Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WHH Trust Board Meeting Part 1
(held in Public)

Wednesday 30 March 2022
10.00am-12.30pm
Via MS Teams

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 30 March 2022, 10.00am – 12.30pm
Via MS Teams

AGENDA ITEM	TIME	AGENDA ITEM	OBJECTIVE/DESIRED OUTCOME	PROCESS	PRESENTER
BM/22/03/22	**10:00**	Patient Story – Inclusive Communication to Improve Outcomes	***To Note***	**Presentation**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/03/23	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***		Steve McGuirk Chairman
BM/22/03/24 **PAGE 5**	**10:17**	Minutes and Action Log of the previous meeting held on 16 January 2022	***For decision***	***Minutes***	Steve McGuirk, Chairman
BM/22/03/25	**10:20**	Matters Arising • Charitable Funds Committte – Virtual approval of Charitable Funds Annual Report & Accounts	***For assurance***	***Verbal***	Steve McGuirk, Chairman
BM/22/03/26 **PAGE 17**	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Simon Constable, Chief Executive
BM/22/03/27	**10:30**	Chairman's Report	***For info/update***	***Verbal***	Steve McGuirk, Chairman

Quality People Sustainability

BM/22/03/28 **PAGE 31**	**10:35**	Covid-19 Situation Report	***To Note for Assurance***	***Report***	Simon Constable, Chief Executive
BM/22/03/29 **PAGE 52**	**10:40**	Integrated Performance Dashboard M3 and Assurance Committee Reports	***For assurance***	***Report***	All Executive Directors
(a) PAGE 114		**Quality Dashboard** • Monthly Nurse Staffing Report	***For assurance***	***Report***	Dan Moore, Chief Operating Officer, Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
(b) PAGE 164		Assurance Report – Quality and Assurance Committee (1.2.22 & 1.3.22)	***To note for assurance***	***Report***	Margareth Bamforth, Committee Chair
		People Dashboard	***For assurance***		Michell Cloney, Chief People Officer
(e) PAGE 172		Assurance Report – Strategic People Committee (22.02.22 & 23.02.22) **please see supplementary pack for supporting documents*	***To note for assurance***	***Report***	Julia Jarman, Committee Chair
		Sustainability Dashboard	***For assurance***		Andrea McGee, Chief Finance Officer & Deputy CEO
(g) PAGE 179		Assurance Report – Finance and Sustainability Committee (16.2.22 & 21.03.22)	***To note for assurance***	***Report***	Terry Atherton, Committee Chair
(h) PAGE 190		Assurance Report – Audit Committee (17.02.22)	***To note for assurance***	***Report***	Mike O'Connor, Committee Chair
(i) PAGE 193		Assurance Report – Clinical Oversight Recovery Committee (15.02.22 & 23.02.22)	***To note for assurance***	***Report***	Terry Atherton, Committee Chair

Quality

BM/22/03/30 PAGE 197	**11:25**	Moving to Oustanding (M2O) Update Report	***To note for assurance***	***Report***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO

Sustainability

BM/22/03/31 PAGE 211	**11:35**	Annual KPI Review & Performance Assurance Framework (PAF)	***To note for assurance***	***Report***	Andrea McGee Chief Finance Officer & Deputy CEO
BM/22/03/32 PAGE 223	**11:45**	Green Plan	***For approval***	***Report***	Lucy Gardner Diretor of Strategy & Partnerships

People

BM/22/03/33 PAGE 295	**11:55**	Engagement Dashboard Q3 Report	***To note for Assurance***	***Report***	Pat McLaren Director of Communications & Engagment
GOVERNANCE					
BM/22/03/34	**12:05**	Delegation of Authority to Approve Annual Accounts/Annual Report 2021/22	***For approval***	***Verbal***	John Culshaw Trust Secretary
BM/22/03/35 PAGE 303	**12:10**	Strategic Risk Register & BAF	***To note for assurance***	***Report***	John Culshaw Trust Secretary
BM/22/03/36 PAGE 359		Trust Board Annual Cycle of Business 2022-23	***For approval***	***Report***	John Culshaw Trust Secretary

SUPPLEMENTARY PAPERS

MATTERS FOR APPROVAL						
BM/22/03/37		Board Committee Cycles of Business for ratification: Audit Committee Finance & Sustainability Committee	***For approval***	Committee: Audit Committee/Finance & Sustainability Committee Date of Meeting: 17 February 22/21 March 22 Agenda Ref: AC/22/02/16 & FSC/22/03/55 Outcome:	***Paper***	John Culshaw Trust Secretary
BM/22/03/38		Charitable Funds Committee Governing Document & Cycle of Business	***For approval***	Committee: Chritable Funds Committee Date of Meeting: 10 March 2022 Agenda Ref: CFC/22/03/10 b & c Outcome:Approved	***Paper***	John Culshaw Trust Secretary

TO NOTE FOR ASSURANCE						
BM/22/03/39		Freedom To Speak Up Bi-Annual Report	***To note for assurance***	Committee: Strategic People Committee Date of Meeting:23 March 22 Agenda Ref: SPC/22/03/25 Outcome: Noted	***Paper***	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO
BM/22/03/40		Infection Prevention and Control (DIPC) Q3	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting:1 March 22 Agenda Ref: QAC/22/03/65	***Paper***	Kimberley Salmon-Jamieson,

				Outcome: Noted		Chief Nurse & Deputy CEO
BM/22/03/41		Learning from Experience Report Q3	***To note for assurance***	Committee: Quality Assurance Comittee Date of Meeting: 1 March 22 Agenda Ref: QAC/22/03/68 Outcome: Noted	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/03/42		Ockenden Progress – Maternity Self Assessment Tool	***To note for assurance***	Committee: Quality Assurance Comittee Date of Meeting: 1 March 22 Agenda Ref: QAC/22/03/64 Outcome: Noted	***Paper***	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO
BM/22/03/43		ATAIN Mortality Review	***To note for assurance***	Committee: Quality Assurance Comittee Date of Meeting: 1 March 22 Agenda Ref: QAC/22/03/64 Outcome: Noted	***Paper***	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO
BM/22/03/44		Hospital Volunteer Annual Report	***To note for assurance***	Committee: Strategic People Committee Date of Meeting: 23 March 22 Agenda Ref: XXXX Outcome:	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/03/45		Learning from Deaths Review Q3 Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 1 March 2022 Agenda Ref: QAC/22/03/69 Outcome: Noted for Assurance	***Paper***	Paul Fitzsimmons Executive Medical Director
BM/22/03/46		Digital Board Report	***To note for assurance***	Committee: N/A (circulated to FSC for information)	***Paper***	Tom Poulter Chief Information Officer/SIRO
BM/22/03/47		Any other business		Steve McGuirk, Chair		
Date of next meeting – Wednesday 25 May 2022						

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 26 January 2022, Via MS Teams	
Present	
Terry Atherton (TA)	Non-Executive Director & Deputy Chair
Margaret Bamforth (MB)	Non-Executive Director
Michelle Cloney (MC)	Chief People Officer
Simon Constable (SC)	Chief Executive
Paul Fitzsimmons (PF)	Executive Medical Director
Julie Jarman (JJ)	Non-Executive Director
Andrea McGee (AMcG)	Chief Finance Officer & Deputy Chief Executive
Steve McGuirk (SMcG)	Chairman
Dan Moore (DM)	Chief Operating Officer
Michael O'Connor (MOC)	Non-Executive Director
Cliff Richards (CR)	Non-Executive Director
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse & Deputy Chief Executive
In Attendance	
Adrian Carradice-Davids	Associate Non-Executive Director
John Culshaw (JC)	Trust Secretary
Jayne Downey (JD)	Associate Non-Executive Director
Lucy Gardner (LG)	Director of Strategy & Partnerships
Dave Thompson (DT)	Associate Non-Executive Director
Liz Walker (LW)	Secretary to the Trust Board (minute taking)
Observing Governors	
Julie Astbury	Public Governor
Dan Birtwistle	Staff Governor
Paul Bradshaw	Public Governor
Nathan Fitzpatrick	Public Governor
Akash Ganguly	Public Governor
Janice Howe	Public Governor
Susan Hoolachan	Public Governor
Kerry Maloney	Public Governor
Norman Holding	Lead (Public) Governor
Anne Robinson	Public Governor
Louise Spence	Staff Governor
Public Observers	
Nikki Cooper	
Apologies	
Pat McLaren (PMcL)	Director of Community Engagement & Fundraising

Agenda Ref	Agenda Item
BM/22/01/01	**WELCOME, APOLOGIES & DECLARATIONS OF INTEREST** The Chair opened the meeting and welcomed those in attendance. No declarations made in relation to the agenda and apologies from Pat McLaren were noted. A member of the public was in attendance Nikki Cooper.
BM/22/01/02	**MINUTES FROM THE PREVIOUS MEETING HELD ON 24 NOVEMBER 2022** The minutes were agreed as an accurate record and approved. TA had circulated minor amendments prior to the meeting which had been actioned. **1. The Board approved the minutes of the meeting held on 24 November 2022.**
BM/22/01/03	**ACTIONS AND MATTERS ARISING** The Action from the meeting on 26 May 2021 regarding a dedicated Board session regarding the 'Green' agenda was noted, and it was agreed a session needed to be organised as soon as possible ideally for the Board meeting in March, notwithstanding the ongoing operational pressures. There had been good progress across all Trusts. The Action Log was reviewed and agreed Action PBM/21/09/35 should remain. Action BM/21/09/125a had been amended and completed, and the action closed. **1. The Board noted the review and amendments made to the action log.** **2. Action - Board session to be arranged at the earliest opportunity. to discuss the 'Green' agenda as per the action.**
BM/22/01/04	**CHIEF EXECUTIVE'S BRIFEING** SC highlighted several key issues from his report, these included the current Covid position, Vaccination as a Condition of Deployment (VCOD), a new approach to retain focus, relating to the quality standards which included a dashboard and would be included as part of the briefing going forward. SMcG noted the dashboard was useful but asked if it could be spread over two pages for it to be easier to read. It summarised key information very well, taking into consideration the number of pages presented for the more expansive Integrated Performance Dashboard. **1. The Board noted the update** **2. SC to amend dashboard for future Board briefings**
BM/22/01/05	**CHAIRMAN'S UPDATE** SMcG added to the point raised around VCOD, it would be an ongoing issue, and as

	part of the Good Morning WHH blog this had been highlighted. It was important to set out the position of the Board to ensure a clear message was communicated on where the Trust stood. As it was law, Trust would need to adhere to this, and along with this a communication would be sent to the Trust Governors to request their current vaccination status and asked everyone to be supportive of this stance. **1. The Board noted the update** **2. Arrange meetings for networks and governors**
BM/22/01/06	**COVID -19 PERFORMANCE SUMMARY AND SITUATION REPORT** SC highlighted the pertinent information contained in Section 2.3 and 2.4, relating to the context of the number of patients in hospital compared between the current wave vs. the first wave. It was noted the peak achieved for wave 4 matched the peak of wave 1, however the number of people in critical care was a fraction in comparison. The impact on vaccinations highlighted how this had made a difference. SMcG asked if it was certain the vaccinations were the reason for the reduction in numbers, and SC responded, although not a certainty, there was a strong inference this had made an impact on the numbers being reduced. SMcG noted recent social media information relating to c. 17k people having the cause of death being stated as purely related to Covid on death certificates. There had been some interesting analysis around this, and there was a difference between those with other co-morbidities, this did not give a clear picture as to how many deaths were directly related to Covid alone. It was advised the number of people in hospital with Covid currently stood at 111, with 47 admitted within a 14-day period. There was further discussion around the difference in the operating environment, along with increased numbers attending A&E, whilst trying to maintain a recovery programme at the same time. SMcG added it was vitally important to continue with the elective recovery programme, as the figures were currently very high for those patients waiting over a year, which would now equate to two years. Regionally there were c.55k patients who had waited over a year, c5k waiting over two years, and this was in the Northwest alone. DM advised there were currently 1,170 patients waiting over 52 weeks, and it was felt this was average for the Northwest, with several variations up and down the country. 1. **The Board noted the report**
BM/22/01/07	**INTEGRATED PERFORMANCE DASHBOARD & COMMITTEE ASSURANCE REPORT** ***Quality Dashboard*** PF opened the item for questions, noting there had been little change in performance outcomes since the last report. What was highlighted was the quality performance regarding Sepsis, as an area for concern.

KSJ commented on the Sepsis screening for emergency patients and noted the plans and current challenges regarding this quality indicator. In December, the trust achieved a target of 71%, a deterioration from the November figure of 79%, however the actual target to be achieved was 90%. For administered antibiotics, this also failed to achieve target, at 65%, again a deterioration from the 79% in November.

The actions had been completed, but had still not moved forward, with further analysis of next steps required. There were three main areas, these included staffing and absence, causing a delay on screening, and handing out antibiotics, there would be analysis undertaken on this over the next few weeks.

Workforce

KSJ noted the sickness absence for the trust was 7.38% in December, a deterioration from November, against a target of less than 4.20%. In January most of the shifts had been backfilled, with staff being moved from other areas. This was parallel to the issues of the increased number of patients in attendance, and would be reviewed week to week, as numbers had increased, and it was not possible to manage this position without additional support.

Work had previously been paused, due to significant absences, however this work was now being picked back up and over the next few weeks would map out how to best take this forward. However, there would be a need to bear in mind absence at 30%. As an interim, the Trust Safety Nurses had moved to carrying bleeps to support Emergency Department and Sepsis management.

With regards to the ratification of the data, the Sepsis data was accurate, however there was no confidence the diagnosis of Sepsis was accurate, due to delays in the information being reviewed, which might not take the patient off the clock and work was underway to review this.

PF added it was not where we needed to be, and in the context of ambulance turnaround times, it was clearly an important system indicator, with risk and underperformance to treat people in a timely manner, which highlighted a clear gap with time windows, but still an important factor.

A discussion took place regarding review of where things were when a target of 79% had been achieved, as this could bring about positive learning. It was noted work with the Deanery, in relation to training around Sepsis and setting a standard could be helpful, ensuring focus at an early stage.

DT asked about Friends and Family Testing score of 25% and asked if the Trust understood the reason behind this. KSJ noted the score was higher than in Cheshire and Merseyside, just below national average. There was negative feedback around waits in ED, and there had been TV screens put into the waiting areas now, along with a call out system which had helped to improve this. SMcG added this was a point well made, and constantly need to do better, however it did depend on how long you waited, the answer was simple, there were too many patients arriving at ED.

ACD asked about the Workforce KPI, assuming this was correlated with staffing areas of concern, and if there were underlying issues. MC responded, pay assurance was discussed at Finance and Sustainability Committee regarding trends around reliance on temporary workforce, and these gaps were linked to sickness absence rates. Incentive schemes had been looked at, however reliance on temporary workers was critical for safe deployment of workforce in those areas that had been red over the last few months. AMcG also added as part of the agency indicator, this was being looked at as part of the annual refresh, with an historic ceiling set by NHSE/I pre pandemic which was how it was currently being measured; however, the indicator was not necessarily correct, and needed to be reviewed.

JJ asked about pressure ulcers and assurance regarding this as marked green, but according to the stats should be red. KSJ explained these are within the national Cheshire and Merseyside target, and there were different levels and categories in terms of severity and harm, there had been no Cat 4 harms recorded, but had seen an increase in Cat 3 cases. The pandemic had added to this increase as it had been difficult to manage and had been represented in a lot of Trusts with ITU's. The Cat 2 incidents were still within the national benchmark, relating to healing of pressure ulcers, and there was a lot of work undertaken with the teams to ensure this was kept to a minimum, with training of all staff taking place. The condition of some patients meant they were more prone to pressure ulcers; however, Cat 3 were the ones currently being reviewed.

CR asked about Cancer targets, and whether the figure from November of 36%, was likely improve in January, and when the data for January would be available. DM responded the cancer data was two months behind, however this was discussed at the Clinical Oversight Recovery Group on a weekly basis, and the forecast was this would be compliant towards the end of January, beginning of February.

SMcG noted although the data was not up to date, areas of high priority did need to be questioned, and it was good to be able to provide a provisional update in some of the areas of recovery where possible.

MB added, although the data was historical, given operational pressures and the current staffing situation described earlier, the quality indicators had held up very well, and were managing to maintain and achieve standards in several areas, except Sepsis.

TA noted assurance provided regarding 2-week wait for breast cancer services, although some of the meetings of the Clinical Recovery Oversight Committee had been stood down, the data was still being received and continued to provide the assurance where necessary.

SMcG added that the email from TA could be shared with the board and will be included as part of the minutes. (see

Safe Staffing and Assurance Report

The report was received and noted. JJ asked about the figure in relation to vacancies as these did not correlate from November where it stated 9 vacancies as in the paper received it stated 99 vacancies. KSJ advised this information was inaccurate and the correct figure was 99 vacancies.

JH asked if tracking was undertaken for harm to staff, and KSJ advised that this was the case.

DT asked whether the HCA vacancies and the current fill rate, which was alarming, was typical across the Trust. KSJ advised this was correct and there had been significant challenges filling HCA vacancies and locum shifts, however it was the same across Cheshire and Merseyside. Currently there was a video which had been released which explained the role of the HCA in more detail, which was hoped would help support recruitment into the roles. There was a high turnover as HCAs as they tended to leave after three to six months. DT responded this was also the case in the care home sector, however it was thought the new Health and Social Care Academy would help going forward. DT also asked if HCAs had access to the same benefits as everyone else, i.e., Salary Sacrifice etc., and it was confirmed this was available to everyone.

SMcG also commented on this, and noted the impact on the vaccinations required, along with other jobs paying a better salary. DM advised the same issues were highlighted across the domiciliary care market, however if there were improved terms and conditions, this would provide a stronger platform for recruitment.

Safe Staffing response to current Omicron Wave

KSJ highlighted the importance of the paper, which had been produced to provide information from the key phase of the last wave and the current wave, and highlighted the work undertaken around safe staffing.

The increase to the BAF was reflective of the current state of play, and meant it identified management of staff in real time, with live staff meetings taking place two to three times a day.

In relation to the NHSP Incentive Scheme, which encouraged HCAs and nurses, including student nurses, to take on additional shifts. This scheme had been approved for extension until the end of February 2022 by the Trust Executive Team on 13 January 2022.

A staffing response plan had been put in place to respond to the surge in ED, particularly in relation to supporting patients. Staff had been identified from non-ward-based nurses, Health Care Assistants and Advanced Health Practitioners, and the rota was in place until the end of January 2022.

The helping hands scheme had been set up and was introduced in December 2021, to support the wards with staff from non-clinical corporate services. Training was available, and it was important to reinforce this to ensure full utilisation, as to date

there had been no access of this service within the Trust.

There would be a reintroduction of volunteers, as this had been paused due to the pandemic.

The paper also looked at ward staffing levels and how national minimum levels were assessed. Currently there were 141 incidents where levels fell below this, and nationally there were several assessment packs available. However, what the paper had not addressed was the health and wellbeing of those staff who had been impacted by this.

SMcG noted his observations, adding it was a useful overview which looked at national tools to enable the effectiveness of different approaches to safe staffing. KSJ added this would be useful to the process.

DT reflected on the Helping Hands scheme and noted the difficulty across the third sector for volunteers, and added he had previous experience and involvement in setting up volunteer groups and would be happy to support with anything he could.

Assurance Report - Quality Assurance Committee

- 12 breaches were reviewed, and the Committee noted appropriate assurance.
- The implementation of the Medical Examiner programme had been successful.

Assurance Report – Strategic People Committee

The report was taken as read. JJ noted the People Strategy had been agreed through Chair's action. Vaccination as a Condition of Deployment had been discussed.

Sustainability Dashboard

AMcG highlighted the Trust was on plan at the end of December with a £1.4m deficit and would carry a risk going into the final quarter with unidentified CIP. The Capital Plan had been submitted. Currently reviewing mitigation and underspend, with ongoing monitoring of capital spend.

Assurance Report – Finance and Sustainability Committee

The report was taken as read.

Assurance Report – Audit Committee

MOC noted there had been several requests for extension of actions and on a general note, there were some issues with auditors and would need to bare this in mind.

Assurance Report – Clinical Oversight Committee

It was agreed the email exchange (referred to above) would be useful and included for information in the minutes.

The Board discussed and noted the report.

BM/22/01/08	**MOVING TO OUTSTANDING** KSJ took the report as being read and noted the key highlights which included the CQC not yet releasing the revised Insight report, therefore the data for the indicators, reported in September 2021, had not been updated. In the absence of the report, the Trust had continued to focus on all indicators declining or below the national average and were monitored through the Red Flags report. ***Oversight of Mock Inspection Programme*** The mock inspection programme had been put on hold due to Covid and capacity issues, and would remain paused, it was hoped it would restart in February. However, there had been a mock inspection carried out on Maternity services, which produced a comprehensive action plan to support this. Another mock inspection was carried out on Outpatients, also from which a supported action plan had been produced. Further proposed mock inspections would be undertaken during Q4 2021/22. ***Accreditation*** Accreditations were going well with final onsite visits scheduled for 22 March 2022, and actions were currently on track for this visit. CR asked about the declining indicators due to surgery, mentioned in the report, and asked if this related to spinal surgery. KSJ confirmed this was related to spinal surgery. DT asked about performance indicator trajectories for Cancer and if these were constantly met, as it highlighted red flags in an earlier report. DM responded this referred to two cancer trajectories for the Trust, waiting more than 62 and 104 days for treatment, as a Trust these were being met and had resulted in the backlog being reduced, however this was disparate from the information. DM said he would take any questions outside of the meeting. **1. The Board discussed and noted the update** **2. Any questions regarding trajectories around Cancer to email DM directly**
BM/22/01/09	**USE OF RESOURCES ASSESSMENTS Q3 REPORT** AMcG provided an update regarding the context around the use of resources assessment and it being an integral part of the CQC process, as well as monthly meetings of the UoR group which reported into the Move to Outstanding group. NHSE/I also undertake inspections however these were currently suspended. Success was about looking back at the previous year, how things had improved and what the intentions were for the next year. Since Q2, the Trust had moved from green to red in relation to non-elective bed days, however it remained better than our peers and the report was being reviewed in more detail to understand the wider content of the report. SMcG asked about the overall assessment due to the current underlying deficit of

	the Trust and whether it had a bearing of the M2O. AMcG advised the Trust could not be marked as good for use of resources as it was reliant on cash support, therefore should not be an issue going forward, but unable to clarify on overall Trust assessment. **The Board discussed and noted the update**
BM/22/01/10	**VACCINATION AS A CONDITION OF DEPLOYMENT (VCOD)** MC highlighted to the Trust Board, the indication of a new proposed risk, which was built on Risk #115 around staffing. There had been guidance, approved by Parliament to apply this within the organisation, as it had to other Trusts in the country. However, the first thing would be engagement with staff side colleagues, and clear steps had been set out, along with a range of mechanisms being put in place to support the current workforce who may be hesitant to comply. The Trust Board were asked to note the actions taken in determining who was and was not in scope, and work was taking place with managers as to what this would look like, along with determination to defend the decisions if staff chose to take further action. For staff to comply, the first vaccine would need to be had by 3 February, with the next step of formal meetings for those who remained unvaccinated. The report ensured the Trust Board was completely sighted on what the Trust needed to do as an organisation in such a challenging timeframe and would provide support to the workforce and any colleagues affected by this issue. For further assurance LG had ensured there were sufficient supplies of the vaccine available for staff to access if required. SMcG added the Trust was clear about compliance with the law, and no other merits would be discussed. It was suspected the CQC may make visits to gain compliance on assurance, and there was a roadmap to get to 1 April 2022. DT thanked KSJ for the assurance received in relation to this topic, and the work undertaken was exemplary. JA asked how students with clinical placements would be treated and MC confirmed HEE and other bodies had been contacted and were looking at a range of avenues for those people coming into the Trust to ensure either they are vaccinated or would be to get vaccinated. SMcG noted it was still likely there would be several people who would not have the vaccine from a principal stance, and it was a high probability there would be several contracts terminated, therefore everything would need to be in place regarding such things as tribunals etc, it was assured processes were in place to expedite this. **The Trust Board discussed and noted the report.**
BM/22/01/11	**BOARD ASSURANCE FRAMEWORK (BAF) AND RISK REGISTER** JC presented an update on the BAF and the Risk Register and noted the updates since the last meeting. There were several proposals to be considered, the first of

	which related to risk #1579, transfer of patients with major trauma, which had an increased score of 16, and had been approved at the Quality Assurance Committee (QAC) on 11 January 2022. The next was the addition of risk #1590 relating to VCOD which had a rating of 20, as this included the potential of staff shortages and other implications for the Trust, this risk was discussed at the Strategic People Committee on 19 January 2022. Also related to VCOD was an increase in rating of 25 to risk #115, which also related to staff levels, this was approved at the QAC on 11 January 2022. The description to risk #1331 had been updated following approval at QAC, as it now better described the current circumstances. The final request of the Trust Board is to consider the amendment of risk #1233 in respect of the timely review of surgical patients. JD queried the description for risk #1233 and PF agreed to relook at the wording ad to amend as necessary. JD asked whether the rating for #115 needed to be at 25. KSJ responded adding at 25 this related to moderate harm relating to staffing, along with additional beds open in the system, which included super stranded patients, which meant stretching staff to capacity beyond what it normally should be, whilst below minimum staffing levels. MOC asked about the score to risk #1233 and the gaps in control, and whether the wording needed to be revisited. PF would review and update as necessary. JJ asked about the risk relating to estate and the new hospital scheme, as this had gone to the top of the priority list, and therefore would expect to see mitigations in place. She also asked if an agreed outline business case had been agreed. LG responded and advised at this stage, two strategic outline business cases, one for Warrington and one for Halton, could not be approved by NHSE/I as a regulator, until funding had been identified. We could however reflect the prioritisation against this risk until the formal outcome was known as to whether it would make the shortlist for this month. **The Board discussed and noted the updates to the risks and approved the amendments.**
BM/22/01/12	**Scheme of Reservations & Delegations and Standing Financial Instructions Update** *Scheme of Reservation and Delegation (SORD* AMcG noted an error relating to tenders and percentages of 60/40, but 70/30 for EPR and the paper would need to be updated to reflect this. *Standing Financial Instructions Update* **The Board approved the SFIs.**

BM/22/01/13	**CYCLE OF BUSINESS _ QUALITY ASSURANCE COMMITTEE** **The Board approved the Cycle of Business.**
BM/22/01/14 - 20	• *Infection Prevention & Control Board Assurance Framework Compliance Bi-Monthly Report* • *Learning from Experience Q2 Report* • *Guardian of Safe Working Q3 Report* • *Charities Commission Checklist (Annual Update)* • *Monthly Neonatal Safety Champions Guideline* • *Warrington Hospital Catering Unit Hot Water Supply* • *Non-Executive Directors – Champion Roles* **The Board noted all reports for assurance.**
BM/22/01/21	**Email Referenced in BM/22/01/07 (for information)** *From Terry Atherton (Chair of Clinical Oversight Recovery Committee (CROC) to Steve McGuirk (Chair)* *"I have spent time reviewing the CROC papers and this was the first meeting for three months, due to the last two being stepped down due to operational pressures. Given the scale of the challenge faced by the Trust, alongside the national focus, I believe that the Board needs to be sighted as to the current position, alongside our recovery trajectories.* *I believe that the Key Issues report arrangements do not provide assurance that the Trust Board now needs to be receiving in relation to the whole aspect of recovery and especially harm reviews necessary as a result of delays in treatments.* *I would therefore recommend the Trust Board hold a specific briefing for the Board as a session deemed necessary to be appropriate."*
The Date and Time of the next Trust Board Meeting is Wednesday 30 March 2022	

Approved …… Dated ……

CHAIRMAN S McGUIRK

BOARD OF DIRECTORS ACTION LOG

Warrington and Halton Teaching Hospitals NHS Foundation Trust

AGENDA REFERENCE	BM/22/03/24 i	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	30 March 2022

1. ACTIONS ON AGENDA

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

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

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

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
	26.05.2021	Any other business	Dedicated Board session to discuss how the Trust can contribute to local boroughs 'Green' agenda	**Chairman / Director of Strategy & Partnerships/ Chief Operating Officer**	**30.03.2022**	**08.03.2022**	• Draft Green Plan to be submitted to Cheshire & Merseyside in January 2022. The final plane to be submitted to Finance & Sustainability Committee & Board in March 2022. • Points for wider discussion and engagement received at the Board Development session in Febraury 2022 • NED only session held on 08.03.2022	
	26.05.2021		Facilitated Board session – to discuss wider health inequalities contribution from WHH.	**Chairman/ Director of Strategy & Partnerships**	**TBC**	**08.03.2022**	• Initial session taken place. Update report to September Board. Deferred to November • Detailed update received at November (2021) Board • Points for wider discussion and engagement received at the Board Development session in Febraury 2022 • NED only session held on 08.03.2022	

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/22/03/26**			
SUBJECT:	**Chief Executive's Briefing**			
DATE OF MEETING:	30th March 2022			
AUTHOR(S):	Simon Constable, Chief Executive			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO BAF RISK:	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

SUBJECT	Chief Executive's Briefing	AGENDA REF:	BM/22/03/26

1) BACKGROUND/CONTEXT

This report provides the Trust Board with an overview of matters on a range of strategic and operational issues since the last meeting on 26th January 2022, 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 (23rd March 2022), we have a total of 75 COVID-19 positive inpatients (14 days or less since their first positive sample); none of those patients are in critical care. In total, 124 of our inpatients have tested positive at any time during their admission (2 of these are in critical care). Two weeks previously those COVID totals were 49 and 95 respectively, so they have been going in the wrong direction. We have discharged a total of 3386 patients with COVID-19 to continue their recovery at home. Sadly, a total of 643 patients with COVID-19 have died in our care.

In terms of community numbers, new daily COVID-19 cases are rising once again. In the latest 7 days fully published (11th March – 17th March) in Warrington there were 832 cases per 100,000 people (the average area in England had 850); 1742 new cases were reported in that week, up 665 compared with the previous week. In Halton, there were 803 cases per 100,000 people; 1042 new cases in that week, up 372 compared with the previous week. These figures are likely to be an under-estimate as testing is not what it once was.

Case numbers are up across the whole of the UK consistently and across all age ranges, with the new variant of Omicron BA.2 becoming dominant, growing faster than the previous variant BA.1 is shrinking. The relaxation of restrictions has led to increased mixing as you would expect, but also an increase in higher risk mixing indoors, with nightclubs and the hospitality sector further opening up. Although we are seeing higher rates in hospitals, at the moment at least 50% is an incidental finding (due to the high community rates), with patients being admitted with other conditions. Fortunately, we are seeing the lowest numbers in critical care (due to the vaccine effectiveness), although the high numbers in hospital is still a significant burden operationally and presents all sorts of challenges to anyone involved in bed management or infection prevention and control.

Our total number of super stranded patients with a length of stay greater than 21 days remains far too high at 117, although it is much better than it has been, peaking at over 170 earlier this year. Looking at it through a slightly different lens, the number of our patients who don't meet the criteria to reside (in an acute hospital) is 126.

In order to assist with the bed capacity gap, and with little further opportunity in terms of wards, especially at Warrington, we are opening up further capacity at Halton; Warrington Borough Council are bringing online an additional 30 beds in a 'new' care home that will work with us on a discharge-to-assess model. Meanwhile we continue to pool resources on the

longer term solutions locally. Unfortunately, there are no quick fixes and no easy answers but there is a plan being enacted.

We are not alone on this, it is a regional and indeed national issue.

Total staff absence is just over 10% (a headcount of 472), the highest it has been for a long time, once again reflecting the increasing community rates and further adding to the pressures described above.

2.2 Overview of Trust Performance

Once again, with this report, I have included a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete datasets. In this case, this is month 11, February 2022. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report and Committee Assurance Reports.

The last few weeks have once again continued to see urgent and emergency care under real pressure across the North West and Cheshire and Merseyside; WHH has been no different. The Omicron burden from January onwards has significantly impacted patient flow, and staff sickness absence both inside and outside of hospital, also affecting our partners, especially with care home closures. Whilst this has improved more recently as case rates came down, there are concerns about the impact that rising case rates once again will have on out-of-hospital capacity.

The Trust continues to undertake a recovery elective programme 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. There is prioritisation of priority 2 patients and 52-week breeches for scheduling into capacity alongside our H2 planning submission in line with national guidance for the reduction of waiting lists. A harm assurance piece is being undertaken on all 52-week breeches to identify any risk of harm for patients who have waited a long time during the pandemic.

Our surgical bed base has been reconfigured to create a surgical floor which incorporates green capacity; this became operational in February 2021 and is being fully utilised. A recovery dashboard is also being utilised to monitor progress against agreed trajectories. This is being updated and new trajectories agreed to recover performance in 2022/23. The post anaesthetic care unit (PACU) is now working at full capacity.

Patients remain on a waiting list and their RTT pathways are still in place and being monitored. An activity report has been developed and is reported routinely at Recovery Board, Executive Team/Strategic Executive Oversight Group (SEOG), Quality & Assurance and the Finance & Sustainability Committee. The Clinical Services Oversight group (CSOG) continues to oversee waiting list and safety of patients.

The Trust has participated in the National Clinical Validation programme and completed the programme of work within the expected timescales.

In February 2022 the waiting list size saw an increase in the total number although the increase has started to plateau. This is attributed to the increase in referrals and new patients being added to the waiting list and as a result of wave 5 with outpatient sessions being cancelled to release staffing.

Due to the increase seen in consecutive months both the Planned and Unplanned Care Groups are formulating revised recovery plans to support reducing the waiting list. The scheduling of patients takes place into the available capacity utilising this prioritisation, including utilisation of the independent sector. For the reasons already noted in this report, there were 1038 x 52-week breaches recorded. These continue to be reviewed weekly and following urgent and cancer cases being listed these are prioritised for treatment.

A new trajectory has been developed for the clearance of these long waits. To mitigate future 52-week breaches, the over 40+ week patients are reviewed and prioritised appropriately.

2.3 Cheshire & Merseyside System Development

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

Recruitment to key senior positions in NHS Cheshire and Merseyside Integrated Care Board (ICB) is continuing. The Health and Care Partnership has made a number of appointments to provide the strategic leadership of the ICB, which can now be confirmed. These appointments are made subject to the passage of the Health and Care Bill through Parliament, which aims to establish the ICB as a statutory body from 1st July.

- **Medical Director:** Professor Rowan Pritchard-Jones will join as Medical Director. He is currently Medical Director at St Helens and Knowsley Teaching Hospitals NHS Trust.

- **Associate Medical Director:** Dr Fiona Lemmens will join the ICB as Associate Medical Director. Fiona is a GP in Liverpool and is currently Chair of the Governing Body of Liverpool Clinical Commissioning Group.

- **Director of Finance:** Claire Wilson, who is currently Chief Finance Officer at Wirral University Teaching Hospital NHS Foundation Trust, has been appointed Director of Finance.

- **Assistant Chief Executive:** Clare Watson, currently Accountable Officer at Cheshire Clinical Commissioning Group, has been confirmed as Assistant Chief Executive.

- **Chief People Officer:** Chris Samosa has been appointed to this role.

- **Chief Digital Information Officer:** Alex Chaplin will be the Chief Digital Information Officer of the ICB following his appointment to the Health and Care Partnership last October.

- **Director of Nursing and Care:** The recruitment process for a permanent appointment continues. Until a substantive appointment has been made, Marie Boles has agreed to be the interim Chief Nurse for the ICS.

- **Director of Performance and Planning:** Anthony Middleton has been appointed to this role.

In addition, nine Place Directors have been appointed for Cheshire & Merseyside. This has been following an inclusive process with the selection panel for each post including the ICB Designate Chief Executive, a non-executive director, a place-specific elected member or members, the relevant local authority Chief Executive, and representatives of both primary care and NHS providers. Working closely with local partners, Place Directors will play a central role in the future integration of health and care, taking a lead on tackling the health inequalities within our communities. For our boroughs, the Place Directors will be:

- **Halton:** Anthony Leo, currently Regional Director of Primary Care and Public Health Commissioning, NHS England and Improvement.
- **Warrington:** Carl Marsh, currently Chief Commissioner NHS Warrington Clinical Commissioning Group

The successful candidates will take up their posts on 1st July 2022, when NHS Cheshire and Merseyside Integrated Care Board (ICB) is established; however they will become involved from early April so they can contribute to the further design of the integration agenda.

NHS England and Improvement is leading the recruitment for the ICB Chair.

I would like to personally congratulate all the successful candidates and wish them every success in these important roles for Warrington and Halton, as well as the wider system.

2.4 A visit from the Prime Minister

We were delighted to welcome the Prime Minister, Rt Hon Boris Johnson MP, to Warrington Hospital on 10th March 2022 on a flying visit between engagements.

The Prime Minister took the opportunity to visit our new MRI Centre and see the new scanner in action, performing an official ribbon cutting to open the centre. He then proceeded to the construction site of our £6.3m expansion of the Emergency Department, where progress is being made at pace ready for a June handover.

We have recently invested over £5.5m in Radiology services including the new MRI Centre and scanner plus a refurbished CT Scanning suite accompanied by CT scanner. As well as our own capital we were successful in bidding for national funding for the two new scanners. The investment has supported the delivery of more and better diagnostic services for patients and

increased our research and teaching capabilities. Diagnostic waiting times for MRI imaging, are now back well within the six-week standard, despite the large backlog of patients arising from the COVID-19 pandemic.

On the Lovely Lane side of the estate the two-storey, 1,170sqm Emergency Department expansion is on track for a June handover, with the completion of the supporting pilings, ground beams and steel in place and the roof deck and first floor already lifted into position. The expansion will enable the creation of a new Same Day Emergency Care centre offering urgent 'hot' clinics, assessment areas, triage space, ambulatory care and primary care in the expanded and redesigned space. It will also increase capacity to deliver acute care for patients in extreme health emergencies.

The investment across both the Warrington and Halton sites is designed to address the constraints and limitations of our aging estate. We also took the time to make the following points to the PM:

- The town of Warrington has simply outgrown its hospital, its ageing buildings and facilities.
- This is evident in the pressures our Emergency Department experiences every day. In a space designed to cope with 150 patients a day we are regularly treating 300. Patient safety and treatment quality remains paramount and our team is to be commended for maintaining high standards despite the restrictions of the estate.
- These investments in our estate will support the Trust to maintain services until such time as we are able to secure a new hospital for Warrington, as well as redevelop and enhance our Halton site in a way that is complementary.
- We have submitted a proposal to secure one of the last remaining eight places in HM Government's national new hospitals programme which will provide grant funding totalling £3.7billion – a final decision on the funding of successful bids is expected later this year; meanwhile we remain committed to making the most of our ageing estate and facilities to ensure the people of Warrington and Halton can access the very best care and support when they need it.

The Prime Minister had a typically warm WHH welcome.

2.5 Vaccination as a Condition of Deployment (VCOD) regulations

HM Government originally passed legislation requiring vaccination as a condition of deployment (VCOD) in the NHS which was due to come into effect from 1st April 2022. However, late on Monday 31st January 2022 the Secretary of State announced that this was now being reconsidered.

A national consultation was launched during February 2022 on the potential revocation of that legislation. The DHSC published the outcome which has confirmed that it was to revoke the COVID-19 vaccination as a condition of deployment mandate in England following strong support. Regulations revoking vaccination as a condition of deployment came into law on 15th March 2022 following the parliamentary process.

WHH follows national regulations regarding COVID Vaccination and therefore has concluded all activity relating to vaccination as a condition of deployment.

2.6 Staff Car Parking Charges

WHH will be reinstating charging for staff car parking from 1st April 2022.

Two years of national funding, provided to support staff during the COVID-19 pandemic, will cease from 31st March 2022. NHS Trusts across England are now reinstating staff parking charges from 1st April, including all the Cheshire and Merseyside hospitals.

These will be at the previous rate with no increases or changes to these prices. Staff can also opt to use the Salary Sacrifice scheme to reduce the impact on take home pay.

Car parking charges were reinstated for patients and the public in April 2021 together with an increase in the number of concessions available. We also introduced a new staff permit system in July 2021 based on a set of points-based criteria. Since the introduction of the permit system, congestion in patient parking areas has eased considerably and, while both Warrington and Halton sites remain extremely busy, the extent of the overcrowding and obstruction issues previously seen have reduced.

A new permit system will be rolled out to manage staff parking permits to replace the previous system introduced as a temporary measure last year. The permit criteria have not changed, and applications are assessed using the same criteria as before.

We will review the system and how it is working in the autumn. A discussion on any longer term solutions will need to wait a little longer until we are clear about the outcome of our new hospitals bid.

2.7 New Hospitals Programme

In July 2021 NHS provider organisations across England were invited to submit expressions of interest (EOI) to the national Health Infrastructure Programme in a bid to secure national capital funding to deliver eight new hospitals. In line with WHH's Estate and Facilities Strategy (2019-2024) we submitted an expression of interest for a new hospital in Warrington and the redevelopment of the Halton hospital site to provide a fit-for-purpose hospital, wellbeing campus and regional elective hub.

The expression of interest had explicit support from a wide range of local and regional stakeholders including MPs, both Local Authorities, Clinical Commissioning Groups, education providers, health and care providers and the public. At the point of submission, the precise process for determining allocation of funding was unclear but an award announcement date of Spring 2022 was outlined.

Eleven organisations from across Cheshire and Merseyside submitted an expression of interest to the programme and during October 2021 Cheshire and Merseyside Health and Care Partnership were asked to locally prioritise schemes. Organisations who had submitted an EOI were invited to present a summary of their case to system partners at the Cheshire and Merseyside Strategic Estates Group. I did this on behalf of the Trust. A system panel,

representing Clinical (medical and nursing) CEOs, Finance and Estates colleagues, met and using nationally determined criteria assessed the expressions of interest. Critical considerations in the prioritisation process were focused on the quality of the existing estate.

WHH's bid was successfully prioritised as joint number one for investment across Cheshire and Merseyside, alongside two other trusts who both have structural issues (reinforced concrete failures) in their buildings like several other hospitals in England. Details of the next stage of the prioritisation process for the EOI process have not yet been formally announced, although it is informally understood to involve a national steering group which will convene to review all of the prioritised schemes across all regions and make recommendations for a short list. The shortlist will then be presented to a panel of Health Executives and Ministers for review and agreement. It is expected that successfully shortlisted Trusts will be required to provide further information for a final decision to be made in Spring 2022.

We continue to maximise opportunities to progress plans within the current footprint, including developing two new health and wellbeing hubs and a community clinic within vacant retail space (partly enabled through national levelling-up programmes, including the Town Deal Fund), as well as progressing plans for our new Assessment Plaza in Warrington, all of which are coming to life day by day.

2.8 Endoscopy

In February, our Endoscopy Unit (on both Warrington and Halton sites) have had their routine JAG (Joint Advisory Group, GI Endoscopy) Accreditation Visit and assessment by the JAG team. Accreditation provides independent and impartial recognition that a service demonstrates high levels of quality. This means that patients can feel confident in their endoscopy service and be assured of receiving high quality consistent care. This visit coincided with the completion of the new refurbished endoscopy unit at Halton.

The feedback about the leadership, the team, the culture as well as the standards of care and facilities was simply outstanding. The whole team are to be congratulated.

2.9 WHH Long COVID Service

Long Covid can affect any organ system and presents with over two hundred possible symptoms. Diagnosis is based on the history and is defined as symptoms due to Covid infection lasting longer than twelve weeks. Age and initial severity of acute illness do not preclude devastating effects lasting months or years. The most common problems are fatigue, brain fog, breathlessness, and pains of various sorts. Issues with work and study can cause further distress.

The service at Warrington and Halton Hospitals is designed to support those without significant organ damage. The team consists of a GP, respiratory nurse, occupational therapist and a psychologist, who between them provide a Personalised Care Plan for each patient. The initial screening is carried out by the GP. Respiratory nurses take a detailed history, covering all functional activity. Some patients are discussed in an informal MDT, and some are assessed face-to-face. The clinic has close links to psychotherapy, community-based Wellbeing Providers, Fatigue Management, and an adapted form of Pulmonary Rehabilitation. Occasionally, a patient may require referral for a respiratory or cardiac opinion. The very

complex patients can be referred on to Liverpool Heart and Chest Hospital for so-called Tier 4 intervention. The Your Covid Recovery website (www.yourcovidrecovery.nhs.uk) is an excellent source of information and advice for all patients. The vast majority will improve over time but need support adjusting to the way they are during their recovery.

A recent report demonstrates that the vaccine reduces the incidence of Long Covid. A 'fingerprint' of immunological and inflammatory markers is being identified. The role of tiny blood clots and cells involved in the immune response, among many other aspects, are being actively researched, giving hope for future treatments, which may also impact upon other post viral conditions such as fibromyalgia.

Funding has been secured for a further twelve months from April 2022. By then, the management of Long Covid is likely to be very different. In the meantime, the clinic uses the tools available to help people maximise their functional ability, maintain a positive outlook and enjoy life as best as they can.

2.10 Safer Prostate Cancer Tests

Last year we introduced a new technique for prostate biopsy into the Trust despite COVID.

Around 52,300 men are diagnosed with prostate cancer in the UK each year. In men, it is the most common cancer in the UK. Prostate cancer doesn't usually cause any symptoms although patients may have associated lower urinary tract symptoms. Rarely, they may present with symptoms of metastatic disease such as bone pain, acute urinary retention or chronic renal failure. Prostate cancer is diagnosed following a raised PSA (prostate specific antigen blood test) followed by an MRI scan and a prostate biopsy.

Traditionally, prostate biopsies have been done by the ultrasound guided trans-rectal method. However, they have a serious risk of sepsis and are subject to significant sampling error, particularly if the tumour is situated in the anterior (front) part of the prostate gland.

The trans-perineal route for biopsy using transrectal ultrasound guidance is an alternative to overcome these challenges. Traditionally trans-perineal biopsies have been done under general anaesthetic using a template (similar to those used in radiotherapy). There have been new innovations in the recent past, both in terms of imaging and kit which allows this procedure to be done under local anaesthetic and take as many as 24 prostate biopsies at one time.

After a visit to a neighbouring trust, support from the Prostate Cancer Alliance and WHH investment with capital expenditure, our Urology Department have set up this new service of “Trans-perineal prostate biopsy” in May 2021. Since then 200 trans-perineal biopsies have been performed.

This service has been rolled out seamlessly without any significant problems. Most trusts who have started this “state of art technique” have done them under general anaesthetic and moved slowly towards local anaesthetic. All five WHH urology consultants are now trained to do this procedure under local anaesthetic. We are auditing the pain score and patient satisfaction since we started and preliminary results are highly encouraging.

2.11 Special Days/Weeks for professional groups

Since our last Board meeting in January 2022, 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:

LGBT+ History Month: February 2022
Time to Talk Day: 3rd February 2022
International Women's Day: 8th March 2022
National No Smoking Day: 9th March 2022
Nutrition and Hydration Week: 14th - 20th March 2022
National Cancer Clinical Nurse Specialist Day: 15th March 2022
Moisture Associated Skin Damage Awareness Day: 17th March 2022
World Down's Syndrome Awareness Week: 21st – 27th March 2022

2.12 Local political leadership engagement

Since the last Board meeting both the Chairman and I have continued regular communication and updates with our local political leadership, through the chief executives of both Warrington Borough Council and Halton Borough Council and the respective council leaders. I have also continued to be in regular communication with all four of our local Westminster MPs – Derek Twigg MP (Halton), Mike Amesbury MP (Weaver Vale), Charlotte Nichols MP (Warrington North) and Andy Carter MP (Warrington South). I have been updating them on the WHH situation, both in terms of COVID-19 as well as other significant issues; 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.

On 22nd March 2022 I also paid a farewell visit to David Parr OBE, outgoing Chief Executive of Halton Borough Council who retires on 31st March. Halton Borough Council has appointed Stephen Young as its new Chief Executive. Mr Young is currently Executive Director of Growth, Environment, Transportation and Community Services at Lancashire County Council.

2.13 Employee Recognition

As reported previously we now have the 'You Made a Difference' awards.

You Made a Difference Award (January 2022) – Jeanette Jones and Adam Grindley

This award was made to the Disability Awareness Staff Network Chair, Jeanette, and Vice-Chair, Adam, for all the work they have done in setting up this network. In a short space of time they have also enabled the new Blue Badge Parking signs, highlighting that not all disabilities are visible. These signs were a direct result of an intervention by our Disability Awareness Staff Network. We are one of the first trusts to achieve this and there is nobody in the area using signs to include hidden disabilities. It has been a great achievement for our network in the short time that it has been going.

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

Chief Executive Award (January 2022): COVID-19 Vaccination Service

This was a long overdue award for a whole team approach to being so very flexible and responsive to the needs of the national COVID-19 vaccination service, stepping up to all the challenges asked of them, often at very short notice. It has been a pivotal intrevtion for our staff but also the wider community. Patient feedback continues to be outstanding.

Chief Executive Award (January 2022): WHH Safeguarding Team

We have had specific external very positive feedback about our Safeguarding Team, which has recently been commended following a Serious Case Review (SCR, an external process). I therefore presented them with my own award.

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

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

- Christine Murphy, Healthcare Assistant - Outpatients
- Mr Marsel Bregu, Consultant Ophthalmologist - Surgical Specialities
- John Vis, Service Improvement Accountant - Finance
- Dr Piotr Lech, Consultant Cardiologist - Medical Care
- Dr S Koppa Narayana, Consultant Endocrinologist - Medical Care
- Mr Ash Acharya, Consultant Orthopaedic Surgeon - Surgical Specialities
- Dr Deepa Jumani, Consultant Anaesthetist - Digestive Diseases
- Dave Gallagher & Team, Ward K25 - Integrated Medicine & Community
- Natalie Roose & Team, Ward Manager – PIU, Digestive Diseases
- Tim Hilton, Biomedical Scientist - Clinical Support Services
- Saneliso Ndebele, Radiographer - Clinical Support Services
- Jenny Johnson, Radiology Assistant - Clinical Support Services
- Mr Giri Hebbar, Associate Specialist – Ophthalmology, Surgical Specialities
- Dulce Lawrence, Ward Manager - A7, Integrated Medicine & Community
- Dr Bharathi, Consultant Gastroenterologist - Digestive Diseases
- Emma Hankin, Waiting List Manager, Digestive Diseases
- Mark Hampson, Head of Resuscitation - Corporate Nursing
- Ms Marta Hovan, Consultant Ophthalmologist - Surgical Specialities
- Wendy Currie, Unit Manager – Endoscopy, Digestive Diseases
- Karen Smith, Unit Manager – Endoscopy, Digestive Diseases
- Louisa Taylor, Senior Business Accountant - Finance
- Denise Dugdale, Divisional Accountant - Finance
- Dr Paul Fitzsimmons, Executive Medical Director
- Usamah Najamraj, Audiologist - Clinical Support Services
- Tracy Harrison, Reception Supervisor - Clinical Support Services
- Dr Chris Bedford, Consultant Paediatrician - Women's & Children's Health
- Carol Beesley, Manager - Children's OPD, Women's & Children's Health
- Lindsay Grant, Opthoptist Specialist - Surgical Specialities
- Lorraine Cartledge, Housekeeper - Clinical Support Services
- Jean Carter, Advanced Radiographer - Clinical Support Services
- Amanda Thomas, Nurse Consultant - Integrated Medicine & Community
- Jennie Myler, Executive Assistant

- Clare Baker, International & Medical Resourcing Manager - HR/OD
- Victoria Woodjetts, Organisational Development Manager - HR/OD
- Emma Painter, Associate Chief Nurse/AHP - Unplanned Care
- Michelle Smith, Lead Allied Health Professional - Clinical Support Services
- Dr Laura Langton, Consultant in ITU - Medical Care
- Dr Anne Robinson, Deputy Medical Director - Executive
- Brian Burge, Head of Procurement - Finance & Procurement
- Paul Webster, Stores Operative - Finance & Procurement
- Chris Barrow, Interim Vaccination Service Manager - Vaccination Service
- Frances Meachin, Sister – Intensive Care Unit

2.14 Signed under Seal

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

Licence to underlet unit 1 in the retail areas at Warrington Hospital

3) MEETINGS ATTENDED/ATTENDING

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

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

4) RECOMMENDATIONS

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

Appendix 1 - CEO Dashboard Month 11 – February 2022

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Quality of Care		
Indicator	**Target**	**Actual**
Incidents over 40 days	0 open	0 (29 open over 20 days)
Sepsis	90%	79% | 80% | 73% | 80%
Duty of Candour	100%	100%
Inpatient Falls (YTD)	20% reduction based on 612 falls in 2019/20	530 YTD
VTE	95%	Quarterly Indicator
Pressure Ulcers (YTD)	Less than 65 for the year	81 YTD
Medication Reconciliation (24 hrs)	80%	69.00%
Staffing Average Fill Rates	90%	Average 86.52%
Care Hours Per Patient Day (CHPPD)	7.9	7.2
NICE Compliance	90%	92.55%
Friends & Family Test (IP/Day Case)	95%	98.00%
Friends & Family Test (ED & UTC)	87%	73.00%
Complaints over 6 months	0	0
Continuity of Carer	51%	77.50%
Healthcare Infections - MRSA	0	1
Healthcare Infections - CDI	Less than 44 for the year	44 YTD
Healthcare Infections - E. coli	Less than 81 for the year	60 YTD
Healthcare Infections - Klebsiella	Less than 23 for the year	25 YTD
Healthcare Infections - P. aeruginosa	Less than 4 for the year	3 YTD
COVID-19 nosocomial (in month) – 8-14 Days 15 Days +	N/A	23 40
Mixed Sex Accommodation Breaches (Non ICU Only)	0	0

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Operational Performance		
Indicator	**Target**	**Actual**
Diagnostic 6 Weeks	99%	78.37%
RTT 18 Weeks	92%	66.97%
RTT 52 Weeks	0	1,038
A&E 4 Hour Wait	95%	67.61%
A&E 12 Hour Wait	0	68 patients
Cancer 14 Days	93%	68.57%
Breast Symptomatic 14 days	93%	51.85%
Cancer 28 Day Faster Diagnostic Standard	75%	61.01%
Cancer 31 Days First Treatment	96%	98.25%
Cancer 31 Day Surgery	94%	100%
Cancer 31 Day Drug	98%	100%
Cancer 62 Days Urgent	85%	74.07%
Cancer 62 Days Screening	90%	80.00%
Ambulance Handovers 30-60 mins	0	95
Ambulance Handovers 60+ mins	0	52
Discharge Summaries 24 hours	95%	80.87%
Discharge Summaries 7 days	0	378
Cancelled Operations – nonclinical	Less than 2%	0.09%
Cancelled Operations – nonclinical not rebooked 28 days	0	0
Urgent Operations Cancelled for a 2nd time	0	0
Fracture Clinic – 72 Hours	95%	42.04%
% Outpatient Appointments Delivered Remotely	25%	12.95%
Super Stranded Patients	Trajectory	134

Appendix 1 - CEO Dashboard Month 11 – February 2022

Warrington and Halton Teaching Hospitals NHS Foundation Trust

People

Workforce

Indicator	Target	Actual
Sickness Absence	4.2%	6.18%
Return to Work	85%	59.04%
Recruitment Time to Hire	65 days or less	73 Days
Vacancy Rates	9% or less	10.40%
Turnover	Less than 13%	15.81%
Retention	85%	83.05%
Core/Mandatory Training	Trajectory	84.79%
Role Based Training	Trajectory	90.75%
Safeguarding Training	Trajectory	68.00%
Workforce Carrying Out a Qualification	2.3%	3.38%
Payspend (month)	£19.79m (Plan)	£20.06m
Bank/Agency Reliance	9% or less	13.95%
PDR Compliance	Trajectory	63.91%

Sustainability

Finance

Indicator	Plan	Actual
Income & Expenditure	Breakeven	£0.5m deficit
Capital	£14.0m	£8.6m spend
Cash	£9.5m	£49.9m balance
Better Practice Payment Code	95.00%	93.00% cumulative
CIP In Year	£3.81m	£4.56m in year savings
CIP Forecast	£4.9m	£1.5m recurrent saving

Strategy

Strategy

- The Trust is refreshing and expanding the site feasibility study for the new hospitals programme to identify a preferred location for a new Hospital in Warrington.
- The Trust's Quality priorities for 2022/23 have been agreed.
- The Trust has submitted an expression of interest to provide a Community Diagnostic Centre on our Halton Hospital site.
- Detailed designs produced by architects in collaboration with health and care providers and stakeholders continue to progress for both the new health and wellbeing hub in Warrington (progressing to stage 4) and the health and education hub in Runcorn (stage 2 completed).
- The Cheshire & Merseyside ICS Green Plan is in development and a final version is due at the end of March, incorporating green plans for all 18 Trusts across the region.
- Refurbishment of Shopping City is due to start in March to accommodate ophthalmology, audiology and dietetics services.

Report to the Board of Directors

AGENDA REFERENCE:	**BM/22/03/28**	
SUBJECT:	**COVID-19 Situation Report**	
DATE OF MEETING:	30th March 2022	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1275** Failure to prevent Nosocomial Infection caused by high transmitability of variant strains, waning effect of vaccines, asymptomatic carriage (staff or patients), false negative test results, high local community prevalence. **#1590** Failure to prevent staff shortages within certain professional groups and / or CBUs caused by individual decision making associated with the amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, introducing the COVID vaccination as a condition of deployment (VCOD) resulting in staffing gaps, a reduction in service provision and risks associated with risk 115 concerning staffing levels. **#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 **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are assessed as only able to work on a non-respiratory pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily Executive Summary which includes data outlining the key information pertinent to the command and control of the pandemic. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where available. This report is part of the continuing development and understanding of demand, capacity and outcomes and will determine future strategic planning. Data up to 25th March 2022 is included.	

PURPOSE: ***(please select as appropriate)***	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO THE BOARD OF DIRECTORS

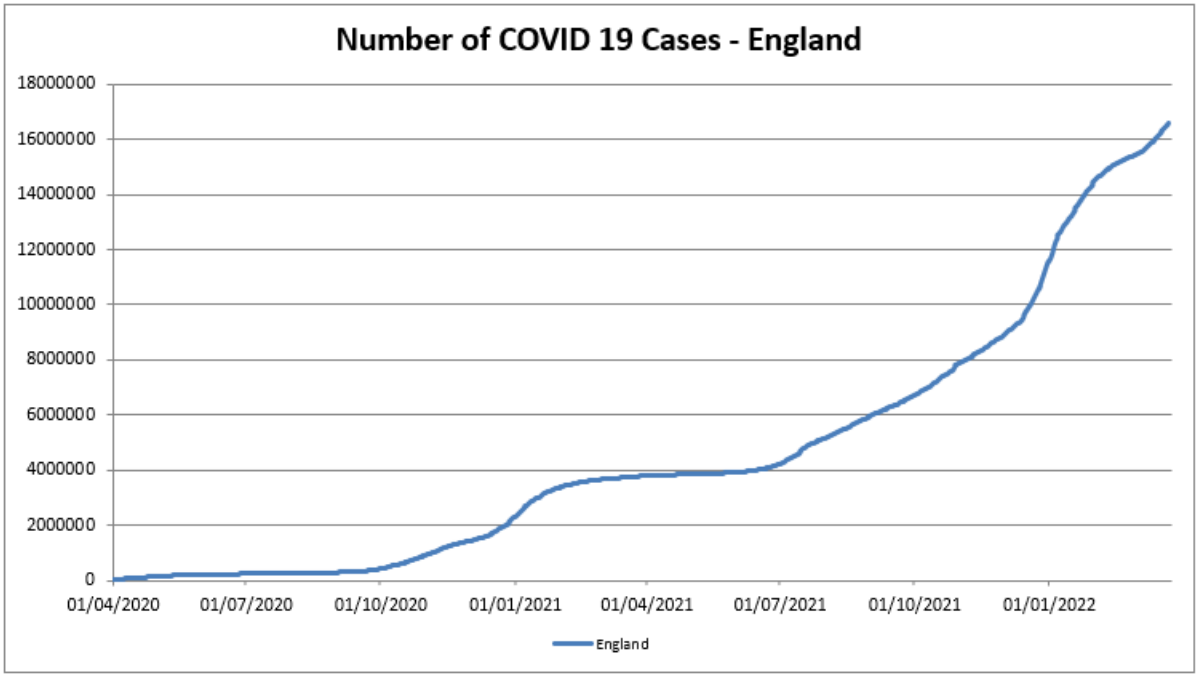
SUBJECT	COVID-19 Situation Report	AGENDA REF:	BM/22/03/28

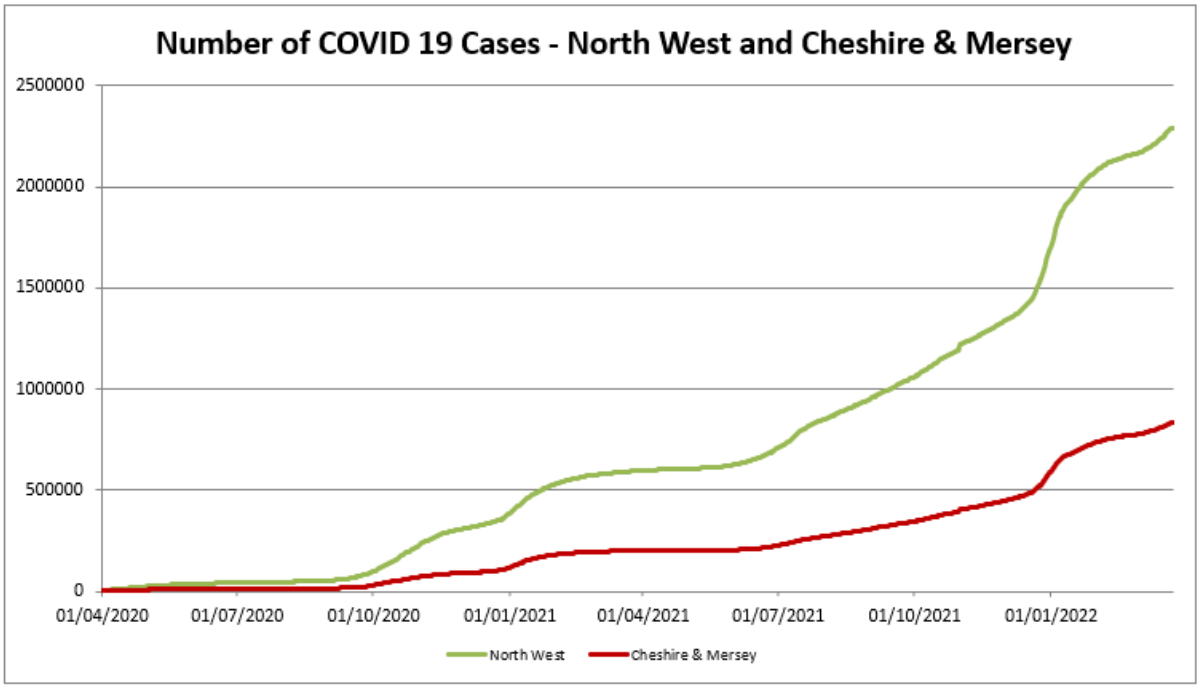
1. BACKGROUND/CONTEXT

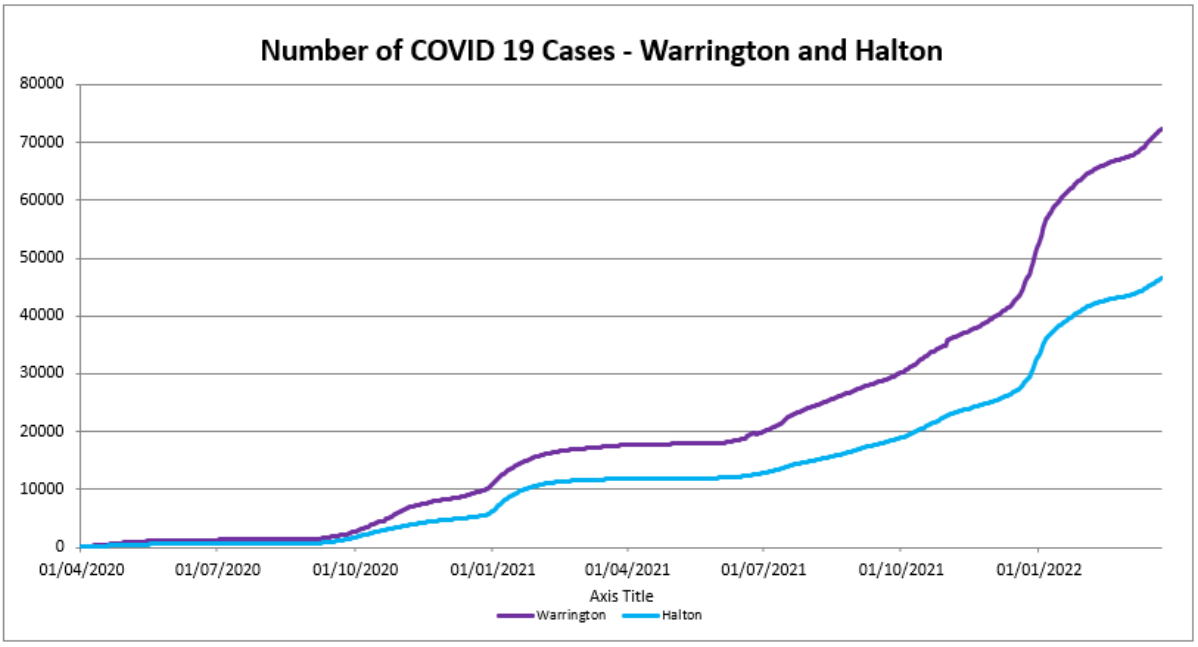
The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily Executive Summary which includes data outlining the key information pertinent to the command and control of the pandemic. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where available. This report is part of the continuing development and understanding of demand, capacity and outcomes and will determine future strategic planning. Data up to 25th March 2022 is included.

2. KEY ELEMENTS

2.1 Number of Reported Cases



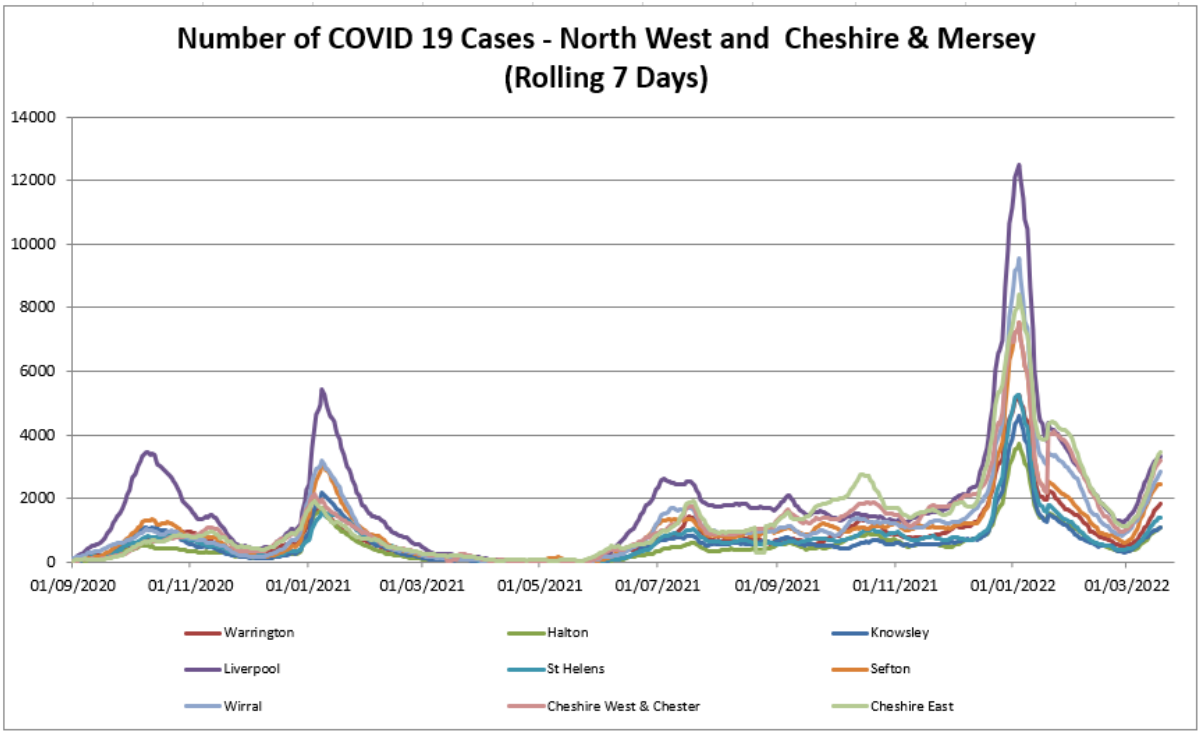


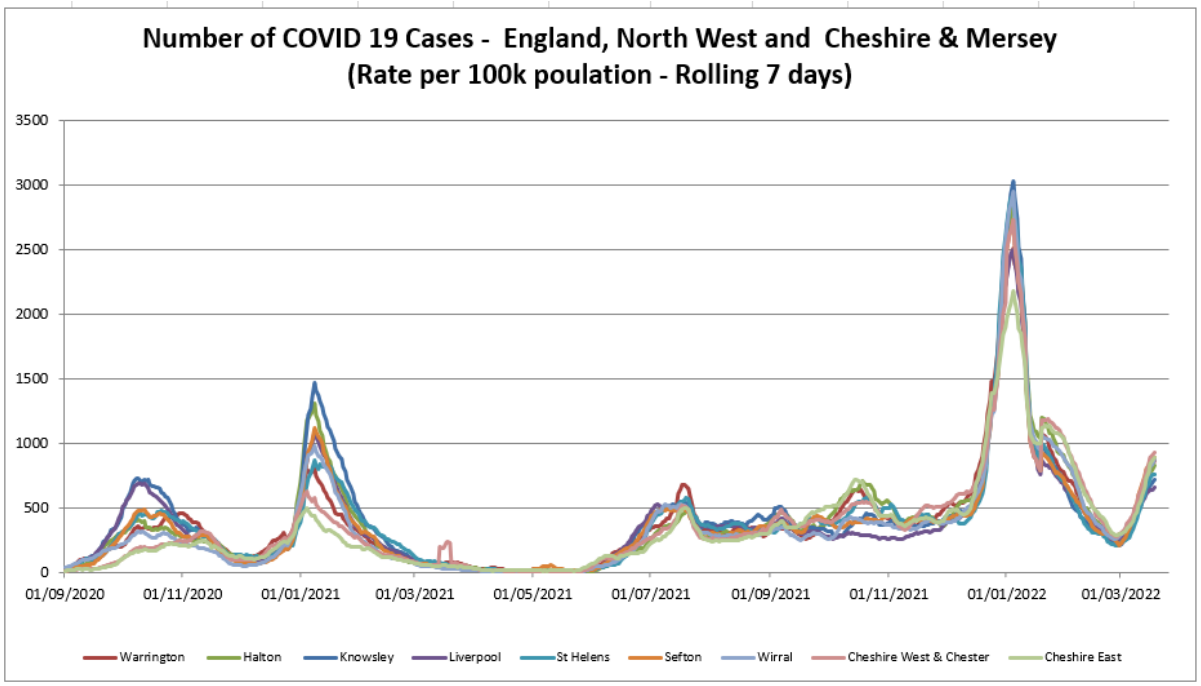


Narrative: As of 24/03/2022, there were 72,264 cases of confirmed COVID-19 reported in Warrington and 46,443 cases reported in Halton. The Trend is in line with the England, Cheshire & Mersey and the North West positions.

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

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

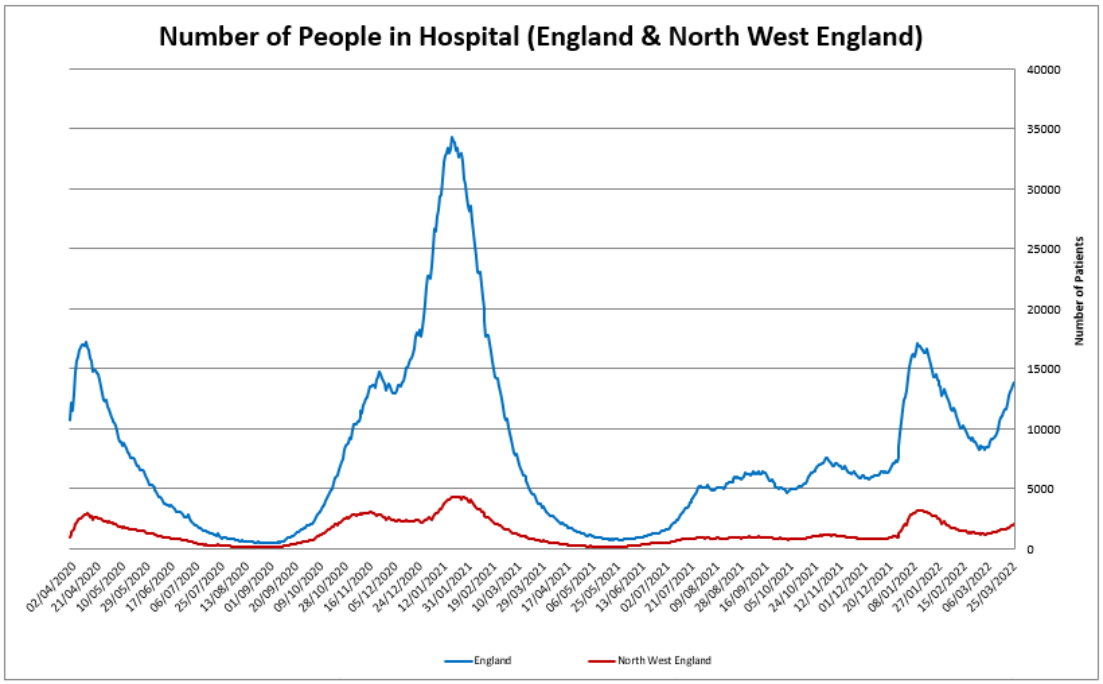


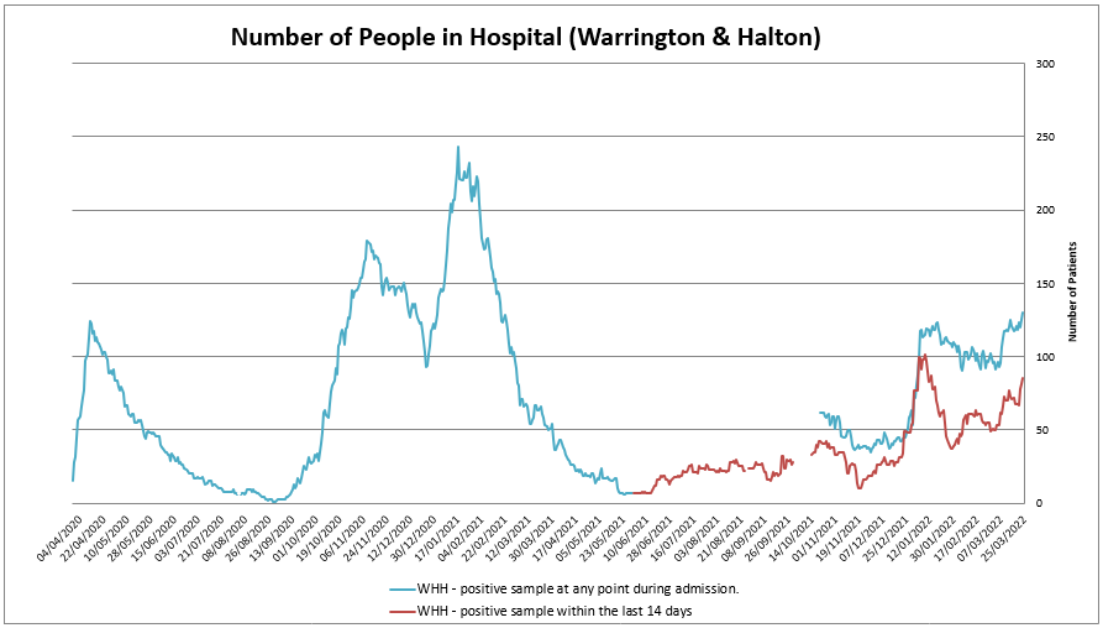


Narrative: The graphs show the infection count and rates per 100k population over a rolling 7 day period. This is a more accurate comparison than total number of cases due to the differences in population. The data shows the latest "Omicron" peak came in early January 2022 with the highest number of infections than at any other point of the pandemic. As at 20/03/2022, (the latest data period for this indicator) Warrington had 884 cases per 100k population and Halton had 865 cases per 100k population which is higher than the Northwest position (705 cases/100k population) and the England position (843 cases/100k population).

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

2.3 Number of People in Hospital

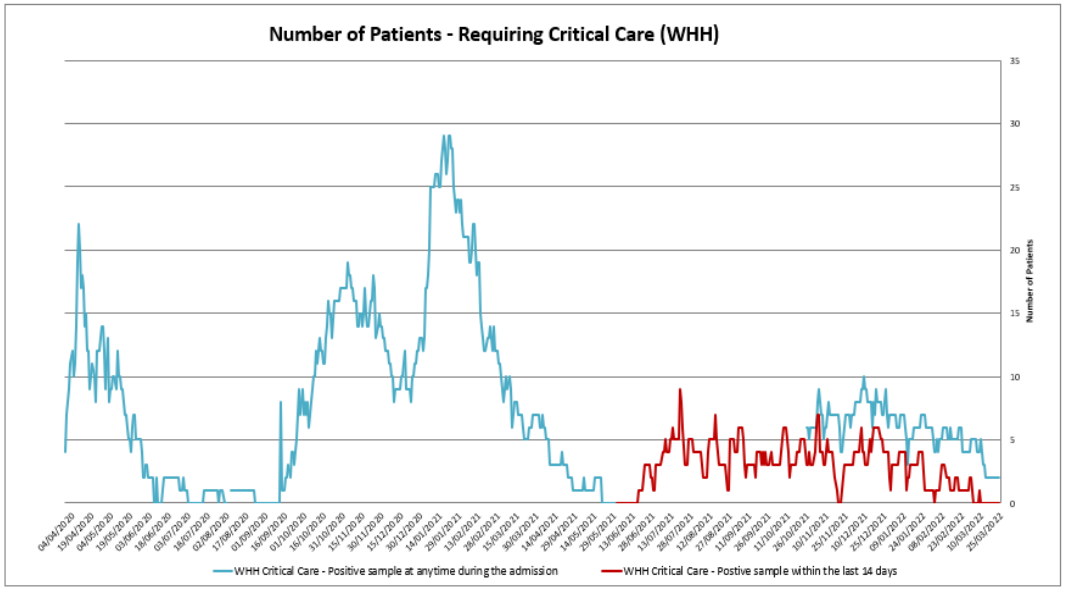




Narrative: As 24/03/2022, there were 85 inpatients being treated by the Trust with confirmed COVID-19 (with a positive COVID-19 sample within the last 14 days) and 130 patients (with a positive COVID-19 test at any point during admission). The peak of the 3rd wave was on 18/01/2021 with 243 inpatients receiving treatment (with a positive COVID-19 sample at any point during admission).
Source:https://www.gov.uk/government/collections/slides-and-datasets-to-accompany-coronavirus-press-conferences (England & North West) and Trust Data (Warrington & Halton).

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

2.4 Number of Patients Requiring Critical Care

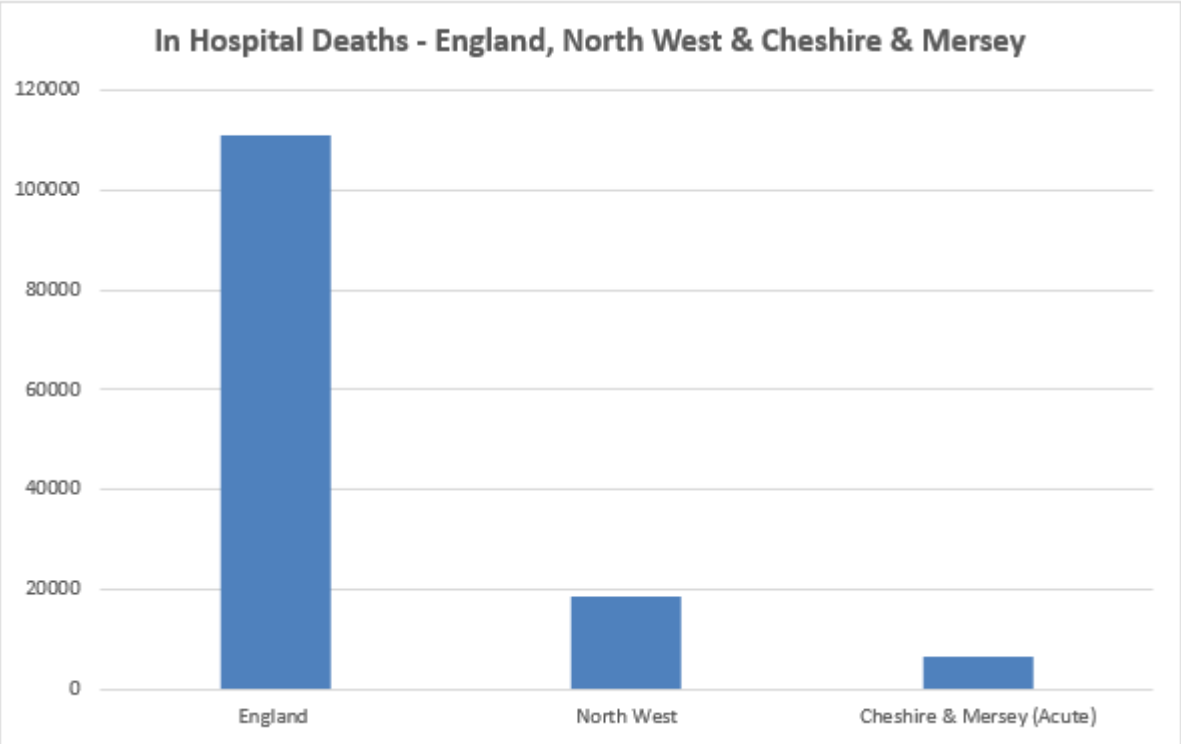


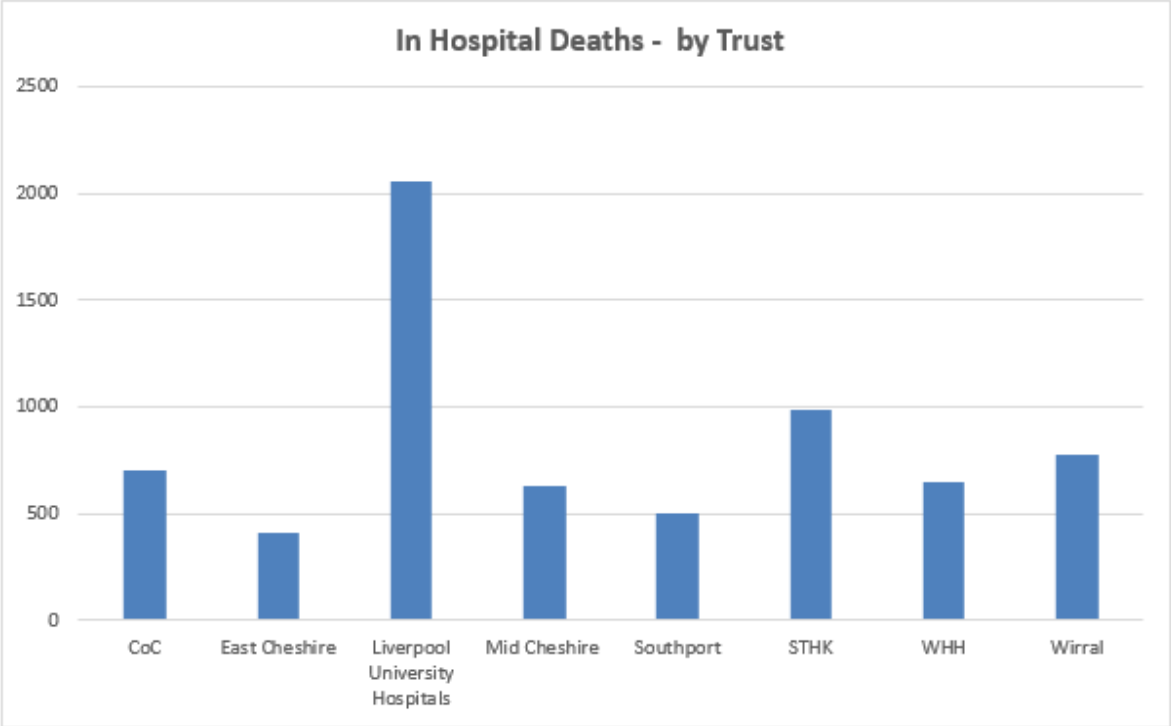
Narrative: As of 24/03/2022, there are 0 inpatients with confirmed COVID-19 (positive sample within the last 14 days) requiring critical care and 2 patients (positive sample at any point during admission).

Source: Trust Data (Warrington & Halton).

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

2.5.1 Number of In-Hospital Deaths





Narrative: As of 25/03/2022, the Trust had reported 643 deaths of inpatients with confirmed COVID-19. The trend is in line with the North West and Cheshire & Mersey positions.

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

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

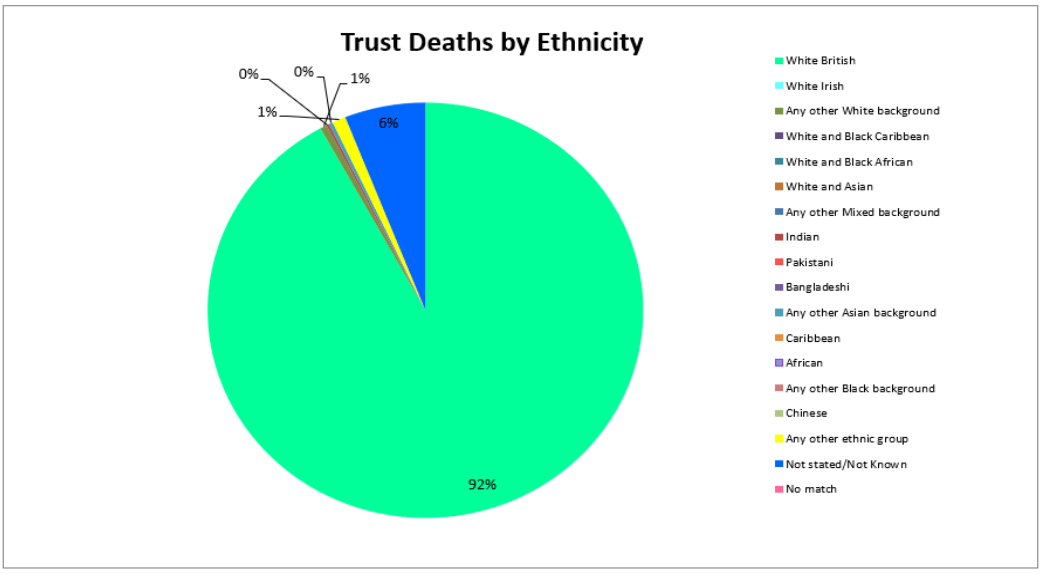
2.5.2 Crude Mortality

February	2020	2021	2022
February (All Deaths)	86	103	84
February (Non-COVID)	86	42	60
February (COVID)	0	61	24
% COVID Deaths (of all deaths)	0.0%	59.2%	28.6%
Discharges	6352	4273	4866
Crude Mortality (deaths divided by deaths+discharges)	1.4%	2.4%	1.7%

	Wave 1 Apr-Aug 2020	Wave 2 Sept-Dec 2020	Wave 3 Jan 2021 - May 2021	Wave 4 June 2021 - Present
All Deaths	405	402	478	790
Non-COVID	272	227	293	649
COVID	133	175	185	141
% COVID Deaths (of all deaths)	32.8%	43.5%	38.7%	17.8%
Discharges	19326	17241	23507	48154
Crude Mortality (deaths divided by deaths+discharges)	2.1%	2.3%	2.0%	1.6%
Crude Mortality COVID-19 (COVID-19 deaths divided by COVID-19 deaths+ COVID-19 discharges)	25.2%	20.3%	16.9%	9.7%

Narrative: Crude mortality in February 2022 was 1.7% compared with 2.4% in February 2021 and 1.4% in February 2020. Crude mortality was 2.1% in wave 1 and 2.3% in wave 2 and 2.0% in wave 3 and 1.6% in wave 4 (to date) with Crude mortality for COVID-19 patients 25.2% in wave 1, 20.3% in wave 2, 16.9% in wave 3 and 9.7% in wave 4 (to date).
Source: Trust Data.

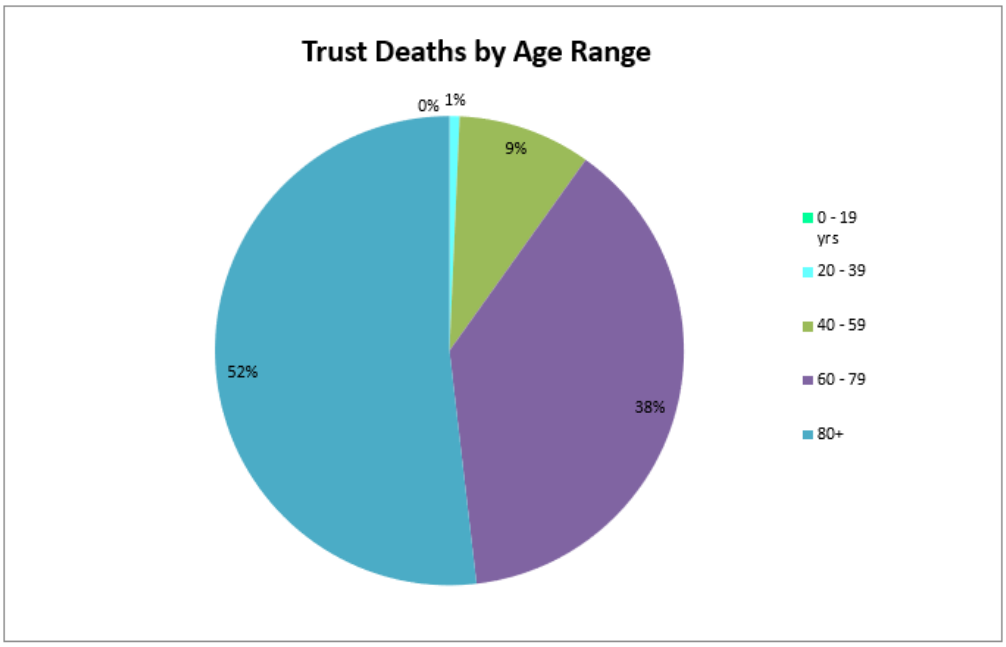
2.5.3 Number of In Hospital Deaths (Ethnicity)



Narrative: As of 25/03/2022, 92% 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", <1% Indian and <1% patient identified as "White Any Other Background". The proportion of White British patient deaths is greater than the national position, however this is as expected when comparing the population of Warrington (96.00% White British) & Halton (98.00% White British).

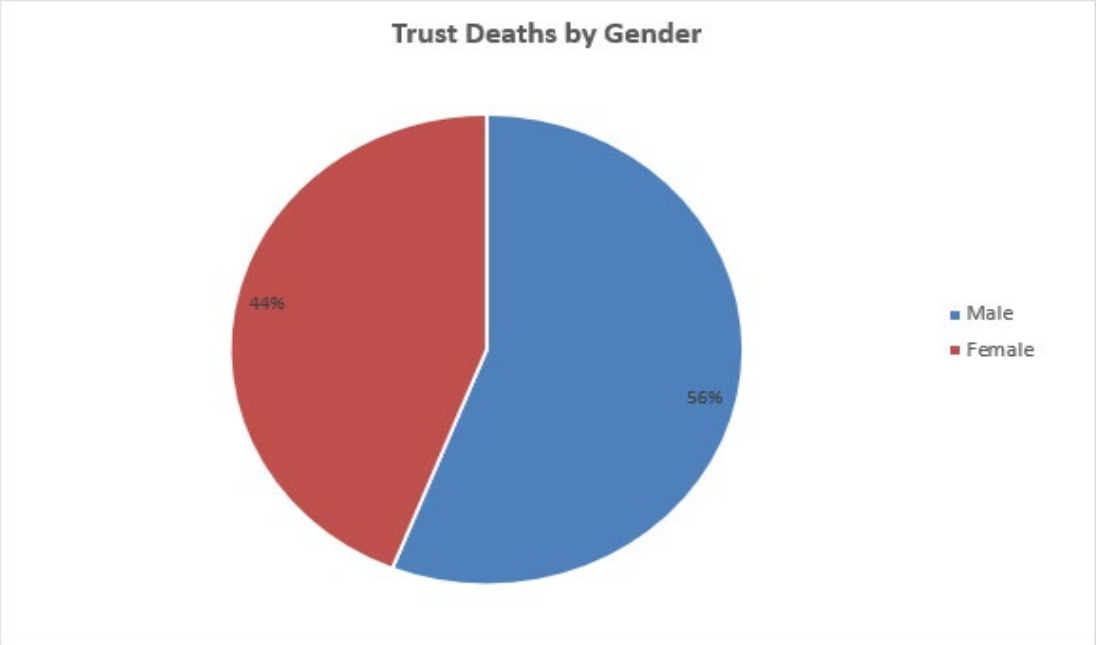
Notes: National data for COVID-19 deaths by ethnicity was not available at the time of writing, having previously been made available on the NHSE website.

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



Narrative: As at 25/03/2022, 90.00% of COVID-19 related deaths were inpatients over the age of 60, which is line with the national position. The average age of death was 77.3 years.
Notes: Data utilised is for the date each death was reported, not the date that the death occurred and therefore there is a 3-5 day time lag for national data.
Source:https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/
(England, North West, Cheshire & Mersey) and Trust Data (Warrington & Halton)

2.5.5 Number of In Hospital Deaths (Gender)

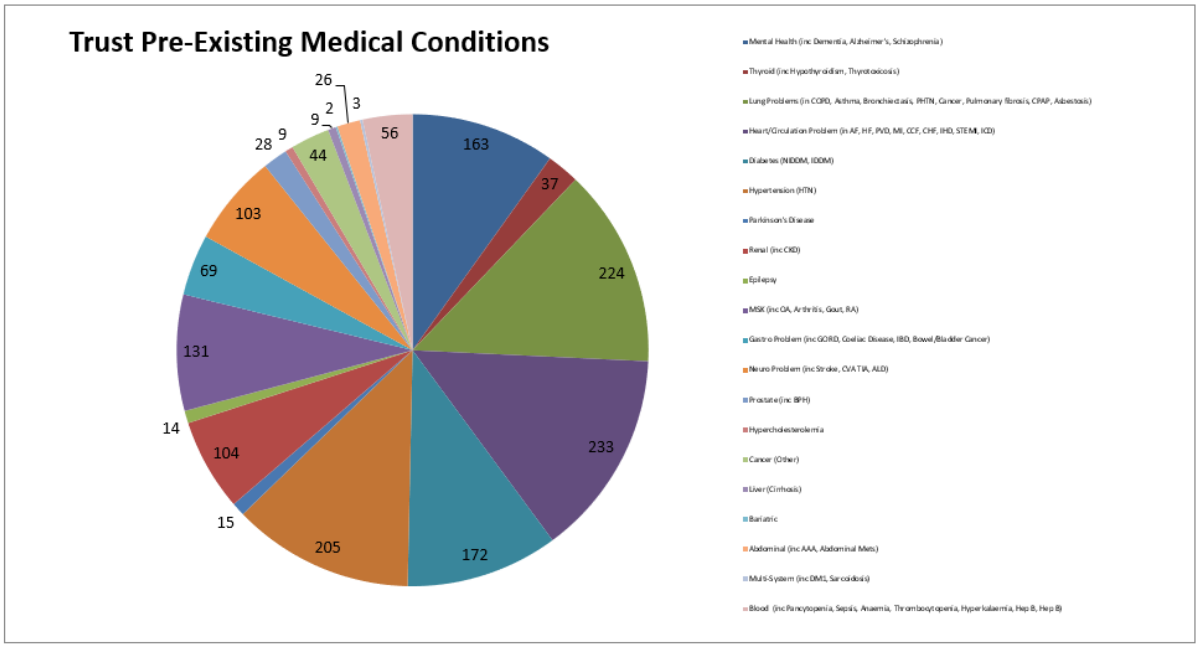


Narrative: As at 25/03/2022, 56% of COVID-19 deaths were male patients and 44% of deaths were female patients.

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

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

2.5.6 In Hospital Deaths - Pre-Existing Medical Conditions



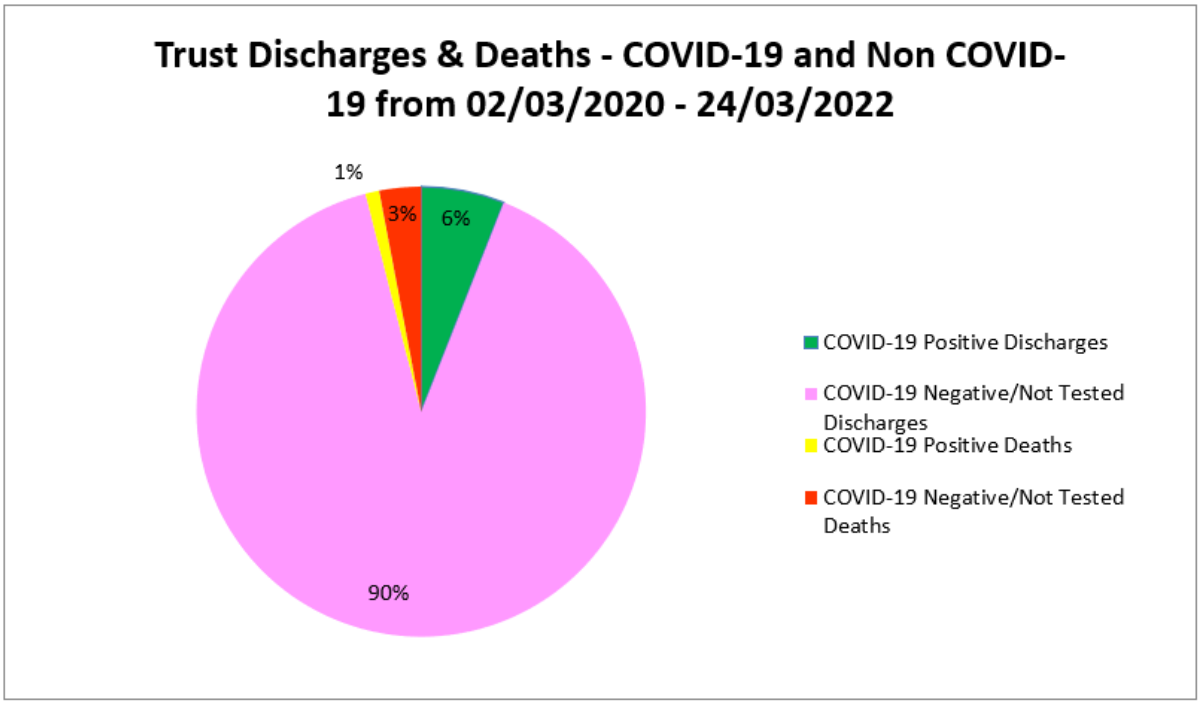
Narrative: As at 25/03/2022, 88% of inpatients who have died with a confirmed COVID-19 positive sample had a pre-existing medical condition recorded. The most common of these were Heart and Lung conditions and Diabetes.

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

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

Source: Trust Data (Warrington & Halton)

2.6 Trust Outcomes

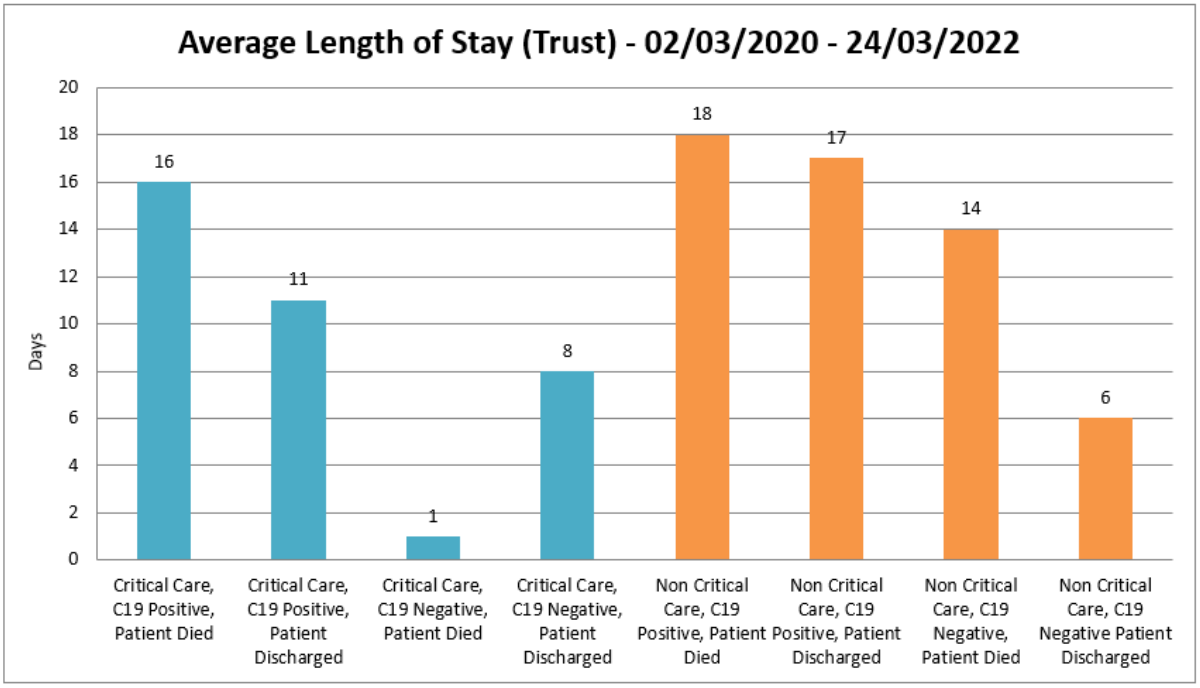


Narrative:

- Between 02/03/2020 – 24/03/2022, the Trust treated 52,231 inpatients (any patient with at least 1-night stay).
- 3,730 (7.14%) inpatients had tested positive for COVID-19.
- 95.95% of all patients were discharged from hospital (COVID-19 and Non COVID-19).
- There was a total of 2,114 inpatients (all causes) who have died; this represents 4.04% of all inpatients.
- 643 inpatient deaths were related to COVID-19 which represented 1.23% of all inpatients and 17.23% of inpatients with COVID-19.
- 129 patients who have died and who had tested positive for COVID-19 were admitted from a care home, 3.45% of all COVID-19 positive inpatients and 20.06% of inpatients who have died with a positive COVID-19 sample.

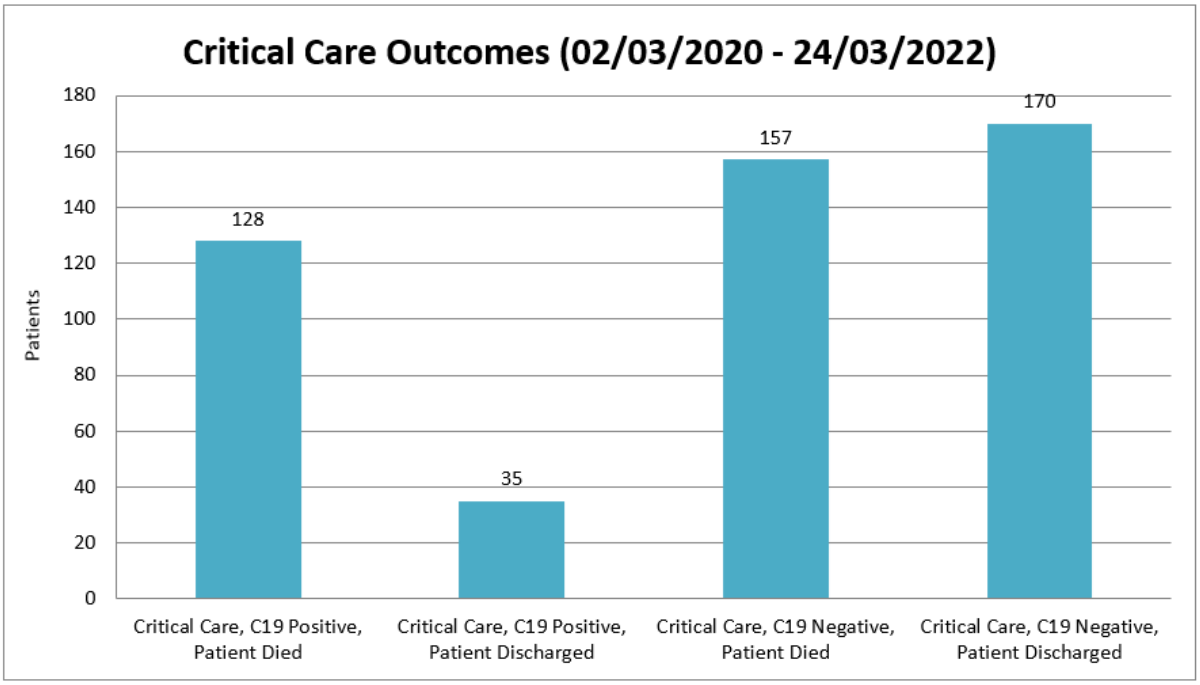
Source: Trust Data

2.6.1 Average Length of Stay



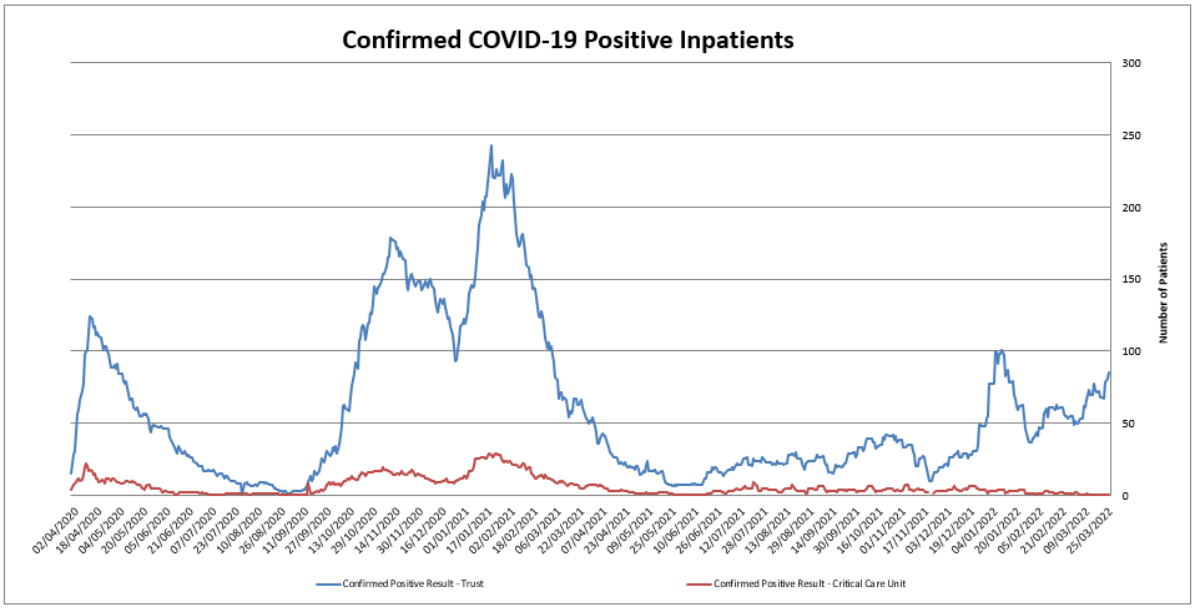
Narrative: From 02/03/2020 – 24/03/2022, the average length of stay for patients who had tested positive for COVID-19 was 15 days in critical care and 17 days in non-critical care.
Source: Trust Data

2.6.2 Critical Care Outcomes



Narrative: From 02/03/2020 – 24/03/2022, there were 285 critical care inpatient deaths (128 COVID-19, 157 non-COVID-19) and 205 critical care inpatient discharges (35 COVID-19, 170 non-COVID-19).
Source: Trust Data

2.7 Confirmed Positive COVID-19 Patients



Narrative: As of 24/03/2022, there were 85 patients who have had a COVID-19 positive test within the last 14 days with 0 patients in critical care.

2.8 Nosocomial Infection

Nosocomial infections are defined as:

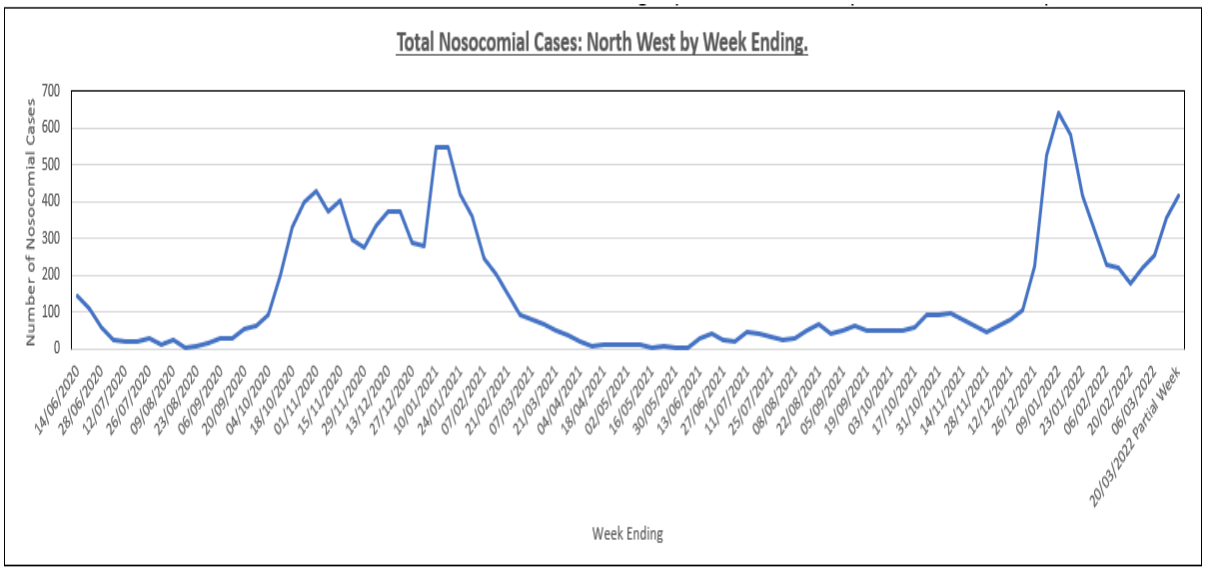
- Length of Stay at the Time of Positive COVID Sample 0-2 Days – Community Acquired
- Length of Stay at the Time of Positive COVID Sample 3-7 Days – Hospital Onset Indeterminable Hospital Associated
- Length of Stay at the Time of Positive COVID Sample 8-14 Days – Hospital Onset Probable Hospital Acquired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

Cheshire & Mersey Benchmarking for Cumulative Nosocomial Infection Rates w/e 20th March 2022

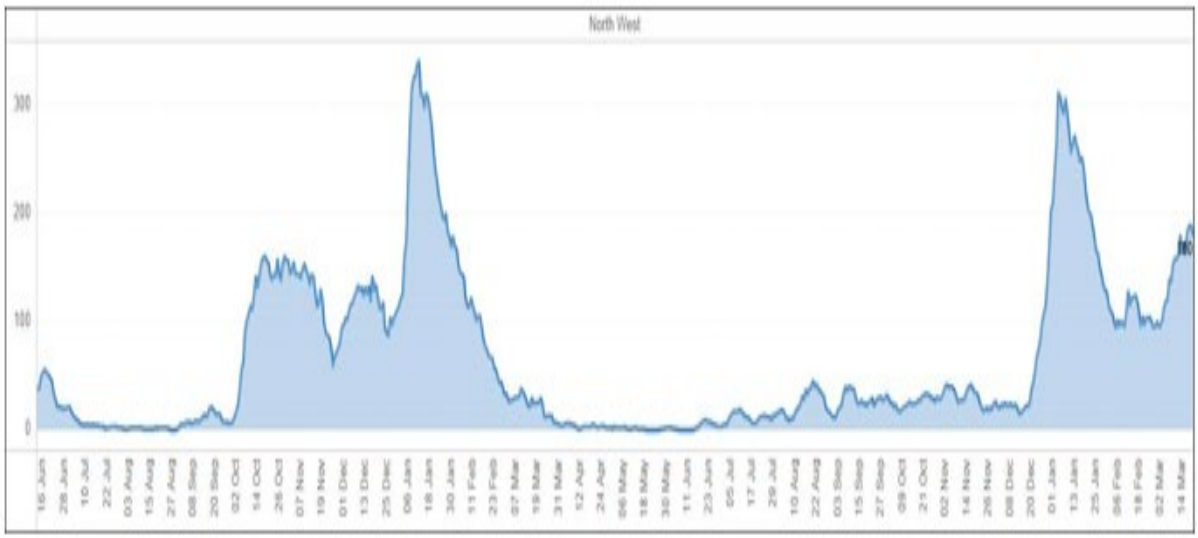
Cumulative Total Since Recording started until latest data available	Sum of Total Nosocomial Cases	Sum of Total Number of COVID-19 Inpatients	Cumulative % Rate
Cheshire And Merseyside STP	**5993**	**37159**	**16.13%**
Countess of Chester Hospitals	615	3189	**19.29%**
Warrington & Halton Hospitals	544	3684	**14.77%**
Liverpool University Hospitals	1562	11315	**13.80%**
Southport And Ormskirk	382	2932	**13.03%**
Mid Cheshire Hospitals	673	3265	**20.61%**
Wirral University Hospitals	481	3660	**13.15%**
East Cheshire Hospital	481	2118	**22.71%**
St Helens And Knowsley Teaching Hospitals	428	4546	**9.41%**

Narrative: The Trust is performing in line with peer Trust and in line with Cheshire & Mersey nosocomial rates of 14.77%.

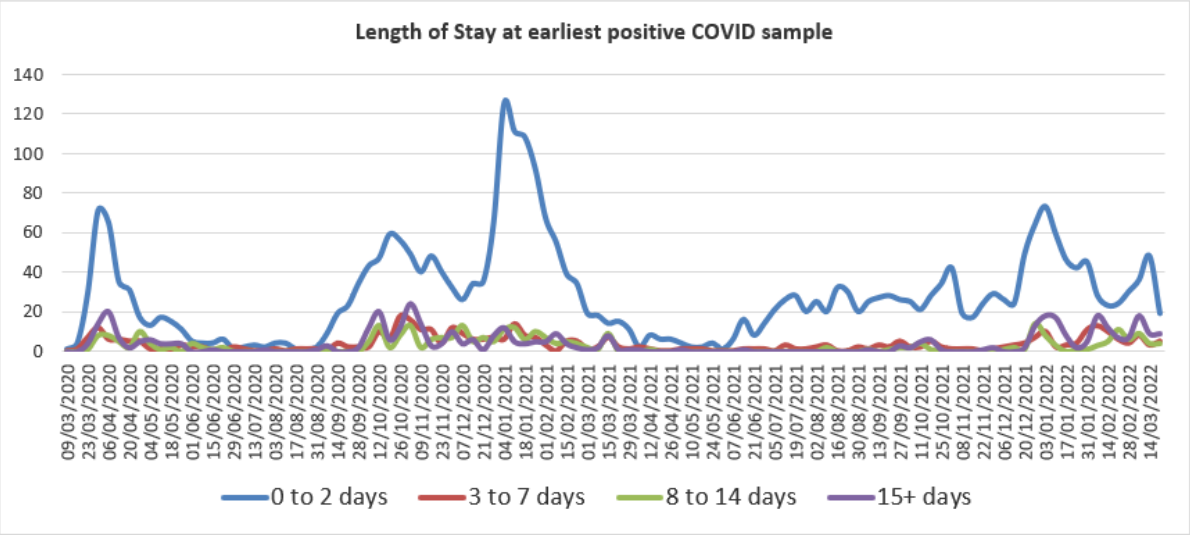
North West

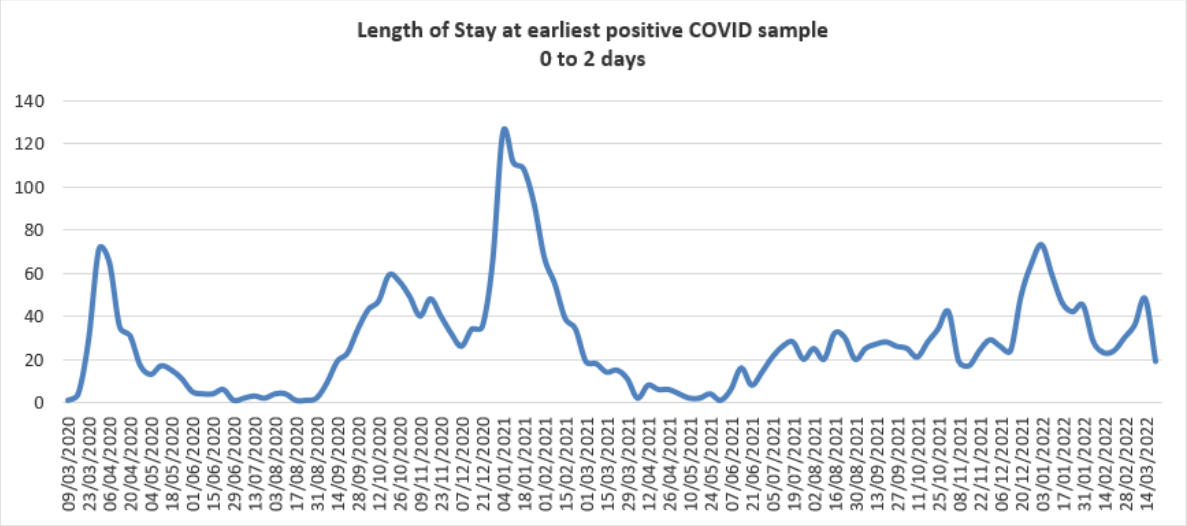


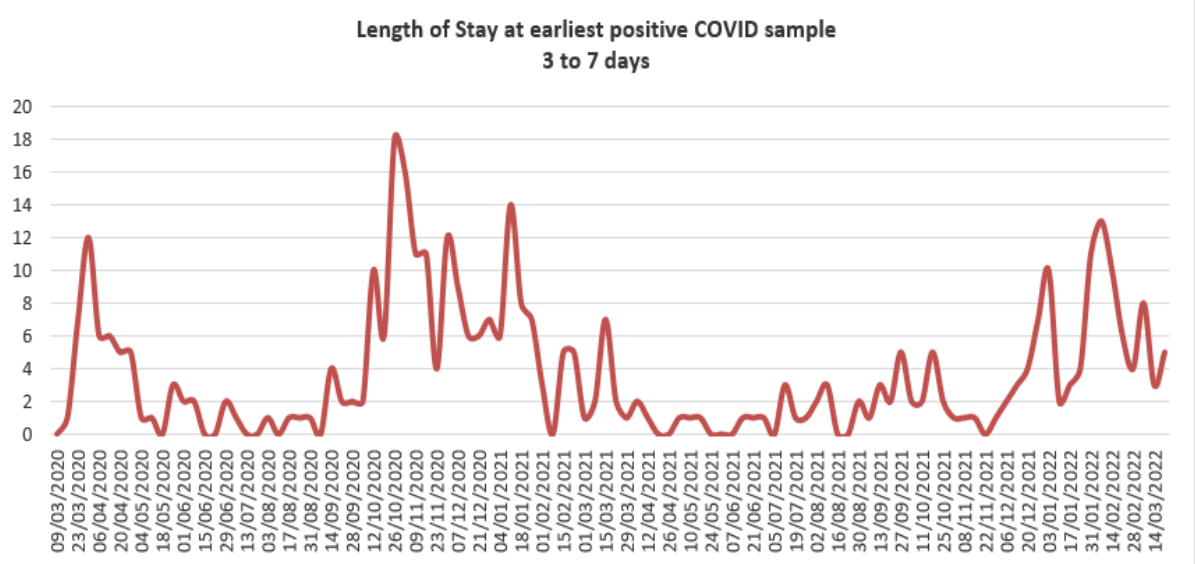
Cheshire & Merseyside

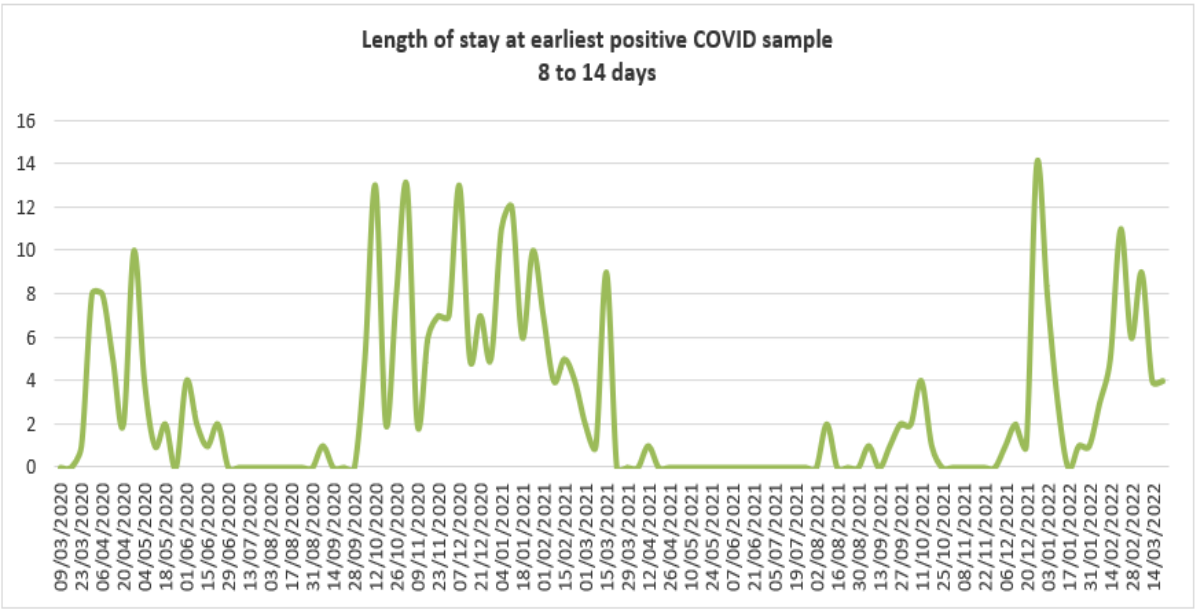


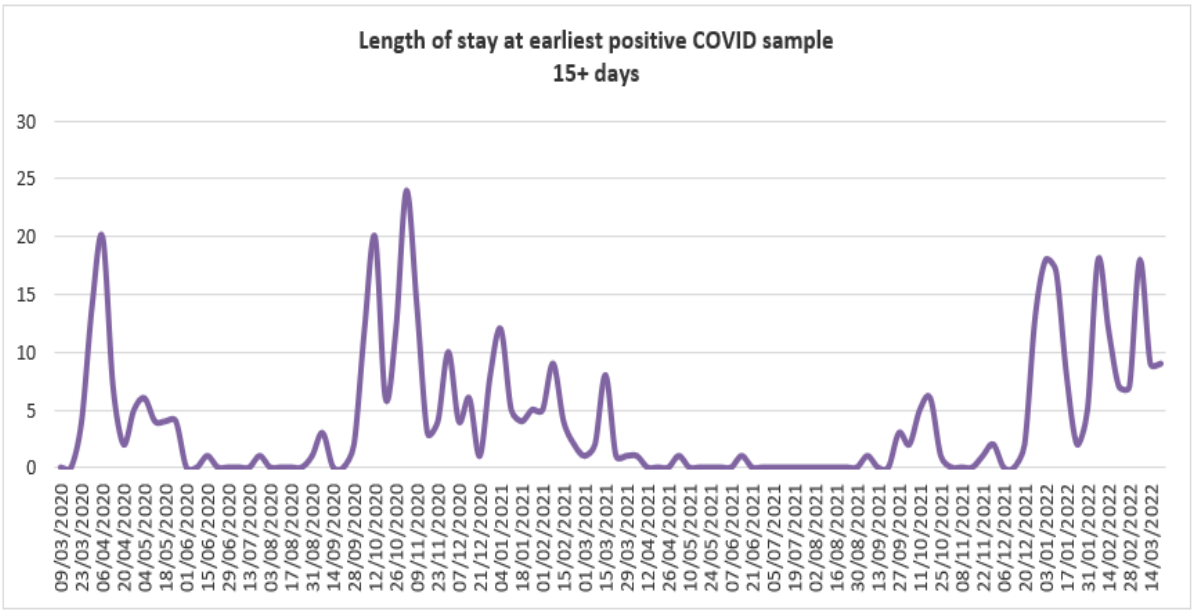
Trust


Length of Stay at earliest positive COVID sample
0 to 2 days
3 to 7 days
8 to 14 days
15+ days


Length of Stay at earliest positive COVID sample
0 to 2 days


Length of Stay at earliest positive COVID sample
3 to 7 days

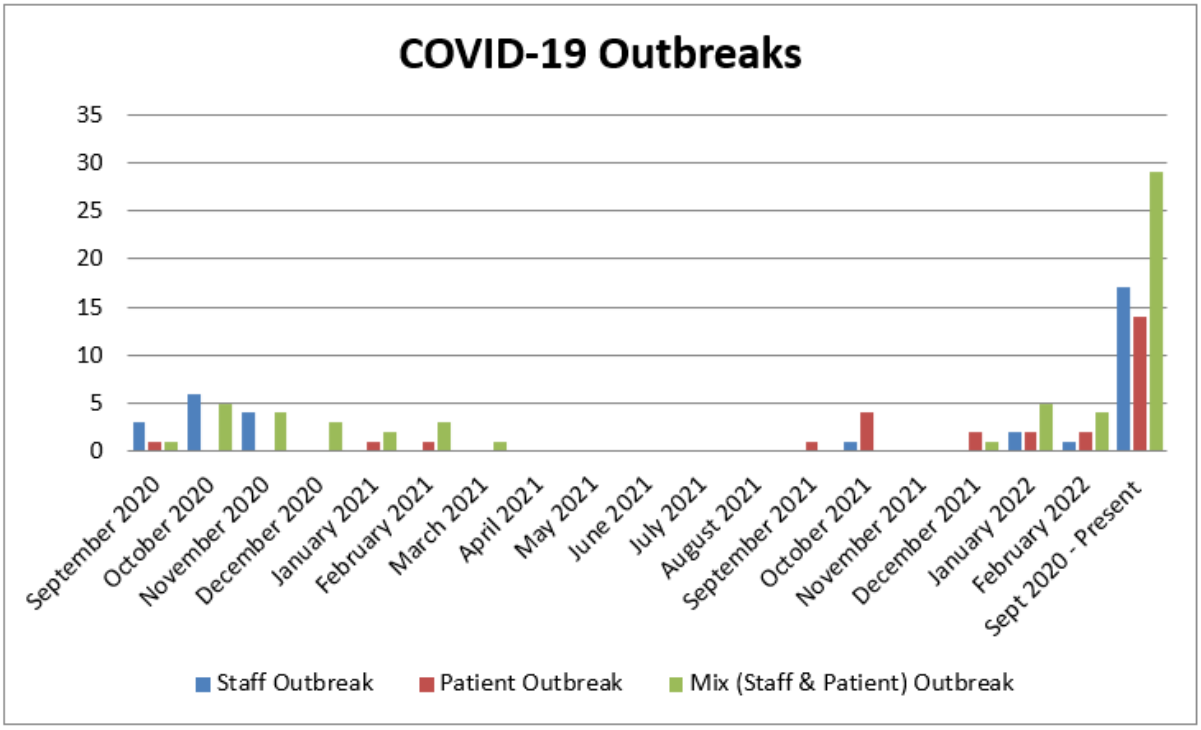




Narrative: The graphs show that the majority of the positive tests come within 2 days of admission or between 3-7 days of admission which suggest these infections were probably picked up in the community and brought into hospital.
Source: Trust Data

2.9 Outbreaks

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



Narrative: In February 2022, there was 1 staff outbreak and 2 patient outbreaks and 4 mixed staff and patient outbreaks at the Trust. As at 24/03/2022, the Trust is managing 4 outbreaks.

Source: Trust Data

3. CONCLUSION

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

4. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/29**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	30th March 2022	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Andrea McGee - Chief Finance Officer and Deputy Chief Executive Dan Moore - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will.. Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#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. **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are assessed as only able to work on a non-respiratory pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	

EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has 78 IPR indicators which have been RAG rated in February as follows: Red: 40 (from 38 in January) Amber: 11 (from 11 in January) Green: 22 (from 24 in January) Not RAG Rated: 5 (from 5 in January) As a result of the COVID-19 pandemic, the Trust has not met the RTT 18 week, RTT 52 week, Diagnostics 6-week, Cancer 2 Week, Breast Symptomatic 2 week, Cancer 28 day faster diagnostic, Cancer 62-day screening or Cancer 62-day urgent standards. A&E and Ambulance Handover performance remains challenging with increased attendances and system pressures. There were 68 patients waiting over 12 hours in A&E in February. Sepsis screening and anti-biotics administration within the one hour timeframe remains a key focus, improvement has been seen in month. A focussed improvement plan is in place with oversight from the Deputy Chief Nurse for Patient Safety and Clinical Education. There was 1 case of MRSA report which was probable community onset associated. CDI cases reported year to date are 44 which is the annual NHSE/I threshold for the Trust. The number of pressure ulcers is above the baseline (based on 2019/20) of 65 with a total of 81 reported year to date. The month 11 position is £0.5m deficit which is in line with plan. The Trust has submitted a breakeven plan for H2 and for the full year. Based on the most recent assessment, the Trust is forecasting achievement of breakeven. This includes recent confirmation that the Trust has secured £1.5m Hospital Discharge Planning funding.			
PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the changes to the Capital Programme approved by Finance and Sustainability Committee as per the agreed delegated authority in December's Extraordinary Board Meeting.			

	2. Approve the proposed amendments to the IPR Dashboard for 2022/23. 3. Note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	SPC, FSC, QAC
	Agenda Ref.	**KPI Annual Refresh & Review** SPC/22/01/05 – Supported FSC/22/02/34 - Supported QAC/22/03/57 - Supported
	Date of meeting	SPC – 19th January 2022 FSC – 16th February 2022 QAC – 1st March 2022
	Summary of Outcome	Supported
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/22/03/29

1. BACKGROUND/CONTEXT

The RAG ratings for all 78 IPR indicators from March 2021 to February 2022 are set out in **Appendix 1.** The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the Trust Board with assurance in relation to the delivery of all Key Performance Indicators (KPIs) across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

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

Table 1: RAG Rating Movement

	January	February
Red	38	40
Amber	11	11
Green	24	22
Not RAG Rated	5	5
Total:	78	78

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

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

Quality

Quality KPIs

There are 9 Quality indicators rated Red in February, an increase from 6 in January.

The 6 indicators rated Red in January, which have remained rated Red in February are as follows:

- Sepsis % Screening for Emergency Patients within 1 hour – the Trust achieved 79.00% in February, an improvement from 58.00% in January, against a target of 90.00%.
- Sepsis % Screening for Inpatients – the Trust achieved 80.00% in February, an improvement from 64.00% in January, against a target of 90.00%.

- Sepsis % Emergency Patients Administered Antibiotics Within 1 Hour – the Trust achieved 73.00% in February, an improvement from 55.00% in January, against a target of 90.00%.
- Sepsis % Inpatients Administered Antibiotics Within 1 Hour – the Trust achieved 80.00% in February, a deterioration from 86.00% in January, against a target of 90.00%.
- Pressure Ulcers – there were 13 pressure ulcers recorded in February (12 Cat 2, 1 Cat 3), a deterioration from 5 recorded in January. Year to Date the number of pressure ulcers recorded is 81, against a target of a 10% reduction based on 65 pressure ulcers in 2019/20.
- Friends and Family Test (ED) – the Trust achieved 73.00% in February, a deterioration from 75.00% in January, against a target of 87.00%.

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

- Healthcare Acquired Infections (MRSA) – there was 1 case of MRSA reported in February, a deterioration from 0 cases in January, against a target of 0. This case was probable community onset.
- Healthcare Acquired Infections (CDI) – there were 8 cases of CDI reported in February, a deterioration from 5 cases in January. This brings the total Year to Date cases of CDI to 44 which is the Trusts NHSE/I threshold (44) for 2021/22.
- Healthcare Acquired Infections (Gram Negative) – there were 4 cases of Klebsiella reported in February, an improvement from 5 cases in January. This bring the total Year to Date cases of Klebsiella to 25 which exceeds the Trust's NHSE/I threshold (23 cases) for 2021/22.

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

- NICE Compliance – the Trust achieved 92.55% in February, an improvement from 88.21% in January, against a target of 90.00%.

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

- Inpatient Falls – the Trust recorded 56 inpatient falls in February, an improvement from 58 inpatient falls in January. However, the Trust has recorded 530 inpatient falls Year to Date which is above the 20% reduction target based on 612 falls in 2019/20.
- Care Hours Per Patient Day (CHPPD) – the Trust achieved 7.2 CHPPD in February, a deterioration from 7.9 CHPPD in January against a target of 7.9.

Access and Performance

Access and Performance KPIs

There are 19 Access and Performance indicators rated Red in February, a decrease from 21 in January. 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 18 indicators which were rated Red in January and remain rated Red in February are as follows:

- Diagnostic 6 Week Target – the Trust achieved 78.37% in February, an improvement from 72.05% in January, against a target of 99.00%.
- Referral to Treatment Open Pathways – the Trust achieved 66.97% in February, an improvement from 66.57% in January, against a target of 92.00%.
- Referral to Treatment 52+ Week Waiting – there were 1,038 patients waiting over 52 weeks in February, an improvement from 1,133 patients in January, against a target of 0. RTT and Diagnostic performance is as a result of the reduction in the elective programme, suspension of services and the associated backlog during the initial phases of the pandemic. The Trust has robust recovery plans in place with clinical prioritisation.
- A&E Waiting Times 4-hour National Target – the Trust achieved 67.61% (excluding Widnes Walk ins) in February, a deterioration from January's position of 69.72%, against a target of 95.00%.
- A&E Waiting Time Trajectory – the Trust did not achieve the trajectory of 85.00% in month.
- A&E 12 Hour Breaches – the Trust recorded 68 12 hour breaches in February, a deterioration from 57 breaches in January, against a target of 0.
- Cancer 14 Days - the Trust achieved 68.57% in January, an improvement from 67.61% in December, against a target of 93.00%.
- Cancer Breast Symptoms - the Trust achieved 51.85% in January, an improvement from 19.67% in December, against a target of 93.00%.
- Cancer 28 Day Faster Diagnostic Standard – the Trust achieved 61.01% in January, a deterioration from 71.37% in December, against a target of 75.00%.
- Cancer 62 Days Urgent - the Trust achieved 74.07% in January, an improvement from 72.34% in December, against a target of 85.00%.
- Ambulance Handovers 30 – 60 minutes – there were 95 patients who experienced a delayed handover in February, a deterioration from 74 patients in January against a target of 0.
- Ambulance Handovers 60 minutes plus - there were 52 patients who experienced a delayed handover in February, a deterioration from 26 patients in January against a target of 0.
- Discharge Summaries sent within 24 hours – the Trust achieved 80.87% in February, a deterioration from 83.88% in January, against a target of 95.00%.
- Discharge Summaries NOT sent within 7 days (to achieve the 95.00% standard) – there were 378 discharge summaries not sent within 7 days to achieve the 95.00% standard in February, a deterioration from 285 discharge summaries not sent in January.
- Super Stranded Patients – there were 134 super stranded patients at the end of February, an improvement from 162 patients at the end of January, against a trajectory of 69 patients.
- Outpatient Appointments Deliver Remotely - the Trust achieved 12.95% in February, a deterioration from 13.14% in January, against a target of 25.00%.
- Fracture Clinic 72 Hours - the Trust achieved 42.04% in February, an improvement from 34.84% in January, against a target of 95.00%.

- COVID-19 Recovery (Inpatient & Daycase) – the Trust achieved 78.50% of inpatient procedures and 95.06% of daycase procedures in February 2021/22 in comparison with activity in the same period in 2019/20, against a target of 95.00%.

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

- Cancelled Operation for non-clinical reasons (not rebooked within 28 days) – there were 0 cancelled operations in February, an improvement from 5 in January, against a target of 0.
- COVID-19 Recovery (Diagnostics) – the average performance across all diagnostic modalities was 109.44% in February 2021/22 in comparison with activity in the same period in 2019/20, against a target of 95.00%.
- COVID-19 Recovery (Outpatients) – the Trust achieved 95.12% of Outpatient Activity in February 2021/22 in comparison with activity in the same period in 2019/20, against a target of 95.00%.

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

- Cancer 62 Days Screening - the Trust achieved 80.00% in January, a deterioration from 100% in December, against a target of 90.00%.

PEOPLE

Workforce KPIs

There are 9 Workforce indicators rated Red in February, an increase from 8 in January.

The 8 indicators which were rated Red in January and remain rated Red in February are as follows:

- Sickness Absence – the Trust's sickness absence was 6.18% in February, an improvement from 8.42% in January, against a target of less than 4.20%.
- Return to Work Compliance – interview compliance was 59.04% in February, a deterioration from 67.41% in January, against a target of 85.00%.
- Turnover – the Trust's turnover was 15.81% in February, a deterioration from 15.72% in January, against a target of less than 13.00%.
- Monthly Pay Spend – monthly pay spend was £274k above budget in February.
- Bank/Agency Reliance – the Trust's reliance was 13.95% in February, an improvement from 16.66% in January, against a target of less than 9.00%.
- Agency Rate Card Compliance – 30.21% of agency shifts were compliant with the rate card in February, a deterioration from 30.34% in January, against a target of 60.00%.
- Agency Shifts Compliant with the Cap – 16.39% of agency shifts were compliant with the cap in February, a deterioration from 17.31% in January, against a target of 49.00%.
- PDR Compliance – PDR compliance was 63.91% in February, a deterioration from 65.17% in January, against a trajectory of 79.00%.

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

- Safeguarding Training – training compliance was 68.00% in February, the same as January against a trajectory (for February) of 71.00%.

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

- Use of the Apprenticeship Levy – the Trust utlised 103.00% of the levy in February, an improvement from 67.00% of the levy in January, against a target of 85.00%.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 3 Finance & Sustainability indicators rated Red in February as follows:

- Capital Programme – the actual spend year to date is £8.6m which is £5.4m below the planned spend of £14.0m.
- Agency Spending – the year to date spend of £11.0m is £3.0m above the plan of £8.0m.
- Cost savings schemes (recurrent) - compared to plan, the recurrent forecast is £1.5m against a plan of £4.9m.

The Income and Activity Statement for Month 11 is attached in **Appendix 5**.

The 2022/23 operational planning has been submitted as draft with a £19.2m deficit, further work is required before final submission in April 2022.

Table 2 details the estimated RTT performance against target for February 2022.

Table 2: Estimated RTT performance against activity for February 2022

Activity	Target	Actual
Non admitted RTT	89%	107%
Admitted RTT	89%	97%
Total	**89%**	**102%**

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

Cash

At month 11 there is a cash balance of £49.9m this relates to:

- Additional income received of £20.6m year to date for COVID-19 top up.
- SLA income received in advance of £2.7m.
- Additional income received in the sum of £2.3m year to date for the recovery of VAT.
- A shortfall in the payment of capital creditors of £9.7m due to the delay to the start of schemes.

- Additional PDC allocation of £2.3m.

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

The forecast cash balance as at 31 March 2022 is £33.7m and is made up of £5.9m working capital cash, £13.0m EPCMS (as above), £4.2m annual leave accrual and £10.6m capital creditors.

Capital Programme

The Capital Programme of £19.6m for 2021/22 was approved at the start of the year. There have been several increases for PDC schemes in H2 (£2.3m) along with a reduction of £2.8m for ED Plaza which has been offered as brokerage in 2022/23. The revised Capital Programme as at month 11 is £19.1m. **Table 3** provides a high-level summary of capital expenditure as at 28 February 2022. There is an underspend of £5.4m year to date. In March, there is £10.5m capital expenditure to be incurred.

Table 3: Capital Expenditure as at 28 February 2022

Capital	Annual Plan	Revised Plan to Date	Expenditure to Date	Variance: Against Rev. Plan	RAG: Variance Against Rev. Plan
	£000	£000	£000	£000	
Trust Funded	18,770	12,712	8,073	4,638	36%
PDC Funded:					
Cardiac Catheterisation Suite	650	650	24	626	96%
Ultrasound	105	105	0	105	100%
MRI Patient Monitor	45	45	45	0	0%
Total Approved Capital Programme as per NHSI Return	**19,570**	**13,512**	**8,143**	**5,369**	
Patient Flow (Tif)	260	130	4	126	97%
Network Switches	249	124	8	116	93%
Clinical Treatment Room (Halton) Upgrade	143	71	111	-40	-56%
NW Imaging Academy Radiology	37	18	1	17	93%
Digital Maternity	306	0	6	-6	-2%
Devices Refresh Agile Working	250	0	195	-195	-78%
Diagnostics Digital Capability (received month 11)	248	0	0	0	0%
Diagnostics Digital Capability (received month 11)	839	0	0	0	0%
PDC Funded: Sub Total	**2,332**	**343**	**325**	**18**	
ED Plaza	-2,859				
Equipment Donated by DHSC	100	100	100	0	0%
Total Forecast per NHSI return	**19,143**	**13,955**	**8,568**	**5,387**	

Variance to plan RAG %'s: Red >10%, Amber 5-10%, Green <5%

Table 4 provides a high-level summary by category.

Table 4: Capital Expenditure by category as at 28 February 2022

Capital	Forecast Plan	Revised Plan to Date	Expenditure to Date	Variance: Against Rev. Plan	RAG: Variance Against Rev. Plan
	£000	£000	£000	£000	
Estates	12,426	10,402	6,530	3,871	37%
IM&T	4,109	2,037	1,560	477	23%
Medical Equipment	3,144	1,516	734	782	52%
Contingency	-536	0	0	0	
VAT refunds prior year	0	0	-256	256	
Total Forecast per NHSI return	**19,143**	**13,955**	**8,568**	**5,387**	

Variance to plan RAG %'s: Red >10%, Amber 5-10%, Green <5%

Estates and medical equipment schemes have returned small underspends to the contingency (£35k and £123k). This has been mitigated with £109k emergency requests and a scheme of £51k for a renal pump and plumbing which was approved by the FSC on 21 March 2022. The main underspend on medical equipment is the Cardiac Catheterisation Suite which is on track for 31 March 2022. The underspends in estates are all being managed through the ED Brokerage and brought forward 2022/23 schemes. No further deterioration has been highlighted for the estates schemes.

IM&T has received significant funds late in the financial year. Weekly meetings have been taking place to manage the procurement.

Table 5 shows the balance of contingency as at month 11 (£0.035m) and the approved capital changes which bring the total to £0.026m. The delivery of the capital schemes, in particular the risks regarding supplier delivery will be monitored closely to ensure further slippage is mitigated. An additional scheme for virtual fracture clinic software (£70k) has been put forward and this which will only be procured if further slippage occurs. The software will reduce the need for additional nurses and therefore reduce future recovery cost pressures.

Table 5: Balance of contingency fund as at 21 March 2022 including approved changes.

Detail	£000s	£000s
Contingency Balance start of month 10		**35**
Return to Contingency		
Slippage		
Urology Equipment	10	
Neonatal Scanner B/f 22/23	86	
Obstetric Portable Ultrasound B/f 22/23	27	
Sub total		**123**
Underspends		
Fire - Halton 30 minute Fire Compartmentation (Phase 2)	18	
Backlog - HV (High Voltage) Maintenance annual	17	
Sub total		**35**
Revised Contingency Balance as at month 10 following return to contingency and underspends		**193**
Changes approved by Chief Finance Officer/Deputy Chief Executive		
Emergency Requests		
Tissue Processor	-37	
Ultrasound Scanners x 2	-43	
Emergency Intercoms	-8	
Hamilton Ventilator 65595	-21	
Sub total		**-109**
Changes Approved by the Finance & Sustainability Committee on 21 March 2022		
Renal pump and plumbing	-51	
Increase in dental chair costs	-7	
Sub total		**-58**
Contingency as at 21 March 2022		**26**
Emergency Requests - items not due for delivery until 2022/23*		
Nurse Call Bell Minor Injuries	25	
Ventilator Test Equipment	21	
Bladder Scanners x 2	21	
Sub total		67

*These items were brought forward from 2022/23 to mitigate the 2021/22 underspend, however the supplier is unable to deliver the items before 31 March 2022 and therefore these have been added back to the contingency.

Appendix 6 contains the updated Capital Programme.

The Trust Board is asked to:

- **Note the changes to the Capital Programme approved by Finance and Sustainability Committee as per the agreed delegated authority in December's Extraordinary Board Meeting.**

3. KEY PERFORMANCE INDICATOR ANNUAL REVIEW

2022/23 Key Performance Indicator Review

The Contracts & Performance Team has met with Executive and Operational leads to review current indicators and to ascertain requirements for new indicators. In addition, the 2022/23 draft NHS Standard Contract and NHSE/I System Oversight Framework have been reviewed to understand changes which may affect performance monitoring. The recommendations outlined have been supported by the relevant committees and are show in **Tables 6, 7 & 8.**

Table 6: Indicators to be Removed

KPI	Rationale
Quality	
There are no Quality indicators recommended for removal at this time.	
Access & Performance	
There are no Access & Performance indicators recommended for removal at this time.	
Workforce	
Cheshire & Mersey Rate Card Compliance	Performance is being measured against the rate card which is 4 years old and has not been uplifted to include the pay awards. The rates were also introduced prior to COVID-19 and the requirement for temporary staff is now greater due to additional sickness and shielding Whilst every effort is made to obtain the lowest possible rates, it is impossible to get this down to the rate card or cap. However, the Trust is paying fair and reasonable market rates and a detailed pay assurance report is provided to the Finance & Sustainability Committee (FSC).
Agency Shifts Compliant with the Cap	
Finance	
System Position	This indicator was originally created prior to the COVID-19 pandemic. With the introduction of Integrated Care Systems and Boards this is less relevant as a standalone indicator. As the ICS/ICBs develop, it may be appropriate to include an indicator in the future which outlines the system position.
CIP Forecast	To simplify the CIP indicators, it is proposed the CIP forecast will be removed. This will leave CIP in year delivered against target and CIP recurrent CIP delivered against target.
Agency Spending	There is no agency ceiling to report against. Agency spending is reported at Finance & Sustainability Committee via a detailed Pay Spend Report. Any issues will be escalated to the Trust Board via the Committee Chairs report.

Table 7: Indicators to be Updated

KPI	Proposed Change	Rationale
Quality		
Incidents	Removal of the "20 days" criteria on the RAG rating. The graph will still show the number of open incidents between 20-40 days.	Standard incident reporting will include incidents open between 20-40 days as some incidents relating to safeguarding, pressure ulcers and those requiring external input will always require appropriate time to consider the complexities of the cases.

Sepsis Indicators	Include a new "Amber" section on the RAG rating as follows: Green: 90% or above Amber: 75%-89% Red: Below 75%	This provides early warning of deterioration and shows that indicators are improving. This is in line with other Quality metrics on the IPR.
Inpatient Falls	To provide an additional graph which shows the number of falls with harm and where falls were avoidable (Serious Incident Completed).	The Trust continues to work to reduce the number of falls, some falls with harm do occur, this additional graph will provide context as to falls which were avoidable/unavoidable
	Baseline to be reset based on 2021/22 (currently the baseline is at 2019/20 due to the COVID-19 pandemic)	The baseline was not reset to 2020/21.
Healthcare Acquired Infections (CDI, E. coli, MRSA)	The RAG rating for these indicators will be updated in line with the national publication of thresholds for HCAIs for each Trust.	To ensure the Trust is performing in line with its agreed national trajectory.
Pressure Ulcers	Inclusion of an additional graph to show community acquired pressure ulcers.	This will provide context and assurance around the quantity of community developed pressure ulcers.
	Baseline to be set based on 2021/22 (currently the baseline is at 2019/20 due to the COVID-19 pandemic)	The baseline was not reset to 2020/21.
Care Hours Per Patient Day/Staffing Average Fill Rates	To provide local/national data where available. Please note that this data maybe several months behind due to publishing timescales.	To provide context and assurance as to the Trusts performance in relation to staffing average fill rates and CHPPD against Trusts locally and nationally.
Complaints	Inclusion of an additional graph which outlines PALS specific concerns received and closed.	To provide additional assurance around PALS concerns.
Friends & Family Test – Inpatient/Daycase and ED	Inclusion of additional detail on the graphs which shows Cheshire & Mersey average performance and the National average performance. Please note that this data maybe several months behind due to publishing timescales.	To provide context and assurance, monitoring performance against Trusts both locally and nationally.
Access & Performance		
RTT 52 Weeks	This indicator will be updated to reflect the new contractual target of no patients waiting over 104 weeks. The 52 week waiters will still be included on the graph for assurance.	Update to the NHS Standard Contract Quality Requirements.
A&E 12 hour wait	This indicator will be updated to reflect the new contractual standard of 98% of patients waiting under 12 hours in ED from arrival to admission, transfer or discharge*. Currently the measure is zero patients should be waiting in the department for more than 12 hours from the decision to admit. *Please note the final NHSE contract has been updated to change this requirement from decision – admission to arrival to admission, transfer or discharge.	Update to the NHS Standard Contract Quality Requirements.

Ambulance Handovers 30 minutes	This indicator to be updated to 95% of patients handed over within 30 minutes. Currently there is a zero tolerance for patients waiting over 30 minutes. Green: 95% or above patients waiting under 30 minutes to be handed over. Red: less than 95% of waiting under 30 minutes to be handed over.	Update to the NHS Standard Contract Quality Requirements.
Ambulance Handover 60 minutes	This indicator to be updated to 100% of patients to be handed over within 60 minutes. This is the current standard, however the indicator has moved to a % of patients rather than a number. Green: 100% of patients to be handed over within 60 minutes. Red: Less than 100% of patients to be handed over within 60 minutes.	Update to the NHS Standard Contract Quality Requirements.
COVID-19 Recovery (Inpatient, Daycase & Outpatient) COVID-19 Recovery (Diagnostics)	Additional graphs to show activity levels in numbers.	NHSE/I System Oversight Framework Metrics.
Workforce		
Sickness absence (calendar days lost to sickness)	To include on the current sickness % indicator, the number of calendar days lost to sickness absence each month.	NHSE Oversight Framework Indicator.
Apprenticeship Levy and % of Workforce Carrying Out a Qualification	Merging of the two indicators. The new indicator will show % of workforce carrying out a qualification and include level of qualification. In addition, a new graph will show funding being spent and any funding that has to be returned to NHSE/I (not used within a 2 year period).	It is proposed that these two indicators are merged as there is duplication in assurance being provided. When the apprentice levy was first introduced, the availability of qualifications was at a lower level (Levels 2 & 3). However, this has evolved, and the levels of qualification are now higher up to Level 7.
Core/Mandatory Training Role Based Training PDR Compliance	All indicators to return to 85% green RAG threshold after temporary amendment to the IPR in 2021/22 to include an improvement trajectory.	Performance has improved in line with the trajectories set, this was a temporary amendment for 2021/22.

Finance
UORR The Use of Resources Ratings (Finance) Indicator is made up of several indicators which are capital services capacity, I&E margin, Liquidity, Agency Spend (Cap) and Distance from Financial Plan. The new System Oversight Framework indicates this will change to include Performance Against Financial Plan, Underlying Financial Position, Run Rate Expenditure and Overall Trend. However, the technical specification has not yet been updated detailing how these metrics are measured. Once this is available, a proposal will be presented to the FSC for support and to the Trust Board for approval.

Table 8: New Indicators

KPI	RAG Criteria	Rationale
Quality		
Acute Kidney Injury	Number of hospital acquired Acute Kidney Injuries (AKI) in month. **RAG Rating:** Green: Less than previous month Red: Greater than previous month Additional detail will be included on the graph around the length of stay for patients with an AKI.	Early diagnosis and treatment of Acute Kidney Injury improves patient outcomes and reduces the length of stay required in hospital.
National Patient Safety Alerts not completed by deadline	Number of CAS alerts with actions not completed by the deadline. **RAG Rating:** Green: 0 Red: 1 or more	NHSE/I System Oversight Framework Metric.
Access & Performance*		
Advice & Guidance (A&G) Activity Levels – numbers of Advice & Guidance Contacts	To include on the IPR for information but will not be RAG rated. Whilst the method of measurement is not available, the Trust can measure the A&G activity levels, and this is important to understand as it is likely to keep patients out of hospital and avoid unnecessary outpatient appointments. This indicator will be reviewed in 6 months or when NHSE/I system oversight framework guidance is updated.	NHSE/I System Oversight Framework Metric. The Trust is awaiting technical guidance from NHSE/I on how these indicators are measured. This may result in this indicator being updated in year.
Patient Initiated Follow Up (PIFU) Activity Levels – number of patients initiated follow ups.	To include on the IPR for information but will not be RAG rated. The Trust is awaiting technical guidance from NHSE/I on how these indicators are measured. Whilst the method of measurement is not available, the Trust can measure the PIFU uptake as this will avoid unnecessary outpatients' appointments and DNAs. This indicator will be reviewed in 6 months or when NHSE/I system oversight framework guidance is updated.	NHSE/I System Oversight Framework Metric. The Trust is awaiting technical guidance from NHSE/I on how these indicators are measured. This may result in this indicator being updated in year.

% of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions	To include on the IPR for information but will not be RAG rated. The Trust is awaiting technical guidance from NHSE/I on how these indicators are measured. This indicator will be reviewed in 6 months or when NHSE/I system oversight framework guidance is updated.	NHSE/I System Oversight Framework Metric. The Trust is awaiting technical guidance from NHSE/I on how these indicators are measured. This may result in this indicator being updated in year.
Average time in department ED	To include on the IPR for information but will not be RAG rated. Whilst guidance or targets have been not been published as part of the NHSE Standard Contract, operationally the time a patient spends in the ED department on average is a good indicator of how efficient the department is performing. There have been discussions nationally around this being a future standard.	This indicator is proposed as a measure of how long on average patients are waiting and will provide assurance on how long a patient spends in ED from presentation to admission/discharge.
Ambulance Handovers 15 minutes	Green: 65% or greater patients waiting under 15 minutes to be handed over. Red: less than 65% of patients waiting under 15 minutes to handed over.	Update to the NHS Standard Contract Quality Requirements.
Workforce		
There are no new workforce indicators recommended at this time.		
Finance		
There are no new Finance & Sustainability indicators recommended at this time.		

*Further indicators will need be included in the Access & Performance section of the IPR once guidance is available as to how performance will be measured. Whilst this paper has included other NHSE/I Oversight Framework metrics that do not have the technical guidance, the Trust doesn't have any way of knowing what the following indicators are measuring:

- UEC Performance Measure
- Ethnicity and most deprived quintile proportions across service restoration and NHS Long Term Plan metrics.
- Proportions of patient activities with an ethnicity code

The proposed changes will result in the increase of the KPIs from 78 to 79 as follows:

	2021/22	2022/23
Quality	25	27
Access & Performance	27	32
Workforce	16	13
Finance	10	7
Total	**78**	**79**

The Trust Board is asked:

- **To approve the proposed amendments to the IPR Dashboard for 2022/23.**

If approved by the Trust Board, these changes will be implemented from May's Board report (April's data).

4. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

5. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

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

6. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the changes to the Capital Programme approved by Finance and Sustainability Committee as per the agreed delegated authority in December's Extraordinary Board Meeting.
2. Approve the proposed amendments to the IPR Dashboard for 2022/23.
3. 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 March 2021 – February 2022

KPI	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22
QUALITY												
Incidents (over 40 days old)	↑	↔	↔	↔	↔	↓	↑	↔	↔	↔	↔	↔
Duty of Candour	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Healthcare Acquired Infections - MSRA	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↓
Healthcare Acquired Infections – Cdiff	↓	↔	↓	↑	↓	↑	↓	↕	↓	↓	↓	↓
Healthcare Acquired Infections – Gram Neg	↓	↓	↑	↓	↑	↓	↑	↕	↓	↓	↓	↑
Healthcare Acquired Infections – COVID-19 Hospital Onset & Outbreaks												
VTE Assessment	↑	↑	↑	↑	↑	↑	↑	↑	↓	↓		
Total Inpatient Falls & Harm Levels	↓	↑	↓	↑	↓	↑	↑	↑	↓	↓	↓	↑
Pressure Ulcers	↓	↑	↔	↓	↓	↑	↓	↑	↑	↓	↑	↓
Medication Safety (24 Hours)	↑	↓	↑	↑	↓	↓	↓	↓	↑	↓	↑	↓
Staffing – Average Fill Rate	↓	↑	↑	↑	↓	↓	↑	↓	↓	↓	↓	↓
Staffing – Care Hours Per Patient Day	↑	↓	↑	↓	↓	↑	↑	↓	↓	↑	↑	↓
Mortality ratio - HSMR												
Mortality ratio - SHMI												
NICE Compliance	↓	↑	↑	↑	↑	↓	↑	↓	↓	↓	↓	↑
Complaints	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Friends & Family – Inpatients & Day cases	↔	↑	↔	↓	↔	↔	↔	↓	↑	↓	↑	↔
Friends & Family – ED and UCC	↓	↓	↓	↔	↓	↓	↑	↓	↑	↑	↔	↓
Mixed Sex Accommodation Breaches (Non ITU Breaches Only)			↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Continuity of Carer	↑	↓	↑	↓	↑	↓	↓	↑	↓	↑	↓	↓
Sepsis - % screening for all emergency within 1 hour.			↑	↓	↑	↑	↓	↑	↑	↓	↓	↑
Sepsis - % screening for all inpatients within 1 hour.			↑	↓	↓	↓	↑	↕	↓	↕	↔	↑
Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis.			↓	↓	↑	↑	↑	↕	↑	↕	↓	↑
Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis.			↓	↓	↑	↓	↑	↓	↑	↓	↑	↓
Ward Moves between 10:00pm and 06:00am												

Key

Improvement in Performance	
Deterioration in Performance	
Static Performance	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating March 2021 – February 2022

KPI	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22
ACCESS & PERFORMANCE												
Diagnostic Waiting Times 6 Weeks	↑	↓	↑	↑	↑	↓	↑	↓	↑	↓	↓	↑
RTT - Open Pathways	↑	↓	↑	↑	↓	↑	↓	↓	↑	↓	↓	↑
RTT – Number of Patients Waiting 52+ Weeks	↓	↑	↑	↑	↑	↑	↓	↓	↑	↑	↓	↑
A&E Waiting Times – National Target	↑	↓	↑	↑	↓	↑	↑	↓	↓	↓	↑	↓
A&E Waiting Times – STP Trajectory	↑	↓	↑	↓	↓	↑	↑	↓	↓	↓	↑	↓
A&E Waiting Times – Over 12 Hours	↓	↑	↔	↔	↔	↓	↔	↓	↓	↓	↓	↓
Cancer 14 Days*	↑	↑	↓	↑	↓	↓	↓	↑	↓	↓	↓	↑
Breast Symptoms 14 Days*	↑	↑	↓	↓	↓	↑	↑	↓	↓	↓	↓	↑
Cancer 28 Day Faster Diagnostic*	↑	↓	↓	↑	↓	↓	↑	↑	↑	↓	↓	↓
Cancer 31 Days First Treatment*	↑	↑	↓	↑	↑	↑	↓	↓	↑	↑	↓	↑
Cancer 31 Days Subsequent Surgery*	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Cancer 31 Days Subsequent Drug*	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Cancer 62 Days Urgent*	↓	↓	↑	↓	↓	↑	↓	↓	↓	↑	↓	↑
Cancer 62 Days Screening*	↑	↓	↓	↑	↔	↔	↔	↓	↑	↓	↑	↓
Ambulance Handovers 30 to <60 minutes	↑	↓	↑	↑	↓	↑	↑	↓	↑	↔	↑	↓
Ambulance Handovers at 60 minutes or more	↑	↓	↓	↑	↓	↑	↑	↓	↑	↑	↑	↓
Discharge Summaries - % sent within 24hrs	↑	↓	↓	↑	↓	↑	↓	↓	↓	↓	↓	↓
Discharge Summaries – Number NOT sent within 7 days	↑	↓	↓	↑	↑	↓	↑	↓	↓	↓	↓	↓
Cancelled Operations on the day for a non-clinical reasons	↑	↓	↑	↓	↑	↑	↑	↓	↑	↓	↓	↑
Cancelled Operations– Not offered a date for readmission within 28 days	↔	↔	↓	↔	↑	↔	↓	↔	↔	↓	↓	↑
Urgent Operations – Cancelled for a 2nd time	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Super Stranded Patients	↓	↓	↑	↓	↓	↓	↓	↓	↑	↑	↓	↑
COVID-19 Recovery Elective Activity												
COVID-19 Recovery Diagnostic Activity												
COVID-19 Recovery Outpatient Activity												
% Outpatient Appointments delivered remotely											↓	↓
% of Patients seen in the fracture clinic within 72 hours											↓	↑

Key

Improvement in Performance	
Deterioration in Performance	
Static Performance	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating March 2021 – February 2022

KPI	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22
WORKFORCE												
Sickness Absence	↑	↓	↓	↑	↓	↑	↓	↑	↓	↓	↓	↑
Return to Work	↑	↓	↓	↑	↓	↑	↑	↑	↑	↓	↑	↑
Recruitment	↓	↑	↔	↑	↑	↓	↓	↑	↔	↓	↑	↓
Vacancy Rates	↑	↓	↓	↓	↑	↓	↑	↑	↑	↓	↓	↓
Retention	↑	↓	↓	↑	↑	↑	↓	↓	↓	↓	↑	↑
Turnover	↓	↓	↑	↓	↑	↑	↓	↓	↓	↓	↑	↓
Bank & Agency Reliance	↑	↑	↑	↑	↓	↑	↓	↑	↑	↓	↑	↑
Agency Shifts Compliant with the Cap	↑	↓	↑	↑	↓	↑	↓	↓	↑	↓	↓	↓
Agency Rate Card Compliance	↑	↑	↑	↑	↓	↓	↑	↓	↑	↓	↓	↑
Monthly Pay Spend (Contracted & Non-Contracted)	↑	↑	↑	↑	↓	↑	↓	↑	↑	↓	↓	↑
Core/Mandatory Training	↑	↑	↓	↑	↓	↑	↑	↑	↑	↑	↑	↓
Role Specific Training	↑	↑	↓	↑	↓	↓	↓	↑	↓	↑	↑	↑
Safeguarding Training									↑	↑	↔	↓
% Use of Apprenticeship Levy	↓	↑	↑	↓	↑	↑	↑	↓	↑	↓	↓	↑
% Workforce carrying out an Apprenticeship Qualification	↑	↑	↑	↑	↑	↑	↓	↑	↓	↑	↑	↓
PDR	↑	↑	↓	↓	↓	↓	↑	↑	↑	↑	↑	↓

Key

Improvement in Performance	↑
Deterioration in Performance	↓
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating March 2021 – February 2022

KPI	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22
FINANCE												
Trust Financial Position	↑	↑	↓	↑	↑	↑	↔	↓	↑	↓	↑	↑
System Financial Position	-	-	-	-	-	-	-	-	-	-	-	-
Cash Balance	↑	↑	↓	↑	↑	↑	↑	↑	↑	↓	↑	↑
Capital Programme	↑	↑	↓	↓	↓	↓	↓	↓	↓	↓	↓	↕
Better Payment Practice Code	↔	↑	↔	↓	↔	↔	↔	↔	↔	↔	↔	↕
Use of Resources Rating	-	-	-	-	-	-	-	-	-	-	-	-
Agency Spending (Monthly)	↓	↑	↑	↑	↓	↓	↓	↑	↓	↓	↑	↑
Cost Improvement Programme – Performance to date		-	-	-								
Cost Improvement Programme – Plans in Progress (In Year)	-	-	-	-								
Cost Improvement Programme – Plans in Progress (Recurrent)	-	-	-	-								

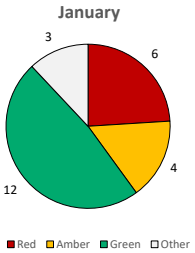
*RAG rating is based on previous month's validated position for these indicators.

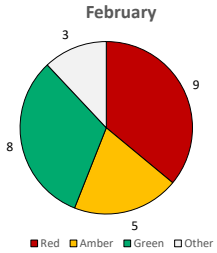
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Integrated Dashboard - February 2022

Appendix 2

Quality Improvement





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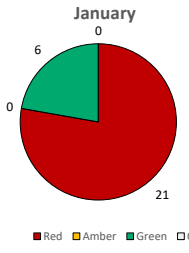
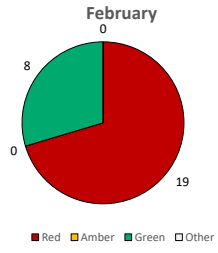
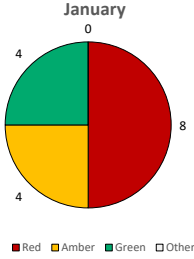
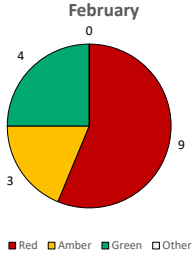


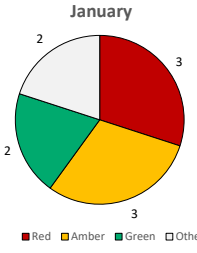


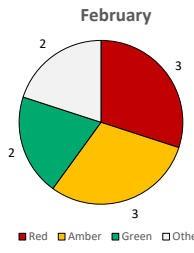
Workforce





Finance





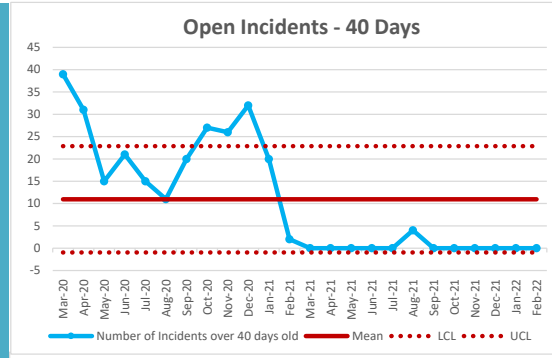
Key:
System Oversight Framework (SOF) | Care Quality Commission (CQC) | Risk Register (RR116) | Trust Strategy (S)

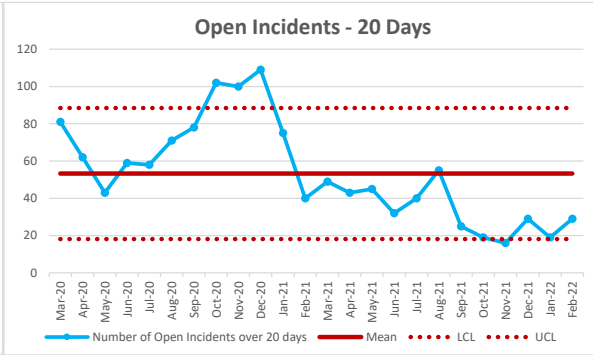
Quality Improvement - Trust Position

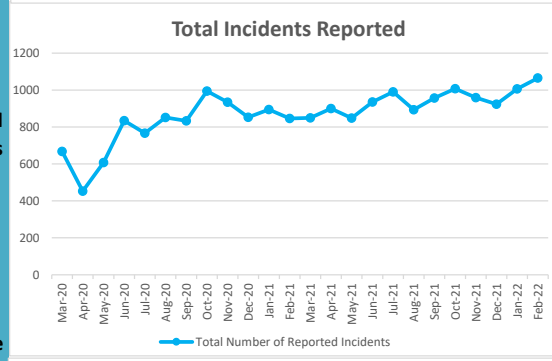
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
There were 0 incidents open over 40 days old and 29 incidents open over 20 days old. The Governance Managers are working closely with the CBU's to keep overdue incidents on a downward trend.	Open Incidents - 40 Days	Incident reporting remains within range with little variance across the Trust.	The Report to Improve Campaign continues with close weekly monitoring of incident reporting Trust wide, CBU and Speciality specific. A weekly governance dashboard provides a focused review of the incident reporting culture and a proactive approach to ensure that reporting is maintained. The grading of incidents is checked daily for each CBU/Speciality.
	Open Incidents - 20 Days	There are 0 overdue 40-day incidents.	There are 29 incidents open over 20 days. As noted previously, incidents over 20 days are monitored centrally and have had a review by the Governance Team. Due to the nature of some of the incidents these will stay open on the system. All incidents are monitored weekly.
	Total Incidents Reported	There were 7 serious incidents reported in February 2022. The 7 SIs declared noted the following themes: 2 missed cancers and 2 falls. No reason for variation has been directly identified, however investigations are ongoing as per the governance process.	The number of SI declared is not a performance metric and work continues with regard to an open and transparent reporting culture. Learning from incidents will continue to impact upon the level of investigation identified with the grading of incidents checked daily. A Trust wide learning framework is being devised.
	Incidents Reported By Month	There were 0 breached serious incident actions in February 2022.	Weekly monitoring continues with appropriate escalation to the CBU leads and Executive oversight from the Safety Oversight Group.
	Serious Incidents & Never Events		
	Serious Incidents Actions Breached		

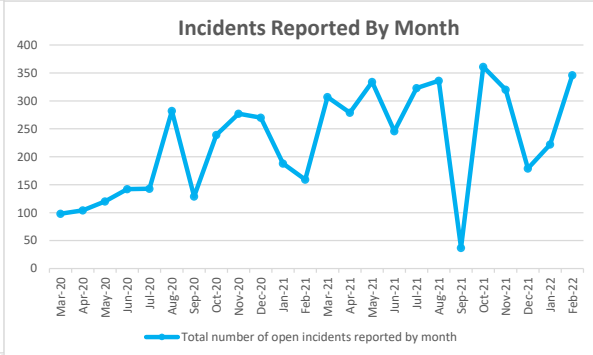
Incidents

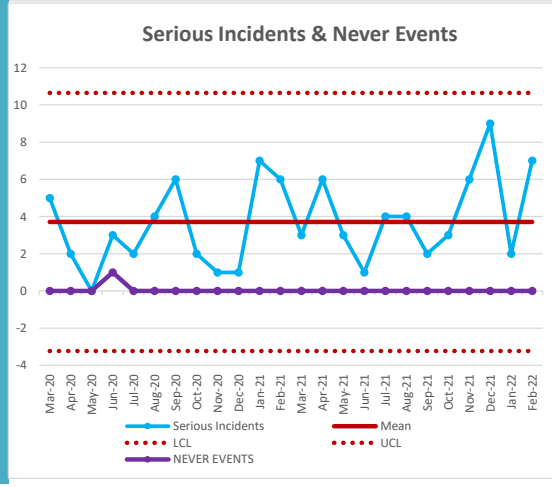
Red: Open incidents outside 40 day timeframe
Amber: Open incidents between 20 - 40 days old.
Green: Open incident within timeframe of 20 days.

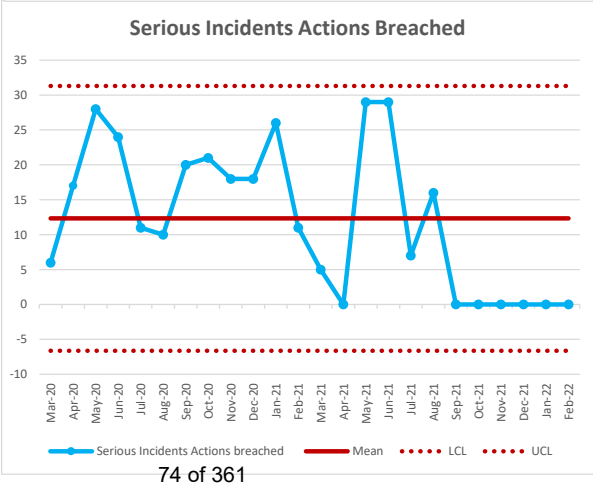












Key:

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

Care Quality Commission (CQC) | Trust Strategy (S)

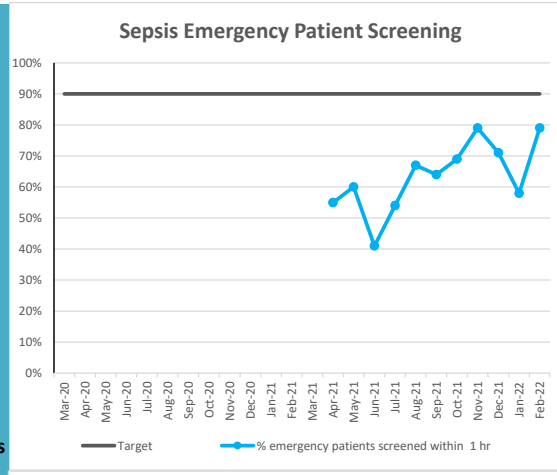
Quality Improvement - Trust Position

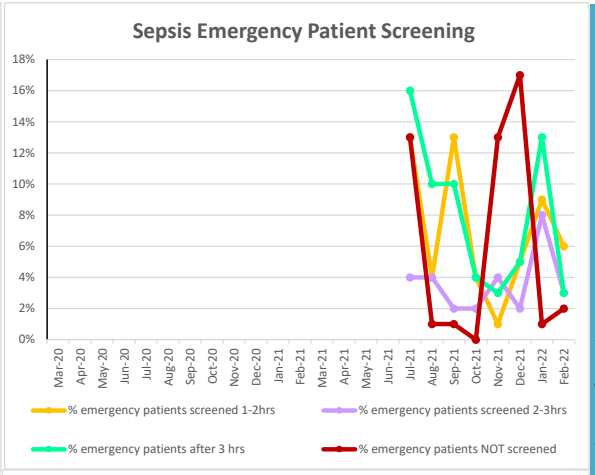
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

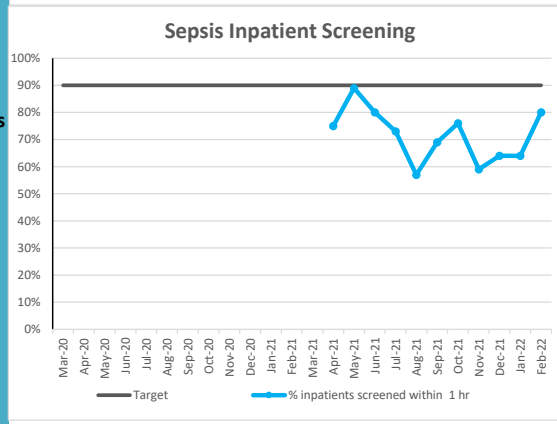
Sepsis - % screening for all emergency patients. Red: Below 90% Green: 90% or Above

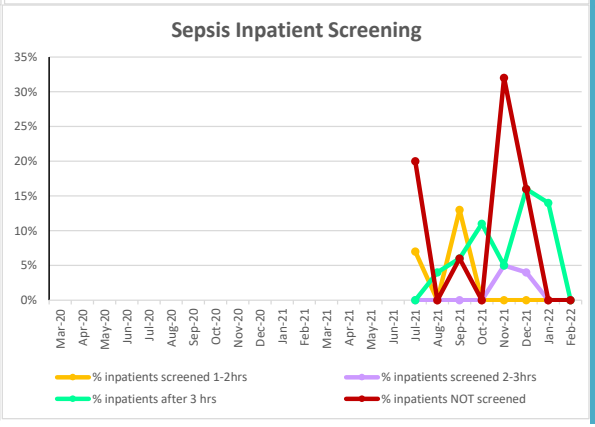
Sepsis - % screening for all inpatients Red: Below 90% Green: 90% or Above

The Trust achieved:
- **79.00% Sepsis screening for all emergency patients with suspected sepsis within 1 hour.**
- **80.00% screening for all inpatients with suspected sepsis within 1 hour.**







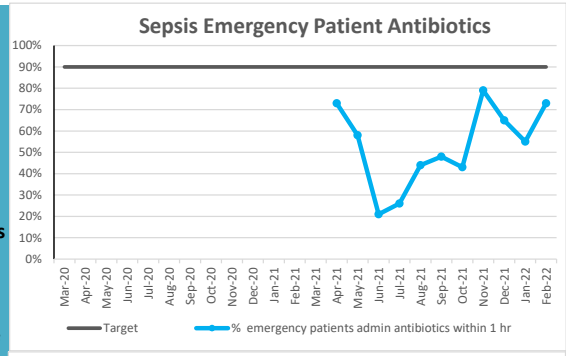
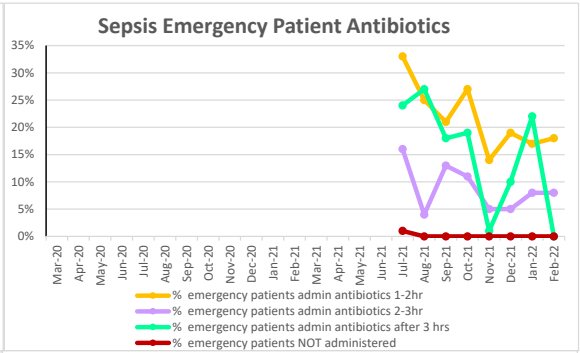
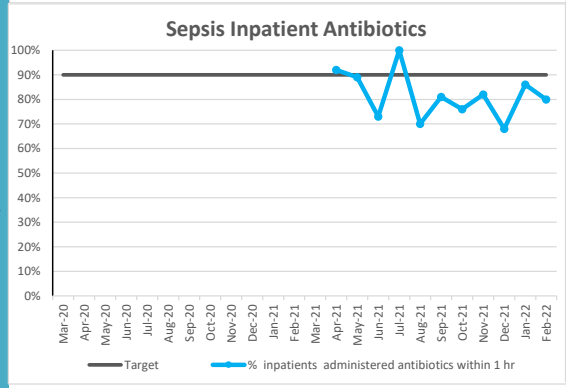
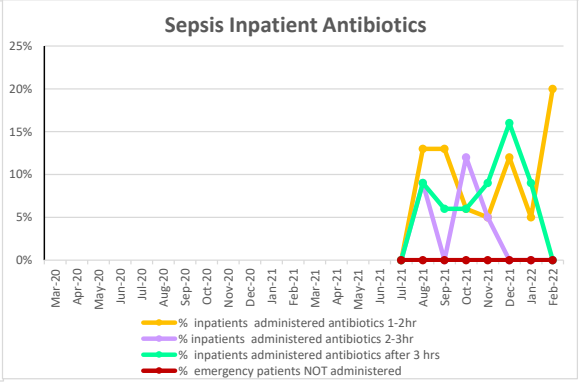
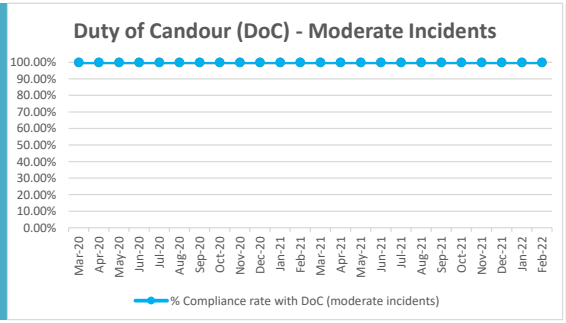
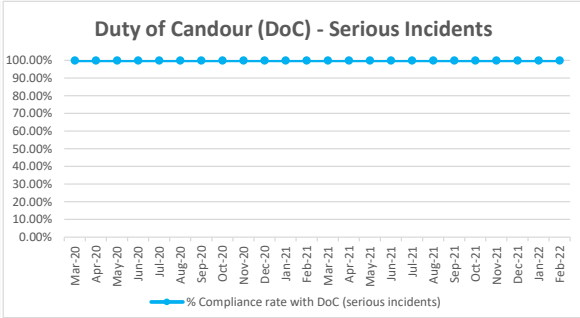


An improvement in screening compliance is noted for February. The increased attendances to the emergency department remains a factor in the challenge to reach 90.00% screening compliance. Improvements are required in relation to completion of the Sepsis 6 pathway .

Weekly sepsis validation meetings are undertaken with the Trust Sepsis Leads/Associate Medical Director to ensure accuracy of audit data. The ED Sepsis Improvement Group meets bi-weekly. The Sepsis training video is now linked to ESR and safety huddles continue in the emergency department to reinforce Sepsis screening and treatment. The Patient Safety Team continue to train staff and reinforce standards within the Emergency Department.

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

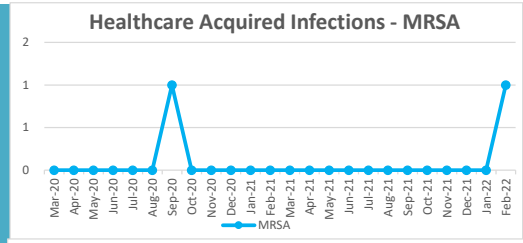
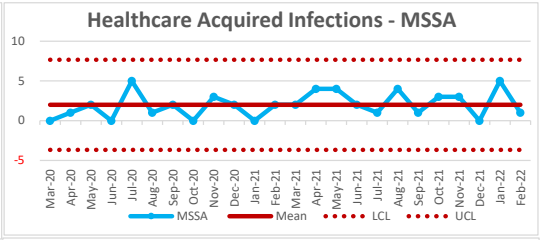
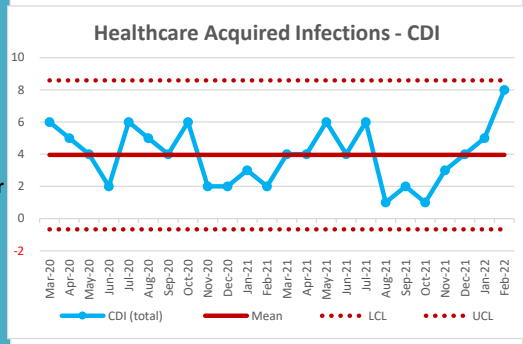
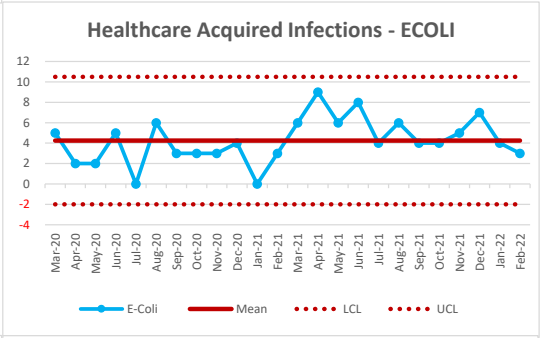
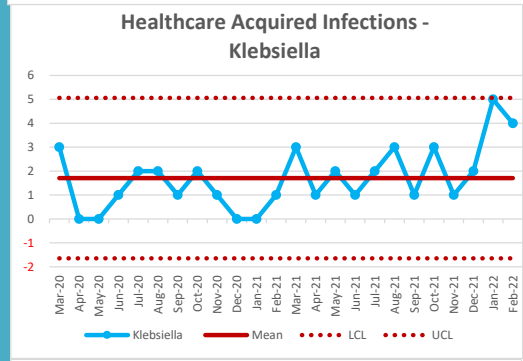
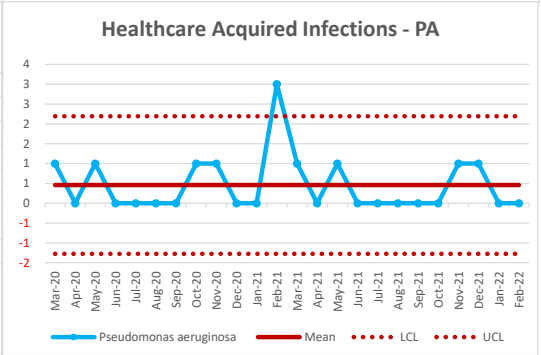
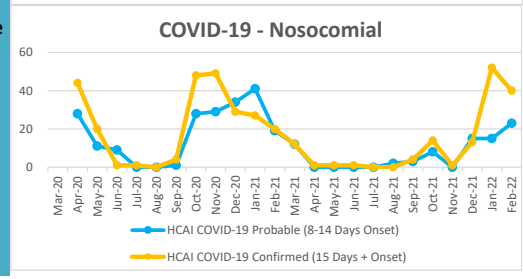
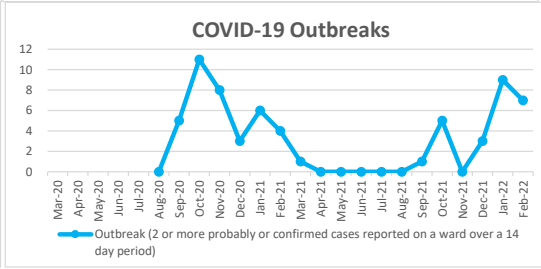
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag sepsis **Red: Below 90%** **Green: 90% or Above**	**The Trust achieved:** **• 73.00% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** **•80.00% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.**	   	**Under utilisation of the Sepsis screening tool and associated prompts has resulted in partial screening for inpatients.**	**Daily audits of the E-obs system by ward is undertaken by the Patient Safety Nurses to ensure inpatients are screened/treated for Sepsis as appropriate. Weekly Sepsis validation meetings are undertaken with the Trust Sepsis Leads/Associate Medical Director to ensure accuracy of audit data. The Inpatient Sepsis Improvement Group meets bi-weekly working with the Quality Academy Team across 3 identified wards, with a roll out plan to share the improvements.**
Duty of Candour **Red: <100%** **Green: 100%**	CQC **The Trust achieved 100% for Duty of Candour in month.**	 	**There is no variance, the Trust remains 100% compliant.**	**Robust weekly monitoring is undertaken by the Patient Safety Manager to ensure compliance is maintained.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Healthcare Acquired Infections **MRSA** Red: 1 or more Green: 0		The MRSA case attended a neighbouring hospital between WHH admissions. A post infection review is in progress. Choice of invasive devices has been identified as an area for improvement.	Action plans are in place for the prevention of HCAI's. There is an increased focus on wards with intravenous device related infections and a drive to improve compliance with aseptic technique training.
Healthcare Acquired Infections **C-Difficile** Red: 44+ per annum Green: Less than 44 per annum		Antimicrobial stewardship is a focus at post-take ward rounds and areas with lower antibiotic formulary compliance. Increased in use of hydrogen peroxide vapour decontamination.	Continue with the current CDI prevention strategy and also look at the use of proton pump inhibitor medication with the Gastroenterology Team. Continued focus on environmental hygiene including a hand hygiene promotion strategy for patients and staff. Continued review of root cause analysis investigations to identify learning.
Healthcare Acquired Infections - Gram Negative **E-Coli** Red: 81+ per annum Green: Less than 81 per annum **Pseudomonas aeruginosa** Green: 4 or Less **Klebsillea** Green: 23 or Less	   	The change in the apportionment rule has increased the number of GNBSI cases apportioned to the Trust.	The GNBSI reduction Group has been established with Quality Academy support. There are 8 wards engaged in phase 1. Focus areas include hydration, continence management, care of urethral catheters, hand hygiene and UTI detection and management. The UTI pathway has been revised and will be launched at Grand Round once ratified. Audit of Klebsiella cases commenced to identify any areas for care improvement.
Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	 	Continuing global COVID-19 pandemic with high number of patients admitted with COVID-19 in February 2022.	Close liaison with operational teams to support patient placement. Outbreak Control Groups are convened to manage outbreaks to prevent transmission to additional patients and staff.

MRSA - 1 community onset/healthcare associated case.

MSSA - 1 Hospital onset case. No threshold set.

CDI - 44 cases/threshold of 44. The UKHSA has flagged the Trust as a low outlier compared to other North West NHS Trusts. 3 cases have been successfully appealed as unavoidable.

E-Coli - 60 cases/threshold of 81.

Klebsiella - 25 cases/threshold of 23.

P. aeruginosa - 3 cases/threshold of 4.

COVID-19:
23 8-14 day probable healthcare associated cases.
40 15+ days cases definite healthcare associated.
7 COVID-19 outbreaks were reported in February 2022.

RR1275

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

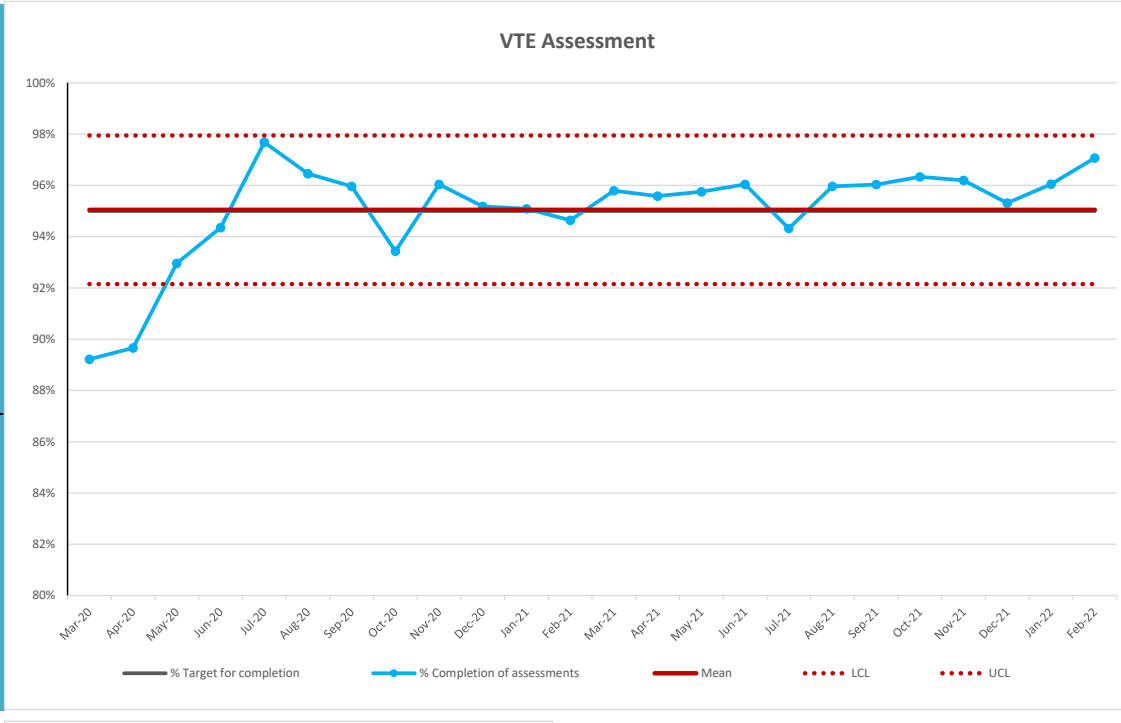
Quality Improvement - Trust Position

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

VTE Assessment

Red: <95%
Green: 95% or above based on previous months' figures due to timescales for validation of data

The Trust achieved 96.05% for VTE assessments YTD 2021/22 from April 2021 - February 2022.



1. Highest monthly figure achieved at 97.03% for VTE risk assessments in February 2022.
2. The quality standard has been achieved consistently above the target for VTE compliance data > 95% since April 2021 with the exception of July at 94.64%.
3. However, if the guidance on the national VTE data collection is to be changed to within 14 hours compliance of VTE RA, there is still a gap to reach >95% compliance as YTD for all assessments completed within 14 hours. It is encouraging to see the gradual upward trend with February figure of 91.52% achieved.

Current systems in place to improve VTE compliance:
Relaunch of a user friendly format of Clinical Data Capture (CDC) form incorporated with VTE risk assessment form in the standardised clerking/PTWR/WR proforma is the key driving force for this improvement and the message getting across to the junior/senior doctors for compliance within 14 hours of admission.
Future proactive approach/plan to improve VTE compliance within 14 hours of admission:
1. To continue to raise the awareness of mandatory VTE RA through communications sent out to all doctors/nursing staff through daily safety huddle.
2. To engage with CBU specific data to improve overall VTE risk assessment compliance by provision of quarterly data.
3. To continue to promote the consistent use of ward round CDC forms to improve VTE compliance.

Key:

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

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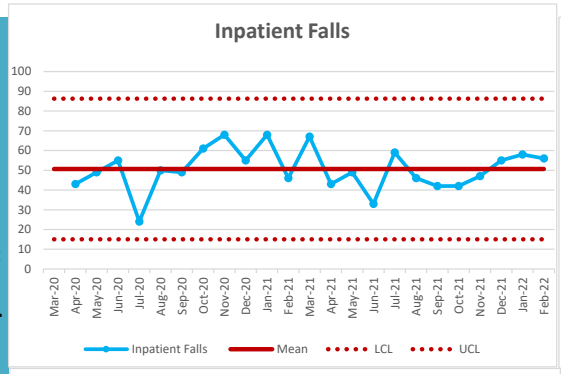
Quality Improvement - Trust Position

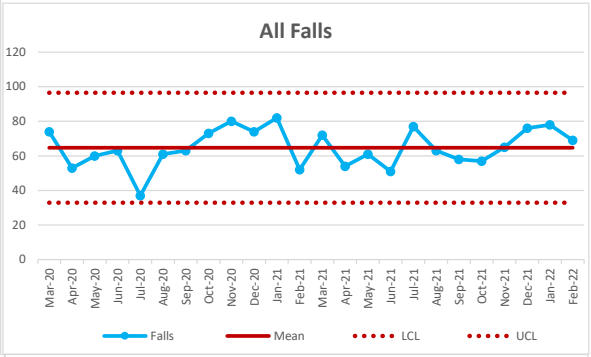
Trust Performance

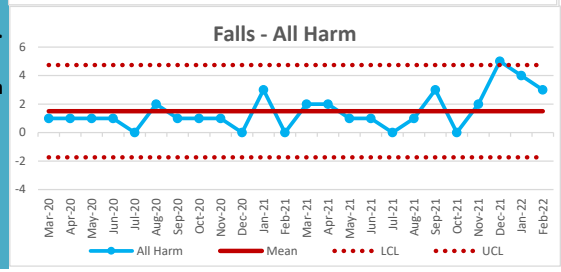
Total number of Inpatient Falls & harm levels
Red: <10% decrease from 19/20
Amber: 10-19% decrease from 19/20
Green 20% or more decrease from 19/20 (612 Inpatient Falls in 2019/20)

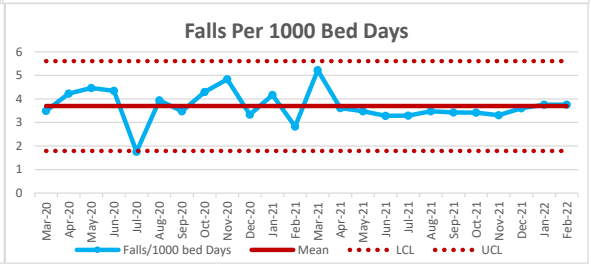
69 total falls were reported, 56 of those were inpatient falls, 2 inpatient falls resulted in moderate harm. 1 outpatient fall resulted in moderate harm. Year to date there have been 530 Inpatient Falls.

Trend









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

There is variation in standards across the Trust in terms of documentation and evidence of appropriate falls prevention measures.

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

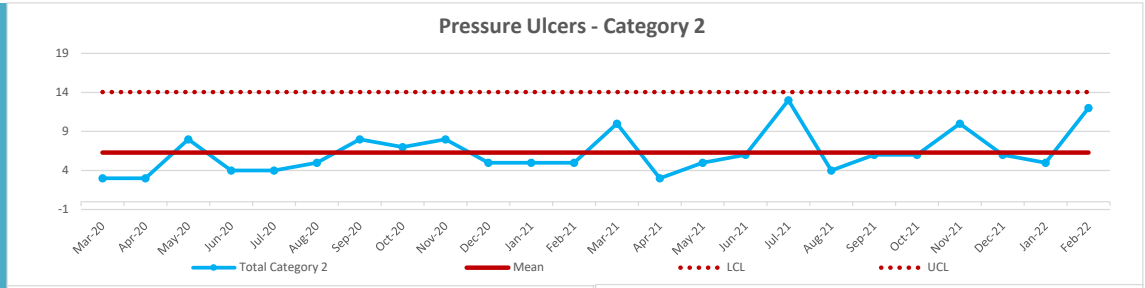
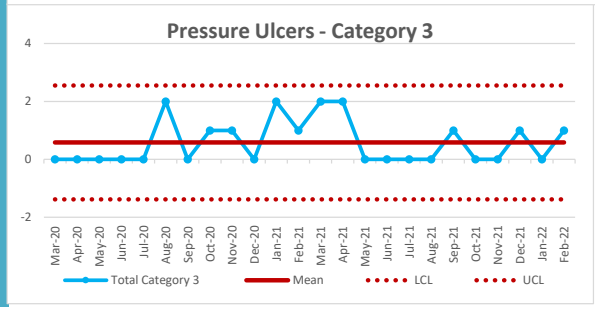
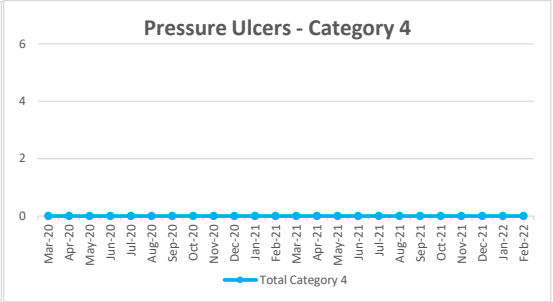
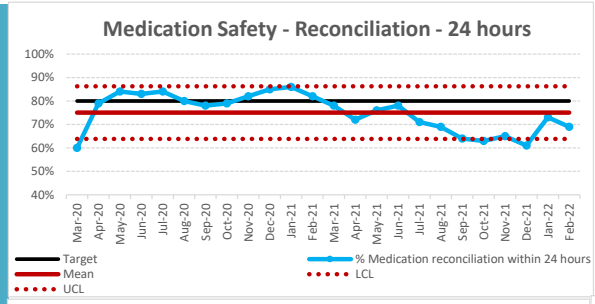
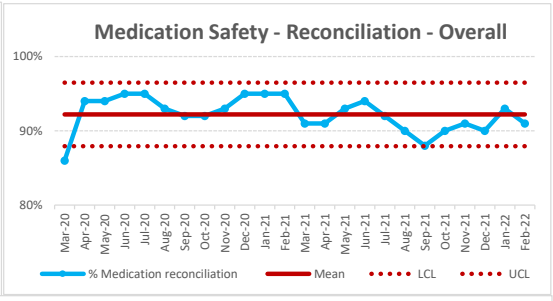
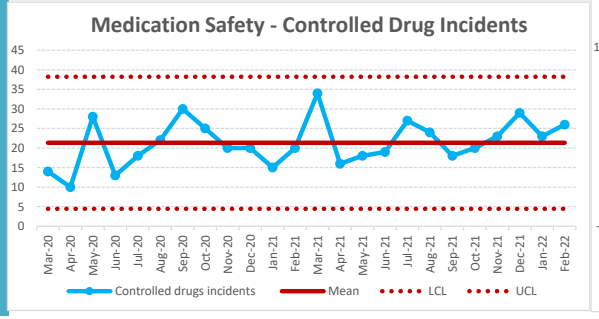
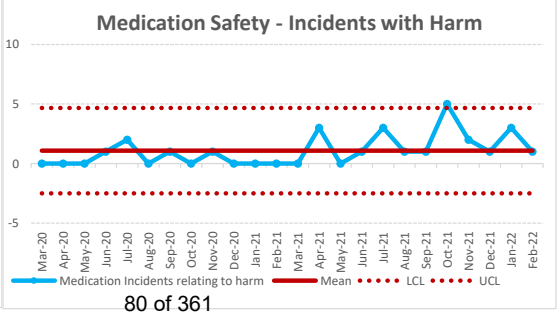
A Trust-wide Falls audit was undertaken in January with the audit report completed, and themes and actions shared with the nursing teams. Weekly Harm Free Care meetings are in place to share lessons learned. Monthly Falls 'Ward Round' on wards with the highest incidence of falls with real time feedback and recommendations. The post falls documentation has been added to the electronic system to allow wider access to review and highlight themes. The quality improvement change package has been reinforced across the wards. A deep dive review of falls resulting in a hip fracture is underway.

Key:

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

Care Quality Commission (CQC) | Trust Strategy (S)

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Pressure Ulcers Based on 65 in 2019/20 Red: 4% reduction or below Amber: 5%-9% reduction Green: 10% reduction or above.	There were 12 hospital acquired category 2 pressure ulcers and 1 hospital acquired category 3 in February 2022. The Trust has reported 5 category 3 pressure ulcers and 76 category 2 pressure ulcers YTD.	  	Standards for the assessment and monitoring of pressure areas have not been met, particularly in relation to the care of skin underneath medical devices.	Areas of highest incidence have developed a specific action plan for their areas and weekly oversight meetings with the Deputy Chief Nurse have commenced. The quality improvement change package has been reinforced with closer monitoring. Device management training is underway with the associated care plan in place.
Medication Safety Reconciliation within 24 hours Red: below 60% Amber: 60% - 79% Green: 80% or above	The Trust achieved 69.00% for medicines reconciliation within 24 hours and 91.00% for overall medicines reconciliation. There were 26 controlled drug incidents, this is within usual variance.	   	Medicines reconciliation is at 69.00% within 24 hours and achieving 91.00% across the inpatient stay. Compliance will further improve once recruited staff commence in post. Incidents reported relating to controlled medicines have increased. The majority are due to errors made in documentation. Controlled drug errors have been the subject of a deep dive report undertaken by the Deputy Chief Nurse.	Remaining pharmacist vacancies have been skill mixed with interviews undertaken in February, to deliver a robust, sustainable clinical service as a result of review of Pharmacy establishment. Improvements need to be made in use of controlled drug registers at ward level. The Patient Safety Nurses will continue to support this agenda.

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

Quality Improvement - Trust Position

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

Staffing - Average Fill Rate

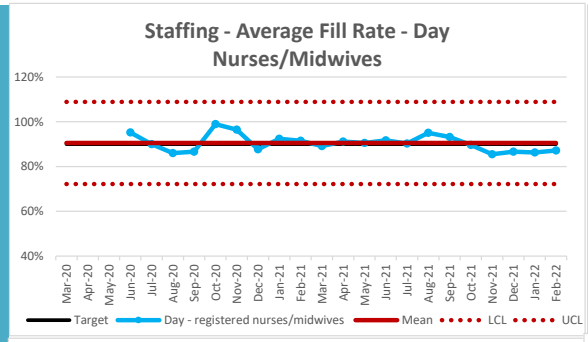
Red: 0-79%
Amber: 80-89%
Green: 90-100%

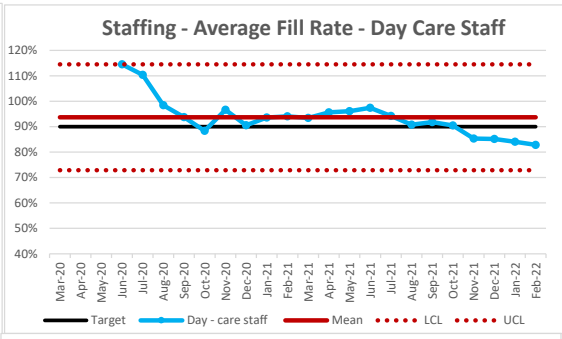
Trust Performance

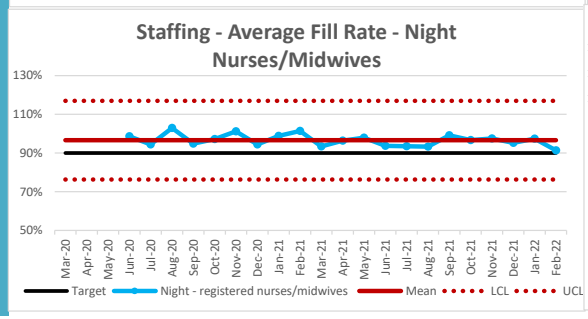
In February 2022, the average staffing fill rates were:
Day (Nurses/Midwife) 87.17%
Day (Care Staff) 82.86%
Night (Nurses/Midwife) 91.37%
Night (Care Staff) 84.66%

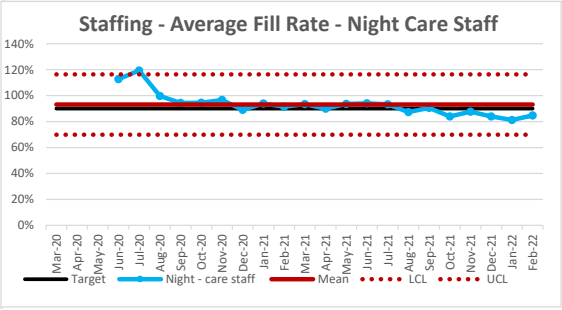
RR115 RR1108

Trend









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

Additional beds in use across the Trust and increased staff absence due to COVID-19 related reasons remains a driver for variation.

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

Acuity and activity is monitored twice daily to ensure safe patient care at all times with oversight by senior nursing staff.
The Trust Workforce Lead has developed a trajectory for the reduction of Health Care Support Worker vacancies to zero at beginning of April, WHH is on track to meet that target. The recruitment of registered nurses continues on a rolling schedule every 2 weeks and includes the recruitment of both refugee and international nurses as apart of a Cheshire and Mersey Team programme of recruitment.
Workforce planning continues to ensure recruitment plans meet turnover rates.

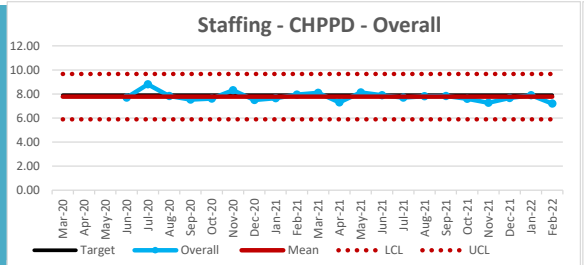
Staffing - Care Hours Per Patient Day (CHPPD)

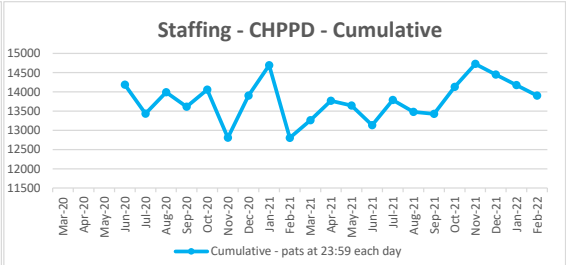
Red: Below 6.0
Amber: 6.0 - 7.8
Green: 7.9 or More

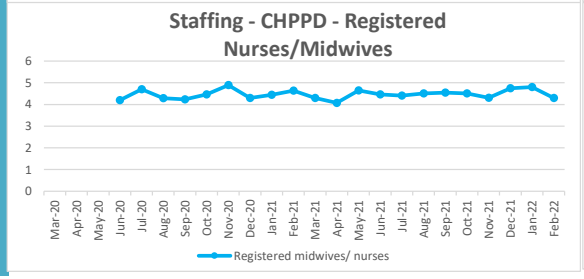
Trust Performance

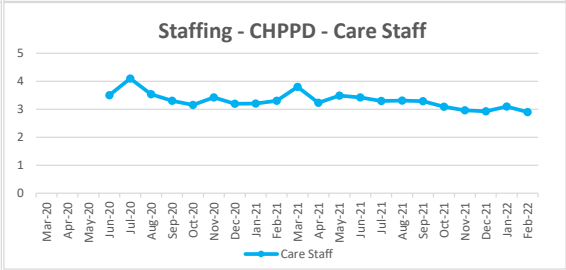
In February 2022, the average CHPPD were:
Nurse/Midwife: 4.3 hours
Care Staff: 2.9 hours
Overall: 7.2 hours

Trend









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

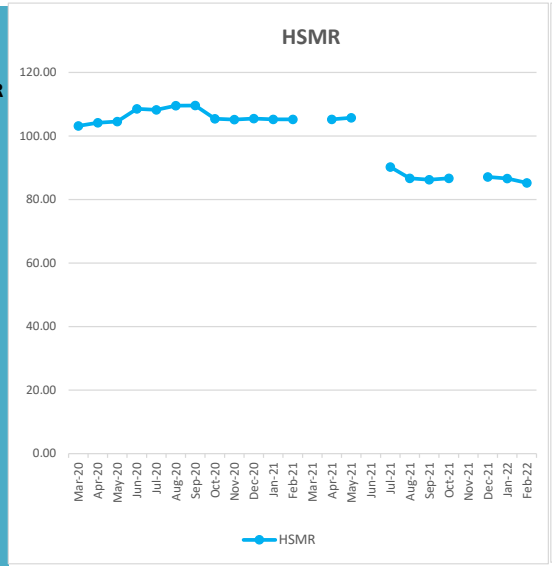
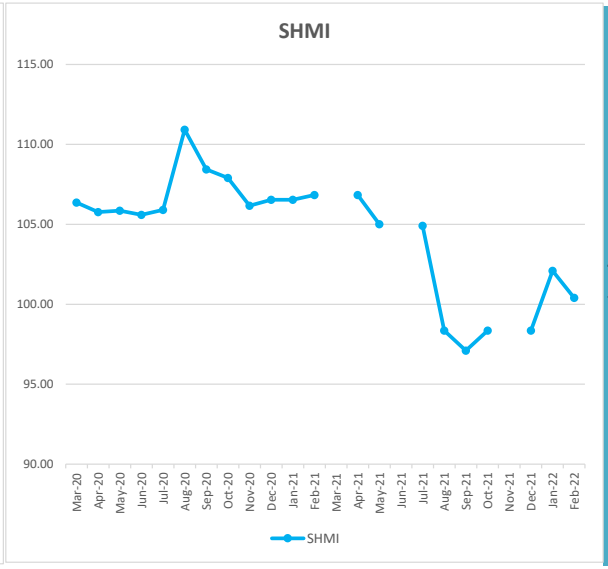
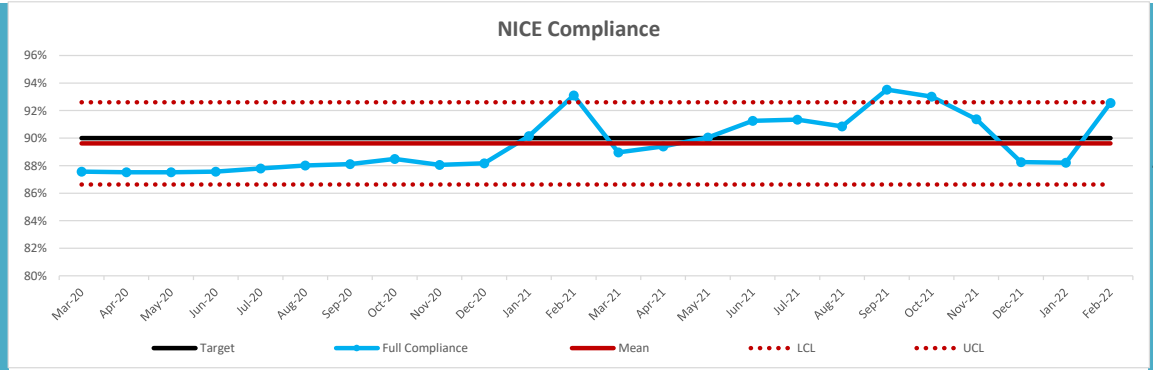
An decrease is noted in CHPPD for February 2022.

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

Staffing levels are systematically reviewed including planned versus actual staffing levels and overall staffing plans remain on track. A Trust wide SOP in place to support the return of COVID-19 exposed staff following risk assessment reducing the reliance on temporary staffing.

Key:
System Oversight Framework (SOF) | Risk Register (RR116)
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 85.24. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 100.41.**	 	**No variation. HSMR and SHMI remain within expected range. NB: The gaps in the chart relate to the time periods whereby our external provider (HED) did not produce a report with the HSMR/SHMI.**	**Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning. SHMI and HSMR continues to reduce month on month.**
NICE Compliance Red: Below 75% Amber: 75% to 89% Green: 90% or Above	**The Trust achieved 92.55% in month.**		**The Trust has met the target of achieving over 90.00% compliance.**	**Work is underway to ensure that actions for outstanding or partially complete compliance is monitored and escalated accordingly to continually improve the position.**

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

Quality Improvement - Trust Position

Trust Performance

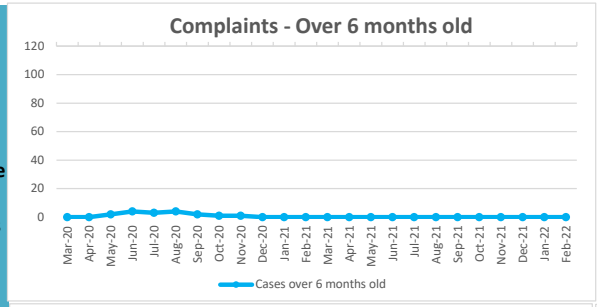
Trend

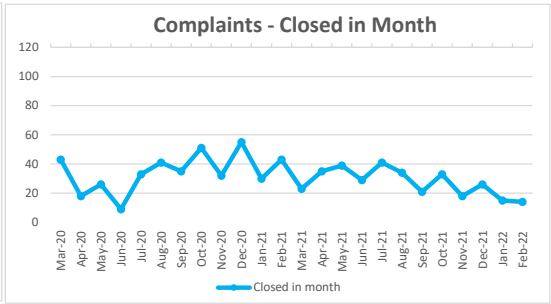
What are the reasons for the variation and what is the impact?

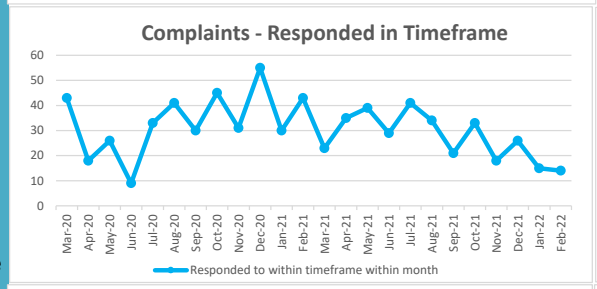
How are we going to improve the position (Short & Long Term)?

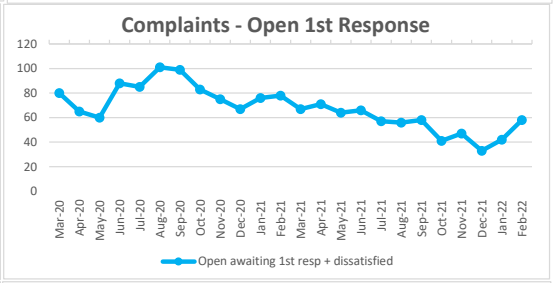
Complaints
Red: Complaints over 6 months old/69% or less responded to within the timeframe
Amber: No complaints over 6 months old, 70% - 89% responded to within the timeframe
Green: No backlog, 90% responded to within the timeframe.

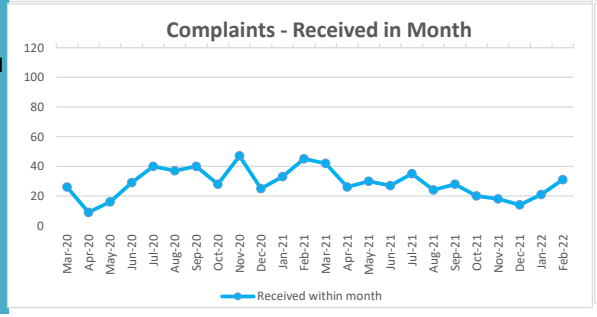
In February 2022, 31 new complaints were received to the Trust which was a increase from the previous month. There have been 4 dissatisfied received in month, which is an increase of 2 from previous month. These have been reviewed by the Associate Director of Governance and Director of Governance to review any trends emerging.

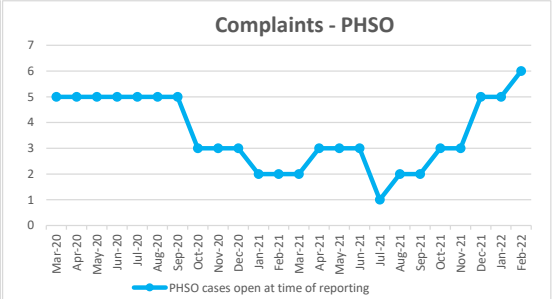










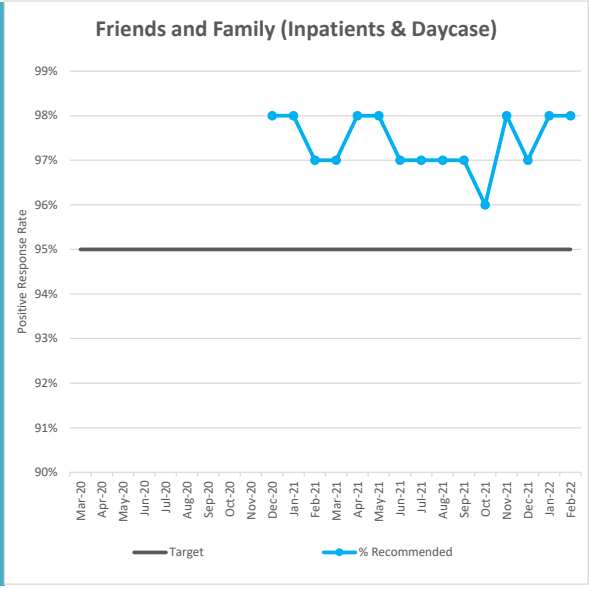
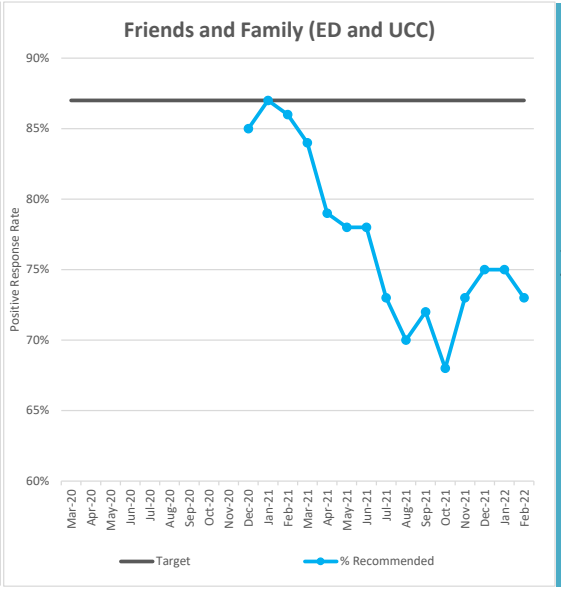
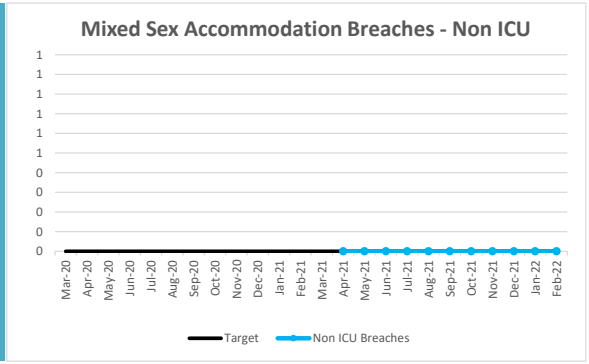
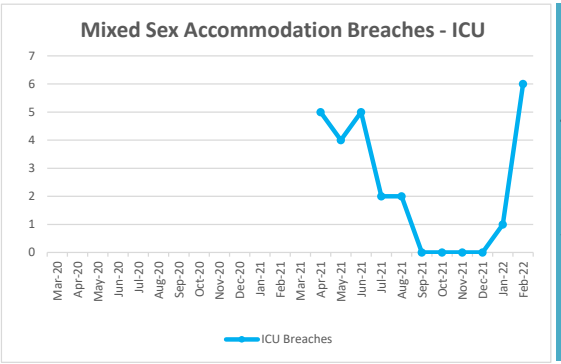


The Trust continues its performance in the timeliness of responding to complaints. There continues to be no complaints over 6 months old, and all complaints are currently within date. There has been an increase in the number of formal complaints received with 58 currently open in February 2022. In January 2022 42 were open. There are no emerging themes to note.

The complaints toolkit has now been completed and a training package is in the process of being developed for Trust wide implementation. Training to continually improve the standard of complaints is being implemented in March 2022 and a programme of work to address complaints in real time (outside of the PALS service) is being developed.

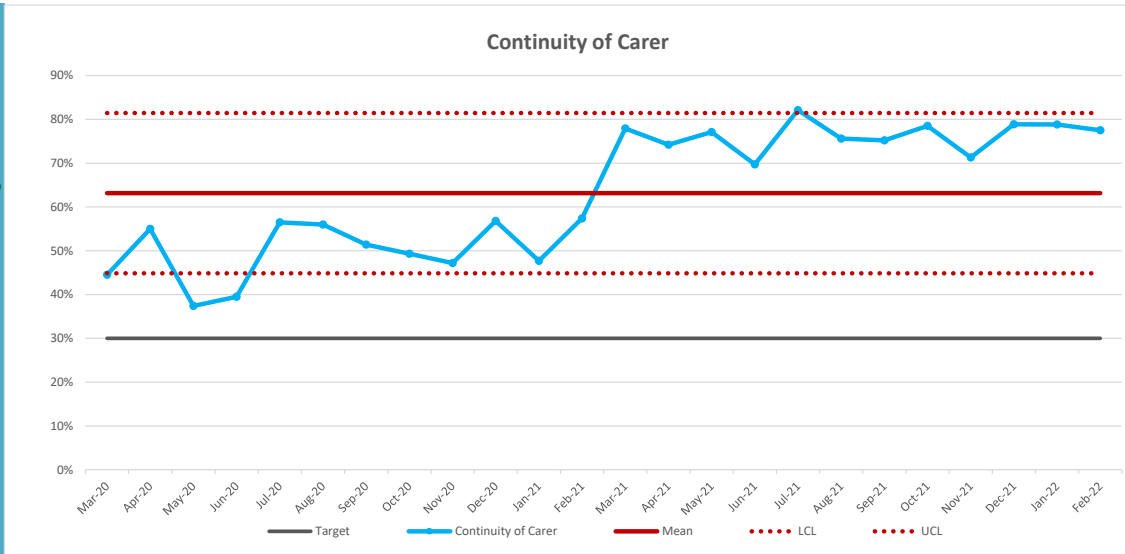
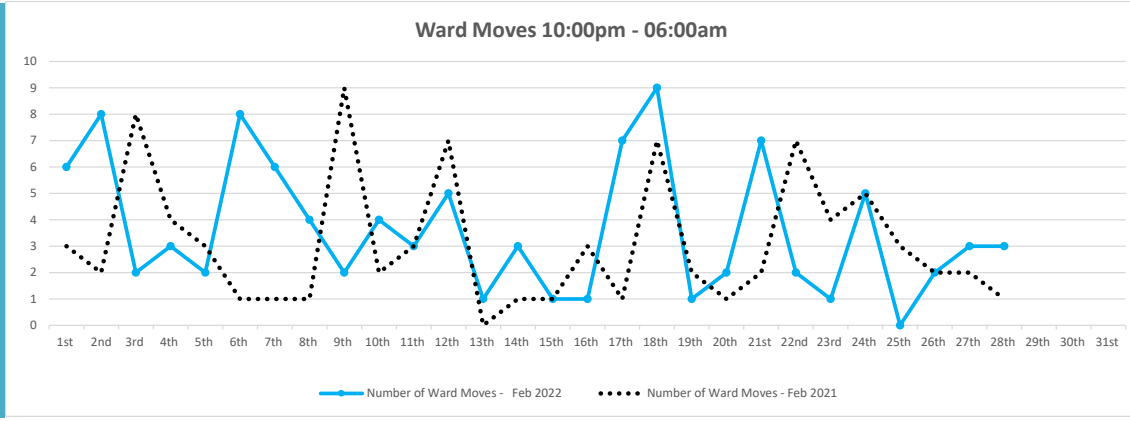
Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more Friends and Family (ED and UCC) Red: Less than 87% Green: 87% or more	The Trust achieved 98.00% in month for Inpatient & Day case FFT and 73.00% for ED/UCC FFT.	 	ED/UCC - The Trust achieved 73.00% positive feedback in friends and family test results in February 2022. This is a drop in position from the previous month. Inpatient/Day case - The Trust achieved 98.00% recommendation rate in February 2022.	ED/UCC - An Emergency Department response group has been developed to improve flow and patient experience within the ED and subsequent in-patient stay across the organisation. ED staff ensure clear communication with patients to explain any delays. It is positive to note there is a 7% increase in positive feedback rate from October 2021 at 68% to January 2022 at 75.00%. Inpatient/Day case - The Trust continues to be highly recommended through the FFT responses. Any variation is addressed locally and monitored through the Patient Experience Sub Committee.
Mixed Sex Accommodation Breaches (Non ITU Only) Red: 1 or more Green: Zero	There were 0 mixed sex accommodation incidents outside of the ITU during February 2022. There were 6 MSA incidents within the ITU.	 	There were 6 mixed sex accommodation breaches reported in February 2022 in the Intensive Care Unit. There were zero breaches within any other ward area.	The introduction of additional capacity and bio quell cubicles has improved patient flow and supported the continual reduction of mixed sex accommodation breaches. In addition, there has been a key focus from the patient flow team to ensure patients are stepped down in timely manner from ICU. A recent mixed sex breach on ward B18 in March 2022 has been investigated and the findings presented to the Trust Executive Team.

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

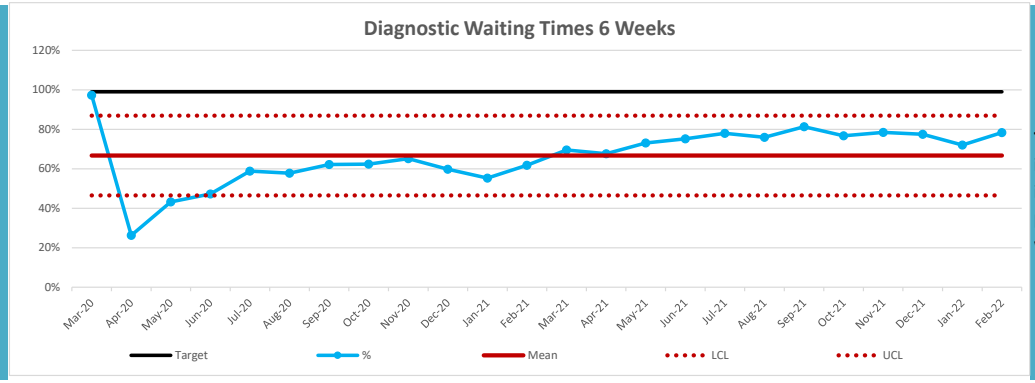
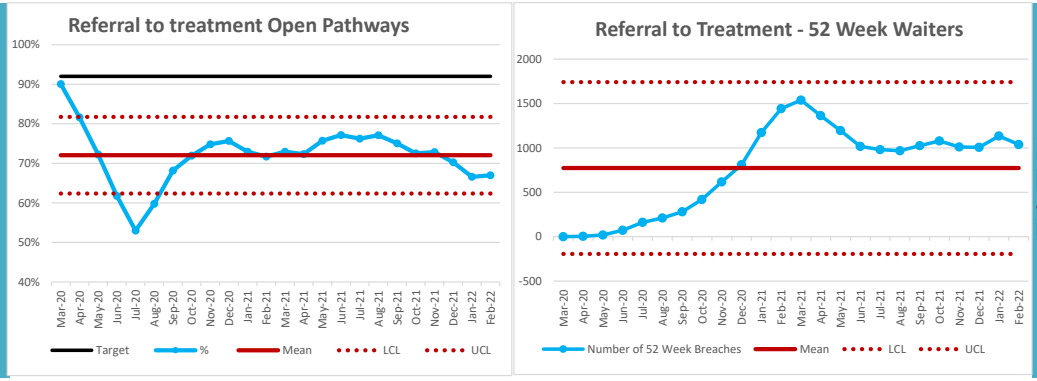
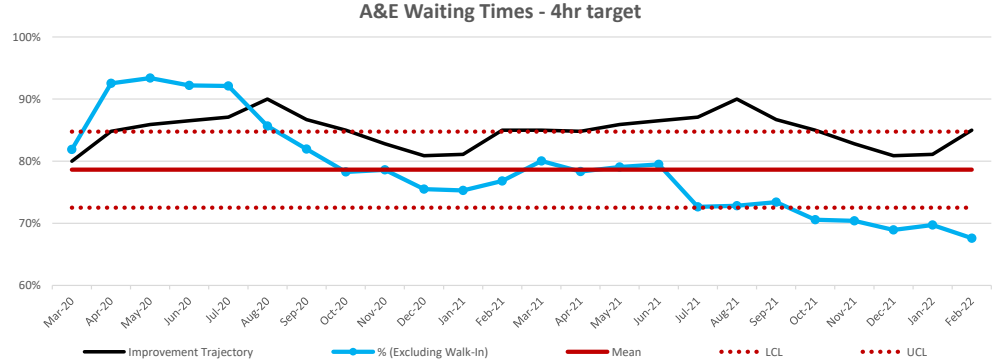
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Continuity of Carer Green: 51% or Above Amber: 35% - 50% Red: below 35%	In February 2022, 100% of Warrington & Halton women are booked onto such a pathway, if 'out of area' bookings are included the figure is 77.5% as we cannot provide the postnatal aspect of the pathway.		The Trust achieved 77.5% onto a CoC pathway (including intrapartum care) in February 2022. This figure varies month on month as it is impacted by the number of women who are "out of area" being booked for care at WHH.	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. WHH continues to work towards ensuring women booked on a pathway receive continuity across the pathway. Updated national guidance was published in October 2021 in relation to Continuity of Carer and a revised action plan is being prepared to reflect the new recommendations. This is reflective in the Cheshire and Mersey data whereby the Trust is currently the only organisation achieving this KPI.
Ward Moves between 10:00pm and 06:00am	There was a total of 86 ward moves between 10pm-6am in February 2022 compared to 101 in February 2021.		The reason for the reduction on ward moves after 10pm for this reporting period compared to last year is as a result of the out of hours patient flow and senior manager on call minimising non essential clinical patient moves.	Increased focus on the reduction of non-essential clinical patient moves at night is part of the improvement workstreams in relation to patient flow. In addition, automatic notifications are applied for patients who have a learning disability or mental health need. This notification is monitored by senior nurses who undertakes a welfare check to ensure no inappropriate moves take place. This process has helped to improve the positive reduction in out of hour patient moves.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

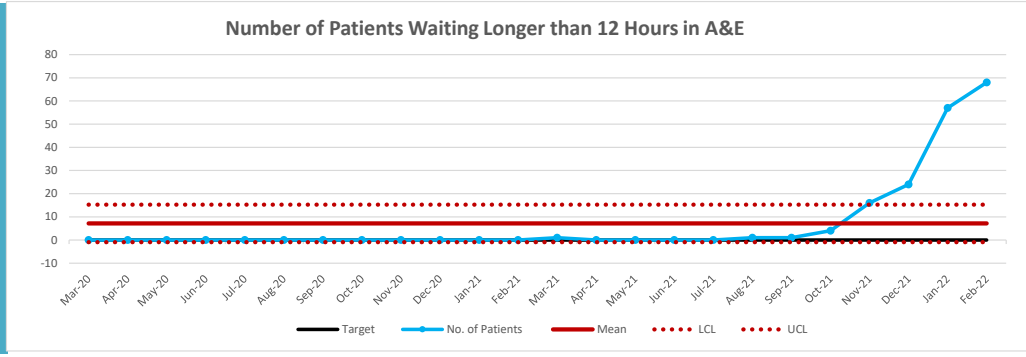
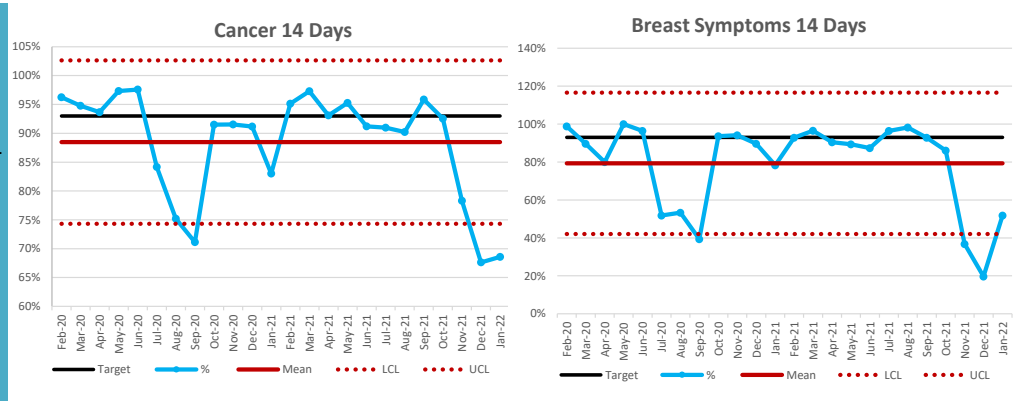
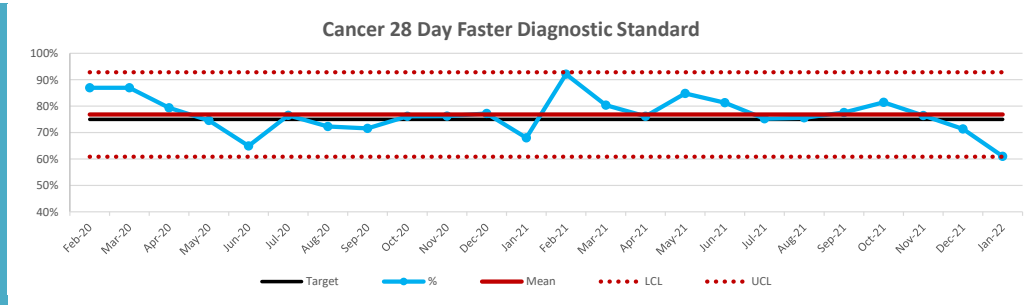
Key: Risk Register RR116 | System Oversight Framework SOF | Care Quality Commission CQC

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	SOF CQC The Trust achieved 78.37% in month. RR1215 RR1125		The diagnostic standard was not achieved in February 2022, this was due to the impact of the COVID-19 pandemic. The position continues to be manged in line with the recovery trajectory.	A recovery plan has been agreed and patients are being clinically prioritised accordingly in line with national guidance. The recovery plan is demonstrating that the actions agreed are delivering recovery with fewer breaches recorded as services are brought back online. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although there has been good progress in radiological modalities, challenges remain in Endoscopy, Cardiorespiratory, Cystoscopy and CT.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or above **RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red**	SOF CQC The Trust achieved 66.97% in month. There were 1038, 52 week breaches in February 2022. RR1125 RR1215		RTT performance and 52 week wait performance in February was compliant against the Trust's H2 plan. Progress has been impacted by Wave 5.	Recovery of the elective programme is taking place with: • Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients. • Elective capacity has been restored at the Halton Elective Centre and the Captain Sir Tom Moore Centre. • The Trust continues to utilise Independent Sector Capacity. • Restoration and recovery plans for 2022/23 have been drawn up in line with Operational Planning Guidance.
Four Hour Standard - National Target Red: Less than 95% Green: 95% or above **Four Hour Standard Waiting Times - STP Trajectory** Red: Less than trajectory Green: Trajectory or above	CQC The Trust achieved 67.61% excluding Widnes walk ins in month. RR1224		There was a further decrease in Type 1 performance attributable to continuing high attends at A&E, a trend continuing to be seen across Cheshire & Merseyside. Bed occupancy at the Trust has continued to be >90% over this period with an increase number patients with a LoS >21, impacting flow and 4 hour performance. Additionally Wave 5 has negatively impacted performance.	• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity to support flow. • An ED recovery group has been established to support demand management and deflection from site. • Additional beds remain open on the Halton site to support bed capacity and flow.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

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

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
The number of patients who has experienced a wait in A&E longer than 12 hours from the decision to admit. Green = 0 Red = > 0	There was 68 patients waiting longer than 12 hours in A&E in month.		There has been a continued deterioration in 12 hour performance in February which is in line with the growing pressures during this period. This Trend is also in line with the trend seen regionally and nationally. The Trust continues to perform well when compared to other Trusts against this standard. The key themes for the breaches are the continuing high urgent care attends and high occupancy restricting flow through A&E.	The Trust will continue to monitor and manage compliance around the 12 hour standard.
Cancer 14 Days Red: Less than 93% Green: 93% or above Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	SOF CQC The Trust achieved 68.57% in November 2021 for Cancer 14 days. The Trust achieved 51.85% in January 2022 for Breast Symptomatic. RR1125		The deterioration in performance is attributable to the increase in referrals to the Breast service as a result of being high profile in the media and Breast Cancer awareness month in October. This impact has been a sustained increase in referrals above demand. Capacity was further restricted in November as a result of Locum Consultant leave and senior medical staff isolating for COVID-19.	The Trust will continue to review capacity with clinical service restoration plans to support ongoing compliance against this standard. Performance against this standard is monitored via the Performance Review Group (PRG), the KPI sub-committee and the Clinical Services Recovery Oversight Group (CSOG). Targeted capacity and demand work has been initiated for the Breast service. The service is expected to fully recover by March 2022, this is on track.
28 Day Faster Cancer Diagnosis Standard Red: Less than 75% Green: 75% or above	SOF The Trust achieved 61.01% in January 2022		The Trust failed the standard in January 2022 owing to the seasonal winter challenges, the breast symptomatic position and Wave 5.	The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG) and the KPI Sub-Committee. Performance is expected to improve in line with the Breast Symptomatic recovery.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Access & Performance - Trust Position

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

Cancer 31 Days First Treatment

Red: Less than 96%
Green: 96% or above

Cancer 31 Days Subsequent Surgery

Red: Less than 94%
Green: 94% or above

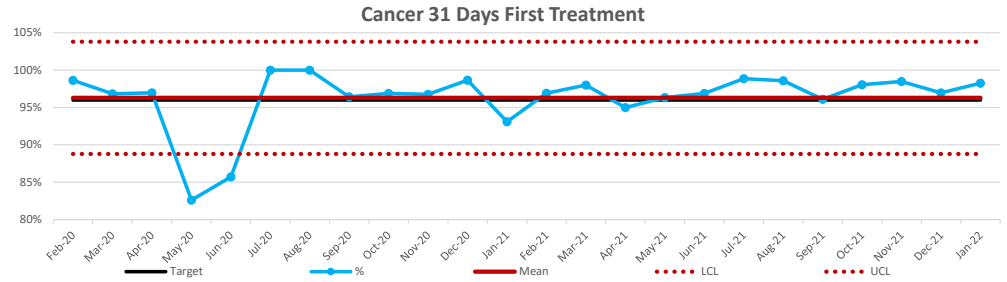
Cancer 31 Days Subsequent Drug

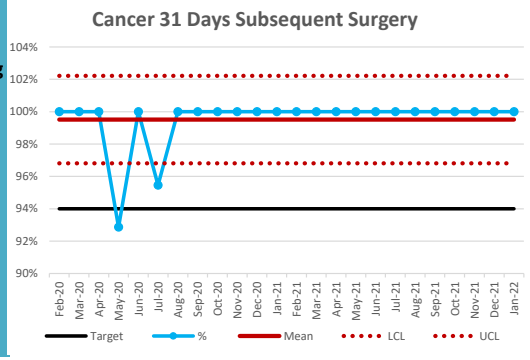
Red: Less than 98%
Green: 98% or above

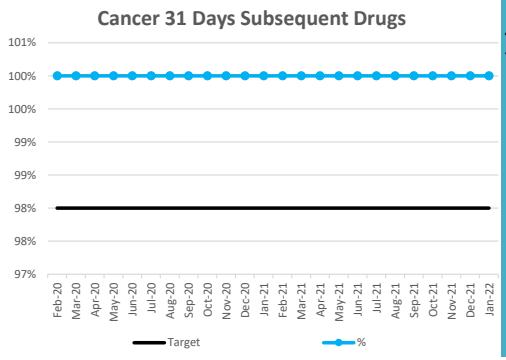
SOF CQC

The Trust achieved 98.25% for Cancer 31 days first treatment, 100% for surgery and 100% for drug treatment in January 2022.

RR1125







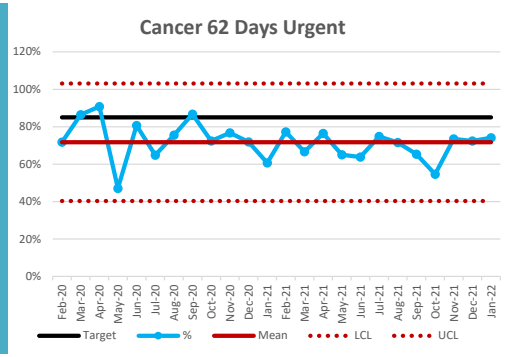
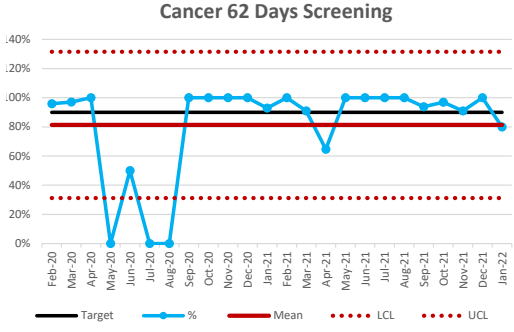
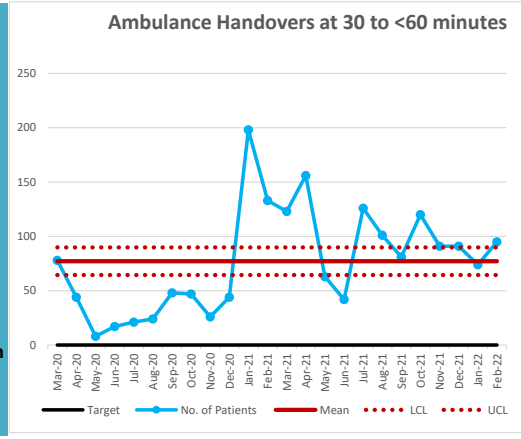
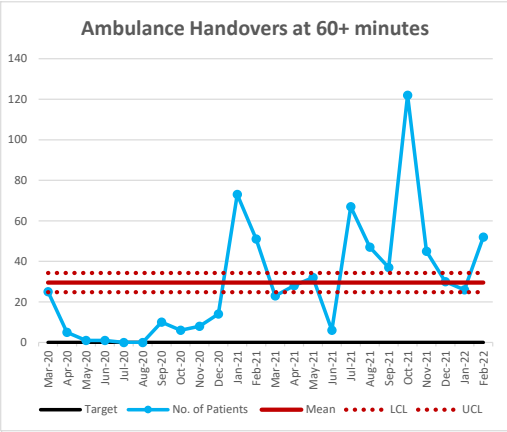
The 31 day cancer target was achieved in January 2022. Good compliance against this standard continues to be tracked.

There remains a risk for performance due to the impact of the pandemic. Capacity is being reviewed in line with clinical service restoration plans.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above **Cancer 62 Days Screening** Red: Less than 90% Green: 90% or above	SOF CQC **The Trust achieved 74.07% for Cancer 62 Day Urgent and 80.00% for Cancer 62 Day in December 2022.** RR1125	 	**The 62 day urgent target was not achieved in January 2022. The Trust is meeting the Cheshire & Merseyside Cancer Alliance agreed trajectories for improvement.**	**There remains a risk for performance due to the impact of the pandemic.**
Ambulance Handovers 30 to <60 minutes Red: More than 0 Green: 0 **Ambulance Handovers at 60 minutes or more** Red: More than 0 Green: 0	**There were 95 patients who experienced a delay in Ambulance Handover between 30 to 60 minutes and 52 patients who experienced a delayed handover over 60 minutes in month.** SOF	 	**Handover performance has improved following the improvement collaborative with the North West Ambulance Service (NWAS).**	**In May 2021, the Trust began a service improvement collaborative with NWAS to improve ambulance handover waiting times. The Trust will continue to work in partnership with the NWAS to identify and implement improvements.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Access & Performance - Trust Position

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

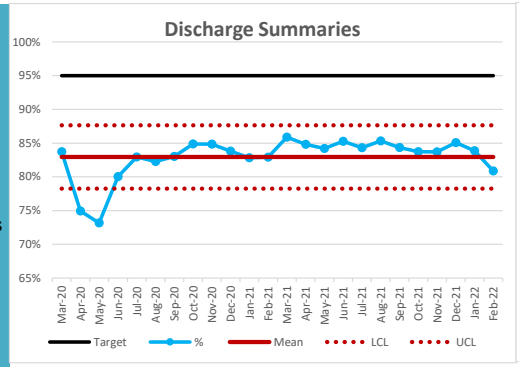
Discharge Summaries - % sent within 24hrs

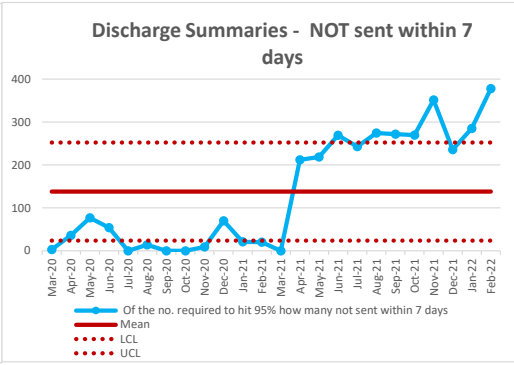
Red: Less than 95%
Green: 95% or above

Discharge Summaries - Number NOT sent within 7 days

Red: Above 0
Green: 0

The Trust achieved 80.87% in month. There were 378 discharge summaries not sent within 7 days required to meet the 95.00% threshold.





Performance of discharge summaries within 24 hours has been maintained despite Wave 5 challenges. Challenges remain for compliance against the 7 day standard. The is attributable to the implementation of the new process. Although this had been identified, progress in resolving this issue has been impacted by the staffing challenges as a result of Wave 5. Further work will be undertaken in Q4/Q1 to resolve this.

The Performance Review Group (PRG) continues to monitor this standard to support improvements.

Cancelled Operations on the day for a non-clinical reason

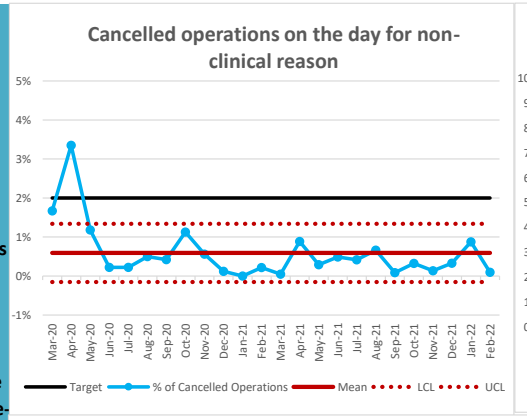
Red: > 2%
Green: < 2%

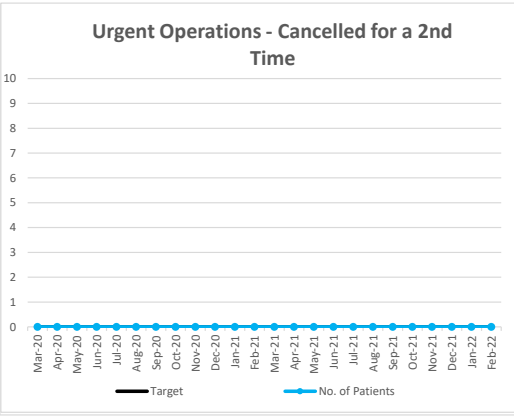
Urgent Operations - Cancelled for a 2nd Time
Green = 0
Red = > 0

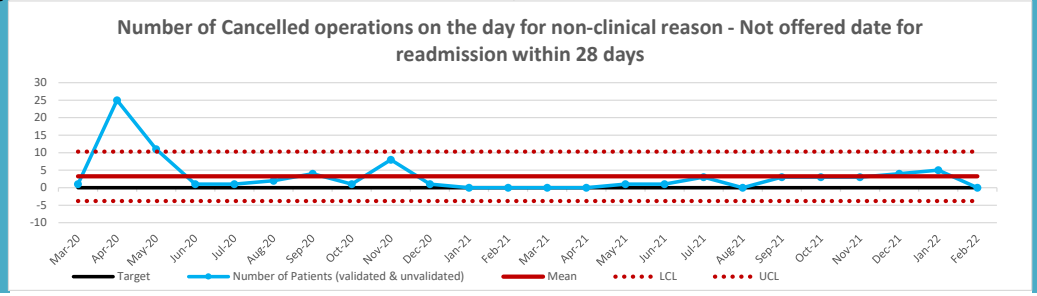
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation

Red: Above zero

0.09% of operations were cancelled on the day for non clinical reasons in month. There was 0 cancelled operations on the day for non clinical reasons in month, where the patient was not re-booked in within 28 days. There were 0 urgent operations cancelled for a second time in month.







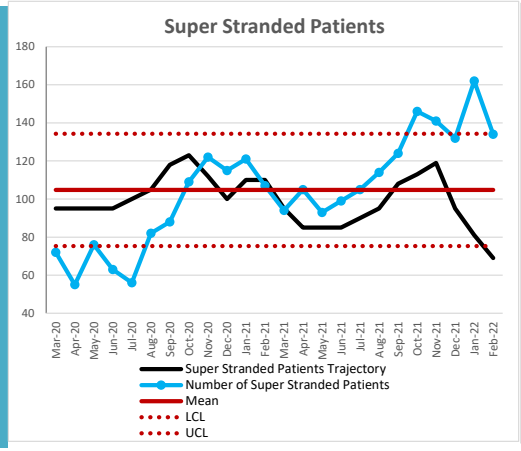
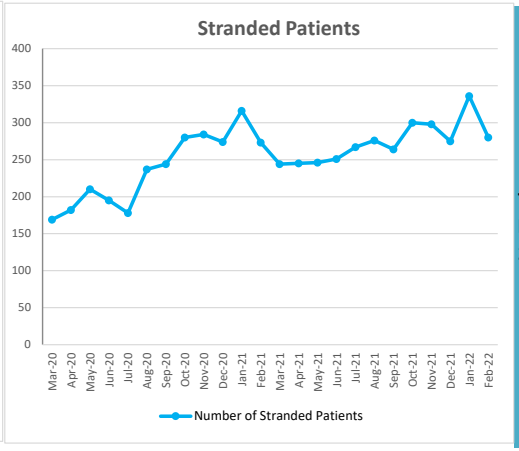
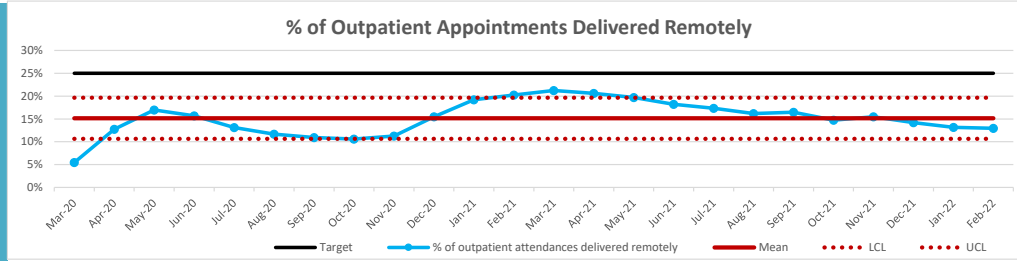
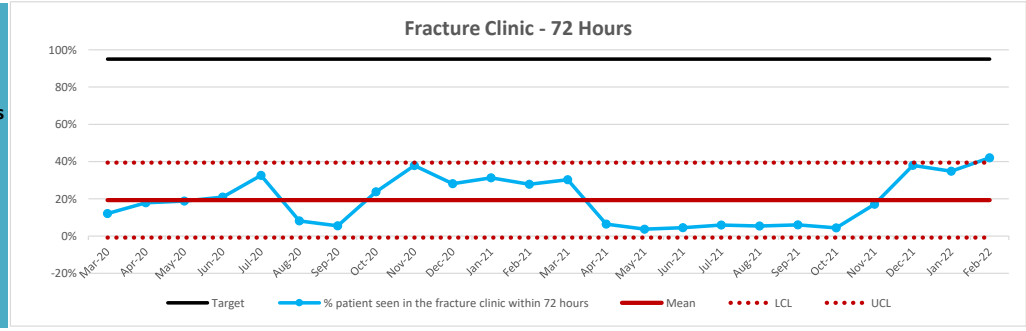
Compliance against this standard remains below the monitored threshold of 2.00% (positive).

Recovery of elective activity continues to be monitored via the Clinical Services Recovery Oversight Group (CSOG).

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

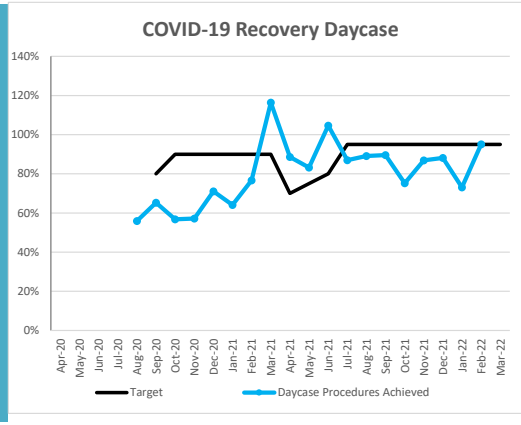
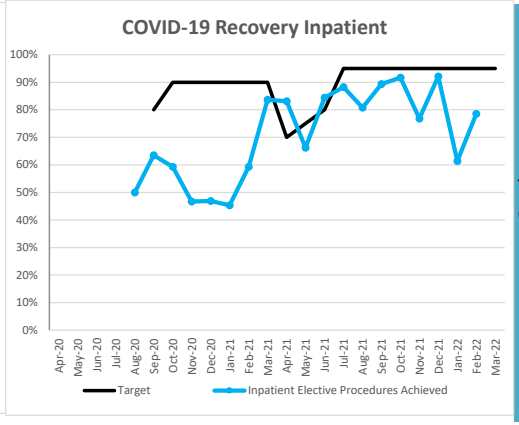
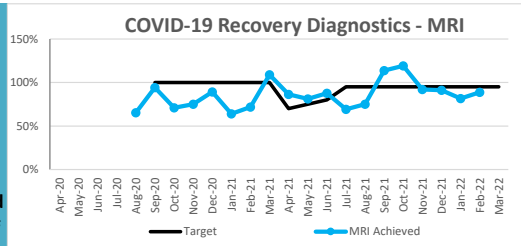
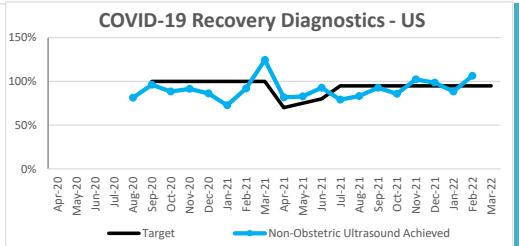
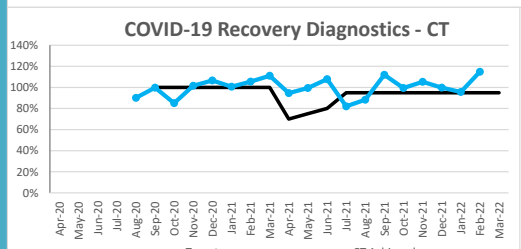
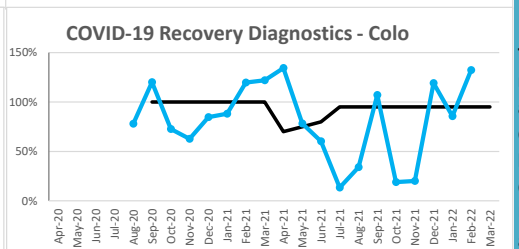
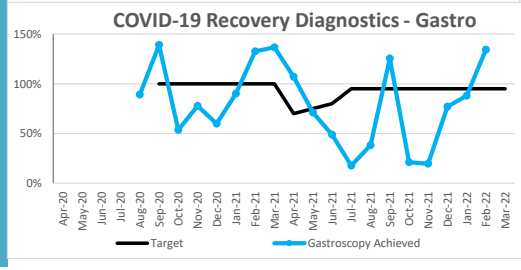
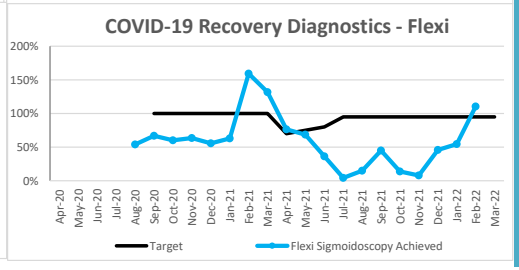
Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Super Stranded Patients **Green: Meeting Trajectory** **Red: Missing Trajectory**	**There were 280 stranded and 134 super stranded patients at the end of February 2022.**	 	**The number of Super Stranded patients has increased to a level not seen since 2017/18.**	**The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available throughout the pandemic.** **The Trust has introduced "Where's best next" Length of Stay meetings on a daily basis to support timely discharge.**
Outpatient Activity Delivered Remotely Green = 25% or more **Red = Less than 25%**	**12.95% of Outpatient Appointments were delivered remotely in month.**		**The Trust did not achieve the standard in month for % of outpatient appointments delivered remotely.**	**The Trust continues to identify opportunities to deliver additional outpatient activity remotely.**
Patients seen in the Fracture Clinic within 72 hours Green: 95% **Red: Less than 95%**	**42.04% of patients were seen in the Fracture Clinic within 72 hours in month.**		**In line with the action plan, the Fracture clinic service has improved performance but continues to track below compliance.** **The service remains on track to achieve this indicator in Q4.**	**The action plan will continue to be monitored within the Planned Care Group.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

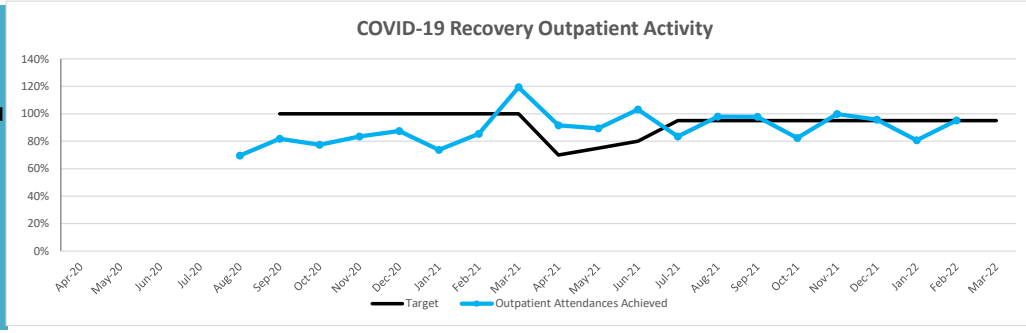
Key: Risk Register RR116 | System Oversight Framework SOF | Care Quality Commission CQC

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
COVID-19 Recovery Elective Activity RED = Below Elective Recovery Target Green = Elective Recovery Target % activity is against activity in the same month in 2019/20			
SOF In February 2022, the Trust achieved the following % of activity against February 2020. This included 95.06% of Daycase Procedures and 78.50% of Inpatient Elective Procedures. RR1125	 	The Trust did meet the aggregated elective activity recovery trajectories for February 2022 in line with the H2 plan.	The Trust monitors progress weekly via PRG and Clinical Services Oversight Group (CSOG) and will progress measures to switch services back on at the earliest opportunity based on the impact of COVID-19.
COVID-19 Recovery Diagnostic Activity RED = Below Elective Recovery Target Green = Elective Recovery Target % activity is against activity in the same month in 2019/20			
SOF In February 2022, the Trust achieved the following % of activity against February 2020. This included: 88.67% of MRI 114.90% of CT 106.34% of Non-Obstetric Ultrasound 110.47% of Flexi Sigmoidoscopy 132.28% of Colonoscopy 134.43% of Gastroscopy RR1125	     	The Trust did meet the diagnostic activity recovery trajectories for February 2022 across a number of specialties. Colonoscopy, Flexi Sig and Gastroscopy have started to show an improvement. Cardiorespiratory, particularly Echo and Ultrasound remain the most challenged areas.	The Trust continues to restore clinical services in line with the national operating guidance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
SOF RR1125 **In February 2022, the Trust achieved 95.12% of Outpatient activity against February 2020.**		**The Trust met the Outpatient activity recovery trajectories for February 2022.**	**The Trust continues to restore clinical services in line with the national operating guidance.**

COVID-19 Outpatient Activity
RED = Below Elective Recovery Target
Green = Elective Recovery Target
% activity is against activity in the same month in 2019/20

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

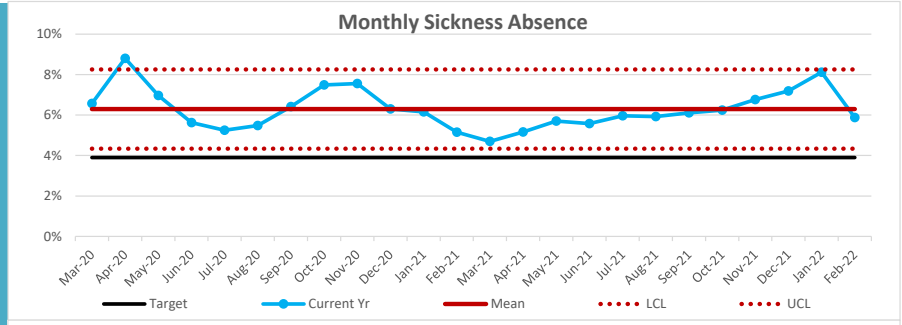
Key:
System Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy ($)

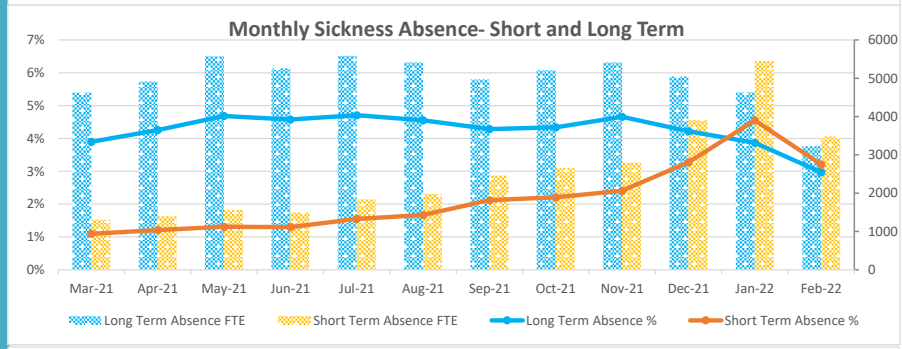
Trust Performance | **Trend** | **What are the reasons for the variation and what is the impact?** | **How are we going to improve the position (Short & Long Term)?**

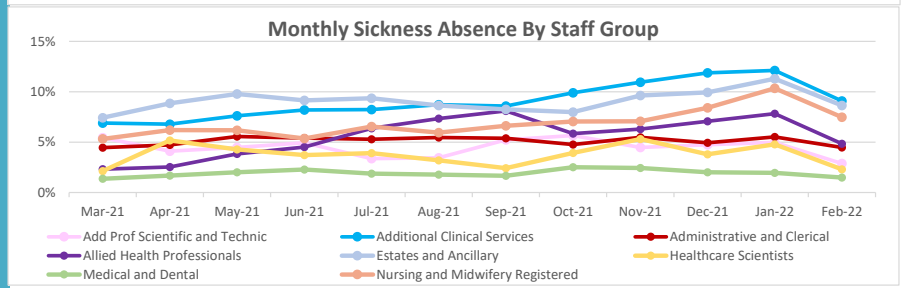
Sickness Absence

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

The Trust's sickness absence rate was 6.18% in month.







RR200 RR1108 RR1134

Sickness absence was 6.18% in February 2022.

Short term absence was 3.21% and 2.97% relates to long term absence.

Sickness absence in February 2021 was 5.45%.

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

The Supporting Attendance project work with NHSE/I is ongoing and is currently focusing on individual management coaching and bitesize briefings on the new Supporting Attendance Policy, including attendance at the Nursing and Midwifery forum.

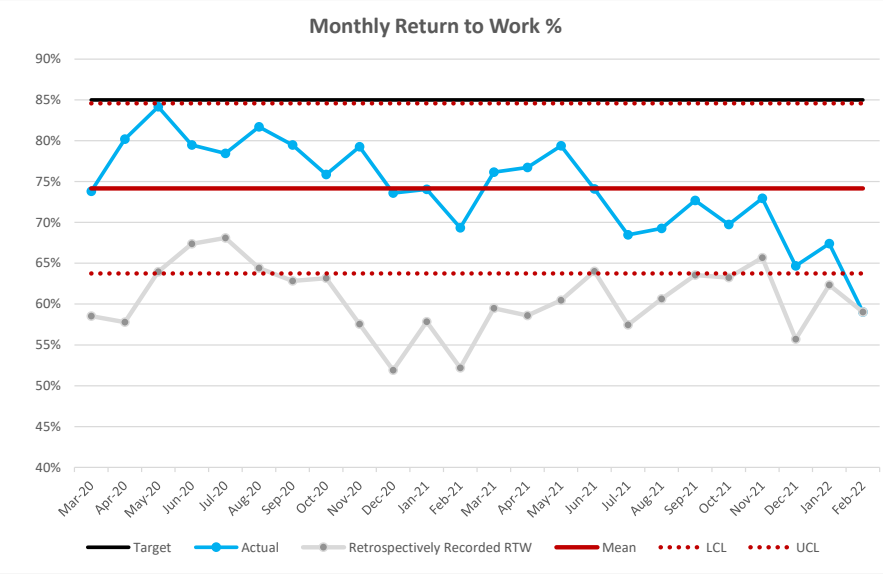
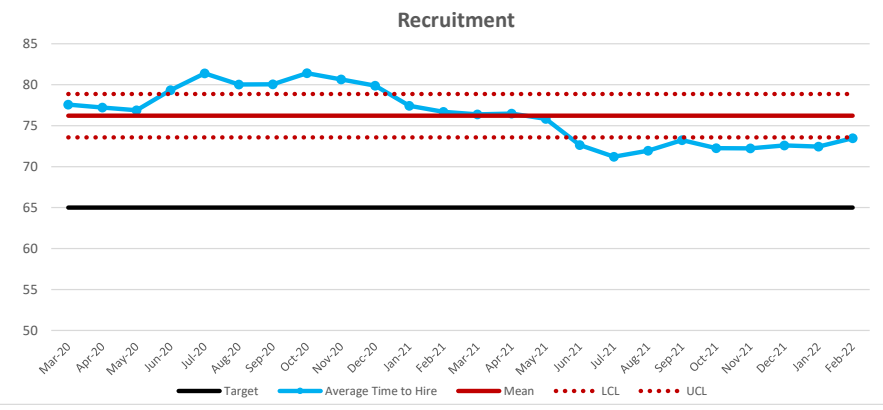
Full training sessions are planned within the Line Management Development programme, which remains on target to commence in April 2022.

The Occupational Health and Wellbeing Team hold triangulation meetings with HR colleagues to review individuals who are under formal stages of the Supported Attendance Management policy to progress the case, through enhancing support and/or to develop interventions.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	**Return to Work (RTW) interview compliance was 59.04% in February 2022.**		**Previous months RTW compliance has increased as managers input historic RTWs that occurred, but were not recorded on the system at the time. The 12 month RTW compliance is 70.15%.**	**Specific support continues within areas of high sickness and low compliance for Return to Work interviews.** **As part of Supporting Attendance project, the Return to Work Interviews have been refocused as Welcome Back Conversations. Bespoke training and one to one management coaching on Welcome Back Conversations is available and continues to be offered across all CBUs.** **A focused Welcome Back Conversation workshop will also be offered as a training opportunity within the essential skills for managers programme.** **In addition, the Workforce Systems teams are arranging monthly drop-in sessions (an expansion to what is currently delivered), part of this offer will include Return to Work data input demonstrations in both ESR and E-Rostering.**
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or below	**The average number of working days to recruit is 73 days, based on the last 12 months average.**		**Recruitment time to hire for February 2022 is 73 working days compared to 77 working days in February 2021. This includes notices periods.**	**The Recruitment team continues to refine communications and engagement with recruiting managers to manage expectations and to proactively consider how recruitment timelines are aligned to best practice.** **In addition, the team is actively developing an inclusive recruitment approach which will have a positive impact on attraction, supporting reduction in the time to hire and potential retention within the organisation.** **It is anticipated that the development of NHS Jobs 3 will enable further options to improve Time to Hire. The Trust is awaiting a national go live date for NHS Jobs 3.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

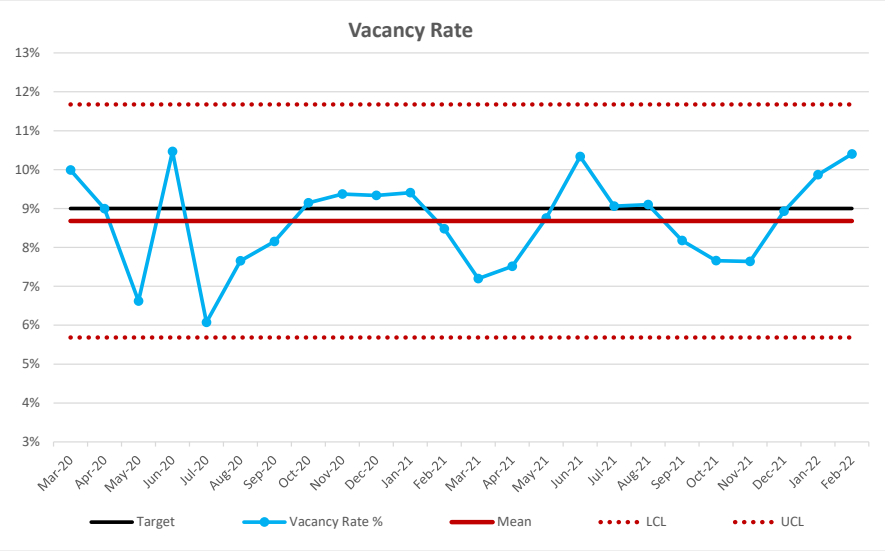
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Vacancy Rates

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

UoR

The Trust's vacancy rate is above the 9.00% target, at 10.40% in February 2022 (457 FTE Vacancies).



The Trust's headcount continues to be the highest on record. This is due to an increase in the number of new starters and a reduction of leavers.
The Trust has launched an Inclusive Recruitment action plan following a gap analysis with the Model Employer action plan.
Job descriptions and adverts now include additional ED&I information on NHS Jobs and further work to develop the Trust recruitment website is taking place. Initial work has been completed on refreshing the recruitment page on the Trust website following input from the Trust Networks, Learning and Development, Wellbeing, Apprenticeships and Recruitment Teams. Further development throughout the year is planned and the Trust is working towards having pages dedicated to different staff groups.
An ED&I video for managers is now available and has been distributed to recruiting managers to raise awareness on bias.
The recruitment team has refreshed the recruitment training offer which will also forms part of the Line Management Development Programme to be launched in April 2022.
The Trust's reward and benefit scheme benchmarks very well and is promoted to candidates and current staff, further plans to promote it wider are in place.
It is anticipated that the development of NHS Jobs 3 will enable further options to support candidate experience.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

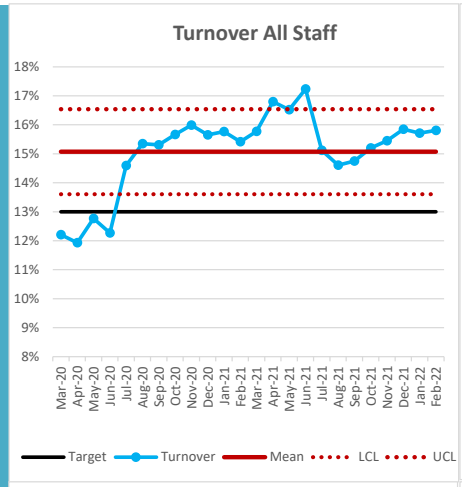
Key:
System Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

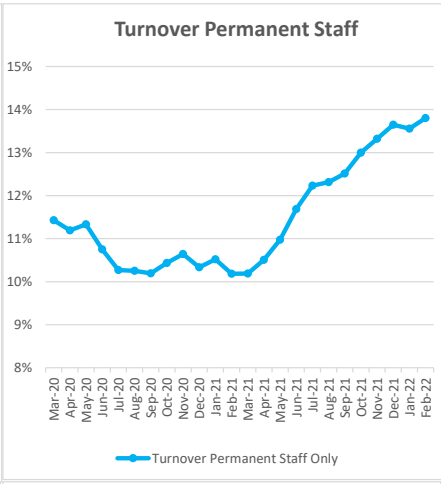
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Turnover

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

Turnover of All staff was 15.81% and Turnover of Permanent staff only was 13.80% in month.

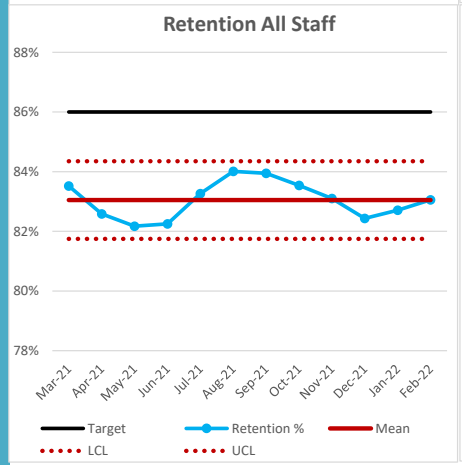


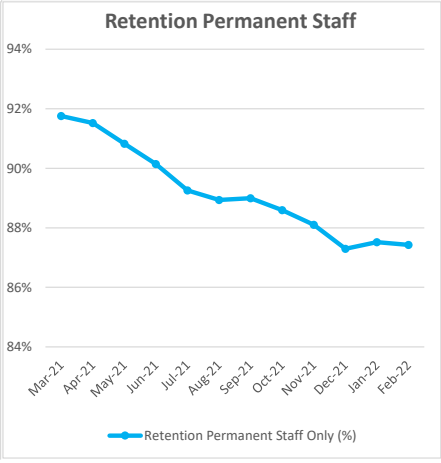


Retention

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

Retention of all staff was 83.05% and Retention of Permanent staff only was 87.42% in month.





For permanent staff only, the Trust is performing at 0.8% above Trust Target for both Turnover and Retention.

Work-life balance continues to be the number one reason people leave WHH.

The Trust participates in the NHSE/I Flex for Future programme and has established an Agile Working Task and Finish Group to develop a strategic approach to agile working and oversee any recommendations for implementation. The Task and Finish group had been paused, however the group will meet again in April 2022.

As a reminder the internal task and finish group will broadly follow the following objectives, based on the national programme:
1. Defining Flexible and Agile working. Understanding the legalities.
2. Understand the organisation's current Agile Working/Flexible Working culture.
3. Understand the systems available to support Flexible and Agile working.
4. Develop an options appraisal for the WHH approach to Flexible and Agile working.
5. Develop material to support Flexible and Agile working promotion, training and toolkits.
6. Review Flexible and Agile working polices to align them to the agreed WHH approach.

Existing team development offers includes Affina, bespoke team sessions, the maternity leadership programme and leadership circles. The Organisational Development team has responded to 163 bespoke requests from teams and individuals in 2021 and has received 19 requests to date in 2022.

The OD team and the Mental Health Wellbeing team are working together to provide team support for the Planned Care Group and all three care groups are to commence on the Affina journey in the early spring. The new line manager programme is nearing completion with an anticipated launch date in April 2022.

The career development offer continues to be utilised with workshops now available on ESR.

The Shadow Board is due to recommenced in March, with an introduction to leadership offer being piloted. Compassionate leadership workshops are taking place with positive evaluation from the first which was held in February.

The first phase of the Scope for Growth talent tool and associated training is due for implementation by April 2022.

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

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

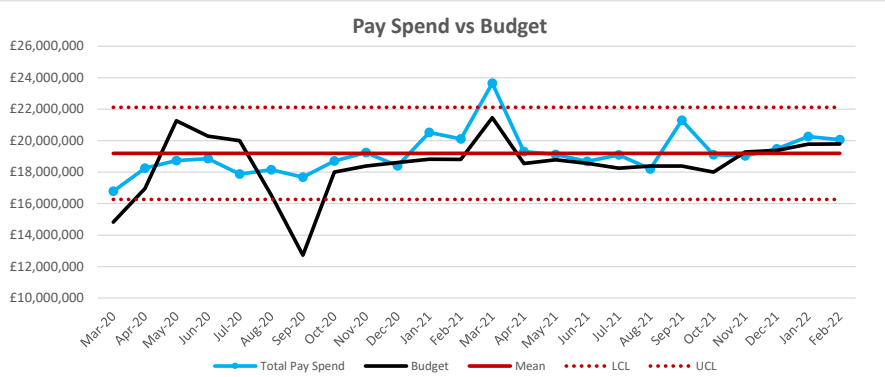
Pay

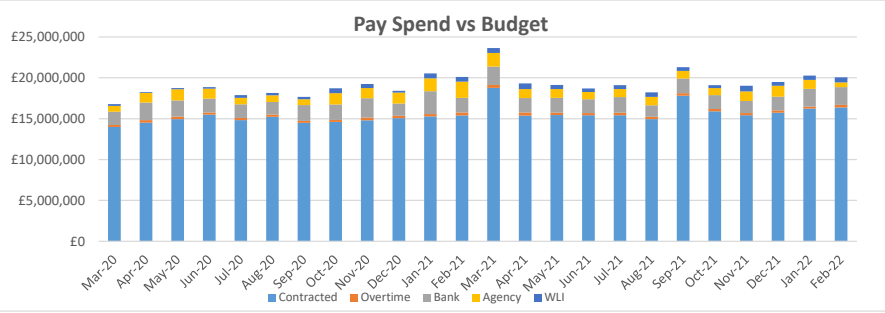
Red: Greater than Budget

Green: Less than Budget

UoR

Total pay spend in February 2022 was £20.06m against a budget of £19.79m.





Total pay spend in February was £20.06m against a budget of £19.79m.

The total pay spend is broken down into the following elements:
- **£16.39m contracted**
- **£2.18m Bank**
- **£0.58m Agency**
- **£0.63m WLI**
- **£0.29m Overtime**

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

Through the Finance and Sustainability Committee (FSC), compliance against Trust processes and rate cards continues to be monitored.

Bank and Agency Reliance

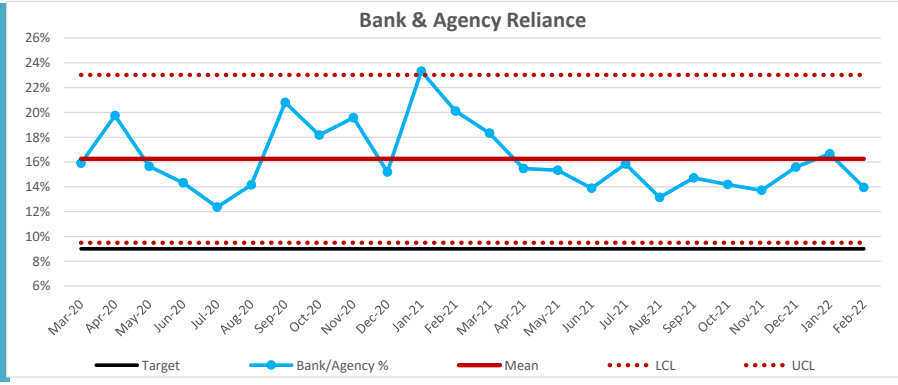
Red: 11% or Above

Amber: 11% to 9%

Green: 9% or Below

UoR

Bank and Agency Reliance was 13.95% in month.



Bank and Agency reliance peaked at 23.30% in January 2021 and there has been a continued reduction since. In February 2022, reliance was 13.95%.

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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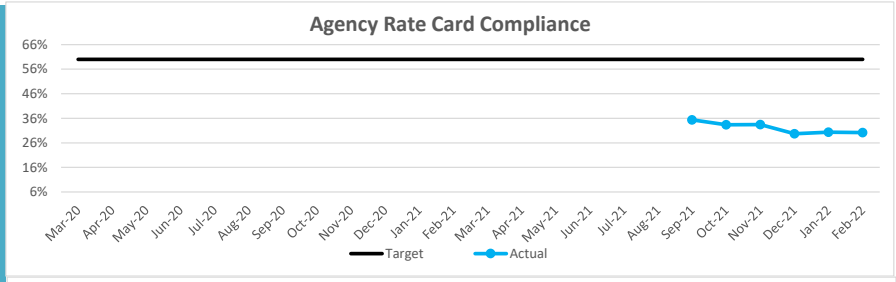
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Agency Rate Card Compliance

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

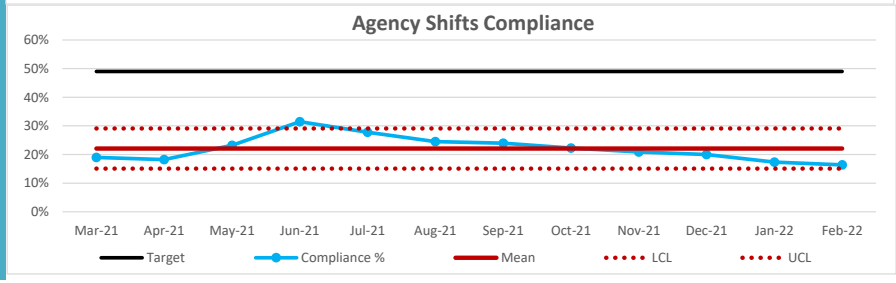
Agency Rate Card Compliance was 30.21% in month.



Agency Shifts Compliant with the Cap

Red: below 49%
Green: above 49%

16.39% of shifts were compliant with the NHSI Price Cap.



Compliance with the NHSE/I rate card was 16.39% in February 2022, non-compliance was highest amongst the following staff groups:

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

Compliance with the Cheshire and Merseyside rate card was 30.21% in February 2022 which is a reduction from the previous month.

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

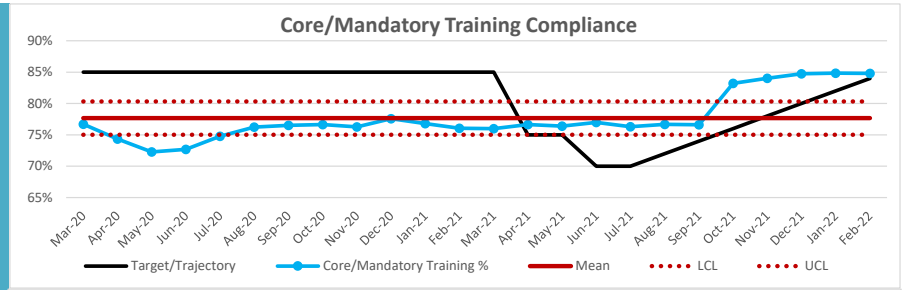
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Core/Mandatory Training

Red: Below Trajectory
Green: Trajectory

CQC

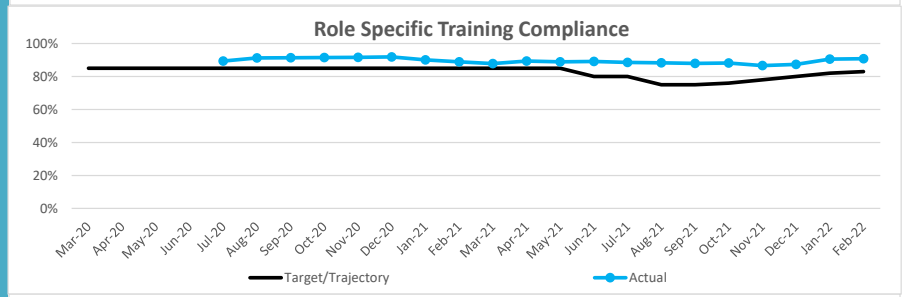
Core/Mandatory training compliance was 84.79% in month.



Role Specific Training

Red: Below Trajectory
Green: Trajectory

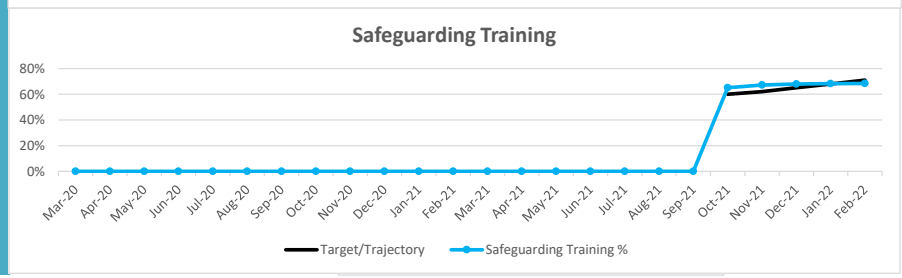
Role Specific Training compliance was 90.75% in month.



Safeguarding Training

Red: Below Trajectory
Green: Trajectory

Safeguarding Training compliance was 68.00% in month.



In February 2022 Mandatory Training compliance was 84.79%, this now excludes Safeguarding Training (Children's and Adults); Safeguarding compliance was 68.00%, and Role Specific Training compliance was 90.75%.

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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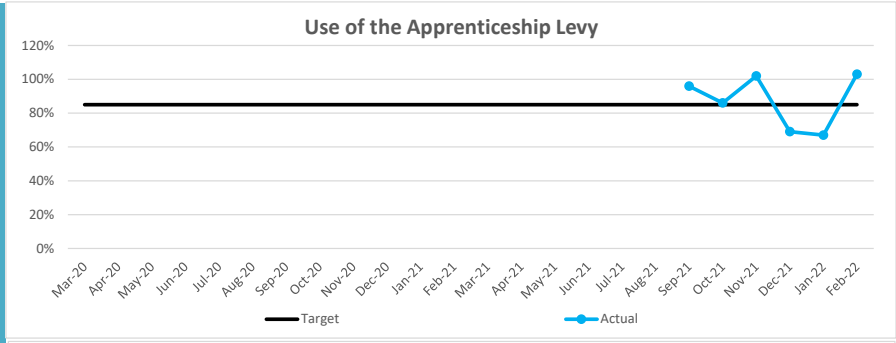
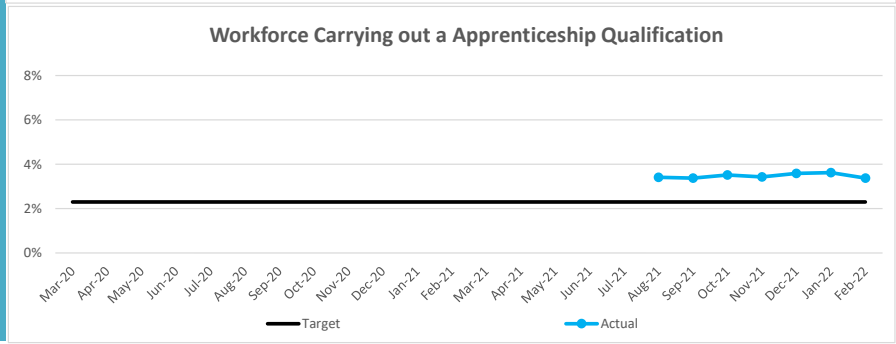
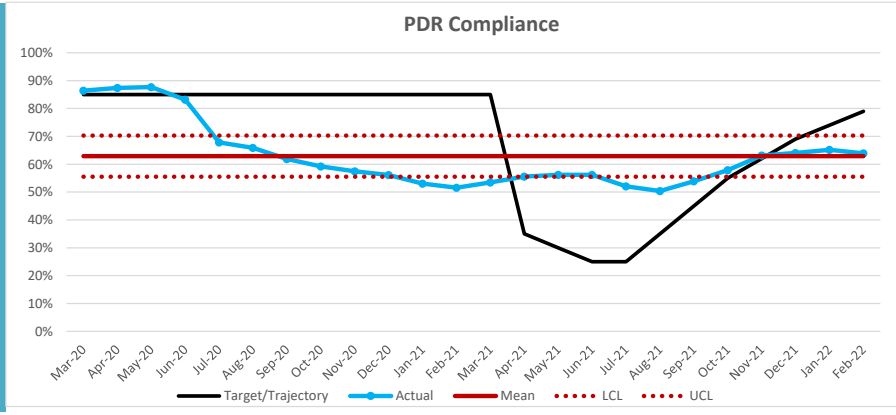
Care Quality Commission (CQC)
Trust Strategy (S)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Use of Apprenticeship Levy Red: below 50% Amber: 50-84% Green: 85% or above	**Use of the Apprenticeship Levy was 103.00% in month.**	**Utilisation of the apprenticeship levy is 103.00% in February 2022, which is above target in month (positive), and 3.38% 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.**
Workforce carrying out an Apprenticeship Qualification Red: below 1.5% Amber: 1.5% - 2.2% Green: 2.3% or above	**3.38% of the workforce was carrying out a qualification in month.**		
PDR Red: Below Trajectory Green: Trajectory	**PDR compliance was 63.91% in month.**	**In February 2022, PDR compliance was 63.91%** **Currently PDR rates are below the trajectories.**	**An improvement trajectory to return to above target compliance has been in place since July 2021. Since January 2022, the Trust has fallen short of the agreed trajectory, which is currently under review.** **The CBUs continue to be supported to develop trajectories to improve compliance, including use of the Wellbeing Check In conversations where appropriate, these are monitored through the Workforce governance structure.**







Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

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

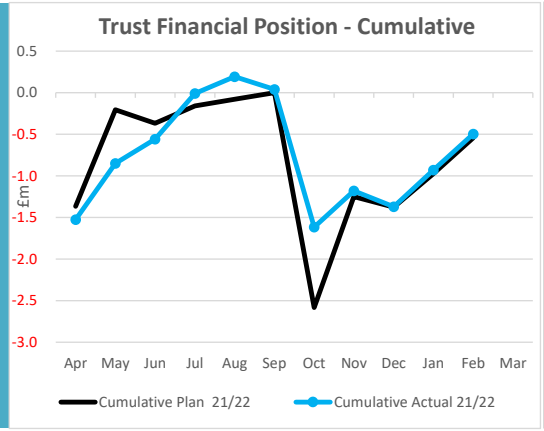
Trust Financial Position

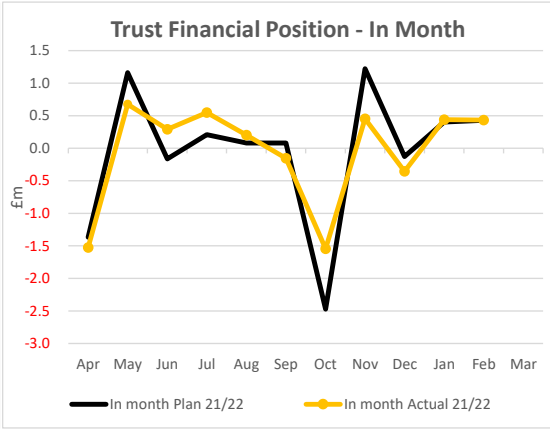
Red: Deficit Position
Amber: Actual on or better than planned but still in deficit
Green: Surplus Position

UoR SOF S

The Trust has recorded a deficit position of £0.5m as at 28 February.

RR134





For the period ending 28 February 2022, the Trust has recorded a deficit of £0.5m. The position includes an overspend on COVID-19 partly offset with underspends in other areas of the organisation.

The Trust is forecasting a breakeven 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.

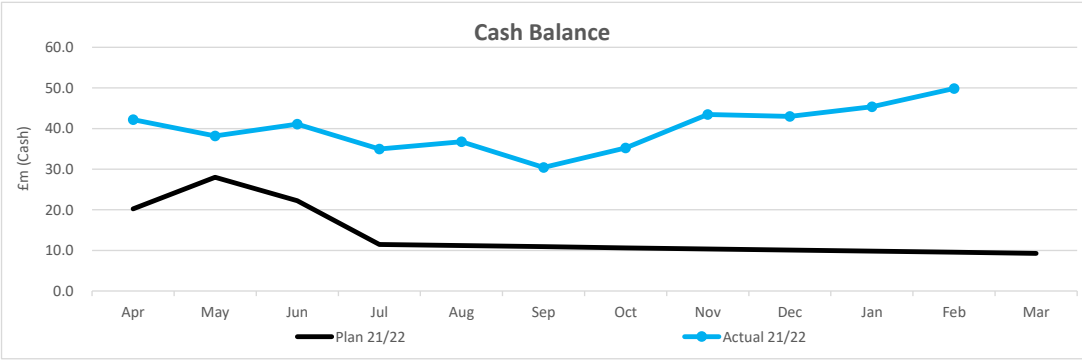
Cash Balance

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

UoR

The current cash balance is £49.9m.

RR134



The current cash balance is £49.9m which is £40m better than the initial cash plan. The current high cash balance is due to VAT recovery, SLA and COVID-19 income and a delay in capital payments.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

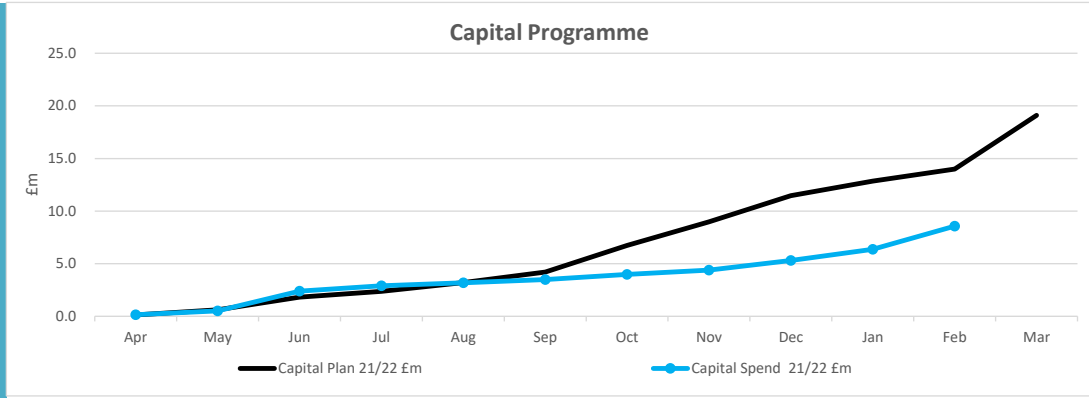
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Capital Programme

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

UoR

The year to date capital spend in month 11 was £8.6m.



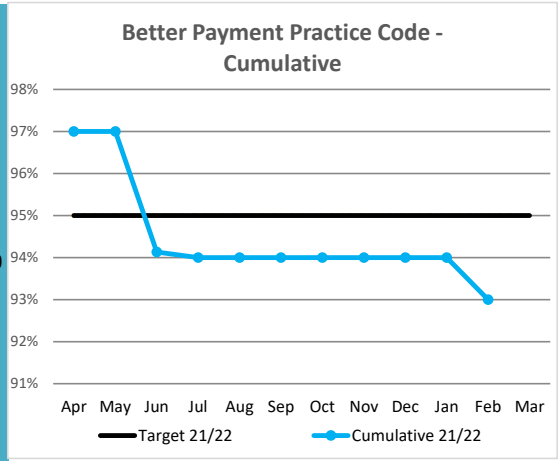
The capital plan is £19.1m of which £2.8m of the ED Plaza monies have been brokered to the C&M system. The actual spend year to date is £8.6m which is £5.4m below the planned spend of £14.0m.

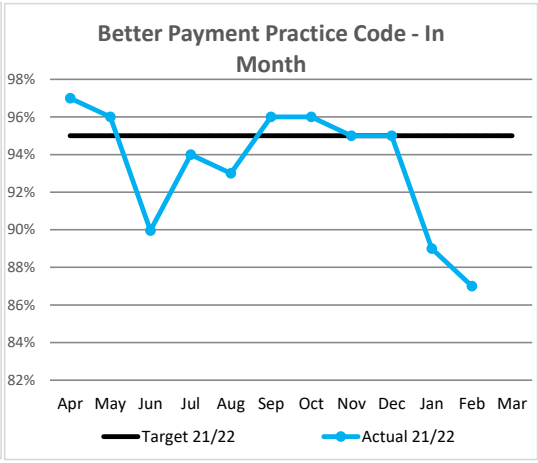
Better Payment Practice Code

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

UoR

In month, the Trust has paid 93.00% of suppliers within 30 days.





Cumulative performance is 93.00% which is below the national target of 95.00%.

Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments.

Use of Resources Rating

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

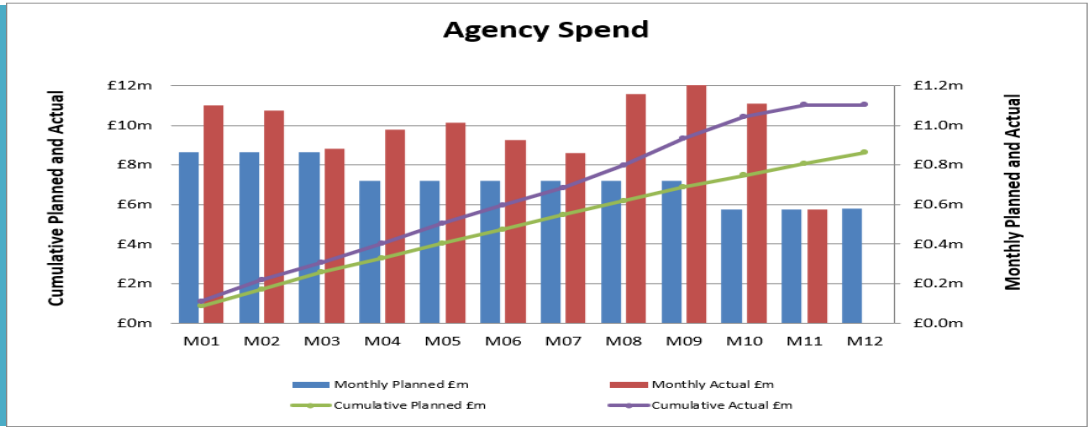
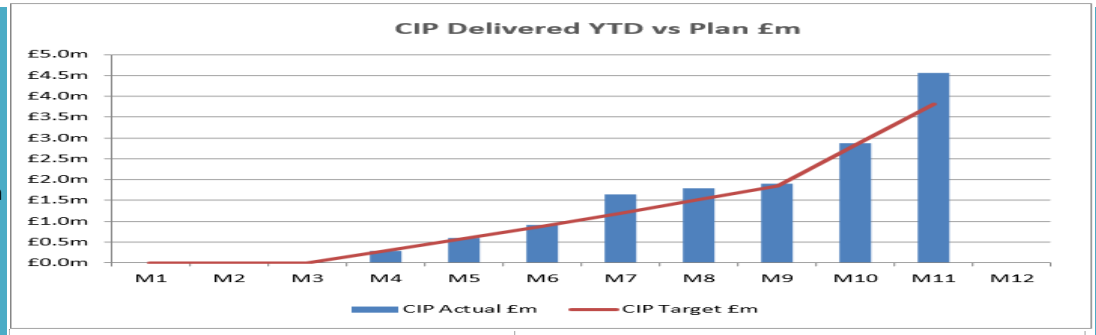
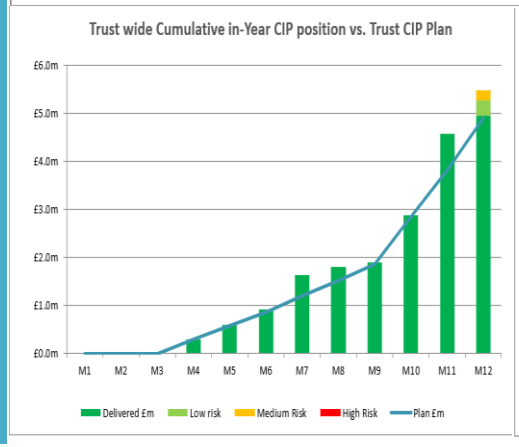
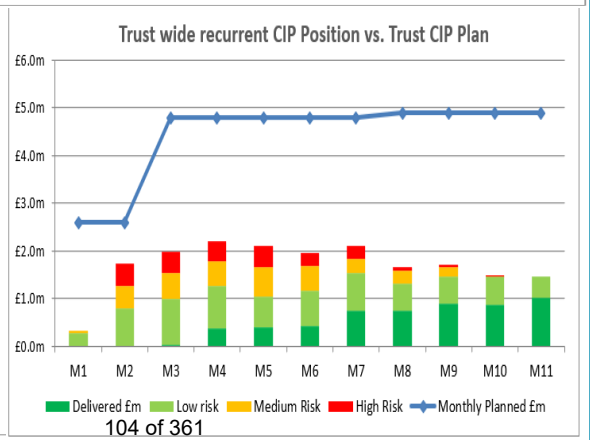
UoR

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	UoR **The actual agency spend in month is £0.6m.**		**The year to date spend of £11.0m is £3.0m above the plan of £8.0m.**	**The Trust continues to monitor and report the use and spend on agency staffing as well as the use of efficient models to reduce costs.**
Cost Improvement Programme - In year performance to date Red: 0-70% Plan delivered YTD Amber: 70-90% Plan delivered YTD Green: >90% Plan	UoR **The year to date savings are £4.56m**		**The year to date savings are £4.56m against a plan of £3.81m.**	**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 **The current forecast based on recurrent schemes identified is £1.5m, against a plan of £4.9m.**	 	**There was no CIP target in Q1 2021/22. The Trust has a target of £4.9m for the year and schemes have been developed with CBU and Corporate Services to deliver the CIP.**	**To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT is being used.**
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 Never Events reported by the Trust. Number of Serious Incident actions breached. Number of open incidents is the total number of incidents that we have awaiting review.
Duty of Candour	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days. Duty of Candour must be completed within 10 working days.
Healthcare Acquired Infections (MRSA, CDI and Gram Negative)	Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to meticillin are termed meticillin susceptible Staphylococcus aureus (MSSA). MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. Clostridium difficule (c-diff) due to lapses in care; agreed threshold is <=44 cases per year. Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections. A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2024.
Healthcare Acquired Infections COVID-19 Hospital Onset and Outbreaks	Measurement of COVID-19 infections onset between 8-14 days and 15+ days of admission. Measurement of outbreaks on wards (2 or more probably or confirmed cases reported on a ward over a 14 day period).
VTE Assessment	Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month.
Total Falls & Harm Levels	Total number of falls per month and their relevant harm levels. This indicator shows total number of falls which occur in the hospital (including staff and public falls) and total number of inpatients falls
Pressure Ulcers	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.
Medication Safety	Overview of the current position in relation to medication, to include; medication reconciliation (overall and within 24 hours of admission), controlled drugs incidents and medication incidents relating to harm.
Staffing Average Fill Levels	Percentage of planned verses actual for registered and non-registered staff by day and night. Target of >90%. The data produced excludes CCU, ITU and Paediatrics.
Care Hours Per Patient Day (CHPPD)	Staffing Care Hours per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
HSMR Mortality Ratio	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.
SHMI Mortality Ratio	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following

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

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

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

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

Appendix 4 - Statistical Process Control

What is SPC?

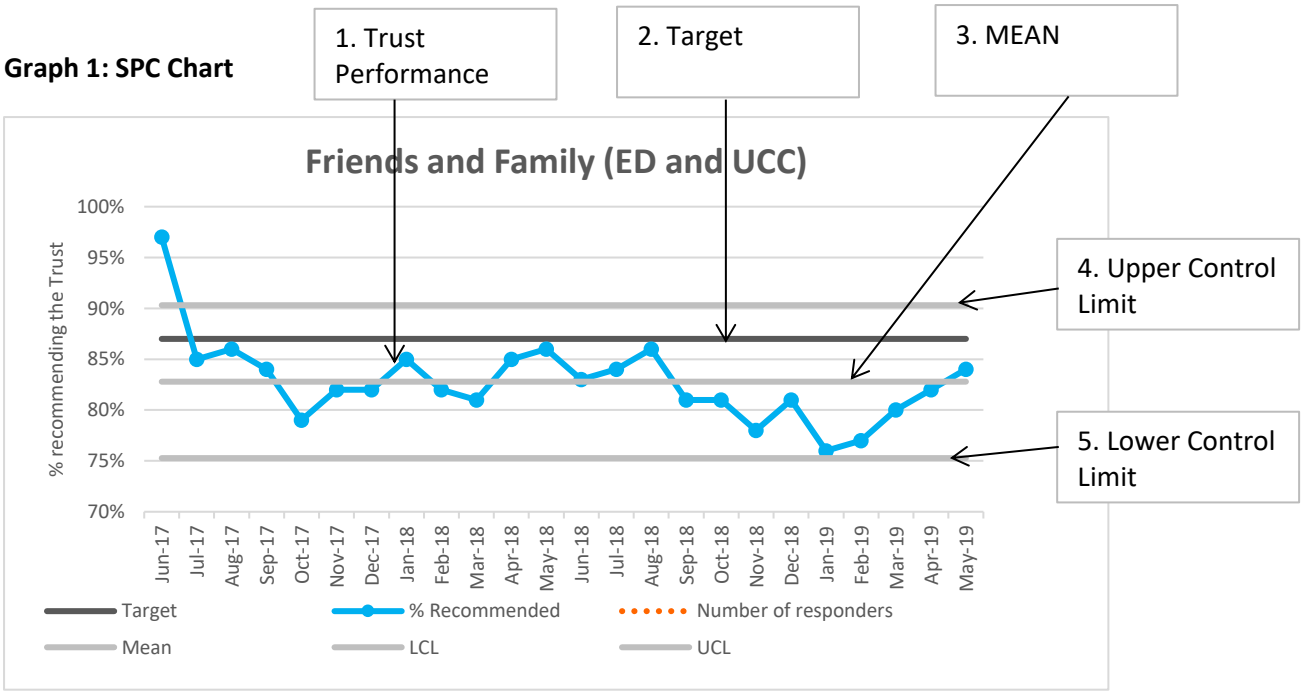
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

SPC Charts

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

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

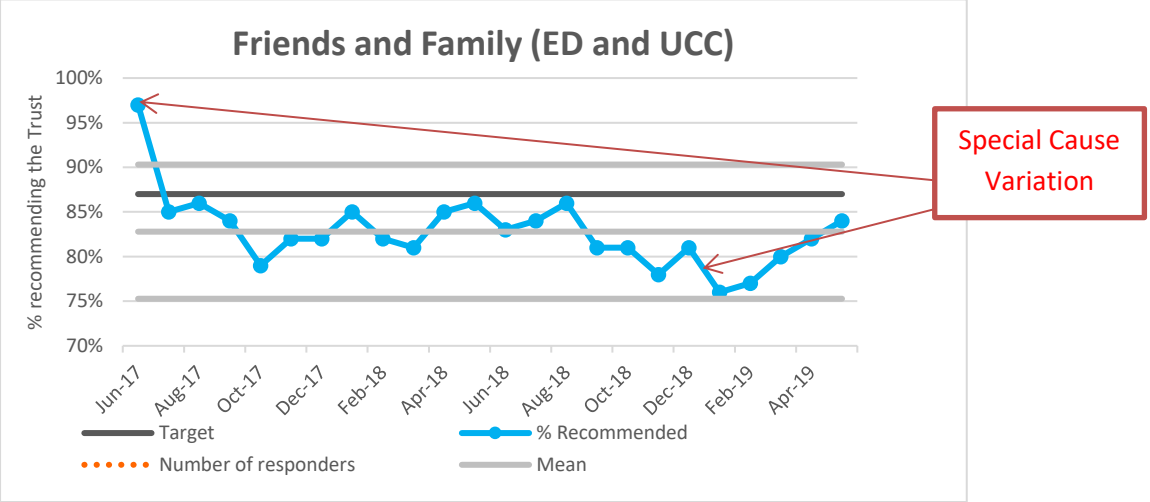
Graph 1: SPC Chart



Interpreting a SPC Chart

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

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



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

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

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

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

Appendix 5

Income Statement, Activity Summary and Use of Resources Ratings as at 28th February 2022

Income Statement	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income						
NHS Clinical Income						
Elective Spells	2,422	1,910	-512	27,849	25,087	-2,762
Elective Excess Bed Days	12	22	10	140	95	-46
Non Elective Spells	5,606	5,313	-294	64,827	62,236	-2,591
Non Elective Bed Days	179	152	-27	1,966	1,670	-296
Non Elective Excess Bed Days	142	114	-28	1,643	1,094	-549
Outpatient Attendances	2,997	2,786	-211	34,466	35,043	576
Accident & Emergency Attendances	1,353	1,374	22	15,506	17,156	1,650
Other Activity	7,440	8,891	1,451	66,619	74,526	7,907
COVID Top up Income (Liverpool CCG)	4,466	3,969	-497	51,406	52,166	760
Sub total	**24,617**	**24,532**	**-85**	**264,422**	**269,073**	**4,651**
Non NHS Clinical Income						
Private Patients	0	-1	-1	0	225	225
Non NHS Overseas Patients	1	0	-1	26	9	-17
Other non protected	81	117	36	888	666	-223
Sub total	**82**	**117**	**34**	**914**	**900**	**-14**
Other Operating Income						
Training & Education	683	767	85	7,508	7,927	419
Donations and Grants	0	0	0	0	100	100
Miscellaneous Income	2,419	1,972	-447	15,647	14,808	-839
Sub total	**3,102**	**2,739**	**-363**	**23,155**	**22,835**	**-320**
Total Operating Income	**27,801**	**27,388**	**-414**	**288,491**	**292,808**	**4,317**
Operating Expenses						
Employee Benefit Expenses	-19,785	-19,771	15	-207,164	-210,474	-3,310
Drugs	-1,558	-1,328	230	-15,092	-16,846	-1,754
Clinical Supplies and Services	-1,924	-1,766	158	-20,686	-20,755	-68
Non Clinical Supplies	-2,947	-2,946	1	-32,232	-32,554	-322
Depreciation and Amortisation	-836	-788	48	-9,666	-8,527	1,138
Net Impairments (DEL)	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0
Total Operating Expenses	**-27,051**	**-26,599**	**452**	**-284,840**	**-289,156**	**-4,316**
Operating Surplus / (Deficit)	**750**	**789**	**39**	**3,651**	**3,653**	**2**
Non Operating Income and Expenses						
Profit / (Loss) on disposal of assets (Excl COVID DHSC)	0	6	6	0	72	72
Loss on disposal of COVID Assets to DHSC	0	0	0	0	-149	-149
Interest Income	0	9	9	0	15	15
Interest Expenses	0	0	0	0	0	0
PDC Dividends	-341	-388	-47	-4,384	-4,339	45
Total Non Operating Income and Expenses	**-341**	**-373**	**-33**	**-4,384**	**-4,401**	**-17**
Surplus / (Deficit) - as per Accounts	**410**	**416**	**6**	**-733**	**-749**	**-15**
Adjustments to Financial Performance						
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0	0	0
Less Donations & Grants Income	0	0	0	0	-100	-100
Remove loss recognised on return of COVID assets to DHSC	0	0	0	0	149	149
Add Depreciation on Donated & Granted Assets	19	18	0	189	203	14
Total Adjustments to Financial Performance	**19**	**18**	**0**	**189**	**252**	**63**
Adjusted Surplus / (Deficit) as per NHSI Return	**428**	**434**	**6**	**-544**	**-496**	**48**

Activity Summary	Planned	Actual	Variance	Planned	Actual	Variance
Elective Spells	2,595	2,735	139	26,764	25,412	-1,352
Elective Excess Bed Days	45	47	2	515	322	-193
Non Elective Spells	2,758	2,341	-416	30,261	27,680	-2,580
Non Elective Bed Days	498	408	-90	5,479	4,660	-819
Non Elective Excess Bed Days	526	11	-515	6,072	4,032	-2,040
Outpatient Attendances (PBR Only)	34,557	33,975	-582	359,864	410,263	50,399
Accident & Emergency Attendances	10,407	9,372	-1,035	111,443	111,495	52

Appendix 6

CAPITAL EXPENDITURE SUMMARY

PERIOD ENDING 28 FEBRUARY 2022

Scheme Name	Approved Programme 2021/22 £000	Budget Amendments Mths 1-11 2021/22 £000	Emergency Requests Mth 11 2021/22 £001	Proposed Budget Adjustments in Mth 12 2021/22 £000	PDC Adjustments 2021/22 £000	Total Revised Budget 2021/22 £000
ESTATES						
Essential power installation - Halton Pharmacy	9	(9)				0
Substation B at Warrington Replace 2no. Air Circuit Breakers and 1no. HV Ring Main Unit	200	(200)				0
Fire - Relocate and replace medical gas AVSU's to clinical wards	20					20
Backlog - Croft Wing Electrical remedial works following fixed electrical testing of clinical areas	30	(26)				4
Backlog - Provide safe surface temperatures of radiators in patient clinical areas	10					10
Backlog - North Lodge Basement Electrical Installation Replacement	225					225
Backlog - Fire install of fire dampers 2nd phase	100	(100)				0
Backlog - Catering Department remove or replace roof lantern	30	(30)				0
Fire - Replacement of obsolete 5000 series fire alarm panels and end of line devices	600	(100)				500
Estates Capital Staffing for Design Team Works	177	28				205
Fire - Halton 30 minute Fire Compartmentation (Phase 2)	150	578		(18)		710
Appleton Wing Circulation Areas Fire Doors	200	(200)				0
Warrington and Halton Gas Meter Replacement	141	(100)				41
Backlog - All areas fixed installation wiring testing	100	(100)				0
6 Facet survey annual update	55					55
Backlog - Water Safety Compliance	1					1
Backlog - Annual Asbestos Management & Remedial	30					30
Backlog - HV (High Voltage) Maintenance annual	40			(17)		23
CMTC Replacement Emergency Lighting	150	(78)				72
Induction Bay	22	(20)				2
ED Plaza	0	3,444				3,444
Paeds (Childrens Outpatients)	700	19				719
ICU/B18	1,000	(184)				816
Shopping City	380	52				432
Warrington Town Hub	100					100
Sub A Statix Fire Protection	50					50
Backlog - Flooring Replacement Works	150					150
Urology	0	801				801
Other	441	(441)				0
ANC Clinic Doors	0	10				10
Breast Unit Relocation	1,200	(312)				888
MRI Estates	908					908
Modular Building	258	30				288
Finance & Comm Development Refurb	42	(42)				0
Appleton Wing Roofing	43					43
Thelwall House Lift	31	(31)				0
Governance Flooring	33					33
Halton Endo Ventilation	0	81				81
North Lodge Basement Fire Compartment	0	6				6
Water Tanks	0	3				3
Kendrick Wing Fire	0	22				22
Warr Hospital Site Appraisal	0	8				8
Mortuary	0	8				8
Lab Air Con - Ha	0	8				8
Nurse Call System -ANDU	0	25				25
Emergency Generator Repair - Nightingale	0	24				24
Damper Power Supply - Burtonwood	0	9				9
Backlog - Water Safety Compliance	50					50
New Hospital Project	0	96				96
Clinical Skills Conservatory Corridor	0	30				30
Electrical Infrastructure	0	200				200
CT Room Ha Upgrade - Now Externally Funded		0			143	143
MaxilloFacial 3rd Surgery		110				110
Main Kitchen Boiler		9				9
Histopathology AFOS Downdraft tables		7				7
Orthopedic Doors		11				11
NW Imaging Academy Radiology Estates - External Funding					29	29
Theatres Kitchen Refurb		15				15
Electrical Infrastructure b/f 22/23		375				375
Micad b/f 22/23		70				70
External Lighting b/f 22/23		300				300
L Shaped Roof		79				79
HR Decoration		60				60
Emergency Intercoms			8			8
Nurse Call Bell Minor Injuries			25	(25)		0
Estates Total	**7,676**	**4,545**	**33**	**-60**	**172**	**12,366**

Appendix 6

IM&T						
IT Staffing	316					**316**
New Maternity system integration to Lorenzo	132					**132**
New Maternity system	100					**100**
005 Cisco Refresh (Phase 1)	192					**192**
006 Comms Cabinets (Phase 2) x 2 (one each site)	90					**90**
007 IP Telephony	65					**65**
012 UPS - Main Server Room at Warrington	190					**190**
013 Data Warehouse Infrastructure Refresh	85					**85**
014 Device Replacement (Tech Refresh)	55	0				**55**
EPMA 1-4	24					**24**
Health & Wellbeing Workplace	13	(13)				**0**
Phase 2 Structure - Digital Project Management and Benefits Management resource	165					**165**
Lorenzo Theatres Licences	218	(218)				**0**
Chief Nurse Information Post	31					**31**
Electronic Patient Record Procurement	243					**243**
SAN	240					**240**
IT Other	0	2				**2**
Audiology Auditbase	0	1				**1**
008 Network Switch Expansion	23					**23**
NW Imaging Academy Radiology IT - External Funding					8	**8**
Patient Flow - Tif Funding					260	**260**
Network Switches - External Funding					249	**249**
Additional Data Storage		64				**64**
Patient Flow Integration		20				**20**
Digital Maternity UTF (Unified Tech Fund)					306	**306**
Devices Refresh b/f from 22/23 Part 1		134				**134**
Devices Refresh Agile Working - NHSX Frontline Digitalisation Bids - Enabling Digital Infrastructure					250	**250**
Diagnostics Digital Flat Screens					25	**25**
Diagnostics Digital Capability Programme					839	**839**
Information Technology Total	**2,182**	**-10**	**0**	**0**	**1,937**	**4,109**
MEDICAL EQUIPMENT						
Call Alarms for Anaesthetic & Recovery Rooms Halton	90	23				**113**
Cardiac Catheterisation Suite	0				650	**650**
Radiology - Fluoroscopy Room	300	54				**354**
Breast Relocation Equipment	216	(216)				**0**
MRI Patient Monitor	58	(45)			45	**58**
ECG Machines	27					**27**
CTG Machines	41					**41**
Radiology Ultrasound Transducer	2					**2**
Paediatric Resusitaire	11					**11**
Blood Bank Fridge	0	2				**2**
Pharmacy Fridge	0	6				**6**
Radiology Detector	0	38				**38**
Ultrasound Machine		0			105	**105**
Ophthalmic Microscope		126				**126**
Operating Tables		60				**60**
Dexa Scanner Turnkey		125				**125**
Heidelberg Anterion		61				**61**
DHSC Donated Equipment		100				**100**
Urology Equipment		42		(10)		**32**
Microtome and Slide Writers - Pathology		51				**51**
Decontamination Shelter		21				**21**
Resuscitaires for Birth Suite		57				**57**
Shoulder Table		14				**14**
MRI Coil		8				**8**
Video Laryngoscope		13				**13**
Optos Camera Interface		8				**8**
Replacement ENT Scope		8				**8**
Ultrasound Scanners B/f 22/23		178				**178**
Anaesthetic Machines B/f 22/23		203				**203**
Birth Suite Labour Beds B/f 22/23		123				**123**
Neonatal Scanner B/f 22/23		86		(86)		**0**
Obstetric Portable Ultrasound B/f 22/23		27		(27)		**0**
Slit Lamps		46				**46**
Accufit Testing		14				**14**
Tissue Processor			37			**37**
Ventilator Test Equipment			21	(21)		**0**
Ultrasound Scanners x 2			43			**43**
MRI Scanner Siemens					128	**128**
MRI Scanner Phillips					95	**95**
Bladder Scanners			21	(21)		**0**
Hamilton Ventilator			21			**21**
Medical Equipment Total	**745**	**1,233**	**143**	**-165**	**1,023**	**2,979**
Total Trust Funded Capital	**10,603**	**5,768**	**176**	**-225**	**3,132**	**19,454**
CONTINGENCY						
Reserves Contingency	1,304	(1,304)				**0**
Contingency	963	(928)	(176)	225		**84**
Accruals to be netted off from peer review		(395)				**(395)**
Contingency Total	**2,267**	(2,627)	(176)	225	0	**(311)**
Grand Total	**12,870**	**3,141**	**0**	**0**	**3,132**	**19,143**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/29(a)**			
SUBJECT:	**Safe Staffing Assurance Report – December 2021 and January 2022**			
DATE OF MEETING:	30th March 2022			
AUTHOR(S):	Ali Kennah, Deputy Chief Nurse			
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):	#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 December 2021 and January 2022. Ward staffing data continues to be systematically reviewed to ensure the wards and departments are safely staffed. Mitigation was provided and associated actions put in place when a ward was below 90%, minimum staffing percentage of planned staffing levels. Registered nurse and midwife sickness absence in the month of December was recorded at 6.21%. Sickness data in January increased to 6.38%. In the months of December and January, on day shifts 12 of the 21 wards were above the 90% target fill rate. To ensure safe staffing levels are maintained, mitigation and responsive plans were implemented to ensure that there is safe delivery of patient care. Care hours per patient day (CHPPD) in December was 7.7 and 8.0 in January, with a year-to-date rate 7.7. This maintains a level of improvement over the last 6 months and assurance on safe staffing This report provides assurance that the Trust is safely staffed, and staffing is monitored as appropriate.			
PURPOSE: *(please select as appropriate)*	Information *	Approval	To note *	Decision
RECOMMENDATION:	Members of the Strategic People Committee are asked to note the contents of this paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	**Strategic People Committee**		
	Agenda Ref.	SPC/22/03/36		
	Date of meeting	23rd March 2022		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Safe Staffing Assurance Report – December 2021 and January 2022	AGENDA REF:	BM/22/03/29(a)

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report – December 2021 and January 2022.

The purpose of this report is to provide assurance with regard to the nursing and midwifery ward staffing levels during the months of December 2021 and January 2022. 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.

Due to increased absences within the nursing and midwifery staff groups across the Trust as a result of the OMICRON variant of COVID-19 in December and early January, additional measures were put in place to support safe staffing across the Trust. A paper was presented to Trust Board in January 2022 outlining the measures in place and the results of a benchmark exercise completed to provide assurance of the plans for safe staffing in line with NHSE/I recommendations (Appendix 1).

This paper provides assurance that shortfalls on each shift are reviewed and addressed, with actions to ensure safe staffing levels are provided and reviewed at the daily staffing meeting. Substantial evidence exists which demonstrate nurse staffing levels significantly contribute to patient outcomes (mortality and adverse events, including levels of harm), patient experience, quality of care and the efficiency of care delivery and therefore essential that the Trust delivers the right staff, with the right skills, in the right place at the right time.

2. KEY ELEMENTS

All Trusts are required to submit staffing data to NHS England via the Unify Safe Staffing return, which is a national requirement for all hospitals to publish information about staffing levels on wards, including the percentage of shifts meeting their agreed staffing levels. In addition, assurance is provided to Trust Board of Directors via the Chief Nurse and Deputy Chief Executive.

During the months of December 2021 and January 2022 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, when fill rates are below 90%, the ward staffing is reviewed at the daily staffing meeting considering acuity and activity and where necessary staff are moved from other areas to support.

In the month of December 2021 and January 2022, 12 of the 21 wards were above their planned 90% target of registered nursing staff for the day shift (Appendix 2&3). To ensure safe staffing levels, mitigation and responsive plans were implemented by the senior nursing team based on acuity and activity for the areas that did not meet 90%.

Red Flags

Staffing levels are reviewed twice daily in the staffing meeting with all areas. Red flags are created by areas where staffing levels drop below the planned establishment. A process has been put in place where red flags are reviewed, resolved, and closed at the staffing meetings which has shown a reduction in open/unresolved red flags and provides assurance of safe staffing levels to meet the patient's needs.

Care Hours Per Patient Day (CHPPD)

CHPPD was developed, tested and adopted to provide a single, consistent and nationally comparable way of recording and reporting staff redeployment on all inpatient wards across all healthcare settings. CHPPD is the total time spent on direct patient care based on the number of occupied beds at midnight. The data is valuable because it consistently shows how well patient care requirements are met alongside outcome measures and quality indicators. The December 2021 and January 2022 Trust wide staffing data was analysed and cross-referenced, with ward level data for validation by the Deputy Chief Nurse and Lead Nurses. The senior nursing team currently collects and reports CHPPD data on a monthly basis.

Table 1 illustrates the monthly CHPPD data. In the month of December 2021 CHPPD was recorded at 7.7 and January 2022 recorded at 7.9 with a 2021/22 YTD figure of 7.7.

Table 1 – CHPPD Data 2020/21/22

Finyear	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2021/22	Apr	13769	4.4	3.3	7.7
	May	13645	4.6	3.5	8.1
	Jun	13134	4.5	3.4	7.9
	Jul	13964	4.4	3.3	7.6
	Aug	13479	4.7	3.3	8.0
	Sep	13428	4.5	3.3	7.8
	Oct	14131	4.5	3.1	7.6
	Nov	14726	4.3	3.0	7.3
	Dec	14448	4.7	2.9	7.7
	Jan	14174	4.8	3.1	7.9
2021/22 Total		138898	4.5	3.2	7.8

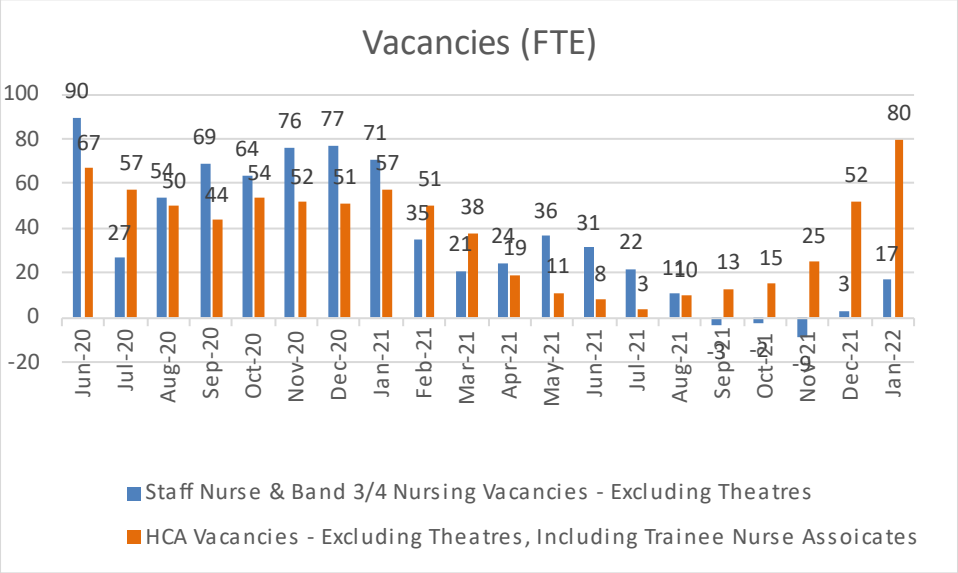
Cross reference of CHPPD and Unify fill rates supports the Trust internal assurance oversight of staffing.

Staffing Levels and Harm

Triangulation of staffing levels with reported harm was completed for December 2021 and demonstrated an increase across the harm profile, highlighted in the Trust Board paper (Appendix 1). Triangulation of data will continue and will be included in the bi-monthly staffing paper going forward.

Vacancy Summary

The chart below shows the nurse and health care assistant vacancy.



HCSW Vacancies

December 2020 and January 2021 vacancy data shows an increase in HCSW vacancies, the bed reconfiguration and B18 business case have contributed to the rise in numbers. Following successful recruitment during February the most recent HCSW vacancy data (17/3/22) is outlined below.

Overall Vacancy	99.42	Figure reported externally via PWR
B3/4 bands to remove from total	-3.82	
B3 (unfunded vacancies)	-17.82	As a temporary ward B3 only has funding until June 2022, this number represents both gaps on B3 for HCSW and across the Trust to backfill B3
In recruitment process	- 55	Close monitoring of this group weekly
CSWD recently passed 6 month training	-15	Will be in post as HCSW before end of March
Total vacancies as at 17/3/22	**7.78**	**Next recruitment planned for 23rd March**

The Trust is part of the Health Care Support Workers (HCSW) programme with NHSE/I with the aim to work towards zero, or as near to zero HCSW vacancy by the 1st of April 2022. There is continuous recruitment ongoing with bi-weekly shortlisting and interviewing and weekly external reporting to NHSE/I to monitor progress.

WHH is on Trajectory to achieve nil HCSW vacancies within the given timeframe. The funding from this programme will support additional establishment to reduce the time to post and a buddy system supported by the Clinical Education Team to support new starters to the Trust alongside an information booklet. In addition, the Workforce Improvement Lead, Interim Lead Nurse for Workforce and HR are working together to ensure all leavers are interviewed to establish trends and lessons to be learnt.

Registered Nursing Vacancies

Recruitment and retention are a priority for the senior nursing team who continue to work with individual teams to support in reducing vacancies for both RN's and HCA. The Emergency Department have successfully held recruitment events specifically for their department, with a positive recruitment outcome position with 21 new starters to commence over the next 3-4 months. The department have created a new starter welcome, WHH Connect (Appendix 4).

Registered nurse vacancies as at 17/3/22, figures include the approved business cases for C21 and B18

Overall Vacancy	76	
*Within Recruitment Process	-23.59	
*Overseas recruitment	-30	Pending approval of business case
Total remaining vacancies as at 17/3/22	22.44	

***Please note that whilst staff above are within the recruitment process and plan and will reduce our total vacancy number, these are not actual staff in post at the time of this report.**

Overseas Recruitment

WHH continues to support the recruitment of International Nurses with a further business case produced in March 2022 in progress to facilitate the employment of 30 International Nurses in 3 cohorts of ten in May, July and September 2022. The recruitment of 30 International Nurses forms part of the Trust registered nurse workforce planning for 22/23 modelled against current vacancies. Progression planning will continue in relation to international nurses as the first cohort original contract was for a 3 year period, after which time they can choose to work elsewhere, therefore we are working with the nurses to ensure they are supported to stay at WHH

WHH have recently recruited 4 nurses from the Refugee Nurses Programme, participants experience practical exercises in a simulated hospital environment, support with communication skills and the English language, The programme was developed at Liverpool John Moores University by Steven

Colfar, Director of Nursing and AHP Workforce for the Northwest at NHS England/Improvement alongside RefuAid, to support qualified refugee nurses to find work in health care.

Recruitment staff and the Trust Workforce Team meet weekly to track new starters and a monthly vacancy report is completed by individual areas to ensure correct local vacancy data is captured.

Escalation Beds

It is important to note that the Trust continues to be extremely challenged with increased activity and as a result additional beds have been opened across the winter period which impacts on the staffing allocation across the Trust. Extra beds have been opened in the following areas:

- Catheter Laboratory
- Extra beds opened on B3, in addition to the original 27 already opened as escalation.
- K25
- Ward A4
- Ward B18
- B4

Between 35 and 53 extra beds have been opened when necessary and the number continues to flex in response to the continued demand.

Temporary Staffing

The Trust is currently working with NHS Professionals (NHSP) to launch the Agency Managed Service (AMS) project with a go live date of the 1st of April 2022. The aim is to remove the responsibility of managing agencies from NHS Trusts, drive performance, efficiency, and cost reduction. NHSP will take over full responsibility for agency management within the Trust including contract management, performance management, relationship management and cascade management.

The Trust continues to manage bed occupancy and staffing in a responsive and planned way. The use of off framework agencies (the framework agreement establishes set parameters that agencies need to operate within) such as Green Staff and Thornbury is monitored with strict controls in place via authorisation from the Chief Nurse/DCEO and Deputy Chief Nurses.
All usage is tracked by the E-Rostering Team. The table below demonstrates 'off framework' agency usage in February

	Emergency Department	ITU	C21	Catheter lab	B18	Total
Thornbury	88.5	25.5	11.5			125.5
Green Staff		299		115	92	506

Sickness Absence – December 2021 & January 2022

Registered nurse and midwife sickness absence in the month of December 2021 recorded at 6.21% showing a slight increase in January 2022 to 6.38%. The cost of bank/agency cover of qualified nursing sickness (at usual bank/agency fill rates) was £238,184 in December and £262,133 for January as detailed in the tables 4 and 5 below.

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

	Dec-21
Contracted Nursing WTE (Band 5 to 7)	1,003.45
% Sickness	6.21%
WTE Equivalent of Sickness	62.31
NHSP Fill Rate	71%
WTE Covered by Temporary Staffing	44.24
Cost at Average NHSP Rates	***238,184***

Table 5 - Registered nurse and midwifery sickness cover – January 2022

	Jan-22
Contracted Nursing WTE (Band 5 to 7)	1,004.20
% Sickness	6.38%
WTE Equivalent of Sickness	64.07
NHSP Fill Rate	76%
WTE Covered by Temporary Staffing	48.69
Cost at Average NHSP Rates	***262,133***

Incentive Scheme

In October 2020 a paper was submitted to the Executive Team to gain agreement to introduce a payment incentive scheme for bank staff through NHSP. This incentive scheme was introduced to manage the significant challenges that the Trust was facing which included increased attendances due to the COVID-19 pandemic, an increase in staff absences and a reduction in the shift fill rate through NHSP. This scheme was initially in place until the end of November 2020 however was extended to include a similar offer in January 2021. A second business case was requested for an extension to the incentive scheme and agreed for the reintroduction of the payment incentive scheme for bank staff through NHSP from the 27th December 2021 and finished at the end of February 2022. This incentive increased NSHP bank fill to promote staff staffing.

- Registered bank fill has increased circa 200 hours per week since go live of incentive scheme
- Highest bank fill rates for 21/22 in January and February 2022
- Total Trust wide utilisation staff 68%
- 57 New starters joined NHSP in Feb'22.
- Reduction of 246 agency hours

Maternity Staffing

- Oversight of current vacancy position of 2.79 B2/3 and 11.61 MW with recruitment plans in place
- Maternity services are escalated in accordance with the Cheshire and Mersey Escalation and Divert Policy (2021)
- Staffing is reviewed daily as a minimum and reported locally and regionally at the Cheshire and Mersey Gold Command Meeting. Where possible each maternity provider within Cheshire and Mersey will offer mutual aid to prevent units going in to divert.
- The Home Birth Service was suspended on 4th January but has now been reinstated ensuring the three place of birth options for women is available, no identified safety concerns were identified as a result of the closure
- The latest Birth Rate Plus review has identified WHH ratio is 1:24 in line with NICE recommendations

Paediatrics and Neonatal Unit

- As with all other areas of nursing, both Neonatal and Paediatric staffing was challenged over the months of December 2021 and January 2022 by increased and unprecedented absence of workforce due to COVID -19 and the Omicron variant. Due to this, there was a reduction of staff with the QIS qualification (Qualified in Speciality) which led to the NNU having to open to emergencies only during these periods. This was managed as per local escalation policy, with no adverse outcomes identified

- Daily sitreps continue to be submitted to the Cheshire and Mersey Paediatric Network, this report notes acuity and staffing levels as well as HDU capacity, COVID- 19 and RSV admissions.

- Recruitment within Neonatal Units has been challenging across the region. At WHH recruitment is underway to ensure we continue to maintain BPAM guidelines.

- A staffing review is currently underway utilising an endorsed Neonatal Nurse Staffing Tool (Dinning) which assists in calculating neonatal staffing establishment based on 12 months of historical clinical activity workloads according to the British Association of Perinatal Medicine (BAPM) categorisation of care. The next bi-monthly staffing paper will include the outcome of the review.

Theatre Staffing

- Theatre recruitment is supported by the Trust recruitment programme. Current vacancy rates stand at 12.5 Nursing/ODP and 3.0 B2 across both sites theatre departments, with plans in place for recruitment

Therapy Staffing

- A business case has been finalised that will support the ongoing development of each therapy service and support the turnover as the main therapy teams are currently under established with turnover high in the region.

- The staffing establishments continues to be reviewed with appropriate skill mixing to support and manage the current high turnover in OT and physiotherapy. Exit interviews have been introduced local to understand any themes. International recruitment is being considered across CH&M.

- The largest amount of OT vacancies is across Therapy Inpatients Services, As part of the therapy recruitment drive, training posts and trainee ACP posts have been advertised internally. OT and Dietetic Apprenticeship Programmes continue to be promoted for nonqualified staff with plans for procurement of the Physiotherapy Apprenticeship Programme

3. RECOMMENDATIONS

Members of the Strategic People Committee are asked to note the content of the report.

Appendix 1 – Report to Board of Directors – January 2022

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/29**	
SUBJECT:	Safe staffing response to current Omicron wave	
DATE OF MEETING:	27th January 2022	
AUTHOR(S):	Ali Kennah, Deputy Chief Nurse, Patient Safety and Clinical Education	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. 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
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The escalation of COVID-19, predominately driven by the Omicron variant has placed significant pressure on the NHS, in particular the impact on staffing and absences. This paper considers the nursing, midwifery, HCA and AHP staff response plans. To ensure the fundamentals of care are provided to patients at WHH, the following resilience processes are in place: • Extension of current NHSP incentive scheme until end of February 2022 • ED response staff plan to support surge • Extension of current Incentive scheme for final year nursing students until end of February 2022 • Creation of a Staffing Hub • Matron as site bleep holder • Helping Hands scheme • Reintroduction of Volunteers into appropriate clinical areas Due to the increased absence of nursing, midwifery and AHP staff and the associated risk, an amendment of Trust Board Assurance Framework (BAF) risk ID 115 from a score of 20 to 25 has been agreed.	

	Following the NHSE/I publication in November 2021 of A key actions document; Winter Preparedness: Nursing and Midwifery staffing, a benchmark exercise against the staffing assurance framework within the document was completed which demonstrates good assurance and is included within this paper. A review of current staffing levels for in patient areas has been completed by the Chief Nurse, Deputy Chief Nurse and Associate Chief Nurses and minimum staffing levels assessed in order to provide the fundamentals of care which are included in this paper. A review of harm, complaints and PALS contacts for December has been completed has been completed and demonstrates the following: • Reduction in complaints received related to nursing care • Increase in moderate harms and in patient falls reported compared to November with correlation to decreased staffing • Slight reduction in Datix incident reporting			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	It is recommended that the Trust Board members note the contents of this paper			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Safe staffing response to current Omicron wave	AGENDA REF:	

4. BACKGROUND/CONTEXT

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

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

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

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

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

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

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

5. KEY ELEMENTS

Ward Staffing Review

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

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

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

Fig.1

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

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

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

Mitigation in place

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

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

Other registered healthcare professionals will need to be able to:

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

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

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

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

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

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

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

Registered Nurse/Midwife current vacancies

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

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

Staffing Assurance Framework

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

Staffing Hub

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

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

Matron as site bleep holder

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

Emergency Department Staffing Response Plan

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

NHSP Incentive Scheme

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

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

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

Pay Incentive Scheme for 3rd Year Nursing Students

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

Helping Hands Scheme

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

Reintroduction of volunteers

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

6. Harm review December 2021

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

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

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

7. Triggers for escalation of staffing and patient safety

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

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

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

8. Recommendations

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

Appendix One – Staffing Assurance Framework

Classification: Official

Publication approval reference: PAR1068

Key actions

Winter 2021 preparedness: Nursing and midwifery safer staffing

12 November 2021, Version 1

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

Planning

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

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

Decision making and escalation

- Even during challenging times, executive directors of nursing should be mindful of the fundamental principles set out in the NQB Safe Sustainable and Productive staffing guidance and Developing Workforce Safeguards guidance.
- When implementing escalation plans, decisions regarding skill mix and nurse ratios should be taken in conjunction with an assessment of patient acuity and dependency, professional judgement and the environment of care.
- In preparation for periods of increased demand, organisations should ensure that staffing plans are reviewed and signed off by the executive director of nursing, with staffing decisions including redeployment and daily deployment of staff led by the senior clinical leadership teams.
- Staffing risk assessments should be undertaken on a shift by shift basis and concerns and issues escalated in a timely manner via clearly established routes. Unresolved issues should be escalated in line with provider governance processes. A system wide discussion and focus should be taken to reach solutions wherever appropriate.
- Escalation mechanisms and governance processes should be clear to all staff and the board should seek assurance that effective escalation occurs and that issues are addressed and recorded.
- Staff should be supported to discuss and raise concerns regarding staffing and their ability to safely care for patients. The board must seek assurance that there are clear mechanisms in place for staff to raise concerns and that these are acknowledged and mitigated where possible.
- Clinical leaders should take a multi-professional and skills-based approach to staffing and ensure each clinical area is supervised by a senior clinical leader.

Staff training and wellbeing

- Supporting the workforce is paramount; boards should seek assurance that there are well-publicised and accessible resources in place for staff.
- Staff wellbeing should be embedded at every level. For example, team-based check-ins, wellbeing support hubs and wobble rooms.

Key actions

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

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

Indemnity and regulation

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

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

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

Governance and assurance

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

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

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

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

Key actions

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

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

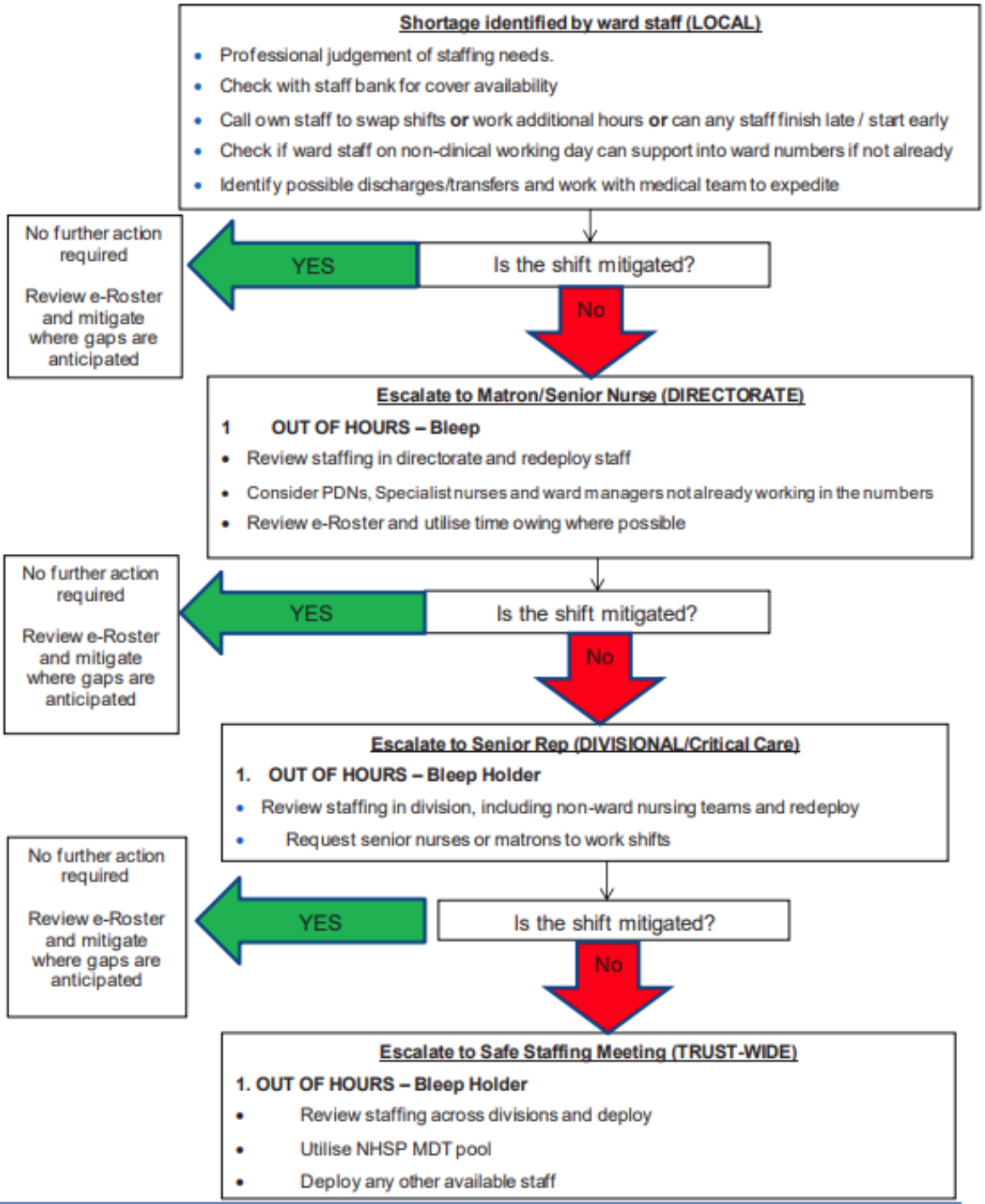
Useful links:

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

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

Appendix 1: Decision tool and escalation framework

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



Appendix 2: Example quality impact assessment

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

Appendix 3: Example staffing SBAR Tool

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

Staffing Escalation SBAR

SITUATION:

Ward:

Date, Shift and Band that require covering:

Number of beds:

Acuity and dependency score:

Describe your concern, include Safety/Quality concern:

BACKGROUND:

Current problem:

Reason for problem on shift:

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

How long has the shift been out to Framework Agency:

ASSESSMENT:

My assessment of the situation is:

Current concern:

Describe actions have been taken to solve the current problem:

RECOMMENDATION:

Based on my assessment I request that you approve:

Things to consider:

Explain what you need:

Appendix 4: Example risk appetite statement

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

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

Appendix 5: Assurance framework – nursing and midwifery staffing

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

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

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

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

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

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

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

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

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

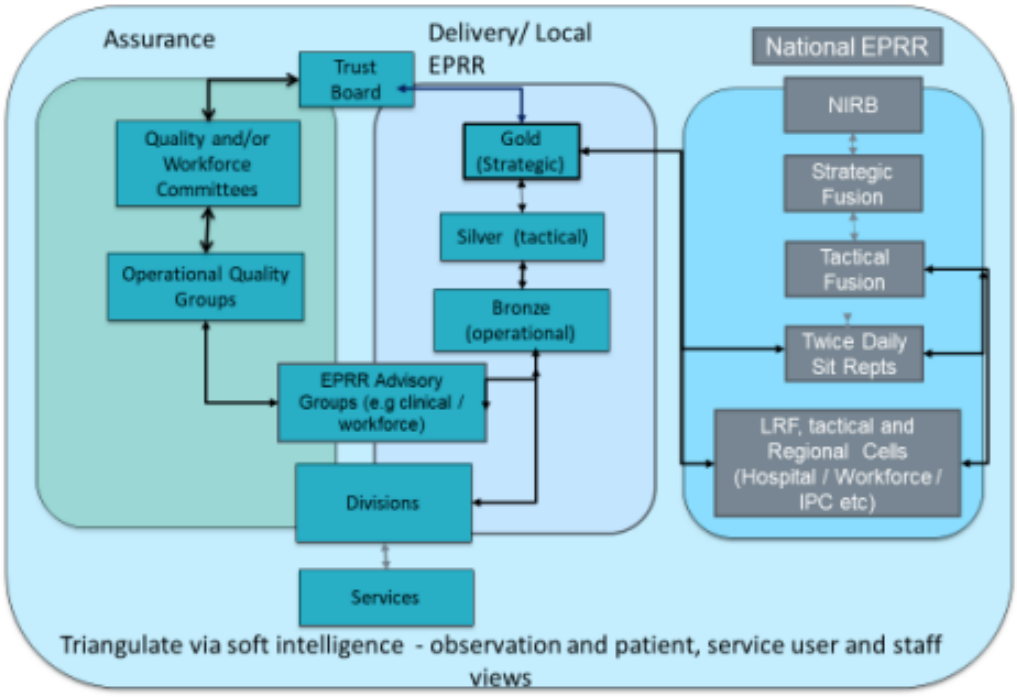
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus						
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges						

Appendix 6: Example safe staffing governance framework

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

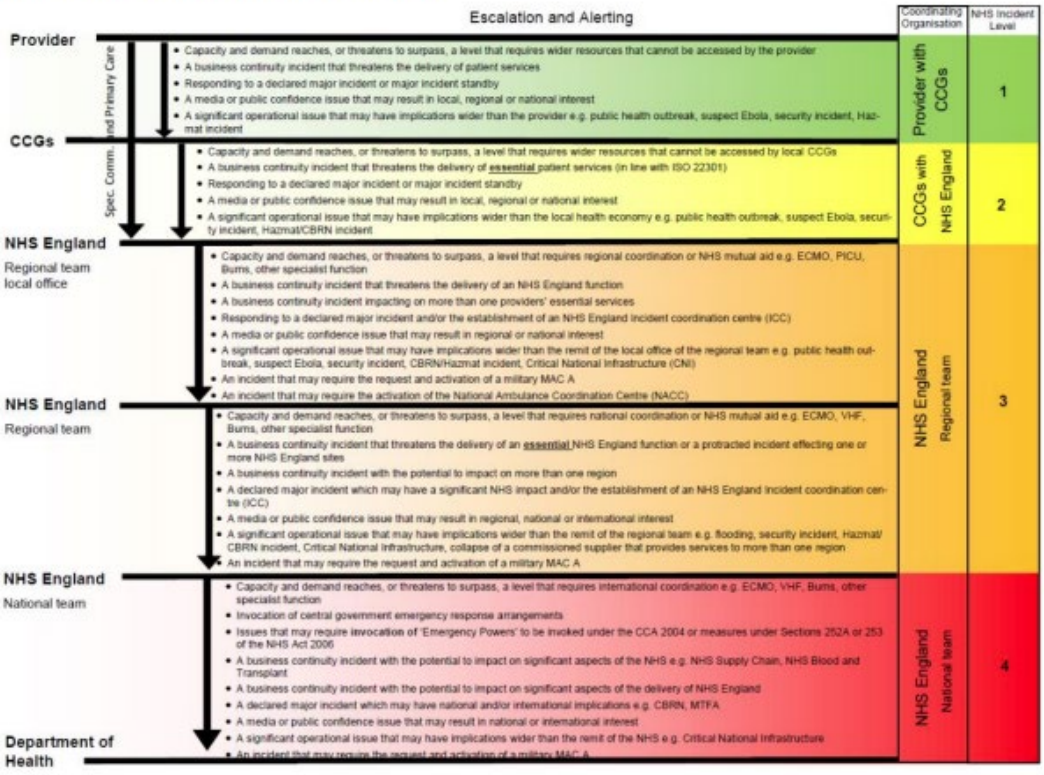
Providers must ensure that non-executive members of the board have clear sight of the significant or sustained operational issues and challenges that are being discussed in the day-to-day delivery of care during these challenging times.

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



Appendix 7: EPRR escalation and alerting

Extracted from NHS England EPRR Framework



18 | Key actions – Winter 2021 preparedness: Nursing and midwifery safer staffing

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

22nd December 2021

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

Dear Colleague,

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

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

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

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

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

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

We are WHH & We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

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

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

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

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

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

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

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

Kind regards,

Kimberley

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

#YourNHSNeedsYou

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

Appendix Four – Staffing Assurance Framework

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

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

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

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

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

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

Appendix Five – Cost of Extending Pay Incentive Scheme

Cost of Extending NHSP Pay Incentive Schemes

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

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

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

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

Cost of Temporary Student Nurse Placements in to HCSW Positions

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

Appendix Six – Nurse Staffing Escalation Flow Chart

Escalation – Safe Staffing Across Adult Wards & Departments

STEP 1

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

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

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

UNABLE TO ESTABLISH SAFE STAFFING LEVELS - ESCALATE TO STEP

STEP 2

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

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

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

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

UNABLE TO ESTABLISH SAFE STAFFING LEVELS - ESCALATE TO STEP

STEP 3

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

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

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

– Night Nurse Practitioner/Site Manager/Matron/On call Manager

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

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

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

Escalation for Safer Nursing & Midwifery Staffing - For Immediate Action

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

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

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

Situation and Background:

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

Actions required:

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 2

Monthly Staffing Data –December 2021

Monthly Safe Staffing Data – December 2021																			
		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1782.50	1448.50	1426.00	1391.50	81%	98%	1426.00	1311.00	1426.00	1219.00	92%	85%	994	2.8	2.6			5.5
DD	Ward A5 G	997.50	997.50	1069.50	1012.00	100%	95%	713.00	713.00	1069.50	874.00	100%	82%	876	2.0	2.2			4.3
DD	Ward A5 E	805.00	805.00	805.00	793.50	100%	99%	878.00	878.00	690.00	801.00	100%	116%	248	6.8	6.4			13.2
MSK	Ward A6	1782.50	1610.00	1782.50	1575.50	90%	88%	1069.50	1161.50	1782.50	1506.50	109%	85%	1022	2.7	3.0			5.7
MSK	CMTC	931.50	1334.00	621.00	713.00	143%	115%	575.00	575.00	575.00	299.00	100%	52%	216	8.8	4.7			13.5
W&C	C20	1127.50	1045.50	848.50	745.50	93%	88%	707.50	707.50	0.00	0.00	100%	N/A	243	7.2	3.1			10.3
W&C	Ward C23	1395.00	1165.00	713.00	586.50	84%	82%	713.00	667.00	713.00	598.00	94%	84%	717	2.6	1.7			4.2
W&C	Birth Suite	2139.00	2196.50	356.50	264.50	103%	74%	2495.50	2668.00	356.50	333.50	107%	94%	236	20.6	2.5			23.1
W&C	The Nest	356.50	207.00	356.50	138.00	58%	39%	356.50	264.50	356.50	253.00	74%	71%	13	36.3	30.1			66.3
W&C	Ward B11	3057.50	2554.50	857.50	740.00	84%	86%	1596.00	1563.40	322.40	322.40	98%	100%	365	11.3	2.9			15.2
W&C	NNU	1782.50	1213.50	356.50	224.60	68%	63%	1782.50	1127.00	356.50	253.00	63%	71%	259	9.0	1.8			10.9
UEC	Ward A1	2,495.50	2799.08	2936.85	2414.75	112%	82%	2215.45	1735.73	1322.35	1020.75	78%	77%	909	5.0	3.8			8.8
UEC	Ward A2	1552.25	1372.75	1918.65	1407.32	88%	73%	999.28	880.02	988.52	938.68	88%	95%	890	2.5	2.6			5.2
UEC	ED	7225.83	6935.50	2962.00	2079.00	96%	70%	4862.83	5277.02	2230.85	1728.78	109%	77%						
MC	ACCU	2495.50	2090.50	1069.50	940.50	84%	88%	1782.50	1730.50	1069.50	1023.50	97%	96%	805	4.7	2.4			7.2
MC	ICU	5704.00	5836.00	1069.5	805	102%	75%	5704.00	5836.00	1069.5	931.5	102%	87%	557	21.0	0.0			21.0
MC	B18	2495.50	1915.00	1426.00	1329.00	77%	93%	2139.00	2086.00	1426.00	983.50	98%	69%	859	4.7	2.7			7.3
IM&C	Ward A7	1480.00	1456.50	1644.22	1683.17	98%	102%	1426.00	1357.50	1064.17	836.00	95%	79%	713	3.9	3.5			7.5
IM&C	Ward C21	1249.00	955.50	1093.75	779.50	77%	71%	716.00	901.00	713.00	673.50	126%	94%	279	6.7	5.2			11.9
IM&C	Ward B14	1069.50	1103.90	1782.60	1318.50	103%	74%	713.00	713.00	1069.50	920.00	100%	86%	744	2.4	3.0			5.5
IM&C	Ward B12	1069.50	968.50	2495.50	2025.50	91%	81%	713.00	713.00	1782.50	1817.00	100%	102%	651	2.6	5.9			8.6
IM&C	Ward B19	1426.00	1116.50	1426.00	1279.50	78%	90%	1069.50	987.00	1426.00	860.50	92%	60%	744	2.8	2.9			5.8
IM&C	Ward A8	1782.50	1401.00	1782.50	1354.00	79%	76%	1426.00	1345.50	1426.00	1092.50	94%	77%	1054	2.6	2.3			4.9
IM&C	Ward A9	1782.50	1552.50	1782.50	1598.50	87%	90%	1782.50	1506.50	1426.00	1322.50	85%	93%	1054	2.9	2.8			5.7
	Total	50114.50	44080.23	31512.57	26393.84	88%	84%	37861.56	36704.67	23592.29	19676.61	97%	83%	14448	4.7	2.9			7.7
		= above 100%			= above 90%			= above 80%			= below 80%								

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 3
Monthly Staffing Data –January 2022

Monthly Safe Staffing Data – January 2022																			
		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	1782.50	1552.00	1426.00	1391.50	87%	98%	1426.00	1380.00	1426.00	1173.00	97%	82%	991	3.0	2.6	0.1	0.0	0.0
DD	Ward A5 G	885.50	977.50	1069.00	1023.50	110%	96%	713.00	713.00	1069.00	943.00	100%	88%	538	3.1	3.7	0.1	0.0	0.0
DD	Ward A5 E	690.00	713.00	690.00	632.00	103%	92%	713.00	713.00	690.00	345.00	100%	50%	193	7.4	5.1	0.0	0.0	0.0
MSK	Ward A6	1782.50	1610.00	1782.50	1587.00	90%	89%	1069.50	1414.50	1782.50	1311.00	132%	74%	999	3.0	2.9	0.0	0.0	0.0
MSK	CMTC	966.00	1138.50	644.00	655.50	118%	102%	644.00	632.50	644.00	253.00	98%	39%	132	13.4	6.9	0.0	0.0	0.0
W&C	C20	1323.00	907.50	816.00	727.00	69%	89%	713.00	747.50	0.00	0.00	105%	N/A	243	7.2	3.1			10.3
W&C	Ward C23	1426.00	1127.00	713.00	713.00	79%	100%	713.00	632.50	713.00	667.00	89%	94%	410	4.3	3.4	0.0	0.0	0.0
W&C	Birth Suite	2139.00	2047.50	356.50	356.50	96%	100%	2139.00	1897.50	356.50	253.00	89%	71%	281	14.0	2.2	0.0	0.0	0.0
W&C	The Nest	356.50	563.50	356.50	310.50	158%	87%	356.50	506.00	356.60	322.00	142%	90%	14	76.4	45.2	0.0	0.0	0.0
W&C	Ward B11	2884.50	2668.50	870.00	820.00	93%	94%	1585.20	1509.60	322.40	322.40	95%	100%	322	13.0	3.5	0.7	0.3	0.0
W&C	NNU	1782.50	1271.50	356.50	225.00	71%	63%	1782.50	1069.50	356.50	333.50	60%	94%	323	7.2	1.7	0.0	0.0	0.0
UEC	Ward A1	2,495.50	2969.20	2920.75	2291.37	119%	78%	1751.72	1672.35	1315.55	1059.08	95%	81%	955	4.9	3.5	0.0	0.0	0.0
UEC	Ward A2	1587.67	1296.67	1880.50	1432.67	82%	76%	998.77	914.35	990.83	851.43	92%	86%	869	2.5	2.6	0.0	0.0	0.0
UEC	ED	7219.75	7170.08	2983.75	2300.50	99%	77%	4837.30	5707.85	2221.60	1921.52	118%	86%						
MC	ACCU	2495.50	2148.00	1069.50	880.00	86%	82%	1782.50	1725.00	1069.50	994.00	97%	93%	809	4.8	2.3	0	0	0
MC	ICU	5704.00	5405.00	1069.5	805	95%	75%	5704.00	5847.80	1069.5	931.5	103%	87%	468	24.0	3.7	0.0	0.0	0.0
MC	B18	2495.50	1946.00	1426.00	1217.50	78%	85%	2139.00	2173.50	1426.00	1041.00	102%	73%	853	4.8	2.6	0.0	0.0	0.0
IM&C	Ward A7	1782.50	1440.50	1782.50	1109.50	81%	62%	1426.00	1426.00	1426.00	1069.50	100%	75%	1050	2.7	2.1	0.0	0.0	0.1
IM&C	Ward C21	1069.50	977.50	1395.00	885.50	91%	63%	713.00	713.00	1069.50	897.00	100%	84%	750	2.3	2.4	0.0	0.0	0.0
IM&C	Ward B14	1069.50	1084.50	1782.50	1233.00	101%	69%	713.00	713.00	1069.50	977.50	100%	91%	744	2.4	3.0	0.0	0.0	0.0
IM&C	Ward B12	1069.50	954.50	2495.50	2118.50	89%	85%	713.00	713.00	1782.50	1817.00	100%	102%	651	2.6	6.0	0.1	0.0	0.0
IM&C	Ward B19	1426.00	1109.00	1426.00	1287.00	78%	90%	1069.50	920.00	1426.00	961.50	86%	67%	734	2.8	3.1	0.0	0.0	0.0
IM&C	Ward A8	1782.50	1412.00	1782.50	1875.00	79%	105%	1426.00	1495.00	1426.00	1265.00	105%	89%	1044	2.8	3.0	0.0	0.0	0.0
IM&C	Ward A9	1782.50	1466.50	1782.50	1547.50	82%	87%	1426.00	1368.50	1782.50	1368.00	96%	77%	1044	2.7	2.8	0.1	0.0	0.0
	Total	49839.77	43955.95	32876.50	27424.54	88%	83%	36554.49	36604.95	25791.48	21076.93	100%	82%	14174	4.8	3.1	0.0	0.0	8.0
		= above 100%			= above 90%			= above 80%			= below 80%								

Appendix 4

FEBRUARY 2022

WHH connect

Keeping in touch on your recruitment jouney

Welcome to WHH!

We are delighted you have decided to join our Emergency Department Team at WHH and look forward to welcoming you to our Trust during 2022.

We know that some of you aren't scheduled to join us just yet, so we wanted to send you a quick update on news from the department and introduce you to some key colleagues. It's also important that you know what support to expect when you join us.

I want you to know that you will become part of a friendly, close-knit family that provides support to one another across departments, wards and specialisms. I firmly believe that joining WHH as a nurse is the start of an exciting journey that is centred on your own personal and professional career development and aspirations.

Thank you for choosing to become part of our family and I look forward to meeting you soon.

Kimberley Salmon-Jamieson,
Chief Nurse,
Deputy Chief Executive (WHH)

Meet and Greet sessions

We are holding virtual meet and greet sessions for newly qualified nurses on the following dates via MS Teams.

We would love it if you could join us on one of these sessions. They are in an informal session to meet the teams and give you the opportunity to ask any questions you may have regarding working on Warrington ED.

We hope to see you there!

17 March – 1pm to 2.30pm
Join on your computer or mobile app
Click here to join the meeting

31 March – 2pm to 3.30pm
Join on your computer or mobile app
Click here to join the meeting

Training and support

So, you've decided to work in ED. What happens next?

I'm Alistair Greenough Emergency Department Practice Educator

My job along with the rest of the ED team is to help you settle into your job. You are joining a tight team who will look after you as best they can.

When you start you will need local induction to the department which should ideally be done on your first day.

My role is a mix of formal training on the ED study days (normally Thursdays) which will have a different theme each week. You will be rostered on one of these days roughly every eight weeks and will appear on you roster as ED study days. These are a great opportunity to carry out joined-up training with the rest of the nursing team and will provide more than enough study time for revalidation, however, you will do much more.

You will work alongside your mentor as much as possible, however, as you are no longer students you will work with regular staff and agency in areas which are all learning opportunities. I will also work clinical shifts alongside you in a supernumerary capacity and will do this if you or we feel you need some extra support.

You will be given an education portfolio consisting of documents which give an overview of what you need to know to be a successful ED nurse. It is not compulsory, but I would recommend using it and we will talk more on induction.

You are a preceptee for one year, so give yourself time to settle in and learn your job. You will learn new things every day you come to work (I know I do, and I've done this for quite a while now). My door is always open so if you need anything please give me a shout.

Clinical Education at WHH

Our wider Clinical Education offer has been enhanced recently with the opening of the Habab Education Centre at Kendrick Wing, Warrington Hospital. The centre was named in memory of WHH colleague Jo Habab and provides a dedicated space for clinical skills development in addition to our Education Centre at Halton.

The Habab Education Centre is light and spacious with four training rooms including a new clinical skills drop-in lab for all staff and students to use. The excellent facilities at the centre have been equipped with new manikins to support the latest methods of training delivery and will provide increased opportunities for clinical simulation exercises and technology-enhanced learning to improve the safety and effectiveness of clinical care.

The Clinical Education team also provide and deliver the Multi Professional Preceptorship Programme to all newly qualified registrants joining the Trust. When you join us, you will be invited to attend a one-day induction, followed by a Preceptorship Fortnight where you will get to meet other preceptees and gain some insight into the other professionals you may come in to contact with during your new role. We will also deliver the some of the important clinical skills you may need as part of your role.

A focus on Health and Wellbeing

As a Trust we're focused on supporting our team and have been continually expanding our offer for our staff which includes everything from a dedicated resource section on the staff extranet to our Sanctuary Mental Wellbeing hub and Wingman Wellbeing Lounge onsite for staff.

We've also been working with Rugby League Cares within ED to help our staff benefit from techniques used by athletes for good mental and physical fitness in a ground-breaking project.

Mental Health First Aiders

My name is Tanya Hughes one of the staff nurses in the department that has recently completed the course to become a mental health first aider, one of several in the ED department.

Our role is to support the mental health and wellbeing of every team member and to empower each individual the fulfil their role in the department.

We also promote the importance of being able to talk and raise any worries or concerns and welcome suggestions to help you and the team support each other and develop together.

We have our mental health and wellbeing board (pictured with me!) with lots of advice on looking after your mental health and wellbeing. My aim is create a culture where every team member can come talk or just offload personal or work related stuff. I recently arranged a coffee morning for people to come and talk or even share ideas for development of the team. Following its success, I plan arrange this once a month to create continuity and evaluate and develop ideas to support each individual and the department. I have also created worry / suggestion box where people can share things anonymously so that we can look at areas that we can help and improve in.

Meet #TeamED

Who's Who in our ED Nurse leadership team

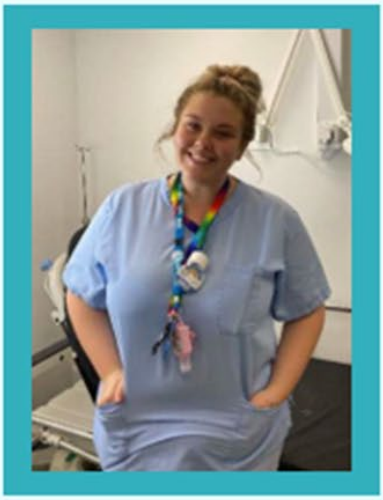
Ali Crawford
Lead Nurse

Michelle Catterall
Unit Manager

Heather Williams
Matron

Rachel Lamb
Matron

Meet some of our amazing ED nurses



Bethany Bell

Staff Nurse

Emergency Department

Bethany works as a staff nurse in our Emergency Department (ED), working across various areas within the department.

As a student Bethany never had the opportunity to work in an Emergency Department but she knew that this is where her passion lay. As soon as she qualified she fulfilled her wish, starting her first post as a nurse in our Emergency Department at Warrington Hospital.

To support Bethany's transition into a newly qualified nursing role and to help her integrate well into the work environment she joined our Preceptorship programme, which consists of:

- Learning basic nursing skills as well as learning about cannulation and IV's.
- Being allocated a mentor for six months, which can be a staff member at band 5,6 or 7 who will offer you continued support.
- Mandatory support group once a month with the Practice Based Educator, offering reflective practice team building exercises and group sessions.

Describing her experience in Warrington ED, Bethany says:

"It's 'The best!' I can say the Nurses are the kindest and most genuine people – they are like a family and support you through every emotion. We work as a team to get the best out of each other to offer the best to the patients and their relatives.

"It's such a fast paced and critical area that it's important to be a good support to one another. You learn so much knowledge and skills, it's a place you are always developing. The role also makes you realise how precious life is and the importance of giving the best care to our patients."

One of Bethany's biggest achievements since being in her post is becoming qualified in Advanced Life Support – something she is incredibly proud of.

Kate Dourley

Staff Nurse

Emergency Department

Hi! I wanted to share how my journey at WHH started.

Four years ago, as a second-year student, I attended one of the Trust's recruitment days with the intention of exploring the options available to me when I qualified as an RN. Much to my surprise I walked away having secured Band 5 Staff Nurse position following a last-minute interview. The following year - still not knowing exactly where in the Trust I wanted to work – I started my Emergency Department placement for 12 weeks as a very nervous third year student.

It is safe to say that the team and department made such an impact on me that I have not left since! I was fortunate enough to be offered a position as a Band 4 whilst awaiting my nursing PIN, soon stepping up to work as a qualified staff nurse.

Since then, I haven't looked back. I have had the support and enthusiasm of the department behind me, which has enabled me to undertake extra training as well as returning to university to complete Masters level modules. All of which has helped to mould me into the ED nurse I am today and has led me to being promoted to a Band 6 Junior Sister role. I am currently being supported to adapt to working in this junior management position and have plans to start further education later this year to assist me in this role. I also work as Placement Lead for the department, which means I have responsibility of co-ordinating student placements and supporting our team in mentoring and facilitating learning for students – something that I am passionate about.

It is true that I have come full circle – I now represent our department at our Trust recruitment days and have been involved in interviewing hopeful candidates that have attended with the same intentions as myself four years ago. I may have met some of you at our recruitment days or as student nurses on placements. I look forward to meeting you and working alongside you in the department soon. Welcome to the best team!

ED News

Our Emergency Department at Warrington Hospital is currently undergoing a £6.3m expansion to help our team see, treat, admit or discharge patients more quickly. The new extension will increase patient assessment capacity and provide a new 'high care' areas for patients with high-risk respiratory or other serious illnesses.

The Paediatric ED also saw significant investment last year with improved facilities for children, young people and families including a sensory room in the waiting area.

This investment in the department is part of the Trust's commitment to make the best of its existing estate pending the outcome of a submission to secure a new hospital for Warrington and surrounding areas.

Key Contacts

For more information or queries please get in touch at:

whh.yourfuture@nhs.net

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/03/29 b		Trust Board	DATE OF MEETING	30th March 2022

Date of Meeting	1 February 2022
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

Due to significant operational pressures the meeting focussed on the key issues requiring discussion and/or approval.

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/22/02/33	**Hot Topic – Staffing & Appraisal of Potential harm**	The Committee received a presentation regarding Staffing & Appraisal of Potential Harm, in particular highlighting the continuation of staff absence which had continued to rise during December and January. The Committee noted: • Review on how to reassess safe staffing on the wards, in particular there was a total of 131 absences on 24 January, and a resilience plan had been put in place along with a review of harms associated with minimum staffing levels. • There had been an increase in falls and pressure ulcers, recorded as Red RAG status, these had occurred on wards where there had been minimum staffing levels. • Pay Incentive Schemes had been introduced during December and January and had been approved to be extended until the end of February. • Volunteers would be reintroduced across the organisation, in order to support the wards, particularly where there were staffing level issues. • The Trust had seen an increase in patients with mental health challenges, and the numbers were becoming more significant.	**The Committee discussed the report and received good assurance**	

		• The reviews undertaken regarding potential harm did not highlight any attributing factors to staff levels as a cause.		
QAC/22/02/35	**Deep Dive/Service Review – Inpatient Sepsis**	The Committee received a presentation which focussed on Inpatient Sepsis, which demonstrated Sepsis Patient Management within the Trust. Of particular note was: • A sample size of 24 was used which showed a performance rate of 68% • In relation to inpatient mortality where Sepsis was recorded as cause of death, 18 of these met the criteria for a SJR. Several learning points came out of this, and no concerns about Sepsis management as being attributable to the cause of death. • Emergency Department Performance data demonstrated several concerns, the challenge relating to Sepsis and assess and treat within the hour. It was noted that sepsis would form part of the planned Quality Inspection, along with sustainability, monitoring and reporting.	**The Committee discussed the report and received moderate assurance.**	**QAC April 2022.**
QAC/22/02/37	**Clinical Harm Reviews**	The Committee received the report and noted: • Clinical harm review process was in place for Cancer delays of 52-week breach and 'P' Codes for surgery, in addition to other patients who were considered to be at risk of potential harm • 2600 harm reviews had been undertaken, with 14 moderate reviews. These were ongoing due to the elective treatment delays. • An update was given on the numbers for 52 week waits and P2 patients.	**The Committee noted and discussed the report and received moderate assurance.** **An update on P2 patients be presented to the next meeting.**	**QAC March 2022**

The Committee also received the following items:

QAC 22/02/34 - Move to Outstanding Action Plan Update

Matters for Approval
QAC/22/02/36 – Strategic Risk Register & BAF

Papers to Discuss and Note for Assurance

QAC/22/02/38 – Maternity Update including Women's Experience of Maternity Care Survey 2021
QAC/22/02/39 – Quality Dashboard

QAC/22/02/40 – SI & Complaints Q3 Report
QAC/22/02/41 – Quality Improvement Report Q3

High Level Briefing Report

QAC/22/02/42 – Patient Safety & Clinical Effectiveness Sub Committee 25.01.22
QAC/22/02/43 – Infection Control Sub Committee 20.01.22
QAC/22/02/46 – Health & Safety Sub Committee 7.12.21
QAC/22/02/47 – Complaints Quality Assurance Sub Committee 18.01.22

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/03/29 b		Trust Board	DATE OF MEETING	30 March 2022

Date of Meeting	1 March 2022
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/22/03/54	**Patient Story – Communication Matters**	The Committee received a patient story highlighting issues raised whilst the patient was waiting in ED. It was noted, although there were a number of issues faced by the patient, it had no detrimental effect on their health. Of specific note were issues raised in respect of handover from staff and confidentiality in additional to noise levels. The patient went onto have surgery and issues to do with pre-operative treatment, preparation for surgery and postoperative care. An important theme was a need for better communication with the patient. It was noted that there were lessons learnt from this and all teams/staff involved have received feedback. The Committee noted the important learning that comes from patient stories and how this can be used to improve patient experience.	**The Committee noted the presentation and received good assurance.**	
QAC/22/03/55	**Hot Topic - Dementia**	The Committee received a presentation focussing on Dementia, with additional supporting information included from the Alzheimer's Society.	**The Committee discussed the presentation**	**Monitoring through the regular reports to QAC re**

		It was noted it was likely there would be 3k people in Warrington and 2k in Halton suffering from Dementia by 2025, with 1m people nationally being affected. The Deep Dive focused on national initiatives, as well as local partnerships and allegiances across Warrington and Halton which had given a wide network across health and social care and charitable organisations. Of particular note was that the Trust had always achieved above 90% for the 3-part dementia tool; however, there were a number of patients with different speciality needs and Forget Me Not Unit was unable to house everyone. For those staff in other areas where Dementia patients were being cared for, it was important to have targeted education and training. It was also noted that the Dementia Strategy was currently in development		**Dementia Strategy and through Patient Experience HLBP/**
QAC/22/03/56	**Deep Dive/Service Review – Inpatient Survey**	The Committee received a Deep Dive presentation on the Inpatient Survey. The Committee noted that the survey was undertaken by IPSOS MORI on behalf of the CQC and was standardised across all organisations. The CQC subsequently used the survey to monitor performance and to act as intelligence and influence inspections in order to identify areas for their Insight Report. Areas identified for improvement were: • Length of wait for bed on arrival • Levels of noise and light at night • Food • Information about medications • Communication following procedure • Feedback methods for patients Areas identified as improved since the previous survey were: • Overall experience	**The Committee noted and discussed the Deep Dive and received good assurance**	

		• Care & Treatment • Doctors • Nurses Work was underway to address the areas identified as requiring improvement. An Action Plan had been produced and this was tracked through the Patient Experience Sub-Committee, and briefed at QAC through a HLB.		
QAC/22/03/58	**Quality Priorities**	The Committee received a presentation providing an update on the 2021/22 Quality Priorities and proposed 2022/23 priorities. It was noted that the Quality Priorities would focus on three domains: • Patient Safety • Clinical Effectiveness • Patient Experience. Following discussing it was agreed to incorporate health inequalities and service development. The amendments were approved post meeting via Chair's actions.	**The Committee discussed the presentation and agreed the 2022/23 Quality priorities.**	
QAC/22/03/61	**Patient Equality Diversity & Inclusion Equality Duty Assurance Reporting**	The Committee received a report outlining the responsibilities as a public sector organisation how the Trust would demonstrate how it would actively work to reduce health inequalities by promoting equity and working to eliminate discrimination.	**The Committee discussed and supported the recommendations receiving good assurance. The report would be presented to the Strategic People Committee for further consideration.**	**SPC March 2022**
QAC/22/03/62	**Strategic Risk Register & BAF**	The Committee received an update on the Strategic Risk Register and BAF and the following was noted. The Committee supported amendment to	**The Committee discussed the and approved the proposed amendments and received good assurance.**	**Trust Board March 2022**

		• Risk #115 – reduced risk rating from 25 to 20 • Risk #1272 - reduced risk rating from 20 to 12 Description amendments would be made on risks #115, 1108, #1272 and #1275. There was a proposal to close risk #1274 due to changes in legislation and to deescalate risks #1172 and #1331. **The Committee supported the proposals.**		
QAC/22/03/63	**Key Discussion points from Clinical Recovery Oversight Committee (CROC)**	The Committee received an update on the key points discussed in the recent Clinical Recovery Oversight Committee (CROC). Specific items of note were: • Total number of patients having harm reviews undertaken was 2942, an increase of 328 from the previous month. • 14 moderate harms had been identified and there had been no increase seen despite the increase in the number of reviews completed.	**The Committee discussed the update and received good assurance**	**CROC April 2022**
QAC/22/03/64	**Maternity Update, including Progress on Ockenden and Q3 Perinatal Mortality Review**	The Committee received an update regarding Maternity services. Of particular note was: • During December there were 57 incidents, 51 no/negligible harm and 6 minor harms. • Progress on Ockenden – The Trust can provide evidence of 63% compliance against the 174 identified areas. A detailed action plan has been developed to comply with all the criteria by September 2022 • The final phase of the Ockenden recommendations will be released in the near future. • The Trust's stillbirth rate was 4.46 per 1000 births and therefore not an outlier	**The Committee discussed the reports and received good assurance**	**QAC April 2022**

The Committee also received the following items:

Items for approval
QAC/22/03/59 – Health & Safety Strategy

Papers to discuss note for assurance

QAC/22/03/65 – Infections Prevention Control & BAF Bi-monthly report

Papers to note for Assurance
QAC/22/03/66 – Quarterly Quality Priorities
QAC/22/03/67 – Quality Strategy Annual Review
QAC/22/03/68 – Q3 Learning from Experience Report
QAC/22/03/69 - Learning from Deaths review
QAC/22/03/70 – Clinical Audit Q3 Report & Forward Plan
QAC/22/03/71 – Dementia Strategy
QAC/22/03/72 – Quality Impact Assessment Report for CIP Plans

High Level Briefing Papers
QAC/22/03/73– Patient Safety & Clinical Effectiveness Sub Committee 22.2.22
QAC/22/03/74 – Infection Control Sub Committee 17.2.22
QAC/22/03/75 – Safeguarding Sub Committee 18.2.22
QAC/22/03/76 – Risk Review Group 7.2.22
QAC/22/03/77 – IG & Corporate Records Group 16.2.22

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/22/03/29 (e)		TRUST BOARD OF DIRECTORS	DATE OF MEETING	31 March 2021

Date of Meeting	23 March 2022
Name of Meeting + Chair	Strategic People Committee: Julie Jarman
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
SPC/22/03/20	**Staff Network Update – Staff Voice**	The Committee received presentations from the Network Chairs of the Disability Awareness Network (D.A.N) and the LGBTQA+ Staff Network about the work that they have undertaken since inception of their Network and their plans for the future.	**Assurance** The committee received assurance that staff voice and more importantly actions and projects are implemented as a result of staff experience.	SPC March 2023
SPC/21/01/ 03/21	**Hot Topic – Supporting Attendance**	The Committee received a presentation regarding the Supporting Attendance project which gave an overview of the following: • Latest absence data	**Assurance** The Committee noted the presentation and received	SPC May 2022

		• Actions that the People directorate are taking around supporting attendance at WHH. The report highlighted that sickness absence from March 2020 – January 2021 has increased month on month and more notable is reflective of high COVID infection rates from October to the peak in January 2022. Sickness absence rates continues to be a challenge across the North West and regionally within Cheshire and Merseyside. Some of the key ongoing actions to support attendance included: • Partnership working and benchmarking practice with NHSE/I • Implementation of Supporting Attendance task and finish group • Launch of new Supporting Attendance policy with accompanying coaching, 1:1 and workshop sessions for line managers and employees • Investment in mental health services to support approach • Working in partnership with Rugby League Cares to enable staff groups who are considered to be "hard to reach" or "seldom heard" are able to remain well at work • Undertaking a review of the on-site Occupational Health and wellbeing service to pull together COVID-19 and BAU elements to continue to support workforce • Rebranding of "Return to Work" interviews as "Welcome Back Conversations" to reflect health and wellbeing culture and approach.	assurance of the work taken to date and plans in place. A request was made to bring back a trajectory for Supporting Attendance targets at the next SPC, and full assurance will depend on the actions being taken resulting in reduced sickness levels.	
SPC/22/03/24	**BAF and Risk Register – Staff**	The Committee received a report relating to workforce risks currently on the BAF and corporate risk register. The Committee were asked to support the following actions: • Reduce risk ID: 1207 which focuses on compliance levels against risk assessments in place and completed for members of the workforce. As the compliance levels have remained consistently high, it is recommended that this risk is reduced from a 16 to an 8 and is de-	**Decision** The Committee noted the report and supported the reduction of risk rating for risk 1207 and its de-escalation to departmental risk register, and supported closing and removing risk 1590 from the BAF.	SPC May 2022

		escalated to the department risk register. The report made it clear what criteria will be looked at for re-escalation of the risk as necessary • Close and remove from the BAF risk ID: 1590 which related to Vaccination as a Condition of Deployment which was removed from legislation from the 15th March and is therefore no longer applicable to the workforce.	We recommend these two changes to risk rating to the Trust Board for approval.	
SPC/22/03/25	**Freedom To Speak Up Bi-Annual Report**	The Committee received an update from the Freedom To Speak Up Guardian in relation to annual activity. The report provided an overview of disclosures including themes which highlighted that the majority of themes focuses on culture, bullying and relationships. The Freedom To Speak Up Guardian, noted that due to the number of disclosures relating to culture, bullying and harassment weekly meetings have continued to take place with HR colleagues to identify any specific areas to focus with some proactive outreach. In addition, there has been significant work in promoting Freedom To Speak Up within the organisation through increasing Freedom To Speak Up Champions across the organisation.	**Assurance** The Committee received assurance that the Trust is promoting Freedom To Speak Up and responding to concerns of the workforce.	SPC March 2023
SPC/22/03/26	**WHH People Strategy Report and Strategic Projects (People)**	The Committee received a report detailing progress against the existing People Strategy. Highlights included: • Development and implementation of individual and management coaching and bitesize sessions to support the new Supporting Attendance policy • Implementation of inclusive recruitment plan with updated EDI statements in recruitment documentation and an accompanying video to educate managers on inclusive recruitment and unconscious bias • Significant OD development supporting teams • Re-starting of agile working task and finish group aligned to organisation's participation in Flex for the NHS programme • Development of behaviour framework aligned to values • Review of Equality Impact Assessments from both a workforce recovery and health and wellbeing intervention perspective.	**Assurance** The Committee were assured of progress against the existing People Strategy objectives and very supportive of a renewed focus on agile working through the task and finish group.	SPC May 2022

		The committee were advised of the significant progress that had been made against the People Strategy dashboard with a refreshed People Strategy due to come to SPC at the next meeting.		
SPC/22/03/27	**Equality Duty Assurance Report (Public Sector Equalities Duty Standard)**	The Committee received the organisation's Equality Duty Assurance Report which gives an overview of how the organisation is meeting its Public Sector Equality Duty Standard.	**Decision** The Committee ratified and approved for external publication to Trust website the EDAR workforce elements.	March 2023
SPC/22/03/28	**Equality Delivery System 2**	The Committee received an overview of the Equality Delivery System 2 (EDS2) which combines the patient and workforce elements and focuses on the organisation's self-assessment against priorities identified in the EDS 2 and feedback from stakeholders to quality assure the self-assessment.	**Decision** The Committee ratified and approved for external publication to the Trust website the EDS2 workforce report.	March 2023
SPC/22/03/29	**Gender Pay Report**	The Committee received the organisation's Gender Pay report which is a national Government requirement. The data is a snapshot date of 31st March 2021. It was agreed that a more in-depth analysis will be undertaken as a basis if a robust action plan (this is not part of the legal requirement)	**Decision** The Committee ratified and approved for external publication to the Government submission portal the Gender Pay Gap report.	Sept 2022
SPC/22/03/30	**Workforce EDI Strategy**	The committee received the refreshed EDI strategy which reflects learning from the refreshed People strategy in terms of style, substance and formatting. The Committee noted that the new EDI Strategy for WHH is clear and good in terms of its intentions to push the EDI strategy forward.	**Decision** The Committee approved the EDI Strategy and agreed for the launch to be in April 2022.	March 2023
SPC/22/03/31	**Chief Officers Report**	The committee received an update from the Chief People Officer with updates provided on the latest position in terms of workplace risk assessments, encouraging the workforce to take annual leave, internal updates and renaming the directorate the People Directorate to reflect national developments and align the team with the refreshed People Strategy.	**Assurance** The Committee received the paper noting the updates and assurance received.	May 2023

		The committee were advised that Vaccination as a Condition of Deployment (VCOD) was revoked and removed from legislation from 15th March and the risk relating to this has already been discussed to remove from the BAF.		
SPC/22/03/32	**Move to Outstanding – Ref Flags Report**	An overview of the CQC red flag indicators relating to workforce that fell below the national average relating to workforce was given to the Committee. Assurances were given linked to the Supporting Attendance management programme to identify any trends or interventions required to decrease sickness levels and also to support teams and managers within the organisation focusing on behaviours and interactions.	**Assurance** The committee noted the report and assurances provided that there are actions and plans in place to mitigate the areas falling below the national average	May 2023
SPC/22/03/33	**Policies and Procedures Report**	The Committee received the report with policies submitted for ratification with exception of the Maintaining High Professional Standards Report. The Committee were informed that there is additional feedback from the British Medical Association that is currently awaiting in order to make slight amendments to the MHPS policy. It was supported by members for Chairs action to be taken on the MHPS policy.	**Decision** The committee noted the report and approved for ratification the policies contained within the supplementary pack. In relation to the MHPS policy, there will be Chairs action taken as a result of the BMA feedback that is currently being awaited.	N/A
SPC/22/03/34	**Workforce Equality Assurance Report**	The Committee received the annual Workforce Equality Assurance Report which provides the organisation with a snapshot of the workforce split by Protected Characteristic. The Committee were keen to hear about the next steps and how the organisation will respond to the data. An updated next steps will be provided to a future SPC meeting.	**Decision** The committee noted the report and approved for publication on the external Trust website the Workforce Equality Assurance Report. The next steps of this report to be provided at a future SPC meeting.	March 2023 Q2 2022/23

SPC/22/03/35	**Employee Relations Report – Detailed Investigations / Disciplinary Report**	The committee received the report which gave an overview of the current employee relations investigations and disciplinaries. The committee noted the report and no further issues were raised.	**Assurance** The Committee were provided with assurance in terms of the actions taken to deal with employee relations and disciplinary cases within the organisation	SPC May 2023
SPC/22/03/36	**Bi-Monthly Staffing Report – Key Issues**	The committee received the report and attention was drawn to work still underway in terms of understanding current vacancy numbers across nursing and midwifery. The committee that the vacancy rate can be difficult to quantify easily due to the extensive ward moves that have taken place according to organisational pressures.	**Assurance** The Committee were provided with assurance that there are actions in place to address any staffing issues as per governance routes.	SPC May 2023
SPC/22/03/37	**Engagement and Recognition Annual Report including National Staff Opinion Survey Report**	The Committee received the report which contained an update on staff engagement and recognition for the year. This included reference to the newly refreshed You Made A Difference recognition awards on a monthly basis and provided detailed analysis on staff survey scores. The Committee was advised that the staff survey results are currently embargoed until 30th March 2022 and a robust analysis will be undertaken to compare with other national Acute Trusts with a further paper being brought to SPC for information and assurance.	**Assurance** The Committee received and noted the report and to bring an updated report to SPC on the action plan for the staff survey results.	SPC July 2022
SPC/22/03/38	**Hospital Volunteer Report**	The Committee noted and received the report and were advised that there are plans to bring the volunteer service in-house to support our approach to volunteering within the organisation.	**Assurance** The committee received and noted the report.	SPC July 2022
SPC/22/03/39	**Annual Health and Wellbeing Guardian Report**	The Committee noted the report which gave an overview of the activity of the Wellbeing Guardian over the past 12 months and provided progress against each Wellbeing Guardian principle. It was highlighted that the organisation is currently self-assessing themselves against the refreshed national Health and Wellbeing Framework which was published in January 2022.	**Assurance** The Committee received and noted the report.	SPC March 2023
SPC/22/03/40	**Operational People Committee**	The committee received and noted the Chairs log of the Operational People Committee.	**Assurance**	SPC May 2023

			The Committee received and noted the report.	
SPC/22/03/41	**Workforce Equality, Diversity and Inclusion Sub-Committee**	The committee received and noted the Chairs log of the Workforce Equality, Diversity and Inclusion Sub-Committee.	**Assurance** The Committee received and noted the report.	SPC May 2023
SPC/22/03/42	**Covid-19 Workforce Recovery Steering Group**	The committee received and noted the Chairs log of the COVID-19 Workforce Recovery Steering Group Committee.	**Assurance** The Committee received and noted the report.	SPC May 2023
SPC/22/03/43	**Key Issues to Board**	The Committee agreed that the key issues to Board included: • Ratification and approval of EDAR, EDS2, Gender Pay Report • Overview of Staff Networks progress and future plans enabling Staff Voice throughout the organisation • Innovation of utilizing Rugby League Cares as an additional lever and support mechanism to reach staff "seldom heard" or "hard to reach" as part of Supporting Attendance management approach • Focus of discussions on agile working with a future paper and approach to be provided at a future SPC meeting.	N/A	N/A

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/03/29 (g)		TRUST BOARD OF DIRECTORS	DATE OF MEETING	16 February 2022

Date of Meeting	**16 February 2022**
Name of Meeting + Chair	**Finance and Sustainability Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
		Matters to discuss and note for assurance		
FSC/22/02/24	Corporate Performance Report	The Committee considered and reviewed the report noting: - • COVID-19 wave 5 had a significant impact during January 2022 leading to opening of additional beds and escalation wards • January A&E performance of 69.72% • Ambulance turnaround continues to perform well • 12 declarable 12-hour trolley waits across December and January therefore will be included in the report from next month • Peak of 173 super stranded patients, important to recognise the length of stay impact of this • Cancer for December achieved the 31 day target but not the 62 day target • Didn't achieve 2 week cancer target – linked to Breast due to increase in referrals and sickness within the team	The Committee **noted** the report	FSC March 2022

FSC/22/02/25	Pay Assurance Report	The Committee considered and reviewed the report noting: - • January 2022 FTE reported with Medical, Nursing and Estates working over and above funded FTE mainly due to additional beds being open • Medical rate card, impact of WLI will be felt in future months • On target with interface scheme of patchwork • VCOD out to consultation as a nation (closes today) awaiting outcome of whether the law will change	The Committee **noted** the update.	FSC March 2022
FSC/22/02/26	Monthly CIP	The Committee considered and reviewed the monthly CIP noting: - • On plan at the end January with £2.9m delivered • CIP plan was backloaded to Q4 but on plan for delivery by the end of the financial year through release of reserves and COVID-19 underspend against plan • £3.4m CIP is non-recurrent which is a pressure for 2022/23	The Committee **noted** the CIP report	FSC March 2022
FSC/22/02/27	Capital Expenditure Update	The Committee considered and reviewed the report noting: - • £6.4m spent against a plan of £12.9m, underspend is a concern • £1.8m brought forward from 2022/23 as mitigation but there is still a significant gap and therefore a risk of underspend by the end of 2021/22 • Schemes over £0.5m were reviewed, specifically the ED plaza, Children's and Urology, Cardiac Catheterisation Suite, fire alarm, shopping city and breast relocation schemes	The Committee **noted** the update.	FSC March 2022
FSC/22/02/28	WLI MIAA Audit Report	The Committee considered and reviewed the report noting: - • Actions on track • New SOP and policy for Medical and Dental WLI ratified at the Executive Team Meeting which includes revised WLI pay rates until the end of the financial year	The Committee **noted** the update.	FSC March 2022
FSC/22/02/29	CAU Portacabin Extension Proposal	The Committee considered and reviewed the report, noting: - • Lease renewal was due on 7 February 2022, extended for 12 months while ED Plaza build continues	The Committee **noted** and the update and **supported** for review at Trust Board.	Trust Board February 2022

FSC/22/02/30	Benefits Realisation Q3 Report	The Committee considered and reviewed the report noting: - • One item still outstanding from 2019/20 and two in progress but recognised substantial progress made from last two quarters • Seven items will be returned in Q4	The Committee **noted** the update.	FSC April 2022
FSC/22/02/31	Cost Report & SLR Update	The Committee noted the report noting: - • Report was deferred from previous month, updated to include Q3 SLR data • NCCI score now 101, 1% higher than the national average • Main drivers for the increase were presented, mainly length of stay and theatre efficiency • Next steps include Costing Steering Group to be re-established and PLICS clinics to be set up	The Committee **noted** the update.	FSC June 2022
FSC/22/02/32	Medical Staffing Review	The Committee noted the report noting: - • £4.6m cost pressure in 2022/23 mainly due to issues around recruitment, sickness and gaps in HEE rotations • Actions to be taken including increased Executive oversight and scrutiny • Medical rate card compliance reviewed and action to be taken to understand non-compliance	The Committee **noted** and the update and **supported** for review at Trust Board.	Trust Board February 2022 FSC May 2022
		Matters to for support and approval		
FSC/22/02/33	Monthly Finance report	The Committee considered the report and capital proposals. Key points to note included: • Deficit position £0.9m which is on plan • Forecasting to breakeven as planned for H2 • CIP achieved • Increase in COVID-19 expenditure mainly due to nursing incentives • BPPC dip in performance due to a push to clear overdue invoices	The Committee **noted** the update and **approved** the change in capital contingency in line with delegated authority.	FSC March 2022

		• Approval of the change in the capital contingency		
FSC/22/02/34	Operational Plans & Budgets	The Committee noted the report noting: - • First activity submission made on 14 February 2022, based on 2019/20 outturn plus additional per planning guidance • First workforce submission due 21 February 2022, based on latest substantive data incorporating pressures that have a WTE impact • First finance submission due 17 February 2022, excludes all system top up and all cost pressures included, currently deficit is £83m but additional cost pressures highlighted as a risk • Overall draft submission to NHSE/I due on 17 March 2022	The Committee **noted** the update.	FSC March 2022
FSC/22/02/35	CIP Target 2022/23	The Committee noted the report noting: - • Guidance requires 1.1% CIP • Expected that this percentage will increase therefore planned for 2.5% CIP • Since the paper was written, 0.9% convergence also required to bring deficit across the System to breakeven over the next three years therefore CIP requirement currently 2% (extra 0.5% remains in current plans) • Phased as 1.1% straight line across the year, 0.9% over Q2 to Q4, additional 0.5% over Q3 and Q4	The Committee **noted** the update and **supported** the 2.5% CIP target and option 3 methodology to allocate the CIP target across the Trust.	FSC April 2022
FSC/22/02/36	Draft Performance Assurance Framework Review & KPI review	The Committee noted the report noting: - • Annual review of PAF including the main proposed updates none of which were highlighted as significant • Annual review of KPIs mainly due to an update to the NHS Standard Contract Quality Requirements	The Committee **noted** the update.	Trust Board March 2022
		Matters to note for assurance		
FSC/22/02/37	Digital Services Board Report	The Committee considered and reviewed the report noting: - • The assurance levels in the report • One item for escalation in relation to the EPCMS Procurement process being extended due to operational pressures as well as to ensure that there is enough clinical input	The Committee **noted** the update.	FSC March 2022

FSC/22/02/38	Risk Register	The Committee noted the report noting: - • There are no new risks or changes to the current risks	The Committee **noted** the update	FSC March 2022

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/03/29 (g)		TRUST BOARD OF DIRECTORS	DATE OF MEETING	30 March 2022

Date of Meeting	**21 March 2022**
Name of Meeting + Chair	**Finance and Sustainability Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
		Matters to discuss and note for assurance		
FSC/22/03/44	Corporate Performance Report	The Committee considered and reviewed the report noting: - • 4hr performance excluded Widnes walk-in activity: 67.61% against 95% standard • Ward B3 and B4 continued to be used for supporting further capacity. • Still doing well in comparison with peers on ambulance turnaround times • LOS of stranded patients peaked in Jan and has started to decrease. • 66.97% against RTT – marginally up on previous month however number of 52-week waiters has reduced to 1038 at the end of Feb MIAA WLI position – report will be shared with minutes • Last month reported 5 recommendations.	The Committee **noted** the report	FSC April 2022

		• Closed recommendation 1. • Recommendations 2 to 5 has a completion date end of March, and all are on track to achieve.		
FSC/22/03/45	Pay Assurance Report	The Committee considered and reviewed the report noting: - • Vacancies increased by 51 FTE this month to 477 vacancies • Compliance with the Trust rate card in February 2022 is 68% following introduction of the rate card • Agency staffing – compliance against the NHSI rate card remains low 16% (NHSE/I) • On target with MIAA WLI audit actions • On target with interface scheme of patchwork • VCOD – revoked last week on 15th March.	The Committee **noted** the report.	FSC April 2022
FSC/22/03/46	Monthly CIP	The Committee considered and reviewed the monthly CIP noting: - • Above plan at the end of February with £4.6m delivered • Expect to overachieve £5.5m against £4.9m • £3.4m CIP is non-recurrent which is a pressure for 2022/23 • Actions for establishing CIP plans for next year.	The Committee **noted** the CIP report	FSC April 2022
FSC/22/03/47	Capital Expenditure Update	a) Capital Position The Committee considered and reviewed the presentation noting: - • £8.6m spent against a plan of £14.0m, underspend is a concern as £10m remaining to be spent in March. • Mitigations are in place, however if any further slippage there will be an underspend. • ED Plaza brokerage has been confirmed in writing from C&M ICS. • Schemes over £0.5m were reviewed, specifically the ED plaza, Children's and Urology, Cardiac Catheterisation Suite, fire alarm, shopping city and breast relocation schemes Underspending - £5.4m b) Schemes over £500k	The Committee **noted** the update and **support** schemes over £500k to go to Trust Board	Trust Board March 2022 FSC April 2022

		i) 2022/23 IM&T Capital Scheme CISCO • Greatest risk is worldwide microprocessor shortages • Agreed to support this scheme to go to Trust Board. ii) Pharmacy Automated Dispensing Systems • Indicative cost of £1.77m • Ability to complete Warrington site first and then Halton and split across financial years. • Agreed to support this scheme to go to Trust Board. • 2022/23 CEDL has not all been distributed by the ICS, only depreciation £7.6m plus ED Plaza £2.9m. • Shortfall of £2.3m • 3 remaining pots which we will bid to fund business critical schemes.		
FSC/22/03/48	2022/23 Planning Update	The Committee considered and reviewed the presentation noting: - • Activity and workforce figures and finances planned for 2022/23 had been submitted last week. • Previously, £34m deficit plan – now £19.2m deficit • Aim for 4% increase in activity on 19/20 • Need to hit zero 104 week waits but expect to increase 52 weeks wait • Included in plans ERF - £7.6m, financial risk of losing 75% if we don't achieve activity plan. • Workforce – 1.82% increase in workforce driven by cost pressures and business cases, • 3% CIP target - Recurrent CIP delivery is going to be a significant challenge. • Deficit will have potential impact on cash and ability to use for EPCMS	The Committee **noted** the presentation and **support** the draft 2022/23 budget and capital proposal	FSC April 2022

		• Capital – original plan submitted to Trust Board was £12.8m – CPG may need to look at managing plan over 18mths if we don't get full CEDL. • Note latest planning gap of £19.2m • Note the risk in the position – ERF & CIP • Support draft 2022/23 budget • Support 2022/23 capital proposal • Note requirement to further reduce the deficit		
FSC/22/03/49	Bi-monthly Strategy Programme Highlight Report	The Committee considered and reviewed the report noting: - • New hospitals programme – refresh of site evaluation option to identify preferred site • Expression of interest for CDC on Halton site submitted and waiting for results – potential risk over revenue - Preferred option – new build adjacent to CSTM but no additional activity till 23/34 • Detailed architect Warrington health and wellbeing hub and Runcorn hub • C&M due to finalise green plan – ours due to go to Trust board • Shopping city – asbestos clearance completed • Concerns were expressed around pathology services from a safety and operational point of view. Full business case is in development.	The Committee **noted** the update.	FSC May 2022
FSC/22/03/50	EPCMS Update	The Committee considered and received verbal update noting: - • Currently in procurement process – final moderation and outcome due on 5th April and will be reported to FSC 20th April. • National directive convergence has been noted • Received notice last week from supplier of Lorenzo that it will be withdrawn from the market. • Risk of migrating back to paper if new system is not procured in time • Require further clarification on ICS position of convergence and clarity on the ceasing of Lorenzo.	The Committee **noted** the update and **escalated** concerns around the System strategy policy announcement alongside the recent advice in respect of Lorenzo	FSC April 2022 Trust Board March 2022

FSC/22/03/51	Risk Register & BAF	The Committee noted the report noting: - • No major change to BAF • Corporate risk register • Slight change risk no. 1127 reduced and de-escalated	The Committee **noted** the Risk Register and BAF report	FSC April 2022
		Matters to for support and approval		
FSC/22/03/52	Monthly Finance report	The Committee considered the report and capital proposals. Key points to note included: • March FRG stood down so no minutes for that next month. • Deficit £0.5m which is in line with plan • Forecasting to breakeven as planned for H2 • Private patient activity and income will be reported in this report in line with audit report recommendation – paper relating to this will be sent to board. • CIP achieved – reliance on non-recurrent items • BPPC 95% compliance – previously system issue with SBS has been resolved and will see improvement in performance. • Approval of the change in the capital contingency ➢ Approval of emergency schemes for £109k (2021/22) and £67k (2022/23) ➢ Approval of renal pump and plumbing and dental chair - £58k ➢ Approval of virtual fracture clinic software • Noted escalation of the cost improvement programme development – concerns raised at the Feb FRG.	The Committee **noted** the update, **approved** the change in capital contingency in line with delegated authority and **escalate** concerns on the development of CIP schemes for 2022/23	FSC April 2022 Trust Board March 2022
FSC/22/03/53	Draft Finance Strategy	The Committee noted the report noting: - • Draft strategy will be taken to the board development day in April – Non execs will be provided copy of documents • Historic financial position with debt of £57m and only 30% of suppliers paid on time. • Significant investment in revenue and capital has been made in the past two years	The Committee **noted** the report.	Board Development Day April 2022

		• 5-year financial plan – underlying deficit depends on the level of income received • Use of Model hospital and GIRFT to develop and identify savings. • Significant impact on cash balances if deficit of £10m v £20m • Efficiencies from use of resources, Strong financial governance, working as a system and collaboration, clear strategic direction.		
FSC/22/03/54	Grant Funding Agreement Warrington Town Deal	The Committee received the report noting: - • Insufficient time to review • Committee members to submit comments to Lucy and John ahead of Board. • Allow Trust to go into the agreement of the grant funding. • Key points to draw attention to – highlighted and raised by Hill Dickinson's. • Concerns raised over involvement of NHS Properties – confirmation that no commitment in place regarding the holder of the lease	The Committee **noted** the update and request for comments.	Trust Board March 2022
FSC/22/03/55	Committee Cycle of Business	The Committee noted the report noting: - • Proposed changes to the cycle of business	The Committee **noted** and **supported** the proposed changes	FSC April 2022

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/03/29h	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	30 March 2022

Date of Meeting	17 February 2022
Name of Meeting & Chair	Audit Committee, Chaired by Michael O' Connor
Was the meeting quorate?	Yes

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

Agenda Reference	Agenda Item	Issue and Lead Officer	Recommendation / Assurance/mandate to receiving body	Follow up/ Review date
AC/22/02/04	**Changes/update to BAF**	The Committee particularly noted the following since the last meeting: • Two new risks had been added to the BAF. • The rating of one risk had been increased • The descriptions of three risks had been updated The high number of risks currently on the BAF was discussed. The increased number was as a result of the pandemic; however, it was likely that the number would begin to reduce in the near future but it was important to follow due process.	**The Committee discussed the report and received good assurance**	**Audit Committee 21 April 2022**
AC/22/03/05	**WLI MIAA Audit Update**	The Committee received an update on the position of the Waiting List Initiative Audit and noted the focus had been on ophthalmology and the report had been finalised, with an overall position of substantial assurance.	**The Committee discussed the report and received good assurance.**	
AC/22/03/06	**Internal Audit Progress Report on Follow-up Actions**	The Committee received a report providing an update in respect of the assurances, key issues and progress against the internal Audit Plan for 2021/22.	**The Committee reviewed and discussed the report and assurances provided. Good assurance was received.**	**Audit Committee 21 April 2022**

		It was noted that there was an outstanding partially completed action in relation to DNACPR decision making. An extension was agreed for completion by 14th April 2022 There were overdue critical or high recommendations		
AC/22/03/07	**Internal Audit Plan & Fees**	The Committee received the Internal Audit Plan for 2022/23. The plan was developed through discussion with Executive Officers and through review of the Trust's Assurance Framework. It wass a risk-based plan and is also designed to include any mandated areas for review and to ensure it is sufficient to provide an opinion at the end of the year. The total internal audit fees for 22/23 are to be confirmed fees. (This will be based on 21/22 fees plus an uplift as per planning guidance).	**The Committee approved the Internal Audit Plan for 2022/23.**	
AC/22/03/08	**Internal Audit Follow Up Report**	The Committee received a report detailing Internal Audit followed up reviews. It was noted that all recommendations followed up had been implemented.	**The Committee discussed the report and received good assurance.**	**Audit Committee 21 April 2022**
AC/22/03/09	**Internal Audit Progress Report**	The Committee received a report providing an update in respect of the assurances, key issues and progress against the internal Audit Plan for 2020/21. 4 reports have been issued; • Key Financial Systems Review – High Assurance • Waiting List Management Review – Substantial Assurance • AF – Phase 1 – Phase 2 to be completed • Waiting List Initiatives Review – Limited Assurance 4 reviews are in progress; • Discharge Planning (Fieldwork in progress) • Mortality Review (Terms of Reference issued) • Clinical Safety Assurance Review (Terms of Reference issued) • Assurance Framework Opinion – Phase 1 (Terms of Reference issued).	**The Committee reviewed and discussed the report and assurances provided. Moderate assurance was received.**	**Audit Committee 21 April 2022**

Other items included on the agenda were:

AC/22/02/03 – Update from Chairs – FSC, SPC, QAC, CFC and CROC
AC/22/02/10 – Report and Updates from External Audit
AC/22/02/11 – Counter Fraud Progress Report
AC/22/02/12 – Review Losses & Special Payments period 1 July 2021 to 30 September 2021
AC/22/02/13 – Review of Quotation & Tender Waivers Q3
AC/22/02/14 – Key Dates for production of the Trust's Annual Accounts and Annual Report 2021/22
AC/22/02/15 – Draft Annual Accounting Policies
AC/22/02/16 – MIAA 2021/22 Checklist Series Governance
AC/22/02/17 – Northwest Skills Development Agency – Bi Annual Report
AC/22/02/18 – ICON Programme

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/03/29 (i)		TRUST BOARD OF DIRECTORS	DATE OF MEETING	30 March 2022

Date of Meeting	**15 February 2022**
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/2022/02/05	Harm Profile update	• 414 patients have a 52+ week wait and require a harm review. Planned surveillance patients are now included in the figures as these patients will require a harm review. • 1203 patients have a wait of less than 52 weeks, and require a harm review to be undertaken. • Each of the high-risk specialities now have a weekly trajectory and action plan.	The Committee noted the update	Next CROC
CROC/2022/02/06	Review of consistency and standardisation of harm across Cheshire & Merseyside	PF reported that the standardisation of harm had been discussed at the Regional Medical Group and the Chief Nurses' meeting. There was significant variance across the region. It was felt that a standardisation across the region would be difficult, however, some principles have been agreed. Action: PF to feedback agreed principles.	The Committee noted the update	Next CROC

CROC/2022/02/07	Waiting List update	Operational guidance has now come out for the 2022/23 planning with a final submission date of 17th March 2022. <u>RTT update:</u> • Total RTT Waiting list size 23,546 (this does not include ASI (Appointment Slot Issue), RAS (Referral Assessment Services) and Planned surveillance patients) slightly higher than the submitted estimate 23,535) Including ASI, RAS Total WL size 26,598. • Additional activity has commenced as part of H2 planning funding bid received. <u>Priority code update: Key Issues</u> • Increase in the number of patients upgraded to a P2. These are mostly coming from harm reviews being conducted. • There is a national steer to ensure there are no patients waiting >104 weeks by the end of March 2022. Early indications are that the Trust will be compliant with this. • Consideration is being given to elective recovery during winter and will form part of the Trust and wider Cheshire and Mersey/ICS (Integrated Care System) winter plan. <u>Cancer: Key Issues</u> • >104 day being achieved in line with the Cancer Alliance trajectories. • >62 trajectory currently one patient off trajectory, recovering from a slight rise post the Christmas period/effect of omicron variant. In terms of end of January H2 planning projection, this Trust is not deemed to be a risk at Cancer Alliance level. • Continued good compliance against 31 day and 28-day Faster diagnosis standard although there is expected to be a decrease in performance against the 28 day FDS due to staffing shortages in January and reported issues with the breast 2ww.	The Committee noted the report.	Next CROC

		• Trajectory and plan have been drawn up to achieve Q3 compliance for 62 day by December 2021. Latest reported performance for December is 72.3% against a trajectory of 85%. This is an internal trajectory. National requirement is by March 2022. • Continued increase in 2ww referrals over and above pre pandemic levels. Breast 2ww referrals in particular have been very high and capacity has not been able to meet demand. This has led to failure of the 2ww standard in October, November, December and January. Work is ongoing to ensure that enough capacity is in place to deliver a recovered position by February 2022. <u>Diagnostics;</u> **Radiology** – • With regard to Non Urgent OP/GP, 91.9% CT and 90.0% Fluoro. **Endoscopy –** • Recovery slowed down during December and January, this is set to recover from February. • New unit opening at Halton • Incentivisation paper agreed at execs until the end of Q4 2021-22. **Cardio Respiratory:** Echoes not meeting 6 week target – actions agreed were - • Continue to triage referrals (both Admin and clinically – reduction in approx. 30% of referrals. • Continue to use agency at weekend. • Continue to offer additional shifts and overtime to staff. • Increase in core capacity of echoes from 7 per day to 10 per day from 28 Feb. • Increase in agency capacity from 66 to 116 per week from 14th Feb.		

		Stress echoes not meeting 6-week target; • Offer additional shifts and overtime to staff • Explore option of clinical triage Sleep studies not meeting 6-week target; • Continue to triage referrals • Continue to offer additional shifts		
CROC/2022/02/08	H2 Planning	DM reported that WHH was producing plans and that the focus now was on 2022/23 planning.	The Committee noted the update	Next CROC
CROC/2022/02/09	Access to Recovery Fund update	Key operational planning figures were being submitted to the Finance & Sustainability Committee on 16th February 2022.	The Committee noted the update	Next CROC
CROC/2022/02/10	Cheshire & Merseyside update	DM advised nil to report by exception. The Trust continues to engage with any options for mutual aid.	The Committee noted the update	Next CROC
CROC/2022/02/11	Elective Fund Progress	DM advised this had supported performance for January and February 2022 and spend continues. DM provided assurance that the use of the funds was being tracked to provide evidence of use. JH confirmed that the £1.7m is available.	The Committee noted the update	Next CROC
CROC/2022/02/12	2022-2023 Planning Progress	DM referenced his previous updates in the meeting to planning progress that is currently under way.	The Committee noted the update	Next CROC

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/30**	
SUBJECT:	**Moving to Outstanding and Red Flags Bi-Monthly Report**	
DATE OF MEETING:	30 March 2022	
AUTHOR(S):	Layla Alani, Director of Integrated Governance and Quality	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**#224** Failure to meet the four hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g., cyber defences), new	

	technology skillsets (e.g., Cloud), unfit solutions (e.g., Maternity), end-of-life solutions (e.g., Telephony), poor performance (e.g., Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g., Civil Contingency measures) and subsequent reputational damage. **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#125** Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Moving to Outstanding Steering Group provides an updated position on performance Trust wide through the analysis of the CQC Insight Report which details 70 performance indicators. Overall the Trust has improved performance since the last report received from the CQC in December 2021. 2 main areas of decline in performance have been noted for which plans are in place: • Sick days for non-clinical staff • GMC enhanced monitoring In order to continually provide assurance of performance in accordance with the indicators monitored through the CQC Insight Report, WHH has developed a focused internal monitoring mechanism known as 'red flags'. This ensures a proactive approach in both sustaining and improving performance. 29 performance indicators were identified internally during the reporting period: • 11 indicators showed further improvement, though this is less than the 13 indicators reported previously (2). This is as a result of sickness across the Trust and nurse staffing vacancies, for which plans are in place. At the time of this report there are 76 Whole Time Equivalent (WTE) nursing vacancies with 23.59 having been recruited pending a start date. A further 30 vacancies will be filled following approval of the overseas nursing recruitment business case. The remainder vacancies will continue to be filled via the two weekly recruitment programme. • 12 indicators showed decline in performance which is an increase of 3 when compared to the last reporting period again relating to sickness and nursing vacancies.

	This report will provide detail including (but not limited to) the following : • The Trust performance against CQC indicators (Insight Report) • The Trust performance against ' red flags' • Matters of regulation • Well led Framework update • CQC enquiries received • Outcome of the CQC engagement meeting • Mock inspection programme This report is written based upon data detailed within the CQC insight report for January 2022 with the next Insight report due to be received from the CQC at the end of March 2022. Internal performance data is provided up to the end of February 2022 to provide the Board of Directors with the most up to date position. Detail relating to the CQC insight data for January 2022 was discussed during the Quality Assurance Committee meeting on 1st February 2022. A further report will be presented at Quality Assurance Committee on 5th April 2022. The cycle of business has now been amended to ensure up to date reporting at this committee ahead of discussion at the Board of Directors.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors are asked to note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**			
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Moving to Outstanding and Red Flags Bi-Monthly Report	AGENDA REF:	BM/22/03/30

1. BACKGROUND

The Moving to Outstanding Steering Group provides an updated position on performance Trust wide through the analysis of the CQC Insight Report. This details the performance position seen by the CQC following the external review of internal data.

In order to continually provide assurance of performance in accordance with the indicators monitored through the CQC Insight Report WHH developed focused internal monitoring mechanisms, known as 'red flags'. This ensures a proactive approach in both sustaining and improving performance.

This report will provide detail including (but not limited to) the following :

- The Trust performance against CQC indicators (Insight Report)
- The Trust performance against ' red flags'
- Matters of regulation
- Well led Framework update
- CQC enquiries received
- Outcome of the CQC engagement meeting
- Mock inspection programme

This report is written based upon data detailed within the CQC insight report for January 2022 with the next Insight report due to be received from the CQC at the end of March 2022. Internal performance data is provided up to the end of February 2022 to provide the Board of Directors with the most up to date position.

Detail relating to the CQC insight data for January 2022 has been discussed during the Quality Assurance Committee meeting on 1st February 2022. A further report will be presented at Quality Assurance Committee on 5th April 2022. The cycle of business has now been amended to ensure up to date reporting at this committee ahead of discussion at the Board of Directors.

2. KEY ELEMENTS

2.1. CQC Insight Report and Internal Red Flag Monitoring

The CQC insight report for January 2022 monitored 70 indicators. The number of indicators changes dependent upon the data collected by the CQC in relation to internal performance data. Table one details WHH performance against these indicators compared to the national average.

Overall the Trust has improved performance since the last CQC insight report in December 2021.
Of the 70 Trust wide indicators monitored by the CQC, 2 were identified as being below the national average. These relate to 'sick days for non-clinical staff' and 'GMC enhanced monitoring' for which there are plans in place monitored by Medical Cabinet, the Workforce Review Group and Strategic People Committee. Indicators showing improvement are also detailed in Table one.

Table one - Trustwide CQC Indicator Performance

Indicator Performance Position	National average	January 2022
Improving indicators		
Active professional registration - medical and dental	98.3%	100%
Active professional registration - nursing and midwifery	97.9%	100%
Equality, diversity and inclusion	9.0	9.4
Health and wellbeing	6.1	6.5
Safe staffing - bullying and harassment	8.0	8.4
Safe environment - violence	9.5	9.5 inline with national average
Safety culture	6.8	6.9
Hospital Standardised Mortality Ratio (Weekday)	100	87.4
Declining indicators		
Sick days for non-clinical staff	4.63%	6.04%
GMC enhanced monitoring	Routine monitoring*	GMC raised concerns with progress against actions – survey outcome awaited

*The General Medical Council (GMC) routinely monitor medical education and training. Enhanced monitoring is used to promote and encourage local management of concerns regarding the quality and safety of medical training. Previously the Trust was requested to develop action plans with regard to medical training. Actions are on track and the GMC National Training Survey is awaited which will confirm assurance of the required improvement.

2.2 Internal Performance Red flag report

WHH has adopted a proactive approach to both sustaining and improving performance through the creation of a 'red flag' monitoring process. This enables the early identification of possible decline ensuring that specific focuses is provided to mitigate such risk.

At the time of reporting to the Moving to Outstanding Steering Group on 17th March 2022, 29 red flags that had previously been identified were presented for further discussion as required. **Table two** details the Trustwide position on improvement, decline or stability in the 29 performance indicators identified internally (red flags), with comparison to the previous reporting period. Details of red flags showing decline are noted within **appendix one,** with plans in place to optimise improvement across these areas. Since the last reporting period 3% of these indicators have been closed.

Table Two below shows that there are 11 indicators showing improvement, though this is 2 less than January 2022. This relates to sickness and nurse staffing vacancies. At the time of this report there are 76 Whole Time Equivalent (WTE) nursing vacancies with 23.59 having been recruited pending a start date. A further 30 vacancies will be filled following approval of the overseas nursing recruitment business case. The remainder vacancies will continue to be filled via the two weekly recruitment programme.

There are 12 indicators showing decline in performance which is an increase of 3 when compared to the last reporting period. 1 indicator that had been stable previously showed decline due to an increase in the number of nurse staffing vacancies.

Table 2 Red Flag Monitoring

Indicator status	Indictor Performance compared to last reporting period	Current position (based on 29 indicators- February)	Previous position (based on 30 indicators - January)
Improving	i	11/29 (37.9%)	13/30 (43.3%)
Declining	h	12/29 (41.4%)	9/30 (30%)
Same	i	6/29 (20.7%)	8/30 (26.7%)
Overall Trust	7 red flag indicators are above or in line with the national average. Focused work is underway as early deterioration identified (**appendix one**)		

2.3 Regulatory Breaches

Following the 2019 CQC inspection 4 regulatory breaches were identified as detailed in **Table three** These will remain open until the ED is next inspected. Due to current system and operational pressures regulation 12 whilst controlled creates risk for all organisations. The ED now have a robust governance dashboard with regular governance meetings chaired by the Clinical Director (regulation 17). In relation to regulation 18 all nurse staffing vacancies have been recruited to with full establishment expected by June 2022. There are no medical staffing deficits in ED.

Table three – Regulatory Breaches (2019)

Regulation Breached	
12: Safe Care and Treatment	Crowding in the emergency department must be reduced so that patients do not have to wait on trolleys in corridors. Regulation 12(2)(b)
12: Safe Care and Treatment	Patients whose clinical condition is at risk of deteriorating must be rapidly identified and reviewed at suitable intervals. Regulation 12(2)(a)(b)
17: Good governance	Information about the performance of the service is accurate and properly analysed and reviewed by the leadership team. Regulation 17(2)(a)
18: Safe Staffing	There are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department. Regulation 18(1)

2.4 Well-Led Framework

The Chief Nurse and Company Secretary met with the Good Governance Institute (GGI) on 9th March 2022 to discuss the potential for GGI to undertake the requisite well led inspection early in the new financial year. This will be a developmental review with an internal well led review to follow for additional assurance.

2.5 Communications

There are three domains (as detailed below) that form part of the well led framework that require support from the Communications Department and Patient Experience Team. Updates were provided against the communications plan at the Moving to Outstanding meeting on 17th March 2022 with actions on track.

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

2.6 Use of Resources

The Use of Resources assessment remains suspended whilst the CQC and NHSI/E develop a revised framework. Internal work continues to be completed ahead of further direction from the CQC.

2.7 CQC Enquiries

From 1 January 2022 the Trust has received 14 new CQC enquiries. This has decreased by 7 when compared to October – December 2021. All enquiries are linked to internal incident investigations. The Director of Integrated Governance and Quality oversees responses to these enquiries and all responses have been provided within timeframe. There are no specific themes identified within these enquiries.

2.8 CQC Engagement Meeting

The CQC Engagement meeting was held on 3 March 2022. There were no concerns raised at the meeting and the Trust were commended upon achievements for Anaesthesia Clinical Services Accreditation (ACSA) and Joint Advisory Group (JAG) accreditation. The CQC commended the Trust upon the work undertaken with regard to the nursing refugee programme. Further information was shared as requested by the CQC.

Other items discussed during the meeting included operational capacity and capability detailing work with system partners alongside recovery, restoration, risk, governance, patient safety and staff wellbeing.

The CQC are now recommencing inspections with a focus upon Emergency Departments and areas where risk is identified. This was discussed on the meeting with the CQC. No concerns were raised for WHH and a further ED mock inspection is planned.

2.9 Mock Inspection Programme 2022/23

WHH has commenced its Mock Inspection Programme following a pause during the pandemic. To date the following areas have been inspected:

- Maternity
- ED – To be reinspected as part of robust preparation due to the revised methods of CQC inspection.
- Surgery
- Outpatients

2.9.1 Mock Inspection Action Plans

An updated position has been collated for the March 2022 Moving to Outstanding Steering Group from the Maternity team which triangulates a number of action plans providing robust assurance of progress made across a number of workstreams. These action plans are being finalised for the other areas that have undergone mock inspection. Any immediate risks are actioned on the day of inspection.

2.9.2 Table Four: Themes from inspections so far

Positive findings	Areas for improvement
Patients treated with kindness, dignity and compassion	Mixed feedback on culture
Patient involvement in care planning	Increase awareness of interpretation services
Staff engagement in the process	Information governance – smartcards to be secured

Positive incident reporting culture	Ensuring that doors that should be secured are at all times
Good understanding of safeguarding	Consistency of IPC screening in departments
PPE adherence by staff	Appraisal completion
Desire to improve from teams	Keyword search for policies to improve access
Patient facing areas were visibly clean	EQUIP training compliance
Equipment availability	

Further inspections are scheduled to take place throughout 2022/23 led by the Chief Nurse.

3.0 Accreditations

3.1 Anaesthesia Clinical Services Accreditation (ACSA)

ACSA accreditation provides assurance that systems and processes are robust in the delivery of anaesthetic care. An ACSA accreditation virtual visit took place on 21st October 2021 with extremely positive feedback received. The final onsite visit to ensure compliance with the ACSA standards ahead of confirming that accreditation is issued is scheduled for 22 March 2022.

3.2 Joint Advisory Group (JAG) on GI Endoscopy accreditation renewal

JAG accreditation provides assurance that systems and processes are robust in the delivery of endoscopic care. A JAG accreditation visit took place on 10th - 11th February 2022. Extremely positive feedback has been received. The Trust are awaiting the final report. It is expected that accreditation will be provided.

3.3 Human Tissue Authority Assessment (HTA)

The Human Tissue Authority Assessment is scheduled to be completed on 16th May 2022. The HTA inspection is a process to ensure compliance with the holding of a HTA licence in accordance with HTA standards. This involves an on-site assessment and analysis of relevant information. Actions are currently on-track for this visit.

4.0 Royal College of Emergency Medicine (RCEM) Action Plan

In 2020 the Royal College of Emergency provided guidance in relation infection prevention and control. There are 2 outstanding actions. These are in relation to:

- IPC 06 – Nursing for Escalation areas – There are 13 whole time equivalent nursing vacancies which have been recruited to. The team will then be at full establishment by June 2022. This can then be closed.
- IPC09 – ED Plaza – The contractor has commenced work. The action will be closed upon completion.

5.0 Table 5: Mandatory Training and Appraisal Compliance

Trajectories for Mandatory training, Role Specific Training, Safeguarding and Appraisal were provided at the Moving to Outstanding Steering Group on 17th March 2022. An overview is shown below:

Training	January 2022 in accordance with outlined trajectory)
Core Skills Training Framework (CSTF)	84.82%
Role Specific Training (RST)	89.92%
Safeguarding	68.14%
Appraisals	64.19%

Compliance trajectories are in place with improvement identified across a number of areas. Challenges remain particularly in relation to appraisals due to operational and staffing pressures for which focused plans are in place. A revised appraisal trajectory aiming to achieve 85% compliance by July 2022 has been submitted for approval to the Strategic Executive Oversight Group.

Whilst compliance is being achieved in accordance with trajectories set focused work is in place to address areas of low compliance that sit within these broader domains e.g Elements of RST including medical consent.

6.0 Coroner File Regulatory 28 Prevention of Future Deaths Reports

The Trust has had no Regulatory 28 Reports issued since 2018.

2 ASSURANCE COMMITTEE

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

3 RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix one

Performance of Red Flag Indicators (29)

Appendix one
Performance of Red Flag Indicators (29)

This table displays the 12 red flag indicators as referenced within the report plus the indicator relating to GMC enhanced monitoring. Four indicators relate to Trust wide performance and 8 relate to specific areas.
Those indicators with * indicate above national average for performance but are showing decline since the last reporting period.

Indicator	February 2022 position	January 2022 position	Trend	Action taken/planned
S2 - Ratio of ward manager nurses to senior and staff nurses *	B5 nurse staffing vacancies: 52	B5 nurse staffing vacancies: 10	↓	• A rolling advert for Band 5 nurses with weekly shortlisting and interviews is scheduled. • A business case has been submitted, March 2022, for 30 international nurses in 3 cohorts of 10 in May, July, and September. •
W3 - Sick days for nursing and midwifery staff	6.84%	6.8%	↓	The top two reasons for absence have been identified: • Anxiety/stress/depression/other psychiatric illnesses – which makes up 30% of absence days. • Chest and respiratory problems (COVID-19) – which makes up 16% of absence days. **Actions** • Supporting Attendance project initiated. • RTWI has been refocused as Welcome Back Conversations. • Bespoke training and one to one management coaching on Welcome Back Conversations offered. • Welcome Back Conversation workshop offered within the essential skills for managers program. • Occupational Health and Wellbeing hold triangulation meetings with HR colleagues to review individuals who are under the formal stages Supporting Attendance Management.
W3 - Sick days for non-clinical staff (%)	6.17%	6%	↓	The top two reasons for absence have been identified: •Anxiety/stress/depression/other psychiatric illnesses – which makes up 27% of absence days. • Chest and respiratory problems (COVID-19) – which makes up 13% of absence days.

				Actions • Supporting Attendance project initiated. • RTWI has been refocused as Welcome Back Conversations. • Bespoke training and one to one management coaching on Welcome Back Conversations offered. • Welcome Back Conversation workshop offered within the essential skills for managers program. • Occupational Health and Wellbeing hold triangulation meetings with HR colleagues to review individuals who are under the formal stages Supporting Attendance Management.
W3 - Sick days for other clinical staff (%)	7.32%	7.12%	↓	The top two reasons for absence are: •Anxiety/stress/depression/other psychiatric illnesses – which makes up 29% of absence days. • Chest and respiratory problems (COVID-19) – which makes up 19% of absence days. **Actions** • Supporting Attendance project initiated. • RTWI has been refocused as Welcome Back Conversations. • Bespoke training and one to one management coaching on Welcome Back Conversations offered. • Welcome Back Conversation workshop offered within the essential skills for managers program. • Occupational Health and Wellbeing hold triangulation meetings with HR colleagues to review individuals who are under the formal stages Supporting Attendance Management.
W3 - GMC Enhanced Monitoring	Concerns with progress	Concerns with progress	⇦⇨	• Action plans regarding the visit report and GMC National Training Survey results have been submitted and accepted by the visit team. • Health Education England advised they would recommend removal from Enhanced Monitoring in July 22 providing the Trust successfully update and maintain action plans, have a positive outcome form the GMC survey and depending on GMC survey results undertake an internal monitoring exercise to update progress in June.

Urgent and Emergency Care

Appendix table two

Indicator	February 2022 position	January 2022 position	Trend	Action taken
R3 - A&E Attendees spending more than 12 hours	68	24	↓	• The Trust has >150 super stranded patients. Currently there are 119 super stranded patients against a target of below 80. Flow work is on-going with system partners to reduce this. Bed occupancy is between 96% - 99%. • Adapted classification to right to reside (reason to be in hospital) / no right to reside (no reason to be in hospital). At the time of reporting there are 146 patients with no right to reside. The plan is to work with partners to reduce this by 50%.

from decision to admit to admission				• Daily system meeting. The system are looking to increase capacity in care homes, considering out of area beds, block booking beds and revising the admission criteria for a care home. • 4 key workstreams identified: - Improving flow through emergency department. - Reduction in volume of patients attending emergency department. - Further expansion of the Same Day Emergency Care pathways (SDEC). - Right infrastructure, capacity, and capability.
R3 Patients spending less than 4 hours in (any type of) A&E (%) - NHS England - A&E SitReps	67.6%	68.9%	↓	• 4 key workstreams identified: - Improving flow through emergency department. - Reduction in volume of patients attending emergency department. - Further expansion of the Same Day Emergency Care pathways (SDEC). - Right infrastructure, capacity, and capability. • Revisiting the ECIST workforce modelling tool.
R3 Patients spending less than 4 hours in majors A&E - NHS England - A&E SitReps	57.1%	59.3%	↓	• Additional escalation beds were opened in January (B4 day case ward) to support the additional pressures within the NEL pathway. • 4 workstreams established focusing on flow within the ED. • EDRG established to look at improvements.
R3 Admissions waiting 4-12 hours from the decision to admit (%) - NHS England - A&E SitReps	70.6%	65.2%	↓	• 4 key workstreams identified: - Improving flow through emergency department - Reduction in volume of patients attending emergency department - Further expansion of the Same Day Emergency Care pathways (SDEC) - Right infrastructure, capacity, and capability.

Medicine

Indicator	February 2022 position	January 2022 position	Trend	Action taken
R3 Referral to treatment, on	90.09%	96%	↓	• RTT Performance for Medicine has dropped to 90.09%. This represents 7 patients that have breached 18w compared with the previous month.

completed admitted pathways in Medicine, within 18 weeks (%) NHS England - RTT Admitted*				• Work is ongoing to improve this position including putting on additional clinics, Patient Initiated Follow Up and using advice and guidance. This is monitored by RTT Group/PRG.

Surgery

One red flag indicator is being monitored for removal as the Trust no longer undertakes this type of surgery.

Indicator	February 2022 position	January 2022 position	Trend	Action taken
R3 Referral to treatment, on completed admitted pathways in Surgery, within 18 weeks (%) NHS England - RTT Admitted	56.2%	67.17%	↓	• The Position in February has dropped on the November position at 56.2% (Not yet fully validated). • This is primarily down to the fact we are dating our most urgent patients as well as our long waiters in line with national guidance. • In January 2022 this was impacted by wave 5 Covid-19 and the cancellation of clinics to release staff to support operational activity. Additional clinics have been planned. • An improvement trajectory has been nationally submitted outlining what is needed to recover the Trust's position. • Until the Trust can reduce the clinically urgent backlog, we will continue to fluctuate around the 55% - 57%. Monitoring is in place at PRG.
R3 - Crude overall hospital length of stay Royal College of Physicians - National Hip Fracture Database (NHFD) - Warrington	16.5 days	13.95 days	↓	• February LOS: 34 patients admitted, 18 discharged • Average LOS: 16.5 Min: 5 days Max: 31 days • LOS remains a focus for the team. There has been limited resource for intermediate care beds impacted further by Covid-19. • Work continues to ensure that the patients that can be discharged are done in a timely manner. There are red to green meeting Mondays - Fridays that helps to focus on prompt discharge of patients and to support with problem solving delays e.g. equipment provision.

Hospital (02 Aug 2021)				

Outpatients

Indicator	February 2022 position	December 2021 position	Trend	Action taken
R3 Patients waiting over 6 weeks for diagnostic test (%)	TBC – this indicator has been reported based on Insight data and estimated position	28.5%	↓	• February has been a challenging month due to unexpected break down of a CT Scanner for a full week, together with half-term staffing challenges. • Extra lists are being added to pull this small backlog back. • Overall, a steady improvement is being seen in all areas of the diagnostic monitoring and reporting. • Close monitoring of performance in all areas is in place.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/31**	
SUBJECT:	**Annual Performance Assurance Framework (PAF) Review – 2022/23**	
DATE OF MEETING:	30th March 2022	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**#224** Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#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. **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are assessed as only able to work on a non-respiratory pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Performance Assurance Framework (PAF) outlines how the Trust develops and maintains effective systems and processes for monitoring, managing and improving performance across the organisation. The PAF is reviewed and refreshed at least annually.	

	The main proposed updates to the PAF for 2022/23 are in relation to: • The removal of the Trust Operational Board and the Executive Team performance report introduced as a temporary measure in 2021/22. • Inclusion of the Care Group Triumvirates in the reporting structures. • Additional detail around the purpose of the Integrated Performance Report (IPR) in section 3.1.1. • Proposed inclusion of Leadership Observational Rounds. • Other minor updates to reflect changes to the organisation including team names and job titles. In addition to the PAF changes, this paper also proposes a presentational change to the IPR. In 2019/20, the Trust introduced Statistical Process Control (SPC) charts onto the IPR dashboard. It is proposed that for 2022/23 the Trust adopts the NHSE/I "Making Data Count" Assurance & Variation icons which visually represent what the SPC charts are indicating. It is proposed that RAG ratings are retained for 2022/23 while the new icons are introduced.			
PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: **1.** Approve the amendments to the PAF as part of the annual refresh. **2.** Approve the presentational amendments to the IPR in relation to NHSE/I "Making Data Count" icons.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance & Sustainability Committee		
	Agenda Ref.	FSC/22/02/34		
	Date of meeting	16th February 2022		
	Summary of Outcome	Supported		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Annual Performance Assurance Framework (PAF) Review – 2022/23	AGENDA REF:	BM/22/03/31

1. BACKGROUND/CONTEXT

The Performance Assurance Framework (PAF) outlines how the Trust develops and maintains effective systems and processes for monitoring, managing and improving performance across the organisation. The PAF is reviewed and refreshed at least annually.

The main proposed updates to the PAF for 2022/23 are in relation to:

- The removal of the Trust Operational Board and the Executive Team performance report introduced as a temporary measure in 2021/22.
- Inclusion of the Care Group Triumvirates in the reporting structures.
- Additional detail around the purpose of the Integrated Performance Report (IPR) in section 3.1.1.
- Proposed inclusion of Leadership Observational Rounds.
- Other minor updates to reflect changes to the organisation including team names and job titles.

In addition to the PAF changes, this paper also proposes a presentational change to the IPR. In 2019/20, the Trust introduced Statistical Process Control (SPC) charts onto the IPR dashboard. It is proposed that for 2022/23 the Trust adopts the NHSE/I "Making Data Count" Assurance & Variation icons which visually represent what the SPC charts are indicating. It is proposed that RAG ratings are retained for 2022/23 while the new icons are introduced and implemented.

2. KEY ELEMENTS

The following amendments are being proposed to the PAF and have been incorporated into the draft updated PAF in **Appendix A.**

- In 2021/22, the Trust Operational Board (TOB) was paused and it was agreed that CBU performance reporting oversight was to be carried out by the Executive Team in the form of a monthly CBU Performance Exception Report. The TOB has now been removed from the reporting structure. The temporary CBU Performance Exception report to the executive team will also be removed. Reporting oversight will be carried out at Care Group level as part of the QPS Executive Review process.
- Inclusion of Care Group Triumvirates and their roles and responsibilities in relation to performance management, oversight and improvement.
- Introduction of Leadership Observation Rounds which are under development.
- Additional minor amendments to reflect updates in the organisational structure have also been included in the updated PAF as part of the annual refresh.

3. STATISTICAL PROCESS CONTROL/MAKING DATA COUNT

It is proposed that the Trust adopts NHSE/I "Making Data Count" icons which outline how the Trust is performing in relation to the Statistical Process Control rules. This will be included in a new appendix within the Trust Board IPR pack.

Each indicator (where relevant) will be given one of the three assurance icons and one of the five variation icons which is based solely on the data and the SPC rules.

Table 1 – NHSE/I Making Data Count Assurance & Variation Icons

Assurance			Variation		
					
Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target	Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

For 2022/23, it is proposed that the Trust retains the traditional Red, Amber, Green ratings alongside SPC icons while the new icons are introduced.

4. RECOMMENDATIONS

The Trust Board is asked to:

1. Approve the amendments to the PAF as part of the annual refresh.
2. Approve the presentational amendments to the IPR in relation to NHSE/I "Making Data Count" icons.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Appendix A

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Performance Assurance Framework – Update for March 2022

Performance Assurance Framework

1. Introduction

1.1 Background

This Performance Assurance Framework (PAF) sets out principles of accountability and the commitment by Warrington & Halton Teaching Hospitals NHS Foundation Trust to establish, maintain and provide assurance of effective systems and processes for managing and improving performance across all levels of the Trust. The PAF was developed to provide clarity of accountability and subsequently assurance from 'Ward/Department to Board'. This is underpinned by a focus on health outcomes for patients and the community. The PAF supports the Trust's ambition of being "Outstanding".

1.2 What is Performance Measurement?

The Trust has many different processes for measuring performance at every level of the organisation. Measuring performance via dashboards, reports and systems is vital for ensuring our services are operating in line with National and Local standards. Measuring performance gives an early indicator of potential risks which can be resolved before they become an issue.

1.3 What is Performance Management/Improvement?

Performance management is about ensuring the delivery of timely, high quality, effective and safe patient care by using Trust resources in an efficient manner. This includes understanding how the Trust is performing, reasons for variation, and barriers to improvement. Once this is understood, actions can be planned and delivered in order to make improvement.

1.4 Scope

The PAF covers all performance requirements set out in the Trust's Operational Plan, NHSE/I System Oversight Framework, NHS Standard Contract, NHS Operational Planning Guidance, by the CQC and the Foundation Trust Licence. Whilst the framework describes the links to individual accountabilities and the contributions that all staff make to the delivery of Trust performance, it does not deal directly with individual performance management, which is covered in the agreed Trust performance management policy/incremental pay progression policy.

1.5 Dependencies

The successful implementation of the PAF is dependent upon the production of information dashboards and reports by the Trust's Digital Analytics Team as well as Operational services who managed their own reporting processes (e.g., Theatres, Pathology, Radiology) and the timely supply of data by the Trust's Finance, Quality and HR teams.

1.6 Associated Polices and Strategies

Whilst the PAF incorporates performance across the whole Trust, it is recognised that the Trust has policies and procedures in place that will contribute to the delivery of this Framework.

2. Role and Function of the Performance Assurance Framework

2.1 Main Purpose

This PAF sets out the approach the Trust undertakes in ensuring there are effective systems in place to monitor, manage and improve performance. Prompt reviews will be undertaken where performance is deteriorating and appropriate actions will be implemented to bring performance back to an acceptable level. The PAF:

- Sets out clear lines of accountability and responsibility for delivery of performance from 'Ward/Department to Board'.

- Support the principle that all staff have a responsibility to contribute towards improving performance of the organisation and everybody should take ownership.
- Create clear understood accountabilities and oversight.
- Ensure performance objectives are agreed and transparent measurements are set to monitor performance against objectives.
- Ensure performance delivery is focused and is seen as a continual process which is embedded in all aspects of organisational activity.
- Provide assurance to the Board, Governors, Regulators, Stakeholders/Partners and the Public that the organisation has strong systems in place to deliver the highest standards of patient care.
- Support the achievement of the Trust objectives.
- Support the delivery of the requirements of the Trust Foundation Licence, NHSE/I System Oversight Framework and the NHS Standard Contract.
- Provide focus on and assurance of best value for money ensuring that services meet the needs of the local population and local health economy.
- Support the delivery of an engaged and motivated workforce with the right skills and capacity to provide consistent, good quality care.
- Recognise good performance and improvement and share good practice.
- Set out the process for managing performance risks/issues with a balance between challenge and support.

In 2022/23, as the Integrated Care Systems & Boards (ICSs) & (ICBs) develop and mature, additional changes to the PAF may be required.

3. Our approach to Performance Management

3.1 Ward to Board Accountability Structure

The accountability structure provides a line of sight from "Ward/Department to Board" and "Board to Ward/Department" as set out in **Appendix 1** and is detailed as follows:

3.1.1 Trust Board Level

The Trust Board meets bi-monthly and receives the Integrated Performance Report (IPR) which is presented with an explanation about performance issues from relevant Executive Directors. The Trust Board may subsequently request one or more performance improvement actions (see 3.3.2) where there is variation with any area of performance.

The Integrated Performance Report (IPR) and the Care Group/CBU IPR are produced by the Trust Contracts & Performance Team with support from Finance, Governance, Digital Analytics and HR. The format of the IPR and Care Group performance reports have been designed to ensure:

- That information is presented in a way which supports an informed discussion by the Board about achieving improvement. This will include the triangulation of data to identify trends and areas considered to be an outlier in terms of performance.
- That the commentary presented by the respective Executive, along quantitative performance data, both explains current performance and identifies the actions that are being taken to provide assurance of continual improvement in quality, safety and performance.

KPIs within the Board IPR are reviewed and agreed at least annually by Board Committees with approval from the Trust Board. KPIs may be changed in year with the minuted support of the appropriate Board Committee and the approval of the Trust Board.

The IPR Dashboard contains the following elements which are designed to provide the Trust Board with assurance around the performance of the Trust against the KPIs and to highlight areas of improvement and good practice:

- Exception Report – the front section of the document is an exception report which highlights KPIs which have been RAG rated Red as well as any movements in KPIs month to month. This section also contains additional information around the Trust's Financial Performance including the capital programme.
- RAG Movements – this section shows a rolling 12-month RAG (Red, Amber, Green) rating and the movement in performance against each KPI.
- Statistical Process Control (SPC) Assurance and Variation Icons (supported by NHSE/I as part of the "Making Data Count" initiative).
- Dashboard – The dashboard details current and historic levels of performance, reasons for underperformance and/or performance deterioration and detail of actions and investigations underway in order to improve performance against the KPI. The dashboard contains Statistical Process Control charts which look at data over time to determine if a process is within control or not. These charts are used alongside traditional RAG ratings to identify areas of focus.

There is an annual rolling programme of auditing of KPIs to ensure there is assurance around the quality of the data and reporting processes which is facilitated by the Mersey Internal Audit Agency (MIAA).

3.1.2 Board Committees (Finance & Sustainability, Quality Assurance, Strategic People, Clinical Oversight Recovery)

Executive Directors and Senior Managers will present updates on performance relative to the Committee remit as appropriate and in addition to the bi-monthly IPR discussed at the Board. The Committee may request one or more performance improvement actions (see 3.3.2) where there is a variation with any KPI. The Committee will escalate any performance variation or highlights to the Trust Board as appropriate via the committee Chair's 'Issues' report.

Each Committee receives regular performance reports as part of its agenda. The KPIs contained in the Committee reports can be changed by approval of Committee members as there may be occasions where the Committee wants to report at a more granular level of detail. Any changes to KPIs need to triangulate to the Trust Board IPR. All changes must be minuted to include the rationale for the change.

3.1.3 KPI Sub-Committee

The KPI sub-committee chaired by the Trust's Chief Operating Officer will review performance at Care Group/CBU level. The sub-committee may request one or more performance improvement actions (see 3.3.2) for any areas of concern. The KPI sub-committee will escalate to the Executive Team as appropriate.

The KPI sub-committee receives the Care Group/CBU level IPR. The KPI sub-committee may approve amendments to the Care Group/CBU Level IPR with a minuted rationale. KPIs at Care Group/CBU level should triangulate with the Trust Board IPR, however the KPI sub-committee may monitor additional indicators at a more granular level to understand performance in-depth.

CBU performance maybe monitored at other sub-committees/groups such as the Finance Resource Group (FRG) and local governance, HR and Finance meetings as appropriate.

3.1.4 QPS Executive Team Review at Care Group Level

The QPS Executive Team Review is chaired by the CEO where a review of each Care Group's performance is undertaken. Discussions will take place to understand any barriers to performance improvement or reasons for variation and will look at any additional support required to address these barriers. The Care Group Triumvirate will be required to attend this forum twice a year and present their position, highlighting any areas of variation, as well as areas of improvement and good practice which can be shared across the Trust. This will form part of the Trust Learning Framework. Actions from the forum will be recorded by a member of the Performance Team. If urgent actions are required, the Care Group will provide an update to the next available Executive Team meeting and will not wait until their next bi-annual review. Prior to the QPS review, the Care Group Triumvirate with support from the Performance Team will prepare a set of slides which contains information relating to progress around priorities identified in business plans which in turn supports delivery of service level strategies and will also focus on the areas of performance around; Quality & Governance and Operational Performance (Quality), People (People) and Finance (Sustainability). The report will also include information about current issues, risks challenges and future plans. The slides will be designed to facilitate discussion.

The Executive Team may request one or more performance improvement actions (see 3.3.2) where there are any areas of variance. The Executive Team will escalate to the appropriate Board Committee or the Trust Board if it feels necessary to do so.

The Executive Team may ask Care Groups to attend Executive Team meetings at any time outside of the review process where there is a potential performance issue.

3.1.5 Leadership Observational Rounds (Draft)

Non-Executive & Executive Leadership Observational rounds are currently being proposed for 2022/23 which will focus on positive interactions, celebrate success, and utilise CQC Red Flags to guide key lines of enquiry with the goal of improvement Leadership Observational Rounds may also utilise performance variation to guide key lines of enquiry. The Leadership Observational Rounds will take place 6 times per year and feedback will be collated as evidence as part of the CQC well led domain. Leadership Observation Rounds are under development and as these mature throughout 2022/23, the role and function of these observations in relation to performance may change.

3.1.6 Care Group/CBU Level

The Care Group & CBU Triumvirate is expected to manage the performance of their services and have appropriate structures/forums in place to do so. The Care Groups & CBUs will be able to access performance information to enable them to monitor and manage performance in real time. Care Groups & CBUs are required to take corrective action to improve areas of underperformance, working with corporate services and other Trust departments as appropriate. Care Groups & CBUs should escalate any areas of performance variance to the appropriate forum. The Care Groups & CBU Triumvirates may request one or more performance improvement actions (see 3.3.2) for an individual Ward, Department, Service or Team where there are any areas of variation.

3.1.7 Ward, Department, Service or Team Level

Ward/Department/Service/Team managers will be able to access appropriate performance reports at that level in order to ensure they are managing day to day performance. Wards/Departments/Services/Teams are accountable to the CBU Triumvirate, who will provide any support, along with corporate services as necessary.

The production of quality, meaningful and timely performance information is fundamental to the delivery of the PAF. Information must be timely, accurate and complete; and follow the principles set out in the Trust's Information Governance and Data Quality Policy.

3.2 Roles & Responsibilities

Specific roles and responsibilities in relation to the ongoing monitoring, management and improvement for the performance of the Trust are as follows:

3.2.1 Chief Executive

The Chief Executive has overall corporate responsibility for performance across the Trust.

3.2.2 Executive Directors

Executive Directors have delegated authority, responsibility and accountability for the areas within their portfolio for ensuring effective performance management structures, systems and processes are in place for reporting, managing and improving performance with robust arrangements in place for addressing performance concerns.

3.2.3 Chief Finance Officer & Deputy Chief Executive

In addition to responsibilities outlined in 3.2.2, The Chief Finance Officer & Deputy Chief Executive has delegated authority for ensuring the overarching Performance Assurance Framework is in place and Executive oversight of the Performance Team activities outlined in 3.2.4.

3.2.4 Performance Team

The Performance Team is responsible for the management, production and development of the Trust and Care Group/CBU IPR as well as the management of the QPS Executive Team Review process. The Performance Team is the gatekeeper of the IPR and is responsible for ensuring any changes are approved via the appropriate governance process and once approved are actioned.

The Performance Team will provide training to the Care Groups & CBUs so that all staff have sight and understanding of the performance KPIs they are accountable for and are aware of the associated consequences of not achieving the required standards.

3.2.5 Digital Analytics Team

The Digital Analytics Team will develop, generate and publish the necessary local reports and dashboards to enable the Care Group/CBU/Teams to monitor and manage performance and will provide data for the Trust and Care Group/CBU level IPRs.

3.2.6 Corporate Services

Corporate services (Finance, Governance, HR, IM&T, Strategy) has responsibility for the production and validation of data for Trust, Care Group & CBU IPR dashboards. Corporate services will provide the necessary support to Care Group/CBUs in order to improve performance in their area.

3.2.7 Care Group Triumvirates

The Care Group Triumvirates has responsibility and accountability for the management and improvement of performance for their CBUs and will implement appropriate performance improvement actions (see 3.3.2). Care Group Triumvirates will hold CBU Triumvirates accountable for the delivery of performance KPIs at CBU level.

3.2.8 CBU Triumvirates

The CBU Triumvirates has responsibility and accountability for the management and improvement of performance for their CBU and will implement appropriate performance improvement actions (see

3.3.2). Each CBU triumvirate will, in turn, hold individual service managers, clinical matrons, specialty leads and, where applicable, Professional Heads of Service, accountable for the delivery of performance KPIs at specialty and service level.

3.2.9 Ward/Department/Service/Team Managers

The Ward/Department/Service/Team managers have responsibility for the management and improvement of performance for their Ward/Department/Service/Team and will implement any improvement actions requested by the CBU Triumvirate.

3.2.10 All Staff

All members of staff contribute to managing and improving performance and are encouraged to suggest areas for improvement and ideas on how improvement can be made. All staff should have an understanding of how their role contributes to performance of the Trust and the impact this has on patient care.

3.3 Performance Risks/Issues

Where there is a risk to the Trust achieving a standard or target or where performance has deteriorated or is an outlier against a benchmark , this should be highlighted as a performance risk/issue and must be detailed as necessary on relevant risk registers All actions and interventions relating to performance risk/issues will focus on ensuring patient safety is paramount, be delivery focussed and proportionate to the level of risk identified and there will be a balance between challenge and support, recognising any organisation wide resource needs.

3.3.1 Identification and Management

A performance risk/issue can be identified by any member of staff at any level of the organisation ("Ward/Department to Board").

Where a performance risk/issue has been identified, it is the responsibility of the Performance Oversight Group outlined below to oversee appropriate actions in order to resolve the issue as soon as possible.

Performance Issue/Risk Area	Performance oversight Group	Support
Ward, Department, Service or Team Level	CBU Triumvirate	Corporate Services
CBU Level	Care Group Triumvirate KPI Sub-Committee Executive Team	
Trust Level	Executive Team Finance & Sustainability Committee Strategic People Committee Quality Assurance Committee Clinical Oversight Recovery Committee Trust Board	

3.3.2 Performance Improvement Actions

A. Informal

Some low/medium level performance issues/risks may be managed locally by reviewing processes and making the necessary operational changes. These performance risk/issues may be as a result of a temporary local issue such as a staff shortage or an unexpected increase in demand. In the first

instance, these performance issues should be managed and resolved locally with the appropriate authority to do so.

B. Remedial Action Plan

Where a performance risk/issue cannot be resolved in the short term and it is likely to have a medium to long term impact on Trust performance, the Performance Oversight Group may request a Remedial Action Plan. The Remedial Action Plan will outline actions to be taken, impact, timescales and review timescales and will be reviewed at an appropriate forum each month. Once the performance oversight group is satisfied that the actions are complete and performance has returned to a satisfactory level, the Remedial Action Plan will be closed.

C. Deep Dive Review

The relevant Performance Oversight Group may request at any time a deep dive into areas where there is a continued performance concern. The Performance Oversight Group will set out terms of reference including timescales. Once the review has been concluded, the Performance Oversight Group will agree next steps this may include setting quality improvement metrics, trajectories for improvement, further investigations, the implementation of a Remedial Action Plan or the establishment of an Improvement Group.

D. Improvement Group

Where performance issues/risks need additional support in order to return to satisfactory levels, a time limited Improvement Group will be established. The Improvement Group will be made up of representatives from corporate and clinical services as appropriate and will be sponsored by an appropriate Executive Director or Senior Manager and will report progress to the Performance Oversight Group.

E. Intensive Support

Where performance has not returned to a satisfactory level after the required support has been provided, the Performance Oversight Group may place a Care Group, CBU or Team into Intensive Support. Intensive Support is a recovery planning and delivering procedure and is a mechanism to direct additional management focus. The performance oversight group will write to the Care Group/CBU/Team to inform them of the decision and will outline the reasons this action has been taken. The Care Group/CBU/Team will be expected to report weekly to the Performance Oversight Group actions taken to improve performance and the impact this has had. This effort will be supported by appropriate corporate resources. The Care Group/CBU/Team will remain in Intensive Support until the performance issue has been resolved. Once the performance oversight group is satisfied that the performance issue has been sufficiently addressed, the performance oversight group will write to the Care Group/CBU/Team to inform them of the decision to bring them out of Intensive Support.

The Intensive Support procedure may be deployed in the following circumstances:

- Where there are continued and persistent performance issue in one or more areas.
- Where there is an ongoing risk to patient safety which has not been addressed, effective delivery of services or any other reasons where it is judged that the level of support is justified by the performance oversight group.
- Where delivery levels against operational performance targets is inadequate as determined by the Performance Oversight Group, where no robust plan has been agreed.
- Failure to operate within the financial parameters outlined without a legitimate reason or evidence of lack of financial controls.

- Any other circumstances where it is assessed that a risk exists which cannot be resolved via normal line management actions or where less intensive recovery actions have failed.

A summary of improvement groups and intensive support provision will be reported to the relevant board committee.

4. Structure and Governance to ensure delivery

4.1 Accountability, Responsibility and Reporting Structure

Appendix 1 sets out the Trust's Accountability, Responsibility and Information reporting structure. Each meeting will have a Terms of Reference, setting out clear roles and responsibilities, objectives and membership and the devolved responsibilities from Board to Ward.

5. Next Steps

This Performance Assurance Framework will be reviewed in March 2023 as part of the annual planning cycle. The PAF will be reviewed and updated as appropriate as new guidance emerges in year.

Appendix 1 - Trust Accountability, Responsibility and Information Reporting Structure – "Ward/Department" to Board

Ward

Granular

Same Data

High Level

Board

CBU/Ward/Departmental

- CBUs/Wards/department leaders
- Review performance and identify risk at granular level weekly and take corrective action as appropriate.
- CBU Triumvirates report up Care Group Triumvirates.

Care Group Triumvirates

- Full review of performance at CBU level
- Review, confirm and identify any risk/issues with agreement of remedial action plans. Risk to be reported through Risk Review Group.
- Support CBUs to improve performance in identified areas.
- Monitoring of remedial actions arising from QPS

Executive Team via monthly CBU Performance Reports and QPS Executive Team Review (Care Groups)

- Executive Committee holds Care Groups to account via the QPS
- Provide support to Care Groups to address identified performance issues.

Board Committees

- Executive Director/Senior Leaders attend committee meetings.
- Board Committees review their performance reports/dashboards
- Deep dives requested by Committee where there is variation in performance.
- Relevant committees assure Board through key issues reports and escalates any issues to Trust Board

Trust Board

- Integrated Performance Report presented by Executive Directors
- Receiving concerns raised by Committee Chairs
- Board request additional actions and assurance where necessary
- Bi-Monthly meeting

PAF upda

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/32**	
SUBJECT:	**Warrington and Halton Teaching Hospitals NHS Foundation Trust Green Plan**	
DATE OF MEETING:	30th March 2022	
AUTHOR(S):	Viviane Risk, Strategy Programme Support Manager Ian Wright, Associate Director for Estates and Facilities	
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Director of Strategy & Partnerships	
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
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#125** Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. **#145** 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.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Climate Change Act 2008 set the UK mandatory target to reduce carbon emissions to net zero by 2050. The NHS is the largest public sector employer and contributes 4-5% of the UK's carbon emissions. The NHS has set the target to achieve net zero by 2040. The "For a Greener NHS" campaign was launched in 2020 by NHS England. We are required to have an approved Green Plan to deliver our net-zero targets by March 2022. While this is a nationally mandated programme, the Trust has a strategic commitment to developing and expanding on its role as an anchor organisation. The Green Plan is a core pillar of this programme. The plan has previously been considered by FSC and the Trust Board in November 2021. Comments have been incorporated and leads and timescales have been assigned to each individual action. The populated action plan has been circulated to all action leads, comments incorporated and feedback addressed in this paper.	

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

RECOMMENDATION:	It is recommended that the Trust Board approves the Trust Green Plan.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee
	Agenda Ref.	FSC/21/11/195
	Date of meeting	17th November 2021
	Summary of Outcome	The Green Plan was reviewed and comments provided.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Warrington and Halton Teaching Hospitals NHS Foundation Trust Green Plan**	**AGENDA REF:**	**BM/22/03/32**

1. BACKGROUND/CONTEXT

The Climate Change Act 2008 set the UK mandatory target to reduce carbon emissions to net zero by 2050. The NHS is the largest public sector employer within the UK and contributes 4-5% of the UK's carbon emissions.

The NHS has set the target to achieve net zero by 2040. The "For a Greener NHS" campaign was launched in 2020 by NHS England. We are required to have an approved Green Plan to deliver our net-zero targets by March 2021.

While this is a nationally mandated programme, the Trust has a strategic commitment to developing and expanding on its role as an anchor organisation. The Green Plan will form a core pillar of this programme by improving the wellbeing of our staff and local citizens and delivering social value.

The plan has previously been considered by FSC and the Trust Board in November 2021. Comments have been incorporated and leads and timescales have been assigned. The populated action plan has been circulated to all action leads, comments incorporated and feedback addressed in this paper.

2. KEY ELEMENTS

2.1 Green Plan Summary

The Green Plan will act as the framework for implementation of sustainability strategies throughout the Trust and will ensure that the Trust delivers against the NHS Longer Term Plan and complies with legislation. The plan is valid for five years and focuses on three key elements:

1. Reducing our carbon emissions;
2. Reducing our contribution to air pollution;
3. Reducing our generation of waste.

The plan details the Trust's carbon baseline and sets out the plan and specific actions the Trust will need to implement over the next five years to achieve our sustainability objectives.

The Plan is comprised of three documents, which are all appended to this report:

- ***Warrington_Halton_Green_Plan_v1.0***
  Sets out key definitions, context, areas of focus, drivers and targets taken that form the basis of the Green Plan. Details our carbon footprint baseline, local and national considerations to help us achieve net zero, and describes in detail the sections of our sustainable action plan.
- ***Carbon_Baseline_v1.0***
  Details our carbon baseline and emissions per year to be achieved to meet net zero targets. Monitors usage and emissions of key areas such as gas, electricity and anaesthetic gases.
- ***Sustainable_Action_Plan_v1.0***

Details our action plan to achieve net zero, grouped in to ten areas of focus. Provides monitoring and evidence documenting framework.

2.2 **Action Leads**
Following the consideration of the green plan and action plan at FSC and Trust Board in November 2021 action leads have been identified and are detailed in the attached sustainable action plan. The action plan has been circulated to all leads for feedback.

2.3 Feedback from action leads
The sustainable action plan was circulated at FSC and Trust Board in November 2021 and no comments on the actions and the outcomes were received. On socialising the sustainable action plan to the assigned leads concerns regarding capacity to deliver the actions has been raised in addition to queries on the detail and definition of how some actions will be achieved.

2.4 Response to feedback
It is recognised that the Trust is in a pressured position and moving forwards there will be a significant focus on COVID-19 receovery. Regarding the feedback received regarding capacity, scope and definition the response is as follows:

- Capacity
  - Where leads raise concerns or challenges regarding capacity to deliver certain actions this will be escalated through the governance channels as detailed in section 6. This will ensure oversight of any risks to delivering actions and provide a platform for discussion and re-prioritisation of actions if required.
  - Scope and Definition
  - While specific actions have been identified for the Trust to achieve the practicalities of defining and delivering them is to be agreed by WHH. It is expected that delivery against the actions will be a collaborative undertaking utilising the expertise of colleagues across the Trust in addition to external expertise where required. In addition Cheshire and Merseyside ICS is underway with a piece of work to set definitions for scope and metrics that can be used across the region.

2.5 Regional Context
In addition to each Trust having their own agreed plan Cheshire and Merseyside ICS are developing a green plan at regional level. This regional green plan incorporates the plans of all Trusts within the footprint. A second version was circulated for comments in February. The ICS plan contains objectives across the areas of: adaption planning, biodiversity and green spaces, digital transformation, equality, diversity inclusion and social value, estates and facilities, food, diet and nutrition, medicines, prescribing and anaesthetic gases, primary care, procurement and single use plastics, sustainable models of care and travel and transport.

A requirement for each Trust to report progress against their own plans to the ICS was detailed in the ICS draft plan, however the detail was not specified. This was raised within WHH's comments and detail is expected in the final version of the ICS Green plan, due by the end of March 2022.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Trust Board is requested to approve the Trust's green plan.

4. IMPACT ON QPS?

The Green Plan supports the Trust's sustainability objectives by forming a core pillar of our work to expand and develop our role as an anchor institution by improving the social wellbeing of our local citizens and delivering social value.

5. MEASUREMENTS/EVALUATIONS

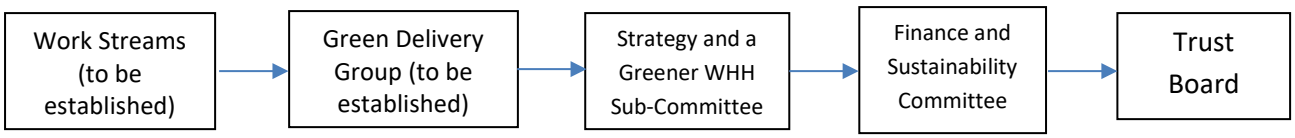
Success of implementation of actions will be evidenced by the Trust achieving the required reductions per year in emissions as detailed in document *Carbon_Baseline_v1.0.*

Emissions will be calculated annually using the Trust's annual energy return to NHSE/I.

6. MONITORING/REPORTING ROUTES

The sustainable action plan (*Sustainable_Action_Plan_v1.0)* will form the basis for capturing and documenting evidence of implementation against each action within each of the eight identified work areas, monitoring frequency and timescales.

Progress monitoring against actions detailed within the Sustainable Action Plan will be through the Strategy and a Greener WHH Sub-Committee. The full reporting route is detailed in the chart below. Work streams will be established once the plan has received final approval to enable implementation and delivery of actions.



Quarterly returns to NHSE/I are also required and are currently completed by Associate Director of Estates and Facilities.

Reporting to and oversight of the ICS is being confirmed and detail is anticipated in the next circulation of the ICS green plan.

In addition to internal work streams, a number of sub-groups are in place at ICS level but have been paused since September 2021. At the March 10th ICS Sustainability Board an updated list of the sub-groups and the members was requested. Once received appropriate representation from WHH will be ensured.

7. TIMELINES

Once approved the plan will be launched to the Trust through April 2022, with ongoing staff engagement planned.

The green delivery group and supporting work streams will be commence from April 2022.

8. RECOMMENDATIONS

It is recommended that the Trust Board approves the plan.

Green Plan

Issue 1.0

Produced for **Warrington and Halton Teaching Hospitals NHS Foundation Trust**

Warrington Hospital

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Contents

1.0 GLOSSARY OF TERMS

Air Pollution- the presence and introduction into the air of a substance which is harmful to human health

Carbon Intensity- a means of calculating the amount of carbon generated for a specific energy source (e.g. electricity)

Carbon Net-Zero- a state in which an organisation emits no carbon emissions from its activities. Or a state in which all carbon emissions are offset

CO_2e (Carbon dioxide equivalent)- a unit used to express total greenhouse gas emissions. There are multiple GHGs, each with a different impact on climate change. CO_2e equates all GHGs to the impact of carbon dioxide. CO_2e is used to report all GHG emissions

Greenhouse Gas (GHG)- a gas that contributes to the greenhouse effect, leading to climate change (e.g. CO_2)

Global Warming Potential- a measurement that enables the comparison of global warming impacts of different greenhouse gases

kWh (kilowatt hours)- a unit of measurement for energy usage (e.g. gas and electricity)

Direct emissions- CO_2e emissions from sources which are owned or controlled by the Trust

Indirect emissions- CO_2e emissions from sources which are not owned or controlled by the Trust, but are generated due to the Trust's activities (e.g. purchase of electricity, procurement, waste disposal)

Scope 1 emissions- direct emissions from owned or controlled sources (e.g. on-site fuel combustion, company vehicles, anaesthetic gases)

Scope 2 emissions- indirect emissions from the generation of purchased electricity, steam, heating, and cooling

Scope 3 emissions- all other indirect emissions that occur in an organisation's supply chain (e.g. purchased goods, employee commuting, waste disposal)

2.0 INTRODUCTION

2.1 Our Commitment to Sustainability

At Warrington and Halton Hospitals NHS Foundation Trust we recognise the scale of the issue that climate change presents in our community. As a healthcare provider we acknowledge our responsibility to minimise our contribution to climate change and integrate sustainability into our organisation to reduce the potential risks for our local population. This Green Plan outlines our commitment to embedding sustainability throughout our organisation.

This Green Plan will serve as an organisation-wide strategy that establishes our strategic objectives and targets for delivering sustainable healthcare within our Trust over the next 5 years. The Green Plan will highlight some of the key successes we have seen to date and build upon these actions with our targets and ambitions for the future. The Green Plan will stand as the central document to guide the Trust's sustainable development over the next five years. We will use the Green Plan to guide us in reducing our environmental impact including carbon emissions, waste and air pollution; reducing our costs; and adding social value into our community.

2.2 Sustainability at a National level

Climate change is not only a significant threat to our environment but also poses a huge risk to human health. Climate change is now considered the greatest environmental threat to global health of the 21st century by many organisations including, but not limited to, the World Health Organisation British Medical Association, the Royal College of Physicians, and the Royal College of Nursing.

In line with the Climate Change Act 2008, the UK has set a mandatory target to reduce carbon emissions to net-zero by 2050. As the largest public sector employer in the UK, the NHS contributes to approximately 4-5% of the UK's carbon emissions and can play a substantial role in supporting this national target. The NHS has set two net-zero targets, to achieve net-zero by 2040 for the NHS Carbon Footprint and by 2045 for the NHS Carbon Footprint Plus. The scope of these two carbon footprints is shown in Figure 1.

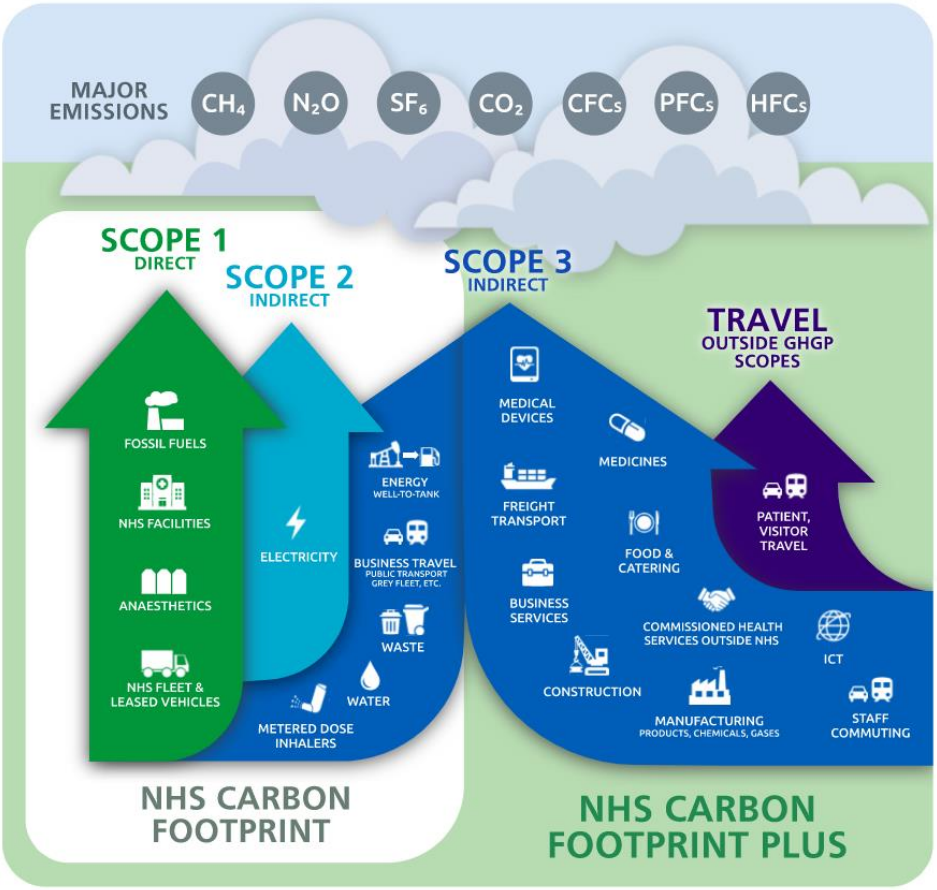


Figure 1 - NHS Carbon Footprint and NHS Carbon Footprint Plus with scope classifications

The "For a Greener NHS Campaign" was announced in 2020 by the CEO of NHS England. This campaign aims to provide top-level support to help NHS Trusts to reduce their impact on the environment and improve health. The campaign builds upon the great work already being done in the NHS to improve sustainability and will provide high-level backing to ensure the NHS can reach net-zero. An expert panel has been established to chart the best route for the NHS to become carbon net-zero, the Trust shall continually review the findings of the panel and update this plan as required. To become a net-zero health service, reduce air pollution and reduce waste the NHS requires the dedication of all Trusts, staff, and partner organisations.

2.3 About Us

We are an NHS Foundation Trust providing first class services at Warrington Hospital and Halton Hospital in the Northwest of England.

Our key mission is to be outstanding for our patients, our communities and each other. To realise this goal, we recognise that we need the engagement and collaboration of our staff, our patients and local population and our partners across the health and care system.
The Trust forms part of the Cheshire and Merseyside Health & Care Partnership a partnership of NHS, local authority, voluntary and community organisations, working together to improve health and wellbeing, and reduce health inequalities across Cheshire and Merseyside. The implementation of our Green Plan will enable our Trust to become a more sustainable organisation and which will support our partner organisations to achieve these ambitions.

2.4 Our Sustainability Objectives

We have three key strategic objectives relating to sustainability, as set out in our Trust Strategy, as displayed in Figure 2.

Figure 2 - Our Sustainability Objectives

To deliver these strategic objectives and implement the Green Plan, the Trust has established a new Sustainability Sub-Committee. This group will report to the finance committee who will report to the board to ensure that the Green Plan receives high-level support and can be delivered effectively.

2.5 Key Areas of Focus

This Green Plan will act as the framework for the implementation of sustainability strategies throughout the Trust. The Plan will enable the Trust to become a more sustainable organisation by ensuring that the Trust delivers the ambitions of the NHS Long Term Plan and is compliant with the latest legislation. The Green Plan will be valid for 5 years and focus on three key aspects:

- Reducing our carbon emissions;
- Reducing our contribution to air pollution; and,
- Reducing our generation of waste.

2.6 Carbon Net-Zero

Carbon net-zero, often referred to as Carbon Neutral, is defined as the state in which an organisation avoids emitting greenhouse gases (GHGs) though its generation and use of energy, travel, waste, travel, medicines and supply chain. Achieving net-zero carbon emissions, or carbon neutrality, is a key aim of national and local policy and a key driver of this Green Plan. To achieve this the organisation must be powered entirely by zero-carbon energy and not produce any carbon emissions from other sources such as from waste, medicines, supply chain or travel. Within the NHS there are aspects where the generation of carbon emissions is unavoidable, where emissions cannot be reduced to zero carbon offsetting through investment

into bio sequestration (e.g. tree planting) and technology-based carbon capture and storage can be utilised to offset the residual emissions and achieve carbon net-zero.

2.7 Format of the Green Plan

The key areas of focus for this plan were derived from the national strategies and guidance that drive the Green Plan. These strategies are detailed in section 4.0 Drivers and Targets.

Section 5.0 *Our Carbon Footprint* details how we have developed our carbon baseline and the changes in emissions that have been observed in our total carbon emissions since 2013. This section also explains the actions that have already been implemented throughout the Trust and the subsequent reductions in emissions.

Section 6.0 *A Pathway to Net-Zero* then details the local and national schemes that may contribute to helping the Trust to reduce our residual emissions and reach net-zero carbon emissions by 2040.

Finally, section 7.0 will set out *Our Sustainable Action Plan.* This section will provide an overview of the specific actions that the Trust will implement over the next 5 years to achieve our sustainability objectives.

3.0 DRIVERS AND TARGETS

This section details both the UK legislation and health sector specific policy which drives sustainable development across the NHS. This section also establishes national and NHS targets which will be adopted by the Trust.

3.1 Sustainability Drivers

The UK Government has set a target of achieving net-zero carbon emissions nationally by 2050. This mandatory target was set in accordance with the Climate Change Act 2008. In recognition of this target and the NHS's significant role in the UK's carbon footprint the NHS has set two net-zero targets, to achieve net-zero by 2040 for the NHS Carbon Footprint and by 2045 for the NHS Carbon Footprint Plus to ensure that the NHS meets to mandatory 2050 target. The scope of these two carbon footprints is shown in Figure 1.

Considerable progress towards this target has been made throughout the NHS. Between 1990 and 2020 the NHS achieved a 62% reduction in its carbon footprint. This was achieved by implementing strategies to reduce carbon dioxide equivalent emissions (CO_2e), air pollution emissions and improve waste management.

The drivers for sustainable development in the NHS are set out in four key NHS specific documents:

- NHS Long Term Plan
- NHS Standard Service Contract 2021/22
- NHS Operational Planning and Contracting Guidance
- Delivering a Net Zero National Health Service

The *NHS Long Term Plan* establishes how the NHS will develop and improve until 2030. The plan includes considerations pertaining to sustainability, including new models of care. The *NHS Standard Service Contract* outlines several targets and objectives relating to sustainability within the NHS. To aid the NHS in achieving the national carbon reduction targets, and develop the resilience of the organisation, the *NHS Operational Planning and Contracting Guidance* provides guidance on the actions required.

The *Delivering a Net Zero National Healthcare Service* report outlines actions that will be implemented by the to reduce emissions. This report explains the modelling and analytics that have been used to determine the NHS carbon footprint and future projections. Outlined in the report are the immediate actions the NHS must take to meet the 2040 carbon net-zero target. This report will be continuously reviewed to ensure the NHS is on track to meet its long-term commitments and is suitably ambitious.

The following targets and objectives are established in the above documents:

- For carbon emissions controlled directly by the NHS (the NHS Carbon Footprint), achieve net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.

- For carbon emissions the NHS can influence (the NHS Carbon Footprint Plus), achieve net zero by 2045, with an ambition to reach 80% reduction by 2036 to 2039.

- Deliver a 4% reduction (in carbon emissions) by shifting to lower carbon inhalers

- Deliver a 2% reduction (in carbon emissions) by transforming anaesthetic practices

- Purchase 100% renewable electricity at all NHS organisations by April 2021
- Transition to zero-emissions vehicles by 2032

- Adopt the single use plastics pledge

3.2 Our Commitment and Targets

In line with national and local drivers the Trust will adopt the following targets:

3.2.1 Carbon Reduction

- We will achieve an 100% reduction of direct carbon dioxide equivalent (CO2e) emissions by 2040. An 80% reduction will be achieved by 2032 at the latest.

- We will achieve an 100% reduction of indirect CO2e emissions by 2045. An 80% reduction will be achieved by 2039 at the latest.

3.2.2 Air Pollution

- We will convert 90% of our fleet to low, ultra-low and zero-emission vehicles by 2028.

- We will cut air pollution emissions from business mileage and fleet by 20% by March 2024.

3.2.3 Waste

- We will sign and adopt the Single-Use Plastic Pledge.

- We will adopt a Zero to Landfill policy by 2021.

4.0 OUR CARBON FOOTPRINT

In order to monitor the reduction in our carbon emissions against our targets we have created a carbon baseline, against which we will compare subsequent annual CO_2e emissions. This section details the methodology used to develop our carbon baseline, the scope of our baseline and provides an overview of our Carbon Baseline and the changes in our emissions to date.

4.1 Developing our Carbon Baseline

Our Carbon Baseline has been measured by reporting the annual carbon dioxide equivalent (CO_2e) emissions of our Trust. The year 2013/14 has been used as our baseline year, in line with previous NHS guidance, all subsequent annual CO_2e emissions will be compared against this year.

To calculate our carbon emissions, we have multiplied our consumption data (e.g. kWh for electricity) with national carbon conversion factors. These carbon conversion factors are produced annually by the Department for Business, Energy, and Industrial Strategy (BEIS) for greenhouse gas reporting. This provides the annual CO_2e emissions for each aspect we have monitored.

4.1.1 Scope of the Carbon Baseline

The Trust's carbon baseline has been developed in line with the NHS Carbon Baseline. This covers the Scope 1 direct emissions and the Scope 2 and Scope 3 indirect emissions which must be reduced to net zero by 2040. The scopes of the NHS Carbon Footprint and NHS Carbon Footprint Plus are defined in **Error! Reference source not found.** above. The following aspects which produce CO_2e emissions are included in our baseline:

- Fossil fuels, including gas and oil
- NHS Facilities
- Anaesthetic Gases
- NHS Fleet & Leased Vehicles
- Electricity
- Business Travel
- Waste
- Water
- Metered Dose Inhalers

Emissions have been monitored at two sites the Warrington site which covers emissions from Warrington Hospital and the Halton site which includes emissions from both the Nightingale Building and the Captain Sir Tom Moore building.

The Trust began monitoring the emissions of anaesthetic gases and metered dose inhalers in 2014. For the purposes of this baseline the 2014 level of emissions from these aspects have been used as the baseline emissions.

4.2 Our Total Carbon Baseline

In 2013-14, our baseline year, the Trust produced 13,877 tonnes of CO_2e (tCO_2e). Of these emissions' electricity was our greatest source contributing 46% of total emissions. Electricity was closely followed by gas which produced 31% of our baseline emissions. Another significant contributor to our carbon emissions in the baseline year was anaesthetic gases, producing 21%.

Table 1 - Carbon Baseline for Warrington and Halton Teaching Hospitals NHS Foundation Trust based on 2013 data (tCO_2e)

Year	Gas	Oil	Anaesthetic Gases	Electricity	Business Travel	Waste	Water	Metered Dose Inhalers	Total
2013-14	4,367	0	2,933	6,385	103	56	4	28	13,997

4.3 Progress against the Baseline

As displayed in Figure 3, we have reduced our total annual carbon emission since the baseline year. In the six years since the carbon baseline year the Trust has achieved a 10% reduction in total carbon emissions, with the total annual emissions decreasing by 1,345 tonnes to 12,532 tCO_2e annually.

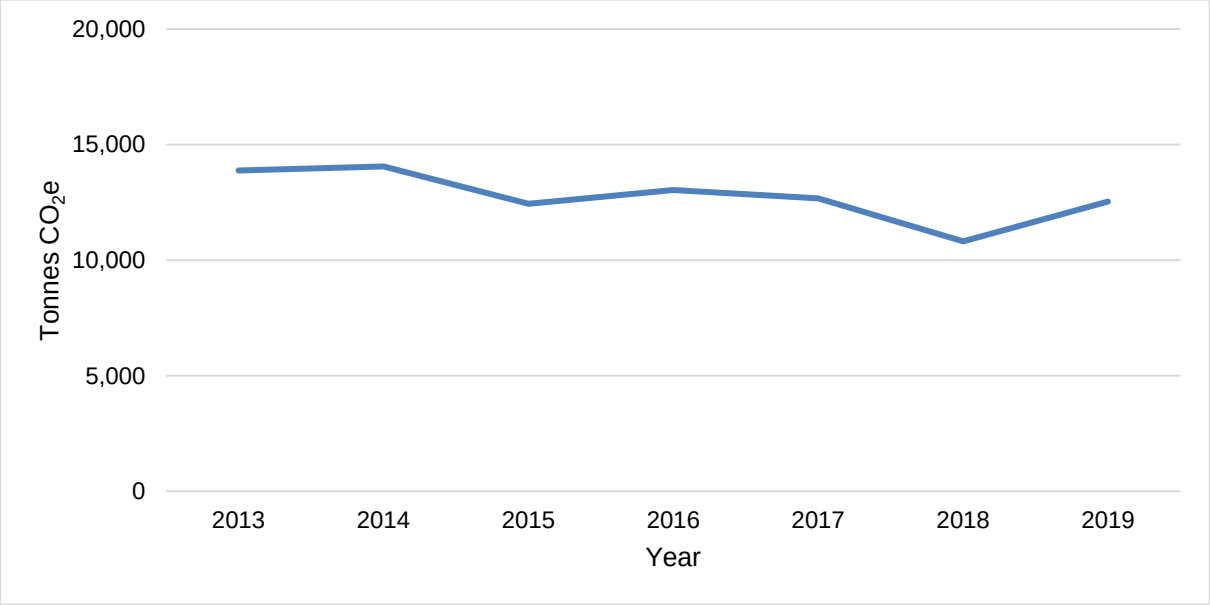


Figure 3 - Total annual CO2e emissions from the Trust

This reduction has been achieved through gains in efficiency in several aspects of the Trust which are detailed in the section below. To achieve the 2032 interim target of an 80% in CO_2e emissions, the Trust must work to reduce emissions by a further 9,757 tonnes to reduce emissions to 2,775 tCO_2e annually. Following this the Trust will then work to reduce our emissions to net-zero by 2040. Section 6 Pathway to Net Zero outlines how we aim to achieve this target, both by implementing actions at the Trust and utilising national support.

Table 2 - Comparison of CO_2e emissions in the baseline year and most recent year

Year	Gas	Oil	Anaesthetic Gases	Electricity	Business Travel	Waste	Water	Metered Dose Inhalers	Total
2013-14	4,367	0	2,933	6,385	103	56	124		13,997

								28	
2019-20	8,905	0	2,292	1,182	72	30	103	47	12,632
Change	+4,538	0	-641	-5,203	-31	-26	0	+19	-1,365

4.4 Key Aspects

The following section provides emissions profile of each key aspect of the Trust, and details how and why the CO_2e emissions have changed for each aspect.

4.5 Scope 1

4.5.1 Gas

As shown in Figure 4 the Trust's emissions from gas have increased since the baseline year. This is due to the use of combined heat power (CHP) stations installed 5 years ago to generate heat and power from natural gas. CHP units were introduced at the Trust to improve the efficiency of energy at the Trust. The CHP units generate both heat and power by capturing the heat which is produced as a by product of electricity generation, this is widely considered to be a more efficient way of producing heat and electricity than conventional generation.

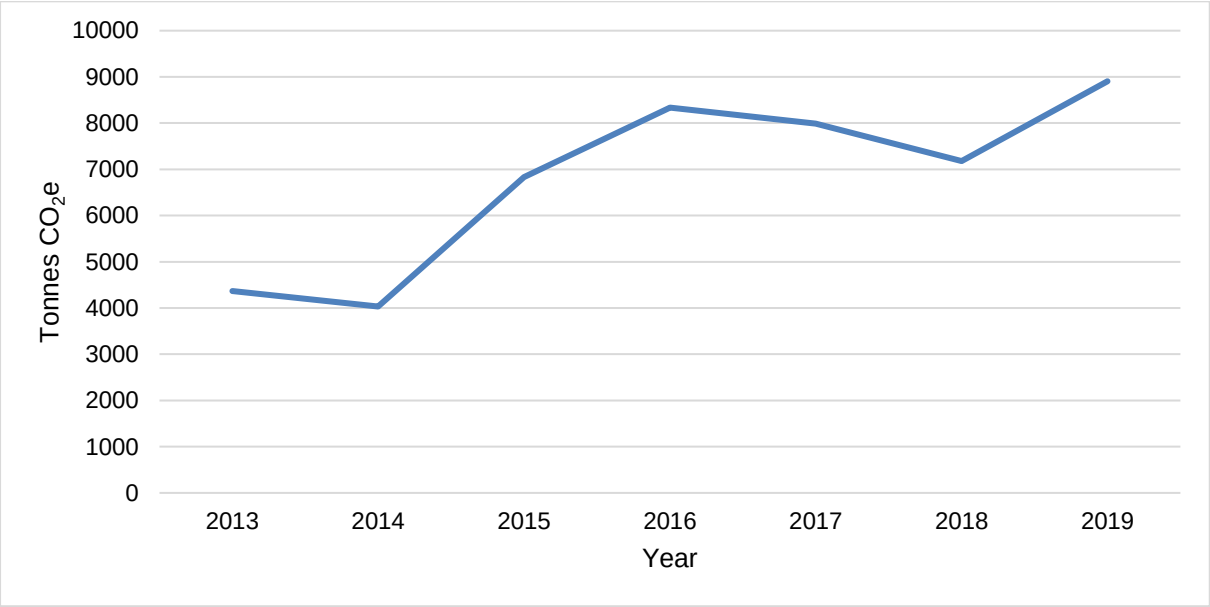


Figure 4 - Total CO_2e emissions from gas consumption at the Trust

As the CHP requires natural gas, the amount of gas consumed at the Trust, and therefore the emissions created, has increased since the baseline year as the demand has increased.

As the CHP produces heat and power it is important to consider these emissions in conjunction with the emissions from electricity at the Trust. Overall a significant reduction in emissions from electricity has been observed at the Trust since the baseline year. When combined, the total emissions from gas and electricity at the Trust were reduced by 6% from the baseline year.

4.5.2 Oil

As shown in Table 2 - Comparison of CO2e emissions in the baseline year and most recent year the Trust has not consumed any oil since the baseline year. Oil is not used a primary energy source at the Trust it is only retained as a backup energy source in the event that the gas supply is disrupted. Having oil as a backup energy source is mandated by the Healthcare Technical Memoranda (HTM).

The Trust have chosen to use natural gas over oil as the primary energy source as oil creates 1.4 times more CO_2e per kWh than natural gas. To ensure that oil does not have to be used, the Trust works to maintain our primary energy sources and equipment to prevent gas or electricity failure events.

4.5.3 Anaesthetic Gases

Several medical procedures carried out within the Trust must be carried out under anaesthesia. This requires the use of the volatile agents including most commonly Desflurane, Sevoflurane and Isoflurane. These volatile agents produce CO_2e emissions when used. Each anaesthetic gas produces different amounts of emissions, Desflurane has a Global Warming Potential (GWP) of 6,810, compared to Sevoflurane which has a (GWP) of just 440. Therefore, the environmental impact of using Desflurane is approximately 15 times greater than that of using Sevoflurane. The Trust already uses relatively low amounts of Desflurane due to the nature of the medical procedures carried. To reduce CO_2e emissions low flow anaesthesia , a technique to minimise the loss of anaesthetic agents to the environment, has been utilised. Between 2013-14 and 2019-20 the Trust have achieved a 22% reduction in emissions from anaesthetic gases as shown in Figure 5.

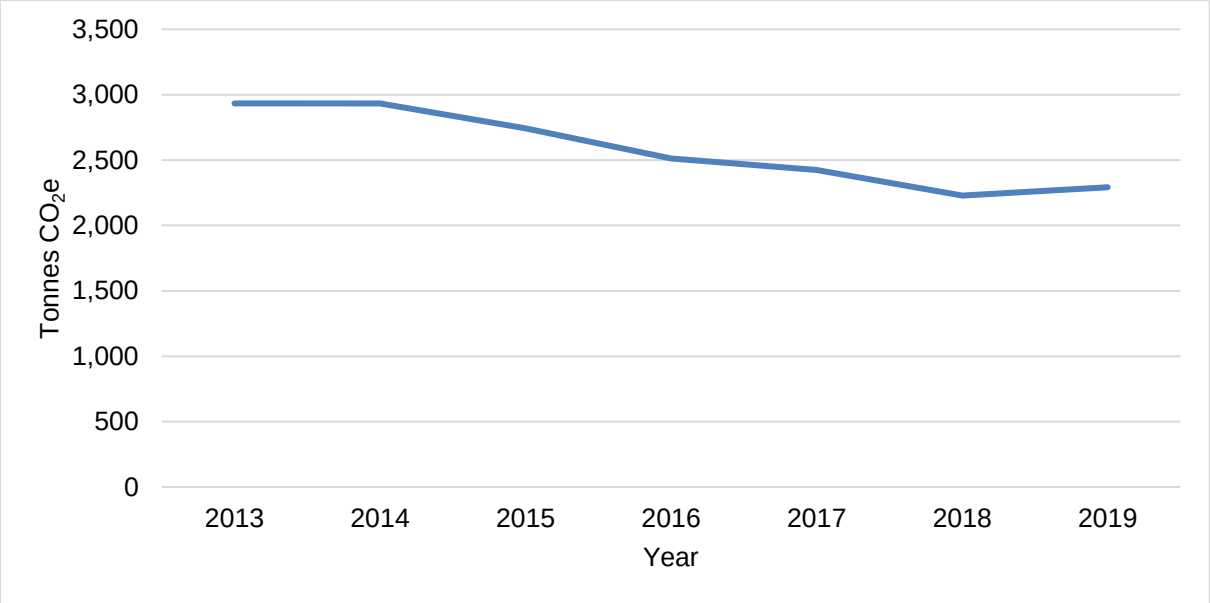


Figure 5 - CO_2e emissions from anaesthetic gas use at the Trust

As the use of anaesthetic gas is unavoidable at the Trust, it will not be possible to reduce these emissions to zero. However, the Trust will work to reduce these emissions further by continuing to favour the use of Sevoflurane over Desflurane and increasing the use of low flow rates, where clinically appropriate.

4.6 Scope 2

4.6.1 Electricity

As shown in Figure 6, the Trust has achieved a significant 81% reduction in emissions from electricity since the baseline year. This has been achieved primarily due to the introduction of the CHP introduced in 2014 as discussed in section 5.5.1 above.

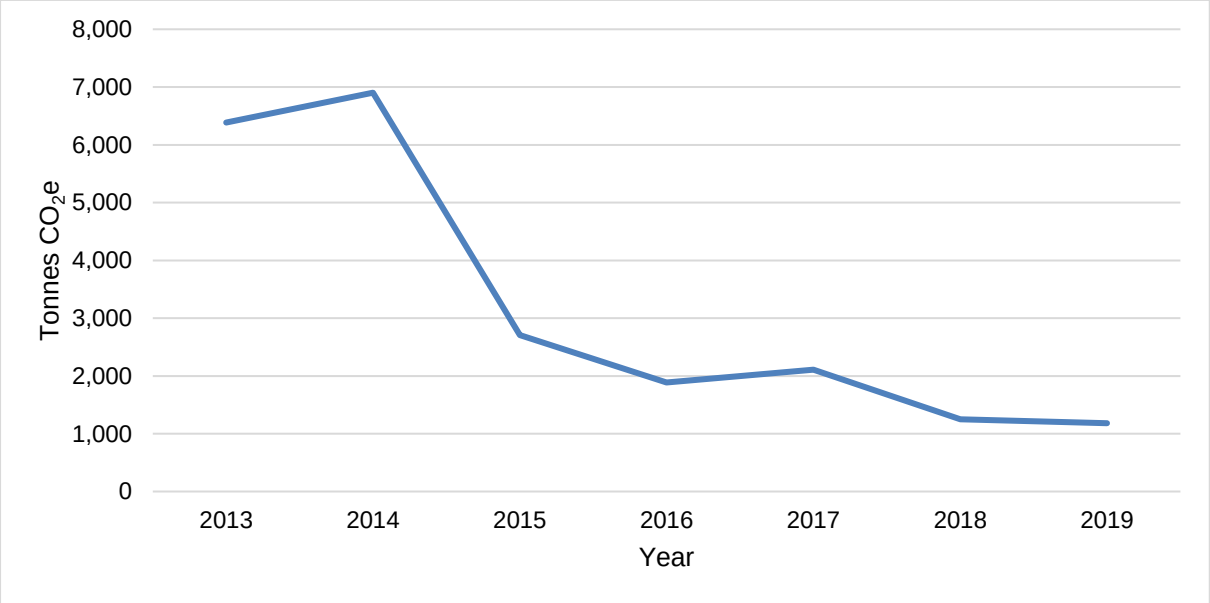


Figure 6 - Total annual emissions from electricity consumption at the Trust

Other factors which have contributed to the reduction in electricity consumption since the introduction of the CHP include gains in efficiency achieved through upgrades to the estate. The Trust have upgraded 3,300 light fitting around the Trust to LED energy saving bulbs, reducing the energy consumption required for lighting.

Another contributor to the reduction in electricity emissions is the reduction in carbon intensity of the electricity imported from the National Grid since the baseline year. Electricity used in the National Grid is generated through a mix of sources including gas, coal, nuclear and renewable source such as wind. The proportion of renewable energy sources which contribute towards the UK's energy mix increases each year, which reduces the carbon intensity of the electricity supplied by the Grid.

The carbon intensity of electricity is calculated and published by the Department for Business, Energy, and Industrial Strategy (BEIS) annually. In the baseline year (2013-14), the carbon intensity was 0.48 kg CO2e; meaning that for every kWh of electricity consumed 0.48 kg of CO2e was produced. By 2019-20 this carbon intensity 0.28 kg CO_2e, a 48% reduction. The reduction in carbon intensity to produce the UK's electricity results in a reduction in the associated emissions. This has enabled the Trust to achieve an 81% reduction in emissions with only a 68% reduction in electricity consumption.

4.7 Scope 3

4.7.1 Business Travel

Since the baseline year the Trust have achieved a 30% reduction in business travel emissions, as shown in Figure 7 - Total CO2e emissions from business travel at the Trust.

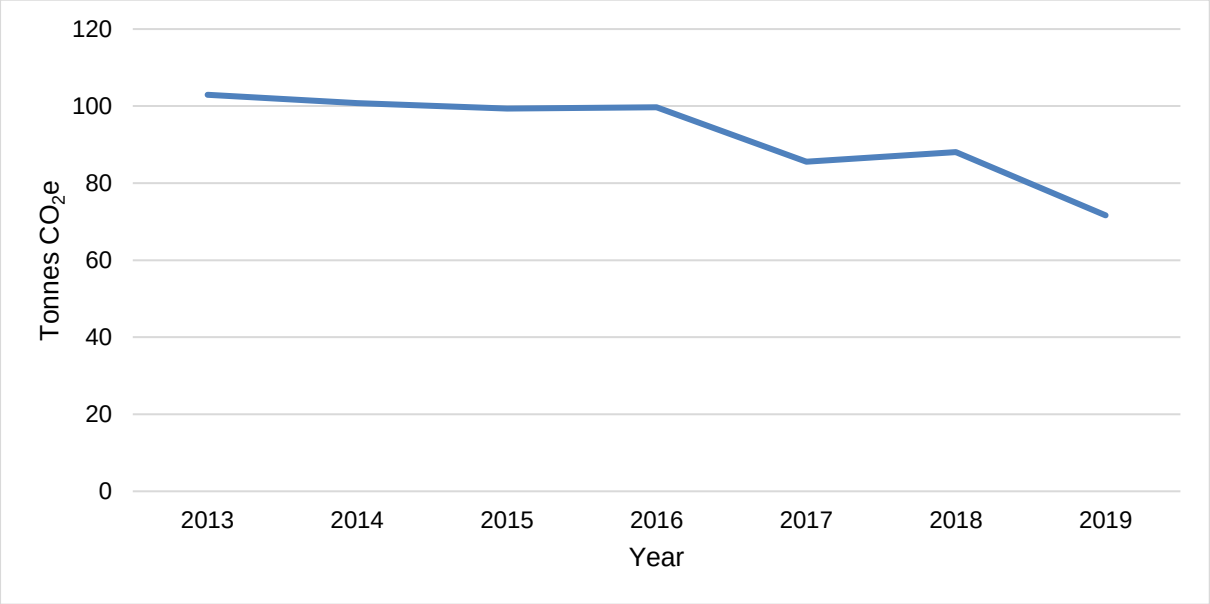


Figure 7 - Total CO_2e emissions from business travel at the Trust

Between 2013 and 2019 annual emissions from business travel were reduced by 31 tonnes CO_2e. This reduction in emissions was achieved by reducing the number of miles travelled from 322,856 miles in 2013 to 246,155 miles in 2019, a significant reduction of 76,701 miles.

As a result of the COVID-19 pandemic there have been significant changes to travel at the Trust. It is expected that there will be a significant reduction in business travel emissions in the 2020-2021 data and that the amount of business travel will continue to be reduced following the pandemic.

Due to the pandemic, staff who were able worked from home. Microsoft Teams has been used to conduct meetings, which significantly reduced the requirement for business travel. Hosting a meeting with ten attendees, who typically travel 10 miles by car, over Microsoft teams saves 28 kg per meeting. Working from home also reduced the number of staff commuting to and from Trust sites. To provide services to patients remotely during the pandemic the Trust also utilised the web-based platform Attend Anywhere. This platform was used to provide video consultations to patients remotely, which therefore reduced the need for patients and staff to travel for appointments. Currently between 50-60% of appointments can be conducted virtually using the Attend Anywhere platform or telephone.

Although adopted in response to the pandemic, these changes in the Trust's working practices have led to a reduction in the Trust's carbon emissions and air pollution due to reduced travel. The Trust intends to continue to enable working from home where practicable to reduce the impacts of commuting. The Trust will also continue to use technology to provide remote services such as providing the option for virtual consultations where clinically appropriate. These changes will enable the Trust to reduce carbon emissions and air pollution and also enable to the Trust greater flexibility and resilience in the future.

4.7.2 Waste

The annual emissions from waste produced at the Trust has decreased since the baseline year, despite a large spike in 2016. As shown in Figure 8, the Trust has reduced the emissions by 46% since the baseline year. This has been achieved through measures to reduce the volume of waste produced.

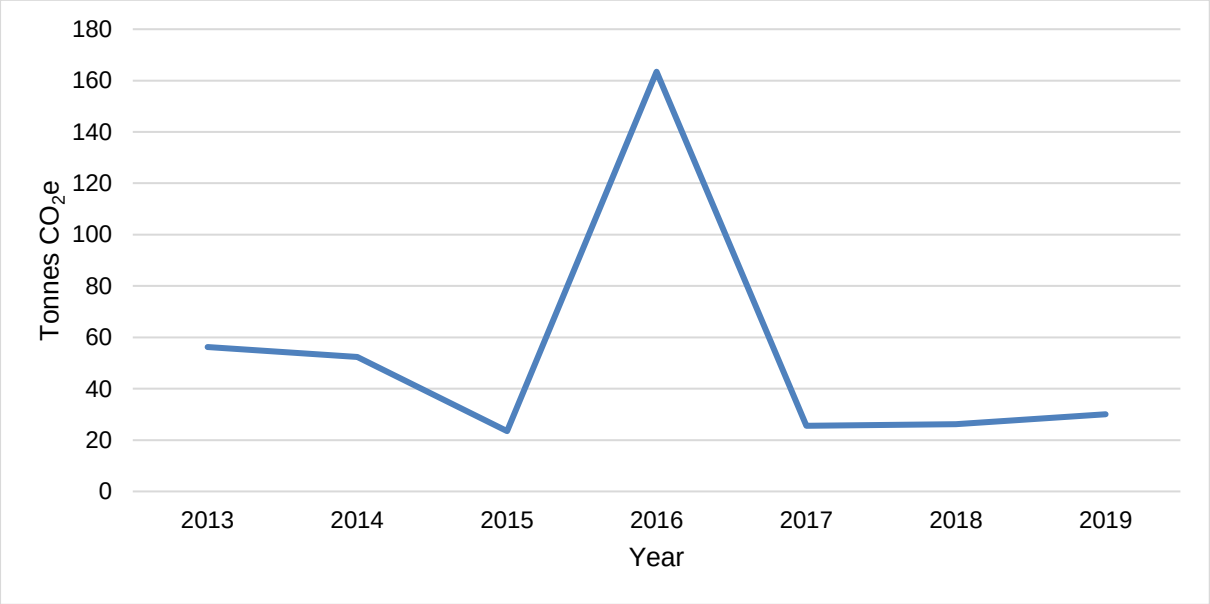


Figure 8 – Total CO_2e emissions from waste at the Trust

In total the volume of waste produced has been almost halved at the Trust since the baseline year with 1,409 tonnes of waste produced in 2019-20 compared to 2,638 in 2013-14, a 47% reduction. This has been achieved through improved waste management, all waste produced at the Trust is segregated offsite by a waste contractor to ensure that as much of our waste is recycled as possible. The Trust aims to reduce the volume of general waste produced and minimise the amount sent to landfill. Where possible we have worked to reuse items to reduce the amount of waste sent to landfill, one way this has been achieved is through the use of our furniture reuse swap shop which enables users to distribute and reuse surplus furniture around the Trust. The production of clinical waste has been reduced where possible to reduce the emissions associated with incineration.

One key area where the Trust has saved resources and minimised the creation of waste is by reducing paper use. We have moved towards paperless electronic systems where possible to minimise paper wastage, save resources and reduce costs as part of our Digital Transformation. Paperless systems have been introduced in both clinical and non-clinical settings within the Trust. We have started a paperless care portfolio, to integrate our services with electronic recording, this includes nurses recording observations electronically. Ambulances have also moved to a digitised proforma system. These changes have not only reduced paper consumption and waste but have significantly improved the legibility of observations and improved efficiency of the services we provide. Paperless systems have also been implemented in non-clinical areas such as electronic invoicing systems and HR document packs. The Trust now uses recycled paper for all draft documents and aims to print only when necessary to reduce paper consumption.

The Trust will continue to work to identify ways to reduce the production of waste in the first instance and ensure that any waste that is created within the Trust is reused, recycled or disposed of in the most sustainable way possible. We will improve the monitoring of our waste management by tracking the percentage of waste that is sent to landfill, incineration and reused or recycled to help us identify key sources of waste within our Trust and minimise the impacts of our waste.

4.7.3 Water

As shown in Figure 9, the Trust achieved a 17% reduction in emissions from water consumption.

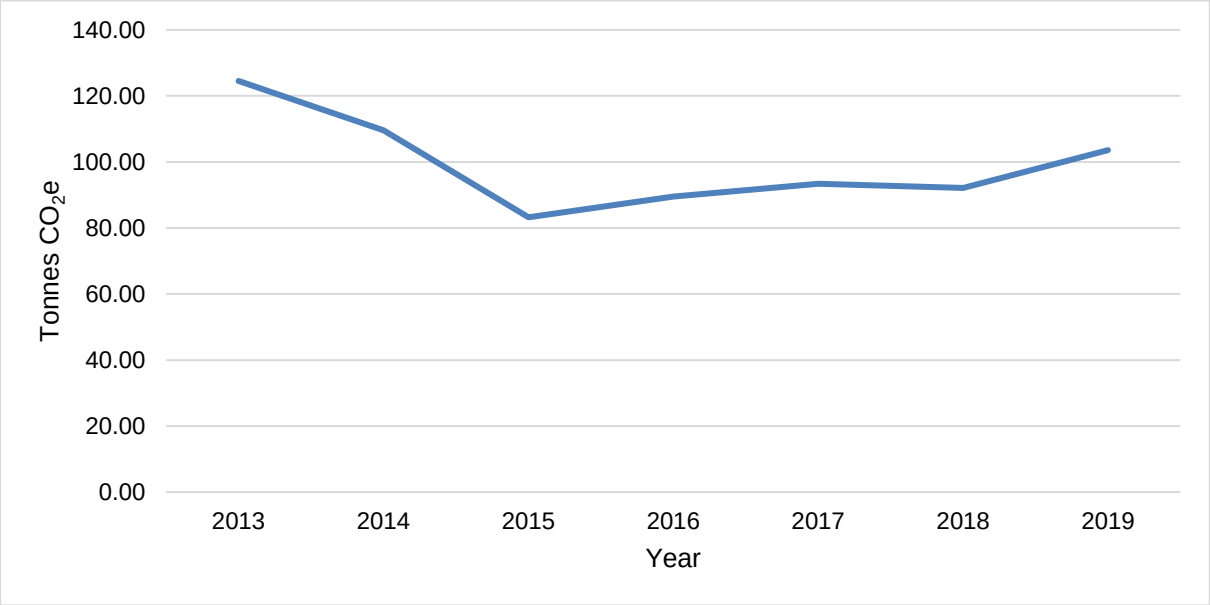


Figure 9 - Total CO_2e emissions from water at the Trust

Although water contributes only a small percentage of our carbon baseline (0.8%), it is important that we aim to use water resources efficiently so that we can save water and reduce costs. We will continue to encourage colleagues to turn off taps when not in use and report any identified leaks to reduce our water consumption. We will also closely monitor our water consumption to identify any major leaks which may waste water.

4.7.4 Inhalers

The Trust prescribes inhalers to treat illnesses such as asthma, two types of inhalers commonly prescribed are pressurised metered dose inhalers (MDI) and dry powder inhaler (DPI). MDI inhalers contain hydrofluorocarbons (HFCs) propellants which are powerful greenhouse gases which when emitted can contribute to climate change. DPI inhalers do not contain propellant gases and therefore have a significantly lower global warming potential (GWP) of approximately 20g CO_2e per dose compared to approximately 500g CO_2e per dose for MDI. As shown in Figure 10, the emissions from inhalers at the Trust have increased 67% since the baseline year. The increase in emissions can be attributed to rise in patients requiring inhalers.

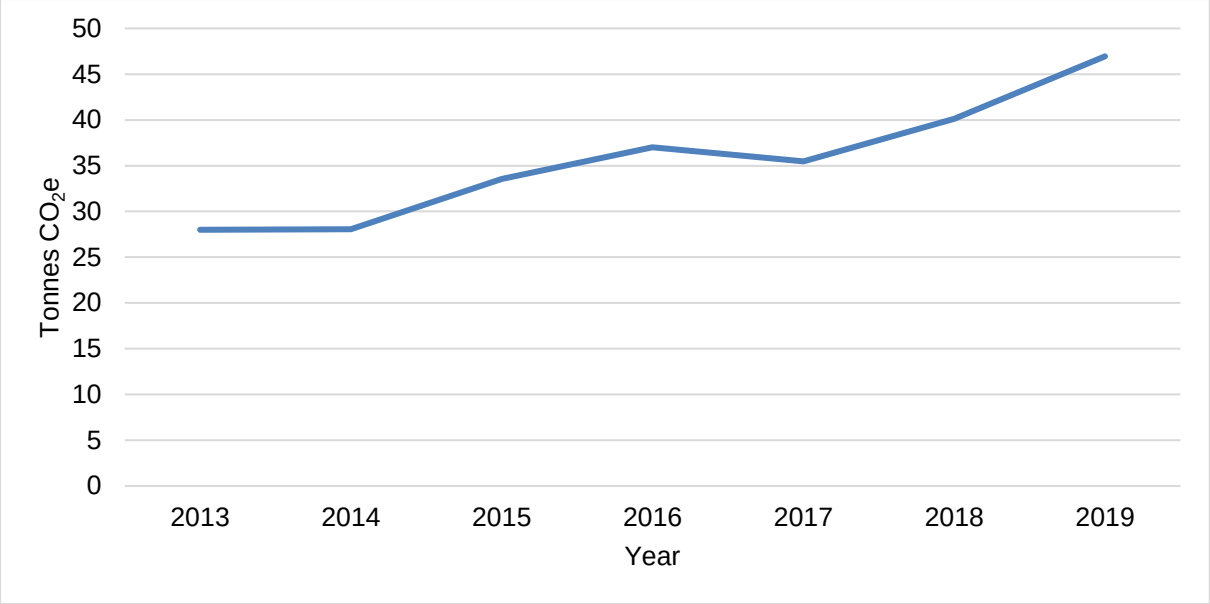


Figure 10 - CO_2e emissions from metered dose inhalers at the Trust

Although a significant rise the emissions contributed by inhalers is small relative to other sources of CO_2e emissions at the Trust. Despite this, the Trust will work to reduce these emissions by using dry powdered inhalers for new patients where clinically appropriate. We will also work to reduce our contribution to air pollution to help to prevent respiratory illnesses worsened by air pollution in our local area. The actions we will implement to address this are detailed in our Sustainable Action Plan.

5.0 A PATHWAY TO CARBON NET ZERO

The Trust has achieved a reduction in CO_2e emissions from the carbon baseline in 2013-14 but a continual effort will be required if we are to achieve our target of reducing our emissions to net-zero by 2040. This section will set out our trajectory to meet the 2040 target and will outline some of the national and local interventions that may enable us to reduce our emissions further.

To guide Trusts towards the 2040 net-zero target, the NHS has set an interim target for an 80% reduction in scope 1 emissions by 2028 to 2032. Key targets are given in Section 4 Drivers and Targets. These targets are not legally binding but have been set as a national commitment by NHS England to encourage the NHS to reach net-zero emissions as soon as possible and to ensure that the the mandatory national 2050 net-zero target is met.

The emissions reductions the Trust must achieve to reach these targets are set out in Table 3. We will continue to monitor our emissions against these targets and publish our progress annually.

Table 3 - NHS carbon emissions targets in percentage terms and tCO_2e

Year	Baseline	2020	2032	2040
Target Emission Reduction (%)	n/a	28	80	100
Target Emissions (tCO_2e)	13,997	10,077	2,799	0

Figure 11 shows the Trust's carbon footprint since 2013 baseline against the NHS's CO_2e targets. As seen, the Trust was unable to meet the NHS's 28% reduction by 2020 target but have achieved an annual reduction in carbon emissions since 2013-14 and in 2018 were on target. The increase in gas consumption since 2018 has been responsible for the spike in emissions observed in Figure 11

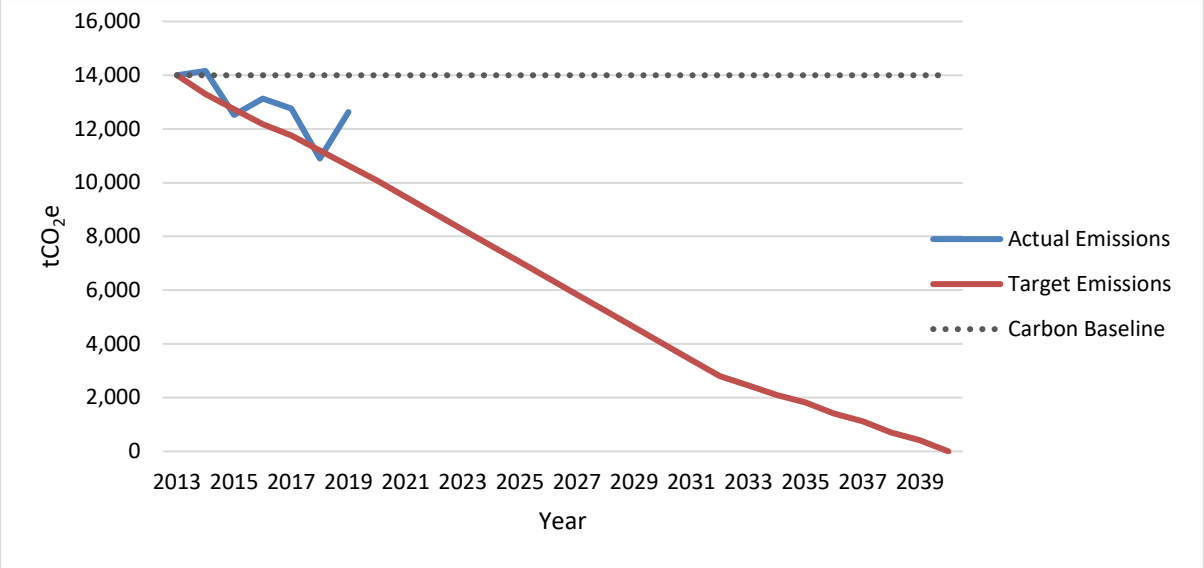


Figure 11 - Trust emissions against the NHS CO2e emissions targets

To reduce our emissions by a further to 2,799 tCO_2e per year by 2032, a continual effort will be required across the Trust. We will focus on improving efficiency where possible and reducing the emissions from our key aspects. To do this we will implement our Sustainable Action Plan, as outlined in Section 7 below. We shall use our Sustainable Action Plan as the framework to guide the implementation of actions over the next 5 years to reduce carbon emissions, air pollution and waste in line with our targets. The Action Plan will also enable us to monitor the progress of our actions over the 5 years.

5.1 Local Considerations

This section outlines the key projects the Trust will complete in the medium to long-term to transform the provision of healthcare within Warrington and Halton area and integrate sustainability into our strategies.

5.1.1 Our New Hospitals

One of our key strategic objectives is to provide our services in an estate that is fit for purpose, supported by technology, and aligned to the needs of our developing populations. One of the key limiting factors to reducing our carbon emissions is the efficiency of our current estate.

Our medium to long term ambition is to create two new, state of the art hospitals for Warrington and Halton with facilities that are designed to meet the health and care demands of our local population in the future and allow us to continue to provide high level care more efficiently. Both sites will be developed with a focus on our local populations and designed around their needs. The new hospitals will aim to support people to live healthy independent lives out of hospital wherever possible, to help improve the health of our local population and prevent hospital admissions.

Our new hospitals have been designed to incorporate sustainability and be adaptable for the future. During the reconfiguration of our sites, we will work to improve our efficiency and create energy savings. The new hospitals and ED Plaza scheme will all aim to be completed to BREEAM excellent standard; this will ensure that best practice will be used throughout the development of these projects. These buildings will be built to be as efficient as possible and

will use LED lighting, double glazing and ventilation sensors throughout. The new capital projects will also include features such as sub-metering and Building Management Systems (BMS) to enable the Trust to monitor energy consumption effectively and work to improve efficiency throughout the lifetime of the buildings.

We have already planted a collection of trees at our Halton site and created a community pond, we will use the opportunity of the creation of two new hospitals to integrate more green spaces onto our estate. This has been shown to be beneficial to the local environment, biodiversity and wellbeing of our community.

5.1.2 Providing Local Care

The Trust are working with local partners to improve the quality of care in the local area and provide accessible services in locations suitable for our patients. From January 2022 we will begin providing services in Runcorn Shopping City to utilise disused retail space and make our services more accessible for our community. This will reduce pressure on our hospitals and help to shift the delivery of our healthcare provision towards a localised approach.

We are working with the Halton Healthy New Town project, which aims to tackle pressing health challenges and promote good health through the considerate design of space and the built environment. This involves a radical rethink of how healthcare services are delivered. A new Wellbeing Campus will be integrated into the new Halton Hospital, here health and care services will be provided, alongside facilities for leisure, exercise and socialising and staff will work together rather than as separate services or departments. This will be a purpose-built health and wellbeing hub where the health and social care system will be integrated. The new site will release the existing site, this will be used to create a range of supporting health and wellbeing facilities, including a nursing home, nursery, rehabilitation centre, community centre, wellness centre and multigenerational housing. The site will also feature communal greenspace areas such as growing spaces, parks, gardens, woodland walks and cycle paths.

We are also involved in the new Warrington Town Deal, a collection of seven projects to regenerate the town. This includes projects such as a sustainable travel programme which will provide a new cycling hub, cycle paths and electric buses. As part of the Warrington Town Deal, we are working to create a new Health and Wellbeing Hub in Warrington Town Centre. This will be accessible by public transport and will reduce travel requirements for local people. This will enable us to provide services in an area that is convenient for our users and reduce patient numbers within our main Warrington Hospital and focus on early intervention to reduce patient numbers.

Education will also be a key factor in completing the Warrington Town Deal. We will work with local colleges to create a Health and Social Care Academy to improve the standard of education across the town. The academy will support professional progression into and across the health and social care sectors for all levels. The academy will provide education and skills-based training. We will then look to provide local employment opportunities within our new Wellbeing Hub.

5.2 National Considerations

Once the Trust has implemented all practicable actions and reduced emissions as far as possible, we will then require national schemes to reduce our final residual emissions to achieve net-zero. This section will outline the key national schemes that have the potential to reduce

CO_2e emissions and air pollution over the next 30 years that could assist the Trust in achieving the net-zero 2040 target.

The UK Government has outlined their commitment to achieving net-zero by 2050 by launching their Ten Point Plan. The Plan will act as a framework to guide the UK's transition to a net-zero economy by 2050 and will be supported by a £5 billion fund to kickstart the Green Industrial Revolution throughout the UK. The Government hopes to support a green recovery from the COVID-19 pandemic by creating 250,000 new jobs by 2030 in green energy and zero-carbon technologies including offshore wind farms, nuclear plants, hydrogen power technologies and carbon capture.

5.2.1 Renewable Energy

The percentage of the UK's energy mix generated from renewables increases year on year, this reduces the carbon intensity of the electricity consumed in the UK and therefore reduces emissions. To achieve net-zero emissions the UK must completely decarbonise electricity. To do so the Government plans to increase the amount of renewable energy generated through the provision of additional offshore wind farms. This is expected to generate 40 GW of energy, enough to power every home in the UK. This will be coupled with carbon capture technology and battery storage so this renewable energy can be utilised to meet demands.

The increase in renewable electricity will make a significant difference to our carbon emissions from electricity, one of our largest sources of emissions.

5.2.2 Emerging Technologies and Opportunities

The Ten Point Plan also outlines how the Government intends to decarbonise heating within the UK through the transition to low-carbon hydrogen. The Government intend to create 5GW of low-carbon hydrogen production capacity by 2030 which would be used for heating and would provide an alternative to fossil fuels such as natural gas and oil. It is estimated that converting the gas grid to hydrogen could reduce UK carbon emissions by an estimated 73%.

This transition to hydrogen technologies will be supported by the Net Zero Hydrogen Fund which will provide £240 million of capital co-investment by 2024/25. Large scale trials for this technology will be carried out within the next few years with large village heating trials to be carried out by 2025 with a potential Hydrogen Town by 2030. This is in addition to privately funded schemes such as the H21 City Gate Project which seeks to begin converting the gas grid to hydrogen within a shorter timeframe.

The Government are currently consulting on 'hydrogen ready appliances' in preparation for the potential conversion of the gas grid and, subject to trial outcomes, will rework the Health and Safety Executive to enable up to 20% hydrogen blending in the gas grid by 2023.

Carbon capture will be used in conjunction with hydrogen heating to enable hydrogen to be rolled out across the UK gas grid at prices that can complete with natural gas costs but without the associated CO_2e emissions. The successful transition from natural gas to hydrogen would enable to UK and the Trust to significantly reduce emissions associated with heating, our largest source of emissions.

The Trust will continue to keep up with new and emerging technologies which could support the decarbonisation of our trust towards net-zero CO_2e emissions over the next 19 years.

5.2.3 Transport

Another key element of the Ten Point Plan is the role of public transport and active travel, to continue to reduce carbon emissions and air pollution. The Government aims to continue to the reduction in transport emissions seen due to travel restrictions during the COVID-19 pandemic through the provision of additional funding for public transport and active travel schemes.

Funding will be available to improve rail and bus networks across the UK. More rail lines will be electrified, and bus and rail networks will be integrated to allow easier travel on public transport networks. Smart ticketing will also be introduced to make travelling by bus and rail more convenient. A National Bus Strategy has been published in addition to the Ten Point Plan which details the plans to create zero emissions buses and super buses which will provide a cheaper, more frequent and reliable bus network. This will be supported by a £3 billion investment into the bus sector. The successful implementation of these schemes would enable easier travel by public transport and will therefore reduce reliance on cars.

Another strategy the Government will utilise is active travel. The Government plans to build thousands of miles of segregated cycle lanes across England to facilitate safer cycling. A dedicated Active Travel body has been set up to monitor the progress of schemes like this and distribute funding accordingly. Encouraging active travel across England will have multiple benefits for the Trust, by supporting the reduction in the Trust's emissions, improving air quality and improving the health and wellbeing of the local population. This could lead to a reduction in patient numbers.

The Ten Point Plan also seeks to address emissions from petrol and diesel vehicles. The sale of all new petrol, diesel vehicles will be banned from 2030, which will be followed by a ban on hybrid models by 2035. This ban has been brought forward by 10 years to accelerate the transition to electric vehicles. The Government has set out a commitment to develop 'Gigafactories' to produce batteries to accommodate the expected increase in electric vehicle manufacturing and support this transition to electric vehicles. The provision of electric vehicle charging points will also be increased.

It is expected that the shift transport created by these schemes will assist the Trust in reducing Scope 3 emissions. Scope 3 emissions are difficult for the Trust to quantity and then reduce as they fall outside of the Trust's direct control. The increased provision of public transport methods and active travel schemes will help to reduce emissions from staff and patient travel and improve air pollution. The transition towards electric vehicles will then assist the Trust in reducing transport emissions including commuting, business travel, and emissions associated with transportation of goods.

6.0 OUR SUSTAINABLE ACTION PLAN

This section provides a summary of the Sustainable Action Plan, which contains a series of 117 actions that the Trust will implement over the next 5 years to reduce carbon emissions, air pollution and waste in line with our targets. The implementation of our Sustainable Action Plan will bring us closer to our 2040 net-zero emissions target and help us to deliver our strategic objectives. The Sustainable Action Plan is not an exhaustive list of possible actions, therefore our Sustainability Team will continue to develop future actions under these headings as required.

To ensure that the Sustainable Action Plan considers all aspects of sustainability, as defined by the United Nations, the Trust have developed the Action Plan in line with the Sustainable Development Action Tool (SDAT) previously published by the NHS Sustainable Development Unit (SDU). The SDAT tool allows NHS organisations to review their sustainability performance and was developed in line with the UN Sustainable Development Goals (SDGs) shown in Figure 12.

Figure 12- UN Sustainable Development Goals

To align with the SDAT, our Sustainable Action Plan is composed of the following 10 sections:

- Corporate Approach
- Asset Management and Utilities
- Travel and Logistics
- Adaptation
- Capital Projects
- Greenspace and Biodiversity
- Sustainable Care Models
- Our People
- Sustainable Use of Resources
- Carbon and Greenhouse Gases

6.1 Methodology

Our Sustainable Action Plan has been developed to ensure that the actions are ambitious but practicable and achievable with the resources available to the Trust. A dedicated lead has been assigned to each action to ensure that they can be implemented successfully. Each action also has a recommended timescale for implementation to enable the progress of the actions to be monitored easily.

To create the Sustainable Action Plan, the Trust conducted a series of colleague interviews with key individuals from several departments across the Trust. The interviews were used to establish the actions that have already been successfully implemented at the Trust, identify key areas for improvement and determine the level of resource available to implement this action plan. Colleagues were interviewed from Estates and Facilities, Procurement, Finance, Pharmacy, Capital Projects, Human Resources, Waste, IT, Strategy and Compliance. The Corporate Approach actions will also ensure that the Trust involves the whole Trust in the development and implementation of this Green Plan. Using the information gathered from the colleagues interviewed, the SDAT was then completed to identify any other key actions that the Trust could implement to become a more sustainable organisation. In addition to these actions identified by colleagues, the Trust conducted a horizon scan of actions implemented at other Trusts that have improved their sustainability performance.

The actions developed throughout these three stages were collated to form a longlist of potential actions. The Trust then reduced the action plan to a shortlist of actions which would have the Trust have the capacity to implement that would be most impactful which have been developed into the Sustainable Action Plan.

6.2 Sections of the Sustainable Action Plan

6.2.1 Corporate Approach

The successful implementation of this Green Plan will require senior level colleague support. Commitment is required for senior management within the Trust to ensure that sustainability goes beyond our Green Plan and becomes an integral part of our policies, procedures and daily working practices. Having senior support will also hold the Trust accountable for meeting the targets set out in this Plan through the implementation of actions to reduce carbon emissions, air pollution and waste.

6.2.2 Asset Management and Utilities

Emissions from utilities contribute a significant proportion of our total carbon emissions. To achieve net-zero CO_2e emissions we recognise that we must decarbonise our energy and improve our utilities management. We will also focus on improve the efficiency of our estate within our future capital projects.

6.2.3 Travel and Logistics

Taking actions to reduce carbon emissions and air pollution requires a change in staff, patient, visitor and supplier travel methods to and from the Trust. Reducing the impact of travel is a key target for the Trust and will be achieved through a number of strategies including encouraging active travel methods, utilising technology and working with out suppliers to improve their transport costs. The Trust will also capitalise on the changes to travel due to the COVID-19 pandemic and will continue to utilise remote working to reduce emissions.

6.2.4 Adaptation

In addition to trying to reduce our contribution to climate change, the Trust also acknowledges the necessity of adapting to the potential impacts of climate change as a healthcare provider. Climate change is considered the greatest environmental threat to health of the 21st century, we must therefore ensure that our organisation is resilient to the risks posed by climate change so that we can continue to provide high quality care.

6.2.5 Capital Projects

As an old estate, inefficiency within our buildings contributes significantly to our carbon emissions. With new hospitals planned, it is crucial that sustainability is embedded throughout each stage of our capital projects process. Our actions will ensure that our capital projects are designed to help reduce our carbon emissions, air pollution and waste and will enable us to meet the needs of our local population in the long term.

6.2.6 Greenspace and Biodiversity

Protecting and improving our greenspace and biodiversity not only improves our local environment but can also be hugely beneficial for the health and wellbeing of our staff, patients and community. By maintaining and enhancing our greenspaces the Trust can improve local air quality and help capture carbon. Greenspaces will be integrated throughout our new estates, and we will work to protect the existing greenspace and biodiversity in our local area.

6.2.7 Sustainable Care Models

To improve the environmental, social and financial impacts of our service delivery and ensure we are continuing to provide an outstanding quality of care it is crucial that we consider the long-term sustainability of our care models. Embedding sustainability into our care models is essential for the Trust to achieve net-zero, therefore we will work with clinical colleagues to improve the sustainability of our care.

6.2.8 Our People

At the Trust we aim to create conditions to promote wellbeing and enable an engaged workforce to improve staff and patient experience. We will implement actions to continue to create a collaborative, and inclusive culture within our workplace and engage our workforce in the Green Plan to ensure all of our colleagues can be involved in our journey to become a more sustainable organisation.

6.2.9 Sustainable Use of Resources

Although it is not possible to reduce waste entirely, by adopting a Trust wide sustainable approach to managing resources, the Trust can begin to reduce waste, carbon emissions and air pollution. To do so we will work to improve our resource consumption and we will work to improve the sustainability of our procurement through collaboration with suppliers and partner organisations to influence our supply chain. We shall also take a proactive approach to minimising the production of waste in the first instance and will utilise the most sustainable disposal methods in line with the waste hierarchy.

6.2.10 Carbon and Greenhouse Gases

Reducing our carbon emissions to net-zero will require a continued Trust-wide effort over the next 19 years. Every department in the Trust can have an impact on our carbon emissions. We will focus on decarbonising our energy supply and improving the efficiency of our estate. We will also work to improve the monitoring of our emissions so that we can identify key hotspot areas for improvement. To maximise emissions reductions, we will also educate our workforce on the importance of mitigating climate change to encourage more efficient behaviours.

WRM Limited
18 Manor Square, Otley, West Yorkshire, LS21 3AY

Tel: 01943 468138

Email: info@wrm-ltd.co.uk Web: www.wrm-sustainability.co.uk

Warrington and Halton Green Plan
Sustainable Action Plan

Module	Reference	Nominated Lead	Number of Actions	Completed Actions
Corporate Approach	CA		9	
Asset Management & Utilities	AM		7	
Travel & Logisitics	TL		7	
Adaptation	AD		11	
Capital Projects	CP		12	
Greenspace & Biodviersity	GS		9	
Sustainable Care Models	SC		17	
Our People	OP		14	
Sustainable Use of Resources	SU		21	
Carbon & GHGs	CG		10	
Total			117	0

Corporate Approach								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
CA-01	**The Trust will prioritise sustainability at Board level.**	*Consideration of sustainability will be made a requirement in all business case applications.*	**All**		Andrea McGee			2021-22
		A standing section on sustainability will be added to our board papers.	**All**		John Culshaw			2021-22
		The Trust will adopt an invest to save approach to projects.	**All**		Andrea McGee			2022-23
CA-02	**The Trust will ensure that tenders are in line with our targets.**	*We will ensure that all our tenders are aligned to our sustainability targets and consider impact on CO2e emissions, air pollution and waste.*	**All**		Alison Parker			2022-23
CA-03	**The Trust shall share best practice with other NHS trusts and organisations**	*We will explore the best platform to share our best practice with other organisations and learn from other organisations.*	**All**		Sustainability Lead			2022-23
CA-04	**The Trust will collaborate with other organisations.**	*We will collaborate with similar organisations where possible to drive down costs and improve efficiency.*	**All**		Alison Parker			Ongoing
		We will work with volunteers and other members of the local community in the delivery of our sustainable development objectives.	**All**		Alison Aspinall			Ongoing
CA-05	**The Trust shall seek to incorporate social value into procurement.**	*We will include social responsibility as a marker of quality in technical tender evaluations.*	**N/A**		Alison Parker			2022-23
		We will evidence which products pose a high ethical and labour standards risk and will implement mitigation processes.	**N/A**		Alison Parker			2022-23
		We will report on the value/volume of goods that we procure ethically.	**N/A**		Alison Parker			2022-23 then ongoing
CA-06	**The Trust will work to improve the sustainability of procurement.**	*We will develop a methodology to help measure and reduce the environmental impact of our procurement.*	**All**		Alison Parker			2022-23
		We will develop a sustainability specification and evaluation criteria that can be effectively incorporated in to our procurement contracts.	**All**		Alison Parker			2022-23
		We shall develop a supplier engagement programme to communicate our sustainability commitments to suppliers and expect them to work with us to help implement our sustainable vision.	**All**		Alison Parker			2022-23
		We will develop a process to ensure that our procurement team understand and can maximise the benefits of whole life costing and circular economy.	**All**		Alison Parker			2022-23
CA-07	**The Trust shall continually review legislative drivers and examples of best practice.**	*We will develop a process for scanning for best practice, changes to mandatory and legislative drivers and adopt these early.*	**All**		Implementation Lead			2022-23
CA-08	**The Trust shall develop a communications plan to promote the publication of the Green Plan.**	*We shall communicate our Green Plan to patients, visitors and the local community.*	**All**		Pat McLaren			2021-22
CA-09	**The Trust will develop processes to maximise the opportunities for our local community.**	*We will work with volunteers and other members of the local community in the delivery of our sustainable development objectives.*	**All**		Alison Aspinall			Ongoing

Asset Management and Utilities								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
AMU-01	**The Trust will run a Switch-Off Campaign to reduce energy wastage.**	*We will run a Trust-wide switch off campaign which will encourage all staff to switch off lights and equipment in non clinical areas when not in use, for example overnight.*	**C**		Ian Wright			2021-22
AMU-02	**The Trust will upgrade lighting across the Trust to improve efficiency.**	*We will continue to upgrade lighting to more efficient LEDs as and when lights require replacement.*	**C**		Ian Wright			On going
		We will install occupancy sensors in appropriate locations on all new future refurbishments and new builds.	**C**		Ian Wright			On going
AMU-03	**The Trust will increase monitoring of energy consumption.**	*We will improve sub-metering throughout the Trust and new buildings to improve the accuracy of our meter data and allow for more specific reduction interventions.*	**C**		Ian Wright			2023-24
AMU-04	**The Trust shall switch to a renewable energy tariff.**	*We will procure 100% renewable electricity.*	**C**		Ian Wright			2023-24
AMU-05	**The Trust will explore options to sell surplus energy.**	*We will look to sell surplus electricity produced in our CHP to the grid.*	**C**		Ian Wright			2022-23
AMU-06	**The Trust will increase sub metering throughout the estate.**	*We will increase the amount of sub metering throughout our estate to improve monitoring and enable targeted reductions to be made to energy consumption.*	**C**		Ian Wright			2023-24
AMU-07	**The Trust shall work with suppliers to improve efficiency.**	*We will continue to upgrade lighting to more efficient LEDs as and when lights require replacement.*	**All**		Ian Wright			Ongoing

Travel and Logistics								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
TL-01	**The Trust will support the transition to electric vehicles.**	*We will install electric vehicle charging points at our two main sites.*	**C & A**		Ian Wright			2022-23
		We shall work with the council to provide electric shuttle buses.	**C & A**		Ian Wright			2022-23
TL-02	**The Trust shall review travel and transport impacts.**	*We will assess our travel and transport and calculate the carbon footprint for our business travel.*	**C & A**		Ian Wright			2022-23
TL-03	**The Trust shall set targets to improve travel impacts.**	*We shall set a local carbon reduction target for business mileage emissions, which is aligned to/or exceed the Climate Change Act 2030 target.*	**C & A**		Ian Wright			2022-23
TL-04	**The Trust shall monitor and try to reduce the environmental impacts associated with our suppliers.**	*Transport shall be considered when procuring key products and services. Efforts will be made to ensure that contracts are locally sourced, i.e. within the Cheshire and Merseyside region.*	**C & A**		Alison Parker			Jun-22
		We will monitor the environmental impacts including CO2e and air pollution associated with the transport and logistics from our supplier.	**C & A**		Alison Parker			2022-23 then ongoing
		We shall engage with suppliers frequently to find solutions to minimise their environmental impacts, such as planning deliveries efficiently and using low-emission vehicles.	**C & A**		Alison Parker			On going
TL-05	**The Trust shall create and publicise site Green Travel Plans.**	*We will develop a Green Travel Plan, which shall be communicated to staff, patients, visitors, suppliers and the local community. This will seek to promote active travel and reduce single occupancy journeys.*	**C & A**		Michelle Cloney			2022-23
TL-06	**The Trust will monitor the transport choices made by staff and patients and help them to reduce their impacts.**	*We will support staff to make lower carbon options (e.g. information on cost and air pollution benefits of salary sacrifice low carbon vehicles).*	**C & A**		Michelle Cloney			On going
		We will provide staff with information about the cost savings and personal benefits of sustainable modes of commuting (e.g. personal travel planning advice, health benefits of active travel, potential personal savings of different modes of transport).	**C & A**		Michelle Cloney			On going
		We will monitor the travel choices of our visitors, patients and staff and carry out an annual staff travel survey to measure the shifts in modes of transport.	**C & A**		Michelle Cloney			On going
TL-07	**The Trust shall introduce requirements for the procurement of vehicles.**	*We shall evaluate new fleet tender and specify electric or hybrid vehicles as a minimum.*	**C & A**		Alison Parker			2022-23

Adaptation								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
A-01	**The Trust shall assess the risks associated with climate change and the ways to mitigate these risks.**	*The Trust will include the potential impacts of climate change in the Trust's Risk Register. As part of this process, the Trust shall review its Heatwave Plan, Cold weather Plan, Excess Death Management Plan, Rapid Relocation Plan and Flood Management Plan*	**C**		Dan Moore			2022-23
		The Trust shall review the identified risks to the workforce and delivery due to changes in disease patters and population health; and find mitigation actions to tackle these challenges.	**C**		Michelle Cloney			2023-24
		We shall assess the risk to local communities from the impacts of our adaptation strategy, e.g. ensuring that flood attenuation doesn't divert water flow to residential areas.	**C**		Ian Wright			2023-24
A-02	**The Trust will align protocols to national adaptation plans.**	*We will develop local protocols aligned to national heat wave plans, cold weather plans and multiagency flood plans) in relation to Civil Contingencies Act, Climate Change Risk Assessment and National Adaptation Plans.*	**C**		Rachel Clint, Dan Moore			2023-24
A-03	**The Trust shall involve staff in the creation and implementation of a climate change adaptation strategy.**	*We will involve representatives from sustainability, finance, estates management, emergency preparedness/planning, HR, business continuity and local partner organisations and communities to ensure we develop a co-ordinated and integrated adaptation plan.*	**C**		Sustainability Lead			2023-24
		The adaptation plan shall be developed inline with the Green Plan and the Trust's resilience planning to ensure the Trust is fit for the future.	**C**		Sustainability Lead			2023-24
		The adaptation plan shall be approved by the Board.	**C**		Lucy Gardner			2023-24
		We will provide training to ensure that our workforce is prepared and trained to deal with different extreme weather scenarios such as staff know how to keep clinical and ward areas cool in the event of hot weather, and how to report high indoor temperatures.	**C**		Helen Wynn			2023-24
		Training is provided to staff relevant to their role, to ensure they understand their roles and responsibilities in relation to adaptation planning.	**C**		Michelle Cloney			2023-24
A-04	**The Trust shall monitor overheating events and use the results to modify our strategy.**	*We will implement a monitoring process for overheating events. The information gathered about overheating events will be used to improve our strategy which will be implemented to mitigate the risk of overheating, particularly in wards and other clinical areas.*	**C**		Ian Wright			2022-23
A-05	**The Trust shall assess the flood risk to the site.**	*We will carry out an assessment of flood risk of our estate, access routes and supporting infrastructure (e.g. utilities, IT and supplies) and workforce based on current and future projected climate conditions.*	**C**		Ian Wright			2022-23
A-06	**The Trust shall assess the financial impacts of climate change on the organisation.**	*We have assessed the financial impacts of climate change to our organisation and the cost of doing nothing, this is clearly communicated to our board.*	**C**		Andrea McGee			2022-23

A-07	**The Trust will look to safeguard vulnerable people during extreme weather events by establishing a coordinated care plan.**	*The Trust shall develop a care plan in coordination with the JSNA or other local organisation, to ensure the safety of vulnerable groups during extreme weather events.*	**C**		John Goodenough			2022-23
A-08	**The Trust shall ensure that vulnerable groups are protected during extreme events.**	*The Trust shall develop plans to ensure vulnerable communities and vulnerable existing patients are prioritised and supported in the event of major and extreme events.*	**C**		John Goodenough			2022-23
A-09	**The Trust shall appoint an Adaptation Lead who shall manage the adaptation planning.**	*The Adaptation lead will be responsible for coordinating adaptation planning, resilience and emergency preparedness at the Trust.*	**C**		Rachel Clint, Dan Moore			Ongoing
		The Trust shall provide the Adaptation lead with sufficient training, CPD opportunities and access to forums to share local and national best practice information.	**C**		Michelle Cloney			Ongoing
A-10	**Monitor the impacts of climate change and the impacts it has on the communities served by the Trust.**	*The public health lead within the trust shall maintain a record of notable and/or extreme weather events on an annual basis including health and care related impacts. The records created by this action will be used to update the trust Risk Register.*	**C**		Rachel Clint			Establish 2022-23 then ongoing
A-11	**The Trust shall work with suppliers to ensure their contingency plans are integrated so delivery of care at the Trust during an extreme event will not be hindered by the supply chain.**	*The Trust will engage with our key suppliers to understand their resilience and contingency plans for extreme weather events and other incidents.*	**C**		Alison Parker			2022-23
		The Trust shall develop a contingency strategy to ensure that crucial resources such as anaesthetic gases and medicines can be provided during extreme events and do not impact delivery of care.	**C**		Ian Wright, Diane Matthew, Guy Hanson			2022-23

Capital Projects								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
CP-01	**The Trust shall seek to incorporate sustainability into all new capital projects.**	*We will seek to achieve a BREEAM standard of Excellent on all new capital projects.*	**All**		Lee Bushell			Audit 2022-23 then ongoing
		We will ensure that sustainability is factored into the design process of all new capital projects.	**All**		Lee Bushell			Create framework 2022-23 then ongoing
		The Trust shall explore how consideration of sustainability can be factored into contracts for new capital projects.	**All**		Lee Bushell			2022-23
		All tenders for new capital projects, including refurbishments and new buildings shall include sustainability as a technical question.	**All**		Lee Bushell			2022-23
CP-02	**The Trust shall assess the efficiency of new builds upon occupation.**	*Once new buildings have been occupied for a suitable period of time, the Trust will assess the resource consumption and carbon emissions of the new building to ensure that the building meets the designed objectives. This will identify any areas of the building which aren't performing*	**All**		Ian Wright			Create tool 2022-23 then ongoing
CP-03	**The Trust will consider the long-term requirements of new buildings in the design process.**	*Whole life costing will be applied to the design and construction of new buildings and refurbishments.*	**All**		Lee Bushell			2022-23
		We will consider adaptation to climate change when designing new buildings to ensure they are resilient.	**N/A**		Lee Bushell			2022-23
		When designing new buildings the Trust will assess projected climate and temperature profiles to ensure that the buildings can cope with changes in climate and extreme weather events.	**N/A**		Lee Bushell			2022-23
		We will prioritise efficiency when designing new buildings and refurbishments to reduce energy consumption.	**C**		Lee Bushell			2022-23
CP-04	**The Trust shall share best practice with other organisations and seek to learn from them.**	*We shall work with other Trusts and organisations to share best practice and lessons learnt regarding improving the sustainability of capital projects.*	**All**		Ian Wright			2022-23
CP-05	**The Trust shall establish a commissioning protocol from the outset of capital projects.**	*The Trust shall use a soft landings extending commissioning protocol to ensure the building is commissioned in a way that facilitates maximum energy efficiency, building performance and maximum usability.*	**All**		Lee Bushell			2022-23
		The opinions of staff, patients, visitors and the local population shall help guide the design process of key capital projects.	**All**		Pat McLaren			2022-23

CP-06	**The Trust shall consult key stakeholders including staff, patients, visitors and the local community when embarking on a new capital project.**	*The Trust shall engage with local health and social care organisations and the local community when designing new buildings and infrastructure to ensure the buildings will meet the needs of its users and allow high quality integrated care to be provided.*	**All**		Pat McLaren			2022-23
CP-07	**The Trust shall ensure sustainability plans are fully aligned with and support the plans for two new hospitals.**	*We will ensure the sustainability plans support the new hospital plans and refurbishment projects.*	**C & A**		Kelly Jones			2021-22 and ongoing
CP-08	**The Trust will consider the use of materials in all new builds.**	*We will ensure that innovative, low carbon materials are embedded into the designs of future builds in order to reduce the embodied carbon associated with construction.*	**C & A**		Lee Bushell			Ongoing
CP-09	**The Trust will utilise brownfield sites for developments.**	*We will ensure that it is policy to prioritise brownfield sites rather than greenfield sites for capital projects.*	**C & A**		Ian Wright			Ongoing
CP-10	**The Trust shall integrate green space into capital projects.**	*We will design embedded green space into access routes to buildings and surrounding buildings in new capital projects.*	**C & A**		Lee Bushell			2022-23 then ongoing
CP-11	**The Trust will conduct a strategic estates review process to identify potential energy efficient building fabric improvement**	*We shall identify priority areas where a spend to save approach could yield cost and carbon savings from estate refurbishment and upgrades.*	**All**		Lee Bushell			2022-23
CP-12	**The Trust shall ensure all staff receive adequate support to design and use Trust buildings sustainably.**	*The Trust shall ensure that all Capital Project staff are sufficiently trained to be able to achieve sustainable outcomes in the projects they contribute to. Job descriptions should specify that Capital Project staff should have experience of energy efficient technologies, space utilisation and adaptation.*	**All**		Lee Bushell			2022-23
		The Trust shall provide an induction for staff upon occupation of a new building so it can be utilised efficiently.	**All**		Michelle Cloney			2022-23 then ongoing

Greenspace and Biodiversity									
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**	
GB-01	**The Trust will commit to planting more trees on our estate.**	*We will work with staff and the local community to plant additional trees on both our sites.*			Ian Wright			2022-23	
GB-02	**The Trust will work to improve local biodiversity.**	*The gardens team will work with local organisations to improve biodiversity on our estate.*			Ian Wright			2022-23	
GB-03	**The Trust will incorporate green spaces into the design of new hospitals.**	*We will ensure that green spaces are provided within the estate of our new hospitals.*			Ian Wright			2023-24	
		We will provide green and natural areas on our estate even where land is constrained e.g. window boxes, verges and potted plants.	n/a		Ian Wright			2022-23	
		We will make our plans for maintaining and enhancing green space and biodiversity and access to such publicly available and easy to understand (e.g. with clear diagrams, images and maps).	n/a		Ian Wright			2022-23	
		We will work closely with our key partners to plan, protect and promote the use of green space across our local area (e.g. identifying and enhancing green routes to our facility).	n/a		Ian Wright			2022-23	
GB-04	**The Trust will ensure that all greenspaces provided are safe and accessible for users.**	*We will assess the health, safety, cleanliness and accessibility (Disability Discrimination Act compliance) of our green spaces with input from users, to ensure that areas are safe and pleasant to use.*	n/a		Jennifer McCartney, Helen Wynn			2022-23	
GB-05	**The Trust will work to increase the biodiversity in our estate.**	*We will actively work to maintain and enhance biodiversity on our estates, for example through monitoring protected species and maintaining high quality green features.*	n/a		Ian Wright			2022-23 then ongoing	
		We will work with local greenspace and biodiversity partners such as wildlife trusts, local bee keepers or volunteers to improve biodiversity on our estate in line with local strategic plans.	n/a		Ian Wright			Ongoing	
GB-06	**The Trust will develop and implement a greenspace and biodiversity strategy.**	*We will develop a board approved green space and/or biodiversity strategy and communicate it to staff, patients and stakeholders.*	n/a		Sustainability Lead			2022-23	
		We will communicate our strategy to staff, patients and stakeholders.	n/a		Pat McLaren			2022-23	
		We shall report on the quality and accessibility of our green spaces and biodiversity regularly to the Board, emphasising the value of green space in health environments.	n/a		Sustainability Lead			Ongoing	
GB-07	**The Trust shall ensure that the estate is managed in a way that causes minimal damage to biodiversity or the natural environment.**	*Our grounds and green spaces shall be maintained in a way that minimises negative impacts (e.g. low use of pesticides and sustainably managing organic wastes).*	n/a		Ian Wright			Audit 2022-23 then going	
		We will engage with suppliers of high biotoxicity risk products to identify and manage these risk (e.g. extraction of raw materials and handling and transport of goods).	n/a		Alison Parker			Audit 2022-23 then going	
GB-08	**The Trust shall integrate wellbeing schemes with our greenspace and biodiversity plans to maximise the health benefits of green spaces.**	*We will provide staff with opportunities, and encourage engagement in, local volunteering activities in maintenance of green spaces and biodiversity.*	n/a		Michelle Cloney			Launch 2022-23 then ongoing	
		We shall promote the health benefits of green space to our staff, patients and the wider community.	n/a		Michelle Cloney			Launch 2022-23 then ongoing	
		We will monitor (e.g. through staff surveys) that staff wellbeing has been improved by greater access to green space during working hours.	n/a		Michelle Cloney			Ongoing	
	The Trust shall provide green space for food	*We will engage staff and patients in food growing onsite or at home and/or local sustainable food sourcing.*	n/a		Michelle Cloney			Launch 2022-23 then ongoing	

GB-09	**green space for food cultivation on our estate and encourage, staff, patient and community engagement.**	*We will provide space for the growth and cultivation of food (e.g. community food projects to support education) and food banks (e.g. sustainable food cities, incredible edible networks etc.).*	n/a		Ian Wright			Launch 2022-23 then ongoing	

Sustainable Care Models								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
SCM-01	**The Trust shall continue to provide virtual services and will explore how this can be optimised in the medium to long term.**	*We shall review the use of virtual consultations and explore how these consultations can be integrated into other systems at the Trust.*	**C&A**		Paul Fitzsimmons			2022-23
SCM-02	**The Trust will continue the digital transition.**	*We will reconciled the GP digital system to enable patient records from the GP to be obtained immediately when patients are admitted to hospital. To improve efficiency.*	**All**		Tom Poulter			2023-24
SCM-03	**The Trust shall utilise technology to provide efficient services and improve patient experience.**	*We will work to align our digital care systems with digital prescribing services.*	**n/a**		Tom Poulter			2023-24
		We shall work to directly integrate the digitalised proforma used in ambulances with the Trust's system to improve efficiency of our care.	**n/a**		Tom Poulter			2023-24
SCM-04	**The Trust will encourage home care where clinically appropriate.**	*We will review home care and try to encourage this where possible, to reduce the number of patients coming into the Trust.*	**All**		Caroline Williams			2023-24
		We shall work to identify which groups should receive large quantities of medicines to their homes, to reduce waste.	**All**		Loraine Derbyshire, Diane Matthew			2022-23
SCM-05	**The Trust will work to ensure that sustainability is factored into Integrated Care System**	*We will work with the ICS to ensure sustainability is embedded into our strategy.*	**All**		Lucy Gardner			2022-23
SCM-06	**The Trust will ensure that prevention is central to our emerging care models.**	*We will embed prevention in the development of all our models of care, both internally and with external partners, to address the wider determinants of health and causes of illness.*	**All**		Lucy Gardner			**2022-23**
		We will educate patients about the importance of a balanced nutritional diet and the benefits to their own health. We signpost vulnerable patients to food banks and other initiatives who have poor access to nutritional food.	**n/a**		Paul Fitzsimmons, Kimberly Salmon-Jamieson			**2022-23**

SCM-07	**The Trust will consider sustainability a factor in quality when designing care models.**	*We link sustainability as a dimension of quality with other dimensions of quality when we design/deliver/commission care models such as fairness/inequalities/social justice.*	**All**		Layla Alani			**Embed 2022-23 then ongoing**
SCM-08	**The Trust will ensure that staff are adequately trained to develop and implement sustainable care models.**	*We will provide training for our board on sustainable care models and how they are developed and deployed, we will also ensure that the Board level lead on Sustainable Development has an understanding of the role of sustainable care models.*	**All**		Sustainability Lead			2022-23
		We will refer to more holistically sustainable (clinically, socially, environmentally as well as financially) care models (or equivalent) in our staff induction and training.	**All**		Michelle Cloney			2022-23
SCM-09	**The Trust shall quantify the co-benefits of adopting sustainable care models.**	*We will quantify the direct health, social and financial co-benefits of some of our emerging and more sustainable care models.*	**n/a**		Sustainablity Lead			2024-25
		We will calculate the environmental / carbon impact of a specific care model(s), to helps identify the most impactful areas or hotspots which will allow us to minimise environmental impacts.	**All**		Sustainability Lead/Technical Lead			2023-24
SCM-10	**The Trust will adopt several principles to improve systems of care.**	*We will use a population needs assessment, JSNA or equivalent to help improve the local systems of care for which we are responsible, to be more clinically, social, environmentally and financially sustainable.*	**All**		Lucy Gardner			2022-23
		We will use a principle and process of using every contact (e.g. Make every contact count) to keep patients healthy, informed, in control, and independent (e.g. supporting patients to live more healthy and sustainable lives).	**All**		Paul Fitzsimmons, Kimberly Salmon-Jamieson			2023-24
SCM-11	**The Trust will integrate the NHS Constitution approach to sustainability into the values of the organisation.**	*We will ensure that the NHS Constitution approach (principle 6) to sustainability is explicitly reflected in the values/mission or definition of quality within the organisation.*	**n/a**		Layla Alani			2022-23
SCM-12	**The Trust will seek the views of patients, staff and local partners to improve services.**	*We will use specific mechanisms (e.g. patient engagement, better incentives, innovative use of technology) to test more sustainable care models.*	**n/a**		Alison Aspinall, Tom Poulter			2023-24
SCM-13	**The Trust will ensure that new sustainable care models developed are**	*We will incorporate resilience and flexibility explicitly in our emerging care models.*	**n/a**		Paul Fitzsimmons, Kimberly Salmon-Jamieson			2023-24
SCM-14	**The Trust will incorporate the sustainable use of resources into care models.**	*Sustainable use of resources will be embedded as a decision criterion in the development / commissioning of care models to measure and reduce the impact / cost of resource usage in health and care delivery (e.g. reducing volume and carbon intensive products, reducing waste and reducing toxic and hazardous substance use where possible).*	**All**		Paul Fitzsimmons, Kimberly Salmon-Jamieson			2023-24
SCM-15	**The Trust will share best practice and lessons learnt with other organisations.**	*We will capture and share our learning internally and externally, including our mistakes, to support future care models.*	**All**		Sustainability Lead			Ongoing
SCM-16	**The Trust will work to reduce carbon emissions created through the prescription and use of asthma inhalers**	*We will work to encourage, where clinically appropriate, the use of dry-powder inhalers (DPIs) in favour of metered dose inhalers (MDIs). Prescribing DPIs where clinically appropriate can significantly reduce CO2e emissions when compared to MDIs.*	**C**		Paul Fitzsimmons			2022-23
SCM-17	**The Trust will work to reduce carbon emissions created through the use of anaesthetic gases**	*We will work to encourage, where clinically appropriate, the use of Sevoflurane as the primary anaesthetic agent in favour of Desflurane. Using Sevoflurane where clinically appropriate can significantly reduce CO2e emissions when compared to Desflurane.*	**C**		Paul Fitzsimmons			2022-23

Carbon and Greenhouse Gases								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
GHG-01	**The Trust will work to reduce emissions from clinical sources**	*We will conduct an audit of anaesthetic gases and nitrous oxide emissions and identify ways to reduce emissions.*	**C**		Guy Hanson			2022-23
		We will encourage the use of low flow rates, where clincally appropriate, to improve efficiency and reduce emissions.	**C**		Guy Hanson			2022-23
GHG-02	**The Trust shall report progress against the Green Plan at least annually to staff, patients and the public.**	*We will report our carbon emissions and trend data to staff, patients and the public annually through our annual sustainability reporting (e.g. using the SDU sustainability reporting tool).*	**C**		Pat McLaren			Establish report 2022-23 then on going
		We will regularly benchmark our performance/approach to sustainable development and social value with similar organisations (e.g. on carbon reduction, resource use and GCC performance).	**C**		Sustainability Lead			Establish report 2022-23 then on going
GHG-03	**The Trust shall work to achieve carbon reductions through all estates investments.**	*We will seek to identify and maximise carbon reduction opportunities in all estates investments, particularly in energy and transport (Such as using the SDU Securing Healthy Returns tool).*	**C**		Ian Wright			22-23
GHG-04	**The Trust shall develop a communications plan to raise awareness of the importance of sustainability and encourage behaviour**	*We will communicate the value we place on being a low carbon organisation due to the adverse effects of climate change on human health to staff and patients.*	**C**		Pat McLaren			2022-23
		We will consistently encourage our staff and patients to consider reducing their carbon emissions from high impact activities such as air travel, vehicle use, energy use and food supply.	**C**		Pat McLaren			2022-23 then ongoing
GHG-05	**The Trust will work to understand the emissions from procurement of goods and services and implement actions to reduce them.**	*We will estimate the carbon emissions of our procurement to identify areas for targeted action (e.g. using the procurement 4 carbon reduction tool (P4CR).*	**C**		Technical Lead			2022-23
		We will identify which of the products and services that we source make the largest contributions to our overall carbon footprint (in use and/or embedded) and will identify interventions to reduce their impacts (e.g. by specifying lower carbon alternatives).	**C**		Technical Lead			2022-23
		We will identify our strategic suppliers and work with them to reduce the overall carbon impacts of the goods and services that they provide to our organisation.	**C**		Technical Lead			2023-24
		We will invite our providers and suppliers to disclose/share their organisation-wide carbon and other environmental impacts (e.g. NO2 and PM2.5) with us and encourage/support them to reduce these.	**C&A**		Technical Lead			2022-23
GHG-06	**The Trust shall quantify scope 2 and 3 emissions.**	*We will quantify our 'citizen' footprint; the carbon impact we have some influence over such as staff commuting habits and patient and visitor travel as well as staff home utility usage.*	**C**		Technical Lead			2022-23
GHG-07	**The Trust shall encourage staff and patients to make choices that consider the environmental impact, where appropriate.**	*We will make carbon emissions 'visible' in key identified high carbon activities where patient and staff choice is available to encourage behaviour change (e.g. choice of lease car, options for travel mode, use of dry power rather than metered dose inhalers, data heavy IT use, turning off lights/equipment).*	**C**		Sustainability Lead			2023-24
GHG-08	**The Trust shall integrate sustainability plans with other local organisations' plans.**	*We will work closely with other local agencies such as our local authority, universities and third sector organisations to contribute to the delivery of area wide carbon reduction strategies and plans.*	**C**		Lucy Gardner			Ongoing
	The Trust shall	*We shall imporve reporting of emissions from agregate sites and work to include these emissions inour carbon baseline.*	**C**		Technical Lead			2022-23

GHG-09	**expand the scope of the Carbon Baseline.**	*We will work to include Scope 2 and 3 emissions in our carbon baseline so that we can monitor our progress against the NHS carbon reduction targets more effectively.*	**C**		Technical Lead, Sustainability Lead			2022-23
GHG-10	**The Trust shall switch to renewable tarrifs.**	*We will change to a green electricity tarriff at all Trust owned sites, effective for the finiancial year 2021/2022.*	**C**		Ian Wright			23 -24

Our People								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
OP-01	**The Trust will continue to allow agile working and work from home to reduce staff travel.**	*We will establish a task and finish group to look at how working from home will be carried out in the medium and long term.*	**C&A**		Michelle Cloney			2022-23
		We will ensure that all suitable staff are able to work from home and have the correct equipment to do so safely, and in line with health and safety regulations.	**n/a**		Michelle Cloney			2022-23
		We will explore a use case to identify how working from home will be continued outsdie of the pandemic and analyse the costs and benefits to working from home both in terms of environmental and social ipact.	**All**		Michelle Cloney			2022-23
OP-02	**The Trust will ensure that staff support the relevant aspects of the Trust's sustainability agenda within their roles.**	*We shall look to embed sustainability into exisiting staff training provided at the Trust, for example staff inductions.*	**All**		Michelle Cloney			2022-23
OP-03	**The Trust will establish a staff sustainability network.**	*We will develop a staff sustainability network to encourage colleagues from all departments and bands to get involved in and champion our sustainability agenda.*	**All**		Sustainability Lead			2022-23
OP-04	**The Trust will run a communications programme to publicise our sustainbility ageneda and targets and involve staff at all**	*We will run a communications piece alongside the publication of our Green Plan to engage our workforce with our sustainability agenda and ecourage behavioural change.*	**All**		Pat McLaren			2022-23
		We will ensure that staff in lower bands feel they have permission to act in this area, for example switching lights off in their departments or reporting an issue such as a leaking tap.	**All**		Michelle Cloney			2022-23
OP-05	**The Trust will encourgage staff engagement with thesustainabity agenda by participating in national campaigns.**	*We will take part in at least one sustianbility related naitonal campagin per year, for example naitonal car free day.*	**All**		Michelle Cloney			2022-23 then ongoing
OP-06	**The Trust will seek to educate staff on the importance of becoming a more sustainable organisation.**	*We will provide Carbon Literacy training for staff to assist in the implementation of the Green Plan.*	**All**		Michelle Cloney			2022-23
OP-07	**The Turst will work to increase spend with SMEs.**	*We will conduct a review of our spend with SMEs and local suppliers within 25 miles.*	**All**		Alison Parker			2022-23
OP-08	**The Trust will seek to incorperate social responisibility clauses in procurement policices.**	*We will work to develop our understanding of social responsibility within procurement and idenity the most effective ways to incorperate this into our procurement policies.*	**n/a**		Alison Parker, Kelly Jones			2022-23
OP-09	**The Trust will provide relevant training for staff to promote sustainable behaviour**	*We will assess the training needs of our workforce and produce talent maps to identify potential to upskill staff and support succession planning.*	**All**		Michelle Cloney			2022-23
		We will agree an awareness raising programme focusing on increasing knowledge and understanding of sustainability and social value amongst our staff.	**All**		Michelle Cloney			2022-23
OP-10	**The Trust shall develop a communications plan to highlight the importance of sustainability at the Trust and enocurgae staff involvement**	*We will develop an active communications strategy linked with the Green Plan to raise awareness about sustainability at every level of the organisation.*	**All**		Pat McLaren			2022-23
		We will encourage our staff to be part of the organisation's sustainability agenda through an engaging and coordinated approach / campaign that staff can identify and contribute to.	**All**		Pat McLaren			2022-23
OP-11	**The Trust will develop an engagement programme to encourage staff to make more sustianable choices**	*We shall support healthy choices in all parts of the workplace, including off site, (e.g. an absence management policy, alcohol drugs and stress management strategies and promotion of healthy food choices).*	**n/a**		Michelle Cloney			2022-23
OP-12	**The Trust will continure to provide initiatives to imporve**	*We will provide support and schemes to all staff dependant on their specific needs (e.g. parents and carers and childcare vouchers, play areas, space for breastfeeding, school holiday play schemes or vouchers for these).*	**n/a**		Michelle Cloney			2022-23

OP-12	**Initiatives to improve staff helath and wellbeing.**	*We will monitor our staff's health and wellbeing through parameters include sickness absense, surveys and staff retention rate to ensure that our health and wellbeing strategies are improving the helath and wellbeing of our staff.*	**n/a**		Michelle Cloney			Ongoing
OP-13	**The Trust shall work with suppliers to ensure that they are working to improve equlaity and diversit in their organisation.**	*We will request access to our suppliers approaches to equality and diversity (e.g. staff diversity figures or % leaders that are female and/or from underrepresented groups).*	**n/a**		Alison Parker			2022-23
		Where appropriate we will ask prospective suppliers to confirm that they comply with the Modern Slavery Act 2015.	**n/a**		Alison Parker			2022-23
OP-14	**The Trust will work to improve employment oppourtunites.**	*We will develop schemes to help long-term unemployed people into work.*	**n/a**		Michelle Cloney			2022-23
		We will work with our local strategic partnership and other key partners to plan improved access to employment opportunities in our organisation.	**n/a**		Lucy Gardner			2022-23
		We will seek to become a living wage employer.	**n/a**		Michelle Cloney			2023-24

Sustainable Use of Resources								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
SR-01	**The Trust will review how waste is managed onsite and work to improve onsite segregation and**	*We will develop a larger waste compound to enable recycling to be segregated onsite.*			Ian Wright			2023-24
		We will compact cardboard packaging onsite to reduce the frequency of collection and improve recycling rates.			Ian Wright			2023-24
SR-02	**The Trust will seek to manage waste according to the waste heirarchy.**	*To reduce waste going to landfill, we will review how much waste goes to landfill and explore waste to energy alternatives for any waste which cannot be recycled, such as clinical waste.*			Ian Wright			2022-23
		We will take a pan-organisation approach to ensure a co-ordinated action on waste minimisation (e.g. procurement. FM, Pharmacy, clinicians etc.), and set specific waste minimisation targets for each area.			Ian Wright			2022-23
		We will engage with staff across all departments to identify high waste areas and identify specific solutions.			Ian Wright			2022-23
SR-03	**The Trust shall review the use of single use items within the organisation and work to reduce them.**	*We will explore the best practice for recycling waste textiles such as uniforms.*			Sustainability Lead			2022-23
		We shall review the use of single use PPE and explore reusable alternatives and greener waste treatment options where resuable options are not viable.			Ian Wright, Lesley McKay			2022-23
		We will explore ways to recycle disposbale curtains, such as the Sterimelt system.			Ian Wright			2023-24
		We will carry out a review of the single use products used within the Trust and work to identify alternative products.			Ian Wright			2022-23
SR-04	**The Turst shall explore reuse schemes for electronic waste.**	*We shall develop a system/process that identifies suitable opportunities to convert our WEEE waste into a resource. We will look to participate in a WEEE waste reuse scheme to reduce wate and reduce costs inline with our cost improvement plans.*			Ian Wright			2023-24
SR-05	**The Trust shall introduce recycling for food waste.**	*We shall work to identify a supplier to provide recycling of food waste from our hostpials, e.g. using anaerobic digestion or composting.*			Alison Parker, Ian Wright			2022-23
SR-06	**The Turst will work to reduce the impact of printing.**	*We will install a print manangment service to monitor printer use and drive a reduction in paper consumption.*			Tom Poulter			2023-24
		We will set all printers across the Trust to print in black and white and double sided as the default setting.			Tom Poulter			2022-24
		We will review the efficiency of our printers and look to uprgrade printers to more efficient models as required.			Tom Poulter			2023-24
SR-07	**The Trust shall continue to work to reduce paper consumption.**	*We shall optimise outpatient case notes by moving to an electronic system instead of the current paper case note system.*			Tom Poulter			2023-24
SR-08	**The Trust shall increase the use of electronic prescribing.**	*We shall roll out elelctronic prescribing in the final two areas to reduce prescirpiton charts and paper.*			Tom Poulter			2022-23
SR-09	**The Trust will reduce reliance on the Hospedia system.**	*We shall move towards patients bringing their own devices for entertainment whilst in hospital to improve the patient experince and improve efficiency.*			Jennifer McCartney			2022-23
SR-10	**The Trust will take measures to reduce pharmacy waste.**	*We will conduct an audit of medicines waste to ensure that they are being segregated correctly and identify any areas for imporvment.*			Diane Matthew			2022-23
		We will commit to using original pack dinspensing where clincally appropriate to reduce cardboard.			Diane Matthew			2022-23
		We will explore options to collect metered dose inhalers for suitable disposal to reduce emissions from landfill.			Diane Matthew, Ian Wright			2022-23
		We will use recylable paper bags instead of plastic bags for medicines.			Diane Matthew			2022-23

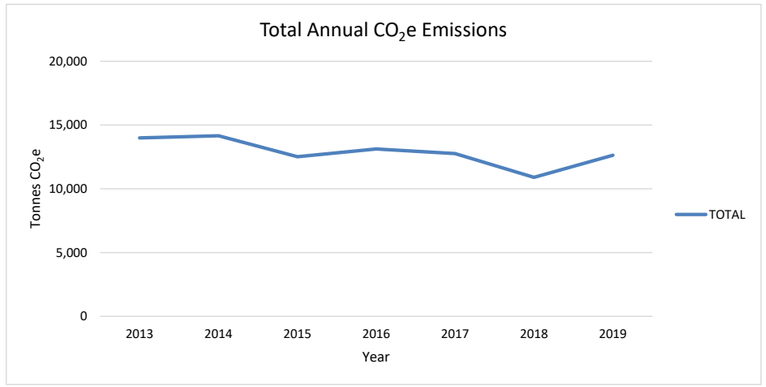
SR-11	**Pharmacy will engage with the Medical Gas Committee to imporve sustaianbility.**	*We will review and rationalise oxygen cylinders at Warrington Hospital, following the COVID-19 pandemic.*			Ian Wright, Diane Matthew			2022-23
SR-12	**The Trust will engage with suppliers to improve sustainability throughout the supply chain.**	*We will work with our suppliers to improve sustainability throughout the supply chain*			Alison Parker			Ongoing
SR-13	**The Trust will include a consideration of sustainability in the tender process.**	*We will ask to view suppliers' social and envionmental policies in bids.*			Alison Parker			2022-23
SR-14	**The Trust will review the ways in which waste can be reduced following the COVID-19 pandemic.**	*We will review how we can reduce waste whilst maintaining adequate levels of infection control.*			Lesley McKay			2022-23
SR-15		*We will seek to reduce single use items used due to the risk of the pandemic, e.g. going back to using handryers instead of paper towels.*			Lesley McKay			2022-23
SR-16	**The Trust will seek to reduce the amount of hazardous chemicals used on our estate.**	*We will work to minimise the use of harmful chemicals such as in cleaning products, and seek to find alternatives.*	n/a		Ian Wright			2022-23
		We will undertake an audit to understand how many of the products we procure contain hazardous substance and use our findings to develop initiatives to replace these where possible with non-toxic or less hazardous alternatives.	n/a		Ian Wright			2022-23
		We will work with our onsite contractors to ensure they also help reduce our use of hazardous/toxic chemicals.	n/a		Ian Wright			2022-23
		We will monitor our progress to ensure that our approach is continual reduction in levels of hazardous substances and chemicals in our estate relative to the size of our organisation.	n/a		Ian Wright			2023-24
SR-17	**The Trust shall publish a waste management plan.**	*We will develop a resource and waste management action plan to apply the waste minimisation hierarchy in our organisations as requirement under the Waste Regulations (England and Wales) 2011.*	Waste		Ian Wright			2022-23
SR-18	**The Trust will work to reduce waste across all areas of the organisaiton.**	*We will increase the capture and monitoring of waste outputs and their associated costs (carbon, financial and social) across different parts of the organisation.*	Waste		Ian Wright			Establish framework 2022-23
		We will continue to use stock management and streamlining of products to reduce waste produced across all areas of the organisation (e.g. Pharmacy, Catering - e.g. the Green Kitchen Standard, FM etc.).	Waste		Alison Parker			2022-23
SR-19	**The Trust shall work collaboratively with our supply chain to reduce waste and improve resource managemnt.**	*We will work with our supply chain to maximise repair and reuse onsite of durable goods within our organisation (e.g. furniture, IT, building materials, walking aids and reusable medical devices).*	Waste		Alison Parker			2023-24
		We will collaborate and engage with other local organisations to share best practice of sustainable use of resources and maximise opportunities (e.g. through frameworks that assess sustainability, combined procurement processes and furniture/equipment re-use scheme).	Waste		Lucy Gardner			2022-23
SR-20	**The Trust will encourage staff to make sustianbel decisions at home.**	*We will engage with our staff to support them to minimise waste and expense at home (e.g. through swap shops, repair facilities, encouragement to recycle or reuse).*	Waste		Michelle Cloney			2022-23
		We will communicate the benefits of sustainable products and services to our employees, to encourage staff to maximise similar benefits at home.	Waste		Michelle Cloney			2022-23
SR-21	**The Trust will work with the Nutrition Team to improve the sustainability of food at the Trust.**	*We will set targets to increase the amount of healthy and sustainable food choices in our organisation, including from catering services as well as on sale to staff, patients and public in vending machines and retail outlets located within our estate.*	Waste		Ian Wright			2022-23
		We will review our catering contracts to include a requirement to maximise the use of fresh and seasonal food to reduce the need for transportantion.	Waste		Ian Wright			2022-23
		We will work with external stakeholders to encourage greater provision of healthy and sustainable food choices more widely in the local area.	Waste		Lucy Gardner			2022-23
		We will track the food miles, consumption patterns and disposal of food and drink products for staff and patients to reduce the environments of catering and food.	Waste		Sustainability Lead			2022-23

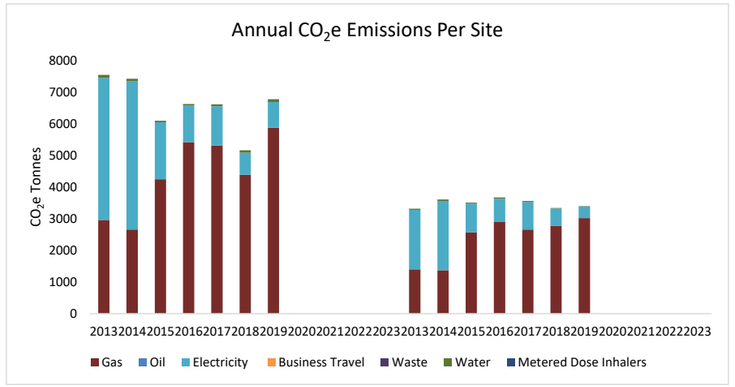
CARBON FOOTPRINT ANALYSIS

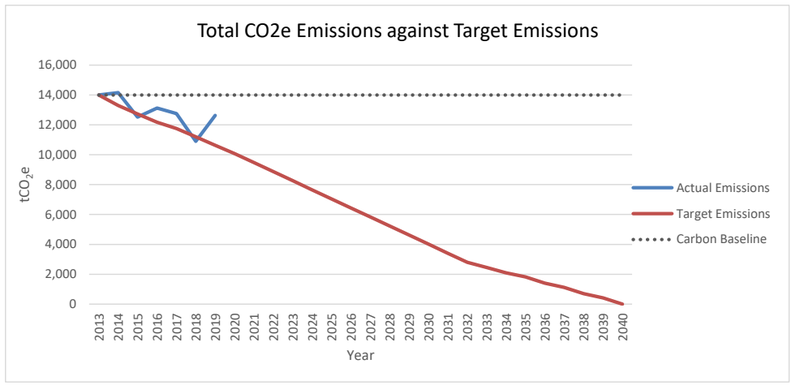
tCO2e/annum

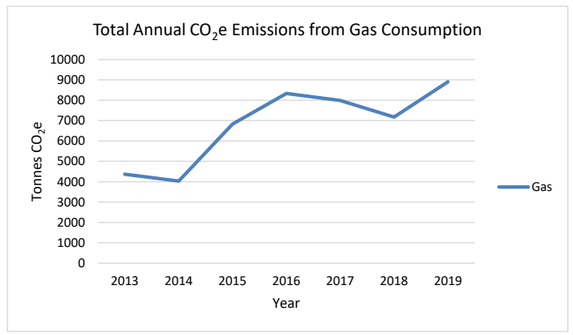
			Gas	Oil	Anaesthetics	Electricity	Business Travel	Waste	Water	Metered Dose Inhalers	TOTAL
		2013	2963.126	0		4,501			94		4,501
		2014	2660.268	0		4,706			65		4,706
		2015	4256.576	0		1,799			51		1,799
		2016	5427.833	0		1,154			52		1,154
		2017	5322.372	0		1,243			56		1,243
		2018	4395.567	0		702			74		702
		2019	5883.215	0		814			87		814
		2020	0	0		0			0		0
		2021	0	0		0			0		0
		2022	0	0		0			0		0
		2023	0	0		0			0		0
		2013	1404.271	0		1,884			31		1,884
		2014	1371.9	0		2,196			44		2,196
		2015	2576.081	0		907			32		907
		2016	2904.522	0		735			38		735
		2017	2664.492	0		865			38		865
		2018	2779.902	0		547			18		547
		2019	3021.974	0		367			16		367
		2020	0	0		0			0		0
		2021	0	0		0			0		0
		2022	0	0		0			0		0
		2023	0	0		0			0		0
		2013	4367.397	0	2,933	6,385	103	56	124.52	28	13,997
		2014	4032.168	0	2,933	6,902	101	52	109.56	28	14,158
		2015	6832.657	0	2,743	2,706	99	23	83.23	34	12,521
		2016	8332.354	0	2,512	1,889	100	163	89.50	37	13,123
		2017	7986.864	0	2,425	2,108	86	26	93.36	35	12,760
		2018	7175.468	0	2,229	1,249	88	26	92.09	40	10,899
		2019	8905.188	0	2,292	1,182	72	30	103.57	47	12,632
		2020	0	0	917	0	0	0	0	44	961
		2021	0	0	217	0	0	0	0	7	224
		2022	0	0	0	0	0	0	0	0	0
		2023	0	0	0	0	0	0	0	0	0

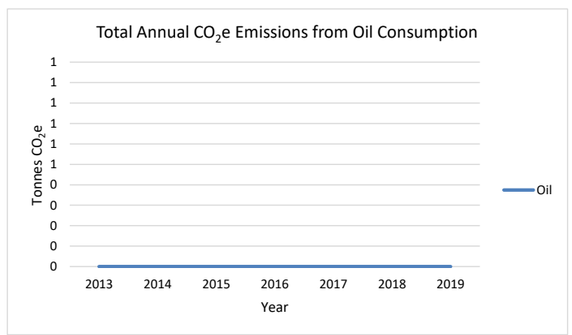
NHS Emissions Targets					
	Year	Baseline	Percentage Reduction	Actual Emissions	Required Reduction
Total	2013	13997	0	13,997	13997
	2014	13997	5	14,158	13297
	2015	13997	9	12,521	12737
	2016	13997	13	13,123	12177
	2017	13997	16	12,760	11757
	2018	13997	20	10,899	11198
	2019	13997	24	12,632	10638
	2020	13997	28	961	10078
	2021	13997	32	224	9472
	2022	13997	37	0	8865
	2023	13997	41	0	8259
	2024	13997	45	0	7652
	2025	13997	50	0	7046
	2026	13997	54	0	6439
	2027	13997	58	0	5833
	2028	13997	63	0	5226
	2029	13997	67	0	4620
	2030	13997	71	0	4013
	2031	13997	76	0	3407
	2032	13997	80	0	2799
	2033	13997	82	0	2450
	2034	13997	85	0	2100
	2035	13997	87	0	1820
	2036	13997	90	0	1400
	2037	13997	92	0	1120
	2038	13997	95	0	700
	2039	13997	97	0	420
	2040	13997	100	0	0

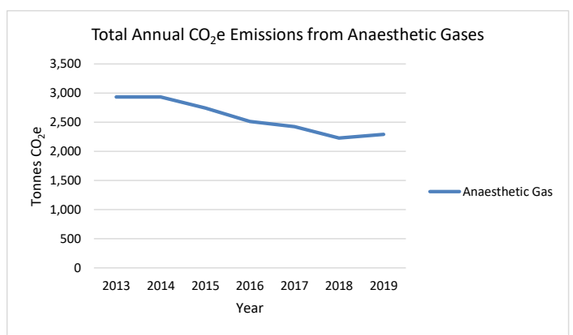

Total Annual CO_2e Emissions
Tonnes CO_2e
20,000
15,000
10,000
5,000
0
2013 2014 2015 2016 2017 2018 2019
Year
TOTAL

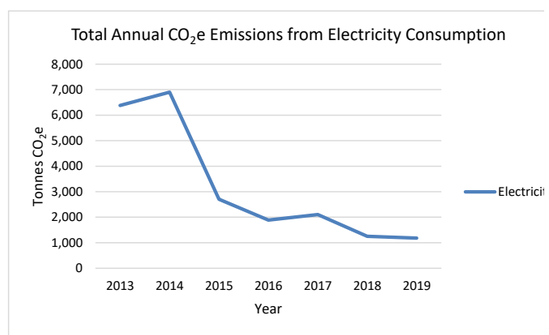

Annual CO_2e Emissions Per Site
CO_2e Tonnes
8000
7000
6000
5000
4000
3000
2000
1000
0
2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023
Gas
Oil
Electricity
Business Travel
Waste
Water
Metered Dose Inhalers

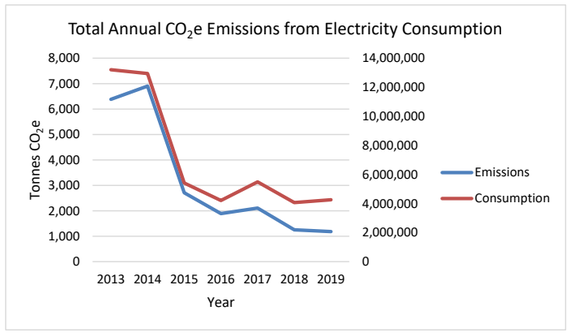

Total CO2e Emissions against Target Emissions
tCO_2e
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040
Year
Actual Emissions
Target Emissions
Carbon Baseline

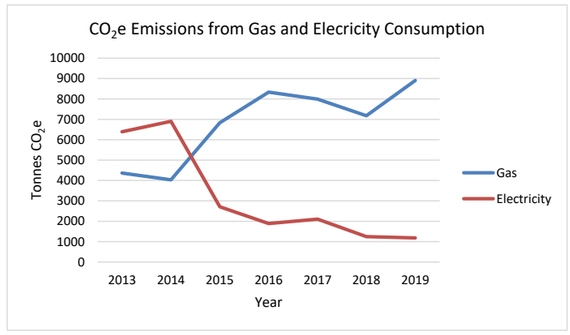

Total Annual CO_2e Emissions from Gas Consumption
Tonnes CO_2e
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
2013 2014 2015 2016 2017 2018 2019
Year
Gas

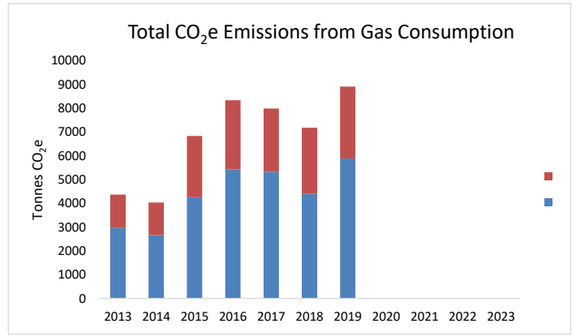

Total Annual CO_2e Emissions from Oil Consumption
Tonnes CO_2e
1
1
1
1
1
1
0
0
0
0
0
0
2013 2014 2015 2016 2017 2018 2019
Year
Oil

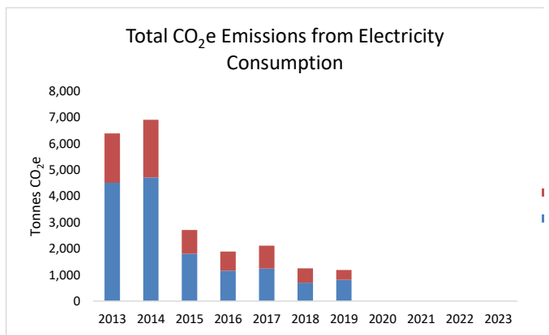

Total Annual CO_2e Emissions from Anaesthetic Gases
Tonnes CO_2e
3,500
3,000
2,500
2,000
1,500
1,000
500
0
2013 2014 2015 2016 2017 2018 2019
Year
Anaesthetic Gas


Total Annual CO_2e Emissions from Electricity Consumption
Tonnes CO_2e
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
2013 2014 2015 2016 2017 2018 2019
Year
Electricit

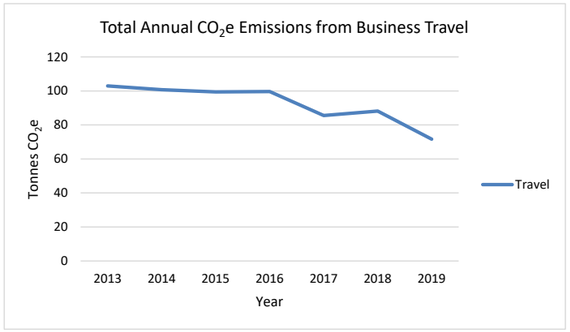

Total Annual CO_2e Emissions from Electricity Consumption
Tonnes CO_2e
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
14,000,000
12,000,000
10,000,000
8,000,000
6,000,000
4,000,000
2,000,000
0
2013 2014 2015 2016 2017 2018 2019
Year
Emissions
Consumption

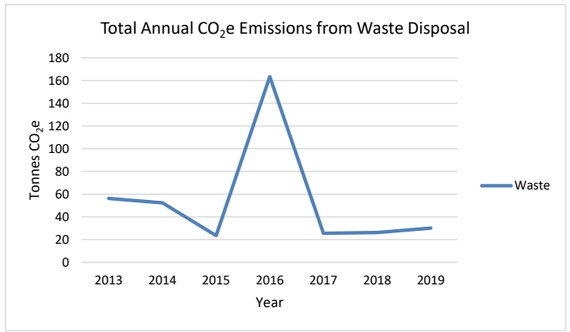

CO_2e Emissions from Gas and Elecricity Consumption
Tonnes CO_2e
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
2013 2014 2015 2016 2017 2018 2019
Year
Gas
Electricity

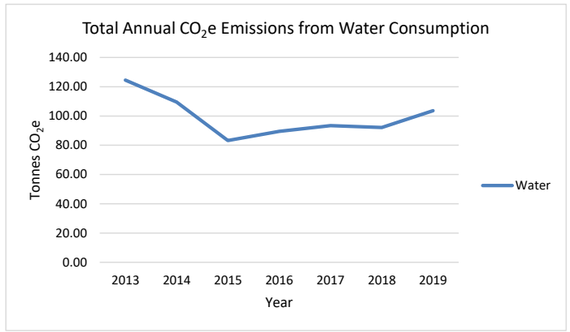

Total CO_2e Emissions from Gas Consumption
Tonnes CO_2e
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023

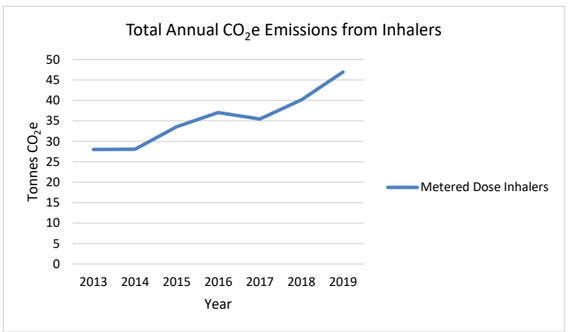

Total CO_2e Emissions from Electricity Consumption
Tonnes CO_2e
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023

ty


Total Annual CO_2e Emissions from Business Travel
Tonnes CO_2e
120
100
80
60
40
20
0
2013
2014
2015
2016
2017
2018
2019
Year
Travel


Total Annual CO_2e Emissions from Waste Disposal
Tonnes CO_2e
180
160
140
120
100
80
60
40
20
0
2013
2014
2015
2016
2017
2018
2019
Year
Waste


Total Annual CO_2e Emissions from Water Consumption
Tonnes CO_2e
140.00
120.00
100.00
80.00
60.00
40.00
20.00
0.00
2013
2014
2015
2016
2017
2018
2019
Year
Water


Total Annual CO_2e Emissions from Inhalers
Tonnes CO_2e
50
45
40
35
30
25
20
15
10
5
0
2013
2014
2015
2016
2017
2018
2019
Year
Metered Dose Inhalers

GAS USE ANALYSIS

Annual Consumption

		Annual Consumption (kWh)	
Warrington	W	2013	16,100,443
		2014	14,381,925
		2015	23,077,127
		2016	29,499,090
		2017	28,900,803
		2018	23,894,143
		2019	32,000,079
		2020	
		2021	
		2022	
		2023	
Halton	H	2013	7,630,251
		2014	7,416,760
		2015	13,966,283
		2016	15,785,445
		2017	14,468,353
		2018	15,111,446
		2019	16,437,170
		2020	
		2021	
		2022	
		2023	
Total		2013	23,730,694
		2014	21,798,685
		2015	37,043,410
		2016	45,284,535
		2017	43,369,156
		2018	39,005,589
		2019	48,437,249
		2020	0
		2021	0
		2022	0
		2023	0

CARBON FACTORS

2013-14

Fuel	Unit	kg CO_2e		
Natural Gas	kWh (Net CV)	n/a		kgCO_2e/kWh
	kWh (Gross CV)	0.18404	Total CO_2e	0.18404

2014-15

Fuel	Unit	kg CO_2e		
Natural Gas	kWh (Net CV)	n/a		kgCO_2e/kWh
	kWh (Gross CV)	0.18497	Total CO_2e	0.184973

2015-16

Fuel	Unit	kg CO_2e		
Natural Gas	kWh (Net CV)	n/a		kgCO_2e/kWh
	kWh (Gross CV)	0.18445	Total CO_2e	0.18445

2016-17

Fuel	Unit	kg CO_2e		
Natural Gas	kWh (Net CV)	0.20444		kgCO_2e/kWh
	kWh (Gross CV)	0.184	Total CO_2e	0.184

2017-18

Fuel	Unit	kg CO_2e		
Natural Gas	kWh (Net CV)	0.20463		kgCO_2e/kWh
	kWh (Gross CV)	0.18416	Total CO_2e	0.18416

2018-19

Fuel	Unit	kg CO_2e		
Natural Gas	kWh (Net CV)	0.20437		kgCO_2e/kWh
	kWh (Gross CV)	0.18396	Total CO_2e	0.18396

2019-20

Fuel	Unit	kg CO_2e		
Natural Gas	kWh (Net CV)	0.20428		kgCO_2e/kWh
	kWh (Gross CV)	0.18385	Total CO_2e	0.18385

2020-21

Fuel	Unit	kg CO_2e		
Natural Gas	kWh (Net CV)	0.20374		kgCO_2e/kWh
	kWh (Gross CV)	0.18387	Total CO_2e	0.18387

Annual CO_2e emissions

		Annual Emissions tCO_2e	
Warrington	W	2013	2,963
		2014	2,660
		2015	4,257
		2016	5,428
		2017	5,322
		2018	4,396
		2019	5,883
		2020	0
		2021	0
		2022	0
		2023	0
Halton	H	2013	1,404
		2014	1,372
		2015	2,576
		2016	2,905
		2017	2,664
		2018	2,780
		2019	3,022
		2020	0
		2021	0
		2022	0
		2023	0
Total		2013	4,367
		2014	4,032
		2015	6,833
		2016	8,332
		2017	7,987
		2018	7,175
		2019	8,905
		2020	0
		2021	0
		2022	0
		2023	0

2021-22

Fuel	Unit	kg CO_2e
Natural Gas	kWh (Net CV)	0.20297
	kWh (Gross CV)	0.18316

	$kgCO_2e/kWh$
Total CO_2e	0.18316

2022-23

Fuel	Unit	kg CO_2e
Natural Gas	kWh (Net CV)	
	kWh (Gross CV)	

	$kgCO_2e/kWh$
Total CO_2e	0

2023-24

Fuel	Unit	kg CO_2e
Natural Gas	kWh (Net CV)	
	kWh (Gross CV)	

	$kgCO_2e/kWh$
Total CO_2e	0

2024-25

Fuel	Unit	kg CO_2e
Natural Gas	kWh (Net CV)	
	kWh (Gross CV)	

	$kgCO_2e/kWh$
Total CO_2e	0

OIL USE ANALYSIS

Annual Consumption

Annual Consumption (kWh)

Warrington	W	2013	0
		2014	0
		2015	0
		2016	0
		2017	0
		2018	0
		2019	0
		2020	
		2021	
		2022	
		2023	
Halton	H	2013	0
		2014	0
		2015	0
		2016	0
		2017	0
		2018	0
		2019	0
		2020	
		2021	
		2022	
		2023	
Total		2013	0
		2014	0
		2015	0
		2016	0
		2017	0
		2018	0
		2019	0
		2020	
		2021	
		2022	
		2023	

CARBON FACTORS

2013-14

Fuel	Unit	kg CO_2e		
Gas Oil	kWh (Net CV)	0.28895		$kgCO_2e/kWh$
	kWh (Gross CV)	0.27176	Total CO_2e	0.27176

2014-15

Fuel	Unit	kg CO_2e		
Gas Oil	kWh (Net CV)	0.289492		$kgCO_2e/kWh$
	kWh (Gross CV)	0.272123	Total CO_2e	0.272123

2015-16

Fuel	Unit	kg CO_2e		
Gas Oil	kWh (Net CV)	2.28832		$kgCO_2e/kWh$
	kWh (Gross CV)	0.27101	Total CO_2e	0.27101

2016-17

Fuel	Unit	kg CO_2e		
Gas Oil	kWh (Net CV)	0.29395		$kgCO_2e/kWh$
	kWh (Gross CV)	0.27631	Total CO_2e	0.27631

2017-18

Fuel	Unit	kg CO_2e		
Gas Oil	kWh (Net CV)	0.28499		$kgCO_2e/kWh$
	kWh (Gross CV)	0.26789	Total CO_2e	0.26789

2018-19

Fuel	Unit	kg CO_2e		
Gas Oil	kWh (Net CV)	0.28544		$kgCO_2e/kWh$
	kWh (Gross CV)	0.26831	Total CO_2e	0.26831

2019-20

Fuel	Unit	kg CO_2e		
Gas Oil	kWh (Net CV)	0.27315		$kgCO_2e/kWh$
	kWh (Gross CV)	0.25676	Total CO_2e	0.25676

Annual CO_2e Emissions

Annual Emissions tCO_2e

Warrington	W	2013	0
		2014	0
		2015	0
		2016	0
		2017	0
		2018	0
		2019	0
		2020	
		2021	
		2022	
		2023	
Halton	H	2013	0
		2014	0
		2015	0
		2016	0
		2017	0
		2018	0
		2019	0
		2020	
		2021	
		2022	
		2023	
Total		2013	0
		2014	0
		2015	0
		2016	0
		2017	0
		2018	0
		2019	0
		2020	
		2021	
		2022	
		2023	

2020-21

Fuel	Unit	kg CO_2e
Gas Oil	kWh (Net CV)	0.2731
	kWh (Gross CV)	0.25672

	$kgCO_2e/kWh$
Total CO_2e	0.25672

2021-22

Fuel	Unit	kg CO_2e
Gas Oil	kWh (Net CV)	0.27318
	kWh (Gross CV)	0.25679

	$kgCO_2e/kWh$
Total CO_2e	0.25679

2022-23

Fuel	Unit	kg CO_2e
Gas Oil	kWh (Net CV)	
	kWh (Gross CV)	

	$kgCO_2e/kWh$
Total CO_2e	0

2023-24

Fuel	Unit	kg CO_2e
Gas Oil	kWh (Net CV)	
	kWh (Gross CV)	

	$kgCO_2e/kWh$
Total CO_2e	0

2024-25

Fuel	Unit	kg CO_2e
Gas Oil	kWh (Net CV)	
	kWh (Gross CV)	

	$kgCO_2e/kWh$
Total CO_2e	0

ANAESTHETIC GAS USE ANALYSIS

SEVOFLURANE BOTTLE NUMBER RAW DATA

		Bottles
Warrington	W	2013 - 14
		2014 - 15	49
		2015 - 16	139
		2016 - 17	121
		2017 - 18	192
		2018 - 19	204
		2019 - 20	129
		2020 - 21	35
		2021 - 22	7
		2022 - 23	
		2023 - 24	
		2024 - 25	
Total		2013 - 14	
		2014 - 15	49
		2015 - 16	139
		2016 - 17	121
		2017 - 18	192
		2018 - 19	204
		2019 - 20	129
		2020 - 21	35
		2021 - 22	7
		2022 - 23	0
		2023 - 24	0
		2024 - 25	0

DESFLURANE BOTTLE NUMBER RAW DATA

		Bottles
Warrington	W	2013 - 14
		2014 - 15	1233
		2015 - 16	1154
		2016 - 17	1057
		2017 - 18	1017
		2018 - 19	931
		2019 - 20	963
		2020 - 21	384
		2021 - 22	92
		2022 - 23	
		2023 - 24	
		2024 - 25	
Total		2013 - 14	
		2014 - 15	1,233
		2015 - 16	1,154
		2016 - 17	1,057
		2017 - 18	1,017
		2018 - 19	931
		2019 - 20	963
		2020 - 21	384
		2021 - 22	92
		2022 - 23	0
		2023 - 24	0
		2024 - 25	0

ISOFLURANE BOTTLE NUMBER RAW DATA

		Bottles
Warrington	W	2013 - 14
		2014 - 15	40
		2015 - 16	11
		2016 - 17	11
		2017 - 18	3
		2018 - 19	9
		2019 - 20	11
		2020 - 21	13
		2021 - 22	0
		2022 - 23	
		2023 - 24	
		2024 - 25	
Total		2013 - 14	
		2014 - 15	40
		2015 - 16	11
		2016 - 17	11
		2017 - 18	3
		2018 - 19	9
		2019 - 20	11
		2020 - 21	13
		2021 - 22	0
		2022 - 23	0
		2023 - 24	0
		2024 - 25	0

SEVOFLURANE CARBON EMISSIONS

		tCO_2e
Warrington	W	2013 - 14
		2014 - 15	8
		2015 - 16	24
		2016 - 17	21
		2017 - 18	33
		2018 - 19	35
		2019 - 20	22
		2020 - 21	6
		2021 - 22	1
		2022 - 23	0
		2023 - 24	0
		2024 - 25	0
Total		2013 - 14	
		2014 - 15	8
		2015 - 16	24
		2016 - 17	21
		2017 - 18	33
		2018 - 19	35
		2019 - 20	22
		2020 - 21	6
		2021 - 22	1
		2022 - 23	0
		2023 - 24	0
		2024 - 25	0

DESFLURANE CARBON EMISSIONS

		tCO_2e
Warrington	W	2013 - 14
		2014 - 15	2,898
		2015 - 16	2,712
		2016 - 17	2,484
		2017 - 18	2,390
		2018 - 19	2,188
		2019 - 20	2,263
		2020 - 21	902
		2021 - 22	216
		2022 - 23	0
		2023 - 24	0
		2024 - 25	0
Total		2013 - 14	
		2014 - 15	2,898
		2015 - 16	2,712
		2016 - 17	2,484
		2017 - 18	2,390
		2018 - 19	2,188
		2019 - 20	2,263
		2020 - 21	902
		2021 - 22	216
		2022 - 23	0
		2023 - 24	0
		2024 - 25	0

ISOFLURANE CARBON EMISSIONS

		tCO_2e
Warrington	W	2013 - 14
		2014 - 15	27
		2015 - 16	7
		2016 - 17	7
		2017 - 18	2
		2018 - 19	6
		2019 - 20	7
		2020 - 21	9
		2021 - 22	0
		2022 - 23	0
		2023 - 24	0
		2024 - 25	0
Total		2013 - 14	
		2014 - 15	27
		2015 - 16	7
		2016 - 17	7
		2017 - 18	2
		2018 - 19	6
		2019 - 20	7
		2020 - 21	9
		2021 - 22	0
		2022 - 23	0
		2023 - 24	0
		2024 - 25	0

TOTAL CARBON EMISSIONS

		tCO_2e
Warrington	W	2013 - 14	2,933
		2014 - 15	2,933
		2015 - 16	2,743
		2016 - 17	2,512
		2017 - 18	2,425
		2018 - 19	2,229
		2019 - 20	2,292
		2020 - 21	917
		2021 - 22	217
		2022 - 23	0
		2023 - 24	0
		2024 - 25	0
Total		2013 - 14	2,933
		2014 - 15	2,933
		2015 - 16	2,743
		2016 - 17	2,512
		2017 - 18	2,425
		2018 - 19	2,229
		2019 - 20	2,292
		2020 - 21	917
		2021 - 22	217
		2022 - 23	0
		2023 - 24	0
		2024 - 25	0

ELECTRICITY USE ANALYSIS

Annual Consumption

Annual Consumption (kWh)

Warrington	W	2013	9,308,044
		2014	8,822,293
		2015	3,595,609
		2016	2,569,171
		2017	3,234,476
		2018	2,283,620
		2019	2,937,230
		2020	
		2021	
		2022	
		2023	
Halton	H	2013	3,896,400
		2014	4,116,662
		2015	1,811,952
		2016	1,635,884
		2017	2,249,690
		2018	1,781,757
		2019	1,325,206
		2020	
		2021	
		2022	
		2023	
Total		2013	13,204,444
		2014	12,938,955
		2015	5,407,561
		2016	4,205,055
		2017	5,484,166
		2018	4,065,377
		2019	4,262,436
		2020	0
		2021	0
		2022	0
		2023	0

CARBON FACTORS

2013-14

Activity	Country	Unit	kg CO_2e	
Electricity generated	Electricity: UK	kWh	0.44548	kgCO_2e/kWh
			Total CO_2e	0.48357
Activity	Type	Unit	kg CO_2e	
T&D- UK electricity	Electricity: UK	kWh	0.03809	

2014-15

Activity	Country	Unit	kg CO_2e	
Electricity generated	Electricity: UK	kWh	0.49023	kgCO_2e/kWh
			Total CO_2e	0.53345
Activity	Type	Unit	kg CO_2e	
T&D- UK electricity	Electricity: UK	kWh	0.04322	

2015-16

Activity	Country	Unit	kg CO_2e	
Electricity generated	Electricity: UK	kWh	0.46219	kgCO_2e/kWh
			Total CO_2e	0.50035
Activity	Type	Unit	kg CO_2e	
T&D- UK electricity	Electricity: UK	kWh	0.03816	

2016-17

Activity	Country	Unit	kg CO_2e	
Electricity generated	Electricity: UK	kWh	0.41205	kgCO_2e/kWh
			Total CO_2e	0.44932
Activity	Type	Unit	kg CO_2e	
T&D- UK electricity	Electricity: UK	kWh	0.03727	

2017-18

Activity	Country	Unit	kg CO_2e	
Electricity generated	Electricity: UK	kWh	0.35156	kgCO_2e/kWh
			Total CO_2e	0.38443
Activity	Type	Unit	kg CO_2e	
T&D- UK electricity	Electricity: UK	kWh	0.03287	

2018-19

Activity	Country	Unit	kg CO_2e	
Electricity generated	Electricity: UK	kWh	0.28307	kgCO_2e/kWh
			Total CO_2e	0.3072
Activity	Type	Unit	kg CO_2e	
T&D- UK electricity	Electricity: UK	kWh	0.02413	

2019-20

Activity	Country	Unit	kg CO_2e	
Electricity generated	Electricity: UK	kWh	0.2556	kgCO_2e/kWh
			Total CO_2e	0.2773
Activity	Type	Unit	kg CO_2e	
T&D- UK electricity	Electricity: UK	kWh	0.0217	

2020-21

Activity	Country	Unit	kg CO_2e	
Electricity generated	Electricity: UK	kWh	0.2331	kgCO_2e/kWh
			Total CO_2e	0.25315
Activity	Type	Unit	kg CO_2e	

Annual CO_2e emissions

Annual Emissions tCO_2e

Warrington	W	2013	4,501
		2014	4,706
		2015	1,799
		2016	1,154
		2017	1,243
		2018	702
		2019	814
		2020	0
		2021	0
		2022	0
		2023	0
Halton	H	2013	1,884
		2014	2,196
		2015	907
		2016	735
		2017	865
		2018	547
		2019	367
		2020	0
		2021	0
		2022	0
		2023	0
Total		2013	6,385
		2014	6,902
		2015	2,706
		2016	1,889
		2017	2,108
		2018	1,249
		2019	1,182
		2020	0
		2021	0
		2022	0
		2023	0

T&D- UK electricity	Electricity: UK	kWh	0.02005

2021-22

Activity	Country	Unit	kg CO_2e		
Electricity generated	Electricity: UK	kWh			$kgCO_2e/kWh$
				Total CO_2e	0
Activity	Type	Unit	kg CO_2e		
T&D- UK electricity	Electricity: UK	kWh			

2022-23

Activity	Country	Unit	kg CO_2e		
Electricity generated	Electricity: UK	kWh			$kgCO_2e/kWh$
				Total CO_2e	0
Activity	Type	Unit	kg CO_2e		
T&D- UK electricity	Electricity: UK	kWh			

2023-24

Activity	Country	Unit	kg CO_2e		
Electricity generated	Electricity: UK	kWh			$kgCO_2e/kWh$
				Total CO_2e	0
Activity	Type	Unit	kg CO_2e		
T&D- UK electricity	Electricity: UK	kWh			

2024-25

Activity	Country	Unit	kg CO_2e		
Electricity generated	Electricity: UK	kWh			$kgCO_2e/kWh$
				Total CO_2e	0
Activity	Type	Unit	kg CO_2e		
T&D- UK electricity	Electricity: UK	kWh			

BUSINESS TRAVEL ANALYSIS

Annual Consumption

Annual Consumption miles

Total		2013	322,856
		2014	322,856
		2015	322,856
		2016	322,856
		2017	286,259
		2018	297,992
		2019	246,155
		2020	
		2021	
		2022	
		2023	
	Total	2013	322,856
		2014	322,856
		2015	322,856
		2016	322,856
		2017	286,259
		2018	297,992
		2019	246,155
		2020	0
		2021	0
		2022	0
		2023	0

CARBON FACTORS

2013-14

Fuel	Unit	kg CO_2e		kgCO_2e/kWh
Petrol	miles	0.31883	Total CO_2e	0.318827

2014-15

Fuel	Unit	kg CO_2e		kgCO_2e/kWh
Petrol	miles	0.31202	Total CO_2e	0.31202

2015-16

Fuel	Unit	kg CO_2e		kgCO_2e/kWh
Petrol	miles	0.3078	Total CO_2e	0.307803

2016-17

Fuel	Unit	kg CO_2e		kgCO_2e/kWh
Petrol	miles	0.3088	Total CO_2e	0.30875

2017-18

Fuel	Unit	kg CO_2e		kgCO_2e/kWh
Petrol	miles	0.29881	Total CO_2e	0.29881

2018-19

Fuel	Unit	kg CO_2e		kgCO_2e/kWh
Petrol	miles	0.29561	Total CO_2e	0.29561

2019-20

Fuel	Unit	kg CO_2e		kgCO_2e/kWh
Petrol	miles	0.29103	Total CO_2e	0.29103

Annual CO_2e emissions

Annual Emissions tCO_2e

Total		2013	103
		2014	101
		2015	99
		2016	100
		2017	86
		2018	88
		2019	72
		2020	0
		2021	0
		2022	0
		2023	0
	Total	2013	103
		2014	101
		2015	99
		2016	100
		2017	86
		2018	88
		2019	72
		2020	0
		2021	0
		2022	0
		2023	0

2020-21

Fuel	Unit	kg CO_2e
Petrol	miles	0.2805

Total CO_2e — $kgCO_2e/kWh$ 0.28052

2021-2022

Fuel	Unit	kg CO_2e
Petrol	miles	0.2805

Total CO_2e — $kgCO_2e/kWh$ 0.28053

2022-23

Fuel	Unit	kg CO_2e
Petrol	miles	

Total CO_2e — $kgCO_2e/kWh$ 0

2023-24

Fuel	Unit	kg CO_2e
Petrol	miles	

Total CO_2e — $kgCO_2e/kWh$ 0

2024-25

Fuel	Unit	kg CO_2e
Petrol	miles	

Total CO_2e — $kgCO_2e/kWh$ 0

INHALER EMISSIONS ANALYSIS

Annual CO_2e emissions

Annual Emissions tCO_2e			Total
Total		2013	
		2014	28.1
		2015	33.6
		2016	37.0
		2017	35.5
		2018	40.1
		2019	46.9
		2020	44.0
		2021	7.0
		2022	
		2023	
Total		2013	28
		2014	28
		2015	34
		2016	37
		2017	35
		2018	40
		2019	47
		2020	44
		2021	7
		2022	0
		2023	0

Annual Consumption

Annual Waste (Tonnes)

W	2013	2,638
	2014	2,458
	2015	1,102
	2016	7,667
	2017	1,202
	2018	1,228
	2019	1,409
	2020	0
	2021	0
	2022	0
	2023	0
Total	2013	2,638
	2014	2,458
	2015	1,102
	2016	7,667
	2017	1,202
	2018	1,228
	2019	1,409
	2020	0
	2021	0
	2022	0
	2023	0

CARBON FACTORS

Incineration:	21.317
Alternative Treatment :	21.317
Landifll:	458.176
WEEE:	21.317
Recovery:	21.317
Recycling:	21.317
Compost:	10.204

Annual Emissions

Annual Emissions (tCO_2e)

W	2013	56
	2014	52
	2015	23
	2016	163
	2017	26
	2018	26
	2019	30
	2020	0
	2021	0
	2022	0
	2023	0
Total	2013	56
	2014	52
	2015	23
	2016	163
	2017	26
	2018	26
	2019	30
	2020	0
	2021	0
	2022	0
	2023	0

WATER USE ANALYSIS

Annual Consumption

Annual Consumption (m_3)

Warrington	W	2013	89235
		2014	61994
		2015	48663
		2016	49066
		2017	53074
		2018	70211
		2019	82961
		2020	
		2021	
		2022	
		2023	
Halton	H	2013	29060
		2014	42087
		2015	30455
		2016	36008
		2017	35673
		2018	17325
		2019	15493
		2020	
		2021	
		2022	
		2023	
Total		2013	118,295
		2014	104,081
		2015	79,118
		2016	85,074
		2017	88,747
		2018	87,536
		2019	98,454
		2020	0
		2021	0
		2022	0
		2023	0

CARBON FACTORS

2013-14

Type	Unit	kg CO2e
Supply	cubic metres	0.3441
Treatment	cubic metres	0.7085

Total CO_2e 1.0526 $kgCO_2e/m^3$

2014-15

Type	Unit	kg CO2e
Supply	cubic metres	0.3441
Treatment	cubic metres	0.7085

Total CO_2e 1.0526 $kgCO_2e/m^3$

2015-16

Type	Unit	kg CO2e
Supply	cubic metres	0.344
Treatment	cubic metres	0.708

Total CO_2e 1.052 $kgCO_2e/m^3$

2016-17

Type	Unit	kg CO2e
Supply	cubic metres	0.344
Treatment	cubic metres	0.708

Total CO_2e 1.052 $kgCO_2e/m^3$

2017-18

Type	Unit	kg CO2e
Supply	cubic metres	0.344
Treatment	cubic metres	0.708

Total CO_2e 1.052 $kgCO_2e/m^3$

2018-19

Type	Unit	kg CO2e
Supply	cubic metres	0.344
Treatment	cubic metres	0.708

Total CO_2e 1.052 $kgCO_2e/m^3$

2019-20

Type	Unit	kg CO2e
Supply	cubic metres	0.344
Treatment	cubic metres	0.708

Total CO_2e 1.052 $kgCO_2e/m^3$

Annual CO_2e Emissions

Annual Emissions (tCO_2e)

Warrington	W	2013	94
		2014	65
		2015	51
		2016	52
		2017	56
		2018	74
		2019	87
		2020	0
		2021	0
		2022	0
		2023	0
Halton	H	2013	31
		2014	44
		2015	32
		2016	38
		2017	38
		2018	18
		2019	16
		2020	0
		2021	0
		2022	0
		2023	0
Total		2013	125
		2014	110
		2015	83
		2016	89
		2017	93
		2018	92
		2019	104
		2020	0
		2021	0
		2022	0
		2023	0

2020-21

Type	Unit	kg CO2e
Supply	cubic metres	0.344
Treatment	cubic metres	0.708

Total CO_2e 1.052 $kgCO_2e/m^3$

2021-22

Type	Unit	kg CO2e
Supply	cubic metres	0.149
Treatment	cubic metres	0.272

Total CO_2e 0.421 $kgCO_2e/m^3$

2022-23

Type	Unit	kg CO2e
Supply	cubic metres	
Treatment	cubic metres	

Total CO_2e 0 $kgCO_2e/m^3$

2023-24

Type	Unit	kg CO2e
Supply	cubic metres	
Treatment	cubic metres	

Total CO_2e 0 $kgCO_2e/m^3$

2024-25

Type	Unit	kg CO2e
Supply	cubic metres	
Treatment	cubic metres	

Total CO_2e 0 $kgCO_2e/m^3$

INHALER EMISSIONS DATA SHEET

Inhaler	Brand Name	Drug Class	Device	Aerosol, Soft Mist Inhaler, DPI	Estimated carbon footprint per 28 days (gCO2e)
ACLIDINIUM 322 micrograms Inhaler 60 Dose Pack	Eklira Genuair 322micrograms	LAMA	Genuair	DPI	1,050
ANORO 55 / 22 micrograms Powder for Inhalation Ellipta Inhaler 30 Dose Pack	Anoro Ellipta 55 micrograms/22 micrograms	LABA/LAMA	Ellipta	DPI	525
BECLOMETASONE (QVAR) 100 micrograms per metered inhalation Autohaler 200 Dose Pack	Qvar Autohaler 100 microgram	ICS	Autohaler	Aerosol	5,698
BECLOMETASONE CFC Free (CLENIL MODULITE) 100 micrograms per metered dose MDI 200 Dose Inhaler	Clenil Modulite 100 microgram	ICS	MDI	Aerosol	5,698
BECLOMETASONE CFC Free (CLENIL MODULITE) 200 micrograms per metered dose MDI 200 Dose Inhaler	Clenil Modulite 200 microgram	ICS	MDI	Aerosol	5,698
BECLOMETASONE CFC Free (CLENIL MODULITE) 250 micrograms per metered dose MDI 200 Dose Inhaler	Clenil Modulite 250 microgram	ICS	MDI	Aerosol	5,698
BECLOMETASONE CFC Free (CLENIL MODULITE) 50 micrograms per metered dose MDI 200 Dose Inhaler	Clenil Modulite 50 microgram	ICS	MDI	Aerosol	11,396
BECLOMETASONE CFC Free (QVAR) 100 micrograms per metered inhalation MDI 200 Dose Pack	Qvar 100 microgram	ICS	MDI	Aerosol	5,698
BECLOMETASONE CFC Free (QVAR) 50 micrograms per metered inhalation MDI 200 Dose Inhaler	Qvar 50 microgram	ICS	MDI	Aerosol	5,698
BECLOMETASONE CFC Free EASI-BREATHE (QVAR) 100 micrograms per metered inhalation Inhaler 200 Dose Inhaler	Qvar Easi-Breathe 100 microgram	ICS	Easi-Breathe	Aerosol	5,698
BECLOMETASONE CFC Free EASI-BREATHE (QVAR) 50 micrograms per metered inhalation Inhaler 200 Dose Inhaler	Qvar Easi-Breathe 50 microgram	ICS	Easi-Breathe	Aerosol	5,698
BECLOMETASONE Rotahaler 1 Rotahaler Pack	Beclometasone Rotahaler	ICS	Rotahaler	DPI	Not available
BUDESONIDE 100 micrograms per metered dose Easyhaler 200 Dose Inhaler	Easyhaler Budesonide 100 microgram	ICS	Easyhaler	DPI	1,050
BUDESONIDE 100 micrograms Turbohaler 200 Dose Inhaler	Pulmicort Turbohaler 100 microgram	ICS	Turbohaler	DPI	1,050
BUDESONIDE 200 micrograms per metered dose Easyhaler 200 Dose Inhaler	Easyhaler Budesonide 200 microgram	ICS	Easyhaler	DPI	1,050
BUDESONIDE 200 micrograms Turbohaler 100 Dose Inhaler	Pulmicort Turbohaler 200 microgram	ICS	Turbohaler	DPI	1,050
BUDESONIDE 400 micrograms per metered dose Easyhaler 100 Dose Inhaler	Easyhaler Budesonide 400 microgram	ICS	Easyhaler	DPI	525
BUDESONIDE 400 micrograms Turbohaler 50 Dose Inhaler	Pulmicort Turbohaler 400 microgram	ICS	Turbohaler	DPI	525
CICLESONIDE (CFC FREE) 160 micrograms per metered dose Inhaler 120 Dose Inhaler	Alvesco 160 microgram	ICS	MDI	Aerosol	2,849
CICLESONIDE (CFC FREE) 80 micrograms per metered dose Inhaler 120 Dose Inhaler	Alvesco 80 microgram	ICS	MDI	Aerosol	2,849
DUAKLIR 340 / 12 micrograms Powder for Inhalation Genuair Inhaler 60 Dose Pack	Duaklir Genuair 340micrograms/12micrograms	LABA/LAMA	Genuair	DPI	1,050
DUORESP 160 / 4.5 micrograms (Budesonide / Formoterol) Spiromax Inhaler 120 Dose Pack	DuoResp Spiromax 160/4.5 microgram	ICS/LABA	Spiromax	DPI	1,050
FLUTICASONE 125 micrograms per metered dose Evohaler 120 Dose Inhaler	Flixotide Evohaler 125 micrograms	ICS	MDI	Aerosol	11,396
FLUTICASONE 250 micrograms Accuhaler 60 Dose Pack	Flixotide Accuhaler 250 micrograms	ICS	Accuhaler	DPI	1,050
FLUTICASONE 250 micrograms per metered dose Evohaler 120 Dose Pack	Flixotide Evohaler 250 micrograms	ICS	MDI	Aerosol	11,396
FLUTICASONE 50 micrograms Accuhaler 60 Dose Pack	Flixotide Accuhaler 50 micrograms	ICS	Accuhaler	DPI	1,050
FLUTICASONE 50 micrograms per metered dose Evohaler 120 Dose Inhaler	Flixotide Evohaler 50 micrograms	ICS	MDI	Aerosol	11,396
FLUTICASONE 500 micrograms per metered dose Accuhaler 60 Dose Inhaler	Flixotide Accuhaler 500 micrograms	ICS	Accuhaler	DPI	1,050
FLUTIFORM (FLUTICASONE / FORMOTEROL) 125 / 5 micrograms Inhaler 120 Dose Pack	Flutiform 125/5 microgram	ICS/LABA	MDI	Aerosol	33,040
FLUTIFORM (FLUTICASONE / FORMOTEROL) 250 / 10 micrograms Inhaler 120 Dose Pack	Flutiform 250/10 microgram	ICS/LABA	MDI	Aerosol	33,040
FLUTIFORM (FLUTICASONE / FORMOTEROL) 50 / 5 micrograms Inhaler 120 Dose Pack	Flutiform 50/5 microgram	ICS/LABA	MDI	Aerosol	33,040
FORMOTEROL 12 micrograms per metered dose Easyhaler 120 Dose Inhaler	Easyhaler Formoterol 12 microgram	LABA	Easyhaler	DPI	1,050
FORMOTEROL FUMARATE 12 micrograms Inhaler 56 Dose Inhaler	Formoterol Fumarate 12mcg Inhaler (56 dose)	LABA	(not specified)	(not specified)	Not available
FORMOTEROL Fumarate 12 micrograms per metered dose (EFORMOTEROL) Turbohaler 60 Dose Inhaler	Oxis Turbohaler 12 microgram	LABA	Turbohaler	DPI	1,050
FORMOTEROL Fumarate 6 micrograms per metered dose (EFORMOTEROL) Turbohaler 60 Dose Inhaler	Oxis Turbohaler 6 microgram	LABA	Turbohaler	DPI	1,050
FOSTAIR 100 / 6 micrograms (Beclometasone / Formoterol) MDI 120 Dose Pack	Fostair 100/6 microgram	ICS/LABA	MDI	Aerosol	18,312
FOSTAIR 100 / 6 micrograms (Beclometasone / Formoterol) NEXThaler 120 Dose Pack	Fostair Nexthaler 100/6 microgram	ICS/LABA	NEXThaler	DPI	2,100
FOSTAIR 200 / 6 micrograms (Beclometasone / Formoterol) MDI 120 Dose Pack	Fostair 200/6 microgram	ICS/LABA	MDI	Aerosol	18,312
FOSTAIR 200 / 6 micrograms (Beclometasone / Formoterol) NEXThaler 120 Dose Pack	Fostair Nexthaler 200/6 microgram	ICS/LABA	NEXThaler	DPI	2,100
GLYCOPYRRONIUM Device with Inhalation Capsules 44 micrograms Breezhaler 1 Breezhaler & 30 Capsules Pack	Seebri Breezhaler 44 microgram, hard capsules	LAMA	Breezhaler	DPI	525

INDACATEROL Device with Inhalation Capsules 150 micrograms Breezhaler 1 Breezhaler & 30 Capsules Pack	Onbrez Breezhaler 150 microgram, hard capsules	LABA	Breezhaler	DPI	525
IPRATROPIUM Bromide 20 micrograms per metered dose Inhaler 200 Dose Inhaler	Atrovent 20 microgram	SAMA	MDI	Aerosol	6,006
IPRATROPIUM Bromide 20 micrograms per metered dose Inhaler 200 Dose Overlabelled Discharge Pack	Atrovent 20 microgram	SAMA	MDI	Aerosol	6,006
NEDOCROMIL 2 mg per metered dose Inhaler (CFC Free) 112 Dose Pack	Tilade CFC-Free Inhaler 2 mg per actuation pressurised inhalation suspension	Cromoglicate	MDI	Aerosol	33040
RELVAR 184 / 22 micrograms Powder for Inhalation Ellipta Inhaler 30 Dose Pack	Relvar Ellipta 184/22 micrograms	ICS/LABA	Ellipta	DPI	525
RELVAR 92 / 22 micrograms Powder for Inhalation Ellipta Inhaler 30 Dose Pack	Relvar Ellipta 92/22 micrograms	ICS/LABA	Ellipta	DPI	525
SALBUTAMOL (AIROMIR) 100 micrograms per metered dose Inhaler 200 Dose Inhaler	Airomir 100 microgram	SABA	MDI	Aerosol	778
SALBUTAMOL (ASMASAL) 95 micrograms per metered dose Inhaler 200 Dose Pack	Asmasal Clickhaler	SABA	MDI	Aerosol	Not available
SALBUTAMOL (CFC Free) 100 micrograms per metered dose Inhaler 200 Dose Inhaler	Salamol 100 microgram	SABA	MDI	Aerosol	778
SALBUTAMOL (CFC Free) 100 micrograms per metered dose Inhaler 200 Dose Overlabelled Discharge Pack	Salamol 100 microgram	SABA	MDI	Aerosol	778
SALBUTAMOL 100 micrograms per metered dose Autohaler 200 Dose Inhaler	Airomir Autohaler 100 microgram	SABA	Autohaler	Aerosol	778
SALBUTAMOL 100 micrograms per metered dose Easyhaler 200 Dose Inhaler	Easyhaler Salbutamol 100 microgram	SABA	Easyhaler	DPI	300
SALBUTAMOL 200 micrograms per metered dose Accuhaler 60 Dose Pack	Ventolin Accuhaler 200 microgram	SABA	Accuhaler	DPI	150
SALBUTAMOL EASI-BREATHE (CFC Free) 100 micrograms per metered dose Inhaler 200 Dose Inhaler	Salamol Easi-Breathe 100 microgram	SABA	Easi-Breathe	Aerosol	778
SALBUTAMOL Rotahaler 1 Rotahaler Pack	Salbutamol Rotahaler	SABA	Rotahaler	DPI	Not available
SALMETEROL (CFC Free) 25 micrograms Inhaler 120 Dose Inhaler	Serevent Evohaler 25 microgram	LABA	MDI	Aerosol	14,560
SALMETEROL 50 micrograms per metered dose Accuhaler 60 Dose Inhaler	Serevent Accuhaler 50 microgram	LABA	Accuhaler	DPI	1,050
SERETIDE 100 (Salmeterol 50 micrograms / Fluticasone 100 micrograms) Accuhaler 60 Dose Pack	Seretide Accuhaler 50/100 microgram	ICS/LABA	Accuhaler	DPI	1,050
SERETIDE 125 (Salmeterol 25 micrograms / Fluticasone 125 micrograms) Evohaler 120 Dose Pack	Seretide Evohaler 25/125 microgram	ICS/LABA	MDI	Aerosol	18,312
SERETIDE 250 (Salmeterol 25 micrograms / Fluticasone 250 micrograms) Evohaler 120 Dose Pack	Seretide Evohaler 25/250 microgram	ICS/LABA	MDI	Aerosol	18,312
SERETIDE 250 (Salmeterol 50 micrograms / Fluticasone 250 micrograms) Accuhaler 60 Dose Pack	Seretide Accuhaler 50/250 microgram	ICS/LABA	Accuhaler	DPI	1,050
SERETIDE 50 (Salmeterol 25 micrograms / Fluticasone 50 micrograms) Evohaler 120 Dose Pack	Seretide Evohaler 25/50 microgram	ICS/LABA	MDI	Aerosol	18,312
SERETIDE 500 (Salmeterol 50 micrograms / Fluticasone 500 micrograms) Accuhaler 60 Dose Pack	Seretide Accuhaler 50/500 microgram	ICS/LABA	Accuhaler	DPI	1,050
SPIOLTO 2.5 / 2.5 micrograms (Respimat) Inhalation Solution 60 Dose Device + Refill Pack	Spiolto Respimat 2.5 microgram/2.5 microgram, Device + Refill Cartridge	LABA/LAMA	Respimat	SMI	728
SPIOLTO 2.5 / 2.5 micrograms (Respimat) Inhalation Solution 60 Dose Refill Pack	Spiolto Respimat 2.5 microgram/2.5 microgram, Refill Cartridge	LABA/LAMA	Respimat	SMI	728
SPIOLTO. 2.5 / 2.5 micrograms (Respimat) Inhalation Solution 1 Device & Cartridge Pack	Spiolto Respimat 2.5 microgram/2.5 microgram, Device + Refill Cartridge	LABA/LAMA	Respimat	SMI	728
SYMBICORT 100 / 6 Turbohaler 120 Dose Pack	Symbicort 100/6 microgram Turbohaler	ICS/LABA	Turbohaler	DPI	2,100
SYMBICORT 200 / 6 Turbohaler 120 Dose Pack	Symbicort 200/6 microgram Turbohaler	ICS/LABA	Turbohaler	DPI	2,100
SYMBICORT 400 / 12 Turbohaler 60 Dose Pack	Symbicort 400/12 microgram Turbohaler	ICS/LABA	Turbohaler	DPI	1,050
TERBUTALINE 500 micrograms per metered dose Turbohaler 100 Dose Inhaler	Bricanyl Turbohaler 500 microgram	SABA	Turbohaler	DPI	150
TERBUTALINE 500 micrograms per metered dose Turbohaler 120 Dose Inhaler	Bricanyl Turbohaler 500 microgram	SABA	Turbohaler	DPI	150
TIOTROPIUM 18 micrograms Handihaler & Inhalation Caps. 1 Device Pack	Spiriva Powder for Inhalation Capsules 18 microgram + HandiHaler	LAMA	HandiHaler	DPI	525
TIOTROPIUM 18 micrograms Inhalation Capsules 30 Inhalation Capsule Pack	Spiriva Powder for Inhalation Capsules 18 microgram	LAMA	HandiHaler	DPI	525
TIOTROPIUM 2.5 micrograms (Respimat) Inhalation Solution 60 Dose Device + Refill Pack	Spiriva Respimat 2.5 microgram Device + Refill Cartridge	LAMA	Respimat	SMI	728
TIOTROPIUM 2.5 micrograms (Respimat) Inhalation Solution 60 Dose Pack	Spiriva Respimat 2.5 microgram Device + Refill Cartridge	LAMA	Respimat	SMI	728
TRELEGY 92 / 55 / 22 micrograms Powder for Inhalation Ellipta Inhaler 30 Dose Pack	Trelegy Ellipta 92 micrograms/55 micrograms/22 micrograms	ICS/LABA/LAMA	Ellipta	DPI	525
TRIMBOW 87 / 5 / 9 micrograms MDI 120 Dose Pack	Trimbow 87 micrograms/5 micrograms/9 micrograms pressurised inhalation, solution	ICS/LABA/LAMA	MDI	Aerosol	18,312
ULTIBRO Device with Inhalation Capsules 85 micrograms / 43 micrograms Breezhaler 1 Breezhaler & 30 Capsules Pack	Ultibro Breezhaler 85micrograms/43micrograms hard capsules	LABA/LAMA	Breezhaler	DPI	525
UMECLIDINIUM 55 micrograms Powder for Inhalation Ellipta Inhaler 30 Dose Pack	Incruse Ellipta 55micrograms	LAMA	Ellipta	DPI	525

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/34**	
SUBJECT:	**Trust Engagement Dashboard Q3 2021-22 Oct-Dec**	
DATE OF MEETING:	30th Marcch 2022	
AUTHOR(S):	James Bates, Interim Head of Communications	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications & Engagement	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X X X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	NA	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The new format Engagement Dashboard is for the period Oct-Dec 2021 inclusive (Q3) and is now linked to the CQC's Well Led Framework (KLOE 7) It also incorporates Engagement and Involvement activity for the first time. The dashboard provides metrics relating to: • Level of success in managing the Trust's reputation in the media and across digital and social platforms • Our engagement and involvement with patients, staff and public via our social media channels • The Trust's website and levels engagement with this key platform • Patient enquiries via our website • Patient/public feedback on the independent platforms (recent addition of GOOGLE) • NEW Patient and Public Involvement and Participation, including our new Experts by Experience programme • NEW Staff Communications **Media** 1. **Covid-19 data from our hospitals** remains a key item of interest among our local and regional media. We continue to publish key Covid-19 stats on our website at 1pm daily which are reported on weekly in local outlets. 2. **Media** **186 media articles/broadcast items about the Trust in Q3. This included two broadcast visits from SKY News and one from BBC.** **Sentiment** - much positive media coverage relating to key initiatives including: a. Dr AlJafari Retirement b. Patient Safety Awards WHH Highly Commended c. Nurse recruitment event d. New Acute Respiratory Unit	

<table>
<tr><td></td><td colspan="4">
e. WHH Charity REMEMBRANCE GARDEN
f. Major Expansion for Warrington Hospital AE
g. WHH Remembers
h. Farewell to Wingman at Warrington
i. Health and wellbeing hub gets approval
j. Neonatal Teddy donation - Charity
k. Habab Clinical Education Centre opening
l. Hospital visiting open for Christmas

Social Media
1. During Q3, there were a total of 1,288 social posts across three social media channels (Facebook, Twitter and Instagram)
2. WHH social media channels reached an audience of over 4.2m, with a combined following of 25k

Website
1. Website visits - average around 30K visitors per month with a peak of 50K in December.
2. Website pages: This quarter ‘COVID-19 current status’ was the most visited web page with 30K views. The peak was Wednesday 29 December 2021.
3. Website referrals: 57.14% of visits came directly from Google
4. Patient/visitor enquiries through the website totalled 711 for the period – this is approximately half that of the summer 2021 – a good indicator that visitors are able to locate content easily and a new FAQs page is helping.

Patient Feedback
1. During Q3, there were 26 reviews about the Trust on key feedback platforms of which 84% were positive. In addition to the traditional platforms (NHS Choices, Care Opinion and I Want Great Care) Google reviews are becoming more commonly used
2. Healthwatch continues to collect ratings on healthcare services in each borough, Halton Hospital is at 4.5* from 66 reviews, RUTC is at 4.5* from 16 reviews and Warrington Hospital is at 3* based on 17 reviews
</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information
X</td><td>Approval</td><td>To note
X</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to note the Engagement dashboard and new metrics linked to KLOE7 in the CQC’s Well Led framework.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Choose an item.</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">Choose an item.</td></tr>
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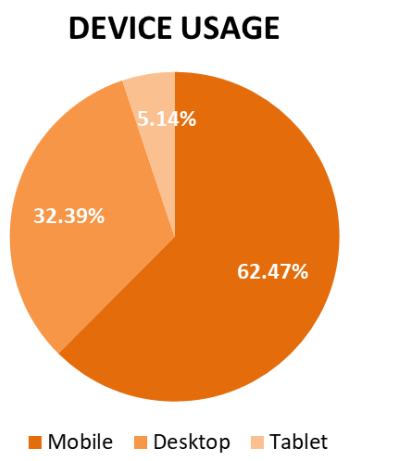
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

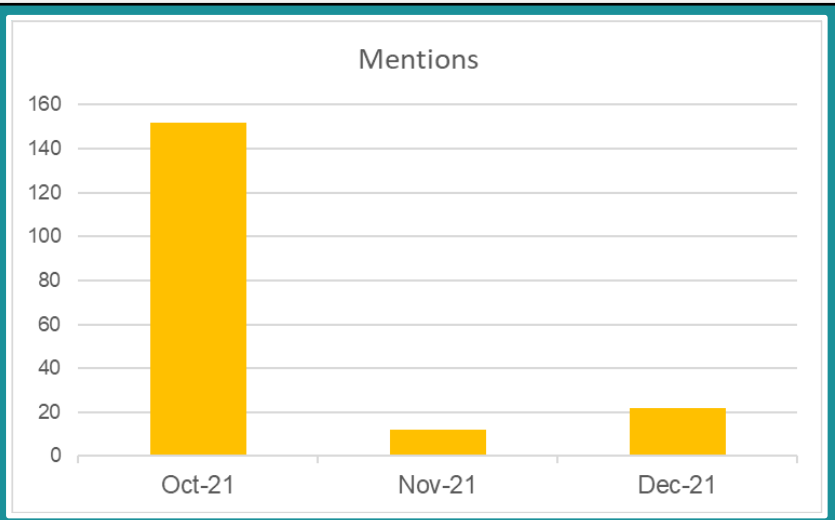
WHH Communications, Engagement and Involvement

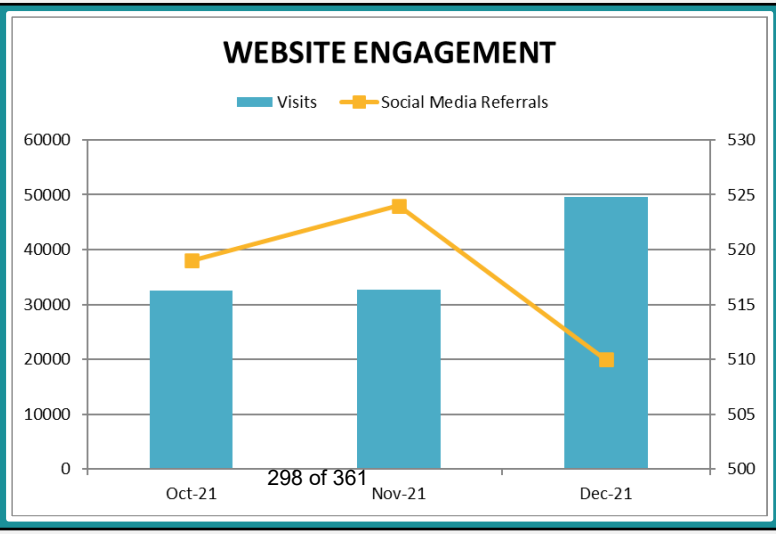
Dashboard Q3 2021-22

‘Well-Led’ KLOE 7: Communicating with the Public

Metric	Media coverage Visits to the public website
Current Performance	During Q3, there were 186 **media** articles/broadcast items about the Trust. **Top positive news stories:** • *Breast cancer treatment boost after £3m Halton Hospital investment* • *Thank you to amazing intensive care staff who treated my wife* **Most viewed/shared negative news stories**: NIL Website: ‘COVID-19 current status’ continues to be the most visited **website** pages, followed by Maternity Services
Actions / Comments	• During Q3 we continued with an alternative media monitoring system – a new supplier commenced in February 2022 and metrics will be significantly more detailed from Q4 • Media coverage was largely positive in the quarter, mainly attributed to the new Breast Centre. • This quarter ‘COVID-19 current status’ was the most visited web page with 30,323 views. The peak was Wednesday 29 December 2021. • 57.14% of those visits came directly from Google and via mobile devices.







Website visits: most popular sections	262,863
/	37,381
/Covid-19 status	30,323
/Maternity	8,691
/Contact us	8,140
/Services	6,290
/Ward contact numbers	6,069
/Blood test clinics	5,920
/Urgent treatment centre runcorn	5,699
/home	5,166
/Work at WHH	5,095

‘Well-Led’ KLOE 7: Communicating with the public

Metric	Social media posts, engagement and sentiment
Current Performance	During Q3, there were a total of 1,288 social posts across three social media channels (Facebook, Twitter and Instagram) WHH social media channels reached an audience of over 4.2m, with a combined following of 25k

Top Posts for Engagement

HEADLINE	SOURCE	
HILLMOUNT CHESHIRE HOSTS SANTA GROTTO FOR WARRINGTON HOSPITAL	Warrington Guardian	
WARRINGTON HOSPITAL NURSE WINS ROYAL COLLEGE OF NURSING AWARD	Warrington Guardian	
WARRINGTON HOSPITAL STARTS MAJOR A&E EXPANSION	Insider Media Limited	

Top Tweet earned 14.3K impressions

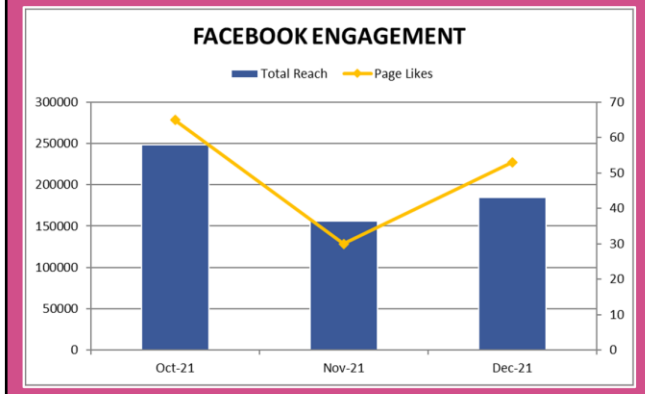
Kylie Leuluai @WarringtonRLFC is encouraging fans to get boosted,
"It is important for the rugby league family to look after each other and by getting the booster you are doing that."

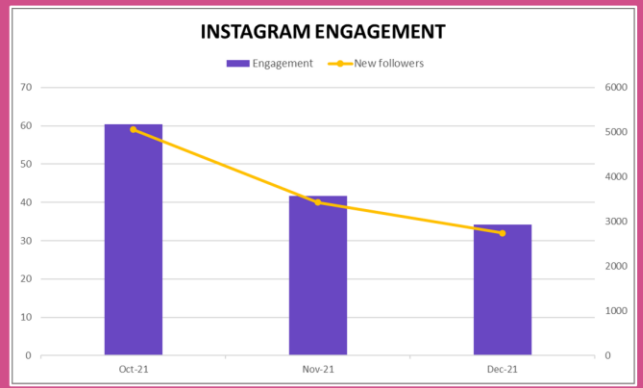
There are Covid-19 boosters available at WHH by booking on: ow.ly/hj5a50Hl4kx
pic.twitter.com/wZbtphFxno

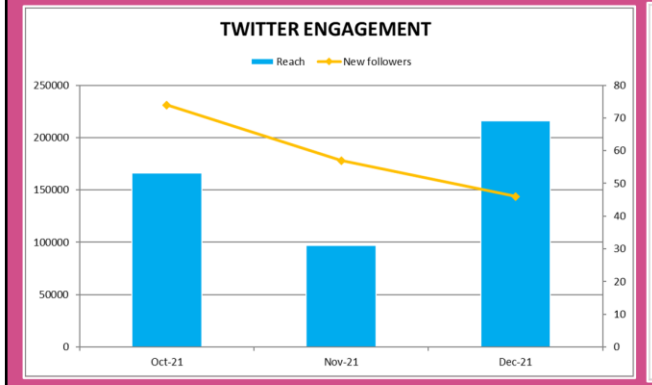
Top FB post

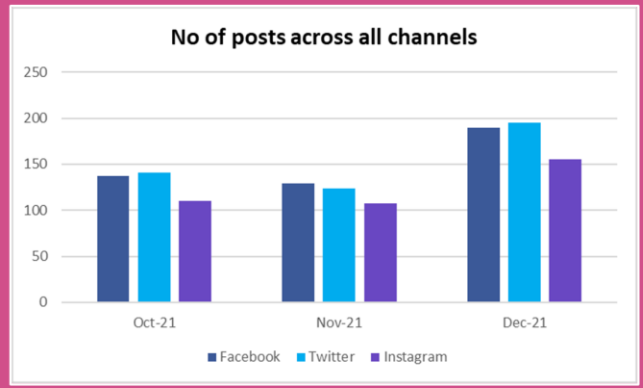
Reach 4[illegible]05

Calling all Nurses 🏥 Come along to our Recruitment Open Day on 28th October



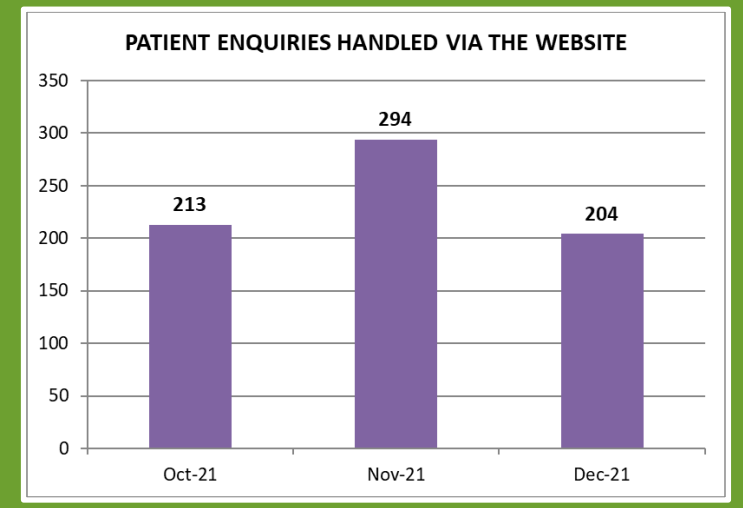






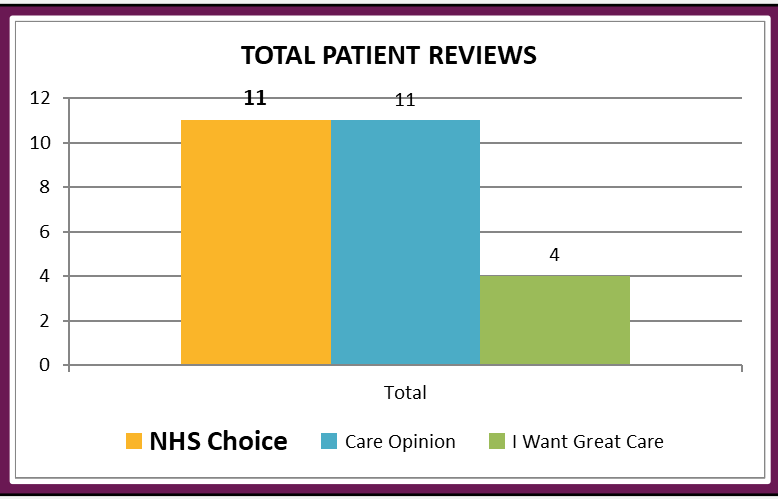
‘Well-Led’ KLOE 7Metrics: Engaging with and Involving our community

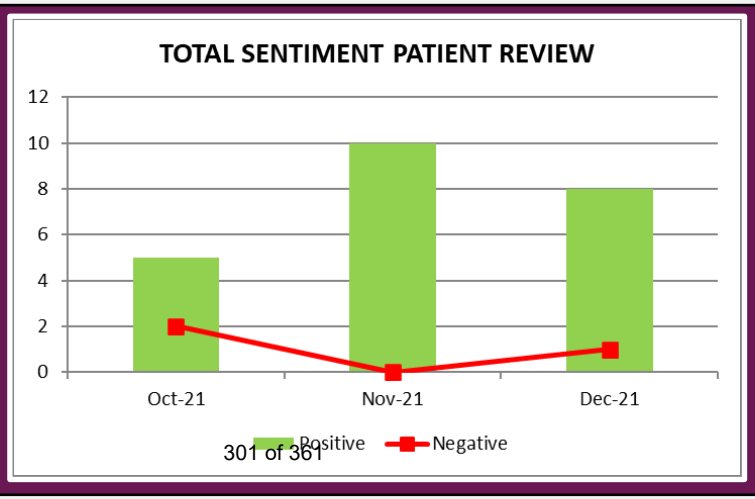
Metric	Engagement opportunities
Current Performance	**Governor Engagement** • The first face to face Governor Engagement Group in two years was held on 3rd February 22 as part of the overall Engagement and Involvement agenda. Three Further public governor constituency meetings (Warrington North, Warrington South plus Runcorn, Widnes and Rest of England combined) will be held during March and will help us to support Governors in their role to give local people a voice within the Trust. A Governor Engagement Toolkit is also in development. **Reducing Health Inequalities** • Our Community Diabetes Specialist Nurse Hannah was talking to shoppers in Warrington and Halton in early March about some of the risk factors for Type II diabetes as part of our activities for World Obesity Day. Diabetes is one of the areas we have identified as a focus within our ‘*Your Health Matters*’ programme of engagement which is aligned to the priority areas for reducing health inequalities in Halton, Warrington and the wider Cheshire and Merseyside region. **Recruitment events** • A second successful recruitment event was held in January 2022 under the ‘Become Part of our WHH Family’ brand. The event at the Village Hotel, Warrington showcased nursing and AHP opportunities at WHH to prospective staff. Interviews were held on the day with 29 conditional job offers made. **Experts by Experience** • WHH Experts by Experience programme is gathering momentum and a new form for Experts by Experience has been developed to guide and support staff in assessing their requirements for patient involvement in the development of service models and major capital projects. We are currently recruiting to our Zero Carbon Cardiology Patient Pilot, a number of quality improvement initiatives, First Impressions programme and also to support the implementation of the Accessible Information and Communication Policy deployment. **Forthcoming items to note:** **Patient, Public Participation and Involvement Strategy** • A refreshed PPP&I Strategy is in development to provide a co-ordinated overarching approach to engagement and involvement activity within the Trust and to ensure effective collaboration with our WHH Quality, Patient Experience and Charity teams along with activity on a Place level.

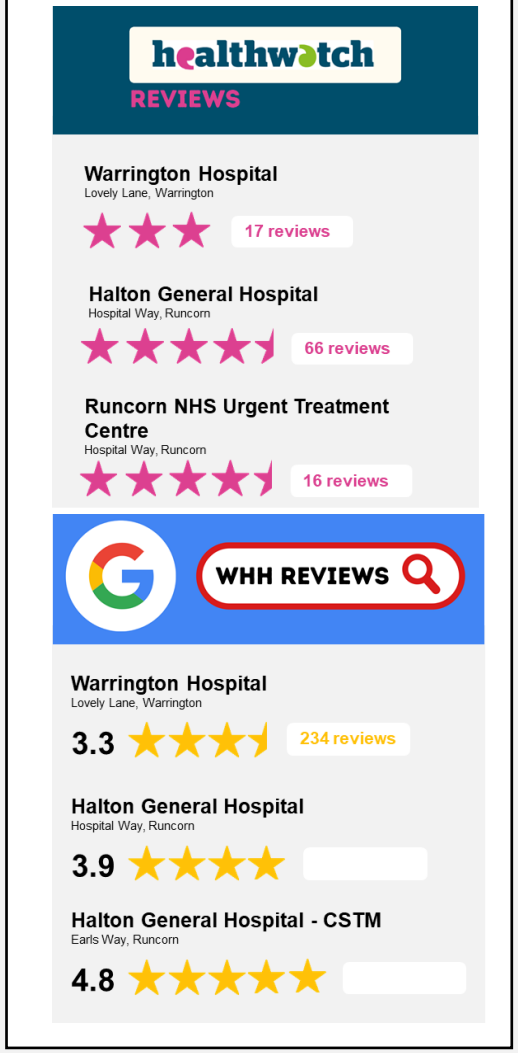


‘Well-Led’ KLOE 7 Metrics : Patient engagement through public channels and media

Metric	**ENGAGEMENT WITH FEEDBACK CHANNELS** Feedback include channels in the public domain : Google reviews, NHS Choices, I want Great Care, Healthwatch
Current Performance	During Q3, there were 26 reviews about the Trust of which 84% were positive.
Actions / Comments	**Top online source for public feedback:** Care Opinion **General Theme:** A&E receive the most reviews. **Positive feedback:** “Recently attended A&E with chest pain and Tachycardia. I can honestly say from the moment I arrived to the moment I left I was treated as though I was a member of their own family. I am now awaiting an appointment for the chest clinic. Long may we be blessed with our wonderful NHS and all those that have worked tirelessly through this awful pandemic. THANK YOU, each and everyone of you.”



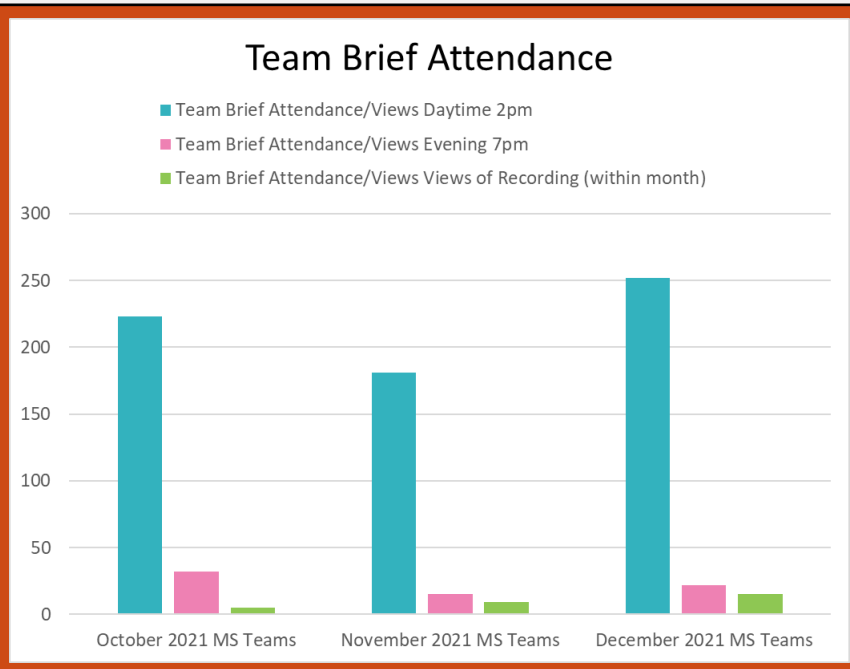




‘Well-Led’ Metrics : Communicating with staff

Metric	**Engagement with Staff Communication Channels** Trust-wide staff communications channels include: The Daily Safety Brief Good Morning WHH from the CEO The Week A closed staff-only Facebook group WHH People Monthly Team Brief Extranet announcements (NEW) Staff App – currently being trialled by 50+ staff
Current Performance	**TEAM BRIEF TOTAL ENGAGEMENT Q3** Attendance • 2pm slot - 656 • 7pm slot - 69 • Watched on catch up – 29 • December saw the highest attendance, top story – COVID-19 Omicron Questions asked • 2pm Brief - 125 • 7pm Brief - 1 • October saw the highest engagement with 47 questions asked. **MEMBERS ON WHH PEOPLE FB PAGE** 600 staff members, December saw an increase of 9% due to the Thank You Awards 2021. Most active date was TYA 2021 20/12/2021 with 499 members reached. STAFF APP – NEW – COMING SOON • App downloads (this will be cumulative) • Most viewed pages

302 of 361



REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/35**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	30th March 2022	
AUTHOR(S):	John Culshaw, Trust Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	✓
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate*)	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Since the last meeting: • No new risks have been added; • The ratings of two risks have decreased and it is proposed to reduce the rating of one further risk; • The description of four risks on the BAF have been amended; • One risk has been closed and one risk has been de-escalated to the Corporate Risk Register. It is also proposed to close one further risk and de-escalate another. Notable updates to existing risks are also included in the paper.	
PURPOSE: *(please select as appropriate)*	Information	Approval ✓ / To note / Decision
RECOMMENDATION:	The Trust Board is asked to discuss and approve the changes and updates to the Board Assurance Framework.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC 22/03/62
	Date of meeting	01.03.2022
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework and Strategic Risk Register report	AGENDA REF:	BM/22/03/35

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

Agreed @ Quality Assurance Committee:

Since the last meeting and following approval at the Quality Assurance Committee on 1st March 2022, the ratings of two risks have decreased and there is a proposal to reduce one further risk

I. Following the amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to introduce the COVID vaccination as a condition of deployment (VCOD) to come into force on the 1 April 2022, the Trust Board agreed to increase the rating of risk **#115** (detailed below) from **20** to **25.** However, as vaccination as a condition of deployment (VCOD) has been officially removed from legislation, it was therefore agreed to reduce the rating back from **25** to **20**

ID	Risk description	Rating (previous)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
115	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	25	20	BAF	Kimberley Salmon-Jamieson	Quality Assurance Committee

II. As the numbers of COVID-19 positive patients in the Trust has started to reduce, it was agreed to reduce the rating of risk **#1272** (detailed below) from **20** to **12** to reflect the current circumstances.

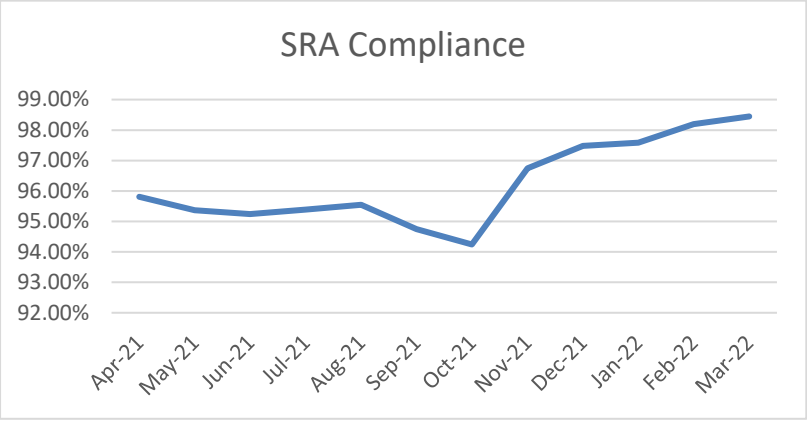
ID	Risk description	Rating (current)	Rating (proposed)	Risk Register	Executive Lead	Monitoring Committee
1272	Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 meters apart, resulting in reduced capacity to admit patients and a potential subsequent major incident.	20	12	BAF	Kimberley Salmon-Jamieson	Quality Assurance Committee

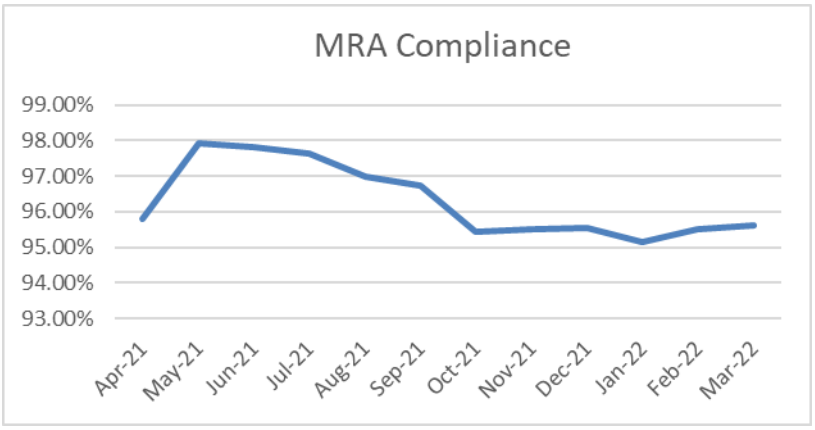
Proposed

Following discussion at the Operational People Committee (OPC) on 17th March 2022, it is proposed to reduce the rating of risk #1207 detailed below from **16** to **8**:

ID	Risk description	Rating (current)	Rating (proposed)	Risk Register	Executive Lead	Monitoring Committee
1207	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. The two staged approach to risk assessments means that this will be caused by either employees not completing the self-risk assessment in a timely manner or managers not acting upon the information provided and completing a management risk assessment, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	16	8	BAF	Michelle Cloney	Strategic People Committee

The two below graphs demonstrate consistent high compliance with both Self Risk Assessments (SRA) and Management Risk Assessments (MRA) and therefore a recommendation will be made to review the risk rating, reducing it to 8 (4 for Consequence and 2 for Likelihood).





Compliance will continue to be monitored and should the compliance levels for SRA or MRA either;

- Drop below 95% for three consecutive months
- Drop below 80% in any one month

The Risk Rating will be reviewed, and a recommendation made to increase the risk rating.

2.3 Amendments to descriptions

Since the last the last meeting and following approval at the Quality Assurance Committee on 1st March 2022, there have been amendments to the descriptions of four of the risks on the BAF to better reflect current circumstances

I. **Risk #115**

Current: *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.*

Proposed: *Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.*

II. **Risk #1272**

Current: *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.*

Proposed: *Failure to provide a sufficient number of beds caused by the increased care demand due to the COVID-19 pandemic and requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 meters apart in respiratory pathway areas, new recommendation in non-respiratory areas – can reduce to 1 metre, resulting in reduced capacity to admit patients and a potential subsequent major incident.*

III. **Risk #1275**

Current: *Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks*

Proposed: *Failure to prevent Nosocomial Infection caused by high transmitability of variant strains, waning effect of vaccines, asymptomatic carriage (staff or patients), false negative test results, high local community prevalence.*

IV. **Risk #1108**

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

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

2.4 De-escalation of Risks

Agreed @ Quality Assurance Committee:

Since the last meeting and following approval at the Quality Assurance Committee on 1st March 2022, it has been agreed close **one** risk and de-escalate **two** risks to the Corporate Risk Register for monitoring.

I. In order to reflect the changing circumstances and legislation it was agreed to close risk **#1274** (detailed below) and continue to monitor staffing levels as part of risk #115

ID	Risk description	Rating (current)	Executive Lead	Monitoring Committee
1274	Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.	15	Kimberley Salmon-Jamieson	Quality Assurance Committee

II. It was agreed to de-escalate risk **#1331** (detailed below) to the Corporate Risk Register for monitoring. The decision was based on whilst the Trust still has capacity issues stepping patients down from ICU, there are currently no issues in terms of patients accessing ICU for elective or non-elective reasons. The use of B18 for escalation has worked well and the Trust has not been required to utilise theatres. The position was maintained through wave 5.

ID	Risk description	Rating (current)	Executive Lead	Monitoring Committee
1331	Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by increased restoration and recovery activity and the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.	15	Dan Moore	Quality Assurance Committee

III. Further to the agreed reduction in the rating of risk #1272 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.

Proposed

Following discussion at the Operational People Committee (OPC) on 17th March 2022, it is proposed to close one risk (**#1590)** and de-escalate one further risk **(#1207)** to the departmental risk register for continued monitoring as described below:

I. As vaccination as a condition of deployment (VCOD) has been officially removed from legislation, it is proposed to close risk **#1590** (detailed below)

ID	Risk description	Rating (current)	Executive Lead	Monitoring Committee
1590	Failure to prevent staff shortages within certain professional groups and / or CBUs caused by individual decision making associated with the amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, introducing the COVID vaccination as a condition of deployment (VCOD) resulting in staffing gaps, a reduction in service provision and risks associated with risk 115 concerning staffing levels.	20	Michelle Cloney	Strategic People Committee

II. Further to the proposed reduction in the rating of risk #1207 as described in section 2.2, it is also proposed to de-escalate the risk to the departmental risk register for continued monitoring.

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	Current Risk Rating	Impact of update on risk rating
115	Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.	• Recruitment / media plan produced and recruitment campaign ongoing – vacancy reduction plan in place including RN/ODP/HCSW • Wards & departments use E-Roster and Safecare data to support staffing ratio management and 'in time' daily management of safe staffing • Proactive student nurse campaign in train Recruitment Assurances • Rolling advert for B5 Nurses recommenced 23rd November 2021 and closed on 31st January	25	Reduced rating to 20

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		with interviews taking place 18th February 2022. • AED recruitment day completed on 28th October with 17 candidates successfully appointed. Maintained contact with candidates through Seasons greetings cards, Newsletter and a meet and greet session. • Combined WHH RN and AHP recruitment day held 28th January with 29 Nurses appointed across UEC, Medical and IMC CBUs. • Career advice events in local schools and colleges • Production of monthly and bi-annual staffing reports received by the Trust Board • The Trust has now successfully placed 96 International Nurses. • From 7th January 4 Refugee Nurses have commenced their training and due to start on their wards from 14th February 2022. HCA • NHSI HCSW winter pressure funding received to support with recruitment and retention of new to care candidates. Weekly monitoring on progress and reporting to NHSI in place. Work now ongoing for pastoral support of new recruits to improve turnover rate in this group. Interviews took place 24th & 26th January 2022 with a total of 17 candidates appointed. Further interviews to take place on 21st February 2022. • Aim for all vacancies to be recruited into with the support of HR, Education and Workforce Improvement Lead. • WHH careers open day held 19th October 2021 to showcase support the Trust offers to HCSW – attendance from local colleges and public		

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• Working in partnership with Rugby League Cares with a view to arrange further careers/recruitment open day for HCSW. Bi-monthly meetings take place • Supporting NHSP with the CSWD/PSS programme and monitoring number of staff who have successfully been appointed <u>Retention Assurances</u> • Registered Nurse Turnover 13.61% • Increased use of temporary staffing through NHSP and off framework agencies – close monitoring arrangements in place – incentives Jan and Feb • Non-ward based when possible <u>Assurance Gaps</u> • Awaiting C21 business case completion • 55 escalated bed and super stranded patient position in Trust		
1273	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.	• Working closely with Warrington Borough Council on a short, medium and long term solution to community bed capacity, matching demand to capacity. • An increase in capacity in the community and a decrease in community prevalence and transmission has resulted in almost all the Care Homes in Warrington & Halton to be open. This has seen a decrease in the number of super stranded patients form a peak of 170 to 115 (03.03.22) • Overall reduction in patients who don't meet the criteria to reside from a peak of c150 to c115	25	No impact on risk rating
1275	Failure to prevent Nosocomial Infection caused by high transmitability of variant strains, waning effect of vaccines, asymptomatic	• Triage and testing on admission. • Risk assessments are in place in all Wards/Departments and rest rooms and being revised as per hierarchies of control	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	carriage (staff or patients), false negative test results, high local community prevalence.	• PPE audits completed weekly on wards and increased frequency during outbreaks • IPC Team liaison with clinical teams on AGP precautions • FFP3 fit testing programme in place • Staff training in safe donning and doffing of PPE – included in mandatory training • Site-wide assessment of ventilation (mechanical and manual) – in progress • Small percentage of unvaccinated staff – under revision - VCOD • Low uptake of LAMP/asymptomatic staff testing – LFD testing by some staff but not centrally reported		
1289	Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm	• Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments • Additional echo activity as per the H2 elective fund plan starting w/e 12th February 2022 delivery an additional c104 echos per week. • Increase in Trust WLI rate agreed until 31.03.2022 to support restoration and recovery. Business Case to support the increase in to 2023/24 currently in development	20	No impact on risk rating
1590	Failure to prevent staff shortages within certain professional groups and / or CBUs caused by individual decision making associated with the amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, introducing the COVID vaccination as a condition of deployment (VCOD) resulting in staffing gaps, a reduction in service provision and risks associated with risk 115 concerning staffing levels.	• On Monday 31st January 2022 the Secretary of State announced that VCOD is now being reconsidered • Consultation on revoking VCOD closed on 16 February 2022 • Response published 1st March 2022 – 90% in favour of revocation • Regulations revoking VCOD will come into force on 15 March 2022 • Government will continue to work with stakeholders to engage those yet to be vaccinated; this includes professional regulators, who will be encouraged to review	20	Recommend to close risk

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		their current vaccination guidance to registrants • Intends to consult on the Code of Practice on the Prevention and Control of Infections to strengthen requirements in relation to COVID-19		
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 future loans will be required which would raise the question if the Trust is a going concern.	• Workshops planned for 2022/2023 budget setting • In 2021/22 the Trust has funded 14 cost pressure business cases, 4 have been completed and approved and there are currently 10 outstanding which are expected to be completed by 31st March 2022. • Participating in exercise to understand run rate for 2020/21 & 2022/23 to support funding envelopes for 2021/22 & 2022/23 • Mitigation plans for the Cheshire & Merseyside £50m gap have been identified. The Trust is currently forecasting a breakeven position. • Risk of unforeseen costs due to current COVID-19 surge • Planning guidance has been received; however income allocations are still unknown. The first draft of 2022/23 operational plan will be submitted on the 14 February 2022 with a final submission on the 28 April 2022. • Monitoring of charitable funds income and annual assessment of investment and reserves policies • Workshops undertaken and continue for 2022/2023 budget setting • Forecast non-recurrent CIP c£3m for 2021/22 will present a pressure for the 2022/23 budget • Second draft of the financial plan is showing a deficit of £21.2m	20	No impact on risk rating
1134	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	• Administrative & Clerical and Estates & Ancillary staff are still experiencing over 1% absence rate related to COVID-19 • Additional Clinical Services and Nursing & Midwifery staff are still experiencing over 2% absence	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		rate related to COVID-19. This impacts requirements for temporary staffing.		
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 who lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber attack, RESULTING IN poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	• Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital (December 21) • Remote devices no longer bypassing the web proxy • Active Directory password set to expire again (covid working from home-related). • Fully recruit to the Digital Service restructure Phase 1 restructure • Outcome of the second Phishing exercise by NHS Digital, communications have been sent out to staff members who entered details for awareness. • Mostly achieving of mandated compliance with DSPT, incorporating CE+ (moderate assurance given by MIAA for the standards audited and substantial in respect of the veracity of the self-assessment) • Temporarily Uninstalled Mcafee on PACS servers for 1 week (10/03/22)	20	No impact on risk rating
1125	Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance	• Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments • Additional echo activity as per the H" elective fund plan starting w/e 12th February 2022 delivery an additional c104 echos per week. • Increase in Trust WLI rate agreed until 31.03.2022 to support restoration and recovery. Business Case to support the increase in to 2023/24 currently in development • The Trust is developing a bid to become a Community Diagnostic Centre (CDC) as part of the second tranche of national funding. This would be situated	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		on the Halton Campus. Bids to be submitted in March 2022 • The Trust will be bidding on 8th March 2022, for Cheshire & Merseyside Elective Restoration Capital Fund with a number of schemes to increase elective capacity on the Halton site		
1079	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services Resulting in the inability to capture all required data accurately, to have 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.	• In order to ensure health visitors are notified, the previous paper based system has been replaced with an electronic notification system, with a failsafe in place to ensure no patients are not notified to the appropriate service. AN electronic HV notification has been set up and tested in Warrington and new are ow working with IT teams in Halton CCG to replicate the electronic notification system we have in Warrington. • Digital Maternity board in place to ensure full oversight is provided. Weekly digital transformation meetings in place to progress operational actions. • Offline working on Lorenzo launched in January 2022 to mitigate risk prior to Badgernet implementation in May. This will support implementation of Maternity Incentive Scheme Safety Action 2 : MSDS submission	20	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. The two staged approach to risk assessments means that this will be caused by either employees not completing the self-risk assessment in a timely manner or managers not acting upon the information provided and completing a management risk assessment, resulting in a failure to comply with our legal	Trust compliance as at 8th March 2022 • Have you offered a Risk Assessment to all staff? - Yes • What % of all your staff have you Risk Assessed? – 96.62% • What % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary? – 95.56% • What % of risk assessments have been completed for staff who are known to be from a BAME	16	Propose to reduce rating from 16 to 8

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	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.	background, with mitigating steps agreed where necessary? – 93.21% Consistently high compliance with both Self Risk Assessments (SRA) and Management Risk Assessments (MRA) has been demonstrated **Gaps** At 10th January 2022: At 8th March 2022: • 65 staff members yet to complete self-assessment (reduced from 231 in September 2021) • 98 Management Risk Assessments are outstanding		
1372	FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case	• Commissioning support of expert third party for development of business cases • EPR SRO and CIO to meet Chief Finance Officer and Trust Chair to agree expectations to assure the support of the Trust Board. • Checkpoint meeting with senior stakeholders to review the potential affordability • Approved business case for a new 3 – 5 year Lorenzo contract in support of time required to complete the procurement and deployment • Implementation of approved Principle CCIO and Associate CCIOs to support the business case production • Pre-procurement market engagement with supply chain, against a pre-agreed discussion framework, to inform further costs and benefits opportunities for OBC • Project Manager assigned. • Financial modelling of realistic collaboration options to provide genuine 5-, 10- and 15-year options to control whole life costs • Identification of further realistic cash releasing benefits • Approved business case for deployment of Lorenzo Theatres	16	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• Contracts for tactical solution signed		
1579	Failure of the Trusts ability to transfer patients with time critical urgent care needs to specialist units able to deliver time critical specialist interventions (Primary PCI, Hyperacute Stroke Intervention, Emergency Vascular Surgery, Major Trauma services etc) CAUSED BY an inability of the North West Ambulance Service, to provide the expected response times for critical transfers due to overwhelming demand on ambulance services, RESULTING IN a delay in transfer and thus potential severe patient harm due to the inability to access time critical specialist interventions without undue delay	• Trust continues to perform well against the ambulance handover times thus supporting the ambulance service • The Trust is working with NWAS on the implementation of a new regional handover process. Awaiting start date from NWAS	16	No impact on risk rating
1108	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are assessed as only able to work on a non-respiratory pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	• 1:1 care rate currently @ c92% • 11 members of staff are still being supported to work in a green pathway, as per Occupational Health risk assessment and recommendations. The NHS is awaiting a national week commencing 28th February. • Daily SITREP to LMS Submitted Gold Command meetings returned to weekly 21/2/22 • Staffing continued to be monitored daily by senior team. • Current absence/sick rate 8.47% and vacancy rate increased to 6.21%	16	No impact on risk rating
1290	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020, resulting in difficulties in procurement of medicines, medical devices, technology products and services, clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.	• Pharmacy continue to manage disruption alerts for medicines supplies related to Brexit. • The Digital department has reviewed all the Trust key IT systems and data flows. The adequacy decision agreed in June 2021 means that personal data can continue to flow between the UK and the EU without restriction. However, the EU Commission has included a 'sunset clause' into its adequacy decision, which strictly limits its	12	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		duration. This means that the UK's decision only lasts for four years until 27 June 2025. If the UK relaxes or changes data rules as part of its future data flow arrangements, or future trade deals, the EU may review the adequacy agreement and could end the free flow of data between the UK and EU. • Re-instigated the Brexit Sub-Group on 9th September 2020 and the group continues to meet bi-monthly, this will be quarterly from January 2022 with the view to stepdown the group if there are no significant items to escalate. Ongoing updates will occur through the Event Planning Group. • Communications plans continue with clinical teams to ensure the Chargeable Patients SOP is embedded. There will be an automated process introduced in March – April 2022 to support this process and for additional assurance alongside the current manual checks.		

3 RECOMMENDATIONS

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

Board Assurance Framework

Board Assurance Framework

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

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	Daniel Moore	Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience.	1	25 (5x5)	8 (2x4)	TBC	Clinical Recovery Oversight Committee
1215	Daniel Moore	Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm	1	25 (5x5)	6 (3x2)	TBC	Quality Assurance Committee
1273	Daniel Moore	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.	1	25 (5x5)	5 (5x1)	TBC	Quality Assurance Committee
115	Kimberley Salmon-Jamieson	Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.	1	20 (5x4)	12 (4x3)	TBC	Quality Assurance Committee
1275	Kimberley Salmon-Jamieson	Failure to prevent Nosocomial Infection caused by high transmitability of variant strains, waning effect of vaccines, asymptomatic carriage (staff or patients), false negative test results, high local community prevalence.	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
1289	Daniel Moore	Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
1590	Michelle Cloney	Failure to prevent staff shortages within certain professional groups and / or CBUs caused by individual decision making associated with the amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, introducing the COVID vaccination as a condition of deployment (VCOD) resulting in staffing gaps, a reduction in	2	20 (4x5)	4 (4x1)	TBC	Strategic People Committee

Board Assurance Framework

		service provision and risks associated with risk 115 concerning staffing levels.					
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
1134	Michelle Cloney	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee
1114	Paul Fitzsimmons	FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR) RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	1	20 (5x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1125	Daniel Moore	Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance	1	20 (5x4)	8 (2x4)	TBC	Clinical Recovery Oversight Committee
1079	Kimberley Salmon-Jamieson	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.	1	20(4x5)	2 (1x2)	TBC	Quality Assurance Committee

Board Assurance Framework

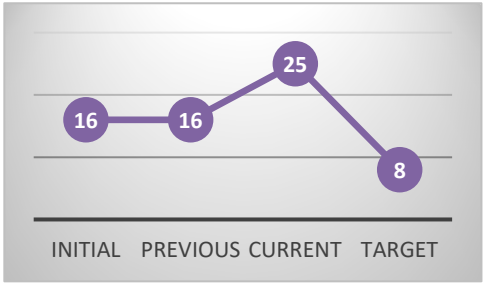
1207	Michelle Cloney	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. The two staged approach to risk assessments means that this will be caused by either employees not completing the self-risk assessment in a timely manner or managers not acting upon the information provided and completing a management risk assessment, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	2	16 (4x4)	8 (2x4)	TBC	Strategic People Committee
1372	Paul Fitzsimmons	FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case	3	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1579	Daniel Moore	Failure of the Trusts ability to transfer patients with time critical urgent care needs to specialist units able to deliver time critical specialist interventions (Primary PCI, Hyperacute Stroke Intervention, Emergency Vascular Surgery, Major Trauma services etc) CAUSED BY an inability of the North West Ambulance Service, to provide the expected response times for critical transfers due to overwhelming demand on ambulance services, RESULTING IN a delay in transfer and thus potential severe patient harm due to the inability to access time critical specialist interventions without undue delay	1	16 (4x4)	8 (2x4)	TBC	Quality Assurance Committee
1233	Paul Fitzsimmons	FAILURE TO review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed CAUSED BY Combined Assessment Unit (CAU) frequently being bedded with inpatients due to overcrowding in the ED and an excess demand for inpatient beds RESULTING IN a lack of surgical assessment bed capacity, poor patient experience, delays in treating surgical patients and increased admissions to the surgical bed base.	1	16 (4x4)	6 (2x3)	TBC	Quality Assurance Committee
125	Daniel Moore	Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	1	16 (4x4)	4 (4x1)	TBC	Executive Management Team

Board Assurance Framework

1108	Kimberley Salmon-Jamieson	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are assessed as only able to work on a non-respiratory pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	1	16 (4x4)	4 (4x1)	TBC	Quality Assurance Committee
145	Simon Constable	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	3	15 (3x5)	8 (4x2)	TBC	Executive Management Team
1290	Andrea McGee	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.	3	12 (3x4)	4 (1x4)	TBC	Finance & Sustainability Committee

Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.
Strategic Objective 2: We will… Be the best place to work with a diverse and engaged workforce that is fit for now and the future
Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.

Board Assurance Framework

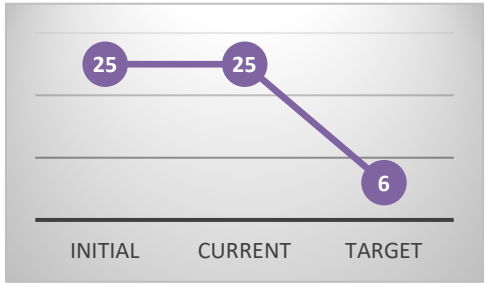
Risk ID:	224	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience.			**Initial:**	16(4x4)
				Current:	25(5x5)
				Target:	8 (2 x 4)
Assurance Details:	•Regular Trust Wide Capacity meetings led by the Senior Site Manager for the day •Systemwide relationships including social care, community, mental health and CCGs •Discharge Lounge/Patient Flow Team/Silver Command •ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing •Controller •Private Ambulance Transport to complement patient providers out of hours •FAU/Hub operational from June 2018 - Now operating 5 days per week. •Discharge Lounge opened 26th November 2018 •Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance. •System actions agreed supporting the Winter Plan •Further development of Rapid Response to avoid admission •Increase IMC provided by the system such as the opening of the Lilycross site •Increase IMC at home •Regular monitored at the Mid Mersey A&E Board •Trust is working with ECIST on a number of Long Length of Stay & Flow improvement projects •ECIST is supporting effective deployment of the national discharge policy •Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. •The Trust participates at the system & regional UEC improvement meeting on each Wednesday •Redeveloped ED 'at a glance' dashboard •Trust implemented NHS 111 first successfully in August 2020 allowing for directly bookable ED appointments •Board approval of capital plan to build new £5m purpose built acute Medical Ambulatory Care area aka ED Plaza •Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings •Integrated discharge Team now in place •Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients •ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised. •Respiratory Ambulatory Care Facility agreed by CCG •Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved •Collaborative working with Orthopaedics in management ok MSK Minor injuries via Minor's Stream •Reinstated CAU 24/7 •Upgrade to Minor's resulting in Oxygen points in all cubicles •Non-Elective flow activity now above 2019/20 activity levels for type 1 & 3 •Operation Re-set undertaken at the end of May 2021 to support flow and discharge •ED Response Group established in August 2021, clinically led by Dr Vondy to review internal ED processes. •Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly. •Monthly Focus on Flow weeks scheduled every month until July 2022 • Additional Senior Manager on call support a weekends • Successful bid for c£618k to support urgent care pressure in H2				

Board Assurance Framework

	ED Plaza due for completion in May 2022 Command & Control initiative in place since 8th December 2022 and ongoing to support pathway 0 and pathway 1 discharges. This is creating necessary capacity to support wave 5. This is in line with national guidance. w/c 3rd January 2022 Ward B4 at Halton converted to provide additional G&A capacity (additional 27 beds) and flow in ED To support capacity for Wave 5, elective activity moved to CSTM Halton facility to protect elective programme	
Assurance Gaps:	•Staffing pressure created as a direct result of COVID-19 Global pandemic. •Confirmed exponential growth in types 1 & 3 as a result of population nedd and lack of access to Primary Care	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12 hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Silver Command and SMOC (out of hours) and Executive on Call.	Field-Delaney, Sheila	31/03/2022	
ED Response Group	Executive recommend the formation of Supportive forum for ED to support current issues highlighted during May2021 operation reset.	ED Response Group Formed and TOR agreed and lead assigned	Vondy, Dr Anna	31/03/2022	
DATIX Reporting for Patients Waiting for a Bed	Staff are encouraged to report near misses of patients who have been waiting for a bed for a long period of time.	Review the DATIX and carry out rapid incident reviews.	Field-Delaney, Sheila	31/03/2022	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG	Field-Delaney, Sheila	31/03/2022	

Board Assurance Framework

Risk ID:	1215	**Executive Lead:**	Dan Moore	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to deliver the capacity required caused by the on-going COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm			**Initial:** 25 (5x5) **Current:** 25 (5x5) **Target:** 6 (3x2)
Assurance Details:	• H2 Planning Guidance submission – October 2021 • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery • Operational planning to be monitored by Gold Command on a daily basis, by Cheshire & Merseyside elective restoration meeting weekly and the Clinical Recovery Oversight Committee (CROC) & Clinical Services Oversight Group (CSOG). This relates to elective surgical activity. • 2021/22 Operational Planning Guidance received in April 2021 outlining planning requirement for the first 6 months. • Elective Recovery Plan Business Case under development to support waiting list recovery for outpatients, cancer and electives in H2 • To support capacity for Wave 5, elective activity moved to CSTM Halton facility to protect elective programme • Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments Radiology • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Department has been supported by the Trust through £380K recurrent funding to recruit additional staff. Advert out 11th June 2020. Recruiting 4 Radiographers, 2 Sonographers, 2 Healthcare Assistants. • Additional staff will support additional capacity through extended working days across all scanners – currently unable to achieve this due to Covid-19 demands. • Additional CT capacity (15 exams per week) will be provided mid-July 2020 via use of mobile CT scanner supported by the National Imaging Team Covid-19 Response initiative. (this has been extended to mid-September 2021) • MR business case supported to provide a mobile MR van until October 2021 until the new static MR capacity commences. • All outstanding requests are clinically reviewed by Senior Consultant Radiologists as per local SOP. Exams are deferred in line with clinical priority. Cancer and Urgent patients are being imaged as per pre-Covid-19 as per national guidance. • Those deferred patients are sent a letter informing of delay, and to contact their Doctor if any concern. The referrer of delayed patients are also sent a letter informing of delay, but this referrer letter includes a direct telephone number to the Senior Radiology Consultants, and also an email address should there be a concern with delaying. Any exams that are highlighted from referrers as not suitable for delay are appointed on the next available appointment. • This delay process has been discussed via Medical Cabinet and agreed as most appropriate process. • This clinical review and delay process is ongoing daily. • Improvement against all modalities for numbers waiting more than 6 weeks noted in April performance. • CT Business case approved to increase CT capacity and support expediting recovery. Unplanned care • The emergency department has been reconfigured to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics in line with Royal College of Emergency Medicine (RCEM) guidance. • Minor injuries is provided in an area in close proximity but separate to the main emergency department. This has provided an opportunity to use the old minors department as Majors 2 to support management of surge demand and avoidance of corridor care. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance.			

Board Assurance Framework

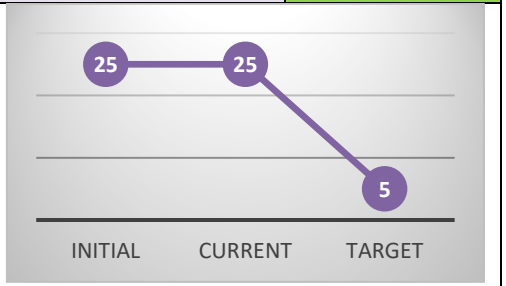
	• In patient capacity is reviewed with the patient flow and CBU teams daily to ensure that there is adequate capacity for all patient groups to be admitted. • ITU business continuity plans have been agreed to escalate critical care as and when required. • Clinic templates have been revised to ensure social distancing measures are in place and patients are not brought to a face to face appointment unless clinically indicated. Virtual appointments are in place (telephone and video) for use where this is clinically appropriate. • Suspected cancer, cancer and clinically urgent patients are allocated out patients and diagnostic appointments as a priority. • Waiting lists are reviewed through the performance review group weekly – outpatients and diagnostics. • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • NHS 111 First pilot went live on 8th September 2020 to reduce attendances to the emergency department and to support the planning of activity in a more streamlined way to reduce overcrowding and risk of nosocomial infection. • Business Case for ED Plaza Scheme approved in 2021/22 Capital Plan • Reconfiguration of Paediatric ED completed and operational • Phase 2 ED Plaza commenced in October 2021. And due for completion in May 2022 • Deployment of Bioquell Pods in ICU live and operational Planned Care • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery. • All elective patients have been clinically reviewed and categorised in line with national guidance. • Suspected cancer, cancer and clinically urgent patients are treated as a priority. • Theatre capacity has been reviewed and additional capacity is now available with the de-escalation of the theatre PODs • The Halton site is being developed as a covid secure site and will be run as an Elective Centre. • Elective Surgery Standard Operating Procedure (SOP) in place • Capacity identified and being utilised at spire Healthcare • Clinical Services Oversight Group (CSOG) established • Clinical Recovery Oversight Committee (CROC) established • Clean/green pathways have been developed for those priority 2 patients (cancer & urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward 5 on the Warrington site. This pathway is set to commence w/c 8th February and replaces the B18 pathway. • A separate pathway has been developed for Emergency surgery and future plans and bed base has been agreed as part of the ward reconfiguration process. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Workforce plans are continually reviewed to ensure that all wards and teams are staffed safely. • Waiting lists are reviewed through the performance review group weekly • Weekly theatre scheduling to ensure listing of patients in line with national guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021 • Continued use of the independent sector (Spire Cheshire) under new contract in 2021/22 with support from the CCG. • Participation in national clinical validation exercise commenced in November 2020 to support and inform patient waiting time status and support safe management of waiting lists.	
Assurance Gaps:	Radiology 1. Harm may be caused due to the incompleteness of clinical information on a referral. This may also be compounded by the referrer incorrectly entering the wrong priority code on the referral.	

Board Assurance Framework

	• It is thought that the letter to the referrer will highlight the exam has been delayed and that the provision of a direct link to the Radiology Consultant team by phone/email will allow these cases to be expedited where appropriate. 2. Harm may be caused by the delay of a routine examination where there is an unlikley serious pathological finding present. • This risk is present in all routine exmas as the waiting time for routine diagnostic imaging is up to 6 weeks as per national targets. This risk is hightened due to Covid-19 and the reduced capacity at present. It is thought the letter to the patient advising to contact their Doctor with any concern will reduce this risk. Unplanned care 1. Estates work is required to complete the segregation of paediatric patients in the emergency department. • This is being progressed with the support of the estates and capital planning team. 2. Expansion of the emergency department is required to ensure any increase in demand can be accomodated in line with RCEM guidance 3. Referrals do not include adequate information to triage and prioritise patietns appropriately • Regular meetings and communication with the CCG and GP's to inform them with recovery progress within the organisation and to highlight/address any identified problems 4. Reduction in face to face primary care appointments having a negative impact on increased attendances. 5. Capacity challenge with social workers to keep on top of demand and necessary patient assessments. 6. Estates work required to increase general ICU Capacity & ICU cubicle capacity e.g. Installation of Bioquell cubicles Planned Care 1. Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility. • This is being progressed with the support of the estates and capital planning team. 2. Waiting list do not include adequate information to triage and prioritise patients appropriately • Regular meetings and communication with the waiting list and scheduling teams and inform them of recovery plans and to highlight/address any identified problems 3. New framework for ISP will not include all specialties currently being undertaken. This will increase waiting list pressure for those specialties on this site.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Install of Bioquell Cubicles	Install of Bioquell Cubicles	Complete Installation	Sharon Kilkenny	28/02/2021	Installation in ICU Complete Jan 2021
Build ED Plaza	Completion of ED Plaza building works	Complete Building work	Sharon Kilkenny	31/05/2022	

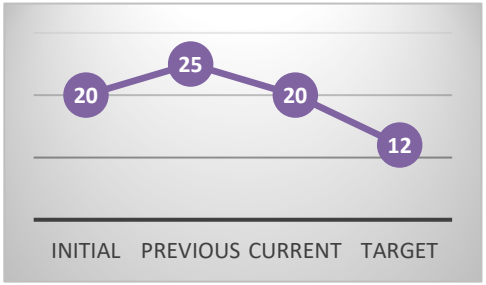
Board Assurance Framework

Risk ID:	1273	**Executive Lead:**	Moore, Daniel	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.			**Initial:** 25 (5x5) **Current:** 25 (5x5) **Target:** 5 (5x1)
Assurance Details:	Integrated Discharge Team comprising of hospital and Local Authority colleagues from Warrington and Halton to develop systems and process of discharge acknowledging difficulties of Covid-19. Daily system pressures meeting that reviews hospital and wider system bed capacity to support safe and timely discharge of patients from hospital to support flows Trust participates in Mid-Mersey Operational Group which supports Out of Hospital Cell discussions in relation to system discharge planning. The number of discharge delays in relation to Super Stranded patients is reported daily in the Executive Summary and reviewed so that Executive Directors can support and escalate pathway delays. 'Where's best next' event initiated in January 2021 with system partners to support safe discharge of patients with long lengths of stay to create capacity through December and January expected winter pressures and support wave 3. Scheme issued by the Government to support indemnity concerns of care homes in relation to caring for COVID-19 patients. It will support the system in the creation of COVID-19 designated setting capacity. New 'Discharge to Assess' process has gone live to reduce the length of stay for a cohort of patients who would otherwise be assessed in hospital can be assessed in a transitional care bed. Progressing the procurement of a new software programme which will be able to accurately track and share system delays with partners. By improving information, it will enable quicker and more effective decisions on discharges. Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly. Monthly Focus on Flow weeks scheduled every month until July 2022 Daily bed meetings organised by the Director of Operations & Performance to provide timely and effective benefits to patient flow Approval of IMC business case which will support a reduction in frailty length of stay and admission avoidance through geriatric input in to the Emergency Department. 500-700 additional domiciliary care hours to be released from w/c 6th December 2021 to support reducing long length of stay and super stranded patients Command & Control initiative in place since 8th December 2022 and ongoing to support pathway 0 and pathway 1 discharges. This is creating necessary capacity to support wave 5. This is in line with national guidance. w/c 10th January 2022, the Trust is supporting system designation of the Lilycross facility as being able to receive COVID positive patients. This is supporting wave 5 bed capacity. Working closely with Warrington Borough Council on a short, medium and long term solution to community bed capacity, matching demand to capacity. An increase in capacity in the community and a decrease in community prevalence and transmission has resulted in almost all the Care Homes in Warrington & Halton to be open. This has seen a decrease in the number of super stranded patients form a peak of 170 to 115 (03.03.22) Overall reduction in patients who don't meet the criteria to reside from a peak of c150 to c115			
Assurance Gaps:	Delays in discharge caused by adherence to Covid-19 infection control pathways and the patient's Covid-19 status. Intermediate Care and other community capacity impacted and restricted by Covid-19 e.g. Care Home and other facility closures due to outbreaks. Access to community capacity impacted by Covid-19 as a result of staff sickness Internal staff shortages to help support discharge planning. Restricted as a result of Covid-19 sickness and self-isolation High number of patients in Warrington awaiting social work assessment, causing a delay in discharges from the acute site in to care homes and intermediate care capacity			

Board Assurance Framework

	Significantly reduced capacity in the domiciliary care market due to the high number of vacancies. This is causing package of care delays.				
Recommendation	**Action Description**	**Actions Required**	**Responsible Officer**	**Deadline Date**	**Completion Date**
Improve discharge planning skills & knowledge	Undertake educational sessions to improve discharge planning skills & knowledge as part of Focus on Flow sessions	Complete educational sessions	William, Caroline	30/01/2022	25/01/2022
Improve quality and effectiveness of Board Rounds	Undertake educational session to improve quality and effectiveness of Board Rounds to help support reductions in length of saty	Complete educational sessions	Harris, Zoe	30/01/2022	25/01/2022

Board Assurance Framework

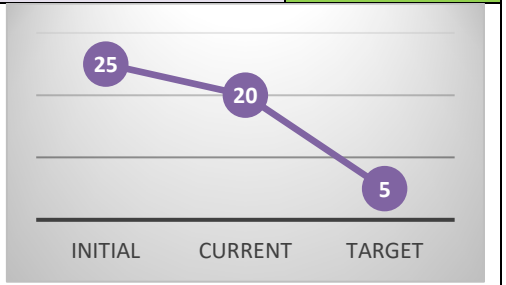
Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.			**Initial:** 20 (5x4) **Current:** 20 (5x4) **Target:** 12 (4x3)
Assurance Details:	• This is first, robust staffing escalation process across WHH to manage staffing daily – This is the forum for responsive staff management and deployment 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 • 4 hourly update shared as part of Gold Command template • Recruitment / media plan produced and recruitment campaign ongoing – vacancy reduction plan in place including RN/ODP/HCSW • Rolling advert for RN's continue. Students who were redeployed to the Trust during the COVID 19 pandemic have been offered substantive posts • 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) • Monthly workforce information produced via workforce dashboard. Information is reviewed and monitored at the Workforce Group Chaired by the Deputy Chief Nurse • Wards & departments use E-Roster and Safecare data to support staffing ratio management and 'in time' daily management of safe staffing • Proactive student nurse campaign in train <u>Recruitment Assurances</u> • Rolling advert for B5 Nurses recommenced 23rd November 2021 and closed on 31st January with interviews taking place 18th February 2022. • AED recruitment day completed on 28th October with 17 candidates successfully appointed. Maintained contact with candidates through Seasons greetings cards, Newsletter and a meet and greet session. • Combined WHH RN and AHP recruitment day held 28th January with 29 Nurses appointed across UEC, Medical and IMC CBUs. • Career advice events in local schools and colleges • Production of monthly and bi-annual staffing reports received by the Trust Board • The Trust has now successfully placed 96 International Nurses. • From 7th January 4 Refugee Nurses have commenced their training and due to start on their wards from 14th February 2022. HCA • NHSI HCSW winter pressure funding received to support with recruitment and retention of new to care candidates. Weekly monitoring on progress and reporting to NHSI in place. Work now ongoing for pastoral support of new recruits to improve turnover rate in this group. Interviews took place 24th & 26th January 2022 with a total of 17 candidates appointed. Further interviews to take place on 21st February 2022. • Aim for all vacancies to be recruited into with the support of HR, Education and Workforce Improvement Lead.			

Board Assurance Framework

	• WHH careers open day held 19th October 2021 to showcase support the Trust offers to HCSW – attendance from local colleges and public • Working in partnership with Rugby League Cares with a view to arrange further careers/recruitment open day for HCSW. Bi-monthly meetings take place • Supporting NHSP with the CSWD/PSS programme and monitoring number of staff who have successfully been appointed <u>Retention Assurances</u> • Workforce Dashboard reporting monthly in relation to leavers • WHH Nursing retention plan to be refreshed for 2022 • 'Transfer Window' implemented allowing staff to move to other specialties without having to apply for role • Registered Nurse Turnover 13.61% • International nurses have all been placed (95 in total) on wards. COVID-19 Assurances • Implemented a graduated and planned nurse staffing response to the COVID-19 Pandemic. • Revised staffing models for the expansion of critical care capacity, acute and supportive respiratory wards • Strengthened daily staffing meetings chaired by the Deputy Chief Nurse for senior oversight • Increased use of temporary staffing through NHSP and off framework agencies – close monitoring arrangements in place – incentives Jan and Feb • Implementation of NHSP incentive scheme for staff to improve fill rates – update monitored weekly • Increased incidence of COVID-19 Omicron variant is leading to increased staff absence. Plans are in place to reduce activity to ensure staff are available from elective areas to support affected areas. • Incentives have been offered to staff able to work increased hours via NHSP – Extended to the end of February 2022 • Minimum ward staffing numbers assessment completed • Non-ward based when possible	
Assurance Gaps:	• Increase staffing pressure due to ongoing use of temporary winter wards (B3, B4 & K25) for which there is no funded establishment • Recruitment Gaps • 0 RN Vacancies in September 21. ED & B18 are recruiting RNs for increased capacity. • Retention Gaps • 13.91% nursing turnover • Significant staffing absences from Dec 2021 due to the increased transmission rate of the Omicron variant • Awaiting C21 business case completion • 55 escalated bed and super stranded patient position in Trust	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
WHH to review international nurse recruitment to support registered nurse vacancy fill.	Targeted recruitment campaign	International nurse recruitment programme in place. Develop a business case. Agreement to join GTECH in partnership with WWL. Business case agreed for 30 nurses. Task and finish group established to support the recruitment campaign and welcome nurses to WHH Application for bid to access financial support for the programme.	Kennah, Ali	31/03/2022	

Board Assurance Framework

Risk ID:	1275	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to prevent Nosocomial Infection caused by high transmitability of variant strains, waning effect of vaccines, asymptomatic carriage (staff or patients), false negative test results, high local community prevalence.			**Initial:** 25 (5x5) **Current:** 20 (4x5) **Target:** 5 (5x1)
Assurance Details:	Restricted site access is in place to reduce the risk of COVID19 transmission. Triage and testing on admission. COVID19 incidents are monitored daily. Risk assessments are in place in all Wards/Departments and rest rooms and being revised as per hierarchies of control 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. Communications through TWSB to staff reinforcing social distancing measures Environmental Safety Action plan in place reported by exception to Silver Infection Control Outbreak meetings held with lessons learned shared across the Trust Signage and written information in place to support social distancing practices Retractable screens between beds spaces in ED PPE audits completed weekly on wards and increased frequency during outbreaks PPE & Swabbing Champions identified Clear curtains are in place all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. Process for assurance of 3 and 5 day swabs in place Bioquell Pods now in place in ICU Bioquell Pods now in place in ED Bioquell Pods now in place B18 Trust completed learning from Nosocomial outbreaks sessions. COVID-19 quality metrics in place Cohorting of COVID-19 positive patients recommenced Programme of OH screening for employees in place for symptomatic and asymptomatic employees with housegold contact. Revised guidance in place for respiratory and non-respiratory pathway Testing amended to included Influenza A&B & RSV. Agreed patient flow pathways based on results of screening. IPC Team liaison with clinical teams on AGP precautions FFP3 fit testing programme in place Staff training in safe donning and doffing of PPE – included in mandatory training			
Assurance Gaps:	Non-compliance with social distancing & PPE Non-adherence to Trust Staff isolation policy Mask station not present at all entrances Cleanliness score (on small number of ward items) sit just below 95% Increased transmission rate of the Omicron variant Site-wide assessment of ventilation (mechanical and manual) – in progress Small percentage of unvaccinated staff – under revision - VCOD			

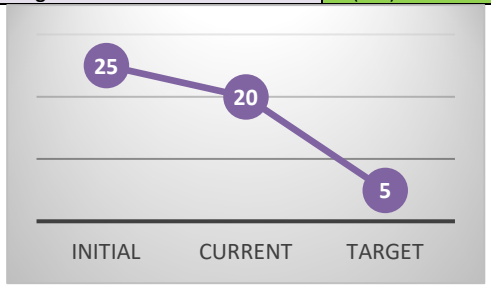
Board Assurance Framework

	Low uptake of LAMP/asymptomatic staff testing – LFD testing by some staff but not centrally reported				
Recommendation	**Action Description**	**Actions Required**	**Responsible Officer**	**Deadline Date**	**Completion Date**
Health and Safety inspections to include the monitoring of social distancing and ensure hand sanitiser and masks are located at each entrance.	Findings from inspections reported to the Health & Safety Sub-Committee Health and Safety inspections continue on an 8 week programme.	Health and Safety inspections to be carried out.	Kennah, Ali	31.03.2022	
Design of mask stations to be reviewed	Design of mask stations to be reviewed	Review to be undertaken	Kennah, Ali	31.03.2022	
Review Nurse cleaning roles & responsibilities	Reviewed as part of a Task & Finish Group to implement revised cleanliness standards	Agree roles and reseponsibilities	McGreal, Julie	31.03.2022	
Review ventilation – mechanical and manual	Site-wide survey to assess compliance with HTM.	Review ventilation – mechanical and manual	Wright, Ian	31.03.2022	

Board Assurance Framework

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

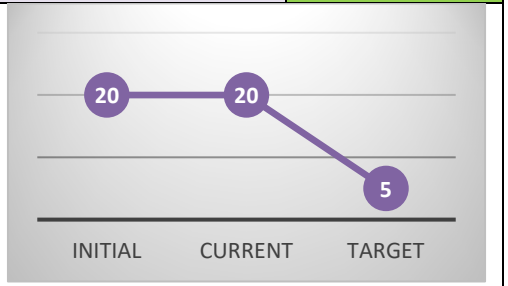
Confirmed continued use of the private sector (Spire Cheshire) in 2021/22. Under new contracting arrangements.
Waiting lists monitored and measured weekly
Post Anaesthetic Care Unit (PACU) remains open and operational
Continue to undertake harm review process and triangulate with waiting list process and Priority 2 patients
Continue to specifically focus on and monitor patients waiting greater than 52 weeks
Continue to ensure urgent cancers are prioritised in line with national guidance
Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site.
Bioquell Pods in ED live and operational
B18 footprint development to support improved Respiratory & Critical response to peaks in the pandemic is underway and set to complete in September 2021.
Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee.
Safe staffing levels reviewed daily. If necessary this may mean a review of clinical services to support the release of staff on a temporary basis.
The re-start of the Warrington site green pathway commenced w/c 8th February in the newly established ward A5 elective footprint. At present this supports cancer and other green pathways on the Warrington site
Clinical Recovery Oversight Committee (CROC) established
Clinical Services Oversight Group (CSOG) established
Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery.
B18 opened in October 2021
Respiratory nursing business case approved to support step down of respiratory patients from ICU to B18 earlier in their care pathway thus creating ICU capacity to support planned care
Additional ultrasound contract awarded to start in January 2022
Successful bid of c£3m to support elective recovery in H2
All priority/urgent cancer P1 and P2 elective plans have been maintained through wave 5
To support capacity for Wave 5, elective activity moved to CSTM Halton facility to protect elective programme
Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments
Increase in Trust WLI rate agreed until 31.03.2022 to support restoration and recovery. Business Case to support the increase in to 2023/24 currently in development
Additional echo activity as per the H2 elective fund plan starting w/e 12th February 2022 delivery an additional c104 echos per week.



Theatres 3 and 4 currently used for Endoscopy rather than as Theatres until the Endoscopy rooms are completed in October 2021
Limited bed base within A5 elective footprint
Increase in COVID-19 ICU patients as a result of wave 4 (July 2021) impacted on scheduling for patients requiring ICU post op

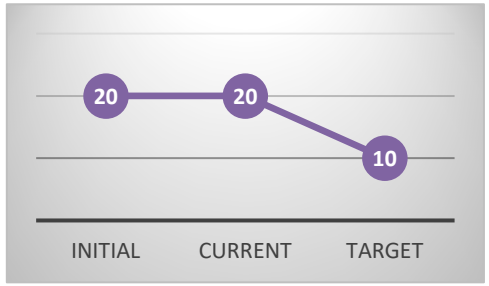
Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop Business Case to increase WLI rate for 2023/24	Develop Business Case	Dan Moore	30.03.2022	

Board Assurance Framework

Risk ID:	1590	**Executive Lead:**	Cloney, Michelle	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Failure to prevent staff shortages within certain professional groups and / or CBUs caused by individual decision making associated with the amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, introducing the COVID vaccination as a condition of deployment (VCOD) resulting in staffing gaps, a reduction in service provision and risks associated with risk 115 concerning staffing levels.			**Initial:**	20 (4x5)
				Current:	20 (4x5)
				Target:	4 (1x4)
Assurance Details:	• Partnership working in place between HR teams, senior operational leaders and staff side to confirm all staff in-scope – through SEOG governance processes • All unvaccinated staff have been identified and supported via email, letter and one to one conversations to ensure that they are fully informed in relation to their personal circumstances and individual decision making – governed through Data Protection connected with legislation and follow-up communications through OH from a patient perspective • Robust communication plan in place including multiple organisational briefing sessions delivered at various times to meet the needs of all staff groups – tailored to meet the needs of the workforce • All unvaccinated staff encouraged to complete form informing the organisation of their intent in relation to vaccination to enable the provision of bespoke support and to enable the organisation to understand the risk to specific services – risks to services identified in next phase of implementation and as part of VCOD redeployment processes. • On Monday 31st January 2022 the Secretary of State announced that VCOD is now being reconsidered • Consultation on revoking VCOD closed on 16 February 2022 • Response published 1st March 2022 – 90% in favour of revocation • Regulations revoking VCOD will come into force on 15 March 2022 • Government will continue to work with stakeholders to engage those yet to be vaccinated; this includes professional regulators, who will be encouraged to review their current vaccination guidance to registrants • Intends to consult on the Code of Practice on the Prevention and Control of Infections to strengthen requirements in relation to COVID-19				
Assurance Gaps:	*Details to follow*				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Risk ID:	134	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that future loans will be required which would raise the question if the Trust is a going concern.			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	10 (5x2)
Assurance Details:	•Core financial policies controls in place across the Trust •Revised governance structure within the Trust to enable strengthened accountability •Finance and Sustainability Committee (FSC) established overseeing financial planning •Regular financial monitoring with NHSE/I •Regular review at Executive team meeting and development sessions •Annual plan development process • Achieved 2020/21 Control Total. • Achieved Break Even H1 2021/22 • Unqualified audit opinion (2020/21) •Corporate Trustee Charities Commission Checklist, reporting annually through Board •Monitoring of charitable funds income and annual assessment of investment and reserves policies •Regular updates to Executive Team, FSC and Trust Board •Financial Resources Group (FRG) and Capital Resources Group that report to FSC • Workshop undertaken with - Exec, CBU, Corporate to review 2021/22 cost pressures • Workshops undertaken and continue for 2022/2023 budget setting • In 2021/22 the Trust has funded 14 cost pressure business cases, 4 have been completed and approved and there are currently 10 outstanding which are expected to be completed by 31st March 2022. •Completed MIAA Governance Checklist received by Audit Committee •H1 Expenditure Budgets approved by the Trust Board on 31st March 2021 •Capital Plan approved by Trust Board on 31st March 2021 (£19.75m) •c£34m cash support secured in the form of PDC in March 2021 •Monthly Report to Executive Team Meeting and FRG includes review of outstanding MIAA recommendations and actions. The report also highlights the number of retrospective waivers compared to the same period in 2019/20. Detail of CIP progress and actions to work with CBUs using benchmarking data such as Model Hospital and PLICS. •Capital is reported monthly detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. •Phase 3 of the Health Infrastructure Programme (HIP) announced. WHH submitted an Expression of Interest (EOI) in September 2021. WHH assessed & submitted by Cheshire & Merseyside Health & Care Partnership to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&M <u>COVID-19</u> • Governance process in place to ensure all additional costs are being approved and monitored – re-introduced for Wave 2, Wave 3 & Wave 4. Further re-introduction in January 2022 related to the latest COVID-19 surge. • Reporting to NHSE/I • Regular attendance to regional and national conference calls • Circulate latest guidance from MIAA Counter Fraud team • 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				

Board Assurance Framework

	• Quarterly Report to Exec & F&SC on COVID Pay Costs • Deloitte Audit completed. Positive report received with one overclaim reported (£112k). Final report received by the Finance & Sustainability Committee in July 2021 and presented to the Audit Committee in August 2021 • Participating in exercise to understand run rate for 2020/21 & 2022/23 to support funding envelopes for 2021/22 & 2022/23 • Executive review of COVID-19 costs completed and supported as part of budget setting. • Clinical Review Oversight Committee (CROC) established to provide oversight and assurance on recovery performance. • Submitted breakeven plan for H1 and H2 • H1 ERF was £3.3m • H2 included ERF of £0.7m • Mitigation plans for the Cheshire & Merseyside £50m gap have been identified. The Trust is currently forecasting a breakeven position.	
Assurance Gaps:	• Inability to develop a strategic plan to deliver a break-even position over the next 5 to 10 years • Non-recurrent and unidentified CIP presents a risk to in-year and future year financial position. • Failure to fully comply with emerging national employment litigation resulting in additional pay costs or the trust receiving potential claims. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Risk that capital needs exceed capital funding resources available. • Need to determine the future run rate which is currently uncertain in order to mitigate risks. • Increased threat of fraud during COVID-19 global pandemic • Uncertainty of the Trust allocation from the Cheshire & Merseyside Integrated Care Board • Cheshire & Merseyside system is required to break-even • ERF Funding is not guaranteed and is non-recurrent & subject to system performance and achievement of five gateways. H2 ERF of £0.7m at risk due to planned activity stepped down across the region • Capital slippage poses a risk to next year's programme. Cheshire & Merseyside capital for 2022/23 oversubscribed. • Risk of unforeseen costs due to current COVID-19 surge • Availability of social care to support the current super stranded position (currently c25% of bed base) • Forecast non-recurrent CIP c£3m for 2021/22 will present a pressure for the 2022/23 budget • Second draft of the Financial plan is showing a deficit of £21.2m	

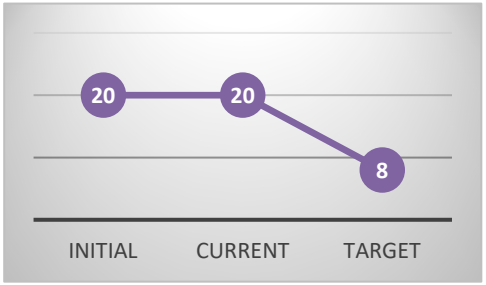
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Submit requested Workforce & CIP information to NW Intensive Support Director	Cheshire and Merseyside Health & Care Partnership in receipt of Tier 1 Intensive Support – Information requested by NHSE/I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

Board Assurance Framework

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

Assurance Details:

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



Board Assurance Framework

	• Regular reporting on compliance with risk assessment requirements is in place and reported at Tactical on a weekly basis.
	• Regular training on COVID-19 Workforce Risk Assessment is in place.
	• A letter was sent out to all staff who have not completed the self-risk assessment in a timely manner, the number of outstanding self-risk assessments reduced by 43%.
	• Trust continues to be challenged by high sickness absence rates nationally the North West has higher sickness absence rates. Trust has conducted a deep dive into their data and also participated in a NHSE/I deep dive to understand the challenged faced. Improving attendance programme commenced in September 2021 incorporating the data findings and recommendations of both deep dives.
	• Overall absence rate is 6.36% for Sept 2021 and is therefore reducing. Sept 2020's absence rate was 6.69%.
	• The Trust has also recently secured funding from NHSI/E to be used to deliver a 4-month project to launch the WHH Supporting Attendance Policy
	• New Supporting Attendance Policy to go live from February 2022 policy is currently in final stages of ratification process.
	  ○ Preventative measures continue to be implemented including;
	  ▪ Occupational Health and Wellbeing interventions
	  ▪ COVID Booster Campaign
	  ▪ Flu Vaccination Campaign
	  ▪ Asymptomatic staff testing
	• The Trust continues to promote the importance of Return to Work interviews to support attendance and bespoke Manager training has been undertaken in pilot areas with high levels of return to work non-compliance.
	• Extensive communications via Trust Safety Huddle and global emails to promote use of PPE, social distancing and compliance with environmental risk assessments restricting numbers within confined staff areas.
	• Participation in LAMP testing. Due to low update a comprehensive communication and engagement plan has been deployed in order to increase compliance. The Trust is currently planning to move towards an Asymptomatic Testing approach.
	• COVID vaccine programme continues with good uptake from across the workforce, with monitoring arrangements in place.
	• COVID-19 Workforce Recovery Steering Group commenced.
	• Supported by funding from NHSI there has been a big push to fill our HCA vacancies, we are currently reporting 28.95 FTE vacancies (31/11/2021).
	• In Nov 2021 overall vacancy rate has continued to reduce to 7.65% compared to a peak in Jun 2020 of 10.5%.
	• 96 of our 96 international Nurses are now in the country.
	• Therefore, as vacancies and sickness absence reduced it is expected our bank and agency reliance reduce and within Nov 2021 reliance on bank and agency staff increased slightly to 13.45% compared to a peak of 23.3% in Jan 2021
	• In response the continuing staff pressures within the care system, national guidance has been released to support organisations to identify fully vaccinated staff who are identified as a contact of a positive COVID-19 case, to return to work, subject to the safeguards put in place.
	• The Trust introduced a tool to support the decision-making process. This tool was developed following the published guidance:
	  ○ Infection prevention and control (IPC) guidance on infection prevention and control for COVID-19
	  ○ Sustained community transmission is occurring across the UK and COVID-19: management of staff and exposed patients or residents in health and social care settings
	• To date implementation of the tool has saved the Trust a total of 1610 days, with 215 staff members having been approved by OH to proceed with the approach.	

Board Assurance Framework

	• Mandated vaccination of NHS staff – following introduction of new legislation on 6th January 2022 the Trust is currently following phase 1 guidance in relation to Vaccination as a condition of deployment (VCOD) there is a separate BAF for VCOD	
Assurance Gaps:	• Staff will receive results and instructions from national Trace and Trace service and will have to self-isolate if the contact is from a household member. • Continued lack of national/regional clarity of the management of long covid in the context of the National agreement. • Potential gaps within services brought by introduction of VCOD. • Administrative & Clerical and Estates & Ancillary staff are still experiencing over 1% absence rate related to COVID-19 • Additional Clinical Services and Nursing & Midwifery staff are still experiencing over 2% absence rate related to COVID-19. This impacts requirements for temporary staffing.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
VCOD to be added to the Board Assurance Framework for enhanced oversight	Submit proposal for the new risk in relation to VCOD to the Trust Board	Approval from the Trust Board to add VCOD risk to the Board Assurance Framework	Roberts, Carl	31/03/2022	

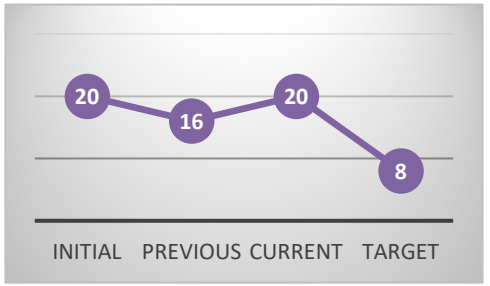
Board Assurance Framework

Risk ID:	1114	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	FAILURE TO provide essential 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..			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	8 (2x4)

Assurance Details:

Assurance:

- **Digital Governance Structure** including weekly structured Senior Leadership Team meetings, Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Data Standards Group reporting to the Information Governance and Corporate Records Sub-Committee with escalations to the Quality Assurance Committee and onwards to the Digital Board, which itself submits highlights to the QAC and resource go to FSC. The **Quality Assurance Committee report provides** assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Cyber Essentials Plus/Audit Actions/IG training figures).
- **Digital annual IT audit** plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with progress monitored at the Trust Audit Committee.
- **Trust benchmarking** activities including Use of Resources reviews (Model Hospital).
- ITHealth Assurance Dashboard is live, monthly external penetration testing is now in place using NHS Digital's VMS service and BitSight security score is live.
- Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. (March 2021)
- Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital (December 21)



Controls:

- **Digital Operations Governance** including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard.
- Active membership of the **Sustainability Transformation Partnership Cyber Group.**
- **Digital Change Management** regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions.
- **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training.
- **Cyber Training** for the Trust Exec Board
- Secured annual capital investment to increase Digital skills and capacity.
- Digital Board support for profiling of a 7 Year Capital investment based upon asset replacement cycle and strategic roadmap (to deliver the approved Digital Strategy (January 2020))
- The use of automatic patching software to rollout security updates to devices.
- Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links.
- 5 servers 2008 R2 unable to install security patches: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system & Winscribe dictation system (all issues resolved).
- Office 2010 being used while end of life due to the N365 deployment plan (100% migrated)
- Secondary secure backup at Halton Data Centre

Board Assurance Framework

	• Remote devices no longer bypassing the web proxy • Active Directory password set to expire again (covid working from home-related). • Fully recruit to the Digital Service restructure Phase 1 restructure • Outcome of the second Phishing exercise by NHS Digital, communications have been sent out to staff members who entered details for awareness.	
Assurance Gaps:	**Gaps In Assurance:** • Mostly achieving of mandated compliance with DSPT, incorporating CE+ (moderate assurance given by MIAA for the standards audited and substantial in respect of the veracity of the self-assessment) **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Current performance of Lorenzo and whether migration to the cloud will provide any benefit. • Development of staff behaviours to protect data evidenced via reduced IG incident report levels, impacted training due to Covid-19 pandemic. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Not all Windows Server 2003 server will be migrated to Windows Server 2016 before the N365 agreement starts. (1 out of 77 servers are at risk of not being migrated in time. The system at risk is Medicorr.) • No local device (PC & laptop) based firewalls in use while on site, dependant on the site boundary firewalls • Using generic logins staff usernames and passwords are stored in browser when selecting "remember me" • No dedicated logging tool to pull all key logs together and provide useable alerts. MIAA to review processes and tools (July 21) •Using no longer supported Exchange 2010 email system for mail archive • Using SharePoint 2010 for the Hub • Lack of process to check antivirus alerts in console. MIAA to review processes and tools (July 21) • Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security).. • No controls in place for Bluetooth connectivity. • No agreed patching schedule for network equipment with the Trust. • Temporarily Uninstalled Mcafee on PACS servers for 1 week (10/03/22)	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Standardised policies and procedures across the C&M STP using the core documentation from standard of ISO 27001 and the DSPT	Standardise policies and procedures across the C&M STP	• MIAA to map the basic standards to form the minimum and gold standard of documentation for Cyber. MIAA and WHHT to create the documentation templates from the mapping: • ISO 27001 (ISMS) • Data Security & Protection Toolkit (DSPT) • Information Security Standard (ISF) • Centre for Internet Security (CIS) • Information Systems Audit and Control Association (ISACA) • National Institute of Standards and Technology (NIST) • Cyber Security Body Of Knowledge (CyBOK)	Deacon, Stephen	31/03/2022	

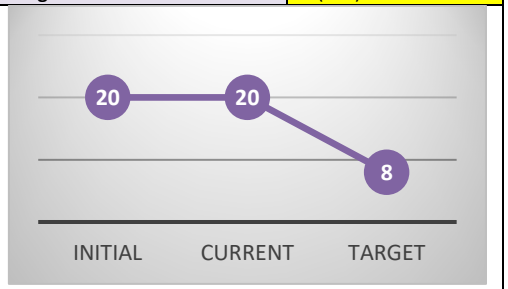
Board Assurance Framework

		[Progress has been slow as core members were trying to provide an automated "bot" style document suite. This was too ambitious, and the group decided to scale it down to templates only. MIAA have writing the templates. The workstream are currently reviewing these documents for the 5th review and providing feedback and will be approved by the May C&M STP Cyber Group. Once approved Digital Compliance would rewrite the local documentation and seek approval from the Information Governance and Records Sub Committee.]			
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system). [Delivers: Best Practice]	Migrate all 2003 and 2008 servers to 2016.	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to Windows Server 2016 • Extend Support for Windows Server 2008 until Feb 2022 NB: Windows Server 2003 is out of support; however, Windows Server 2008 is still in support until March 22. [All simple migrations have been completed by IT Services. A report was presented at the October's Digital Board, providing progress made in the decommissioning of Windows 2003/2008 servers, the timetable for decommissioning the remaining servers and the mitigations identified for those servers which are unlikely to be decommissioned before 31st December 2020. The only server at risk is the Medicorr Server. As part of the DSPT requirements we have asked for an update action plan.]	Deacon, Stephen	31/03/2022	
Migrate the last 9 endpoints devices to Windows 10	Migrate the last 9 endpoints devices to Windows 10	4 devices migrated with 5 devices left The below endpoint devices can be replaced: 1 x Laptop in Medical Engineering – Unsure why this is still in use.	Waterfield, Tracie	31/03/2022	

Board Assurance Framework

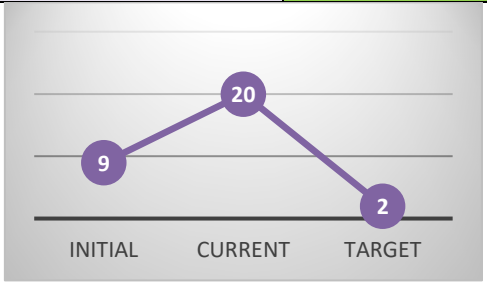
		(Deployment contacting ME regarding whether still in use) Endpoint devices more complicated to migrate: 1 x Dexa Scanner computer – This cannot be replaced at the moment, however, a new dexa scanner has been procured, just waiting on delivery and installation (waiting on date). 1 x Ophthalmology Fundus imaging computer – This cannot be upgraded/replaced as the Fundus camera is not Windows 10 compatible. Conversations on going with the department around replacement camera or removing use of the system altogether. 1 x Pathology Cognos client – This is some sort of information reporting system used in Pathology. They have supposedly purchased a replacement, just not implemented it yet (waiting on date) 1 x Cardiology (can be replaced but need to contact the 3rd party)			
Turn on device firewalls, to help limit a spread of an infected device infected other devices on the internal network	Turn on local device firewalls	Prioritise workload to look at turning on personal firewalls Create a test group Phase turn on / turn on [Meeting set up for 03/09/21]	Deacon, Stephen	31/03/2022	
Define escalation process for cyber incidents out-of-hours	Define escalation process for cyber incidents out-of-hours	Meet with IMersey regarding process	Deacon, Stephen	31/03/2022	

Board Assurance Framework

Risk ID:	1125	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	8 (2x4)
Assurance Details:	• Following national EPRR guidance for Cancer & RTT • All patient referrals are being prioritised due to clinical need • Rejected referrals are following recognised procedures particularly ensuring all have a clinical review to determine outcome • Moved a high proportion of OPD activity to virtual. • One elective theatre maintained for cancer and clinically urgent cases • Maintaining monthly reporting for each external standard • Discussed at the NED led Clinical Recovery Oversight Committee (CROC) • Discussed at the Clinical Services Oversight Group (CSOG) • Constitutional Standard Performance reporting to the Finance & Sustainability Committee (F&SC) • Executive attendance at the weekly Elective Restoration meeting for Cheshire & Merseyside. Linked with the ICS Governance Structure • H2 planning linked to restoration & recovery agreed with NHSE/I • Restoration & recovery achievement of constitutional standards will be further impacted by wave 5. This will be addressed in the 2022/23 activity plan in line with planning guidance issued on 24th December 2021. • Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments • Additional echo activity as per the H" elective fund plan starting w/e 12th February 2022 delivery an additional c104 echos per week. • Increase in Trust WLI rate agreed until 31.03.2022 to support restoration and recovery. Business Case to support the increase in to 2023/24 currently in development • The Trust is developing a bid to become a Community Diagnostic Centre (CDC) as part of the second tranche of national funding. This would be situated on the Halton Campus. Bids to be submitted in March 2022 • The Trust will be bidding on 8th March 2022, for Cheshire & Merseyside Elective Restoration Capital Fund with a number of schemes to increase elective capacity on the Halton site				
Assurance Gaps:	Some weekly reporting reduced as per guidance				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop Business Case	Develop Business Case to increase WLI rate for 2023/24	Develop Business Case	Dan Moore	30.03.2022	

Board Assurance Framework

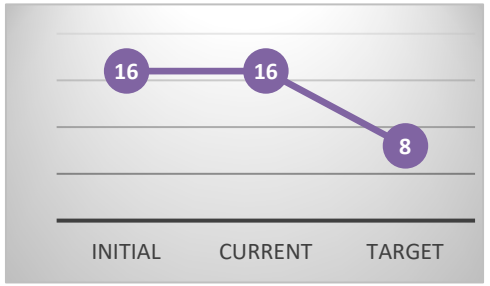
Risk ID:	1079	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.			**Initial:** 9 (3x3) **Current:** 20 (4x5) **Target:** 2 (2x1)
Assurance Details:	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 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 (LCM) Support currently in place to cleanse historical data In order to ensure health visitors are notified, the previous paper based system has been replaced with an electronic notification system, with a fail safe in place to ensure no patients are not notified to the appropriate service. AN electronic HV notification has been set up and tested in Warringotn and new are ow working with IT teams in Halton CCG to replicate the elctronic notification system we have in Warrington. Presentation provided by prospective suppliers on 18th December 2020 Clevermed identified as the preferred supplier in February 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 May Digital Maternity board in place to ensure full oversight is provided. Weekly digital transformation meetings in place to progress operational actions. Staff training schedule initiated to ensure all staff can be supported during the implementation phase. Increased training sessions may pose a potential staffing pressure and risk in terms of COVID/Omicron variant status and potential reduction in staffing. Off line working on Lorenzo launched in January 2022 to mitigate risk prior to Badgernet implementation in May . This will support implementation of Maternity Incentive Scheme Safety Action 2 : MSDS submission			
Assurance Gaps:	Lack of connectivity to ensure that systems can operate Lack of data to provide internet hotspot			

Board Assurance Framework

	The current digital solution is contributing to poor data quality and its detrimental care quality and activity income effects, poor staff moral and concerns by regulators Work related stress due to additional hours required to achieve correct level of data inputting leading to sickness absence Lack of assurance that all women are captured for both operational clinical and financial ends. This leads to uncaptured activity and risk to safety if women are not entered onto the system appropriate due to the above Loss of income due to poor data quality. The cross checking is dependent on time being available for the team to complete this time consuming task Ineffective use of midwifery time- midwives continuing to report excessive additional effort to correct omissions and inaccuracies, impacting upon carer/woman relationship and data quality, and leading to concerns that the current situation may impact the Trust's aspirations to achieve outstanding status.

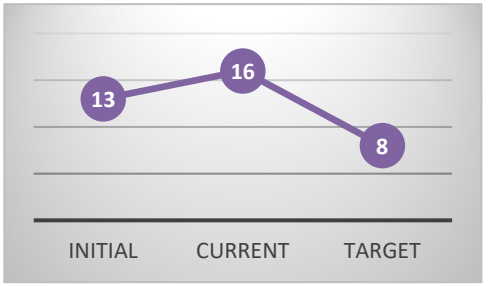
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Implementation of new EPR system	New EPR is fully in use and all training completed	Implementation plan Training of staff on new EPR.	Arya, Dr Rita	31/05/2022	

Board Assurance Framework

Risk ID:	1207	**Executive Lead:**	Michelle Cloney, Chief People Officer	**Rating**	
Strategic Objective:	Strategic Objective 2: We will… Be the best place to work with a diverse and engaged workforce that is fit for now and the future				
Risk Description:	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. The two staged approach to risk assessments means that this will be caused by either employees not completing the self-risk assessment in a timely manner or managers not acting upon the information provided and completing a management risk assessment, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)
Assurance Details:	The Trust COVID-19 Workforce Risk Assessment Tool was developed by the HR and OD Team and launched in July 2020. The electronic tool enables all members of staff to undertake a self-assessment and followed by a risk assessment with their line manager where required. The implementation of the tool was supported by guidance, virtual training and regular reporting. Trust compliance as at 8th March 2022 Have you offered a Risk Assessment to all staff? - **Yes** What % of all your staff have you Risk Assessed? – **96.62%** What % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary? – **95.56%** What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary? – **93.21%** Reports of any outstanding self-assessment and risk-assessments are provided to managers on a daily basis and numbers of outstanding assessments by CBU / Department are escalated to Tactical Meeting. In addition, the HR Team proactively make contact with any managers where there are outstanding assessments. Consistently high compliance with both Self Risk Assessments (SRA) and Management Risk Assessments (MRA) has been demonstrated				
Assurance Gaps:	At 8th March 2022: •65 staff members yet to complete self-assessment (reduced from 231 in September 2021) •98 Management Risk Assessments are outstanding				

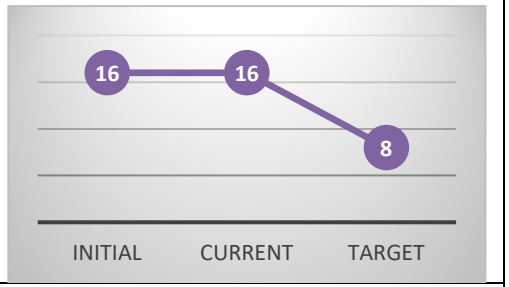
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Further encouragement on the completion of the Self-Risk Assessments to be sent, outlining the formal process that will be followed should the self-risk assessment not be completed	Letter sent requesting the completion of Self-Risk assessments.	• Further communication to staff re the importance of completing Self-Risk Assessments • Completion of Self-Risk assessments	Carl Roberts and Laura Hilton Deputy Chief People Officers	~~30/11/21~~ 31/01/22 The above new deadline is proposed, following the 60% reduction of SRAs following the initial letter	No longer required - 98.4% compliance and consistently above 94% since April 2021

Board Assurance Framework

Risk ID:	1372	**Executive Lead:**	Paul Fitzsimmons	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case			**Initial:**	12 (3 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)
Assurance Details:	Assurance: • Trust Board approved Outline Business Case has moved the project to the Outline Business Case stage • EPR Project B oard (and escalation/assurance through Digital and Trust Boards) • Regular, documented conference call with NHSE, NHSX and NHSD • Noted support of the Health Care Partnership Digital Board • Commissioning support of expert third party for development of business cases • EPR SRO and CIO to meet Chief Finance Officer and Trust Chair to agree expectations to assure the support of the Trust Board. • Checkpoint meeting with senior stakeholders to review the potential affordability Controls: • Approved business case for a new 3 – 5 year Lorenzo contract in support of time required to complete the procurement and deployment • Trust financial modelling includes 3 – 5 year Lorenzo costs • DXC working with Trust to migrate Lorenzo to AWS platform in spring 2021 to improve baseline performance • Trust performance Task & Finish group has introduced measures such as auto desktop reboots and Tech Refresh continues to assure all desktops are less than 5 years old • Implementation of approved Principle CCIO and Associate CCIOs to support the business case production • Pre-procurement market engagement with supply chain, against a pre-agreed discussion framework, to inform further costs and benefits opportunities for OBC • Project Manager assigned. • Financial modelling of realistic collaboration options to provide genuine 5, 10 and 15 year options to control whole life costs • Identification of further realistic cash releasing benefits • Approved business case for deployment of Lorenzo Theatres • Contracts for tactical solution signed				
Assurance Gaps:	Gaps In Assurance: • None Gaps In Controls: • Deployment of dedicated Maternity EPR and thus avoidance of the associated risks . Go live date in May 2022				

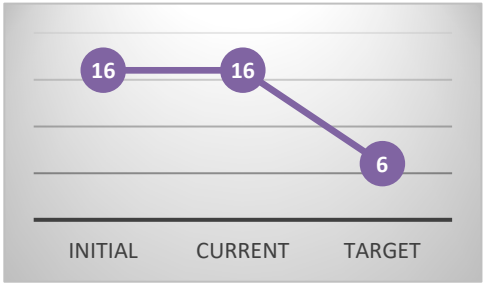
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Maternity go live	Maternity go live	Maternity go live	Deacon, Stephen	30/04/2022	

Board Assurance Framework

Risk ID:	1579	**Executive Lead:**	Daniel Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure of the Trusts ability to transfer patients with time critical urgent care needs to specialist units able to deliver time critical specialist interventions (Primary PCI, Hyperacute Stroke Intervention, Emergency Vascular Surgery, Major Trauma services etc) CAUSED BY an inability of the North West Ambulance Service, to provide the expected response times for critical transfers due to overwhelming demand on ambulance services, RESULTING IN a delay in transfer and thus potential severe patient harm due to the inability to access time critical specialist interventions without undue delay			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)
Assurance Details:	• LHCH PPCI pathways have been adjusted to give guidance for patients not being transferred for more than 120 minutes. • UEC are following the escalation process to the ROC/NWAS Control room to discuss patients transfer needs on an individual basis. • All SMOC's and Silver Command are aware of the escalation process. • With regards to trauma issues, UEC have raised this at the regional network meeting. For assurance a high level paper is presented to Trust Wide Trauma Group and Patient Safety and Clinical Effectiveness Sub Committee. • Trust continue to perform well against the ambulance handover times thus supporting the ambulance service • The Trust is working with NWAS on the implementation of a new regional handover process. Awaiting start date from NWAS				
Assurance Gaps:	NWAS assess there response times based upon current active and waiting calls when there regional activity is high. However, there is still significant delays.				

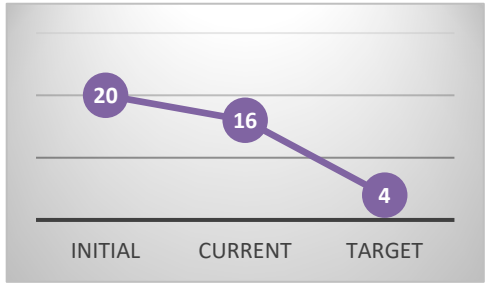
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Implement new escalated ambulance handover process	Work with NWAS to support the development of a regional escalated handover process.	Implement new escalated ambulance handover process	Sharon Kilkenny	30.04.2022	

Board Assurance Framework

Risk ID:	1233	**Executive Lead:**	Paul Fitzsimmons	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	FAILURE TO review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed CAUSED BY Combined Assessment Unit (CAU) frequently being bedded with inpatients due to overcrowding in the ED and an excess demand for inpatient beds RESULTING IN a lack of surgical assessment bed capacity, poor patient experience, delays in treating surgical patients and increased admissions to the surgical bed base.			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	6 (2 x 3)
Assurance Details:	Assurance: • CAU assessment capacity and availability considered on a thrice daily basis in bed meetings • CAU assessment capacity status considered at twice weekly Tactical Board • Regular CAU steering group meetings will continue to review effectiveness of controls Controls • Ensuring CAU assessment capacity is preserved or reinstated is a standing priority at bed meetings and Tactical Board • Other escalation areas bedded before escalation to bed CAU • A surgical ambulatory nurse co-ordinator supports surgical emergency admission patient flow • New ways of surgical working implemented 17/1/22 to mitigate risk by pulling patients requiring operative intervention directly to theatres from the ED and CAU to avoid delays to surgery caused by a lack of beds • Completion of the ED plaza will negate this risk as the dedicated assessment areas in the ED plaza cannot be bedded and as such surgical assessment capacity will be preserved				
Assurance Gaps:	Gaps in Controls • An admission avoidance clinic is set up but cannot be utilised effectively as no alternative assessment area is available to bring patients back to when CAU is bedded. • During periods of excess bed demand CAU is very likely to be a bedded area limiting the availability for the surgeons to review any admission avoidance patients. • Surgeons may struggle to find assessment areas in ED to treat patients • Any delay in the ED Plaza program will delay the resolution of this risk				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Completion of ED plaza	Increased dedicated assessment capacity delivered in ED plaza	Completion of ED plaza	Wright, Ian	01/04/2022	

Board Assurance Framework

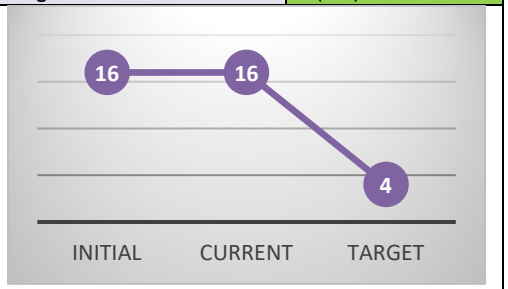
Risk ID:	125	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to provide safe, secure, fit for purpose hospitals and environment caused by the age and condition of the WHH estate and limited available resource resulting in a risk to meeting compliance targets, staff and patient safety, increased backlog costs, increased critical infrastructure risk and increased revenue and capital spend.			**Initial:**	20 (5x4)
				Current:	16 (4x4)
				Target:	4 (4x1)
Assurance Details:	Controls: 2018 C&M H&CP Estates strategy – updated annually Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out Capital Planning Group and associated capital funding allocation process Planned Maintenance Program Reactive maintenance regime Annual asbestos survey - asbestos management survey makes an assessment of the condition of any materials present and determine the likelihood of any fibres being released. Annual PLACE assessments Assurance: External estates compliance audit carried out in November 2019 which has in formed a number of remedial actions to improve compliance across the estate Monthly Estates compliance audit Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers Fire Safety Group – monitors fire safety issues across the trust and provides assurance to Cheshire fire and rescue service on Fire Safety Management PLACE assessment action plan and monitoring - Capital Planning Group – determine how the trust capital is spent Use of resources group – monitors how cost effective and value for money estates and facilities are in relation to a number of national and regional benchmarks New hospitals for Warrington and Halton groups – providing a platform to address the critical infrastructure and backlog risk 20-21 capital programme approved which includes £2.27m to address backlog maintenance Business Case for ED Plaza Scheme approved and due for completion in March in February 2022 Commencement of Phase 2 (although approved) reliant on capital funding in 2021/22 which is now confirmed. Progress will now be made against the scheme with indicative construction completion date of January 2022. Critical Infrastructure Capital Funding to support schemes with critical and high levels of backlog maintenance approved Cancer Alliance funding of £0.5m for endoscopy enabling work at Halton to improve the environment Phase 1 of CT Buildings work complete Additional staff rest areas deployed to support social distancing and reduce staff nosocomial infection during rest and break times during the Covid-19 pandemic. Approved and recruiting for additional Estates Compliance Manager role to support routine compliance and routine small estates works. New MRI build set to be completed in October 2021 New Endoscopy roofing infrastructure at Halton set to be completed in November 2021 Capital schemes to improve paediatric outpatients due for completion in April 2021 Capital schemes to develop a Urology Investigation Unit set to be completed by April 2022 Mortuary refurbishment set to be completed by November 2021				

Board Assurance Framework

	Ward B18 refurbishment completed in October 2021 Moving clinical services out of the Kendrick Wing and new Breast clinic opened at Halton in September 2021 Residual screening service to be opened at Bath Street by March 2022 Capital project plan for 2022/23 being worked up to upgrade Warrington kitchen facilities.	
Assurance Gaps:	Estates staffing - reduced staffing numbers since 2011 has impacted on ability to carry out elements of essential maintenance – review to be undertaken in 2021 Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome Cost pressures – unfunded elements of maintenance in I&E budget Use of Resources - benchmarking against backlog maintenance and critical infrastructure risk are below national medium Threat to the delivery of capital schemes due to the pandemic e.g. manufacturing delays, additional costs of construction relating to IPC guidelines and the unavailability of an appropriately skilled workforce.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Upgrade Warrington kitchen facilities	Following a review of the kitchen facilities at Warringotn Hospital. An improvement plan in place to progress	Complete upgrade of kitchen facilities	Ian Wright	31/12/2022	

Board Assurance Framework

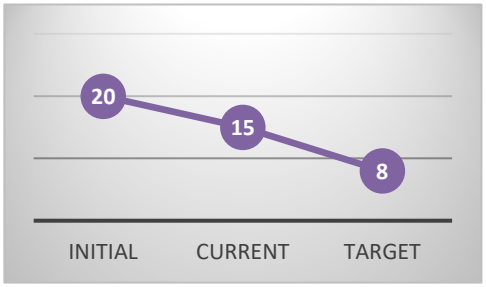
Risk ID:	1108	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are assessed as only able to work on a non-respiratory pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.			**Initial:**	16 (4x4)
				Current:	16 (4x4)
				Target:	4 (4x1)
Assurance Details:	Provided listening events and 1:1 meetings for all staff. This has resulted in accumulated feedback to identify key themes to be addressed. Review of all processes. Interim Head of Midwifery in post New CBU manager appointed and in post. Appointment of 9.2 WTE midwives. Daily staff meetings taking place to intensively monitor staffing. NHSP and agency staff are being used to back fill shifts where possible. Nursing staff utilised for C23 when it is not possible for a midwife to fill the post. When short staffed on C23, an extra maternity support worker is asked to work. NICE staffing red flags linked to Safecare implemented at beginning of June 2021 Midwifery management team strengthened – Two matrons in acting posts until end September 2021 All additional 9.2 WTE Midwives in post. Midwives redeployed across the unit as appropriate 1:1 care rate currently @ c92% Birth suite Manager appointed and in post 9th June 2021 Additional 3 Band 7 Birth suite Co-ordinators appointed 1st Feb 2021. Interview for permanent posts 27th June 2021 Birthrate plus full review funded by Local Maternity System to be carried out by 31st Dec 2021 3 X Interim managers extended until 30th June 2021 Board approved 6 recurrent additional band 7 WTE midwife posts and 1.58 band 6 WTE in March 2021 to support the roll out of the Continuity of Carer model – recruitment on going Daily staffing meeting and redeployment of staff to maintain safe staffing levels Birth Rate plus review has been undertaken and awaiting draft report end of October. This will incorporate Halton staffing and acuity in the report. Midwifery Staffing challenges continue and reviewed daily. Cheshire and Mersey Escalation and Divert Policy updated to support internal and external escalation. Weekly LMS gold command staffing meeting to identify staffing hotspots and need for mutual aid. Staffing vacancies appointed awaiting start date. 11 members of staff are still being supported to work in a green pathway, as per Occupational Health risk assessment and recommendations. The NHS is awaiting a national week commencing 28th February. Daily SITREP to LMS Submitted Gold Command meetings returned to weekly 21/2/22 Staffing continued to be monitored daily by senior team.				
Assurance Gaps:	Potential for uncertainty across the services as a result of COVID-19 pandemic Short term sickness 1 matron in maternity - 1 matron has stepped down Covid pressures remain and are exacerbated by the current annual leave absences this is a regional and national concern. Gold command and a daily / weekly sit rep has been created. Transfer of maternity service from Halton to WHH from 1st November 2021 including staff transfer and need to complete local induction which will add to current staffing pressures. Current absence/sick rate 8.47% and vacancy rate increased to 6.21%				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Continue to review staffing on a regular basis with daily reviews, and monitor vacancy rates closely to ensure prompt recruitment to any midwifery vacancies. Birth rate plus is currently in progress to be completed by the end September.	Actions to monitor staffing	daily reviews	Owens, Catherine	28/02/22	

Board Assurance Framework

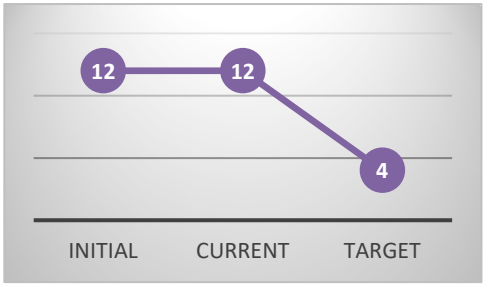
Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.			**Initial:**	20 (5x4)
				Current:	15 (5x3)
				Target:	8 (4x2)
Assurance Details:	The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the C&M Health and Care Partnership plans. The Trust has developed effective clinical networking and integrated partnership arrangements. Some examples include: - The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. - Council and CCG in both Warrington & Halton supportive of development of new hospitals. Agreement with key stakeholders to progress single programme and proceed with OBC development. - Agreement of sustainability contract with Warrington CCG and subsequently Warrington & HaltonSystem Financial Recovery Plan - Regular Strategy updates are provided to the Council of Governors - Clinical strategy wide engagement - Clinical Strategy approved by Trust Board - CBU specialty level strategies complete and incorporated in business plans. - Initial talks held with Elective Care C&M Lead in relation to the suitability of Halton as a potential Elective Care Hub. Opportunity to accelerate elective hub as part of Covid recovery - Trust has met with Cheshire & Merseyside leads for Women's and Children's review to demonstrate strength of local Women's and Children's services and help inform outcomes of regional review. - Breast Centre of Excellence opened to consolidate breast screening in Warrington but to commence in April 2022 - DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. Phase 3 of the HIP announced. WHH submitted an Expression of Interest (EOI) in September 2021 - Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. - Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside. Currently options for further development do not include any option where WHH is a hub. All options proposed include Essential Services Labs (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESLs. Pathology OBC supported by the Trust Board - Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services to commence from summer 2022. - Director of Strategy invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington				

Board Assurance Framework

	- Town Deal plan for Warrington submitted. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £22.1m funding approved for the Town investment plan, including £3.1m for the Health & Wellbeing Hub and £1m for the Health & Social Care Academy. - The Trust is leading the development of the detailed plan for the Health & Wellbeing Hub. - Strategy refresh completed and approved at Trust Board to confirm 2020/21 priorities. - Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. - In February 2021 the Government White Paper, "Integration and Innovation: working together to improve health and social care for all - The Department of Health and Social Care's legislative proposals for a Health and Care Bill" was published. - The Trust Board agreed in March 2021 that a transaction between BCH and WHH is no longer required, given that the White Paper enables an acceleration of place-based integration including all commissioners and providers. - The Trust has been awarded Social Value Award status recognising the contribution to the outcomes of local populations. It is one of only two organisations in Cheshire & Merseyside to receive the award. - £90k funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington - WHH commenced a focussed programme of work on addressing health inequalities, the green agenda and our role as an anchor instiution. Initial work recognised as the exemplary within Cheshire & Merseyside. - Consistent Trust representation within Cheshire & Merseyside ICS to support transition to ICS. WHH CEO appointed as Head for Clinical Pathways within C&M. - Trust representation on newley established place based Boards within both Warrington & Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected. - WHH assessed & submitted by Cheshire & Merseyside Health & Care Partnership to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&M	
Assurance Gaps:	Risk to securing capital funding to progress new hospitals Sefl assessments of both Warrington & Halton hospitals place based governance development indicate that Halton is 'emerging' (stage 2 of 4) and Warrington is establishes (stage 3 of 4). There is a requirement to further develp as places to ensure both boroughs can benefit from potential future autonomy.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Progress plans for new hospitals to be best placed to secure funding when available	Develop SOCs and participate in competitive process for HIP funding	Develop SOCs and participate in competitive process for HIP funding	Lucy Gardner	SOCs – April 2020 Expression of Interest due September 2021	SOCs – March 2020
Actively participate in and contribute to the development of integrated care partnerships at PLACE & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Simon Constable	31/03/2022	

Board Assurance Framework

Risk ID:	1290	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices, technology products and services, clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.			**Initial:**	12(3x4)
				Current:	12 (3x4)
				Target:	4 (1x4)
Assurance Details:	• The Brexit Sub Group has been stepped up with key leads for the associated work streams (Procurement, Pharmacy, EPRR, Finance, Communications, HR and Information). • The Procurement Department has undertaken a review of all suppliers as part of the national self-assessment exercise which was completed as C&M HCP system. Whilst this piece of work has been completed with no apparent adverse impact the Procurement Department continues to monitor fulfilment of orders to adopt a process of early investigation where supply appears to be disrupted. In addition, the Procurement Department is implementing processes to monitor prices to determine if there has been any financial impact upon exit from the EU. To date there are no significant price increases noted and this monitoring will continue. • Pharmacy continue to manage disruption alerts for medicines supplies related to Brexit. To date there have been no medicines supply issues linked to the end of the EU transition period, however recent logistical changes have impacted on the way some items are delivered. This has not caused much of an impact on the service and will be monitored through Brexit Subgroup or escalated if there is an impact on business continuity. • Nationally, lessons in supplies and medicines have been captured from the COVID-19 period and there has been assurances made around national supplies of PPE and consumables. • 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. The adequacy decision agreed in June 2021 means that personal data can continue to flow between the UK and the EU without restriction. However, the EU Commission has included a 'sunset clause' into its adequacy decision, which strictly limits its duration. This means that the UK's decision only lasts for four years until 27 June 2025. If the UK relaxes or changes data rules as part of its future data flow arrangements, or future trade deals, the EU may review the adequacy agreement and could end the free flow of data between the UK and EU. • Assurance letters and communication regarding the EU settlement scheme have been circulated as a reminder about the settlement scheme. An assurance exercise based on the EU settlement scheme was submitted to NHSE in May 2021, indicating no significant risks. The HR and OD team continue to monitor settlement status, impacts on leavers and new starters and the robust recruitment process includes reference to EU settlement status. • Re-instigated the Brexit Sub-Group on 9th September 2020 and the group continues to meet bi-monthly, this will be quarterly from January 2022 with the view to stepdown the group if there are no significant items to escalate. Ongoing updates will occur through the Event Planning Group. • In December 2020 NHSE/I completed an assurance exercise with NHS Trusts to ensure EU Exit SRO and EU Exit Team in place. • Processes developed by UEC and Finance to ensure chargeable patients are managed appropriately. From the Chargeable Patients point of view, there are no risks to financial procedures, patients or staff. Additional processes and a dashboard have been shared for assurance purposes. Communications plans continue with clinical teams to ensure the Chargeable Patients SOP is embedded. There will be an automated process introduced in March – April 2022 to support this process and for additional assurance alongside the current manual checks. • Daily SitRep reporting was stepped down on 08/06/21 as per communication from NHSE. • Single point of contact in place for operational response, aligned with the regional Level 3 incident expectations.				

Board Assurance Framework

	• An EU Exit deal was established on 24th December 2020. The impacts of the terms of this deal and the implications on the supply of medicines and consumables are under review nationally and locally. The Brexit Subgroup continues to meet to monitor the implications of the established deal. • The subgroup continues to meet quarterly to monitor national changes, including the current logistical challenges associated with EU exit.	
Assurance Gaps:	Continued national uncertainty on the terms of the EU exit. Trusts being requested not to stockpile supplies. Potential price increases to supplies. Winter pressures, COVID-19 pressures and increase demand on Workforce and UEC.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
#					

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/36**			
SUBJECT:	**Trust Board Cycle of Business 2022-2023**			
DATE OF MEETING:	30th March 2022			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first 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)***	All			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board and Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. The Trust Board Cycle of Business 2022-2023 is presented for approval			
PURPOSE: ***(please select as appropriate)***	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the 2022-2023 Cycle of Business for Trust Board			
PREVIOUSLY CONSIDERED BY:	**Committee**	N/a		
	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

PUBLIC TRUST BOARD – DRAFT CYCLE OF BUSINESS
JANUARY 2022 - MARCH 2023

	OWNER	JAN 2022	MAR 2022	TBC 2022 YEAR END	MAY 2022	JULY 2022	SEPT 2022	NOV 2022	JAN 2023	MAR 2022
Engagement story (15 mins)		X	X		X	X	X	X	X	X
OPENING BUSINESS										
Chairman's Opening Remarks, Welcome, Apologies & Declarations	**CHAIR**	X	X	X	X	X	X	X	X	X
Minutes of Previous Meeting & Action Log	**CHAIR**	X	X	X	X	X	X	X	X	X
Chief Executive's Report	**CEO**	X	X	X	X	X	X	X	X	X
Chairman's Report	**CHAIR**	X	X	X	X	X	X	X	X	X
QPS ASSURANCE										
Integrated Performance Dashboard incl Monthly Nurse staffing report	**EXECS**	X	X	X	X	X	X	X	X	X
PAF/ Review and refresh of Trust Integrated KPIs (April prior to formal signing in May)	**CFO&Dep CEO**		X	X						X
QUALITY										
Annual Complaints Report	**CN&Dep CEO**				X					
Learning From Experience Summary Report	**CN&Dep CEO**	XQ2	X Q3		XQ4		XQ1		XQ2	XQ3
Annual Health & Safety Report	**CN&Dep CEO**					X				
DIPC Report Annual	**CN&Dep CEO**					X				
DIPC Quarterly Report	**CN&Dep CEO**		XQ3		XQ4		XQ1	XQ2		XQ3
Infection Prevention and Control Board Assurance Framework Compliance Bi-monthly Report	**CN&Dep CEO**		X		X	X	X	X	X	X
Safeguarding Annual Report	**CN&Dep CEO**					X				
Moving to Outstanding (M2O) Update Report	**CN&Dep CEO**	X	X		X	X	X	X	X	X
Mortality Review (Learning from Deaths Quarterly Report)	**EMD**		XQ3		XQ4		XQ1	XQ2		XQ3
Medicines Management & Controlled Drugs Annual Report	**EMD**				X					
Annual SIRO Report	**CIO**				X					
Quality Strategy Update	**CN&Dep CEO**				X					
WHH Maternity Services - Compliance with Ockenden	**CN & Dep CEO**	X	X		X	X	X	X	X	X
CNST annual submission	**CN&Dep CEO**				X DRAFT TBC					
PEOPLE										
NHS Staff Opinion Survey	**CPO**				X					X
Nurse Staffing Bi-Annual report	**CN&Dep CEO**					X	X			X
GMC Re-validation Annual Report incl Statement of Compliance	**EMD**							X		
Engagement Dashboard Quarterly Report	**DC&E**	X Q3			Q4	X Q1		X Q2		
Engagement Dashboard Year End Report	**DC&E**				X					
Two year Patient and Public Participation and Involvement (PPP&I) Annual Report	**DC&E**				X					
Patient and Public Participation + Involvement Strategy Review	**DC&E**				X					
Guardian of Safe Working Quarterly Report	**EMD**	X Q3			XQ4	X Q1		X Q2		
Freedom To Speak Up – Guardian Bi-annual Report (Jane Hurst)	**CN&Dep CEO**		X				X			X
Hospital Volunteer Annual Report	**CN&Dep CEO**		X							X
Patient Experience Strategy Annual Review	**CN&Dep CEO**		X							X
SUSTAINABILITY										
Operational Plan & Budgets Approval	**CFO&Dep CEO**		X							X Final
Annual Capital Programme	**CFO&Dep CEO**		X							X
Emergency Preparedness Annual Report	**COO**					X				
EPRR Assurance Letter/Statement of Compliance	**COO**						X			
Use of Resources Quarterly Report	**CFO&Dep CEO**	XQ3			XQ4	XQ1		XQ2	XQ3	
COMMITTEE ASSURANCE REPORTS										
Audit Committee	**TRUST SEC**		X		X		X	X		X
Quality Assurance Committee	**CN&Dep CEO**	X	X		X	X	X	X	X	X

		JAN 2022	MAR 2022	TBC 2022	MAY 2022	JULY 2022	SEPT 2022	NOV 2022	JAN 2023	MAR 2022
	OWNER			YEAR END						
Finance & Sustainability Committee	**CFO&Dep CEO**	X	X		X	X	X	X	X	X
Strategic People Committee	**CPO**	X	X		X	X	X	X	X	X
Clinical Recovery Oversight Committee (wef May 2021)	**COO**				X	X	X	X	X	X
YEAR END										
Annual Report & Accounts Sign Off (inc Quality Account)	**CFO+Dep CEO/ CN&Dep CEO**			X						
Code of Governance Compliance & Compliance with Licence Annual Return – completion of FT4 Declaration, Condition G6 + certification of training of Governors – due end of May annually	**TRUST SEC**			X /YrEnd Audit						
Code of Governance Compliance & Compliance with Licence Annual Return – completion of Cos7 - due end of June annually	**TRUST SEC**				X Cos7					
Code of Governance Compliance & Compliance with Licence Annual report (for Year End / Audit Committee)	**TRUST SEC**			YrEnd Audit						
GOVERNANCE										
Strategic Risk & BAF Update	**TRUST SEC**	X	X		X	X	X	X	X	X
Annual Review Scheme of Reservation & Delegation (SORD) & Standing Financial Instructions (SFIs)	**DOF**		X							X
Risk Management Strategy Annual Report	**CN&Dep CEO**					X				
Board Annual Cycle of Business	**TRUST SEC**		X							X
Board Sub-Committee Cycle of Business for Ratification	**TRUST SEC**	QAC	AC &FSC		SPC & CROC				QAC	AC&SPC &FSC
Board Sub-Committee ToRs for ratification	**TRUST SEC**	QAC	CROC		SPC			FSC	QAC	AC2022& 2024 CROC
Charities Commission Checklist (annually)	**DC&E**					X				
WHH Charity Annual Report	**DC&E**						X DRAFT			
Charitable Funds Committee Governing Document (next March 2024)	**CHAIR/TRUST SEC**		X							
Charitable Funds Committee Cycle of Business	**CHAIR/TRUST SEC**		X							
Digital Board Report	**EXEC MED DIRECTOR**	X	X		X	X	X	X	X	X
Committee Chairs Annual Reports:										
Quality Assurance Committee Annual Report	**CHAIR**					X				
Finance & Sustainability Committee Annual Report	**CHAIR**				X					
Audit Committee Annual Report	**CHAIR**						X			
Strategic People Committee	**CHAIR**		X							X
CLOSING BUSINESS										
Any other business & Date of next meeting	**CHAIR**	X	X		X	X	X	X	X	X