.0	0.0	5.5
	Total	43736.57	40641.67	31229.08	28761.91	93%	92%	33203.3	33282.58	23997.22	21421.75	100%	89%	13261.5	5.6	3.8	0.0	0.0	9.4
		= above 100%			= above 90%			= above 80%			= below 80%								

Appendix 4

November 2020 - Mitigating Actions

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

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

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

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
Ward A4	73%	99%	101%	102%	Vacancy - band 6 1.72 wte recruitment in process Sickness rate - 14.39% Action taken - sickness absence managed as per policy
Ward A5	68%	110%	102%	75%	Vacancy - nil Sickness rate - 5.27% Action taken - sickness managed as per policy
Ward B18	127%	55%	100%	30%	Vacancy - Sickness rate - 4.95% Action taken - sickness managed as per policy
Ward A6	81%	101%	104%	88%	Vacancy - band 6 = 1.25 WTE trauma coordinator post, band 5 = 4 WTE remaining with 3 RN commencing april 2021 , band 2 = 0 WTE Sickness rate - 2.71% short term and 7.14% long term 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	99%	108%	100%	42%	Vacancy - band 5 = 3 WTE with new starters already factored in commencing April and September 2021 , band 2 = 0 WTE Sickness rate - 0.67% short term and 5.38% long term 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	93%	98%	100%	0%	Vacancy - 0.0wte Sickness rate - 11.24% Action taken - sickness and absence managed in line with OH & HR
Ward C23	90%	76%	92%	97%	Vacancy - 0.0wte Sickness rate - 11.26% Action taken - Sickness absence managed in line with OH & HR policy
Delivery Suite	99%	94%	97%	81%	Vacancy - 0.0% Sickness rate - 7.99% Action taken - All managed with HR policy

The Nest	92%	90%	82%	90%	Vacancy - 0.0% Sickness rate - 0.0% Action taken - No concerns
Ward B11	98%	96%	102%	100%	Vacancy - 1 WTE Band 5 Recruitment in progress - aim to be fully established Sickness rate - 3.57 WTE Long-term - Maternity Leave 3 WTE HDU 14 days Action taken - Sickness managed in accordance with Trust attendance Policy -
NNU	73%	138%	64%	106%	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	81%	116%	77%	89%	Vacancy - 1x nurse educator post out to advert / B6 x2 /B5 x 2.72 / B4 x 3.82 Ongoing recruitment and 2x international B5 RNs commencing Spring Sickness rate - 5.82% Managed in line with policy Action taken - agency and NHSP usage remains high, WM filling shortfalls in staffing. Staffing discussed daily
Ward A2	97%	98%	97%	110%	Vacancy - Band 5 x 0.25 /Band 4 x 1.12 Ongoing recruitement at Band 5 Sickness rate - 1.73% Managed in line with policy Action taken - Staffing discussed daily, WM filling gaps in staffing, less reliance on agency/NHSP
	120%	78%	142%	156%	Vacancy - Band 7 x 1 temp x1 permanent / Band 6 x3.78 Sickness rate - 6.93% managed in line with policy Action taken - Ongoing recruitment, reliance on agency/nhsp due to acuity, staffing escalated daily
ACCU	76%	107%	95%	106%	Vacancy - 0 Sickness rate - 6.4% (total) Action taken - All sickness managed as per Attendance Management policy
ICU	105%	93%	103%	95%	Vacancy - 6.3 Sickness rate - 5.5% Action taken - International recruitment will fill all vacancies in the next 3 months
Ward A7	78%	88%	92%	58%	Vacancy - band 5 4.61, band 2 3.31 Sickness rate - band 6 1.92, band 6 sheilding 1.84, band 2 maternity 0.61, band 2 sheilding 2.53 Action taken - use of agency and nhsp to fill shortfalls, recruitment in progress
Ward C21	93%	100%	100%	109%	Vacancy - 0 agaist agreed establishement Sickness rate - Action taken - Staffing above establishment due to patient need. sickness managed in accordance to policy
Ward B14	101%	91%	100%	98%	Vacancy - no vacancy at band 5 band 2 2.0 wte awaiting start date Sickness rate - LTSx1 maternity leave x2 hca's Action taken - CSWD supporting band 2 vacancy sickness being managed in line with attendance policy

Ward B12	99%	78%	100%	98%	Vacancy - Band 5 awaiting start date Band2 2.11.Vacancy Sickness rate - LTS x3 and STS all being managed in line with attendance policy Action taken - recruitment ongoing in CBU
Ward B19	79%	92%	99%	87%	Vacancy - 1 B6 2 B5 Sickness rate - managed as per HR policy Action taken - trust recruitment in progress
Ward A8	87%	68%	88%	68%	Vacancy - 2 band 6, 4 band 5, 2 HCA Sickness rate - being managed in line with HR Action taken - Vacacnies recruitemtn in process
Ward A9	83%	86%	106%	84%	Vacancy - band 5 x4 wte vacancy international recuritment on ward working supernumary Band 2 x2 wte Sickness rate - maternity leave x2 HCA's Short term sickness LTS x1 HCA Action taken - sickness being managed in line with HR OH and attendance policy CSWD are supporting with HCA vacancy and awiting start date of new band 2's
Total Fill Rate (%)	93%	92%	100%	89%	

Warrington and Halton Hospitals International Nurse Recruitment Summary – April 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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Table 1 Progress Tracker for International Nurses Wigan Wrightington and Leigh (WWL)

	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 planned for 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 • 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. One of the nurses is in hospital with Covid 19 has been since arrival in UK. All now out on wards from the 5/4/21 • ICU x 2 • Theatres x 3 • A7 x 1 • Ward A6 x2

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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 09/04/21 x 1	06/04/21	30/04/21	1 nurse only arriving in the UK 27/4/21 awaiting OSCE date she will join Cohort of MC for induction. Wards allocated: • A&E x1 • A1 x2 • A2x 2 • ICU x3 …….2 nurse to follow after OCSE • Theatre x 1 • A4 x 1

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	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		Plan to be 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	TBC	Provisional date 22/05/21		OSEC training dates not confirmed we are on the waiting list for dates for these nurses.

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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 -12 nurses arrive in the UK	01/06/2021	13-15/07/2021	TBC	21 May x 12	
CIRC Cohort 4	23rd July 2021 – 12 nurses arrive in the UK	02/08/2021	09/09/2021	TBC	23 July x 12	
CIRC Cohort 5	10TH September 2021 -12 nurses arrive in the UK	20/09/2021	01/11/2021	TBC		Moved training date by a week which in turn moved the arrival date
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						

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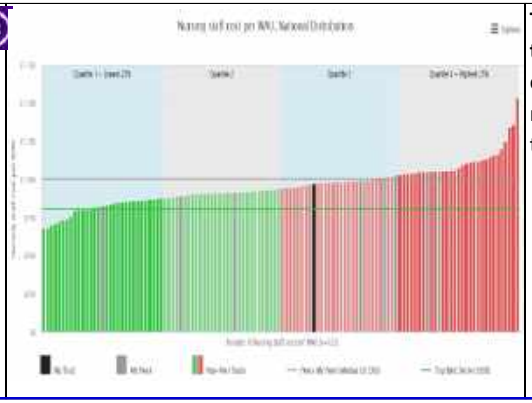
Moving to Outstanding – Use of Resources Assessment

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: Maintain** **Best Quartile: £883** **WHH Position:** **£976** **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 a number a vacancies and continues t recruit to nursing posts to reduce agency costs. The Trust has recruited a number of International Nurses which has commenced in training/posts and will continue to do so throughout 2021/22.

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 21/05/68 b i	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	26 May 2021

Date of Meeting	6th April 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/21/04/86	**Matters Arising**	QAC/21/03/60 ENT deep dive, following assurance of monitoring through the PSCESC, the Chair of QAC agreed no requirement for report to be presented to QAC, items for escalation would be reported through Committee Governance. There will be a 6-month review of ENT incidents and complaints. QAC/21/02/37 – position statement 18 March 2021 7 FAX machines remain, two (Pathology) likely to remain in the longer term. **93%** of FAX machines Warrington decommissioned, **86%** of FAX machines at Halton decommissioned. Circa **90%** of machines decommissioned in total across Warrington, Halton and CMTC. QAC agreed action to be closed 06.04.2021	The Committee noted the updates and received good assurance	
QAC/21/04/88	**Hot Topic – Safeguarding**	The Committee received an overview of challenges and impact of COVID-19 Pandemic relating to Safeguarding (SG) including strengthened collaborative working with Warrington and Halton Safeguarding partnerships and Mental Health (MH) partners, strengthening existing pathways demonstrated through Core 24/7 Psychiatric support in ED. Of particular note was: - Assurance that reviews of LD patients from COVID-19 subject to Trust's internal governance framework including Structured Judgement Reviews and external LADO review.	The Committee noted the comprehensive report and assurance of the management and oversight of Safeguarding particularly during the COVID-19 Pandemic.	**QAC 04.05.2021**

		- Training and education for staff strengthened through the ICON programme to support children under 2 presenting with abusive head trauma. - LD, Autism and Children and Adults MH strategies in place. Existing priorities remain in place for 2021, for review in December 2021 for accurate reflection of safeguarding pre, during and post COVID-19. - Changes due to recent Intercollegiate changes in Adults Safeguarding training requirements highlighted, requirements for face to face as opposed to E-learning and more role specific training, lead-in times to achieve 100% compliance. SEOG (Executives) to agree what is to be reported to Trust Board and build-in lead in times to achieve 100% prior to presenting to Strategic People Committee.		
QAC/21/04/89	**Moving to Outstanding (M2O)**	The Committee received the following update: - M2O T&F Group established, first three assessment frameworks sent out to 'core services', Maternity, Urgent and Emergency Care and Outpatients. - 1 enquiry from CQC since February 2021, responded to fully. - Insight report – key elements highlighted, 2 areas declining as a consequence of RTT and pause in elective programme, assurance that all monitored on appropriate Trust risk registers. - Clinical staff sickness absence deterioration due to shielding and staff absence, deep dive undertaken, reported and monitored at Strategic People Committee. - One active outlier (Maternity) from 2018, re-audit due to take place April 2021.	The Committee reviewed and noted the comprehensive report and good assurance provided of monitoring processes in place.	**QAC 04.05.2021 Trust Board 26.05.2021**
QAC/21/04/90	**Deep Dive Review – Medicines Management**	The Committee received a high level summary of key points/findings and factors influencing medicines related workload/activities in 2020-21, including ward/department reconfigurations, access, activity and patient flow, infection prevention and control requirements, evolving COVID trials, EPMA, availability of medicines and development of virtual clinics and vaccination clinics. - All processes relating to medication safety and wastage remained in place with flexibility to support ward reconfigurations/relocations etc. - Medication wastage reduction, modifying how medication is dispensed and medicine reconciliation, prior to COVID achieved 50% within 24 hours, 80% overall, current position 82% within 24 hours and 93% overall. - Medication Incidents (Harm) lessons learned continued to be shared Trust-wide including Safety Briefings. - Improvements in omitted medicines incidents, consolidating EPMA work.	The Committee noted the comprehensive report and received good assurance	**n/a**

		- Focus on VTE risk assessments, monitored daily, shared through daily Safety Briefing. - Clinical Trials maintained through COVID-19 including new treatments for COVID. - Focus to review equipment relocated due to ward/department reconfigurations (Controlled Drugs, Meds reconciliation), explore proposals to retain Pharmacy staff in admissions/ED and ward areas to support further improvement - Further strengthening and improving the discharge process to identify patients day before discharge to ensure discharge summaries/TTOs in place.		
QAC/21/04/92	**Review of Waiting Lists and Clinical Harm Review**	The Committee particularly noted: - Clinical and non-clinical wait times. - Weekly Clinical Services Oversight Group to report to Clinical Recovery Oversight Committee. (CROC) New trajectories for March outturn for Cancer Standards to be reported to CROC. - RTT – 18 weeks, decrease in performance by 1.2% from January 2021 to 71.71%, number of patients waiting greater than 18 weeks increased from 5432 to 5792. - 52 week waits - off trajectory, 1442 against Phase 3 trajectory of 137. Some growth anticipated by May. Trajectory submitted to C&M, performance may be recovered sooner than forecast as activity is switched on. Continued focus on T&O and Ophthalmology Diagnostics – decrease in number of patients waiting over 6 weeks of -707 to 3536. - P2 – two trajectories submitted to C&M (1) when 52-week waits would be eradicated, submission by end March 2022; (2) P2 patients overdue waits, eradicated by July/August 2021 Clinical Harm Reviews (CHR) February position statement, 242 cases reviewed to date, 11 moderate harm, 5 in Urology, 4 in T&O and 2 in Surgery. One potential harm pending investigation. Duty of Candour completed for all. Patients provided with dates for next treatment in pathway, monitored at weekly CSOG, Clinical Recovery Oversight Committee (CROC) Terms of Reference. - Activity reporting to CROC to commence 12 April 2021, direct reporting to Trust Board. QAC supported the CROC ToR which had been ratified at the Trust Board 31 March 2021 and approved at FSC on 24 March 2021.	The Committee noted the updates and received moderate assurance.	**CROC 27.04.2021** **Trust Board 26.05.2021**

QAC/21/04/94	**Maternity Safety Champion Report**	**Maternity Report - Monthly SI Report, Ockenden Review and Clinical Negligence Scheme for Trusts (CNST) update** The Committee particularly noted: CNST Progress – maternity guidance reviewed, main changes, the removal of some sub requirements within safety actions three (ATAIN), four (workforce planning) and nine (safety champions); an amended the approach to validate MSDS data; changes within safety action eight's standards with the removal of the 90% threshold for training. Maternity Safety Champions - Recent appointments, Neonatal Safety Champion Delyth Webb; Paediatric Maternity Safety Champion Sarah Jackson. Maternity Safety Champion walk arounds continue. Ockenden Review – confirmation of compliance reported 5 March 2021 following check and challenge meeting with Regional Maternity representatives. Partial compliance in the Maternity Assurance and Assessment Tool and compliant in all other aspects. Delay in opening NHSI/E electronic portal to enable compliance monitoring and evidence submission, Trust will be able to submit evidence to move to full compliance when Portal is open. High level summary of Maternity Serious Incidents (SIs) noted.	The Committee noted the comprehensive report and received good assurance	**QAC 04.05.2021 and Trust Board 26.05.2021**
QAC/21/04/95 (a)	**Quality Priorities 2021-22**	The Committee was provided with an update on the proposed Quality Priorities for 2021/22 and particularly noted: - Priorities had been identified following extensive stakeholder events and feedback from a wide range of internal and external forums/partners, data analysis from internal data and national and regulatory priorities and requirements. Proposed Quality Priorities 2021-22 - Patient Safety - Clinical Effectiveness	The Committee approved the Proposed Quality Priorities for 2021-22 which will be monitored at PSCESC and QAC aligned with the Trust Quality Strategy and Annual Business Plan.	**Trust Board 26.05.2021**

		- Patient Experience As per NHS England guidance 15 January 2021 NHSFTs are not required to include national quality indictors within proposed Quality Priorities due to the on-going global pandemic.	Good assurance was provided	
QAC/21/04/95 (b)	**Annual Quality Strategy Update**	The Committee noted: - Progress relating to the Trust Quality Strategy and 2020-21 Quality Priorities. - Full compliance for 4 Priorities, 5 Partial Compliance. - Supportive work related to partial and non-compliance 2020-21 Priorities to continue during 2021-22. - Decondition/PJ Paralysis – non-compliance, implementation plan halted prior to commencing due to COVID-19. Priority to form part of Falls and Pressure Ulcer Collaboratives supported by Quality Academy Improvement work.	The Committee noted the comprehensive report and received moderate assurance	**QAC Ongoing**
QAC/21/04/96	**DNACPR and decision-making process**	The Committee noted: - Review of DNACPR decision making processes at WHH March 2020-December 2020 considering incidents, complaints, claims, PALS and SJRs; Audit; Assurance against CQC national recommendations; Actions for improvement. - Improvement following audit of DNACPR documentation compared with October 2019-March 2020, further improvement work to continue relating to Best Interest meetings. - Task and Finish Group established to support DNACPR decision making to respond to CQC recommendations. - Assurance provided that there had been no blanket decisions taken, particularly for LD/NH patients following recent national concerns and that all DNACPR discussions/decisions recorded. Assurance that discussions take place with family, patients and carers, circumstances assessed on a case by case basis. - Additional assurance provided in that all patients with LD are automatically 'flagged' on WHH systems ensuring that appropriate staff can provide appropriate support and treatment, negating any occurrence of blanket decisions.	Good assurance provided of processes and monitoring in place to support accurate recording and documentation of DNACPR discussions.	**Progress report to QAC on 05.10.202**1

QAC/21/04/98	**Review of Mortality Nosocomial COVID-19**	The Committee received a presentation, noting: - Mortality reporting and recording process for Infection Prevention governance process highlighted, including RCAs, sharing of learning and recording on Datix. - 30 cases reviewed, 6 identified as HOpHA (Hospital Onset probable) and HOdHA (Hospital Onset definite); RCA's completed. - Medical Examiner (ME) completed 72 mortality reviews where COVID-19 appears on death certification at 1a or 1b, 43 are noted on the Governance tracker for RCA review - RCAs completed where assessment of care overall was 1 or 2 and the patient acquired COVID-19 in hospital - WHH ME service reviewing 50-60% of non-coronial cases to increase to 100% with additional ME resource; 5 internal ME reviews were available to review where COVID-19 is recorded on the death certification and where the HOpHA or HOdHA definitions were met. - NW position of 22% nosocomial deaths, 11% probable, 11% definite. - WHH reported 17% probable, 16% definite. - Themes continue to be highlighted, discussed at SJRs and learning shared through a number of internal Forums/Groups, aligned with NW guidance.	Good Assurance provided of robust process and monitoring in place to reduce nosocomial transmission. NW SJR Cell guidance received 1 April 2021 to be incorporated into a formal report to May QAC.	**QAC 04.05.2021**

The Committee noted a number of reports for assurance
- Dementia Strategy Q3/Q4 Report
- Dementia Strategy Annual Review
- Quality Improvement Progress Report Q3/Q4
- 'First Do No Harm' Cumberlege Inquiry – to report to a future QAC
- Committee Effectiveness Annual Survey Outcomes

The Committee received the High Level Briefing Reports from the following Sub Committees:
- Patient Safety and Clinical Effectiveness Sub Committee
- Health and Safety Sub Committee
- Patient Experience Sub Committee
- Quality Academy Board
- Infection Control Sub Committee
- Infection Prevention and Control Sub Committee
- Equality, Diversity & Inclusion Sub Committee

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BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 21/05/68 b i	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	26 May 2021

Date of Meeting	4 May 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/21/05/ 115	**Matters Arising**	QAC/21/04/88 Mandatory Training – quality elements. Update received. Future report/monitoring at SPC. Action closed. QAC/21/03/68 Radiology Timeframes –no matters escalated or safety concerns reported following review of SI's following Radiology Deep Dive. Oversight at Patient Safety Clinical Effectiveness Committee (PSCESC). Action closed. Chairs action – ED&I QAC/21/04/110 D&I Action plan approved via Chairs Action. QAC/21/08/149 – 'First do No Harm' Cumberlege Inquiry MB/KSJ to meet, update to June QAC.	The Committee noted the updates and received good assurance	**QAC 01.06.2021**
QAC/21/05/ 117	**Hot Topic - DNACPR**	The Committee received an overview of Trust response, actions and processes put in place following benchmarking against CQC recommendations. Of particular note was: - CQC interim and final reports published following review of evidence across 47 stakeholders. - Themes included information, training and support and consistent approach to advanced care planning to support consistent standards	The Committee reviewed and noted the presentation and the good assurance provided of progress and mitigations against the recommendations	**n/a**

		- No blanket decisions made relating to DNACPR at WHH, Improved oversight and assurance of DNACPR processes. - Specific education/training included CPR, Serious Illness Programme conversations, importance of clear documentation and recording of DNACPR discussions. - Oversight and monitoring of the Action Plan at Resuscitation Committee and DNACPR Decision Making Group. - Patient Information Leaflet to be introduced to provide advice and support in written form. - Freedom to Speak Up Guardian in place, discussion at MRG and Deteriorating Patient Group to support staff who raise concerns.		
QAC/21/05/ 118	**Deep Dive – ED Triage**	The Committee received a high level summary of outcomes of the ED Triage review over period 1.12.2018 and 30.11.2020. Of particular note was: - 13 Cases reviewed, 9 not directly related to triage; 2 directly related to triage; 2 related to incorrect pathway not followed. - Main improvements put in place between 2019 and 2020 included Navigation handover forms, head injury pathway, COVID Triage changes, Pain assessment, Silver trauma and rapid swabbing in triage. - A number of elements of assurance provided including positive reporting culture. - 1 incident reported following a further review in the last 6 months. - Streaming and Triage process reviewed by Senior Clinical Team and SOP updated; - Senior Clinician present in Triage between 9am-5pm - Relaunch of Front-End Working Group to be led by Senior Clinical, Nursing and Practice Educator colleagues. - Improvement work taken place relating to Staff attitudinal complaints, further improvement needed due to increase in complaints since November 2020. - Deep dive requested into the increase in Trust attitudinal complaints and review of each case to be undertaken. - Deep dive requested into attitudinal complaints and benchmarking for comparative analysis of similar size Trusts as WHH an outlier year on year.	**The Committee noted the comprehensive report and good assurance of the management and oversight** Oversight and monitoring will continue at PSCESC, reported to QAC high level briefing reports.	**QAC 01.06.2020**

QAC/21/05/119	**Board Assurance Framework (BAF) and Strategic Risk Register**	The Committee received an update of strategic risks on the BAF and approved the reduction of the ratings of five risks; all of which related to the COVID-19	The Committee supported and approved the amendments to the BAF and received good assurance	**QAC 01.06.2021 and Trust Board 26.05.2021**
QAC/21/05/120	**CNST Maternity Incentive Scheme**	The Committee received a presentation providing a progress report on the 10 maternity safety actions included in the NHS Resolution Maternity Incentive Scheme Year 3.	The Committee noted the updates and received good assurance.	**Trust Board 26.05.2021**
QAC/21/05/122	**Maternity Safety Champion Report**	**Maternity Report and Ockenden Review update report** The Committee particularly noted: Maternity Safety Champions – quarterly newsletter in place along with 'You Said.. We Did' that highlights the main issues and elements of processes put in place as a result. Midwifery staffing and support (investment in team leader Band 6 and 7 posts, recruitment monitored to enable speedy recruitment), Elective Caesarean Section List review and actions that had been taken. Ockenden Review – the following matters were highlighted: - Perinatal Mortality Reviews (using the Perinatal Mortality Review Tool) Quarter 2, 3 and 4. - Grading of care of Mother and Baby. - Learning and improvement identified from reviews highlighted. - LMS – CQC status. It was explained that the Trust is not an outlier. - Comparator of achievement of Ockenden IEAs highlighted and national comparative data. WHH compares well with other Trusts in C&M. (a) **Monthly SI Report** High level summary of Maternity Serious Incidents (SIs) noted.	The Committee noted the updates and received good assurance.	**QAC 01.06.2021 and Trust Board 26.05.2021**

QAC/21/05/123	**Review of Mortality – Nosocomial COVID-19**	The Committee received a further update to that received in the April meeting and noted the assurance provided of comprehensive governance framework in place for oversight and scrutiny in reviewing all deaths appropriately	Good assurance provided of a robust process and monitoring in place to reduce nosocomial transmission	

The Committee received and noted Complaints Annual Report and Risk Management Annual Update report.

The Committee noted a number of further reports for assurance

- Legal Consideration of Governance during COVID-19
- Learning From Experience Q4 Report
- Clinical Audit Q4 Report
- Quality Priorities Q4 Report
- DIPC Infection Control Q4 Report
- Quality Improvement Progress Report
- Enabling Strategy 6-month Progress report
- Nursing and Midwifery Strategy update report
- Critical Care Staffing Surge Assurance Report

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

- Palliative Care and End of Life Steering Group
- Risk Review Group
- Infection Prevention and Control Sub Committee
- IG and Corporate Records Group
- Equality, Diversity & Inclusion Sub Committee

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/05/68 c		TRUST BOARD OF DIRECTORS	DATE OF MEETING	26 May 2021

Date of Meeting	**21 April 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/21/04/66	Corporate Performance Report and Review of Waiting Lists and Clinical Harm Review Report	The Committee considered and reviewed the report noting:- • 80.05% March A&E performance which is an improvement but below target. 4 consecutive weeks of growth in March, increase in levels at Halton • There needs to be a focus on the over 60 minute handover as the number exceeding this has increased when compared to pre-pandemic levels. • 72.94% RTT performance this is stabilising • In March 2021 the waiting list size saw a decrease from February 2021 (-178) this remains above our agreed trajectories and highlights the continued increase of referrals. Scheduling of patients takes place into the available capacity utilising this prioritisation, including utilisation of the independent sector • The diagnostic target was not achieved in March 2021 and the number of patients waiting increased which relates to the impact of the COVID-19 pandemic. However, the number of breeches	The Committee **noted** the updates and received moderate assurance.	FSC May 2021

		• decreased by -427 again in March 21. A recovery plan and new trajectory has now been agreed and patients are being clinically prioritised accordingly in line with national guidance. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). • Cancer performance the 62-day target was not achieved in February 21. The 31 day standard has been achieved as forecast last month. The 2 week wait standard was achieved in February however the breast symptomatic standard was not achieved. Both standards have already been achieved in March. • A 12 hour breach occurred on 30 March and will be reflected in future reports		
FSC/21/04/67	Pay Assurance Report	The Committee considered and reviewed the report noting: - • Continue to maintain oversight and scrutiny • Going forward will provide more on international nursing in coming months • Pressures continue for services with vaccination support, sickness and Clinically Extremely Vulnerable staff. There are 205 CEV of which 30 are working in Amber areas, and 101 have been moved to Green areas • Increased grip to control bank utilisation for agencies not managed by NHSP • Consultation review with all CBU for the Warrington rate card • Action to move away from use of Off Framework agency with exception to ITU due to vacancies and sickness • Only the Chief Nurse/Deputy CEO and 2 other senior staff members can authorise any other Off Framework agency in future	The Committee **noted** the update	FSC May 2021
FSC/21/04/68	COVID-19	The Committee noted the verbal update:- • The position at the end of March was presented • The forecast has reduced by £0.5m to £35.5m compared to £36m in February • Deloitte Report appended to the main finance report	The Committee **noted** the update	FSC May 2021

FSC/21/04/70	Financial plan	The Committee received the updated operational plan • Timetable noted with final submission on 4 May • Noted the activity trajectory full recovery by Dec 2022 • Workforce changes reviewed • Reviewed the changes from expenditure presented at 31 March Board • Proposed I&E highlighting the expected income and the assumptions. It should be noted the Trust has received 2 Control totals for H1 and clarity is being sought • Unable to draw conclusions on the estimates for H2 • Noted the review required for both Medical and ED staffing and CIP plans still required with Quality Impact Assessments	The Committee **support** the update to be presented to Board on 28 April 2021	Board April 2021
FSC/21/04/71	Digital Services Board Report	The Committee considered and reviewed the report noting: - • Comprehensive report • Two issues are Lorenzo position day to day performance and potential financial risk regarding the Lorenzo contract • Currently awaiting a revised contract offer	The Committee **support** the update to be presented to Board on 28 April 2021	Board April 2021
FSC/21/04/71	Deep Dive Digital	The Committee received an update of potential deep dive areas and asked for prioritisation and for these to be added to the Committee plan.	The Committee **support** suggestions	FSC May 21
FSC/21/04/73	Medical Establishment Review	The Committee considered and reviewed the report noting: - • The pressure funding was noted along with CBU by CBU review • The need to continue with the medical workforce steering • group • Finalise / introduce the new rate card for locum medical pay within 2 months • The need to carry out a further detailed medical productivity piece of work	The Committee **noted** the update	FSC June 21
FSC/21/04/74	Additional Capital Overview	The Committee noted the report:- • Cases over £500k will be presented to Exec, FSC and Board for approval.	The Committee **noted** the progress	

		• Monthly reports for each scheme over £500k will go to Execs and FSC		
FSC/21/04/75	MIAA final capital audit report	The Committee noted the MIAA report, highlighting: - • Limited assurance with 11 recommendations • Noted the issue of the substantial capital plan and pandemic in 2020/21 • Several actions have commenced including project plans and Associate Director attendance to Executive meeting each month • An update will be brought to FSC monthly • Chair of FSC to update the Audit Committee	The Committee **noted** the report and **supported** for presenting to Audit Committee	Audit Committee April 21 FSC May 21
FSC/21/04/76	Annual Deep Dive in relation to risk register	The Committee noted the report, noting the changes during the year:- • BAF 1 new risk on November, 2 risk ratings amended, 2 risk titles update, no risks de-escalated • 3 new risks added to corporate risk register and 2 closed	The Committee **noted** the report	FSC April 22
FSC/21/04/77	Monthly Finance report incl: (a) Draft Capital Planning Group minutes (29.01.2021) (b) FRG minutes (meeting cancelled)	The Committee considered the report and capital proposals. Key points to note included: • Finished the year with £6.9m adjusted deficit as per the NHSE/I monitoring documents • This has changed from £11.9m deficit due to the additional income for the annual leave accrual to £7.6k since 31 March additional £0.7m income for annual leave • Cash £47.9m due to improved position, capital profile and additional PDC receipts in March • Achieved 90% BPPC for the year with 96% achieved in March • Capital delivered was £25.7m, which was £1.2m below budget • Agency was high in 2020/21 due to COVID-19 and needs to be managed closely during 2021/22 • Year end figures are subject to external audit	The Committee **noted** the updates and received good assurance The Committee **approved** the changes to the capital plan	FSC May 21
FSC/21/04/78	Risk Register including	The Committee considered the Risk Register noting the following:- • No risks to escalate to Trust Board • No change to risk ratings	The Committee **noted** the updates	FSC May 2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/05/68 c		TRUST BOARD OF DIRECTORS	DATE OF MEETING	26 May 2021

Date of Meeting	**19 May 2021**
Name of Meeting + Chair	**Finance and Sustainability Chaired by Terry Atherton – NED attendance only, meeting held virtually due to Operation Reset, agenda restricted to cover Corporate Performance and Capital Oversight. Financial performance to be reported to the Trust Board in the Integrated Performance Report on 26 May 2021.**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
FinChair 01	Corporate Performance Report and Review of Waiting Lists and Clinical Harm Review Report	The Chair and NED member of the Committee considered and reviewed the report noting:- In considering the detail below, we should be mindful of the current Operation Reset. • Four hour performance ex Widnes for April 78.33% March 80.05% Increase in attendances 1113, total 9803. • Graphs provide detail though those on P6/7 ends 3/21. • C&M performance highlighted on P10 - we are 5 out of 8; type 1 only 3 out of 8. In reality we are the middle of the pack. (For some reason LUFT not in this data set)	The Committee **noted** the updates and received moderate assurance.	FSC June 2021

		• There is a new format for Ambulance handover on P11 indicating we are third out of 10 sites in terms of performance. • LOS data on P13 is a little unclear to me. • P14 details the usage of assessment areas. • Super-stranded at end of April were 102. • RTT 72.32% for April (72.94%) in line with trajectory. • April saw inpatient & day case activity exceed trajectory of 72% at 87%. Recovery data included in the Report now falls under the oversight of the Clinical Recovery Oversight Committee & is there for information only.		
FinChair 02	Additional oversight of Capital	The Chair and NED of the Committee considered and reviewed the report noting: - • This Report is provided for Assurance. • Capital Programme for 2021/2 is £19.6m • Page 50 highlights the schemes over £500K which is what this item is about. Note the RAG rating on Page 52. • It should be noted that the ED Plaza scheme only has Board Approval in principle, as the costings were not firm when the case was considered at Board. A final decision was therefore reserved until we have firm costings. As F&SC Chair, I am content with the detail provided for Assurance purposes.	The Committee **noted** the update	FSC June 2021
FinChair 03	MIAA Capital Review Progress Report.	The Chair and NED of the Committee noted the MIAA Capital Review Progress Report. • This Report is provided for Assurance. • There are 7 actions for Estates, 1 high & 6 medium risks. • There are 4 for Finance, 1 no action, I medium & 2 low risks. • Updates are provided & are RAG rated.	The Committee **noted** the update	FSC June 2021

		• The MIAA Report as detailed requires close monthly monitoring at each F&SC until all recommendations are finally implemented & confirmed by MIAA follow up. As F&SC Chair I am content with the progress to date.		
FinChair 04	MRI Capital Estates Programme Business Case	The Chair and NED of the Committee received the MRI Capital Business Case • This Business Case seeks F&SC support before going to Board on 26 May. • The Report refers to Appendix 1 - this is at Page 112. This is the Business Case that went to Board in 2020. • To summarise, the original Business Case sought Estates costs of £1,008,000 plus Turnkey costs of £200,000 to a total of £1,208,000. • The amended Business Case was eventually approved by Board involving Estates costs of £1,650,580 & Turnkey costs of £378,420 to a total of £2,029,000. • Essentially Board is asked to approve a carry forward of unspent Capital from last year to the current year of £907K. this includes a contingency of £115K. • The Turnkey works were completed a £375K against the budget of £378K, whilst the Estates spend in 20/21 was £743K against the budget of £1651k; an underspent of £907K (bit of rounding up). Work is expected to be completed by 17 August 2021 & the risks are detailed on Pages 68/69. • There is an increase in total net revenue costs albeit these are quoted including capital charges. • The main savings are ceasing the hire of a mobile scanner at £451K per annum.	The Committee **support** the business case to be presented to Board on 26 May 2021	Board May 2021

		As Chair of F&SC, I am happy to add my support to the Business Case as detailed.		
FSC/21/05/	Summary	That concludes my consideration of these Papers in the absence of a formal meeting of the Finance & Sustainability Committee for the Month of May 2021.		Board May 2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 21/05/68 d	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	26 May 2021

Date of Meeting	29 April 2021
Name of Meeting & Chair	Audit Committee, 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/21/04/28	**Changes/update to BAF**	The Committee particularly noted the following: No new risks had been added to the BAF and no amendments to the descriptions of any of the risks on the BAF. <u>Amendments to Risk Ratings</u> Rating of one risk (#1126) had been amended on two occasions, from 25 to 15 and a further reduction in the rating to 10 relating to Oxygen levels as the number of COVID-19 patients reduce, the expected use of O2 should also reduce Risk #1126 also de-escalated to the Corporate Risk Register for monitoring	**The Committee discussed the report and received good assurance**	**Trust Board 26.05.2021 Audit Committee 19.08.2021**
AC/21/04/29	**Progress Report on Internal Audit Follow-up actions**	The Committee received a report providing details of Internal Audit Reports with any outstanding management actions. The Committee particularly noted: - 6 audits with 12 overdue management actions for which the Committee considered extensions. 3 were requests for first-time extensions, 3 for a second extension	**The Committee discussed the report and received moderate assurance.** **AMcG to write to Exec Leads to highlight impact**	**Audit Committee 19.08.2021**

		- Overdue Critical and High recommendations – one high recommendation overdue relating to Overtime Review 2018-19.	**of not achieving original action deadlines**	
AC/21/04/30	**Internal Audit Progress Report**	The Committee received a report providing an update in respect of the assurances, key issues an progress against the internal Audit Plan for 2020/21. Three reports issued: - Escalating Deteriorating Patients – Moderate Assurance - Management of Capital Programme – Estates – Limited Assurance - Data Security and Protection Toolkit Assurance – Readiness Review	**The Committee reviewed and discussed all the reports and assurances in the report that there is adequate response and monitoring to actions identified. Moderate assurance was received**	**Audit Committee 19.08.2021**
AC/21/04/31	**Head of Internal Audit Opinion 2020-21**	The Committee noted that: - Review coverage focussed on 3 areas (1) organisations Assurance Framework; (2) number of core and mandated reviews completed, some requests made to extend deadlines (3) individual risk-based assurance reviews - Overall internal audit opinion of **moderate assurance** assigned. - The timescales for completing of follow-up recommendations negatively impacted the assurance opinion	**The Committee reviewed the report, noting the overall opinion of moderate assurance.**	**Audit Committee April 2022**
AC/21/04/36	**Anti-Fraud Annual Report 2020-21**	The Committee received the report detailing the work undertaken in 2020/21 and noted: - s. - All standards reviewed at the end of the year, all areas rated Green with the exception of 1 area, Standard 2.4, relating to the Declaration of Interest - Suggested that 80% compliance rate in the report was NHS SFA compliance standard (Declaration of Interests) - Awareness sessions had been delivered, briefings, alerts and bulletins issued, fraud referral assessments undertaken and other investigation activities undertaken during the year. - WHH not an outlier relating to number of investigations undertaken.	**The Committee reviewed and discussed the report and noted a current moderate assurance. However:** **Further meeting to take place to review suggested government standard component 12 prior to submission on 31.05.2021.** **Final outcome to be**	**Audit Committee 19.08.2021**

			reported to the next Audit Committee	
AC/21/04/39	**Losses and Special Payments 01.01.2021-31.03.2021**	The Committee particularly noted: - The value of Losses and Special Payments reported for Q1 January 2021 to 31 March 2021, £72,850. The value of Losses and Special payments reported for year to 31 March 2021 is £269,925 compared to £275,199 2019/20.	**The Audit Committee reviewed and discussed the report and received moderate assurance**	**Audit Committee 19.08.2021**
AC/21/04/40	**Quotation and Tender Waivers 01.01.2021-31.03.2021**	The Committee particularly noted: - 44 waivers at a value of £2,052,593, including 8 waivers specifically related to COVID-19 at a value of £497,231, 14 Waivers relating to delivery of Capital Programme £752,092. - 2019-20 there had been 70 Waivers, year ended position 31 March 2021, 112 waivers reported at a value of £4,939,065. - No quotation waivers over £40k reported January & February 2021, one reported in March 2021, for PA Consultancy relating to the New Hospitals Programme. - Above £80k quotation waivers - 1 in each month of January, February and March 2021. - Excluding waivers relating to COVID-19, increase of 24 waivers reported (120%) compared to the same period for last year, increase in value by £1,402,182 (225%). - Retrospective waivers (excluding COVID related waivers), 22% of the total number submitted, increase by 42%. There was disappointment expressed in the increase in retrospective waivers, however some assurance of training in place and that narrative had been added to explain reasons if/why competitive tender process not followed.	**The Committee noted the report and received moderate assurance** **Reassurance provided that monitoring continues, letters had been sent to all CBU Managers reminding them of the appropriateness of waivers and the process to be followed, in addition a training package is to be rolled out May 2021.**	**Audit Committee 19.08.2021**

AC/21/04/41	**Going Concern Report**	The Committee received and approved the preparation of the accounts on the Going Concern basis statement in Section 7 of the report	**The Committee approved the Going Concern Statement and received good assurance.**	**Audit Committee 10.06.2021**
AC/21/04/44	**Draft Unaudited and Financial statements 2020-21**	Committee received a high-level summary of year end prior to external audit for inclusion in Final Accounts Submission. Thanks were recorded to the Finance Team for their efforts in producing the year end accounts in challenging operational circumstances	**The Committee noted the draft accounts and received good assurance**	**Audit Committee 10.06.2021**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/05/68 e		TRUST BOARD OF DIRECTORS	DATE OF MEETING	14 April 2021

Date of Meeting	**14 April 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/21/04 /02	Terms of Reference	• The Terms of reference were reviewed	The Committee **approved** the Terms of Reference.	
CROC/21/04 /03	Clinical Prioritisation & Scheduling Standard Operating Procedure (SOP)	Report presented for noting • Reviewing real time means scheduling issues quickly picked up • 13 RCAs currently under review • Historic touch points still there but if clinician feels another review is required this can be acted upon in the clinical service.	The Committee **noted** the updates and received moderate assurance.	CROC May 2021
CROC/21/04 /04	Waiting List update	Report presented for assurance • Slide deck is currently shared breaking down to priority codes • BI suite being produced to • 1580 patients expired review • T&O longest waiters in line with national trend • Priority 2 back log has been the priority in line with C&M planning • Trend data will be key in giving the Committee assurance • Agreed waiting list and clinical harm review to be removed from FSC Agenda	The Committee **noted** the report and received moderate assurance.	CROC May 2021
CROC/21/04	Recovery	• For assurance Presentation & Briefing Document	The Committee **noted**	CROC May

/05	Completion Forecast Weekly C&M Activity Recovery Summary	• P2 pack for information but should note the risk of not comparing like with like in other Trusts. WHH P2 position on page 52 highlights WHH benchmarked position • 523 P2 patients currently waiting, 182 have TCI leaving 341 patients with no TCI • Ophthalmology, Urology and T&O form 69% of P2 patients (in line with the national trend) • Expected to not have overdue P2 by August 2021 in line with C&M trajectories 52 week position • There are 1545 patients waiting over 52 weeks. • Key specialties within the 52 week category are: T&O and Urology which combined form 43% of the waiting list. • Other specialties with high volumes include ENT Maxs Facs, Ophthalmology and Gynae, which along with T&O and Urology form 79% of long waiters • The run rate shows the trust will be back on track with no 52 week breaches by March 2022 • The trust has planned a phased trajectory to recover activity in line with the operational planning guidance for 21/22. Agreed separate report on cancer is required for this Committee	the update	2021
CROC/21/04 /06	Harm Profile	Update For assurance data presented key points to note include:- • 13 initial Harm reviews have been identified to date. These are currently being senior reviewed to determine the final outcome. • All patients have been assessed for treatment and 9 patients have already been treated, 3 have dates in April • 1 patient not medically fit, will be kept under review • All (13) Duty of Candour's completed The Committee noted the plan for harm reviews of the 52 week+ patients		CROC May 2021
CROC/21/04 /07	Speciality Overview	• Deferred to next meeting		CROC May 2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/05/68 e		TRUST BOARD OF DIRECTORS	DATE OF MEETING	27th April 2021

Date of Meeting	**27th April 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/21/04 /02	Cycle of business	• The cycle of business was reviewed	The Committee **noted** the Terms of Reference.	
CROC/21/04 /03	Harm Profile update	Update For assurance data presented key points to note include:- • 104 reviews completed, therefore an overall reduction of 484 reviews completed since 7th April 2021. • 385 had harm reviews completed and 99 were patients already treated or with a TCI • SOP (Standard Operating Procedure) has been completed and ratified at Clinical Services Oversight Group (CSOG). • The focussed reviews in progress are T&O (Trauma and Orthopaedics), Urology, Gynae and General Surgery	The Committee **noted** the updates and received moderate assurance.	CROC May 2021
CROC/21/04 /04	Waiting List update	• 52-Week Wait Position Plan -v- Actual as of March 2021: 1 ,890 and actual of 1,545 for March 2021 • Patients waiting greater than 18 weeks reduced from 5792 in February	The Committee **noted** the report and received moderate	CROC May 2021

		2021 to 5492 in March 2021 • Priority 2 Trajectory at end of March 2021- Planned March 551, actual 514; planned April 526, actual 512) • Endoscopy – the number of patients waiting for an endoscopy procedure at the end of March 2021 was 884. This is a reduction of 570 patients from the start of the year.	assurance.	
CROC/21/04 /05	Recovery Completion Forecast Weekly C&M Activity Recovery Summary	• Activity is based on achieving the 2019/20 outturn. • Day case and inpatient rates are tracking at 80% based on 2019-2020 outturn against a trajectory of 70% for April. • Outpatient rates are tracking at 97% and by May 2021 this percentage will be 100%. • 52 week wait/restoration is tracking at 1496 (forecast) at the end of April – this is below trajectory.	The Committee **noted** the update	CROC May 2021
CROC/21/04 /07	Speciality Overview	• A report has been developed for one year and captures all specialties and is in the process of being completed. Once completed, all the specialist areas will have a target trajectory to December 2022. Specialities completed are General surgery, Urology and Trauma and Orthopaedics. • The following specialties are yet to be developed: Ear Nose and Throat (ENT, Ophthalmology, General Medicine, Gastroenterology, Cardiology, Respiratory Medicine (Thoracic), Rheumatology, Geriatric Medicine, Gynaecology and Specialty Other.		CROC May 2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/005/68 e		TRUST BOARD OF DIRECTORS	DATE OF MEETING	13th May 2021

Date of Meeting	**13th 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/21/04 /02	Terms of Reference	• The Terms of reference review and added the Associate Director for Planned Care.	The Committee **approved** the Terms of Reference.	
CROC/21/04 /03	Harm Profile update	• An agreement to collect additional data on the harm proforma to indicate where harm had occurred on the patients journey. • Overall following last week's meeting there has been a further reduction of 106 reviews completed, therefore an overall reduction of 700 reviews completed since 7th April 2021. • 495 harm reviews have been completed an increase of 110 since last week. 205 of the 700 were patients already treated or with a TCI in next couple of weeks • No new harms identified in the 110 completed this week. • Focussed governance review for T&O and Urology trajectories. • Additional validation support has now been identified to assist with the work and due to start on the 11th of May		

CROC/21/04/04	Waiting List update	Report presented for assurance ➢ RTT: At the end of April 2021, the 52-week trajectory was met against the agreed trajectory. The number of breeches recorded was 1386 (not finalised) against a trajectory of 1806. - Priority code waiting times In Line with national guidance and the CVP the Trust has been applying priority codes to the inpatient waiting list. At WHH 99% of the patients have been assigned a P-Code. ➢ Warrington and Halton (WHH) have a total 514 patients with a p2 code assigned to them and a trajectory for clearance of the backlog by the end of August. - Cancer: Patients in the 104+ day's category; there are 21 against a trajectory of 31 (-10 under). - Patients in the 62+ day's category; 62 against a trajectory of 120 (-46 under).	The Committee **noted** the report and received moderate assurance.	CROC May 2021
CROC/21/04/05	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. WHH P2 position on page 52 highlights WHH benchmarked position • 523 P2 patients currently waiting, 182 have TCI leaving 341 patients with no TCI • Ophthalmology, Urology and T&O form 69% of P2 patients (in line with the national trend) • Expected to not have overdue P2 by August 2021 in line with C&M trajectories 52 week position • There are 1545 patients waiting over 52 weeks. • Key specialties within the 52 week category are: T&O and Urology which combined form 43% of the waiting list. • Other specialties with high volumes include ENT Maxs Facs, Ophthalmology and Gynae, which along with T&O and Urology form 79% of long waiters	The Committee **noted** the update	CROC May 2021

		• The run rate shows the trust will be back on track with no 52 week breaches by March 2022 •		
	Access to Recovery Fund update	• The Elective Recovery Fund (ERF) is accessible at system level based on activity performance thresholds for H1 • The thresholds are staged: April 70%, May 75%, June 80%, July to September 85% for both elective and outpatient activity • Overall system performance will be reviewed with subsequent funds to be allocated by the C&MHCP, the methodology of which to be shared with DoFs w/c 10 May • Submission of draft activity plans for WHH result in meeting all required activity threshold % targets • Acute providers' access to ERF funding will be subject to meeting both the required activity thresholds and the requirements for five 'gateways'		CROC May 2021
CROC/21/04/07	Speciality Overview	• VMD explained that all the speciality trajectories contained in the report are what the Trust is being monitored on externally.		CROC May 2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/05/69**			
SUBJECT:	**Moving to Outstanding Steering Group**			
DATE OF MEETING:	**26 May 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 through high quality, safe care and an excellent patient experience.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an update regarding: • The findings of the maternity mock inspection. • The Trust's first Transitional Monitoring Approach Assessment from the CQC. • The Moving to Outstanding work streams. • The 5 CQC enquiries received between February 2021 and May 2021. • The assurance arrangements in place within the Trust relating to the CQC's 'Protect, respect, connect – decisions about living and dying well during Covid-19'. • The next CQC Trust Monitoring Assessment focused on Maternity Services is scheduled for 24 May 2021. • CQC's new strategy, launching 27 May 2021.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors is asked to note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Moving to Outstanding Steering Group		
	Agenda Ref.			
	Date of meeting	22 April 2021		
	Summary of Outcome	The Steering Group discussed and noted the updates within the report.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED:	None			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Moving to Outstanding Steering Group	AGENDA REF:	BM/21/05/69

1. Background

This report will provide an update on CQC compliance and the new methods of assessment being undertaken.

2. Key Elements

The Moving to Outstanding Task and Finish Group has successfully completed the first mock inspection of Maternity and an action plan is in place. This will be monitored via the M20 Steering Group.

A program of mock inspections has been agreed and will continue over the course of 2021. The outcome of these inspections with be reported to the Quality Assurance Committee. A mock inspection is being planned for ED in June 2021.

The CQC have commenced their Transitional Monitoring Approach assessments. This approach focuses upon safety, how effectively a service is led and how easily people can access the service. The information gathered will direct the CQC as to whether a focused inspection is required based upon considered risk. These assessments are not considered as inspections and services are not rated/re-rated following these meetings.

The Trust had its first CQC Transitional Monitoring Approach assessment on 12 May 2021. Positive feedback was received. A further Transitional Monitoring Approach Assessment is scheduled for 24 May 2021 with a focus on Maternity Services.

The Moving to Outstanding Steering Group received updates regarding the following workstreams:

- Palliative and End of Life Care
- Medicines Improvement Group
- Use of Resources
- Child Health Improvement Group
- Well-Led

All work streams are on track and will be reviewed as part of the Mock Inspection process. A new workstream has been established in Outpatients to support this area in achieving and outstanding level of practice.

Between February 2021 to May 2021 the Trust has received 5 enquiry requests:

- 3 complaint responses – These currently remain under Trust review.

- 1 enquiry is linked to the CQC's monitoring approach. The enquiry is a request for final investigation reports relating to 4 separate incidents at the Trust. The incidents are not linked and there are no themes identified. Two reports have been provided.
- 1 enquiry related to assurance in relation to maternity services – the Deputy Director of Governance has provided this information.

The CQC provide the Trust with a bi-monthly Insight Report. The Trust has introduced a new process to review and seek assurance regarding any indicators detailed within the CQC's Insight Report. The new process includes:

- Ensuring that the data set used by the CQC is accurate.
- A review of the indicator to understand CQC data.
- Action planning, where appropriate to improve performance.

Whilst focusing on CQC's revised strategic priority of developing access to 'live Trust data', the Data Warehouse Team have been working closely with the Moving to Outstanding Task and Finish Group to develop a 'live CQC Insight report'. The new report, which is still in development, will enable internal review of live data. This will enable prompt access to information indicating any variation in performance and strengthen compliance monitoring.

The CQC produced the final version of their report, 'Protect, Respect, Connect – decisions about living and dying well during Covid-19'. The report links to DNACPR decision making across the system, which is identified as a Quality priority for 2021/2022. The Deputy Director of Governance, Deputy Chief Nurse and Associate Director of Governance have reviewed the 11 recommendations within the CQC's report and have revised the Trust's existing DNACPR action plan to address any areas for improvement. This has previously been shared with the Quality Assurance Committee (May 2021).

The CQC are launching their new strategy on 27 May 2021. The Trust commenced planning for the potential impact of CQC's change in strategic direction in October 2020.

3. Recommendations

The Board of Directors is asked to note the report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/05/70**			
SUBJECT:	**Maternity SI Report**			
DATE OF MEETING:	**26 May 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 through high quality, safe care and an excellent patient experience.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	#1108 Section 43(2) exempts information whose disclosure would, or would be likely to, prejudice the commercial interests of any legal person (an individual, a company, the public authority itself or any other legal entity).			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report will provide detail on the number of maternity incidents reported at WHH during March 2021 and any closed investigations along with learning identified.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors is asked to note the learning from incidents detailed in this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/05/122b		
	Date of meeting	4th May 2021		
	Summary of Outcome	The Committee noted the report		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

Maternity Incident Report: Quality Assurance Committee

Warrington and Halton Teaching Hospitals NHS Foundation Trust

April 2021

Background:

This report will provide detail on the number of maternity incidents reported at WHH during March 2021 and any closed investigations along with learning identified.

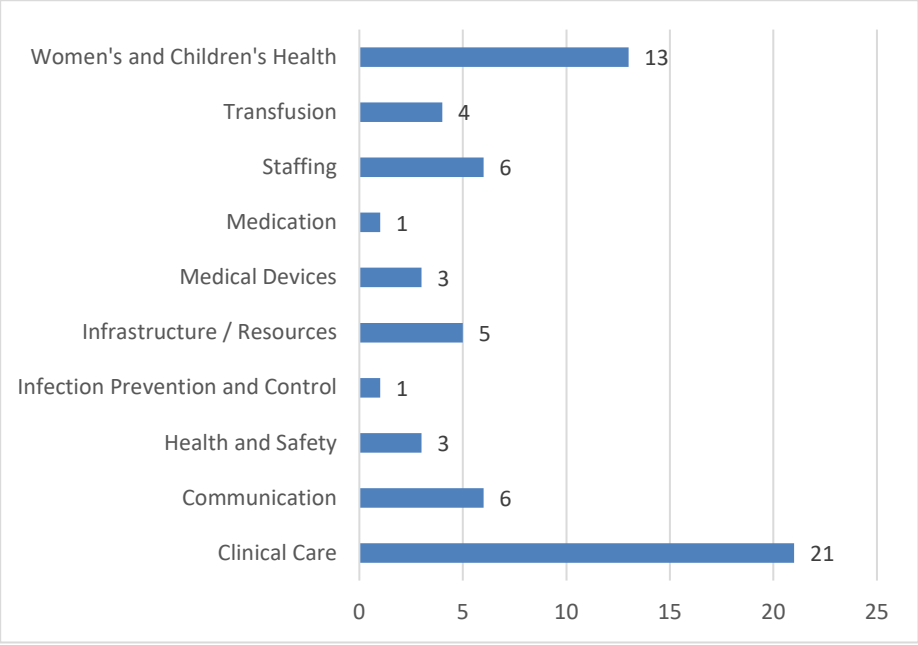
Incidents reported in March 2021

In March 2021 there were:

No harm incidents 59;

Low harm incidents 4.

Top ten reporting themes are noted below:



Completed Root Case Analysis (RCA) , Health and Safety Investigation Branch investigations (HSIB) and PMRT in March 2021.

- Two concise Root Cause Analysis (RCA) investigations were shared with families
- 1 Healthcare Safety Investigation Branch (HSIB) and investigation completed
- 1 Perinatal Mortality Review Tool (PMRT) report completed

Maternity Incident Report: Quality Assurance Committee

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Learning incident delay: Transfer and treatment:

Incident detail:

There were missed opportunities to transfer the patient to the birth suite when the patient felt faint and had lost 500ml of blood. The delays in suturing and a delay in transfer to obstetric area resulted in haematoma evacuation in theatre.

- Any Clinical findings that need obstetric review outside of obstetric emergencies (with the exception of perineal suturing) must be transferred to Birth Suite.
- Severe perineal pain is suggestive of a haematoma and the woman must receive an immediate obstetric review.
- Where any transfer is taking place, a midwife must be present. An SBAR handover must take place.
- Concerns regarding patient wellbeing or suspected must be escalated to the senior midwifery team using fully completed SBAR.
- Blood loss of 500mls or more is a PPH and the woman should be transferred immediately from The Nest to Birth Suite.

Maternity Incident Report: Quality Assurance Committee

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Learning incident: Delayed scan

Incident detail:

The patient attended Ultrasound for a dating scan. There was a 4.3mm fetal pole with sadly no heartbeat. This was confirmed by a second Sonographer. The lady should have been offered a second scan 7-10 days later. This was not arranged.

- The process of providing a second opinion in Ultrasound is open to misinterpretation between colleagues if there is no discussion and agreement as to the specific content of the imaging report for the exam prior to publication.
- The Trust standard operating procedure has been updated to ensure that it is clear that a private ultrasound scan should not inform decision making and a Trust can should always undertake own imaging when it contributes to decision making. Management should not be based on the Ultrasound report alone, instead used in conjunction with the complete clinical picture.
- Sonographers advised to change language on reports since incident to be more descriptive and not direct patient management, unless guided by agreed protocols.

All learning from investigations are monitored on SMART action plans and recorded in Datix.

Maternity Incident Report: Quality Assurance Committee

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Learning incident from HSIB and PMRT

HSIB report

Incident details:

- *Patient had relocated due to a family bereavement and care had been transferred.*
- *The patient missed 3 routine check ups from 28 weeks to 35 weeks.*
- *When the baby was born they were "dusky in appearance" -baby required therapeutic cooling.*
- *There were concerns whether pre natal care could have contributed.*

No safety recommendations made and positive feedback has been shared with the midwife who was in attendance at the birth for her quick recognition and response when the baby's condition deteriorated.

PMRT

Incident details:

- *Patient had the implant for contraception when she presented to the Emergency Department 4 days before she gave birth with back ache.*
- *Clinical history and symptoms were suggestive of muscular skeletal pain and pregnancy was not considered. The patient sadly went on to have a still born baby.*
- Ensure women of childbearing age who present with back pain are offered a pregnancy test – reflected in ED triage policy.
- Exploration of triage algorithm in the electronic patient record to ensure that all women of childbearing age are asked if they could be pregnant.

- **Further Reporting**

This update will be reported to Trust Board as part of Ockenden requirements.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/21/05/71	
SUBJECT:	**Use of Resource Assessment (UoRA) Update – Q4 2020/21**	
DATE OF MEETING:	26th May 2021	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer and Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#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. The Trust's Use of Resources Group restarted in April 2021.	

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 – Q4 2020/21**	**AGENDA REF:**	BM/21/05/71

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 4 2020/21. Progress has been impacted by the COVID-19 pandemic with UoRA meetings suspended during the Quarter. Performance against each UoRA KLOE is set out in **Appendix 1**, the full detail for each KLOE indicator can be found in **Appendix 2**.

The following movements in the UoRA dashboard indicators have taken place since the Quarter 4 report:

- Nursing Costs Per WAU – this indicator has moved from Green to Red. This indicator does not include agency costs and therefore as vacancies are recruited to, this increases the costs per WAU. This is positive from a Quality and UoRA viewpoint as it means substantive posts have been recruited to, however the increase in staffing due to COVID-19 means the benefits have not been fully realised in the reduction of agency costs. Nursing costs are reviewed and reported to the Finance & Sustainability Committee.

UoRA National Status

UoRA inspections continue to be suspended nationally in response to COVID-19. The Model Hospital is now being updated. At this time, there are no timescales when the inspections will resume or the format future inspections will take given the potential impact of additional costs, resources and the reduction in activity due to COVID-19.

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
17th May 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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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

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.

NHS 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)

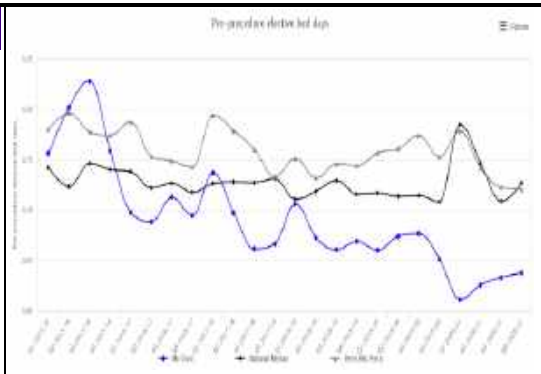
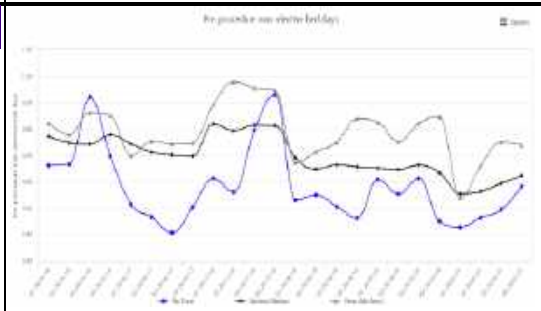
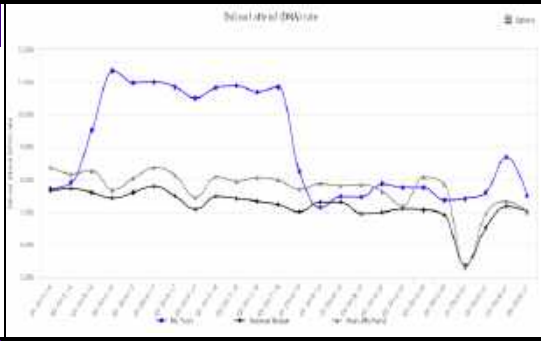
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q4 2020/21

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 reduction in theatre cancellations and improving productivity and efficiency. Performance against this metric is further monitored via the Theatre Performance Dashboard. The Theatre dashboard has been enhanced using Power BI dashboards which allows a "Live" view of theatre performance and productivity. 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 reduction in theatre cancellations and 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.
Did Not Attend Rate - Rate of patients not attending their outpatient appointment	**National Median: 7.02%** Q4 2020/21 **Peer Median: 7.00%** **Target: National Median** **Best Quartile: 5.87%** **WHH Position:** **7.51%** **Ranking:** **07/09 Peer Group** **Quartile:** **3 (2nd Worse)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		**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.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position

National Median

Peer Median

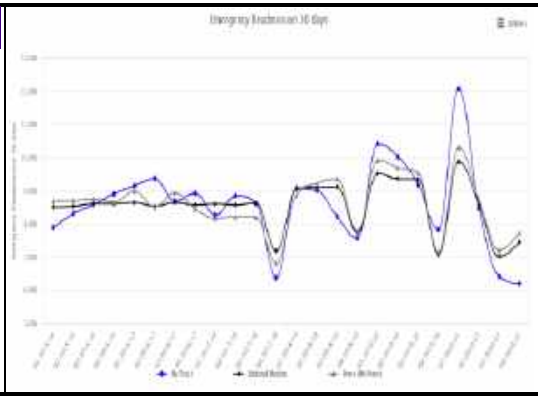
Key

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

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

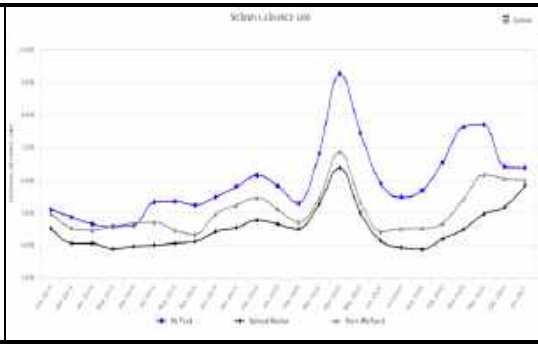
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q4 2020/21

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: Deborah Smith/Carl Roberts

Staff Sickness - Percentage of staff FTE sick days.	**National Median: 5.84%** **Peer Median: 6.00%** **Best Quartile: 4.29%** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: Trust Board, SPC** **Source: HSCIC - NHS Digital iView Stability Index**	**January 2021** **Target: 4.2%** **6.38%** **6/10 Peer Group** **3 (2nd Worse)**		**The Trust is performing worse than the national and peer medians.** Significant strategic and operational work has been undertaken to improve the 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

UoR

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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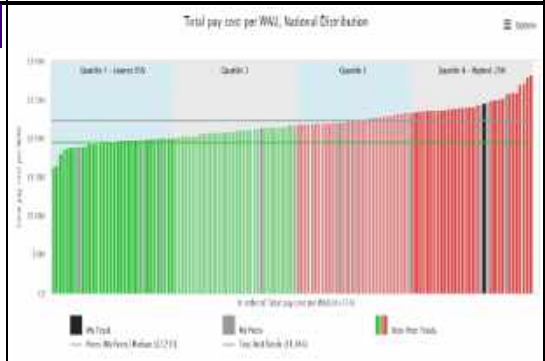
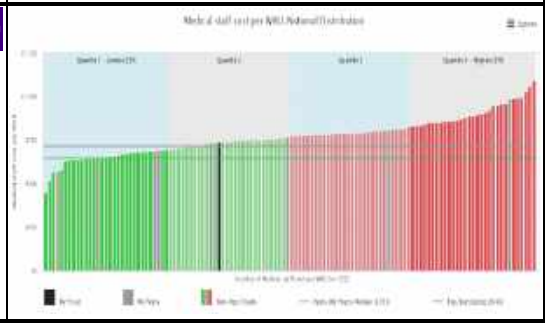
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q4 2020/21

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: 86.3%** **December 2020** **Peer Median: 86.5%** **Target: National Median** **Best Quartile: 88.7%** **WHH Position:** **84.60%** **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.
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.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

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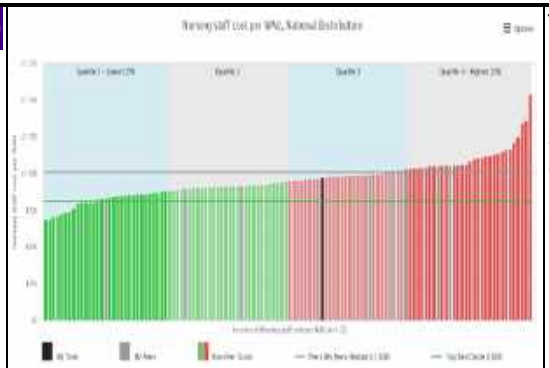
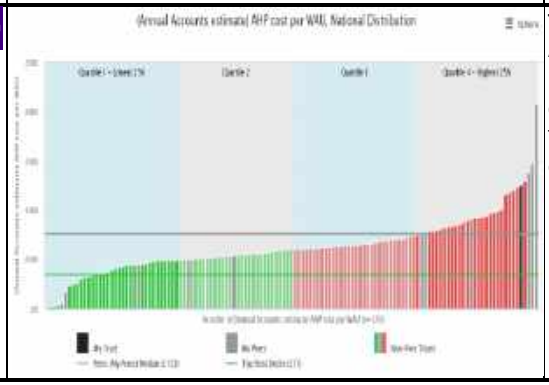
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q4 2020/21

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: Maintain** **Best Quartile: £883** **WHH Position: £976** **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 (28 are working on the Wards, 13 are on the Trusts Induction, 19 are studying towards their OSCE and 36 are currently going through the pre-employment clearances). The Trust has also addressed vacancies within the Healthcare Assistant staff group from 63 vacancies in January 2021 to 0 in March 2021.
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: £121** **2018/19** **Peer Median: £153** **Target: £153** **Best Quartile: £99** **WHH Position: £251** **Ranking: 08/11 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 peer medians.** Across the therapy element of AHP, pay costs for community/other work has been included in the cost per WAU calculation on Model Hospital. This indicator includes costs for staffing who are outsourced via Service Level Agreements to other Trusts. This activity is not included in the WAU, if these costs were removed, the revised estimated costs per WAU would be £123 which brings the Trust in line with the national median.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

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Peer Median

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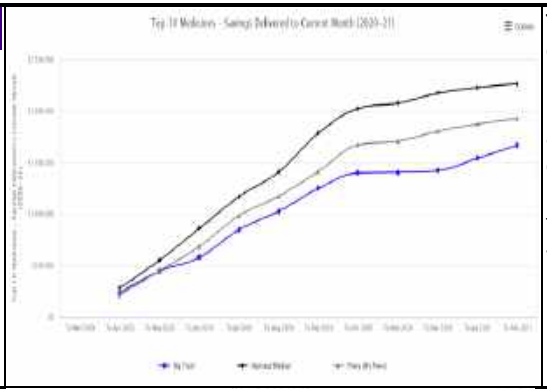
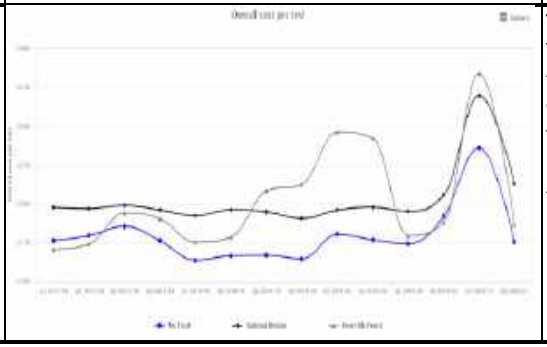
Use of Resources Assessment Dashboard - Q4 2020/21

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: £915k** **February 2021** **Peer Median: £1.93m** **Target: Benchmark** **Best Quartile: N/A** **WHH Position:** **£1.67m** **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 £1.67m as of February 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** **Q3 2020/21** **Peer Median: £1.67** **Target: Maintain** **Best Quartile: £1.71** **WHH Position:** **£1.42** **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. It is anticipated that the cost per test will rise as a result of the COVID-19, as the number of tests performed has reduced. This will be 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

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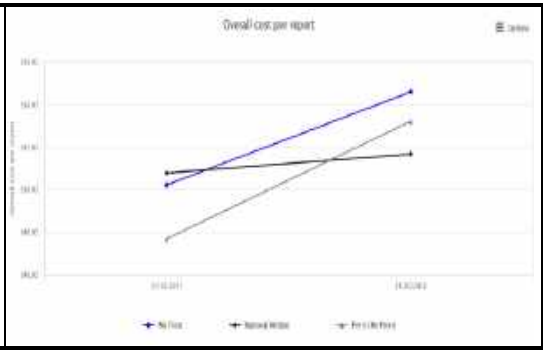
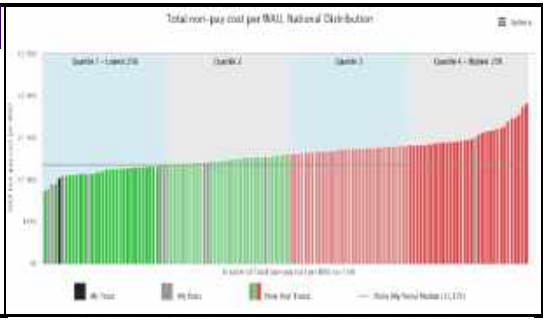
Use of Resources Assessment Dashboard - Q4 2020/21

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
IM&T

KLOE Operational Lead: Jane Hurst
KLOE Operational Lead: Alison Parker
KLOE Operational Lead: Deborah Smith/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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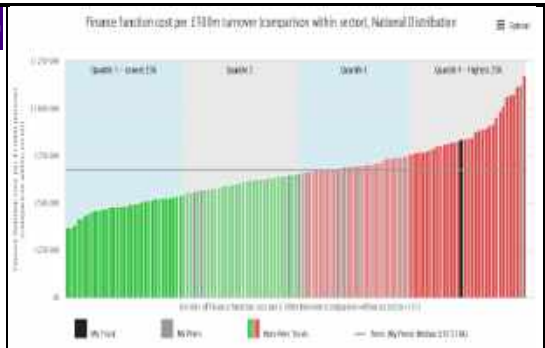
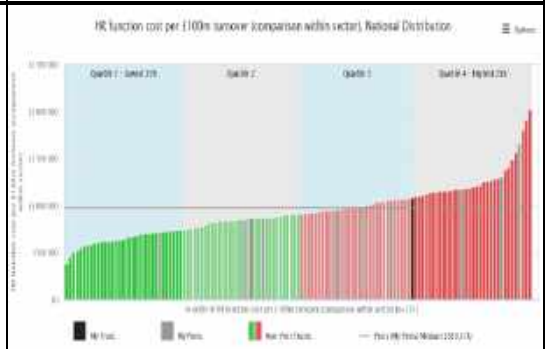
Use of Resources Assessment Dashboard - Q4 2020/21

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 an overall reduction in Finance costs per £100m income in 2018/19 from £852k to £839k which includes the restructure of some teams and the removal of posts. The Trust is currently above the national median based on costs per £100m income; however the absolute cost of the finance function is below the national median. There remains an issue with the way the SBS costs are treated and this has affected the position, if these costs were removed, it would bring the Trust to below the national median.
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 are higher 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. 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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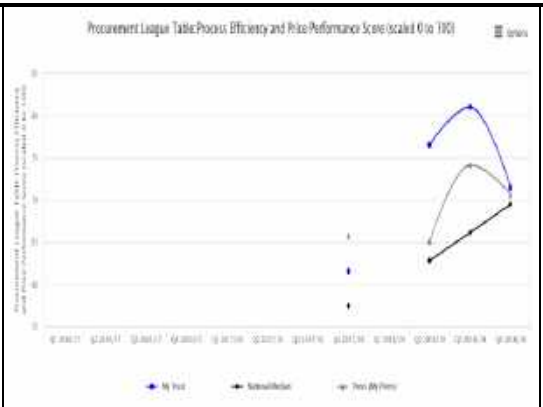
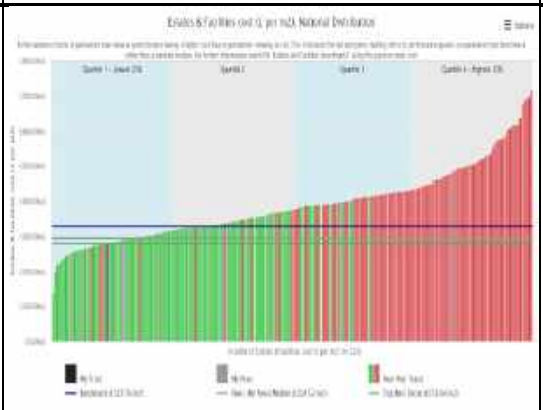
Use of Resources Assessment Dashboard - Q4 2020/21

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 better the national and peer median for the Procurement Process Score.** Contributing to the League Table position is the use of EDI (Electronic Transfer of Orders and Invoices). The Trust has never used an external supplier to manage its catalogues which is contributing factor in the use of EDI; the Trust manages its own catalogues resulting in the performance against the use of EDI being lower. Pre COVID-19 the Trust was engaged to move to Edge for Health which is currently suspended and will be revisited in Q2 2021/22. This will improve the EDI 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.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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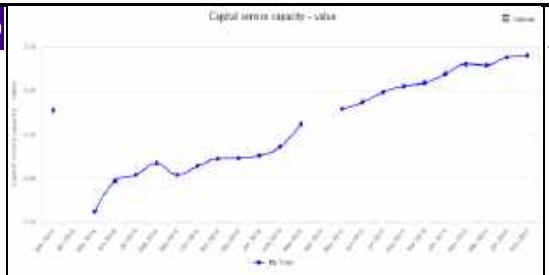
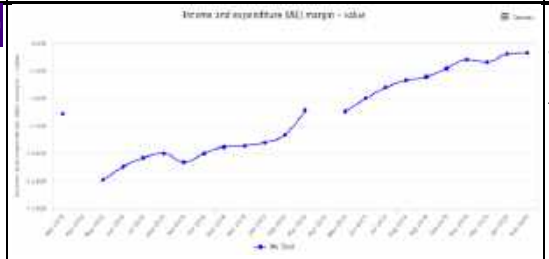
Use of Resources Assessment Dashboard - Q4 2020/21

KLOE 5: Finance

KLOE Operational Lead: Jane Hurst

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
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 Financial position has significantly changed since April 2020 due to the COVID-19 pandemic under the new financial regime in 2020/21.
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 and an adjusted deficit of £6.8m as per the NHSE/I requirement. The forecast for 2021/22 is £7m deficit. Cheshire & Mersey has a gap of £98m as at 5th May 2021. 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's cash position was c£20m throughout 2020/21, this was due to all Trusts receiving an extra income payment in M1 to support cashflow. As a result, the Trust has been able to pay suppliers promptly resulting in an improvement in compliance against the better practice payment code (BPPC) which was 90% (Cumulative) for the year. The Trust requested additional cash for; the deficit, the ability to continue paying creditors promptly, annual leave accrual and to increase the minimum cash held to 7 working days. This additional support of £30m was received in March 2021. Due to delays in capital scheme completion and the receipt of unplanned income in March, the Trust cash position at 31/03/2021 was £47m. As the capital expenditure and annual leave are incurred, this will reduce significantly. The Trust will have an increased balance of c7 working days cash which is a increase from c2 days cash previously.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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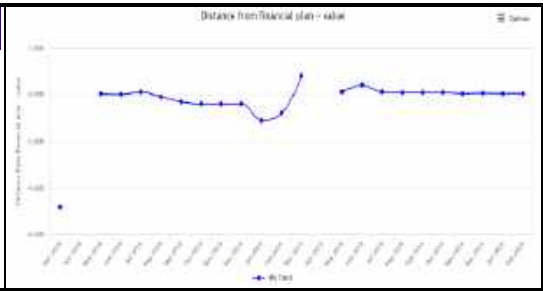
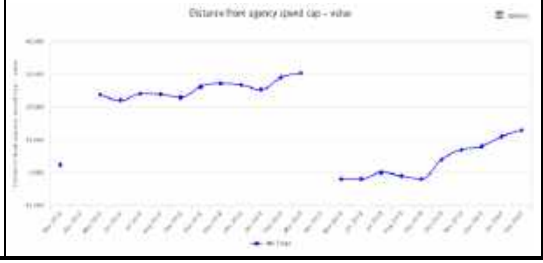
Use of Resources Assessment Dashboard - Q4 2020/21

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**		The Trust's annual plan was updated several times during 2020/21 to reflect the changing financial regime. The Trust closed the year with a deficit in line with NHSE/I's planned deficit for the Trust.
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 was no agency cap for 2020/21, however the Trust continued to closely monitor agency spending for both business as usual and COVID-19 requirements. The annual plan submitted to NHSE/I prior to COVID-19 included an annual agency spend (including locums) across all staff groups of £8.6m. The actual expenditure for 2020/21 was £15.3m of which £9.0m related to COVID-19.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q4 2020/21

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. **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.	• Progression of collaboration opportunities through mutual aid/SLAs to maximise use of assets e.g. Walton Centre Pain service and support recovery. • Focus on Discharge/Where Best Next – programme of work to improve discharges, improving flow, ensuring patients are at the most appropriate point of care. • Virtual Enhanced Care – review and re-design of processes to improve patient care/experience. • Patient Transport Services – reprocurement of patient transport services including capacity/demand management. • Hospital Handover Improvement Project – project to review ambulance handover times and improve flow in ED. • COVID-19 Recovery – recovery programme for the Trust to achieve the elective activity target. • Breast Service Reconfiguration – the Trust is in the process of a consultation for the reconfiguration of breast screening and surgery.
People - Sickness	**Deborah Smith/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. Ongoing, lead via the Strategic Workforce Lead for the STP/ICS.	**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.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q4 2020/21

KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
People - Retention	**Deborah Smith/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:** • Development of a line manager retention masterclass. • Launch of a kindness, civility and respect campaign. • Introduction of the working carers passport. • Embed a programme of Workforce Recovery to maintain the current focus on employee Health and Wellbeing. • Roll out a programme of engagement and training with line managers.
People - Staff Costs per WAU	**Deborah Smith/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 vacancies are currently being filled by NHSP Bank and Agency staff. 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. As at 28/04/2021, of the 96, 28 are working on the Wards, 13 are on the Trusts Induction, 19 are studying towards their OSCE and 36 are currently going through the pre-employment clearances (due to arrive in May, July and September). Following their supernumerary, wards will be able to reduce their reliance on Temporary Staffing. • Reduction of HCA Vacancies to 0 FTE; in January 2021 the Trust had 63 FTE Vacancies across the Healthcare Assistant Band 2 Workforce, the programme of work aimed to reduce these to 0 by March 2021. Through centralised recruitment and dedicated support in both Occupational Health and the Recruitment team, the Trust report 0 FTE vacancies at 31/03/2021. In addition the Trust had also recruited an additional 38 HCAs to replace the Students Nurses due to leave employment on 30/04/2021 and any natural turnover. It is anticipated the Trust will remain at 0 FTE vacancies from 30/04/2021.	**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. • Potential expansion of the International Recruitment Programme so it covers Medics, AHPs 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.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resources Assessment - Action Plan Q4 2020/21

KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
Clinical Support - Pharmacy	**Diane Matthew**	**Savings on Medicines:** The Trust delivered £1.7m of savings on medicines in 2019/20 and £1.7m in 2021/22 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. Further roll-out to ophthalmology is planned.	• **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 3 specialities scheduled for go live: Neonates and Paediatrics rollout for summer 2021; Intensive Care currently on hold following COVID-19 pressures and functionality testing. • **ePMA Phase 4:** Integration with JAC system (Stock Control) contingent upon JAC upgrade to cloud-based system, scheduled for May 2021. • **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 for the future.
Clinical Support - Radiology	**Mark Jones**	**Radiology Efficiencies:** • The Trust no longer outsources Vascular Ultrasound at a cost saving of £140K per year. • The department has reduced Ultrasound outsourcing by approx 30%. • The department continues to minimise external reporting services, one of few departments in area not to have regular outsourcing for reporting. • 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.	**Radiology Efficiencies:** • The Trust is installing 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 and will see a reduction in operational costs. • Cheshire & Mersey STP/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.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q4 2020/21

KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
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. **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. **Collaborative Working:** The Pathology Team is working in collaboration with 3 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 which generates additional income. In addition, a simple e-booking system for patients who need vaccinations, swabs or blood tests has been developed.	**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. **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 work similarly to tried and tested PACS technology and has been developed by Philips. **Pathology Efficiency & Quality:** The Trust is piloting the phlebotomy and transfusion application in ED, 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.
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. The Estates & Facilities team has a strategy to reduce underutilised and empty space (currently 38.7% non-clinical space and 2.5% empty space), however this has been impacted by COVID-19 due to the need for social distancing measures. Investment in backlog maintenance in 2020/21 to improve the critical risk infrastructure. **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.	**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) - on hold due COVID-19. A plan has been developed for a collaborative approach across C&M as current contracts expire new Trust will be included. Opportunities to bid collaborative to reduce costs. • Progression/Expansion of agile working to reduce floor space (this has been accelerated by COVID-19, however due to social distancing requirements, the ability to remove desks has been affected). **Energy Saving Schemes:** • Internal replacement of emergency lighting to improve efficiency. • Recruitment of a sustainability manager in 2021/22 to drive forward the sustainability agenda. • Cost neutral proposal for electric car charging points. • Capital spend on projects that will reduce critical infrastructure risk and long term estates maintenance costs. **Collaboration & Sustainability:** • Monitor critical infrastructure risk and how this has had an impact on estates maintenance costs.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q4 2020/21

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, North West Boroughs and Bridgewater via Service Level Agreements. • Strategy meetings have been restarted via MS Teams for C&M Procurement collaboration. The programme plan has been revisited and a review of the PID has been developed to outline objectives, governance and leadership. • Further work is being undertaken to develop a collaborative contract register and a monthly progress report. • A sub-group has been established to establish plans regarding the delivery of actions re the ICS Based Procurement Guidance. **Procurement Efficiency:** • The Trust is fully engaged with SCS (Spend Comparison Service) participating in training, webinars and events. • The Trust implemented the Cheshire & Mersey agency rate card (with estimated savings of £0.8m) in November 2019. • 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. **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. • Re-commence data analytics re the Spend Comparison Service. • 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. • Engagement in 10 collaborative procurement projects across the Cheshire & Mersey system.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q4 2020/21

KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
Finance	**Jane Hurst**	**Financial Planning, Sustainability & Controls:** • Close scrutiny of CIP (limited CIP in 2020/21). • 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 £500k. • The Trust is working with the system to deliver a breakeven position in 2021/22. • Delivery of CIP of c1% in 2021/22. • Delivery of £19.5m Capital Programme in 2021/22.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/05/73**			
SUBJECT:	**Board Assurance Framework**			
DATE OF MEETING:	26th May 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: • No new risks have been added to the BAF; • The ratings of six risks has been reduced. • There have been no amendments to the descriptions of any risks on the BAF; • One 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 21/04/91 & QAC 21/05/119		
	Date of meeting	06.04.2021 & 04.05.2021		
	Summary of Outcome	The Committee reviewed, discussed and approved the amendments		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework and Strategic Risk Register report	AGENDA REF:	BM/21/05/73

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 no new risks have been added to the BAF.

2.2 Amendment to Risk Ratings

Since the last meeting, the ratings of **6** risks have been reduced.

COVID-19 demand has significantly reduced and continues to do so. As the number of COVID-19 patients reduce, the expected use of O2 should also reduce. At the Quality Assurance Committee (QAC) on 6th April 2021 the it was agreed to reduce the risk rating of risk #1126 from 15 to 10.

ID	Risk description	Rating (previous)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
1126	Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.	15	10	BAF	Dan Moore	Quality Assurance Committee

Following approval at the Quality Assurance Committee on 4th May 2021, the ratings of a further five risks were reduced.

As the number of COVID-19 positive patients has reduced and the Nosocomial outbreaks has also reduced, it was therefore agreed to reduce the ratings of risks #1272 and #1275 from 25 to 20.

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
1272	Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident.	25	20	BAF	Kimberley Salmon-Jamieson	Quality Assurance Committee

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
1275	Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks	25	20	BAF	Kimberley Salmon-Jamieson	Quality Assurance Committee

Following the continued reduction COVID-19 positive patients, reduction in staff absences, installation of Bioquell Pods, B18 development and confirmed continued use of the private sector, it was agreed to reduce the rating of risk #1289 from 25 to 20.

ID	Risk description	Rating (initial)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
1289	Failure to deliver planned elective procedures caused by the Trust's decision to pause some elective procedures in order to ensure safe staffing and critical care capacity during the COVID-19 pandemic, resulting in potential delays to treatment and possible subsequent risk of clinical harm	25	20	BAF	Dan Moore	Quality Assurance Committee

Due to the falling numbers of COVID-19 positive patients and reduction in community prevalence, it was agreed to reduce the ratings of risks #1131 and #1132 from 25 to 15. The risks would remain on the Strategic Risk Register to acknowledge the pace at which the situation can change and continues to that the Trust continues to operate in a heightened sense of alert.

ID	Risk description	Rating (initial)	Rating (current)	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.	25	15	BAF	Dan Moore	Quality Assurance Committee

ID	Risk description	Rating (initial)	Rating (current))	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	25	15	BAF	Dan Moore	Quality Assurance Committee

2.3 Amendments to descriptions

Since the last meeting there have been no amendments to the descriptions of any of the risks on the BAF.

2.4 De-escalation of Risks

Further to the approved reduction in the rating of risk #1126 as described in section 2.2, it was also agreed to de-escalate the risk to the Corporate Risk Register for monitoring. The risk will continue to be reviewed at the monthly Risk Review Group Meetings.

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
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	• Operational Planning Guidance submission – 23rd April 2021 • 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 • Improvement against all modalities for numbers waiting more than 6 weeks noted in April performance. • Business Case for ED Plaza Scheme approved in 2021/22 Capital Plan • Clinical Services Oversight Group (CSOG) established • Continued use of the independent sector (Spire Cheshire) under new contract in 2021/22 with support from the CCG.	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	• Bioquell Pods now in place in ICU • Bioquell Pods to be in place in ED by the end of April 2021.	Risk rating reduced to 20

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	potential subsequent major incident.		
1273	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.	• Established Patient Flows Oversight Group (PSOG) to develop and support pathways relating to discharge efficiency.	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	• Bioquell Pods now in place in ICU • Bioquell Pods to be in place in ED by the end of April 2021. • Trust undertaking learning from Nosocomial outbreaks sessions.	Risk rating reduced to 20
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	• Confirmed continued use of the private sector (Spire Cheshire) in 2021/22. Under new contracting arrangements. • Continue to undertake harm review process and triangulate with waiting list process and Priority 2 patients • 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. • 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. • Clinical Recovery Oversight Committee (CROC) established • Clinical Services Oversight Group (CSOG) established	Risk rating reduced to 20
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 7.5 (Year to date position 7.8) HCA There are currently 29 Health Care Assistant vacancies within the Trust. All vacancies to be recruited to by April 21. Interviews weekly; • 94 have been recruited • 62 going through pre employment checks • 15 commenced induction in March	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		All recorded on spreadsheet tracker – currently -3 • Media campaign with Warrington Guardian - April • Weekly meeting and reporting to ensure we achieve target • Reserve list • Working up a process with NHSP and HR to ensure all HCA's are automatically recruited by NHSP. RN Recruitment • There are currently 73.41wte registered nurse vacancies within the Trust. • 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. • 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. <u>Assurances Gaps</u> Recruitment Gaps 73.41 RN Vacancies Retention Gaps 10.25% nursing turnover	
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	<u>Assurance updates</u> • Notified that non-NHS income will be provided to the Trust and will improve forecast outturn position – value to be confirmed by NHSE/I. • Budget Setting process underway for 2021/22 • c£34m cash support secured in the form of PDC in March 2021 • Achieved 95% BPPC May, June & July 2020, 98% BPPC August, 98% September, 96% October, November 96%, December 92%, January 87%, February 96%, March 96% • Executive review of COVID-19 costs which need to remain in place for 21/22 underway • Clinical Review Oversight Committee (CROC) to be established to provide	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	question if the Trust is a going concern.	oversight and assurance on recovery performance. • Interim Expenditure Budgets approved by the Trust Board on 31st March 2021 • Capital Plan approved by Trust Board on 31st March 2021 (£19.75m) • Achieved 2020/21 Control Total. • Deloitte Audited completed. Positive report received with one overclaim reported (£112k). Draft report to received by the Finance & Sustainability Committee in April 2021; • 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. <u>Assurance Gaps</u> • Uncertainty of the Trust allocation from the Cheshire & Merseyside Health & Care Partnership • Cheshire & Merseyside system is required to break-even	
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	• Engagement plan in place to continue to increase uptake for Lateral Flow Testing. • Recommencement of redeployment hub to provide oversight of shielders, ensure redeployment of workforce and equipment to those working from home due to home working/redeployment home working. • Extension of existing temporary changes to terms and conditions to support the covid response e.g. special leave, retirement, overtime until 31.03.2021. • In April 2021 overall sickness absence has reduced to 5.21% compared to a peak in April 2020 of 9.1%. • In April 2021 overall vacancy rate is 7.51% compared to a peak in Jun 2020 of 10.5%. • The majority of the employed Medical and Nursing Students left the organisation in April 2021 to continue/finalise their studies. This was supplemented with the mass recruitment of HCAs between Jan and Apr. We're currently reporting a single HCA vacancy.	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• 60 of our 96 international Nurses are now in the country with 28 of these working supernumerary on the Wards, as they gain experience, they'll be included in the numbers, reducing the requirement for temporary staff. • Therefore, as vacancies and sickness absence reduced it is expected our bank and agency reliance reduce and within April 2021 reliance on bank and agency staff reduced for the third month in a row and is now 15.3% compared to a peak of 23.3% in Jan 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 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.	• Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. • Using generic logins staff usernames and passwords are stored in browser when selecting "remember me".	No impact on risk rating
1207	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a	• Outstanding assessments have been escalated to Tactical Meeting and Chair has requested detailed information for individuals in the CBUs with the highest number outstanding.	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating

	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.	• A dedicated workforce risk assessments inbox has been setup as a single point of contact/support for managers
		Position @ 18th March 2021
		• 94.6% staff risk assessed
		• % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary – 98.2%
		  ○ Of the 38 staff know to be at risk who are yet to have a management risk assessment 46% have had the COVID Vaccine.
		  ▪ HR continue to support managers to complete the risk assessments.
		• % of risk assessment have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary – 97.4%
		• 91.2% of our staff have received the COVID Vaccine
		•	

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.	• 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	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	• 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 – posts out to recruitment • Daily staffing meeting and redeployment of staff to maintain safe staffing levels • Short term sickness 1 matron in maternity	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
145	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services 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.	• Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services to commence form September 2021. • The Trust is leading the development of the detailed plan for the Health & Wellbeing Hub. • 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.	
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.	• LAMP training sessions commenced. • LAMP testing commenced in ED/ICU • LAMP testing commenced in Wards A7/A8 by the end of March 2021 • Review of Clinically Extremely Vulnerable (CEV) taking place in line with National Guidance	No impact on risk rating
1290	Failure to provide continuity of services caused by the end of the EU Exit Transition	• Monitoring of prices continues, and fluctuations will be measured on a monthly basis. The Procurement department are aware of some price	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	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.	increases looming and are looking at mitigation as prices increase. • The Information Governance team continue to monitor the ICO website for news of the data adequacy decision. • Assurance letters and communication regarding the EU settlement scheme were sent out in February 2021 • 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. • On 19th February 2021 the EU Data Protection Commission launched the process towards the adoption of two adequacy decisions for transfers of personal data to the United Kingdom, one under the General Data Protection Regulation and the other for the Law Enforcement Directive. The publication of the draft decisions is the beginning of a process towards their adoption. This involves obtaining an opinion from the European Data Protection Board (EDPB) and the green light from a committee composed of representatives of the EU Member States. Once this procedure will have been completed, the Commission could proceed to adopt the two adequacy decisions. Adoption will allow for the free flow of data between the EU and UK. There is a webinar in place on 7th May to review this workstream. • Processes developed by UEC and Finance to ensure chargeable patients are managed appropriately. • Single point of contact in place for operational response, aligned with the regional Level 3 incident expectations; • 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	

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		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. There is a webinar in place on 7th May to review this workstream. • 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.	

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's decision to pause some elective procedures in order to ensure safe staffing and critical care capacity during the COVID-19 pandemic, resulting in potential delays to treatment and possible subsequent risk of clinical harm	1	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

Board Assurance Framework

1134	Michelle Cloney	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee
1114	Phill James	FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	1	20 (5x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1079	Kimberley Salmon-Jamieson	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.	1	20(4x5)	2 (1x2)	TBC	Quality Assurance Committee
1207	Michelle Cloney	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	2	16 (4x4)	8 (2x4)	TBC	Strategic People Committee
125	Daniel Moore	Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	1	16 (4x4)	4 (4x1)	TBC	Trust Operations Board
1108	Kimberley Salmon-Jamieson	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by Covid, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team	1	16 (4x4)	4 (4x1)	TBC	Quality Assurance Committee

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1124	Kimberley Salmon-Jamieson	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff	2	15 (3x5)	8 (4x2)	TBC	Quality Assurance Committee
145	Simon Constable	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	3	15 (3x5)	8 (4x2)	TBC	Trust Operations Board
1331	Daniel Moore	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.	1	15 (3x5)	5 (5x1)	TBC	Quality Assurance Committee
1332	Daniel Moore	Failure to provide a suitable patient environment caused by the rapid creation and opening of additional capacity/wards resulting in potential harm	1	15 (3x5)	5 (5x1)	TBC	Quality Assurance Committee
1274	Kimberley Salmon-Jamieson	Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.	1	15 (3x5)	5 (5x1)	TBC	Quality Assurance Committee
1290	Andrea McGee	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.	3	12 (3x4)	4 (1x4)	TBC	Finance & Sustainability Committee
1205	Phill James	FAILURE TO send accurate continuity of care information medication and / or allergies information from the Lorenzo EPR to external stakeholder. E.g. GPs CAUSED BY errors within the Lorenzo EPR electronic discharge summary code and/or configuration, i.e. the DXC PAN summarises the issue as:	1	10 (2x5)	5 (1x5)	TBC	Quality Assurance Committee

Board Assurance Framework

		"Discharge medications documented in Lorenzo do not match those showing on the discharge summary – this results in some medications being duplicated, missing completely or being incorrectly cited into appropriate sections." The medications section of the Discharge summary is split into the four heading of "Continued", "Stopped", "Changed" and "UnChanged" but the Trust response has deduced that medications are also appearing in the allergies section of the discharge summary. RESULTING IN patient harm due to errors and/or omissions within the medications and allergies information that is transmitted from the WHH FT Lorenzo EPR to its external stakeholders for approximately 4% of all patient discharges for the affected period. *** There is currently no evidence of patient harm but there is evidence of potential for harm to result *****					

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:

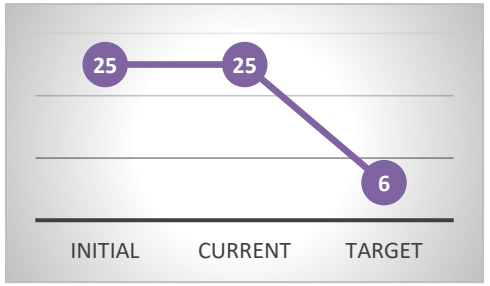
- Operational Planning Guidance submission – 23rd April 2021
- Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery
- Operational planning to be monitored by Gold Command on a daily basis, by Cheshire & Merseyside elective restoration meeting weekly 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

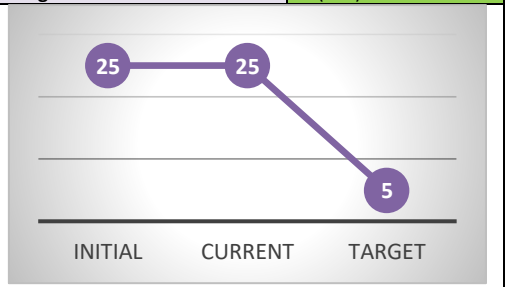
	• Waiting lists are reviewed through the performance review group weekly – outpatients and diagnostics. • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • NHS 111 First pilot went live on 8th September 2020 to reduce attendances to the emergency department and 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 • 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. 2. Expansion of the emergency department is required to ensure any increase in demand can be accomodated in line with RCEM guidance	

Board Assurance Framework

	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.

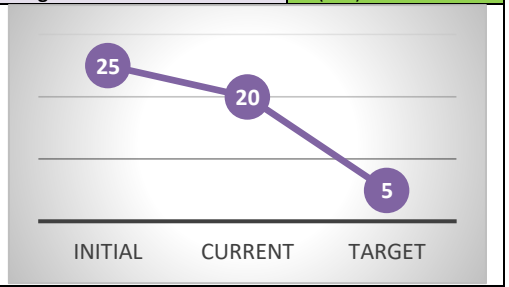
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
ED Plaza building works	Completion of ED Plaza building works	Complete Building work	Sharon Kilkenny	31/03/2020	Phase 1 completed
Install of Bioquell Cubicles	Install of Bioquell Cubicles	Complete Installation	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. Trust participates in Gold Command System call which supports regional decisions on discharge capacity e.g. access to Nightingale and other such supportive facilities The number of discharge delays in relation to Super Stranded patients is reported daily in the Executive Summary and reviewed so that Executive Directors can support and escalate pathway delays. '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.				
Assurance Gaps:	Delays in discharge caused by adherence to Covid-19 infection control pathways and the patient's C0vid-19 status. Intermediate Care and other community capacity impacted and restricted by Covid-19 e.g. Care Home and other facility closures due to outbreaks. Access to community capacity impacted by Covid-19 as a result of staff sickness Internal staff shortages to help support discharge planning. Restricted as a result of Covid-19 sickness and self-isolation 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				

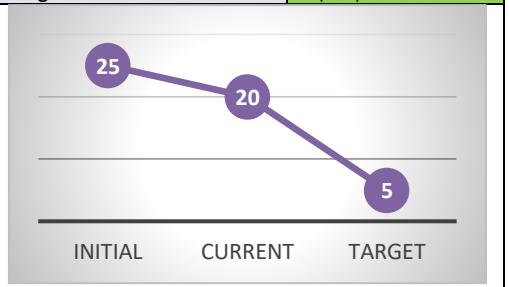
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

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 to be in place in ED by the end of April 2021				
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
To develop a Trust Wide Environmental Plan to identify appropriate mitigations to minimise the risk of transmission.	Development of a Trust Wide Environmental Plan.	Develop Plan	Layla Alani	30.10.2020	30.10.2020
All individual clinical areas to complete a risk assessment to include bed space.	Completion of a Ward base risk assessment.	Completion of a Ward base risk assessment.	Layla Alani	30.10.2020	06.11.2020

Board Assurance Framework

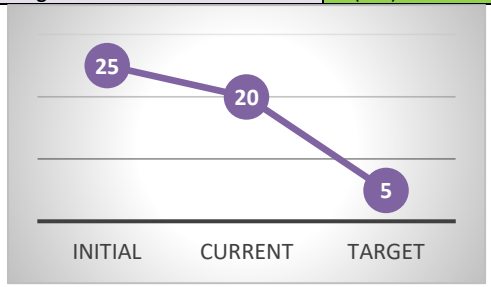
Risk ID:	1275	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to prevent Nosocomial Infection caused by asymptomatic 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 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 to be completed in clinical areas to be agreed and introduced Bioquell Pods now in place in ICU Bioquell Pods to be in place in ED by the end of April 2021 Trust undertaking learning from Nosocomial outbreaks sessions.				
Assurance Gaps:	Non-compliance with social distancing				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Review of 3 & 5 day swab process to provide assurance of timely completion & reporting of daily SitRep.	Review of 3 & 5 day swab process to provide assurance of timely completion & reporting of daily SitRep.	Complete review and present updated outcome to review at Silver Meeting	Ali Kennah	21/04/2021	21/04/2021
Ensure Electronic systems of reporting 3 & 5 day swabbing are aligned	Continue to work with the business information team	Continue to report outcomes at the silver meeting	Ali Kennah	30/04/21	

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's decision to pause some elective procedures in order to ensure safe staffing and critical care capacity during the COVID-19 pandemic, resulting in potential delays to treatment and possible subsequent risk of clinical harm			**Initial:**	25 (5x5)
			Current:	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



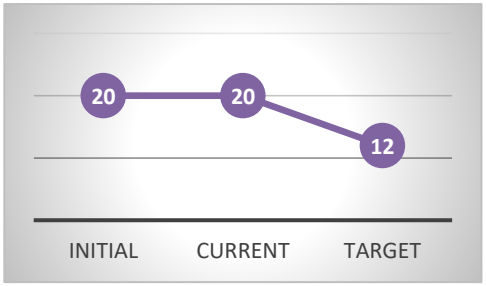
Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop plan for Ward 18 Footprint to support alternative critical care escalation.	Develop plan for Ward 18 Footprint	Kilkenny, Sharon	28/02/2021	28/02/2021
Complete the B18 development	Complete the B18 development	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 with 12 nurses accepted an offer of employment at WHH in July 2020. Students who were redeployed to the Trust during the COVID 19 pandemic have been offered substantive posts
- International Nurse Business Case has been approved for 30 Registered Nurses – we have set up a task and finish group to implement this. We have recruited 73 HCAs since February 2020 with rolling HCA recruitment programme in place
- National staffing guidance has been utilised to inform new staffing models
- Care Hours Per Patient Day (CHPPD) currently 7.6 (Year to date position 7.8)



<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 plan to achieve 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 March 21 we have 73.41wte band 5 vacancies.

HCA

There are currently 29 Health Care Assistant vacancies within the Trust. All vacancies to be recruited to by April 21.

Interviews weekly;

- 94 have been recruited
- 46 going through pre employment checks
- 15 commenced induction in March

All recorded on spreadsheet tracker – currently -3

Board Assurance Framework

	• Media campaign with Warrington Guardian - April • Weekly meeting and reporting to ensure we achieve target • Reserve list Working up a process with NHSP and HR to ensure all HCA's are automatically recruited by NHSP. RN Recruitment There are currently 73.41wte registered nurse vacancies within the Trust. 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. <u>Retention Assurances</u> • Workforce Dashboard reporting monthly in relation to leavers • WHH Nursing retention plan to be refreshed for 2020 • Burdett Nursing Trust award winners • Highly commended for nursing retention data provision • 'Transfer Window' implemented allowing staff to move to other specialties without having to apply for role • Registered Nurse Turnover 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. <u>COVID-19 Assurances</u> • Implemented a graduated and planned nurse staffing response to the COVID-19 Pandemic. • Revised staffing models for the expansion of critical care capacity, acute and supportive respiratory wards • 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 <u>Recruitment Gaps</u> • 73.41 RN Vacancies in March 21 <u>Retention Gaps</u> • 10.25% nursing turnover	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Targeted recruitment campaign	WHH to review international nurse recruitment to support registered nurse vacancy fill.	International nurse recruitment programme in place. Develop a business case. Agreement to join GTECH in partnership with WWL. Business case agreed for 30 nurses. Task and finish group established to support the recruitment campaign and welcome nurses to WHH	R Browning C Roberts	31.03.2021	

Board Assurance Framework

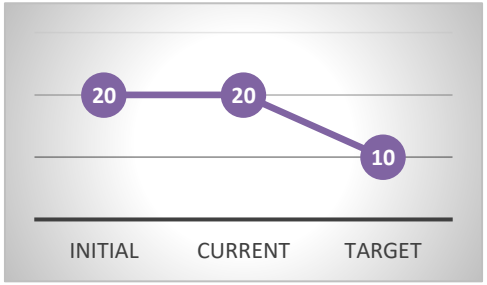
		Application for bid to access financial support for the programme.			
To reduce HCA vacancies within the Trust to less than 20	Introduce a more targeted monthly recruitment campaign for HCA's which will be led by CBU's	Deep dive into HCA recruitment and retention data to inform a targeted approach to recruitment. Rolling programme for monthly recruitment in place. Any staff who are suitable for employment are offered to other CBU's as part of the monthly recruitment campaign. We have expansion of the CSWD programme through NHSP which supports WHH HCA recruitment as many of these staff successful gain substantive employment. Advertisement campaign in regional and local media	J McCartney R Browning	April 2021	

Board Assurance Framework

Risk ID:	134	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that future loans will be required which would raise the question if the Trust is a going concern.			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	10 (5x2)

Assurance Details:

- •Core financial policies controls in place across the Trust
- •Revised governance structure within the Trust to enable strengthened accountability
- •Finance and Sustainability Committee (FSC) established overseeing financial planning
- •Regular financial monitoring with NHSI
- •Regular review at Executive team meeting and development sessions
- •Annual plan development process
- • Achieved 2020/21 Control Total.
- •Positive Value for Money conclusion & unqualified audit opinion (2019/20)
- •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 of 2020/21 cost pressures
- • 2021 cost pressures supported by Trust Board. Business cases being developed to secure required levels of funding.
- •Trust Board approval of Capital Plan including the requirement for PDC as part of the final programme
- • Receipt of £51.8m PDC funding to repay revenue and capital loans in full in September 2020.
- •Completed MIAA Governance Checklist received by Audit Committee
- •Cancer Alliance funding of £0.5m for endoscopy enabling work at Halton to improve the environment
- •Interim 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



COVID-19

- Governance process in place to ensure all additional costs are being approved and monitored – re-introduced for Wave 2 & Wave 3
- Reporting to NHSE/I
- Regular attendance to regional and national conference calls
- Attend Recovery Board to monitor financial impact of the changes relating to Covid19 Recovery plans – identifying revenue and capital expenditure
- 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
- Submitted COVID-19 capital bids to NHSE/I & Hospital Cell to support Business as Usual & Recovery plans
- Monthly Report to F&SC on COVID Pay Costs
- Deloitte due to commence audit of all capital and revenue COVID-19 Expenditure w/c 21 January 2021

Board Assurance Framework

	• Deloitte Audited completed. Positive report received with one overclaim reported (£112k). Draft report to received by the Finance & Sustainability Committee in April 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.	
Assurance Gaps:	• Inability to develop a strategic plan to deliver a break even position over the next 5 to 10 years • Non-recurrent CIP presents a risk to in-year and future year financial position. • 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	

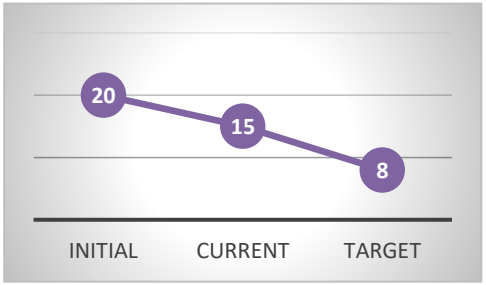
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Submit requested Workforce & CIP information to NW Intensive Support Director	Cheshire and Merseyside Health & Care Partnership in receipt of Tier 1 Intensive Support – Information requested by NHSE/I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

Board Assurance Framework

Risk ID:	1134	**Executive Lead:**	Cloney, Michelle	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain			**Initial:**	20 (4x5)
				Current:	15 (3x5)
				Target:	8 (4x2)

Assurance Details:

- A COVID-19 nursing advice line has been created, to provide a range of advice and guidance to the workforce.
- An OH call centre has been created, which enables all calls to be answered and triaged by a team of administrators.
- The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff)
- Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical.
- An enhanced wellbeing offer has been developed, linked to learning from Wuhan, Italy and the British Psychological Society.
- A specialist extranet page has been developed which includes all national wellbeing offers, and links to discounts for our NHS staff during this period of time.
- Mental health wellbeing drop in sessions have been introduced across both Warrington and Halton sites, with a specific wellbeing email address created for any enquiries to the wellbeing hub.
- Facilitated conversations are available to staff working on COVID-19 wards.
- Face to face counselling on-site.
- Telephone counselling.
- Alternative therapies such as relaxation therapy.
- Additional support put in place for Black, Asian and Minority Ethnic staff including a specific risk assessment
- Guidance on risk assessments for various groups of staff has been issued to managers with clear expectation on completion.
- Staff events have been stood down to support socially distancing in work.
- Additional groups of staff were brought into the organisation, including:
  - Medical Students
  - Nursing Students
  - AHP Students
  - Medical 'Returners'
  - Nursing 'Returners'
  - AHP 'Returners'
- Work ongoing to retain returners within the Trust via Nursing Workforce Lead, specially final year student nurses.
- Following national guidance, amendments have been made to the pre-employment check process to support speedier recruitment
- The Workforce Information Hub has supported the 'real time' reporting of absence, to enable a clear picture of current staffing.
- A Temporary Workforce Redeployment Hub has been established to support staffing levels by identifying staff who are available for redeployment and match them with demand. This hub has reduced its capacity as the Trust moved into Phase 3 of the Recovery plan in August 2020, but is ready to be re-established should this be required.
- Retirement Policy has been updated to allow a shorter break (24 hours) in service.
- National annual leave changes mean that staff can carry forward any untaken annual leave above 20 days into the next leave year. In addition, a local scheme has been introduced to allow substantive staff to sell annual leave back to the Trust during the period 26th March 2020 to 30th June 2020.



Board Assurance Framework

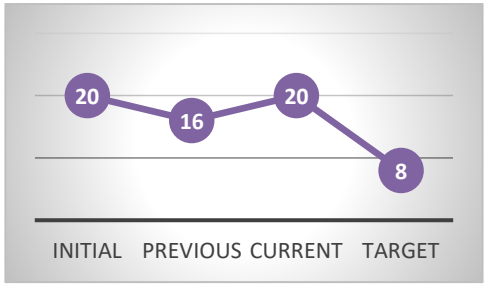
	• All additional hours and bank shifts worked by medical staff between 7th April 2020 and 31st May 2020, will be paid at the enhanced rates. This arrangement was extended until 9 June 2020 to review the scheme and consider whether this should continue – decision taken by Strategic Oversight Group to revert back to Pre-Covid Enhanced and Standard rates of pay. • A plan is in place to support workforce recovery including health, wellbeing, leadership, teams, HR and resourcing. • All staff who are shielding are have individual reviews with line managers, supported by HR, to discuss impact on role and support to work from home. • Partnership working is in place with Cheshire Fire and Rescue to utilise their staff members available for redeployment. • Process in place for escalation of any potential local 'hot spots' of COVID-19 in teams on a weekly basis to Infection, Prevention and Control and Microbiology Teams • Central log in HR Department to capture all sheilding staff – process in place for on-going updates. National shielding ceased on 1 August 2020. A Covid Secure SOP was written to support the safe return of shielding staff to work or to agree working from home arrangements as appropriate to a completed Risk Assessment signed off by Occupational Health professionals. Covid Secure areas under regular review by Microbiologist via Tactical Group commenced in September 2020. • Electronic system is in place to support the roll out of a new COVID-19 Workforce Risk Assessment Tool in line with Risk Reduction Framework • Regular reporting on compliance with risk assessment requirements is in place • Regular training on COVID-19 Workforce Risk Assessment is in place • International Recruitment Business Case approved by Trust Board in September 2020 for an additional 30 nurses. Campaign to start immediately. • NHSE/I Letter received by Trust related to concerns around sickness absence rate. Nationally the North West has higher sickness absence rates. • A number of local outbreaks – Patient to Patient and Staff to Staff - are being managed within the Trust and have been reported to NHSE/I. This has led to ward closures and service changes to continue to provide the services. Staff have been isolating and supported via Occupational Health. • Increased capacity for staff swabbing in September 2020 to meet increased demand due to increased local prevalence, local lockdown introduced for Warrington & Halton and local outbreaks within the Trust. • Introduced an Outbreak Management Group (Microbiology, Infection Prevention & Control, Operational Management Team, Health and Safety, Clinical Governance and senior nurses) to trace and trace and manage the outbreaks and demand for information externally. • Extensive communications via Trust Safety Huddle and global emails to promote use of PPE, social distancing and compliance with environmental risk assessments restricting numbers within confined staff areas. • National Trace and Trace app launched 24 September 2020. The national advice is less nuanced than local intelligence and so the risk of staff being instructed to self-isolate has increased. Issue raised with regional NHSE/I Chief People Officer as the local advice which is more specific to local circumstances would conflict with the national directives. Clear message to follow national directive received by Trust on 28.09.20 An organisation not complying with national directives would be breaking the law and subject to a corporate fine of £10,000 per incident. • Participation in Lateral Flow Testing • Engagement plan in place to continue to increase uptake for Lateral Flow Testing. • Moving over to LAMP testing, which we anticipate will increase uptake as it is less invasive for staff. Currently awaiting confirmation of external funding and then can agree a go live date. • Occupational Health opening times have been extended since 4 January 2021. • COVID vaccine programme in place. Good uptake from across the workforce, with monitoring arrangements in place. • COVID-19 Workforce Recovery Steering Group to be implemented. • Overall absence rate (Sickness and isolating/sheiling) is 7.54% (04/03/21) and is therefore reducing	

Board Assurance Framework

	• Business cases have now been approved to recruit a total of 96 International Nurses which 36 are already in the country • Supported by funding from NHSI there has been a big push to fill our HCA vacancies, we currently are predicting to be at 0 FTE by 31/03/2021. • Our HCA Vacancies have been supplemented by the recruitment of Nursing Students (25 FTE), in post until Apr-21, by this time it is forecasted the equivalent number of HCAs will have been recruited ensuring our HCA vacancies remain at 0 FTE • A number of Medical Students have also been recruited to support across the Trust • Recommencement of redeployment hub to provide oversight of shielders, ensure redeployment of workforce and equipment to those working from home due to home working/redeployment home working. • Extension of existing temporary changes to terms and conditions to support the covid response e.g. special leave, retirement, overtime until 31.03.2021. • In April 2021 overall sickness absence has reduced to 5.21% compared to a peak in April 2020 of 9.1%. • In April 2021 overall vacancy rate is 7.51% compared to a peak in Jun 2020 of 10.5%. • The majority of the employed Medical and Nursing Students left the organisation in April 2021 to continue/finalise their studies. This was supplemented with the mass recruitment of HCAs between Jan and Apr. We're currently reporting a single HCA vacancy. • 60 of our 96 international Nurses are now in the country with 28 of these working supernumerary on the Wards, as they gain experience, they'll be included in the numbers, reducing the requirement for temporary staff. • Therefore, as vacancies and sickness absence reduced it is expected our bank and agency reliance reduce and within April 2021 reliance on bank and agency staff reduced for the third 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 coming weeks. • 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	

Board Assurance Framework

Risk ID:	1114	**Executive Lead:**	James, Phill	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	FAILURE TO provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, CAUSED BY increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber attack, RESULTING IN poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statatory obligations (e.g. Civil Contigency measures) and subsequent reputational damage.			**Initial:** **Current:** **Target:**	20 (5x4) 20 (5x4) 8 (2x4)
Assurance Details:	**Assurance:** • **Digital Governance Structure** including weekly structured Senior Leadership Team meetings, Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Data Standards Group reporting to the Information Governance and Corporate Records Sub-Committee with escalations to the Quality Assurance Committee and onwards to the Digital Board, which itself submits highlights to the QAC and resource go to FSC. The **Quality Assurance Committee report provides** assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Cyber Essentials Plus/Audit Actions/IG training figures). • **Digital annual IT audit** plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with progress monitored at the Trust Audit Committee. • **Trust benchmarking** activities including Use of Resources reviews (Model Hospital). • 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. **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)) • Oct & Nov security patching back on desktop-based machines as workaround is in place for the emergency peg board incompatibilities.				
Assurance Gaps:	**Gaps In Assurance:** • No parent committee for reporting • Achievement of mandated compliance with DSPT, GDPR and Cyber Essentials Plus and the EU NIS directive. • Deployment of NHS Digital Secure Boundary for the Internet connection				

Board Assurance Framework

	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. • Implementation of an effective workforce plan via an approved structure investment business case that delivers fit for purpose levels of skills, resilience and capacity. • 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). • Office 2010 being used while end of life for up to 5 months due to the N365 deployment plan • Not all Windows Server 2003 server will be migrated to Windows Server 2016 before the N365 agreement starts. (1 out of 77 servers are at risk of not being migrated in time. The system at risk is Medicorr.) • 5 servers 2008 R2 unable to install security patches: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system & Winscribe dictation system. • No 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"

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Standardised policies and procedures across the C&M STP using the core documentation from standard of ISO 27001 and the DSPT	Standardise policies and procedures across the C&M STP	• MIAA to map the basic standards to form the minimum and gold standard of documentation for Cyber. MIAA and WHHT to create the documentation templates from the mapping: • ISO 27001 (ISMS) • Data Security & Protection Toolkit (DSPT) • Information Security Standard (ISF) • Center for Internet Security (CIS) • Information Systems Audit and Control Association (ISACA) • National Institute of Standards and Technology (NIST) • Cyber Security Body Of Knowledge (CyBOK) [MIAA to make a proposal to secure funding for a resource to draft up the policy templates and iMersey exploring the platform to be used to hold and share the policy templates.]	Deacon, Stephen	31/06/2021	
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or	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	Deacon, Stephen	30/06/2021	

Board Assurance Framework

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]		[Status January 21] Total Completed % Complete 2003 Servers 22 15 68.2% 2008 Servers 79 48 60.8% [Status February 21] Total Completed % Complete 2003 Servers 22 15 68.2% 2008 Servers 80 49 61.3% [Status March 21] Total Completed % Complete 2003 Servers 22 15 68.2% 2008 Servers 80 50 62.5% [All simple migrations have been completed by IT Services. A report was presented at the October's Digital Board, providing progress made in the decommissioning of Windows 2003/2008 servers, the timetable for decommissioning the remaining servers and the mitigations identified for those servers which are unlikely to be decommissioned before 31st December 2020. The only server at risk is the Medicorr Server]			
To upgrade all windows 7 to Windows 10 before end of March 2020 [Delivers: Best Practice]	To upgrade all windows 7 to Windows 10 before end of March 2020	• Deployment and Desktop Team to go out and reimage the devices around the Trust. [99% migrated – November 2020] 10 outstanding devices to be migrated: Department: Outstanding Pathology 2 (Issues with the software – a mitigation plan will be needed by IT Seniors) Catering 1 (Waiting on MenuMark system upgrade) Ophthalmology 4 (Waiting on 3rd party post Covid-19) Theatres 2 (Covid-19 hotspot, unable to access) ED 1 (Covid-19 hotspot, unable to access)	Deacon, Stephen	31/03/2021	

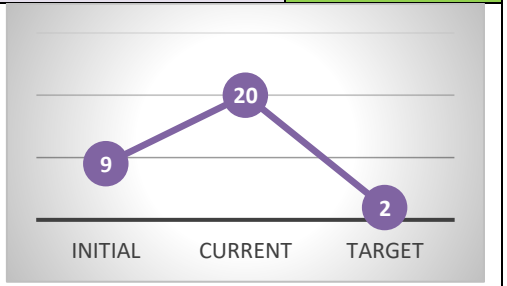
Board Assurance Framework

		The 5 devices in Audiology have now been migrated to windows 10. IT Services have completed the migration as far as they can until the issues above can be resolved. CIO/SIRO has been made aware and is happy with the current risk. IT to look at the rest during the IT Seniors meeting to give an evaluation on dates. IT are looking into Whitelisting these devices so that only the designed software can be run on these devices, mitigating the risk. The Virtual Desktops (VDI) Windows 7 and Blue Prism image migration to the Windows 10 image is set to be complete by the beginning of April 21			
As part of Cyber Essentials+ all unsupported software should be updated or isolated from internet based networks. Office 2010 will need upgrading to the latest version of Office for all endpoint devices on the WHHT network. [Delivers: Best Practice]	Migrate from Office 2010	• Secure funding and take advantage of the NHS Digital's N365 discount licensing offer (May 20 – COMPLETE) • Submit the Trust's licensing requirement (June 20 - COMPLETE) • NHS Digital approval (August 20 - COMPLETE) • Migrate to N365 using remote installing software SCCM (Sept 20) • Phase 1 – IT Technical Team Migration (OCT 20) • Phase 2 – Rest of Digital Services and key system leads (NOV 20) • Phase 3 – Rest of the Trust (FEB 21) • Phase 4 – Mop up (APR 21) [The timescales for the above corporate Covid pandemic restrictions. Digital Services will do its upmost to complete the migration ahead of schedule.]	Deacon, Stephen	06/04/2021	
Deliver fit for purpose Lorenzo EPR Performance and agility of changes to deliver the paperless strategy. [Delivers: Optimisation / Timeliness]	Work with supplier to assure EPR performance whilst enhancing Digital capability (people and finance).	• Work with EPR supplier to safely migrate Lorenzo to the modern cloud solution. • Implement staffing structure enhancements within financial opportunities (i.e. capitalisation of roles).	Gardner, Matthew	31/08/2021	

Board Assurance Framework

DXC to create a RED Health Team	DXC to create a RED Health Team	Red Team liaises with local Digital Services and investigates performance-related issues and both DXC and Local Trust act on any recommendations • DXC to provide technical support to investigate performance-related issues (COMPLETE) • DXC to produce a findings report (COMPLETE) • Digital Services to review the report (IN PROGRESS) • Feedback local review back to DXC • Act on any recommendations • Retest for improvements [Recommendations being acted upon.]	Deacon, Stephen	31/04/2021	
Implementation of the revised staff structure	Implementation of the revised staff structure	Draft costs have been obtained and the business case has been written with to exec approval and waiting on HR to give the go ahead to go to staff consultation. [Consultation complete. Process to now to get the staff in place.]	Deacon, Stephen	31/04/2021	
Mitigate 5 2008 servers not patching	Mitigate 5 2008 servers not patching	System Action Plan Symphony document server Decommissioned server (COMPLETE) Data warehouse app server MS was able to repair the Windows updates system manually, so it is up to date. Data Warehouse Team to progress migrating the apps off. (COMPLETE) Trust Print Server The OS is repaired and updating now. (COMPLETE) Dawn Anticoagulant system The OS cannot be repaired. The migration they are about half way through now tackling the Zebra printers Winscribe dictation system	Deacon, Stephen	31/04/2021	
DXC to move the cloud with the latest version of SQL (backend database) and using a single instance for Trust data	DXC to move Lorenzo to the cloud	• Migrate the data onto the cloud using the latest version of SQL [Migration will occur before moving to new contract.]	Caisley, Sue	31/08/2021	

Board Assurance Framework

Risk ID:	1079	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.			**Initial:**	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:	1207	**Executive Lead:**	Michelle Cloney, Chief People Officer	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)

Assurance Details:

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

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

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

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

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

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

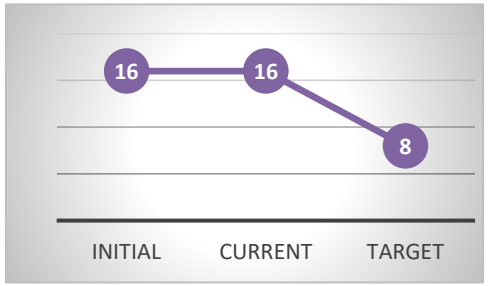
Training for line managers is in place and on-going Audit process is in place and live Staff communications have included:

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

Regular reporting to Recovery Board (twice weekly) and Executive Team (daily) is in place

Position @ 18th March 2021

- 94.6% staff risk assessed
- % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary – 98.2%
    - Of the 38 staff know to be at risk who are yet to have a management risk assessment 46% have had the COVID Vaccine.

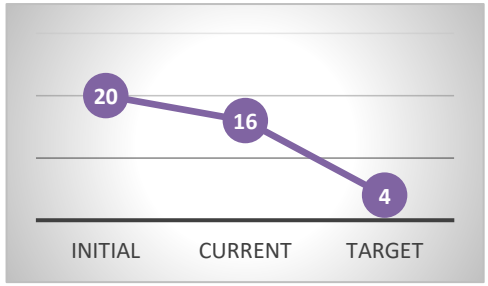


Board Assurance Framework

	▪ HR continue to support managers to complete the risk assessments. • % of risk assessment have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary – 97.4% • 91.2% of our staff have received the COVID Vaccine • Outstanding assessments have been escalated to Tactical Meeting and Chair has requested detailed information for individuals in the CBUs with the highest number outstanding. • A dedicated workforce risk assessments inbox has been setup as a single point of contact/support for managers • Routine contacting of managers with outstanding assessments from HR Team • Escalation process in place to escalate to senior HR Team member if no response after 2 contacts	
Assurance Gaps:	The required quick turnaround requires enagement at all levels of the organisation. The Trust requires all staff to recognise the importance of the Workplace Risk Assessment and therefore make accessing the training and support available a priotiy. To ensure the Workforce Risk Assessments are completed in a timely manner and to a high standard. Due to the nature of COVID-19 our knowledge of it is changing constantly; therefore it is a challenge to keep up-to-date with the guidance and then react appropriately through changes in our processes Circa 406 staff members yet to complete self-assessment	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
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	31/10/2021	

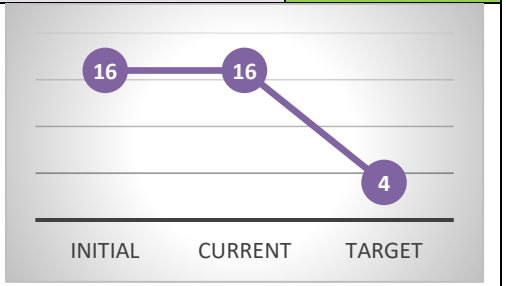
Board Assurance Framework

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 to be completed by 26th January 2021. This will increase the Paediatric ED Urgent Care footprint allowing for a better segregated flow of paediatric patients to support Covid-19. 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

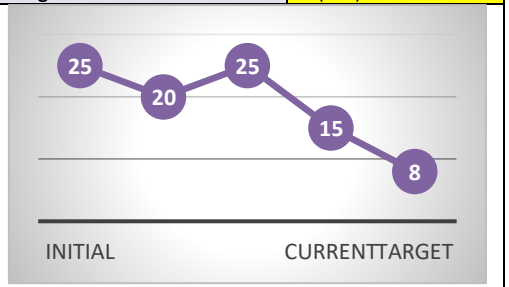
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Complete Premises Assurance Model by April 2021	Set up working group with Estates and Finance team to complete the documentation and file the evidence required to complete the PAM)	By completing, analysing 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, 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. Midwifery management team strengthened – Four Matron in post until 31st March 2021 All additional 9.2 WTE Midwives in post. Midwives redeployed across the unit as appropriate 1:1 care rate currently @ 92% Interim Birth suite Manager appointed and in post 15th Feb 2021 (NHSP) Additional 3 Band 7 Birth suite Co-ordinators appointed 1st Feb 2021 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 – posts out to recruitment 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			

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	30/06/2021	
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 April 2021. Advert for Band 6 posts awaiting closing date prior to interviews being arranged.	Gould, Debby	30/06/2021	

Board Assurance Framework

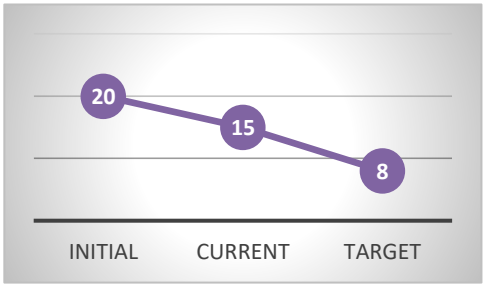
Risk ID:	1124	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff			**Initial:**	25 (5x5)
				Current:	15 (3x5)
				Target:	8 (4x2)
Assurance Details:	**PPE - General** ▪ A number of DHSC managed centralised PPE stores in place across the country with PPE issued in accordance with Trust demand profiles, Procument oversse and manages this in and out of hours process in place, daily monitoring process and escalation to the NSDR, extended opening hours in procurement and 7 day service, issuing PPE material management services i.e topping up areas, etc ▪ Centralised Cheshire & Merseyside (extending across the North West as necessary) mutual aid plan in place led by the Trust's Chief Finance Officer & Deputy CEO ▪ Regional mutual aid arrangements in place ▪ Where services are re-started, recovery forms and PPE burn rate to be documented on appropriate proformas with monitoring via the Elective Planning Meeting, with escalation to the Recovery and Strategic Groups. ▪ No staff member to work without appropriate PPE. ▪ National managed PPE inventory process is in place; The Managed Inventory (now known as Auto Replenishment) is based on the Trusts actual demand averaged out over the previous 7 days. Stock is pushed out based on 14 days stock holding. Gowns and FFP3 are remain tightly controlled. Inventory will include details of FFP3 masks required ▪ National PPE Strategy in place to support the management and monitoring of stock levels. ▪ PPE stock levels reported daily with early escalation via the Tactical Board ▪ Entrance Safety Team in place across the three formal open entrances at Warrington site in accordance with the lockdown plan to help supply PPE to patients, public and staff. ▪ The Health and Safety Team visit ward and departmental areas, which in addition to reviewing the environment, checks the stock and availability of PPE and addresses shortfalls at the time. ▪ We have 58 PPE champions to support the clinical teams and ensure correct PPE is available ▪ The Trust has a back-up storage provision in the form of the Arena Conference and Convention Centre (ACC) in Liverpool ▪ Nationally work is being undertaken for 80% off PPE to be manufactured in the UK ▪ The Trust has a clearly defined escalation processes in place ▪ The Trust has a clearly defined internal stock control systems in place **PPE – Quality** ▪ Participation in Quality Improvement Programme with NHE/I on Fit Testing with focus on high risk areas ▪ National team are taking additional steps with quality control. Associated Director of Procurement will escalate any issues to the national team **PPE – FFP3s** ▪ Fit Testing support is in place via the DHSC and has been utilised by the Trust bringing increases fit test pass rates. General consensus that Trusts need a ring fenced number of staff to provide a Fit Testing service. On-site NHSE/I support for Fit Testing until March 2021. Live database to demonstrate compliance with the number of staff Fit Tested ▪ Training and education of staff, Fit Testing programme in place for FFP3/FFP2 respirators, risk assessment and contingency plan in place if recommended PPE stock is not available ▪ Supply issues continue with 3m with regard to FFP3 with Trusts encouraged to move to more sustainable FFP3 models. In line with this the Trust has recently changed its preferences from 100% 3m to include a further two FFP3 masks where there has been a fit test % achieved.				
Assurance Gaps:	Current shortage of specific PPE equipment e.g. small Solway FFP3 respirators and expected shortage of 8833 respirators, Repeated Fit Testing will be required as different makes/models of FFP3 respirators are supplied – with potential to disrupt service provision.				

Board Assurance Framework

	Increased demand for PPE as recovery plans will increase demand, service provision may be affected if PPE is not available. Balance of usage required to ensure recovery plans do not impact on PPE for care of patients with Covid-19. Supply of gowns with adequate fluid repellency level Availability of fluid resistant surgical masks and visors Current shortage in gowns which may lead to inadequate protection Fragile and uncertainty of future PPE availability 8833 respirators and small Alpha Solway are no longer available Revised IPC Guidance with 3 distinct pathways – Red, Amber and Green. Trustwide risk assessments in place. Visiting to be re-introduced which will impact PPE usage

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Support stable provision of FFP3 masks	Continue to trial aleternative FFP3 Masks	Continue to trial aleternative FFP3 Masks	Kennah, Ali	31/03/2021	

Board Assurance Framework

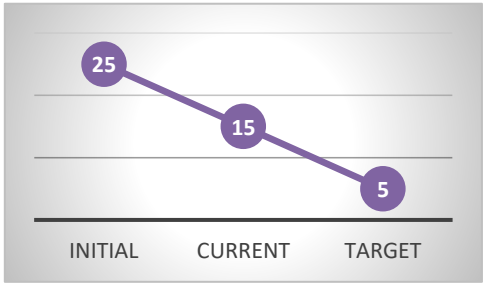
Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.			**Initial:**	20 (5x4)
				Current:	15 (5x3)
				Target:	8 (4x2)
Assurance Details:	The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the C&M Health and Care Partnership plans. The Trust has developed effective clinical networking and integrated partnership arrangements. Some examples include: - The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. - 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	

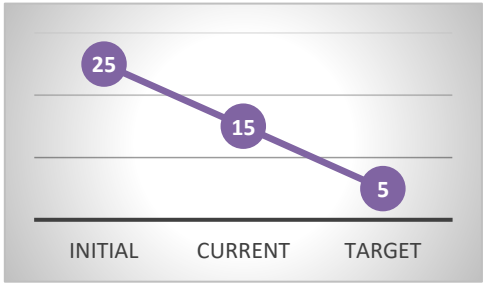
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Progress plans for new hospitals to be best placed to secure funding when available	Develop SOCs and OBCs	Develop SOCs and OBCs	Lucy Gardner	SOCs – April 2020 OBCs – Q4 2021/22 Warrington Q3 2021/22 Halton	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:	1331	**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 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.			**Initial:**	25 (5 x 5)
				Current:	15 (3 x 5)
				Target:	5 (1 x 5)
Assurance Details:	• Creation of additional appropriate clinical areas with appropriate clinical staff; • Non-urgent elective procedures stepped down to help support sufficient staffing levels and provide additional clinical areas. • Daily submission of Critcon score to SEOG, Gold Command and the wiser network to optimise the deployment of mutual aid as required. • National 'Call to Arms' to encourage experienced ICU Nurses & Doctors to return to work; - 2 staff joined ICU from external providers • Internal 'Call to Arms' for staff who have previous experience of the ICU setting and communications with Managers to support release - 15 staff identified – worked in Wave 1 and 2 on a part and full time basis depending on availability and release from current role. 86 staff identified in the re deployment process under Category A (category A are staff in the trust with Critical care experience or transferable skill suitable for critical care) • AHP, Proning & Transfer Teams created to support ICU staff • Transfer out of ICU via the Critical Care Network to support decompression; • Mutual aid in place to ensure adequate provision of essential equipment e.g. Non-Invasive Ventilation (NIV) • Incentive scheme in place to help support sufficient staffing levels; • Off framework agency usage to help support sufficient staffing levels; • Nurse buddy system in place;				
Assurance Gaps:	• Limited estate • Limited O2 flow capacity • Limited staffing				

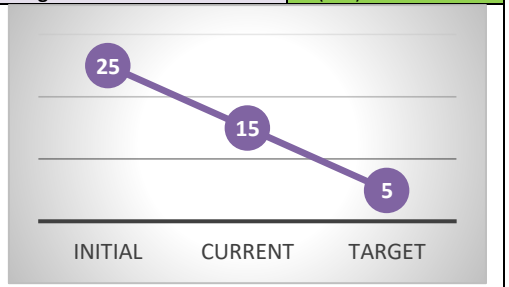
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Risk ID:	1332	**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 a suitable patient environment caused by the rapid creation and opening of additional capacity/wards resulting in potential harm			**Initial:**	25 (5 x 5)
				Current:	15 (3 x 5)
				Target:	5 (1 x 5)
Assurance Details:	• Failure Modes & Effect Analysis (FMEA) process completed prior to opening; • IPC review and signoff completed; • Estates review and signoff; • Equipment checks in place including Resus equipment, beds, mattresses and medicines trolley prior to opening; • Review by Pharmacy to ensure appropriate medications are supplied, correctly stored and available for use; • Ensure appropriate IT equipment e.g. computers on wheels got EPMA available and systems are updated; • Change forms reviewed and updated at Tactical meetings; • Creation of rotas/E-Roster to ensure safe staffing levels; • AHP/Therapy review to ensure appropriate available for patient needs; • Facilities review to ensure appropriate food and drink available; • Wider communications to advise all clinical teams of opening of additional clinical areas e.g. Medical Emergency Team.				
Assurance Gaps:	• Limited estate capacity • Limited O2 flow capacity				

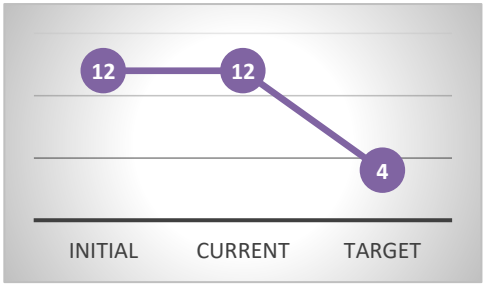
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

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 to be introduced February 2021 project group in place LAMP training sessions commenced. LAMP testing commenced in ED/ICU LAMP testing to commence in Wards A7/A8 by the end of March 2021 Review of Clinically Extremely Vulnerable (CEV) taking place in line with National Guidance				
Assurance Gaps:	Potential for unsafe staffing levels.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Introduce LAMP testing	LAMP testing to be introduced	Complete LAMP training	Louise Rylett		

Board Assurance Framework

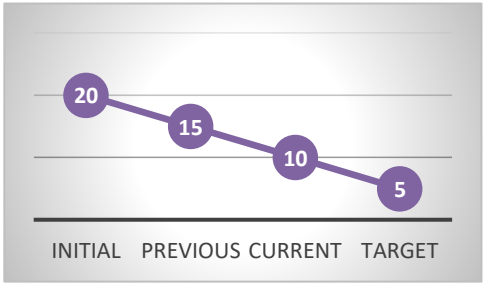
Risk ID:	1290	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Failure to provide continuity of services caused by the end of the EU Exit 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. Monitoring of prices continues, and fluctuations will be measured on a monthly basis. The Procurement department are aware of some price increases looming and are looking at mitigation as prices increase. This work will continue through Q1 as per the guidance from NHSE/I. • 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. 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. There is a webinar in place on 7th May to review this workstream. • 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 were sent out in February 2021, Trustwide communications continue as a reminder about the settlement scheme. • Re-instigated the Brexit Sub-Group on 9th September 2020 and the group continues to meet at least monthly. • In December 2020 NHSE/I completed an assurance exercise with NHS Trusts to ensure EU Exit SRO and EU Exit Team in place. • NHSE/I to communicate further details of national changes and updates to guidance. • 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. • Daily SitRep reporting continues to monitor the impacts of the EU Exit. • 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.				

Board Assurance Framework

Assurance Gaps:	Continued national uncertainty on the terms of the EU exit. Trusts being requested not to stockpile supplies. Potential price increases to supplies. Winter pressures, COVID-19 pressures and increase demand on Workforce and UEC.

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

Board Assurance Framework

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

Board Assurance Framework

Assurance Gaps:	**Gaps In Assurance:** • No further gaps in assurance **Gaps In Controls:** • Issue, test and deployment of a proven resolution; • Robust WHHFT PAN receipt, review and act process for all PANs.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Recover As this is a third similar event in the past 12 months the Trust should now de-risk the lack of assurance demonstrated by DXC and implement more robust and comprehensive site testing.	Ensure a range of test patients records are exercised in all Lorenzo acceptance tests to incorporate a range of patient complexities and history permutations.	Document and implement strengthened Trust discharge summary acceptance test process for all Lorenzo EPR releases (Emma O'Brien) [Governance requested distribution list for Digital Services in relation to Lorenzo PANs, Digital Services have provided the distribution list.]	O'Brien, Emma	30/04/2021	
Recover Ensure PAN notices are processed robustly and without delay and dovetail into clinical risk processes.	Document and implement more robust PAN receipt, confirmation, triage and management process.	• Review existing PAN management process (10/07/20 - Sue Caisley) • Consider automation of Datix for all PANs (10/07/20 - David Kelly) • Ensure Email is not a weakness (10/07/20 - Sue Caisley) • Ensue DXC seek formal response of receipt and action (10/07/20 - Sue Caisley) • Review PAN format for aiding Trust triage and prioritisation in response to potential threat to patient care, i.e. understand why the DXC assessment of this risk was "Medium" (17/07/20 - Sue Caisley) [Governance requested distribution list for Digital Services in relation to Lorenzo PANs, Digital Services have provided the distribution list.]	Caisley, Sue	30/04/2021	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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**