WHH Board of Directors Meeting Part 1

Wednesday 24 NOVEMBER 2021
10.00am-12.30pm
Microsoft Teams

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

Wednesday 24 November 2021 time 10.00am -12.30pm

MS Teams

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

REF BM/21/11	ITEM	PRESENTER	PURPOSE	TIME	
BM/21/11/148	Digital Patient Story – 15 MINUTES	Kimberley Salmon – Jamieson, Chief Nurse & Deputy CEO	Film	10.00	
BM/21/11/149	Welcome, Apologies & Declarations of Interest	Terry Atherton Deputy Chair	N/A	10.15	Verb
BM/21/11/150	Minutes of the previous meeting held on 29 September 2021	Terry Atherton Deputy Chair	Decision	10:17	Encl
BM/21/11/151	Actions & Matters Arising	Terry Atherton Deputy Chair	Assurance	10:20	Encl
BM/21/11/152	Chief Executive's Report – *To follow*	Simon Constable, Chief Executive	Assurance	10:25	Encl
BM/21/11/153	Chairman's Report	Terry Atherton Deputy Chair	Information	10:35	Verb

Quality People Sustainability

BM/21/11/154	COVID-19 Performance Summary Report and Situation Report – *To Follow*	Simon Constable, Chief Executive	Assurance	10:40	Enc
BM/21/11/155 (a)	Integrated Performance Dashboard and Committee Assurance Reports	All Executive Directors Daniel Moore Chief Operating Officer	To note for assurance	10:45	Enc
(a i)	- Quality Dashboard including o Monthly Nurse Staffing Report	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO			Enc
(b)	- Key Issues report Quality and Assurance Committee (05.10.2021 02.11.2021)	Margaret Bamforth Committee Chair			Enc
	People Dashboard	Michelle Cloney Chief People Officer			Enc
(c)	- Key Issues Strategic People Committee (17.11.2021)	Anita Wainwright Committee Chair			Enc
	- Sustainability Dashboard	Andrea McGee Chief Finance Officer & Deputy CEO			
(d)	- Key Issues Finance and Sustainability Committee (20.10.2021 and 17.11.2021)	Terry Atherton Committee Chair			
(e)	- Key Issues Clinical Recovery Oversight Committee (14.10.2021 & 16.11.2021)	Terry Atherton Committee Chair			

Quality

BM/21/11/156	Moving to Outstanding (M2O) Update Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	To note for assurance	11.30	Enc

BM/21/11/157	**COVID-19 Overview Report**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**To note for assurance**	**11.35**	**Enc**

Sustainability

BM/21/11/158	**Use of Resources Q2 Report**	**Andrea McGee Chief Finance Officer & Deputy CEO**	**To note for assurance**	**11.45**	**Enc**
BM/21/11/159	**WHH as an anchor** • **Update on heath inequalities, social value and the green agenda** • **Draft Green plan**	**Lucy Gardner Director of Strategy & Partnershps** **Ian Wright Associate Director of Estates & Facilities**	**To note for assurance**	**11.50**	**Enc**

People

BM/21/11/160	**Engagement Dashboard Q2 Report**	**Pat McLaren Director of Communications & Engagement**	**To note for assurance**	**12.00**	**Enc**

GOVERNANCE

BM/21/11/161	**Strategic Risk Register & BAF (Full BAF in Supplementary Papers)**	**John Culshaw Trust Secretary**	**To note**	**12.05**	**Enc**
BM/21/11/162	**Runcorn Shopping City Public Consultation Outcome Report (Please see Supplementary Papers)**	**Pat McLaren Director of Communications & Engagement**	**To note for assurance**	**12.10**	**Enc**
BM/21/11/163	**Breast Screening Consultation**	**Lucy Gardner Director of Strategy & Partnerships**	**To note for assurance**		**Enc**

MATTERS FOR APPROVAL

	ITEM	Lead (s)				
BM/21/11/164	**GMC Re-validation Annual Report incl Statement of Compliance**	**Anne Robinson Acting Executive Medical Director**	**Committee**	Strategic People Committee	**12.20**	**Enc**
			Agenda Ref.	SPC/21/09/72		
			Date of meeting	22.09.2021		
			Summary of Outcome	Approved		
BM/21/11/165	**Board Sub Committee Terms of Reference for Ratification:** - **Finance & Sustainability Committee** - **Quality Assurance Committee**	**John Culshaw Trust Secretary**	**Committee**	Finance & Sustainability Committee and Quality Assurance Committee		**Enc**
			Agenda Ref.	FSC 21/09/157 & QAC/21/10/241		
			Date of meeting	22.09.21 & 21.10.2021		
			Summary of Outcome	Approved		
BM/21/11/166	**Constitution amendments – Governor responsibilities**	**John Culshaw Trust Secretary**	**Committee**	Council of Governors		**Enc**
			Agenda Ref.	CoG/21/11/66		
			Date of meeting	11.11.2021		
			Summary of Outcome	Approved		

MATTERS FOR NOTING FOR ASSURANCE

	ITEM	Lead (s)				
BM/21/11/167	Infection Prevention and Control Board Assurance Framework Compliance Bi-monthly Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/21/11/274		
			Date of meeting	02.11.2021		
			Summary of Outcome	Noted		
BM/21/11/168	Infection Prevention and Control (DIPC Q2) Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/21/11/278		
			Date of meeting	02.11.2021		
			Summary of Outcome	Noted		
BM/21/11/169	Mortality Review Q2 Report	Anne Robinson Acting Executive Medical Director	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/21/11/282		
			Date of meeting	02.11.2021		
			Summary of Outcome	Noted		
BM/21/11/170	Guardian of Safe Working Q2 Report	Anne Robinson Executive Medical Director	Committee	Strategic People Committee		
			Agenda Ref.	SPC/21/11/102		
			Date of meeting	17.11.2021		
			Summary of Outcome	Noted		
BM/21/11/171	Patient Safety Strategy	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		
			Agenda Ref.	QAC 21/11/276		
			Date of meeting	02.11.2021		
			Summary of Outcome	Noted		

	Any Other Business	Terry Atherton Deputy Chair	N/A	16:55	Ver
	Date of next meeting: Wednesday 26 JANUARY 2022, Trust Conference Room				

Conflicts of Interest

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

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

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

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

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

Interests fall into the following categories:

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

GLOSSARY OF TERMS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 29 September 2021 via MS Teams

Present	
Steve McGuirk (SMcG)	Chairman
Simon Constable (SC)	Chief Executive
Terry Atherton (TA)	Deputy Chair, Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
Alex Crowe (AC)	Executive Medical Director & Chief Clinical Information Officer
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Daniel Moore (DM)	Chief Operating Officer
Andrea McGee (AMcG)	Chief Finance Officer & Deputy Chief Executive
Cliff Richards (CR)	Non-Executive Director
K Salmon-Jamieson (KSJ)	Chief Nurse & Deputy CEO and Director of Infection Prevention & Control (DIPC)
Anita Wainwright (AW)	Non-Executive Director
In Attendance	
Michelle Cloney (MC)	Chief People Officer
Lucy Gardner (LG)	Director of Strategy & Partnerships
Pat McLaren (PMcL)	McLaren, Director of Communications & Engagement
John Culshaw (JC)	Trust Secretary
D Carter	Project Director, Women & Childrens *(Item BM/21/09/119)*
Julie Burke	Secretary to The Trust Board
Observing Members of the public 1	N Holding Lead Governor S Fitzpatrick, C McKenzie, A Robinson, A Kinross, P Bradshaw Public Governors, L Mills Staff Governor, N Newton Partner Governor; 3 Staff members

BM/21/11/119	**Engagement Story**, The story had been received and discussed at the September Quality Assurance Committee. DC shared an overview of a patient story illustrating multi-disciplinary work and support to manage a patient with complex challenging behaviour in acute paediatric setting, highlighting learning and outcomes for all. The story demonstrated how different areas across the health economy had worked together providing support for the patient who required urgent assessment by Child and Young People's Mental Health Services (CYPMHS). Hourly risk assessments undertaken to ensure safe environment for all, the patient requiring 1:4 support during care. DC advised this had been one of the most complex cases she had seen in her NHS career and challenged as a system due to a national lack of Tier 4 beds. All staff involved in the care of the patient had been supported by the Executive and Senior Nursing Team, DC thanked KSJ and JG for their support. Areas of outcomes and learning highlighted: - The requirement to have a rapid tranquilisation policy for children - Early escalation; effective teamwork within Trust and external agencies

	- Joined up working with CAMHS and agency; Additional training for staff. - Paediatric Rapid Tranquilisation Policy and Standard Operating Procedure (SOP) in place. The patient remained with WHH for 10 days and was extremely grateful and thanked all staff for their care and support. The patient had subsequently returned home to mum without any unnecessary delay due to the support package put in place. KSJ recognised the great work undertaken by the Paediatric Team in such challenging circumstances and the rapid response and support from all areas to de-escalate in light of the complex safeguarding issues, as well as the efforts and support of departments outside of ED, including Estates and Governance colleagues. MB thanked DC for this overview recognising the efforts to manage the challenging satiation against the backdrop of COVID challenges, recognising the very positive outcome for the patient and mum to ensure the patient was returned home. CR recognised the support of the Anaesthetic Team to the patient and staff. SMcG thanked DC for the overview and the considerable challenge presented to the Team and wider organisation, the sensitive and responsive care provided, the positive outcome. On behalf of the Board, he conveyed thanks to all departments involved in offering their support.
BM/21/11/120	**Welcome, Apologies & Declarations of Interest** The Chairman welcomed all to the meeting, advising that the CEO would join the meeting later due to urgent meeting. No apologies noted. LG made the following declarations of interest, appointed Governor of Warrington & Vale Royal College, Husband employed by Weightman's solicitors, one of the Trust's legal representative. On behalf of the Board, the Chairman wished I Jones well on his forthcoming retirement, thanking him for his contribution and support to the Board. He also wished A Crowe every success on his new appointment, thanking him for all his support to WHH.
BM/21/11/121	**Minutes of the meeting held 28 July 2021** Pg 5 BM/21/07/92 6th para relating to Sepsis clock start to be reworded. With this amendment, the minutes of the meeting held 28 July 2021 were agreed as an accurate record.
BM/21/11/122	**Actions and Matters Arising. Action log and updates noted and recorded.**
BM/21/11/123	**Chief Executive's Report** The comprehensive report was taken as read. The Chairman asked if colleagues had any questions to raise these when SC joined the meeting. No questions raised. **The Board noted the report.**
BM/21/11/124	**Chairman's Report** The Chair reported meetings continue, internal and external meetings including Board, Council of Governors, Governor Briefing meetings and 1:1 Lead Governor meetings. External meetings included Local Authority CEOs, NW Chairs, local partners and

	stakeholders. Since the last Board, a number of appointments had been made including 2 Non-Executive Directors (NEDs), 3 Associate NEDs, and Executive Medical Director. The Chair had supported local NHS organisation in their NED recruitment and appointment. Attended ICS Board stakeholder session for the Chair appointment. Recommendation made, announcement on appointment awaited. ICS Board CEO recruitment process underway. The Chair had recently visited Catering Department and invited back with the Lead Governor to observe logistics of preparation and delivery food to staff and patients. **The Board noted the update.**
BM/21/09/125a	**IPR Dashboard and IPR Key Issues** The Chair introduced the report, requesting an update on response to the increased ED demand and mitigating actions, Sepsis performance for Quality and Performance portfolios. **Quality –** KSJ reported the Trust had achieved 12 months free of MRSA Bacterium. Sepsis - current position and mitigations in place to support improvement include, Executive oversight of figures, reviewed on a weekly basis by herself, AC and Senior Clinical leaders. Daily escalation process from ED to support improved performance, enhanced support in ED, focussed communication/recruitment plans to be rolled out w/c 4 October 2021. Very senior leaders (Deputy Chief Nurse) supporting screening in ED and administration of antibiotics. Screening position - within 1 hr 62% in September, between 1-2 hrs 22%. Updated action plan to be presented for oversight, scrutiny and assurance of mitigations in place to October Quality Assurance Committee. Antibiotic administration within 1 hr 47%. Business cases being progressed for additional Pharmacy Support and Antibiotic business case as previously reported to Board. In-patient Sepsis screening August 53%, 70% screening with 1 hour, Antibiotic (IV) screening 70% within 1 hour, 13% between 1-2 hours. Only a small number of patients receiving screening after this timeframe. Staffing and recruitment challenges escalated to Senior Team, supporting communication across the department to ensure on track. Enhanced training and leadership in place. KSJ reassured the Board that patients are reviewed through the Mortality Review Group (MRG) with Sepsis on death certificates. No harm identified through Sepsis, other contributing health factors had contributed. Full report to be reviewed to October QAC. CR enquired of nature of delays, was this due to delay in bloods being taken and when results received and/or of handover delays. KSJ explained number of contributing factors to overall delay of administration of IVs or screening, including different delays experienced on different days, significant increase in ED attendances and acuity of those presenting. - Clinical practice changed to support improvement in time to take bloods,

reassurance provided through enhanced training risk will be minimised.
- Way and time required for IVs to be reconstituted of 20-30 minutes.
- Staffing challenges discussed earlier, 20% nursing turnover in ED, mitigations to fill vacancies include backfill with locums and reassigning staff to areas of need.
- Patient Safety Team located in ED Triage to identify at risk patients and Acute Physician identified to attend and support Sepsis Champion and wider ED team
- Referring to handover delays, KSJ highlighted particularly staffing challenges, increased attends in ED at any one time, some practice issues taking bloods and some gaps in training. Again KSJ reassured the Board of combined Executive and Senior oversight in place.

AC concurred with discussion acknowledging circa 1000 additional ED attends, high acuity per month and increased prevalence of Sepsis. Reassurance provided of quick resolution supported by daily digital recording to monitor daily and weekly compliance.

MB reassured the Board of the robust monitoring and scrutiny of Sepsis at QAC reflecting the on-going improvements and work that had taken place.

Access and Performance

DM outlined challenges and mitigations to unlock pressures, managing volatility in demand.
ED - 11% increase in August compared to same period 2019-20, compounded with acuity of patients and delays to discharge patients home / care setting due to challenges in Domiciliary Care, impacting on Ambulatory Care capacity.
Impact of Wave 4 experienced June/July/August.
Despite challenges, regionally the Trust 14th out of 40 Trusts for Type 1 attendances.
Mitigations to support improvement include robust winter planning, B18 closure this week. Opportunity to open additional beds in October at Warrington, anticipate some challenges relating to staffing.

Clinically led ED Response Group progressing 3 workstreams including front door triage, to reduce numbers into ED including signposting of primary care patients to most appropriate care setting to support management of attendances.

Length of Stay - business case progressing to increase Intermediate Care at Home provision. CCG and Local Authority providing non-recurrent funding of £900k to increase this capacity.
The Trust recognised regionally for 30 minute and 60-minute ambulance handovers.

Quality Assurance Committee (QAC) Assurance Report 02.08.2021 and 07.09.2021. MB - no matters of escalation. Sepsis discussed earlier. Received Deep Dive review of Learning Disabilities, learning and actions. Assurance from Coroner following inquest of processes followed. Robust reporting in place through Safeguarding Committee and QAC. LD Strategy in place and LD identified as Quality Priority in 2021-22. Further detail relating to action place to October QAC.

Maternity Champion Safety Report - review of Neonatal Guidance to October QAC and future Board. Additional scope being added on Maternity Safety Champion role.
SMcG referred to regional and some national discussion relating to role of 'Champions'

and how increase in role / responsibilities could confuse role of Governance Committees, Executives and Champion role. Further guidance anticipated end of the year.

Monthly Safe Staffing Reports, June 2021 and July 2021

The reports were taken as read providing detail of ward staffing data which continues to be systematically reviewed to ensure the wards and departments remain safe. No issues escalated. KSJ highlighted:

- HCA vacancies improvement June and July, slight increase in month, working on strengthened HCA recruitment, fluctuation of staff applying.
- Clinically Extremely Vulnerable Staff (CEVS) guidance on staff returning to work which will improve position.
- Work progressing to support Paediatrics winter planning due to Bronchiolitis and RSV surge being experienced.
- Fluctuation in Neonatal staff actual and planned for last 6 months. Contributory factory gap in Ward Manager role, now appointed to which will support improvement. Reduction in vacancies from 5 to 4, backfill arrangements in place.
- Appendices 1 and 2 submitted nationally to Unify, errors when transcribed to Appendices 3 and 4. Corrected report to be circulated post meeting.

CR referred to (1) respiratory virus and references made to mutually clinical aid and implications of staff moving between organisations and (2) update on overseas nurses.
KSJ explained (1) suggestion from Local Maternity Service (LMS) and Director of Nurses this could be considered, currently WHH provide mutual aid supporting other units taking women to birth at WHH. (2) KSJ had met with a number of International Nurses, positive feedback, settling into study and homelife, some supported by arrival of family.
Staff had opportunities to work on different wards, supported by Practice Educational Team. Positive feedback from International Nurses in ED (8) despite challenging environment, nurses moved to other wards when they requested. 1 RN from international cohort in ED.

AMcG referred to escalation beds B3 in report, funding ringfenced for Q1 and Q4 and of funding pressure if ward remains open in Q3.

DM provided an overview of key recovery standards, overview and scrutiny continues at Clinical Recovery Oversight Committee (CROC).

- P2 - over 52 weeks on track to achieve trajectory of no more than 100 by end of September, current position 117. Anticipate figure of no more than 60 next month.
- 52 week waits on track with trajectory of no patients end of March 2022. Improvement in Q3 anticipated.
- Elective restoration tracking above NHSE/I standard 95% of 2019-20 activity for day patients.
- Outpatients tracking 95% July/August, compliance reported for September 2021.
- Radiology on track to achieve by October 2021, work ongoing with other modalities to improve position.
- Cancer over 62 days and over 104 days, compliance against trajectories.
- No issues escalated to NHSE/I.

TA added monitoring of recovery continues at CROC including P codes, harm reviews and waiting times. Challenges highlighted ultrasound and endoscopy, cardio-respiratory and

echo-cardio. Issues identified in September performance report to CROC, 3 issues escalated to September FSC due to overlap in some areas for CROC and FSC, demonstrating robust governance and oversight in place. Outcomes of deep dive into waits and recovery plan to October CROC (endoscopy issues).
Harm Reviews being completed, reassurance patients reviewed in line with processes, acknowledgement more challenging to identify mental health harm-related issues.

AC reported confirmation of funding allocation to C&M to support Digital Electronic Programme of £1.59m, bids submitted, outcome awaited.

People - MC referred to sickness absence indicator and mitigations to improve position.

- Support work continues with CBUs to safely deploy staff brought back into the workforce, 70 individuals since July equating to 500 recovered days.
- OH review commissioned to include review of Attendance Management support given to Managers, ensuring alignment with services.
- Guidance relating to cessation of classification of CEVS. Risk Assessments to be refreshed, monitoring and reporting to Tactical Group.
- SMcG enquired if OH review will include review of any change to individual roles and potential impact on individual terms and conditions if unable to return to their substantive role or permanently displaced. MC confirmed all implications will be reviewed.
- RTW - deterioration reported primarily due to self-isolation, staff absence and delay in recording of information on two platforms, E Roster and ESR. Working with CBUs to understand blocks. Working towards one platform to support improvement of timely recording of information.
- SMcG referred to some frustration from Managers of support from OH not always accurate and objective to negotiate staff returning to work and for this to be considered as part of the OH review.
- MC explained the complexities of the trajectory to achieve Safeguarding trajectory within 3 years of 85%. SPC had supported the recommendation to separate out Safeguarding Mandatory Training Indicator from the overall Trust Mandatory Training Indicator, setting trajectory of 90% by March 2023 when this will revert to one overall Mandatory Training Indicator. Board approved this recommendation.

Strategic People Committee (SPC) Assurance Report 22.09.2021 - no issues escalated.

CEO joined the meeting.

Sustainability – AMcG highlighted

- Period ending August 2021, Trust achieved £0.2m surplus against planned deficit of £0.1m, £0.3m favourable variance, on track to achieve break-even by end of H1.

Risks highlighted included

- Elective Recovery Fund (ERF) - will not achieve July/August/ September; CIP funding gap of £2.7m for the year to be addressed approaching H2.
- Planning guidance and funding envelope for H2 awaited.

- Capital Programme - the Board considered and approved the proposed changes to the capital programme detailed in the report which had been supported at September Finance and Sustainability Committee.

The Board:

	• **Noted, reviewed and discussed the report.** • **Approved the Capital schemes to be funded from the contingency.** • **Noted schemes that are no longer required in 2021-22 to be moved back into the contingency.** • **Noted the NHSE/I Provider Finance Return for month 5 matches the report.** • **Approved the proposed amendment to the Workforce section of the IPR.** Finance & Sustainability Committee (FSC) (25.08.2021 & 22.09.2021. No issues escalated. Clinical Recovery Oversight Committee (CROC) 23.07.2021, 18.08.2021 & 14.09.2021. discussed earlier. Audit Committee (19.08.2021) – Reassurance provided of processes in place and progress made to begin to close down MIAA Recommendations Follow-Up Actions. Work continues to reduce the number of Quotation and Tender Waivers. No further matters escalated or questions raised.
BM/21/11/126	**Moving to Outstanding Update Report** The report was taken as read, providing an update on CQC compliance, 'Red Flags' and operational matters. - Clinical and performance Red Flags continue to be monitored at M20, assurance provided actions in place to address. - CQC activity increased, increase in data requests recently including incidents. No trends identified to date. - Maternity Mock CQC internal inspection undertaken, progress reported against action plan, monitored at M2O. - ED Mock CQC internal inspection undertaken, outcomes to be finalised and reported to M20, QAC and ED Response Group. - Initial meeting with CQC relating to Shopping City proposals, no concerns highlighted. - Anaesthetic Accreditation assessment in October 2021, full compliance required as Accreditations used for internal inspections. - Endoscopy Accreditation due January 2022. - Correction in report noted (Pg 149) 2.5 RCEM Action Plan, IPC 06 Nursing for Escalation Areas business case had been presented to FSC and Trust Board. - SMcG asked for consideration to be given of involvement of NEDs in future internal mock inspections. • **The Board reviewed, noted and discussed the report and assurance provided of monitoring in place.**
BM/21/11/127	**Bridgewater Maternity Service Transfer** Discussion moved to consider in Part 2 of the Board.
BM/21/11/129	**Strategic Priorities** LG shared the poster summarising the refreshed Trust Strategic Priorities and Objectives, approved in July 2021, to be used in the public domain. Discussion took place relating to the wording at the end of the first Sustainability Objective *being guided by the principles of social value* and reference to *anchor*

	organisation, exact meanings and if these should remain. Following discussion, it was agreed to leave these references in, providing more detail in KPIs to measure outcomes which includes public and social value. Objectives will be kept under review to ensure still current. • **The Board supported the content of the poster.** • **Future Board session to include discussion on what public and social value and anchor organisation means for the Trust and the wider Green Agenda.**
BM/21/11/130	**Flu Campaign & COVID Vaccine Booster Plan** The report was taken as read which provided information about the planning, implementation and delivery of a joint vaccination programme for COVID-19 Booster Vaccination and Influenza Vaccination. MC highlighted there had been a significant uptake in the Flu Vaccination to date (1141 staff), COVID Booster (100 staff). The programme is aimed at vaccinating: - Frontline NHS staff and Health and Social Care Workers, external to the Trust (COVID-19 booster vaccine only), and, - WHH Trust staff: Influenza vaccine– intention of offering to all staff COVID-19 booster vaccine – frontline / patient facing staff, in accordance with JCVI Guidance. Discussion took place regarding the definition of Frontline NHS staff and Health and Social Care Workers and lack of consistency from JCVI guidance, 'Green Book' guidance and NHSE/I. SC had asked for consistency across the ICS on staff to be included as staff perceived to be non-care staff, could still come into contact with patients/staff in the hospital environment. *Definition quoted: Non-clinical staff in healthcare settings This includes non-clinical ancillary staff who may have social contact with patients but are not directly involved in patient care. This group includes receptionists, ward clerks, porters and cleaners.* LG advised capacity to deliver COVID Booster to all staff and 4500 H&C workers external to the Trust. The Board considered the proposal to offer the COVID Booster vaccination to all staff working in the hospital and community. This would exclude CEVS still working from home cohort would be included in the 1-10 JCVI Group. LG advised clear communications would be circulated as currently offer to Friends and Family cannot be made due to request to offer Booster vaccination to all staff and the 4500 H&C workers as mentioned earlier. **The Board:** • **Reviewed and discussed the report and supported the proposal to offer COVID Booster to all staff and 4500 H&C works external to the Trust.** • **Approved the report, specifically the 'Healthcare Workers Flu Vaccination Best Practice Management Checklist' and the process for delivering Flu Vaccination programme as detailed in the report.**
BM/21/11/131	**Strategic Risk Register and Board Assurance Framework (BAF)** The report was taken as read. JC highlighted the following for the Board to review and consider proposals for the BAF since the last meeting and the rationale. The proposals

	had been approved at the appropriate Sub Committees and Quality Assurance Committee Chairs Actions on 7 September 2021. Since the last meeting: - One new risk had been added to the BAF - it was agreed to re-escalate risk #1331 from the Corporate Risk Register at an increased rating of 15 to reflect the current pressures (bed capacity). - The Board were asked to consider and approve the addition of a further risk, following support from the Clinical Recovery Oversight Committee (CROC), to re-escalate risk #1125 from the Corporate Risk Register, reflecting the current situation (Failure to achieve constitutional access standards) at a rating of 20. - The description of one risk on the BAF had been amended, risk **#1331** following re-escalation to the BAF to reflect current situation. There had been no amendments to the ratings of any risks and no risks had been de-escalated from the BAF since the last meeting. The Board also reviewed notable updates to existing risks #224, 1215, 1273, 1275, 1289, 115, 134, 1134, 1114, 1207, 125, 145, 1274, 1290. • **The Board reviewed and noted the BAF and Strategic Risk Register providing assurance of processes for oversight, scrutiny, management and escalation of strategic and corporate risks.** **The Board approved:** • **The proposed amendments outlined above and the updates to existing risks.**
	Any Other Business - No matters raised
MATTERS FOR APPROVAL/RATIFICATION	
BM/21/09/133	**Audit Committee Chairs Annual Report 2020-21** The Board **ratified** the Annual Report, approved via Audit Committee on 19 August 2021.
BM/21/09/134	**Changes to the Constitution** The Board **ratified** the Strategy, approved at Council of Governors on 12 August 2021.
BM/21/09/135	**Charitable Funds Committee (CFC) Governing Document and Cycle of Business** The Board **ratified** these documents, approved at CFC on 9 September 2021.
BM/21/09/136	**GMC Revalidation Annual Report (Medical Appraisal)/NHSE Statement of Compliance & NHSE Annual Organisation Audit (AOA)** The Board **ratified** the ToR which had been approved by the Strategic People Committee on 22 September 2021.
BM/21/09/137	**EPRR Assurance Compliance Letter** The Board **ratified** the document which had approved by the Finance and Sustainability Committee on 22 September 2021.
BM/21/09/138	**Digital Systems Tender Evaluation Criterion** The Board **ratified** the report, approved by the Finance and Sustainability Committee on 22 September 2021.

MATTERS FOR NOTING FOR ASSURANCE	
BM/21/09/139	**Infection Prevention and Control Board Assurance Framework** This report had been reviewed, discussed and noted by Quality Assurance Committee on

	7 September 2021. **The Board noted the report.**
BM/21/09/140	**Infection Prevention and Control Q1 Report** This report had been reviewed, discussed and noted by Quality Assurance Committee on 7 September 2021. **The Board noted the report.**
BM/21/09/141	**Learning from Experience Q1 Report** This report had been reviewed, discussed and noted by the Quality Assurance Committee on 7 September 2021. **The Board noted the report**
BM/21/09/142	**Mortality Review Q1 Report** This report had been reviewed, discussed and noted by Quality Assurance Committee on 7 September 2021. **The Board noted the report.**
BM/21/09/143	**Freedom to Speak Up Bi-Annual Report** This report had been reviewed, discussed and noted by Strategic People Committee on 22 September 2021. **The Board noted the report.**
BM/21/09/144	**Guardian of Safe Working Q1 Report** This report had been reviewed, discussed and noted by Strategic People Committee on 22 September 2021. **The Board noted the report.**
BM/21/09/145	**Bribery Act 2010 and Trust Anti-Bribery Strategy** This report had been reviewed, discussed and noted by Audit Committee on 19 August. **The Board noted the report.**
BM/21/09/146	**Digital Board Report** This report had been reviewed, discussed and noted by Finance and Sustainability Committee on 22 September 2021. **The Board noted the report.**
	Next meeting to be held: Wednesday 24 November 2021

Signed …… Date …….

Chairman ……..

BOARD OF DIRECTORS ACTION LOG

Warrington and Halton Teaching Hospitals NHS Foundation Trust

AGENDA REFERENCE	BM/21/11/151	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	24 November 2021

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/21/05/	26.05.2021		Facilitated Board session – to discuss wider health inequalities contribution from WHH.	**Chairman/ Director of Strategy & Partnerships**	**24.11.2021**		Initial session taken place. Update report to September Board. Deferred to November	
BM/21/07/94	28.07.2021	COVID-19 Overview Report	Presentation of key points to future Board.	**Chief Nurse & Deputy CEO**	**24.11.2021**			

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
	26.05.2021	Any other business	Dedicated Board session to discuss how the Trust can contribute to local boroughs 'Green' agenda	**Chairman / Director of Strategy & Partnerships/ Chief Operating Officer**	**Date TBC**		Draft Green Plan to be presented to November Board, Agreed to defer this session to a later date to include discussions re: anchor organisation, social value and the wider Green Agenda, refer to minutes BM/21/09/129	
BM/21/05/67	26.05.2021	COVID Situation Report	Reflective report of COVID and summary of summer activity to future meeting at an appropriate time point.	**CEO**	**Date TBC**			

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/21/09/125 a	29.09.2021	Nurse Staffing Report	Amended report to be circulated post meeting	**Chief Nurse & Deputy CEO**		**29.09.2021**	Report circulated	

RAG Key

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

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/152**			
SUBJECT:	**Chief Executive's Briefing**			
DATE OF MEETING:	24th November 2021			
AUTHOR(S):	Simon Constable, Chief Executive			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO BAF RISK:	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

SUBJECT	Chief Executive's Briefing	AGENDA REF:	BM/21/11/152

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 29th September 2021, some of which are not covered elsewhere on the agenda for this meeting.

2) KEY ISSUES

2.1 Current COVID-19 Situation Report

As at the time of writing, 19th November 2021, we have a total of 15 COVID-19 positive inpatients (14 days or less since their first positive sample); 1 of those patients is in critical care. In total, 40 of our inpatients have tested positive at any time during their admission (6 of these in critical care). This is a better position than my last report. We have discharged a total of 2537 patients with COVID-19 to continue their recovery at home. Sadly, a total of 562 patients with COVID-19 have died in our care.

In terms of community numbers, new daily COVID-19 cases remain relatively high but have fallen slightly in the last couple of weeks. In the latest 7 days fully published (8th November – 14th November) in Warrington there were 366 cases per 100,000 people (the average area in England had 410); 767 new cases were reported in that week, down 7 compared with the previous week. In Halton, there were 420 cases per 100,000 people; 545 new cases in that week, up 44 compared with the previous week.

Vaccination of our boroughs (aged 12s and over) has achieved 82% for the first dose and 75% for the second dose in Warrington; for Halton, the figures are 79% and 72% respectively. We have now commenced our own 'flu vaccination alongside our COVID-19 booster programme.

The COVID-19 Booster programme started on Monday 27th September 2021. In terms of the COVID-19 Vaccination programme so far, as of 15th November, WHH had administered 62,894 doses. We have vaccinated 93.87% of WHH staff; 91.61% of WHH staff have had their second doses; 59.32% of WHH staff have had their booster dose. These figures are higher than the national and regional average for the NHS.

2.2 Cheshire & Merseyside System Development

As the C&M Integrated Care System moves towards a statutory footing from 1st April 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. It has been announced that Graham Urwin is to be the Chief Executive designate of the new C&M Integrated Care Board. We are already working with Graham in his current role in the North West regional team. We also pay an active role in the newly formed Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative; Ann Marr is the lead chief executive and Linda Buckley is the newly appointed Managing Director. We have now had two very productive CMAST development sessions, the one most recently including

chairs and chief executives of the 13 consituent provider trusts. I continue to play a role as medical lead chief executive for the hospital cell as it it transitions into the CMAST model.

2.3 Senior Leadership Changes

In my last report I confirmed the appointment of Dr Paul Fitzsimmons as Executive Medical Director. Paul will take up his post on 1st December 2021. Dr Anne Robinson is kindly acting as medical director until Paul arrives in the Trust. Dr Robinson has also become our GMC Responsible Officer from 8th November 2021, the requisite training and authorisation having been completed.

Since my last Board report, we have also formally welcomed in the substantive appointments to our Care Group structure in support of our clinical business units. I have previously advised that we have been strengthening our operational management to support the ongoing demands of restoration and recovery 'post' COVID-19. We have now established all the new posts, the triumvirates of which are as follows:

Hilary Stennings, Associate Director - Clinical Support Services
Dr Alison Davis, Clinical Director - Clinical Support Services
Deborah Hatton, Lead Nurse - Clinical Support Services

Val Doyle, Associate Director - Planned Care
Mr Mark Tighe, Associate Medical Director - Planned Care
Natalie Crosby, Associate Chief Nurse - Planned Care

Sharon Kilkenny, Associate Director - Unplanned Care
Dr Mark Forrest, Associate Medical Director - Unplanned Care
Emma Painter, Associate Chief of Nursing - Unplanned Care

Corporate service support, specifically HR and finance, will relate to these Care Groups.

2.4 The official opening of new facilities at Halton Hospital

On 30th September we carred out the official opening of our new Breast Care Centre at the Captain Sir Tom Moore (CSTM) building and the new Pre-Treatment Centre just behind the CSTM – the result of a £3m investment in our Halton Hospital site.

The Breast Care Centre located on the ground floor offers a superior location for women in Halton, Knowsley, St Helens and Warrington to choose to attend for their routine breast screening mammograms. It also provides comprehensive diagnostics and support to patients that have anomalies on routine breast screening or those who have noticed breast changes or found lumps that are referred in via their GP. In creating this centre we have relocated our assessment and symptomatic clinics from the outdated and unsuitable Kendrick Wing, supported by an extensive public consultation.

The centre is home to two new mammography rooms, two ultrasound clinic rooms, consultation and counselling rooms and is located on the ground floor, next to the existing MRI/CT service which is usually involved as part of a cancer diagnosis. It is also below our

existing surgical ward which, under a dedicated 'green pathway', now carries out a wide range of cancer surgery in addition to its longstanding orthopaedic operations.

For patients requiring procedures, including cancer surgery, we also opened our new modular Pre-Treatment Unit to the rear of the CSTM. This unit supports the elective 'green pathway' with pre-surgery COVID-19 swabbing as well as carrying out full pre-operative work ups. Patients are no longer required to enter the hospital for these tests and instead can drive up for COVID-19 swabbing or present for pre-operative examination through the green pathway.

It is thanks to the extreme hard work, enthusiasm and commitment of our clinical, clinical support and corporate services teams that we were able to deliver both projects in record time, and on budget.

2.5 Other Developments in Planned Care

COVID-19 has had a significant impact on all those patients waiting for elective procedures when all trusts were instructed to suspend their elective programmes to redeploy resources to the front line. This saw our flagship estate, the Captain Sir Tom Moore building, effectively moth-balled and our theatres and endoscopy in the Nightingale building fall silent. But there were still patients who needed surgery for their cancers, or those requiring surgery that could not wait such as those sustaining injuries. We developed a COVID-lite or 'green' pathway at Warrington initially for these patients, using two dedicated and separated theatres and a 'clean' ward on B18 for admissions and recovery. In this way we were able to continue planned care, albeit on a much lower level. Having successfully achieved the green pathway, we then moved this to a new Elective ward on A5 and to Halton as soon as staff were available.

Halton is a natural and obvious choice to host our planned care programme. We are one of very few Trusts in the region to have a dedicated 'cold' site where we can safely continue our elective work and this is continuing at the Captain Sir Tom Moore Building with Endoscopy in the Nightingale Building. The way that our teams have adapted to these many upheavals and changes has been fantastic and it is great to see (almost) everyone back doing their day jobs. Our teams and their leaders have committed to everything we have asked of them not least our ward teams who have undergone two bed reconfigurations in the last 12 months.

Restoring our elective programme, and addressing the many patients waiting for their procedures is the number one priority of our Planned Care Group. We are constantly evolving to be able to undertake more elective procedures at Halton and the creation of our Post Anaesthetic Care Unit (PACU) at CSTM has enabled us to treat more high risk patients on the cold site than previous thanks to this innovation. The PACU provides enhanced care for high-risk patients who previously would have required an HDU bed at Warrington. At the Warrington site we have developed a plan for an elective ward ensuring that these were ring-fenced beds for those patients that could only be treated at Warrington; because of these plans WHH saw activity returning to 95% of patients treated in line with delivery prior to the pandemic. As Halton is a dedicated elective site it is also strategically well-placed to assist the Cheshire and Merseyside region with mutual aid and conversations are ongoing with regional colleagues.

Our Women's and Children's service is very diverse and this is based at Warrington, although we have just received the first women to the Halton Community Midwife service at Halton which transferred to us from Bridgewater Community Health (BCH). This is to support 'continuity of carer' which means that women should have consistent care by a midwife known to them throughout their pregnancy, birth and afterwards. This has many benefits for women and their babies and has been shown to increase the quality of the overall experience for women and families. We extend a very warm welcome to the BCH midwives who transferred to us – becoming part of our WHH family.

Planned care have delivered some major schemes and are optimistically planning to deliver some future major capital programmes within our services which will make a huge difference to both patients and staff. To date we have delivered:

- £2.1m invested in the new breast centre at Captain Sir Tom Moore Building
- £2.0m for the PACU development
- £1.0m invested in a modular pre-treatment centre – again protecting our green pathway with a COVID-19 swabbing service as well as end to end pre-op checks
- A5 Elective ward on the surgical floor at Warrington
- Upgrade for the endoscopy unit at Halton
- Plans to redesign the top floor of the CSTM building to create a dedicated Day Case Unit
- Plans to create new theatres and relocate theatres from the Nightingale Building

2.6 Developments in Clinical Support Services

Our Clinical Support Service (CSS) Care Group is the most diverse Care Group, comprising nearly all the professions including all of our allied health professionals and clinical scientists.

Clinical Support Services supports the organisation to ensure that all patient pathways run smoothly, our 'customers' being the six other clinical business units. CSS encompasses Pathology (haematology, microbiology, clinical chemistry and histopathology), Radiology, Breast Screening, Infection Prevention and Control, Outpatients, Pharmacy and the wide range of Therapies that we offer our patients.

The primary focus is to support recovery following COVID-19, where waiting times for diagnostics should normally be less than six weeks. We are doing well clearing our backlog in diagnostics and similarly in outpatients; these two elements are key to moving our patients on to their next course of treatment or indeed discharge back to their GP. At the same time we are maintaining the safety of staff and patients while COVID-19 continues to thrive in our communities.

Each of our services has adapted and innovated the way they work to accommodate patients as a result of the pandemic. We want to keep that innovation while at the same time providing our patients with safe, timely, excellent care. Outpatients has seen patients move to video and telephone appointments (in addition to face to face) which provides a convenient and reduced-risk way for people to see their healthcare professional. As a result of the pandemic this team has had to rearrange tens of thousands of appointments - as well

as taking on our much-admired vaccination service. They are back to working in 'real time' now but the impact of COVID-19 still requires that cancelling and rebooking goes on.

Radiology is one of those services that can't be delivered virtually and our teams have done an amazing job, during and since the pandemic to keep patients safe. Imaging slots are now slightly longer as IPC measures must be adhered to before and after each patient and all our SOPs had to be updated accordingly. The pressure on the teams as they turned their attention to working through the backlog of patients across 7-days a week was immense and – as if that wasn't enough - we've invested in lots of new imaging equipment which all had to be tested and deployed with minimal disruption to patients – a really outstanding effort

Pathology services have played a massive role over the last 19 months – with Microbiology (and our excellent Infection Prevention and Control team) taking centre stage with COVID-19 swabbing and rapid testing to keep us all safe. The recent UKAS inspection of our accreditation to ISO 15189 (the pathology equivalent of a CQC inspection) was particularly exceptional with a very low number of findings across the board and zero in Biochemistry, something which the inspector said he had never encountered before.

Our Pharmacy took on a huge role half way through the pandemic with the advent of the vaccine, overseeing the processing and administration of more than 60,000 vaccines to date and now they've started on the seasonal 'flu challenge. They also innovated the way they worked to ensure that they enabled prompt discharge by ensuring patients weren't delayed waiting for TTOs. We have also been delighted to welcome Chief Pharmacist Dr Diane Matthews' new deputies, James Parker and Victoria Young to the service.

It was a real pleasure to see the celebratipn of a huge part of our service recently as part of international AHP day under the new leadership of AHP lead Michelle Smith. So many different professions providing essential therapies, diagnostics and treatments to our patients both in our hospitals and in the community - dietitians, occupational therapists, operating department practitioners, orthoptists, physiotherapists, podiatrists, prosthetists and orthotists, radiographers and speech and language therapists to name a few.

Some major capital programmes have been delivered recently which will make a huge difference to both patients and staff:

- Complete refurbishment of our mortuary concluding in the coming weeks provides an enhanced experience for our bereaved families and undertakers with our staff seeing significantly improved working conditions. We can now truly care for our deceased patients right up to the time they leave our hospital.
- Recent completion of the new £2.1m Breast Care Centre at Captain Sir Tom Moore where we now offer a comprehensive diagnostic service for those with suspected breast cancer from mammography to ultrasound, CT and MRI scanning.
- New MRI Scanner and major expansion of the centre at Warrington plus a new CT scanner and expanded patient areas separating in and outpatients preserving the privacy and dignity of all.

- Forthcoming expansion of the breast screening service at Bath St Warrington, where – subject to public consultation – we will relocate the last of our breast services from the aged Kendrick Wing.

2.7 Development of the new Acute Respiratory Unit (ARU) on Ward B18

In October we took the first step in enacting our 'winter plan' to better enable us to cope with whatever winter and the pandemic has yet to bring. Part of this plan has been a brand new specialist purpose-built respiratory unit adjacent, and connected to, ITU which will also give us a minimum of 10 extra beds on the Warrington site to help ED pressures.

The 28-bedded unit is split into 21 general respiratory beds and 7 enhanced care beds in the respiratory enhanced care unit (RECU). The enhanced care area is based upon the Respiratory Support Unit model referenced in recent national guidance and will provide a safe and effective environment to manage complex respiratory illnesses. However, the real USP of the new unit is its flexibility, with the ability to escalate up to 14 enhanced care beds to cope with further pandemic or winter surges. With 4 bespoke Bioquell cubicles and 3 further isolation side rooms, the new unit also has more capacity to manage a variety of respiratory communicable infections. It also has a state-of-the art procedure and treatment room, a new relatives/quiet room and much better changing and break facilities for staff.

The B18 ARU is really the culmination of incredibly close working between respiratory medicine and critical care colleagues all through the COVID-19 pandemic. This collaboration led to innovations such as the 'little black box' CPAP machines which brought recognition to the trust at a national level. Most importantly, this 'COVID collaborative' has led to the development of common shared pathways, bids for equipment, staff training and a whole lot more.

COVID-19 also brought us significant challenges in managing patient experience. The loss of face-to-face visiting, not being able to see a loved one for days or even being able to be taken outside to get some natural light and a breath of fresh air has made an already difficult time much worse. The team consulted with some of their patients about the things they missed the most whilst in hospital. Hence, during the re-design, the theme of 'outdoor spaces' emerged. Respiratory patients struggling with breathlessness often prefer to be by a window. Whilst this is not always possible, our fabulous estates team helped us simulate the outdoors by adding cloud lighting panels and wall murals. As part of our patients' therapy, we added an area with a park bench to encourage a 'walk to the park to sit on the bench'. We have also invested in more communication devices, such as iPads, for patients to be able to see their loved ones whilst in hospital.

Our aim is that this new unit will be the base from which we will continue to provide excellent high quality care to our acute respiratory patients and also future proof ourselves to manage further pandemic surges and other demands upon our service, the trust and the wider local community.

2.8 Same Day Emergency Care/ED Assessment Plaza

In my last board report I confirmed that the contract for the above had been signed under seal by myself and the Chairman. This time I am able to confirm that work has started. Indeed

it was with huge pride that we welcomed BBC North West to Warrington on Friday 29th October 2021 to report on the 'ground breaking' of our £6.3m expansion of our Emergency Department. The Same Day Emergency Care Centre opens in the Spring of next year and will enable our considerably over-stretched service to more quickly see, treat, admit or discharge patients – we are regularly seeing in excess of 300 patients a day, double the capacity of the current estate.

The ground floor of the 1,170sqm extension faces on to Lovely Lane will be exclusively for patient care and will offer urgent 'hot' clinics, assessment areas, triage space, ambulatory care and primary care in the expanded and redesigned space. The second floor will be home to administration, equipment and staff rest areas which currently occupy valuable ground floor space in the existing emergency department. This space will now also be used for patients.

2.9 Quality Academy Summit

On 7th October 2021 we were pleased to be hosting our annual Quality Academy Summit (held virtually via MS Teams), showcasing the best in health research, evidence-based practice and Quality Improvement at WHH. The theme this year was an important one: "COVID-19: Celebrating success and supporting recovery."

The Summit was launched by our Chief Nurse & Deputy Chief Executive, Kimberley Salmon-Jamieson, before handing over to the Quality Academy Leads who introduced the different elements of our Quality Academy such as Quality Improvement, Research and Innovation and Knowledge and Evidence Services.

This year were were also very pleased to be joined by Dr Chris Smith who is the Chief Operating Officer at the National Institute for Health Research (NIHR) Clinical Research Network for the North West Coast. Dr Smith has been instrumental in helping us set up the Halton Clinical Research Unit.

2.10 Armistice Day

Armistice Day this year was marked with a new ceremony at WHH. Our newly-formed Veterans Staff Network has been incredibly busy over recent weeks constructing the beautiful poppy fields and rivers at both Halton (phase 1 courtyard close to Endoscopy) and Warrington (Appleton Wing Wellbeing courtyard) and I was pleased to take part in both dedication services with members of our Veteran's Network and guests. Our inaugural remembrance and dedication service and parade was held at Warrington this year, it will be Halton next year and alternate thereafter. I will say a sincere thank you to the Veterans Staff Network and supporters for all their hard work in getting both sites ready in time for this special day, starting off a new 'tradition' at WHH.

2.11 Special Days/Weeks for professional groups

Since our last Board meeting in September, a number of topics, professional or interest groups or disciplines have had special days or weeks marked locally, nationally or internationally. WHH has recognised, embraced and celebrated all of these.

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

Black History month: October 2021
Cyber Security Awareness Month: October 2021
World Menopause Day: 11th October 2021
World Thrombosis Day: 13th October 2021
Allied Health Professionals Day: 14th October 2021
Wear it Pink Day (for breast cancer awareness): 22nd October 2021
Stress Awareness Week: 1st - 5th November 2021
Movember: November 2021
World Radiography Day: 8th November 2021
Anti-bullying Week 2021 (One Kind Word): 15th - 19th November 2021
International Stop Pressure Ulcer Day: 18th November 2021
World Antibiotic Awareness Week: 18th - 26th November 2021

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; similarly they have asked questions on behalf of their constituents. All of our senior stakeholders are active participants and members of our New Hospitals Strategic Oversight Group.

2.13 Employee Recognition

In the summer we announced the start of a slightly different approach to the Employee of the Month and Team of the Month awards scheme that we used to run pre-pandemic, and that we suspended last year. These have become the 'You Made a Difference' awards.

You Made a Difference Award – Mark Jones, Radiology Services Manager

I was very pleased to make the first award in October following a nomination and panel adjudication process. I was delighted that the very first recipient was Mark Jones, Radiology Services Manager. Mark was nominated by a colleague and the citation speaks for itself.

"Mark has been amazing with all the staff in Radiology throughout the pandemic and is a genuinely kind and considerate person who has everyone's best interest at heart. I remember one of the first things he said around March 2020 was that we need to think about the impact the pandemic would have on the staff and make sure everyone was supported both practically (working hours/breaks etc.) and in terms of people's wellbeing, and immediately took practical steps to ensure that this was the case."

"We are very fortunate to have a manager who is an amazing example of what this means in practice, a real people person who makes a huge difference and is really prepared to go the

extra mile for their staff. I would really appreciate it if he could be considered for a kindness badge. He really made a difference."

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

Chief Executive Award (October 2021): Warrington Catering Team
This award has recognised the efforts of our Warrington Catering Team in supporting the different offer to staff in the food court on the Warrington hospital site. The team, mobilised an in-house offer to staff at very short notice. They have also had significant positive feedback about the quality of the food and the customer service experience. Owing to this success, an expanded offer for staff is being worked-up.

Chief Executive Award (November 2021): Dr Luke Dias, Consultant Anaesthetist
Dr Luke Dias, Consultant Anaesthetist, has had a number of very powerful thank you messages from other staff members over the past few months, including those who had worked with him looking after some very sick patients (some of which needed ITU). It was also remarked that Dr Dias had an especially positive and kind approach to this team-work which was very much appreciated by all concerned.

Appreciation of WHH staff from patients, family, visitors and colleagues
I have also specifically recognised the work of the following colleagues:

- Ian Jones, Non-Executive Director - Trust Board
- Mark Rigby, Head of Theatre Services, Digestive Diseases
- Nathan Taylor-Thompson, Ward Manager A4 & Team
- Rachael Baxter, Ward Manager A3 & Team
- Mr Paul Jamieson, Consultant Urologist - Surgical Specialities
- Julie Delamere, Staff Nurse - Integrated Medicine & Community
- Linda McMullen, Healthcare Assistant - Outpatients
- David Thompson, Biomedical Scientist - Clinical Support Services
- Maria Martin, Nurse Consultant - Urgent & Emergency Care
- Caroline Stretch, Microbiology Operations Manager - Clinical Support Services
- Linda Doherty & Team, Ward C20 - Women's & Children's Health
- Julie Monks, Upper GI Cancer Team - Digestive Diseases
- Janice Rustage, Upper GI Cancer Team - Digestive Diseases
- Emily Iyes, Upper GI Cancer Team - Digestive Diseases
- Joanne McDonagh, Upper GI Cancer Team - Digestive Diseases
- Julie Burke, Board Secretary – Executive
- Jacqueline Griffiths, Staff Nurse - Outpatients
- Anna Cleary, Senior Audiology Assistant - Clinical Support Services
- Amanda Heaton, Head of HR - HR/OD
- Claire Grice & Team, PACU - Digestive Diseases
- Angela Hough, Specialist Nurse - Urgent & Emergency Care
- Mr Noaman Sarfraz & Team, Consultant Surgeon - Surgical Specialities
- Lee Bushell, Head of Capital Projects - Estates and Facilities
- Ailsa Gaskill-Jones, Matron - Women's & Children's Health

- Kerry Benjamin, Business & Performance Manager - Finance
- Ann Skinner, Staff Nurse - Women's & Children's Health

2.14 Signed under Seal

Since the last Trust Board meeting, no further items have been signed under Seal by myself.

3 MEETINGS ATTENDED/ATTENDING

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

- NHSE/I COVID-19 System Leadership (Bi-weekly)
- 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)
- C&M and NW Critical Care Network Gold Command Calls (Twice 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)
- Clinical Research Network North West Coast Priority Health Steering Group (Monthly)
- Clinical Research Network North West Coast Partnership Board (Quarterly)

4) RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Report to the Board of Directors

AGENDA REFERENCE:	**BM/21/11/154**	
SUBJECT:	**COVID-19 Performance Summary and Situation Report**	
DATE OF MEETING:	24th November 2021	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	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*)	#1135 Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision. #1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #115 Failure to provide adequate staffing levels in some specialities and wards. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #1126 Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.	
EXECUTIVE SUMMARY (*KEY ISSUES):*	The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily 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 20th November 2021 is included.	

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

RECOMMENDATION:	The Trust Board is asked to: 1. Note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	

FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

REPORT TO THE BOARD OF DIRECTORS

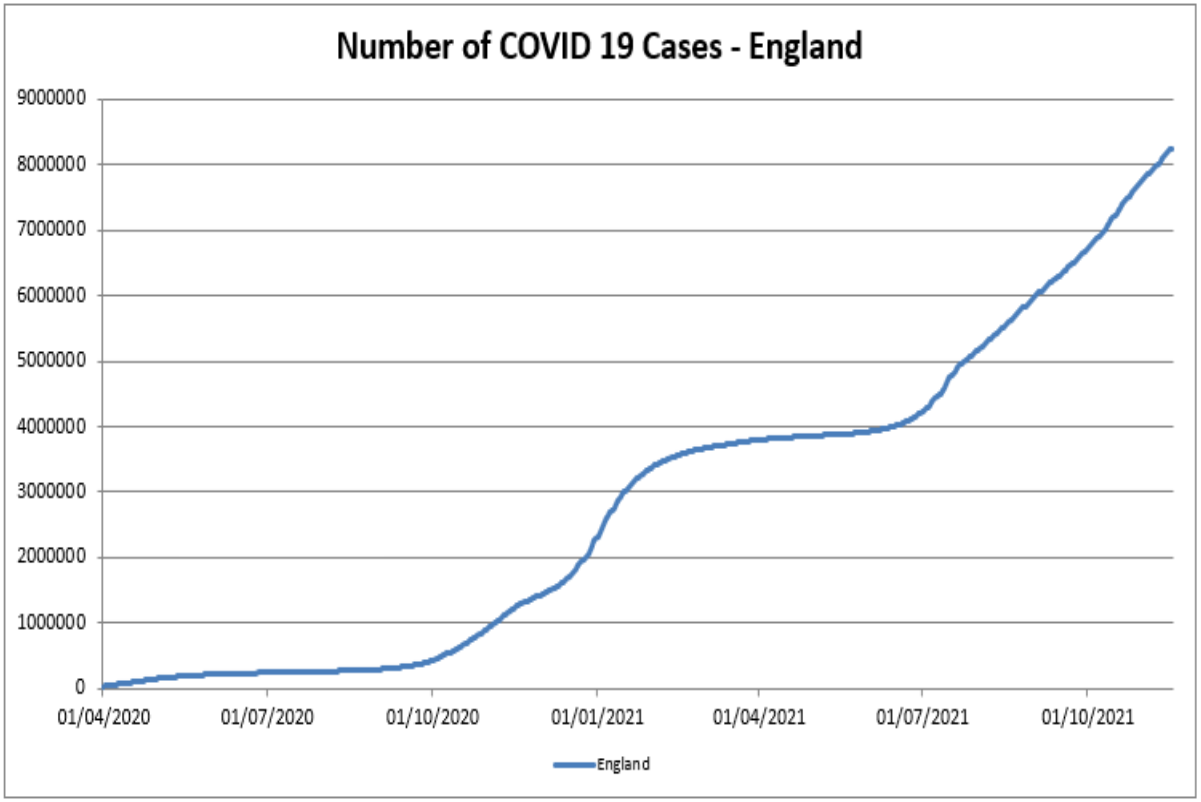
SUBJECT	COVID-19 Performance Summary and Situation Report	**AGENDA REF:**	BM/21/11/154

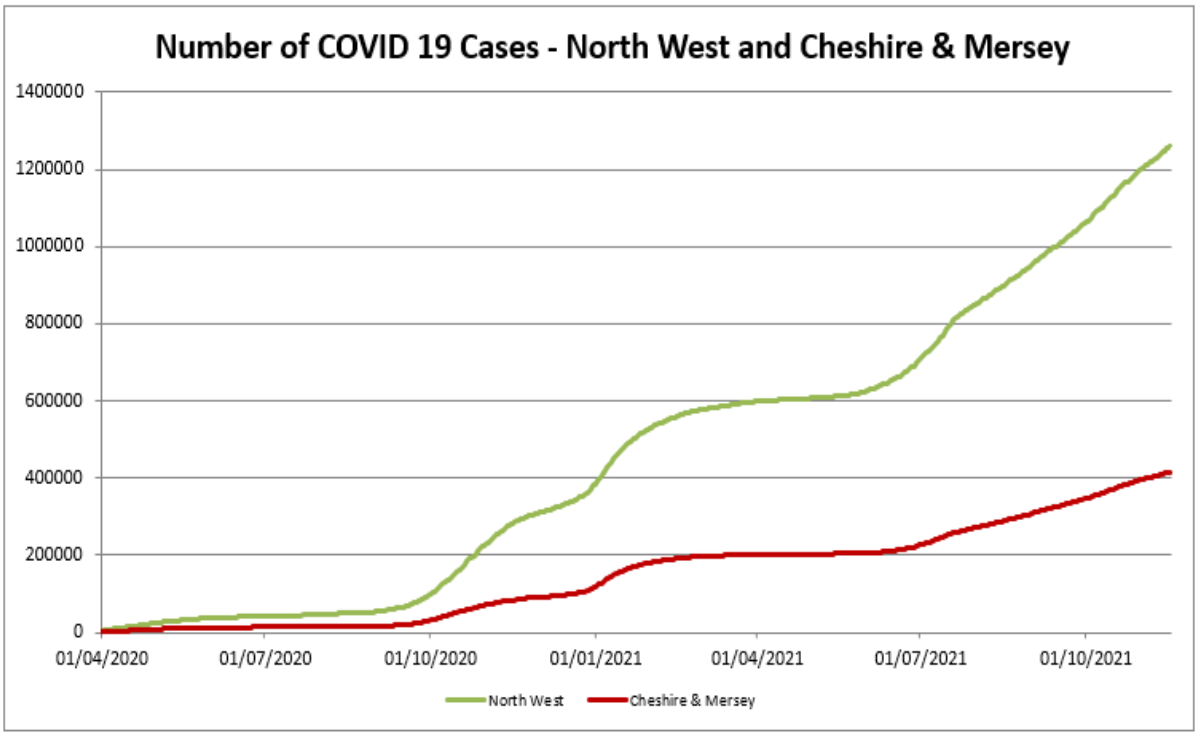
1. BACKGROUND/CONTEXT

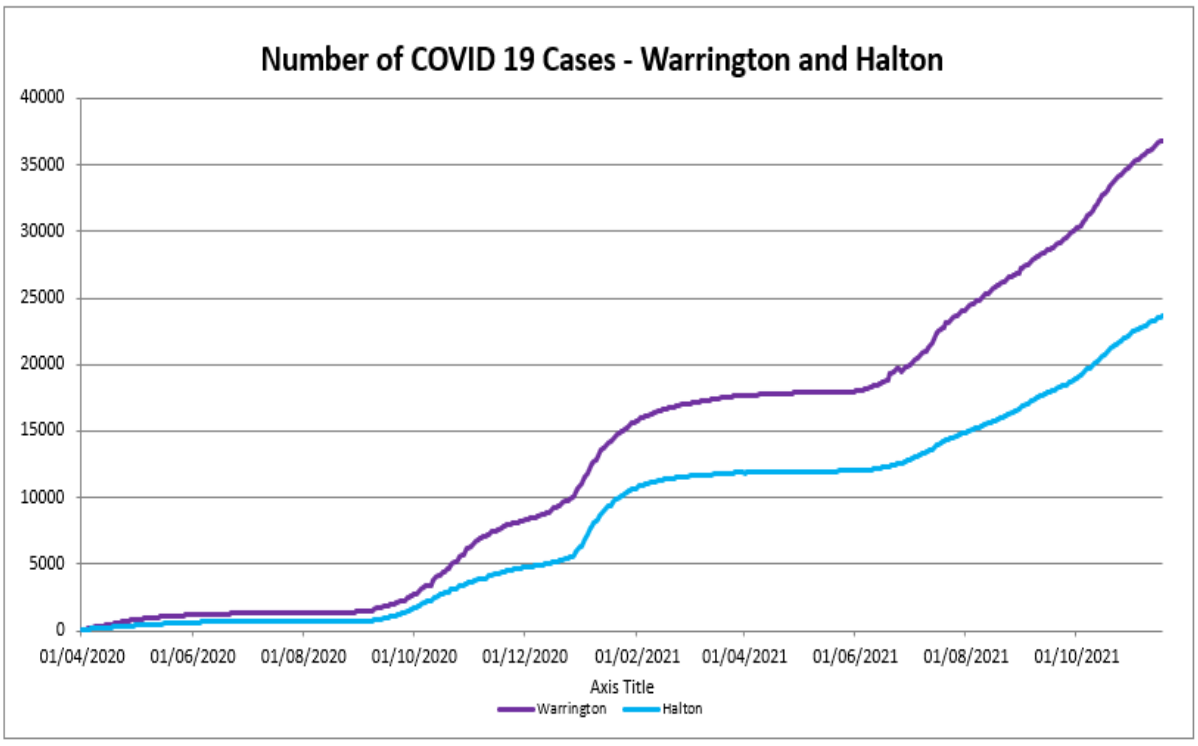
The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily Executive Summary which includes data outlining the key information pertinent to the command and control of the pandemic. This paper provides an overview of 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 20th November 2021 is included.

2. KEY ELEMENTS

2.1 Number of Reported Cases



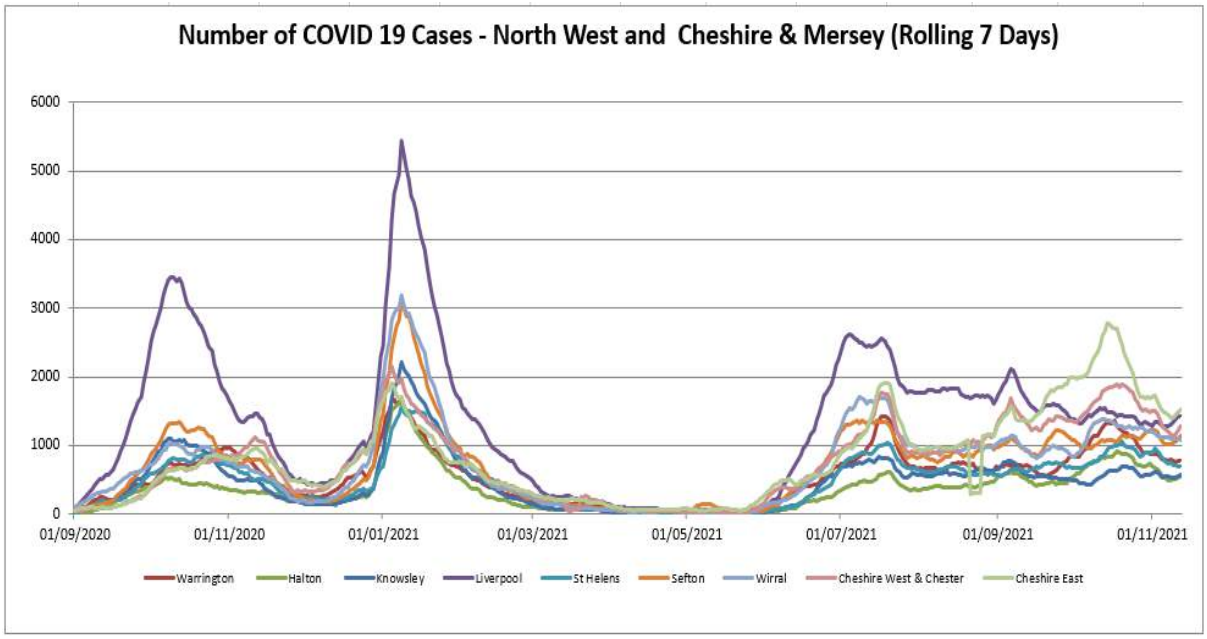


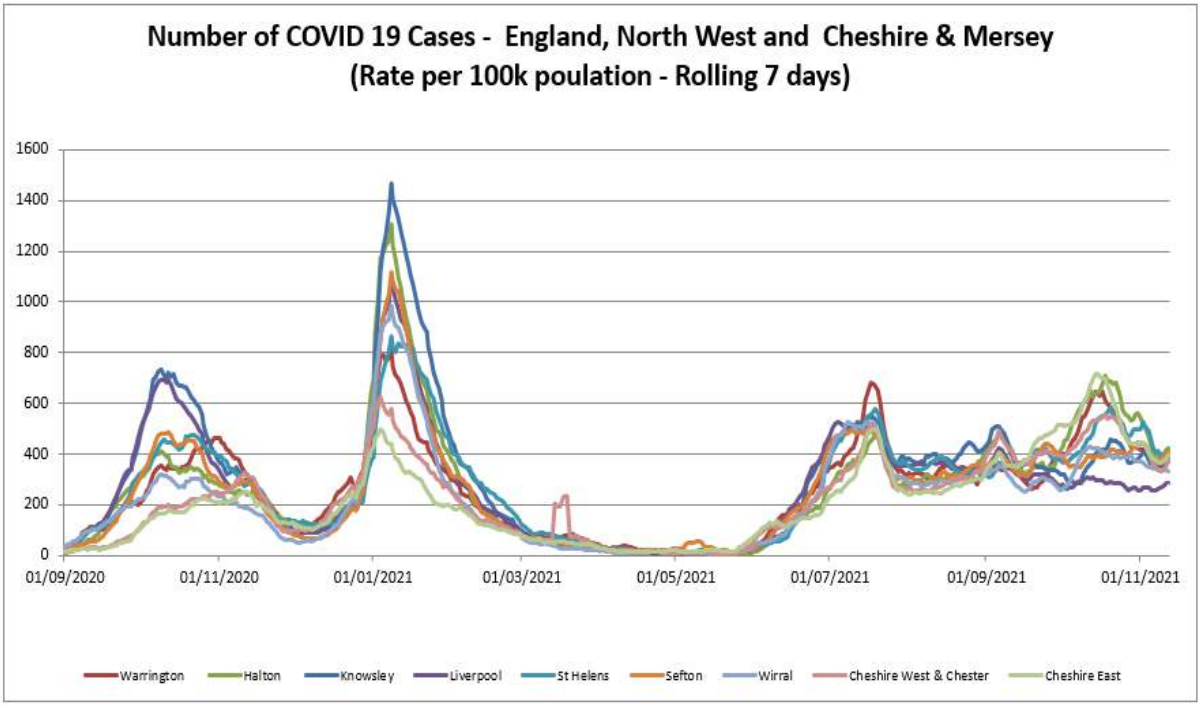


Narrative: As of 20/11/2021, there were 37,139 cases of confirmed COVID-19 reported in Warrington and 23,852 cases reported in Halton. The Trend is in line with the England, Cheshire & Mersey and the North West positions.

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

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

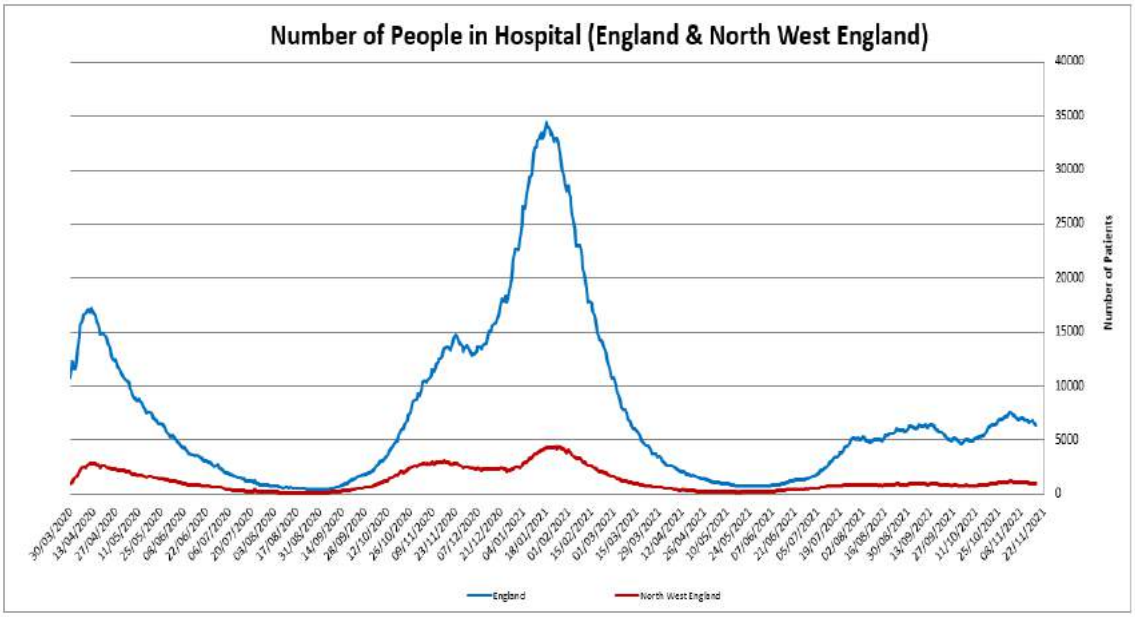


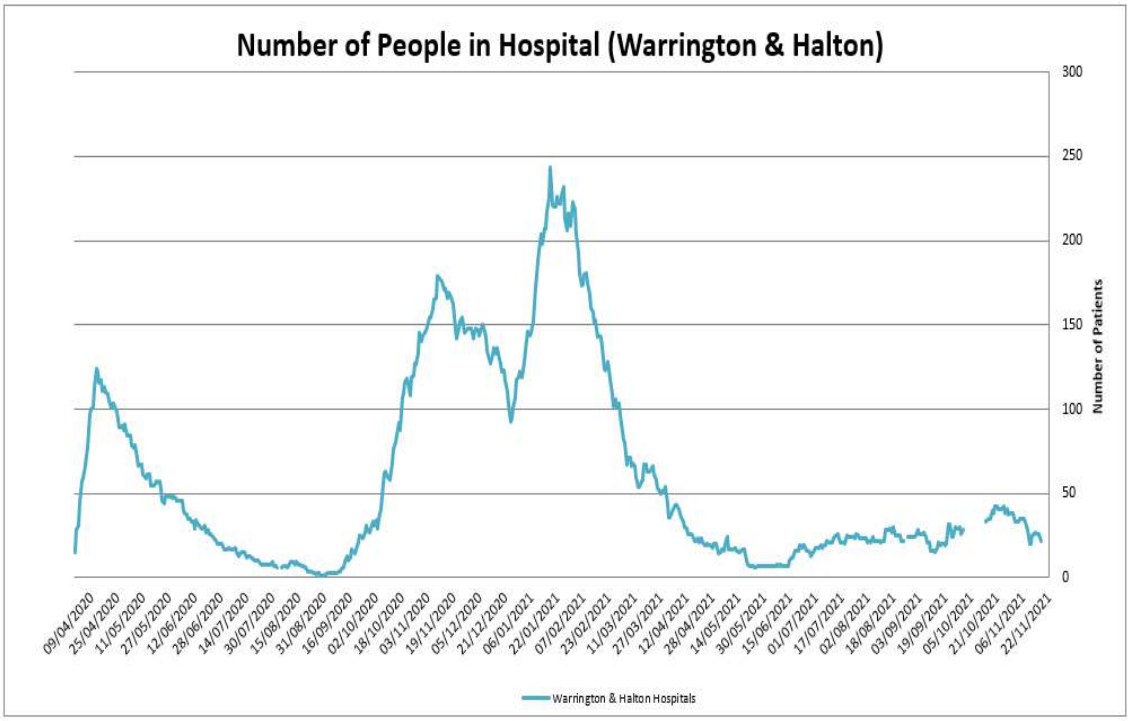


Narrative: The graphs show the infection count and rates per 100k population over a rolling 7 day period. This is a more accurate comparison than total number of cases due to the differences in population. The data showed a significant decline between the January peak and May which is in line with the national lockdown measures and COVID-19 vaccination programme. There has been smaller peaks and waves since August 2021. As at 16/11/2021, (the latest data period for this indicator) Warrington had 367.2 cases per 100k population and Halton had 428.5 cases per 100k population which is higher than the North West position (369.5 cases/100k population) and the England position (409.5 cases/100k population).

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

2.3 Number of People in Hospital

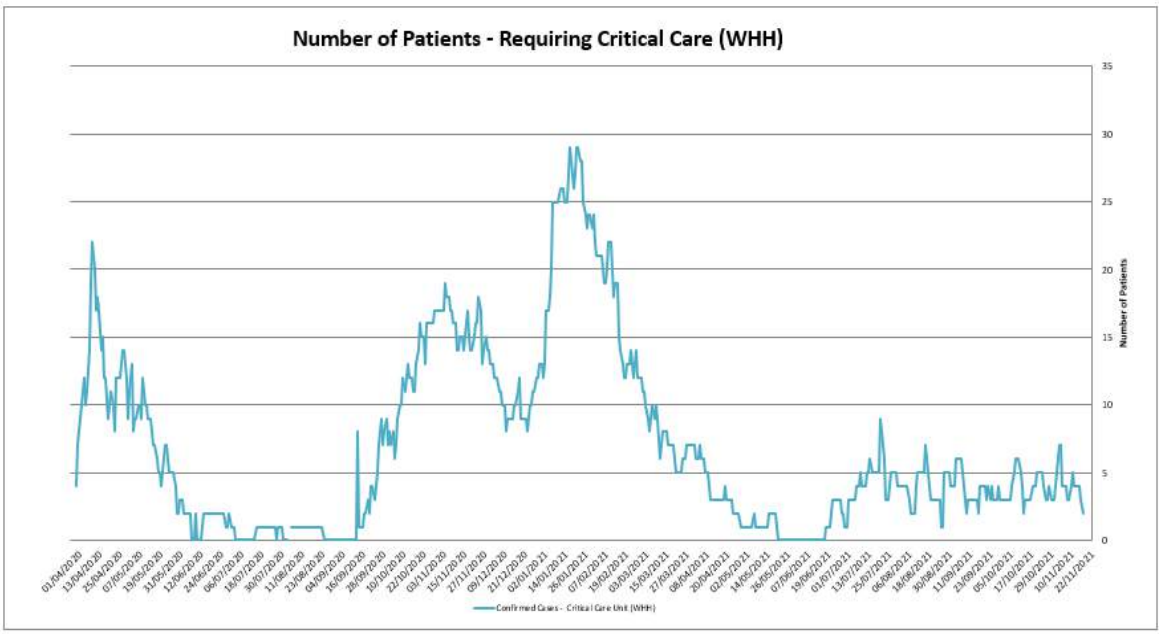




Narrative: As 19/11/2021, there were 14 inpatients being treated by the Trust with confirmed COVID-19 (with a positive COVID-19 sample within the last 14 days). The peak of the 3rd wave was on 18/01/2021 with 243 inpatients receiving treatment. There was a continued declined between February and May. The highest number of inpatients being treated through the 4th wave (since June 2021) was 42 inpatients on 21/10/2021.

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

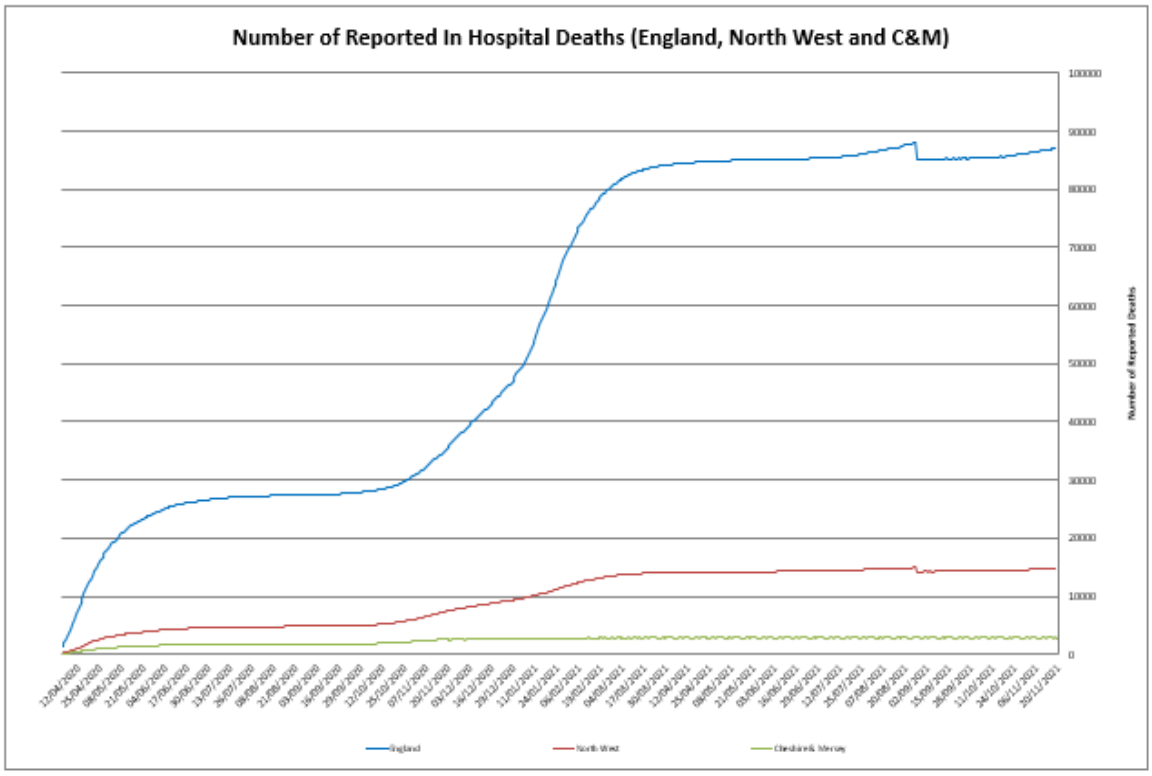
2.4 Number of Patients Requiring Critical Care

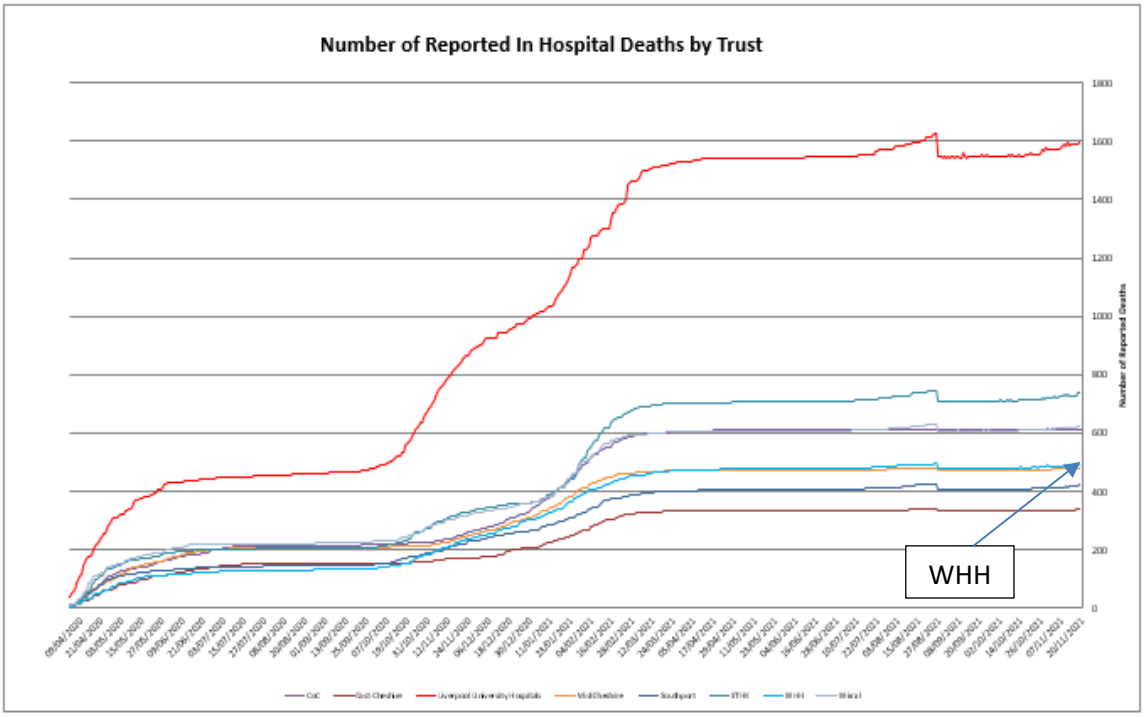


Narrative: As of 19/11/2021, there was 1 inpatient with confirmed COVID-19 (positive sample within the last 14 days) requiring critical care. During the 4th wave the Trust has had between 1 and 9 patients in critical care with confirmed COVID-19.

Source: Trust Data (Warrington & Halton).

2.5.1 Number of In-Hospital Deaths





Narrative: As of 20/11/2021, the Trust had reported 563 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.

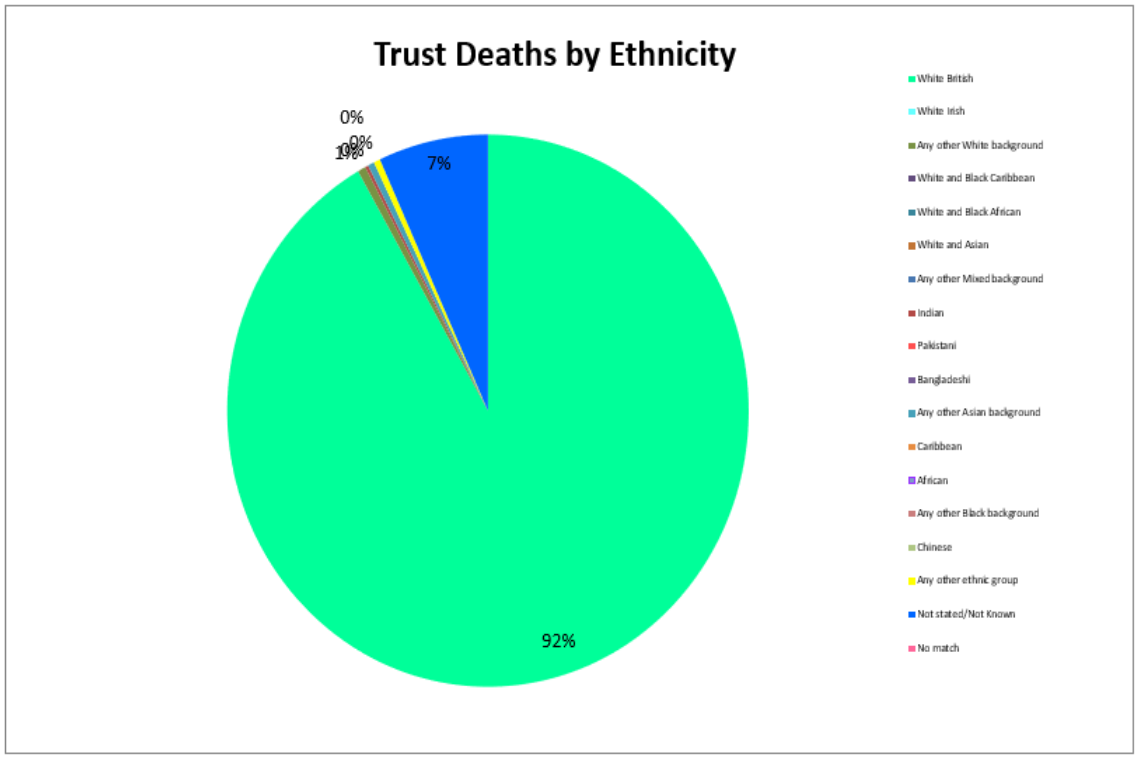
2.5.2 Crude Mortality

	2020	2021
October (All Deaths)	114	100
October (Non COVID)	66	76
October (COVID)	48	24
% COVID Deaths (of all deaths)	42.1%	24.0%
Discharges	4392	5178
Crude Mortality (deaths divided by deaths+discharges)	2.6%	1.9%

	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	431
Non-COVID	272	227	293	369
COVID	133	175	185	62
% COVID Deaths (of all deaths)	32.8%	43.5%	38.7%	14.4%
Discharges	19326	17241	23507	28339
Crude Mortality (deaths divided by deaths+discharges)	2.1%	2.3%	2.0%	1.5%
Crude Mortality COVID-19 (COVID-19 deaths divided by COVID-19 deaths+ COVID-19 discharges)	25.2%	20.3%	16.9%	10.8%

Narrative: Crude mortality in October 2021 was 1.9% compared with 2.6% in October 2020. Crude mortality was 2.1% in wave 1 and 2.3% in wave 2 and 2.0% in wave 3 and 1.5% in wave 4 (to date) with Crude mortality for COVID-19 patients 25.2% in wave 1, 20.3% in wave 2 and 16.9% in wave 3 and 10.8% in wave 4 (to date).
Source: Trust Data.

2.5.3 Number of In Hospital Deaths (Ethnicity)

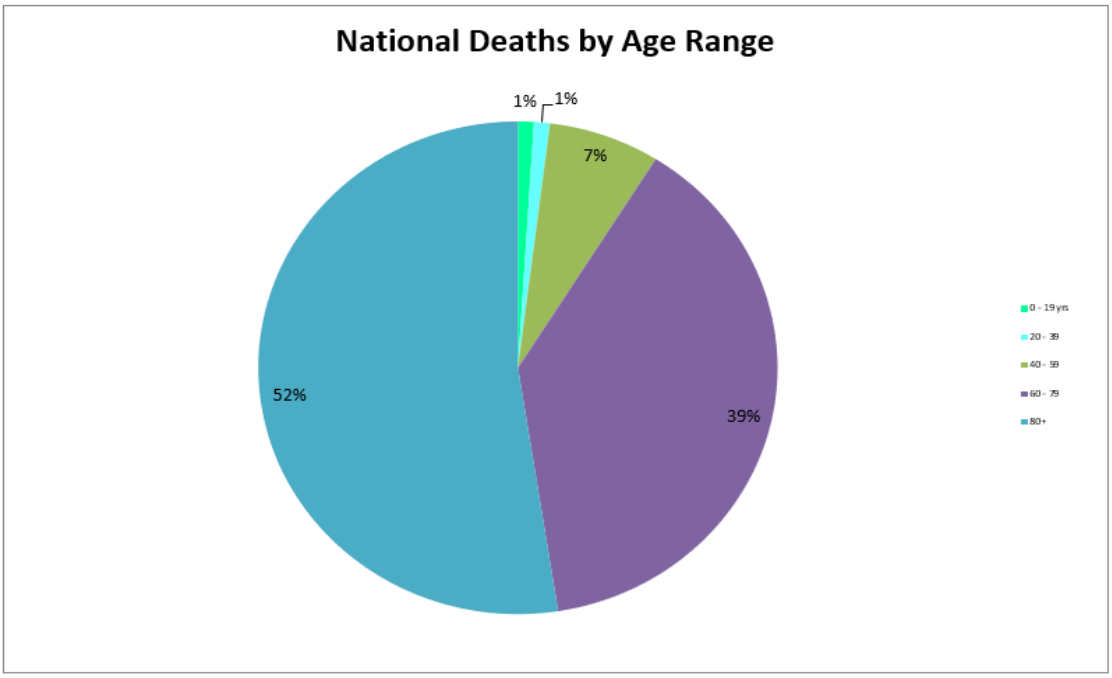


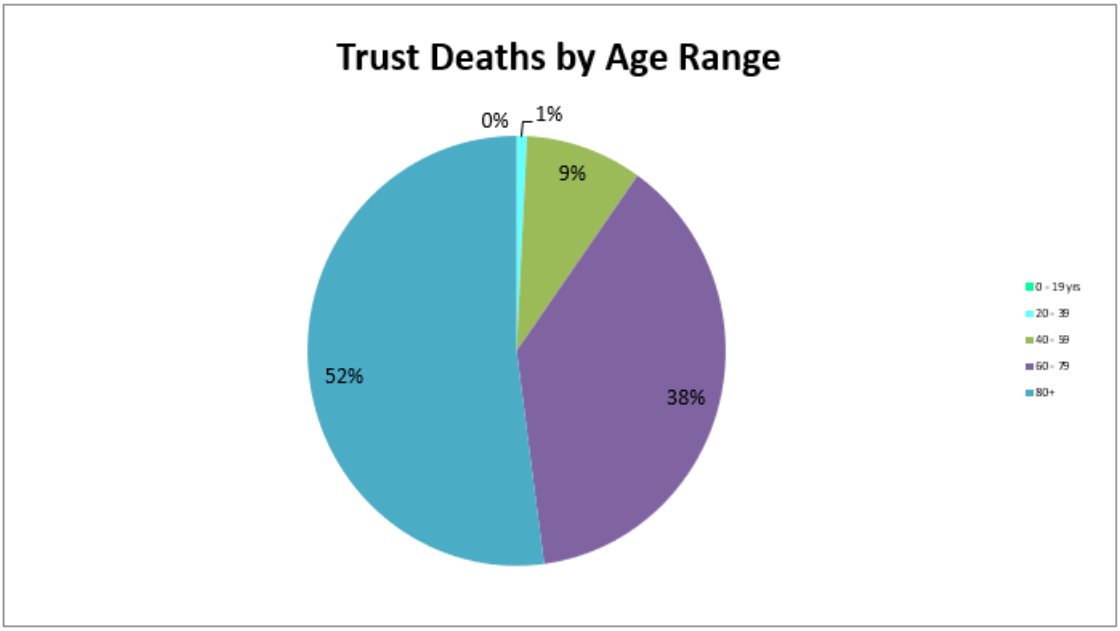
Narrative: As of 20/11/2021, 92% of reported deaths were patients who identified as "White British", with 7% patients' ethnicity "Not Stated/Not Known", <1% patients' ethnicity stated as "Any Other Ethnic Group", <1% patients stated as "Asian" or "Asian British", <1% Indian and <1% patient identified 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)

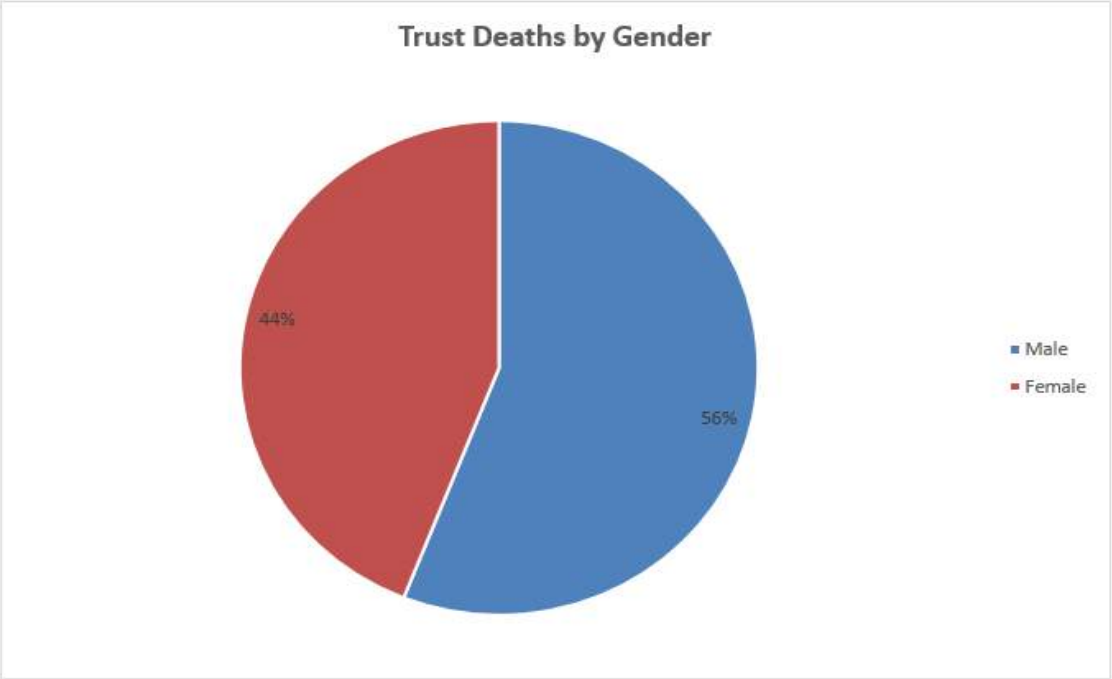
2.5.4 Number of In Hospital Deaths (Age Range)





Narrative: As at 20/11/2021, 90.0% of COVID-19 related deaths were inpatients over the age of 60, which is line with the national position. The average age of death was 77.4 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)

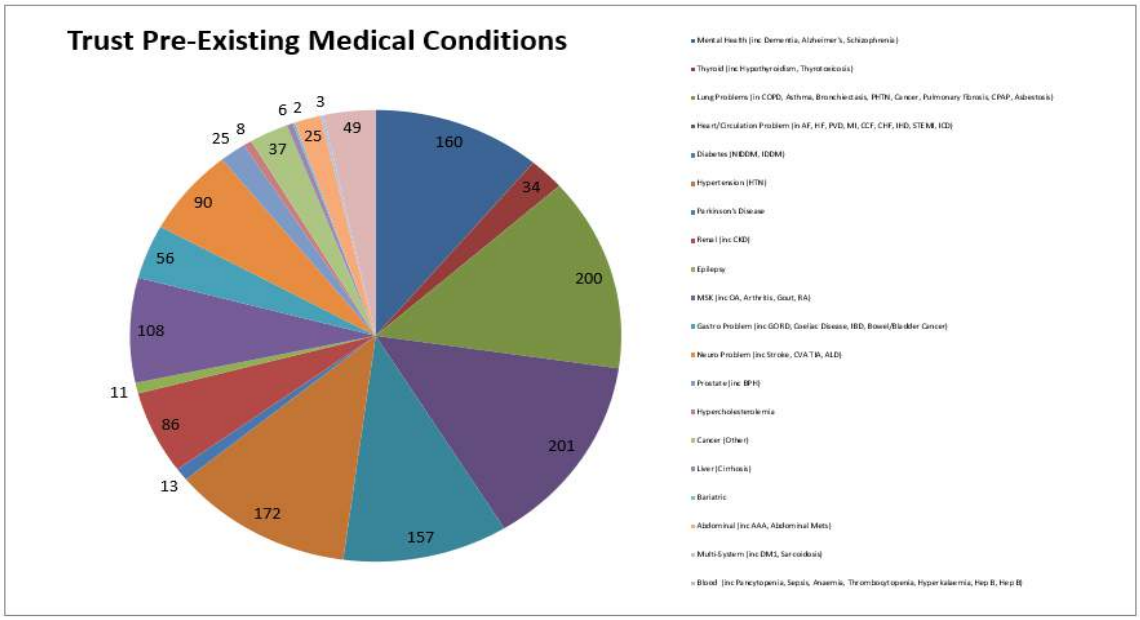


Narrative: As at 20/11/2021, 56% of COVID-19 deaths were male patients and 44% of deaths were female patients.

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



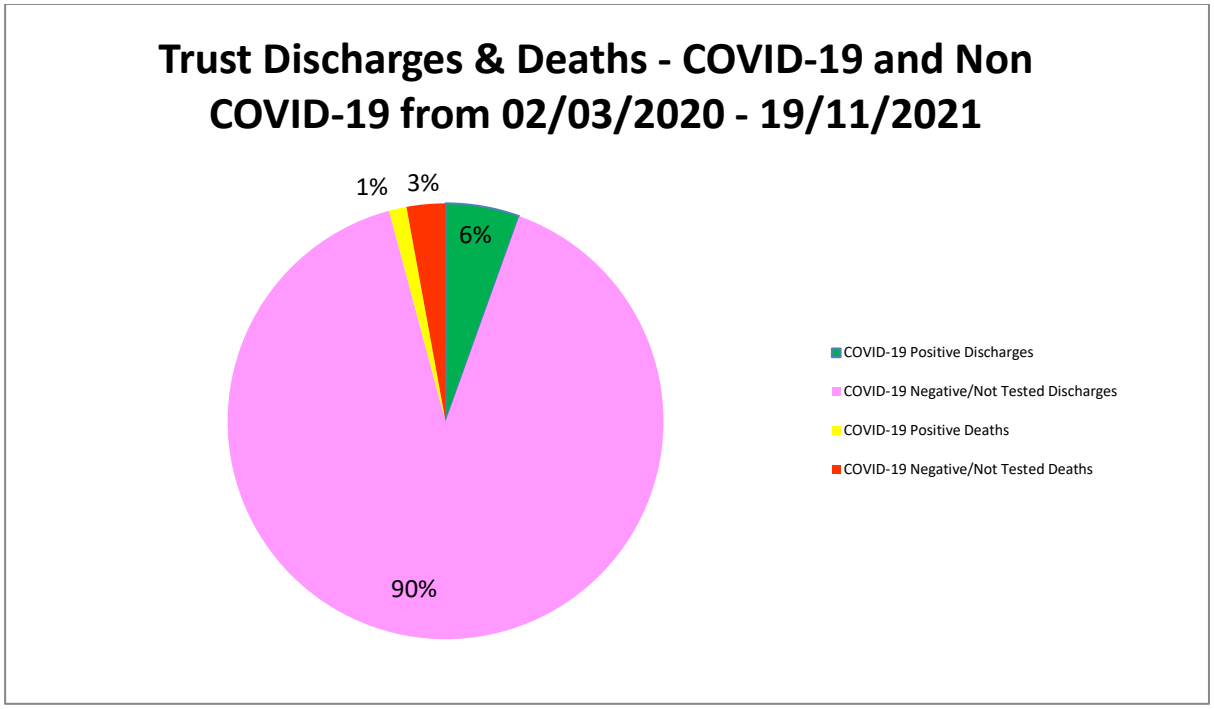
Narrative: As at 20/11/2021, 87% of inpatients who have died with a confirmed COVID-19 positive sample had a pre-existing medical condition recorded. The most common of these were Heart and Lung conditions and Diabetes.

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 maybe some omissions.

Source: Trust Data (Warrington & Halton)

2.6 Trust Outcomes

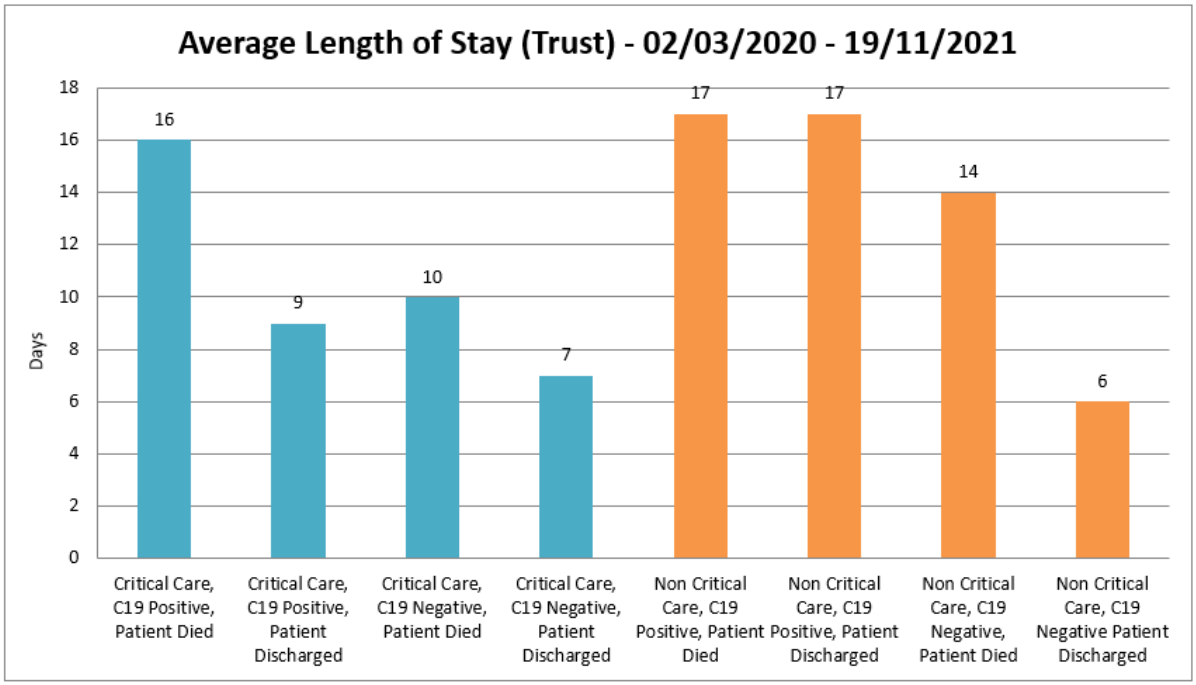


Narrative:

- Between 02/03/2020 – 20/11/2021, the Trust treated 43,519 inpatients (any patient with at least 1-night stay).
- 2,940 (6.75%) inpatients had tested positive for COVID-19.
- 95.93% of all patients were discharged from hospital (COVID-19 and Non COVID-19).
- There was a total of 1,769 inpatients (all causes) who have died; this represents 4.06% of all inpatients.
- 563 inpatient deaths were related to COVID-19 which represented 1.29% of all inpatients and 19.09% of inpatients with COVID-19.
- 100 patients who have died and who had tested positive for COVID-19 were admitted from a care home, 3.40% of all COVID-19 positive inpatients and 20% of inpatients whom have died with a positive COVID-19 sample.

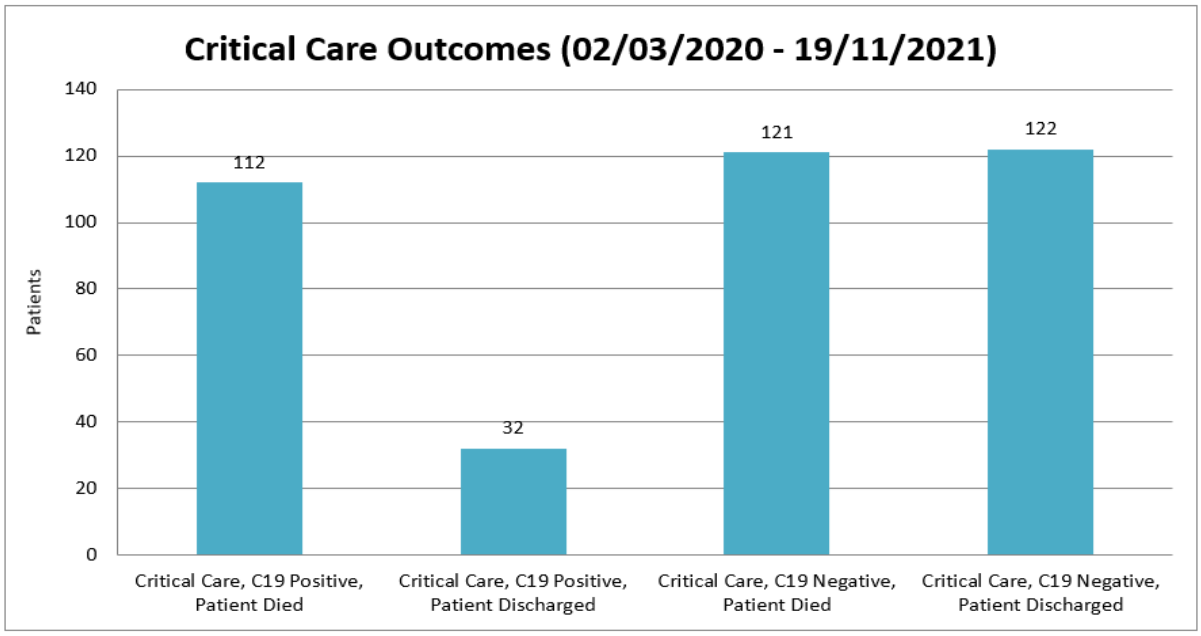
Source: Trust Data

2.6.1 Average Length of Stay



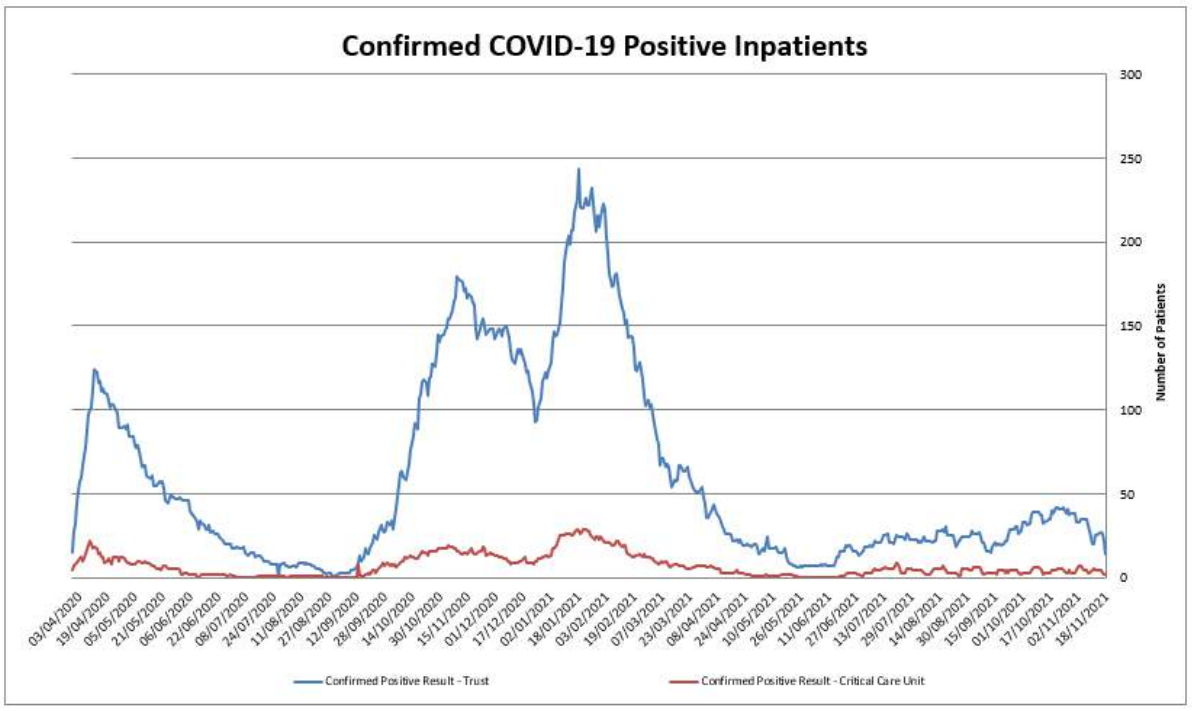
Narrative: From 02/03/2020 – 19/11/2021, the average length of stay for patients who had tested positive for COVID-19 was 14 days in critical care and 17 days in non-critical care.
Source: Trust Data

2.6.2 Critical Care Outcomes



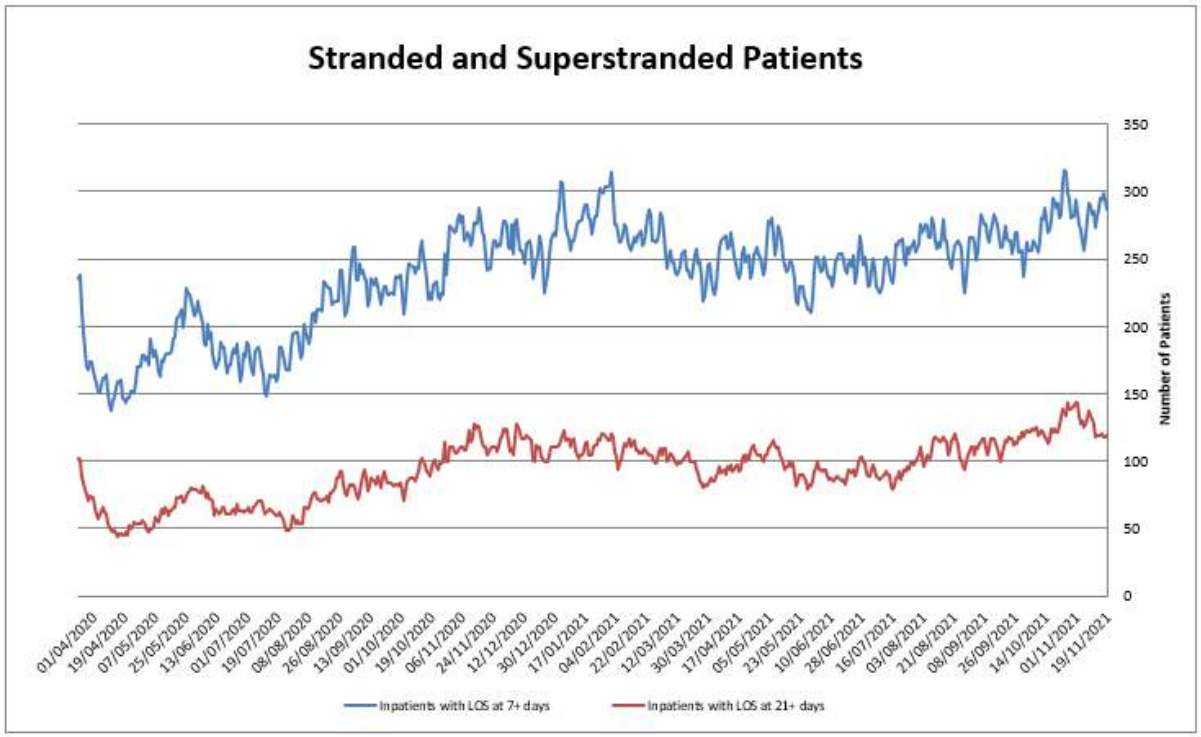
Narrative: From 02/03/2020 – 19/11/2021, there were 233 critical care inpatient deaths (112 COVID-19, 121 Non-COVID-19) and 154 critical care inpatient discharges (32 COVID-19, 122 Non-COVID-19).
Source: Trust Data

2.7 Confirmed Positive COVID-19 Patients



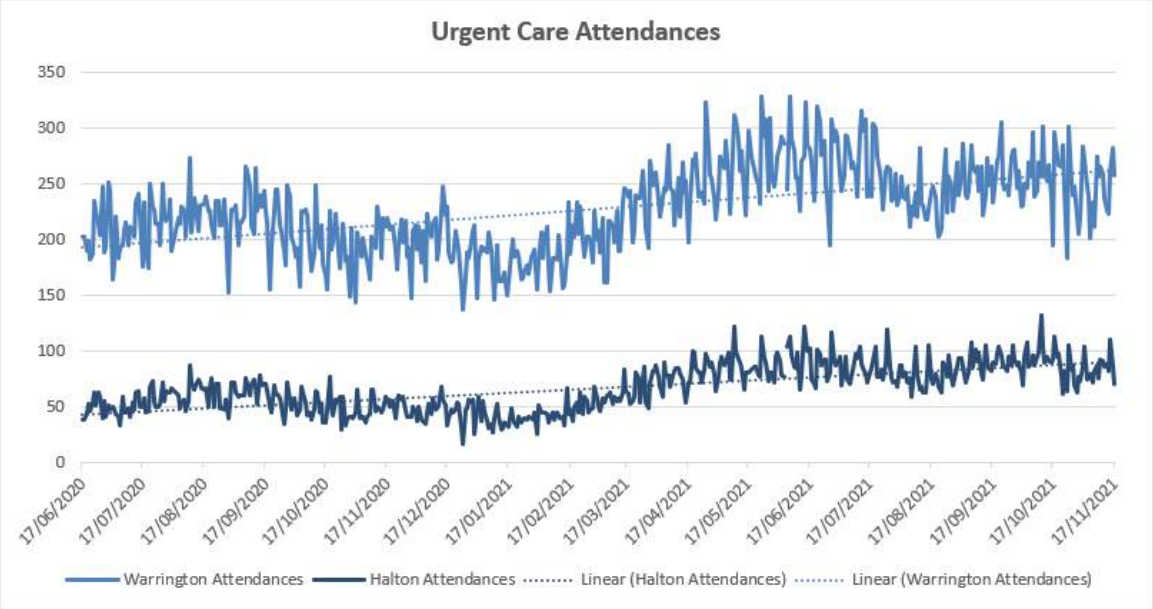
Narrative: As of 18/11/2021, there were 14 patients who have had a COVID-19 positive test within the last 14 days with 1 patient in critical care.

2.8 Stranded/Super Stranded Patients



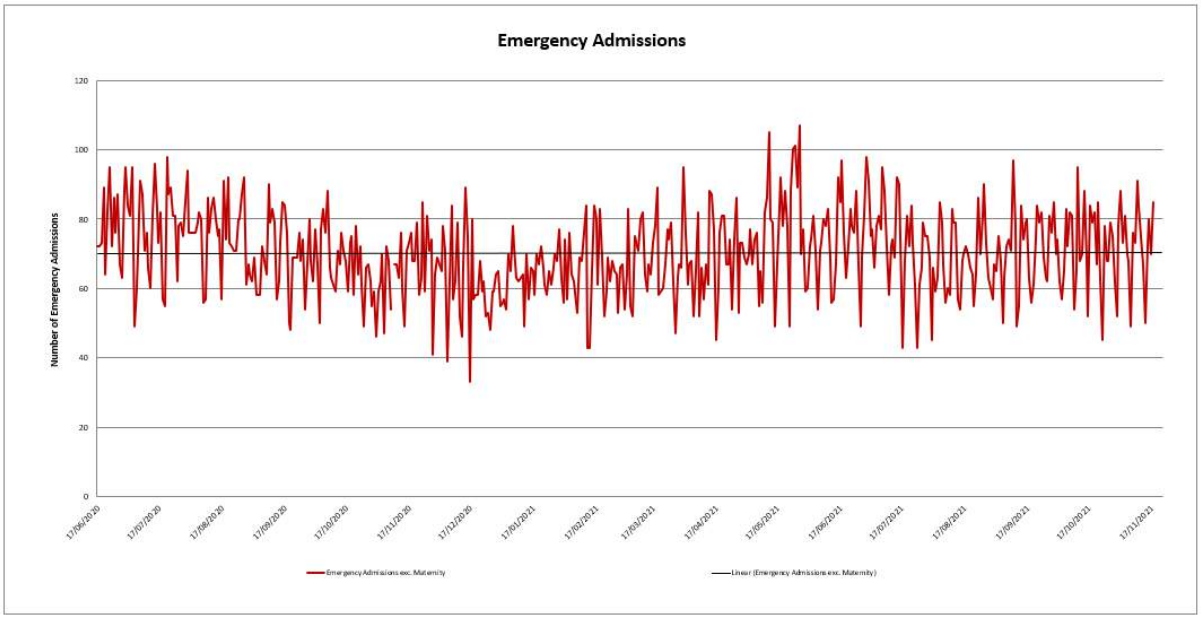
Narrative: On 20/11/2021, there were 292 Stranded and 123 Super Stranded patients in the hospital.
Source: Trust Data

2.9 Urgent Care



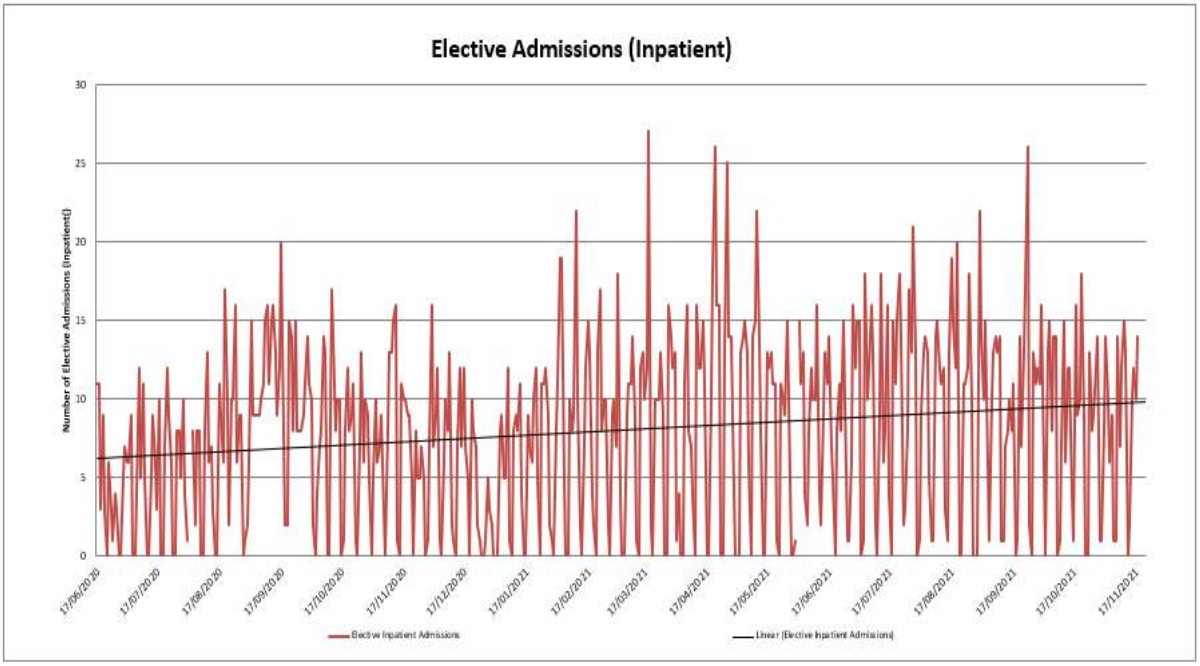
Narrative: There has been a step change in urgent care attendances since April 2021. In the 6 months November 2020 – April 2021, the average number of urgent care attendances at Warrington was 205 per day and in Halton was 53 per day. In the 6 months May 2021 – October 2021, the average number of urgent care attendances at Warrington was 259 per day and in Halton was 85 per day.
Source: Trust Data

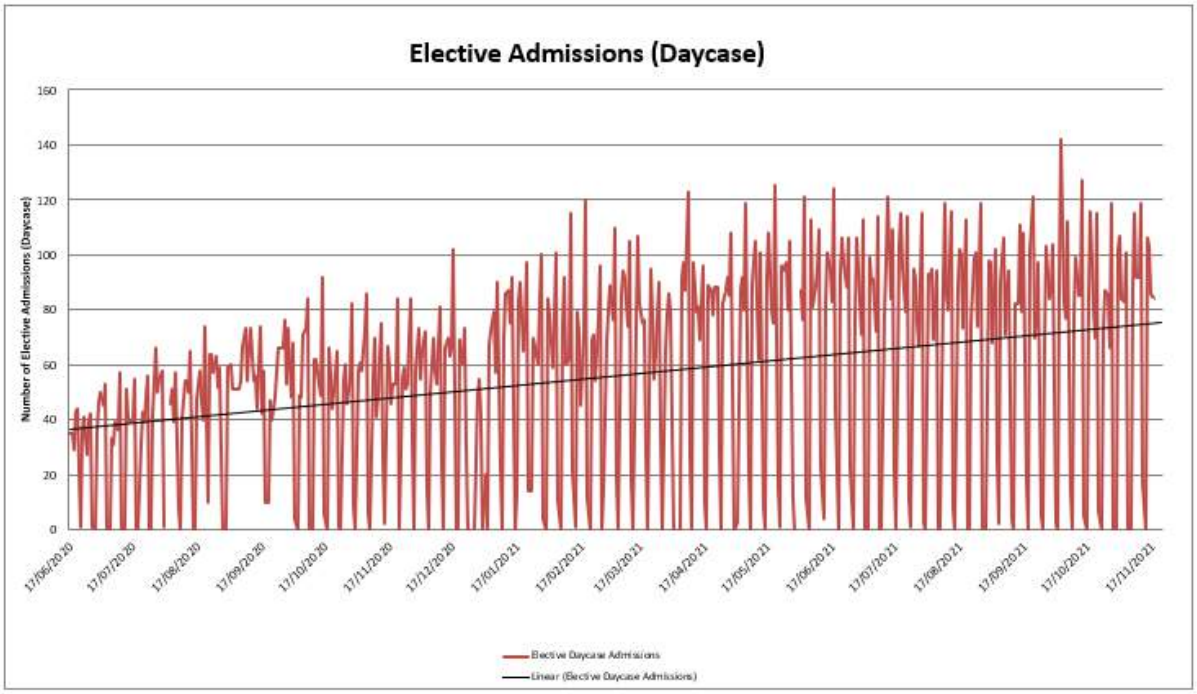
2.10 Emergency Admissions



Narrative: In the 6 months November 2020 – April 2021, the average number of emergency admissions was 65 (11,809 in total). In the 6 months May 2021 – October 2021, the average number of emergency admissions was 72 (13,297 in total).
Source: Trust Data

2.11 Elective Admissions/Daycases



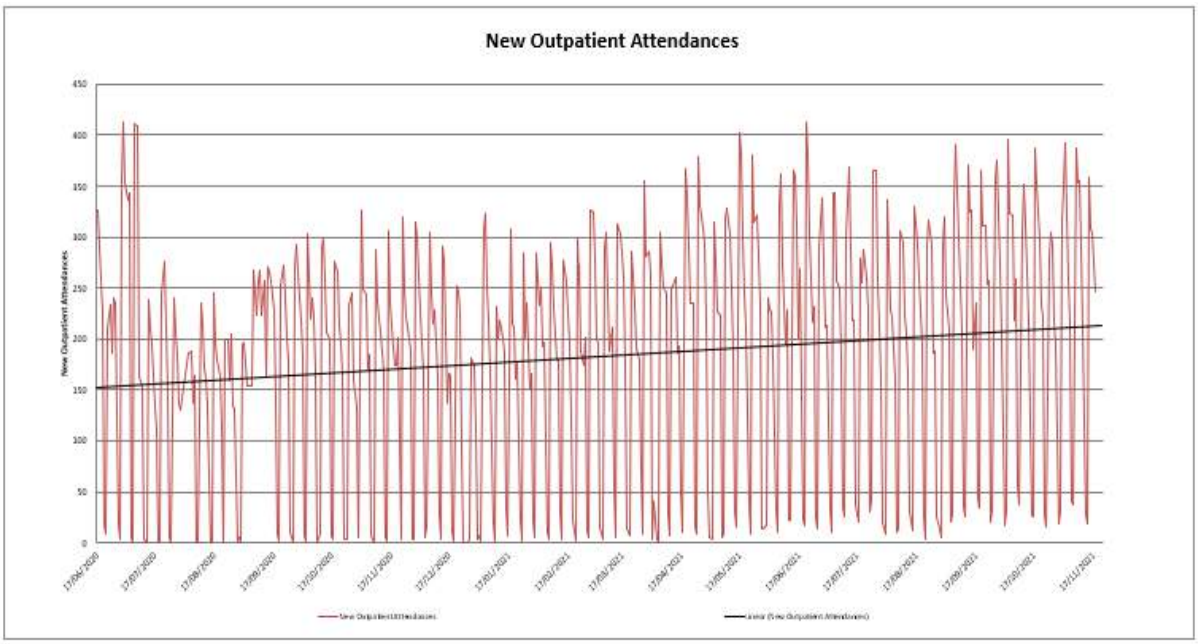


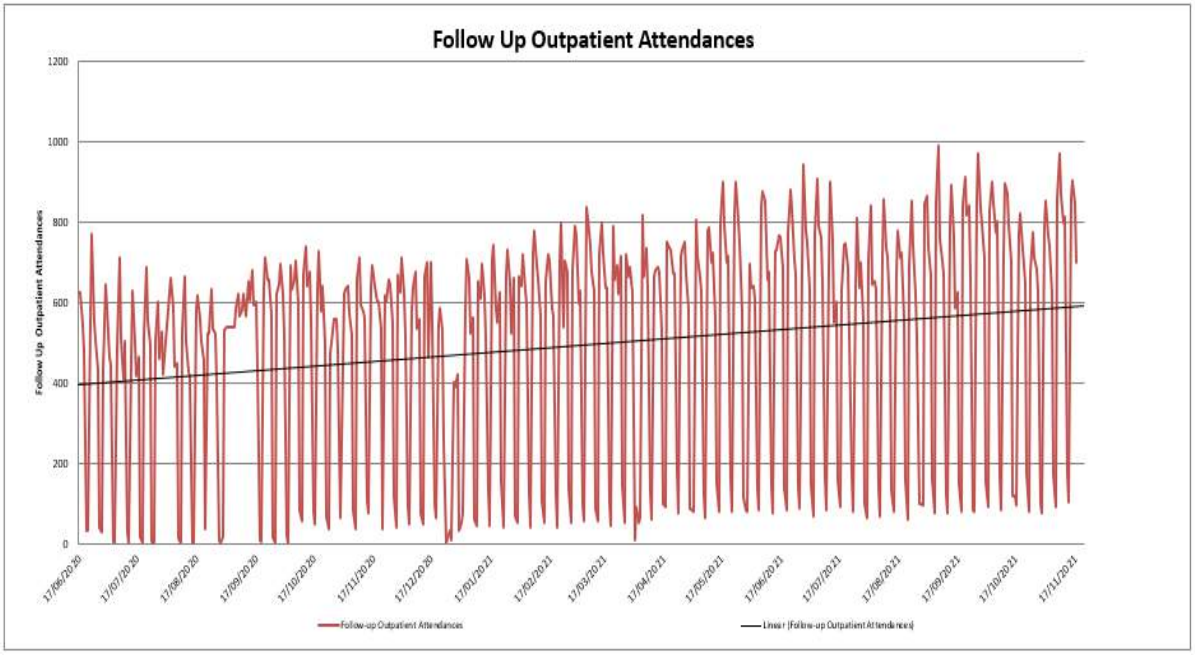
Narrative: In the 6 months November 2020 – April 2021, the average number of elective admissions was 7 (1,347 in total), this includes weekend days. In the 6 months May 2021 – October 2021, the average number of elective admissions was 9 (1,653 in total), this includes weekend days.

In the 6 months November 2020 – April 2021, the average number of daycases was 54 (9,893 in total), this includes weekend days. In the 6 months May 2021 – October 2021, the average number of daycases was 66 (12,107 in total), this includes weekend days.

Source: Trust Data

2.12 Outpatient Attendances





Narrative: In the 6 months November 2020 – April 2021, the average number of new outpatient attendances was 169 (30,513 in total), this includes weekend days. In the 6 months May 2021 – October 2021, the average number of new outpatient attendances was 199 (36,760 in total), this includes weekend days.

In the 6 months, November 2020 – April 2021, the average number of follow up outpatient attendances was 472 (85,093 in total), this includes weekend days. In the 6 months May 2021 – October 2021, the average number of follow up outpatient attendances as 542 (99,813 in total), this includes weekend days).

Source: Trust Data

2.13 Nosocomial Infection

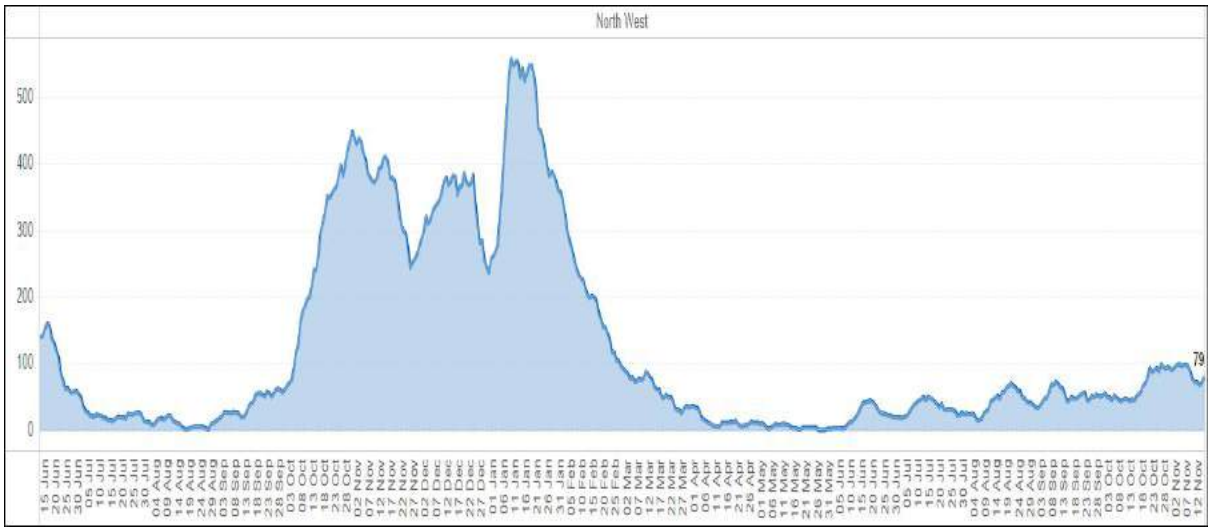
Nosocomial infections are defined as:

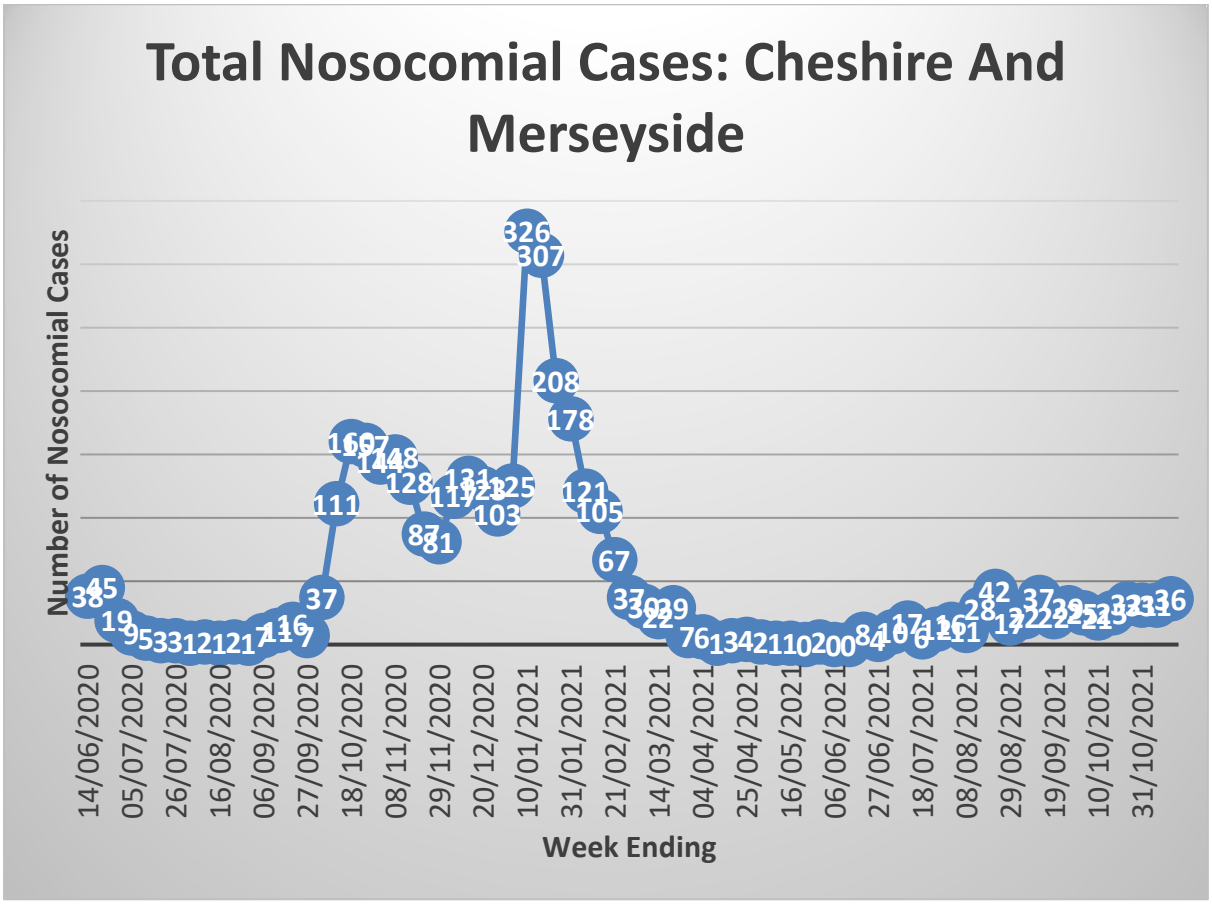
- Length of Stay at the Time of Positive COVID Sample 0-2 Days – Community Acquired
- Length of Stay at the Time of Positive COVID Sample 3-7 Days – Hospital Onset Indeterminable Hospital Associated
- Length of Stay at the Time of Positive COVID Sample 8-14 Days – Hospital Onset Probable Hospital Acquired
- 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 14h November 2021

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	**3791**	**28060**	**13.51%**
Countess of Chester Hospitals	420	2561	**16.39%**
Warrington & Halton Hospitals	385	2880	**13.36%**
Liverpool University Hospitals	1024	8470	**12.08%**
Southport And Ormskirk	288	2251	**12.79%**
Mid Cheshire Hospitals	407	2519	**16.15%**
Wirral University Hospitals	336	2804	**11.98%**
East Cheshire Hospital	259	1624	**15.94%**
St Helens And Knowsley Teaching Hospitals	235	3431	**6.84%**

Narrative: The Trust is performing in line with peer Trust and in line with Cheshire & Mersey nosocomial rates of 13.36%.




Total Nosocomial Cases: Cheshire And Merseyside
Number of Nosocomial Cases
Week Ending
14/06/2020
05/07/2020
26/07/2020
16/08/2020
06/09/2020
27/09/2020
18/10/2020
08/11/2020
29/11/2020
20/12/2020
10/01/2021
31/01/2021
21/02/2021
14/03/2021
04/04/2021
25/04/2021
16/05/2021
06/06/2021
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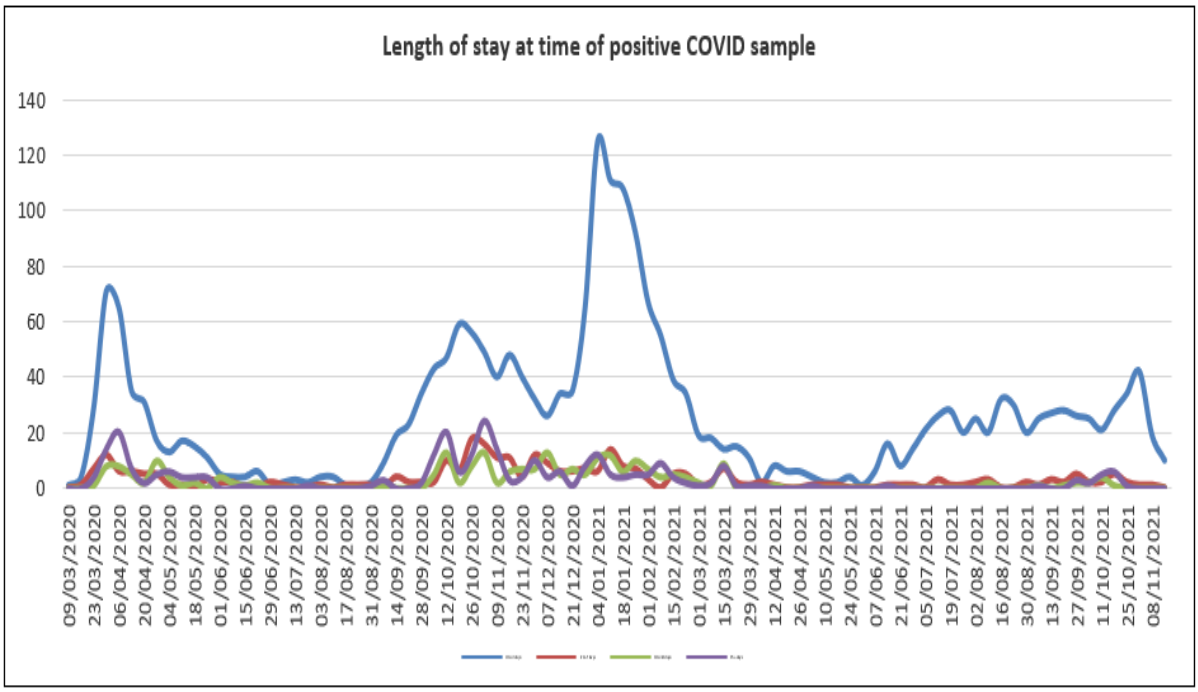
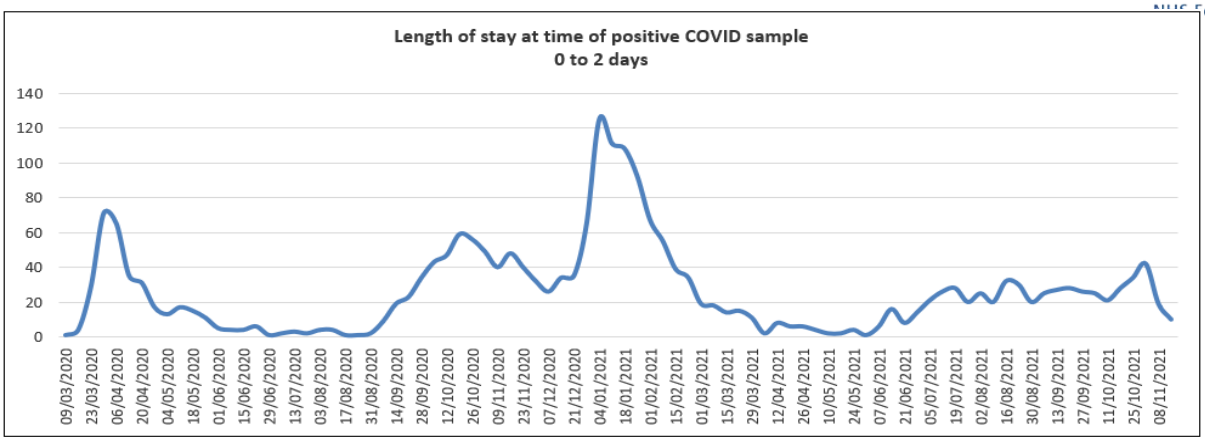
08/08/2021
29/08/2021
19/09/2021
10/10/2021
31/10/2021


Length of stay at time of positive COVID sample
140
120
100
80
60
40
20
0


Length of stay at time of positive COVID sample
0 to 2 days
140
120
100
80
60
40
20
0
09/03/2020
23/03/2020
06/04/2020
20/04/2020
04/05/2020
18/05/2020
01/06/2020
15/06/2020
29/06/2020
13/07/2020
03/08/2020
17/08/2020
31/08/2020
14/09/2020
28/09/2020
12/10/2020
26/10/2020
09/11/2020
23/11/2020
07/12/2020
21/12/2020
04/01/2021
18/01/2021
01/02/2021
15/02/2021
01/03/2021
15/03/2021
29/03/2021
12/04/2021
26/04/2021
10/05/2021
24/05/2021
07/06/2021
21/06/2021
05/07/2021
19/07/2021
02/08/2021
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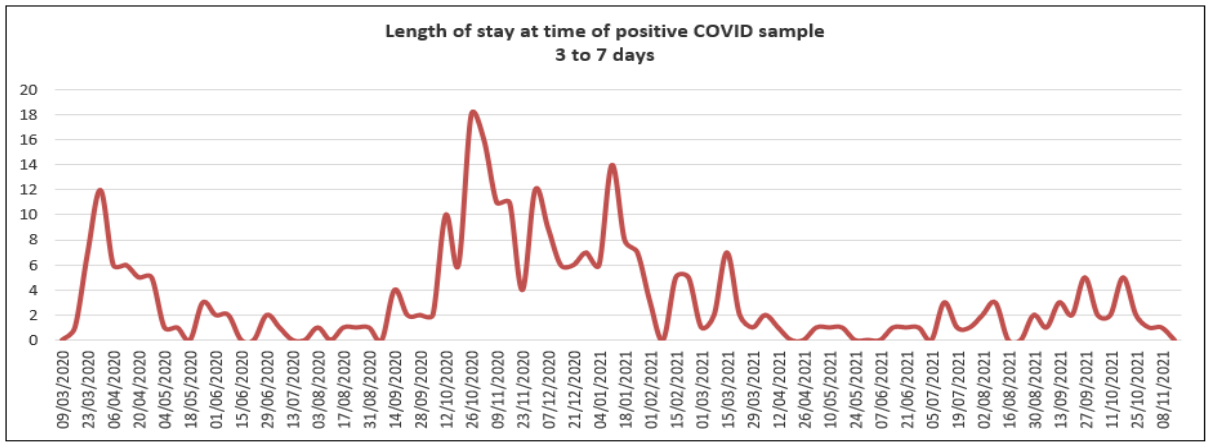
13/09/2021
27/09/2021
11/10/2021
25/10/2021
08/11/2021


Length of stay at time of positive COVID sample
3 to 7 days
20
18
16
14
12
10
8
6
4
2
0
09/03/2020
23/03/2020
06/04/2020
20/04/2020
04/05/2020
18/05/2020
01/06/2020
15/06/2020
29/06/2020
13/07/2020
03/08/2020
17/08/2020
31/08/2020
14/09/2020
28/09/2020
12/10/2020
26/10/2020
09/11/2020
23/11/2020
07/12/2020
21/12/2020
04/01/2021
18/01/2021
01/02/2021
15/02/2021
01/03/2021
15/03/2021
29/03/2021
12/04/2021
26/04/2021
10/05/2021
24/05/2021
07/06/2021
21/06/2021
05/07/2021
19/07/2021
02/08/2021
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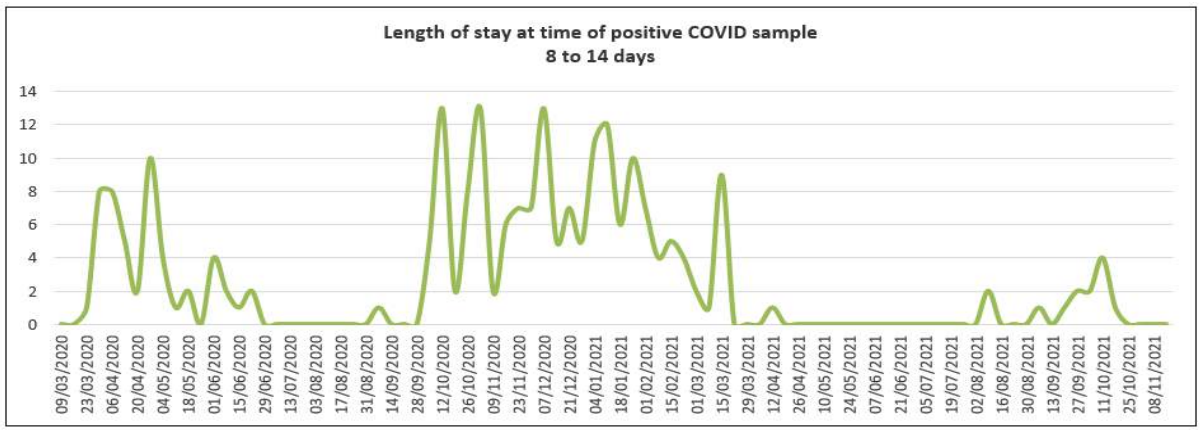
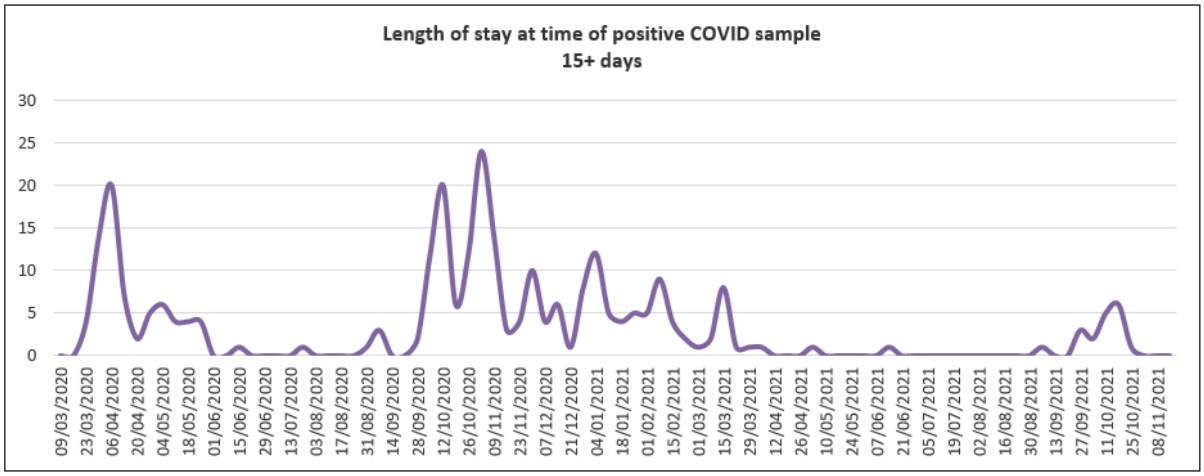
13/09/2021
27/09/2021
11/10/2021
25/10/2021
08/11/2021


Length of stay at time of positive COVID sample
8 to 14 days
14
12
10
8
6
4
2
0
09/03/2020
23/03/2020
06/04/2020
20/04/2020
04/05/2020
18/05/2020
01/06/2020
15/06/2020
29/06/2020
13/07/2020
03/08/2020
17/08/2020
31/08/2020
14/09/2020
28/09/2020
12/10/2020
26/10/2020
09/11/2020
23/11/2020
07/12/2020
21/12/2020
04/01/2021
18/01/2021
01/02/2021
15/02/2021
01/03/2021
15/03/2021
29/03/2021
12/04/2021
26/04/2021
10/05/2021
24/05/2021
07/06/2021
21/06/2021
05/07/2021
19/07/2021
02/08/2021
16/08/2021
30/08/2021
13/09/2021
27/09/2021
11/10/2021
25/10/2021
08/11/2021

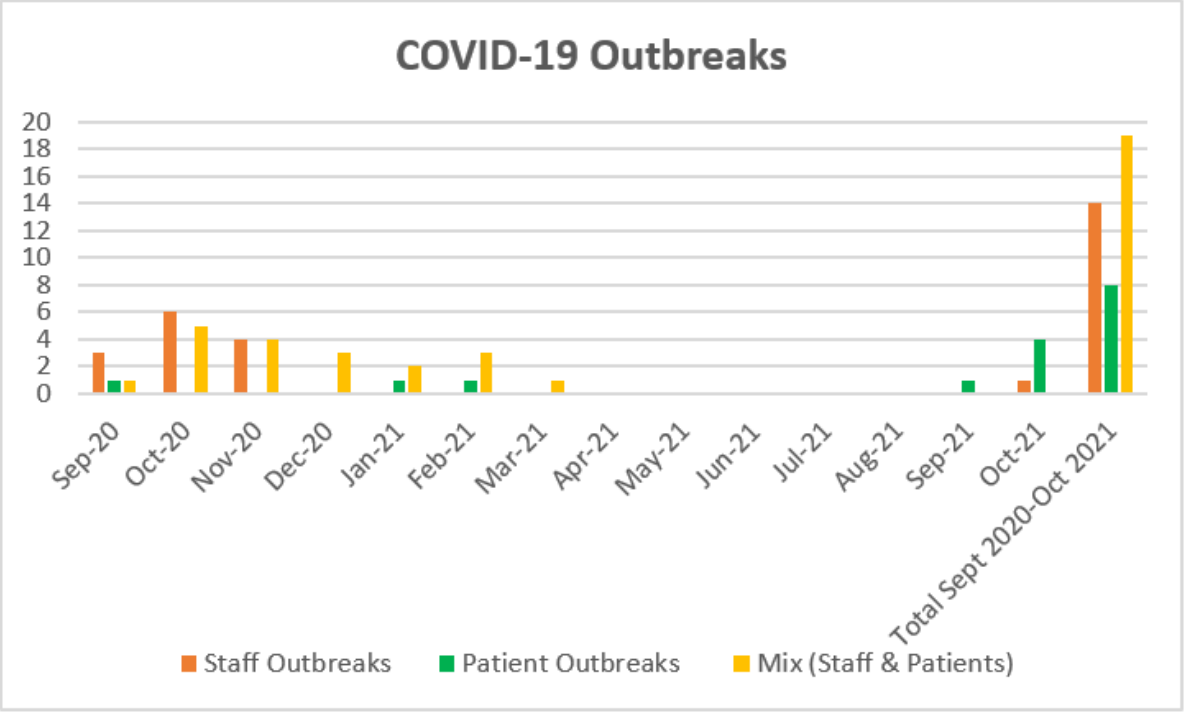

Length of stay at time of positive COVID sample
15+ days
30
25
20
15
10
5
0
09/03/2020
23/03/2020
06/04/2020
20/04/2020
04/05/2020
18/05/2020
01/06/2020
15/06/2020
29/06/2020
13/07/2020
03/08/2020
17/08/2020
31/08/2020
14/09/2020
28/09/2020
12/10/2020
26/10/2020
09/11/2020
23/11/2020
07/12/2020
21/12/2020
04/01/2021
18/01/2021
01/02/2021
15/02/2021
01/03/2021
15/03/2021
29/03/2021
12/04/2021
26/04/2021
10/05/2021
24/05/2021
07/06/2021
21/06/2021
05/07/2021
19/07/2021
02/08/2021
16/08/2021
30/08/2021
13/09/2021
27/09/2021
11/10/2021
25/10/2021
08/11/2021

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

Source: Trust Data

2.14 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 October 2021, there was 1 staff outbreak and 4 patient outbreaks at the Trust.

Source: Trust Data

3. CONCLUSION

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

4. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.

This report will be presented quarterly going forward at the Trust Board in March 2022, July 2022, November 2022 and January 2023.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/155**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	24th November 2021	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Anne Robinson, Acting 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)***	#1215 Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic. #1272 Failure to provide enough beds caused by the requirement to adhere to social distancing guidelines. #1273 Failure to provide timely patient discharge caused by system-wide COVID-19 pressures. #1275 Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission. #1289 Failure to deliver planned elective procedures caused by the Trust's decision to pause some elective procedures in order to ensure safe staffing and critical care capacity during the COVID-19 pandemic. #115 Failure to provide adequate staffing levels in some specialities and wards caused by the inability to fill vacancies and staff sickness. #134 Financial Sustainability a) Failure to sustain financial viability caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has 76 IPR indicators which have been RAG rated in October as follows: Red: 32 (from 31 in September) Amber: 9 (from 9 in September) Green: 30 (from 31 in September) Not RAG Rated: 5 (from 5 in September)	

	As a result of the COVID-19 pandemic, the Trust has not met the RTT 18 week, RTT 52 week, Diagnostics 6-week, Breast Symptomatic 2 week or Cancer 62-day urgent standards. The Trust has achieved all other cancer standards. A&E and Ambulance Handover performance remains challenging with increased attendances. There were 4 patients waiting over 12 hours in A&E in October. Sepsis screening and anti-biotics administration within the one hour timeframe remains a key focus. A focussed improvement plan is in place with oversight from the Deputy Chief Nurse for Patient Safety and Clinical Education. Friends & Family Test A&E performance has been impacted by the increased attendances in ED, however this is reflected across the region. Budgets have not been finalised for H2 2021/22. The month 7 financial position is therefore a deficit of £1.7m. This paper proposes two additional KPIs to be included within the Access & Performance Section of the IPR. These are the % of outpatient appointments being delivered remotely and performance in relation to the Fracture Clinic.			
PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the increase in the Capital programme of £0.1m in relation to donated equipment. 2. Note the Capital schemes approved as an emergency by the Chief Finance Officer/Deputy Chief Executive in Table 5. 3. Approve the Orthopaedic Doors Capital scheme to be funded from contingency outlined in Table 5. 4. Approve the additional Key Performance Indicators to be included in the Access & Performance section of the IPR outlined in Table 6. 5. Note the contents of this report.			

PREVIOUSLY CONSIDERED BY:	**Committee**	Finance & Sustainability Committee
	Agenda Ref.	FSC/21/11/201 (Additional KPIs)
	Date of meeting	17th November 2021
	Summary of Outcome	Supported
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	**AGENDA REF:**	BM/21/11/155

1. BACKGROUND/CONTEXT

The RAG ratings for all 76 IPR indicators from November 2020 to October 2021 are set out in **Appendix 1.** The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the Trust Board with assurance in relation to the delivery of all Key Performance Indicators (KPIs) across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

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

Table 1: RAG Rating Movement

	September	October
Red	31	32
Amber	9	9
Green	31	30
Not RAG Rated	5	5
Total:	76	76

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

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

Quality

Quality KPIs

There are 5 Quality indicators rated Red in October, the same number as in September.

The 5 indicators rated Red in September, which have remained rated Red in October are as follows:

- Sepsis % Screening for Emergency Patients within 1 hour – the Trust achieved 69.00% in October, an improvement from 64.00% in September, against a target of 90.00%.
- Sepsis % Screening for Inpatients – the Trust achieved 76.00% in October, an improvement from 69.00% in September, against a target of 90.00%.

- Sepsis % Emergency Patients Administered Antibiotics Within 1 Hour – the Trust achieved 43.00% in October, a deterioration from 48.00% in September, against a target of 90.00%.
- Sepsis % Inpatients Administered Antibiotics Within 1 Hour – the Trust achieved 76.00% in October, a deterioration from 81.00% in September, against a target of 90.00%.
- A focussed improvement plan is in place with oversight from the Deputy Chief Nurse for Patient Safety and Clinical Education. A business case has been approved for the provision of pre-made antibiotics which will improve performance against these indicators. This went live on 5th November 2021.
- Friends and Family Test (ED) – the Trust achieved 68.00% in October, a deterioration from 72.00% in September, against a target of 87.00%.

Access and Performance

Access and Performance KPIs

There are 17 Access and Performance indicators rated Red in October, the same number as in September. 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 16 indicators which were rated Red in September and remain rated Red in October are as follows:

- Diagnostic 6 Week Target – the Trust achieved 76.72% in October, a deterioration from 81.29% in September, against a target of 99.00%.
- Referral to Treatment Open Pathways – the Trust achieved 72.50% in October, a deterioration from 75.04% in September, against a target of 92.00%.
- Referral to Treatment 52+ Week Waiting – there were 1,078 patients waiting over 52 weeks in October, a deterioration from 1,025 patients in September, against a target of 0. RTT and Diagnostic performance is as a result of the reduction in the elective programme, suspension of services and the associated backlog during the initial phases of the pandemic. The Trust has robust recovery plans in place with clinical prioritisation.
- A&E Waiting Times 4-hour National Target – the Trust achieved 70.59% (excluding Widnes Walk ins) in October, a deterioration from September's position of 73.42%, 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 4 x 12 hour breaches in October, a deterioration from 1 breach in September, against a target of 0.
- Cancer 62 Days Urgent - the Trust achieved 64.17% in September, a deterioration from 71.62% in August, against a target of 85.00%.
- Ambulance Handovers 30 – 60 minutes – there were 120 patients who experienced a delayed handover in October, a deterioration from 81 patients in September against a target of 0.

- Ambulance Handovers 60 minutes plus - there were 122 patients who experienced a delayed handover in October, a deterioration from 37 patients in September against a target of 0.
- Discharge Summaries % sent within 24 hours – the Trust achieved 79.35% in September, a deterioration from 84.00% in October, against a target of 95.00%.
- Discharge Summaries NOT sent within 7 days (to achieve the 95.00% standard) – there were 476 discharge summaries not sent within 7 days to achieve the 95.00% standard in October, a deterioration from 285 discharge summaries not sent in September.
- Cancelled Operation for non-clinical reasons (not rebooked within 28 days) – there were 3 cancelled operations in October, the same number as in September, against a target of 0.
- Super Stranded Patients – there were 146 super stranded patients at the end of October, a deterioration from 126 patients at the end of September, against a trajectory of 113 patients.
- COVID-19 Recovery (Inpatient & Daycase) – the Trust achieved 91.98% of inpatient procedures and 75.28% of daycase procedures in October 2021/22 in comparison with activity in the same period in 2019/20, against a target of 95.00%.
- COVID-19 Recovery (Diagnostics) – the average performance across all diagnostic modalities was 59.23% in October 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 80.89% of outpatient attendances in October 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 Red to Green in month as follows:

- Cancer 2 Week Wait - the Trust achieved 95.86% in September, an improvement from 90.23% in August, against a target of 93.00%.

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

- Cancer 2 Week Breast Symptomatic - the Trust achieved 92.86% in September, a deterioration from 98.25% in August, against a target of 93.00%.

PEOPLE

Workforce KPIs

There are 7 Workforce indicators rated Red in October, an increase from 6 in September.

The 6 indicators which were rated Red in September and remain rated Red in October are as follows:

- Sickness Absence – the Trust's sickness absence was 6.30% in October, an improvement from 6.35% in September, against a target of less than 4.20%.
- Return to Work Compliance – interview compliance was 63.25% in October, a deterioration from 69.07% in September, against a target of 85.00%.
- Bank/Agency Reliance – the Trust's reliance was 14.18% in October, an improvement from 14.72% in September, against a target of less than 9.00%.

- Agency Shifts Compliant with the Cap – 22.75% of agency shifts were compliant with the cap in October, a deterioration from 23.98% in September, against a target of 49.00%.
- Agency Rate Card Compliance – 34.31% of agency shifts were compliant with the rate card in October, a deterioration from 35.37% in September, against a target of 60.00%.
- Monthly Pay Spend – monthly Trust pay spend was £1m above budget in October.

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

- Turnover – staff turnover was 15.11% in October, a deterioration from 14.73% in September, against a target of less than 13.00%. However, when excluding temporary staff, the position is 12.91% in October 2021.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 3 Finance & Sustainability indicators rated Red in October:

- Capital Programme – the actual spend year to date is £3.9m which is £2.7m below the planned spend of £6.7m. However, the Trust has committed orders of £7.9m.
- Agency Spending – the year to date spend of £6.8m is £1.4m above the plan of £5.5m.
- Cost savings schemes (recurrent) - compared to plan, the recurrent forecast is £2.1m against a plan of £4.8m. Further work to increase identification of CIP schemes is underway across the Trust.

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

- Trust Financial Position – the Trust recorded a deficit of £1.7m. The Trust's submission to NHSE/I did not include a financial plan as this has not been finalised. Submission without plan was in line with the national position.

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

COVID-19 expenditure for Month 7 2021/22 is £0.7m, this is £0.4m higher than the planned spend of £0.3m (month 6 was £0.3m higher than plan). This is largely due to £0.3m for COVID-19 sickness and isolation and £0.1m agency and bank spend in ICU.

The Trust's Elective Recovery Fund (ERF) allocation for H1 has been confirmed at a total of £3.3m.

The criteria for the ERF has been amended for H2, which now uses completed Referral to Treatment (RTT) activity as the baseline for the ERF calculation. ERF performance remains at system level; therefore, the system must also achieve the overall performance target of 89.00% before any additional income is released. **Table 2** details the RTT performance against target for October 2021.

Table 2: RTT performance against activity for October 2021

Activity	Target	Actual
Non admitted RTT	89%	88%
Admitted RTT	89%	61%
Total	**89%**	**83%**

As the Trust did not exceed the national target of 89.00% collectively for October, no ERF will be available for the Trust. The draft H2 plan currently anticipates achievement of £0.7m, in Quarter 4.

Cash

A revised forecast cash position was produced in August 2021 with a planned cash level at Month 7 of £27.9m against an actual balance of £35.2m. The key factors that have impacted the cash in month are the receipt of HEE funds of £3.4m and £5.2m COVID-19 top up.

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

Capital Programme

The Capital Programme for 2021/22 has been approved at £19.6m. In month 7 the Trust received an increase of £0.1m for donated equipment. The Capital programme has therefore increased to £19.7m. **Table 3** provides a high-level summary.

Table 3: Capital Expenditure excluding commitments as at 31 October 2021

Capital	Annual Plan	Original Plan to Date	Revised Plan to Date	Expenditure to Date	Variance: Against Rev. Plan
	£000	£000	£000	£000	£000
Trust Funded	18,770	9,689	5,796	3,851	1,945
PDC Funded:					
Cardiac Catheterisation Suite	800	400	800	0	800
Total Approved Capital Programme	**19,570**	**10,089**	**6,596**	**3,851**	**2,745**
Equipment Donated by DHSC	132	132	132	132	0
Total Planned Capital Investment	**19,702**	**10,221**	**6,728**	**3,983**	**2,745**

Table 4 provides a high-level summary by category.

Table 4: Capital Expenditure by category excluding commitments as at 31 October 2021

Capital	Annual Plan	Original Plan to Date	Revised Plan to Date	Expenditure to Date	Variance: Against Rev. Plan
	£000	£000	£000	£000	£000
Estates	15,462	7,723	4,995	3,402	1,593
IM&T	2,172	1,230	635	520	115
Medical Equipment	2,087	957	1,098	294	804
Contingency	-19	311	0	0	0
VAT refunds prior year	0	0	0	-233	233
Total Planned Capital Investment	**19,702**	**10,221**	**6,728**	**3,983**	**2,745**

Underspends in Estates schemes are due to delays in the ED Plaza, an underspend on ICU/B18 and delays in the final sign off of the Breast Unit. IT schemes have been delayed due to recruitment issues. Medical equipment underspends are due to procurement of equipment taking longer than anticipated for the Cardiac Catherisation Suite.

Table 5 shows the balance of contingency as at month 7 (£0.364m) and the proposed capital changes in Month 8 which bring the total to £0.194m.

Table 5: Balance of contingency fund as at 31 October 2021 and proposed changes in month 8.

Detail	£0
Total Contingency available as at month 7	**364**
Proposed changes in month	
Emergency approved by CFO/CEO	
Microtome and Slide Writers - Pathology	-51
Decontamination Shelter	-21
Histopathology Downdraft tables	-7
Resuscitaires for Birth Suite	-57
Shoulder Table	-14
Main Kitchen Boiler	-9
sub-total	**205**
Trust Board Approval Required	
Orthopaedic Doors	-11
sub-total	**-11**
Contingency - closing balance as at 9th November 2021	**194**

An exercise is underway with the ICS to review the risk of any schemes not completing by 31 March 2022.

The Trust Board is asked to:

- **Note the increase in the Capital programme of £0.1m in relation to donated equipment.**
- **Note the schemes approved as an emergency by the Chief Finance Officer/Deputy Chief Executive in Table 5.**
- **Approve the Orthopaedic Doors scheme to be funded from contingency outlined in Table 5.**

3. RECOMMENDED UPDATES/AMENDMENTS TO THE IPR

Table 6 outlines two proposed indicators to be added to the Access & Performance section of the IPR which was supported by the Finance & Sustainability Committee on 17th November 2021.

Table 6: Proposed New KPIs

KPI	RAG Criteria	Rationale
Fracture Clinic Patients Seen within 72 Hours	**RAG Criteria:** Green: 95% of Patients Seen within 72 Hours Red: Less than 95% of Patients Seen within 72 Hours The proposed RAG criteria allows for a 5% tolerance for 'patient choice', DNA's and where delaying review of patients may be in patient's best interest e.g. planned ward discharges. A 95% target will provide assurance of how well the Trust is adhering to BOAST (British Orthopaedic Association Standards for Trauma and Orthopaedics) guidelines of review within 72 hours of presentation of injury.	The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury. This additional KPI will monitor progress against this standard.
% of all outpatient activity delivered remotely via telephone or video consultation	RAG Criteria Green 25% or more Red: Less than 25% The proposed RAG criteria is based on The 2021/22 NHS Planning Guidance which states that at least 25% of outpatient attendances should be delivered remotely via telephone or video consultation. 25% is also the target on the draft NHSE/I Oversight Framework dashboard.	A new indicator on NHSE/I System Oversight Framework as part of Transformation of Outpatient Care.

The Trust Board is asked to approve the addition of two new Key Performance Indicators to be included in the Access & Performance section of the IPR.

This amendment will increase the overall number of indicators on the IPR from 76 to 78. If approved by the Trust Board, the changes will take place from January's IPR Board Report (December'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 increase in the Capital programme of £0.1m in relation to donated equipment.
2. Note the Capital schemes approved as an emergency by the Chief Finance Officer/Deputy Chief Executive in Table 5.
3. Approve the Orthopaedic Doors Capital scheme to be funded from contingency outlined in Table 5.
4. Approve the additional Key Performance Indicators to be included in the Access & Performance section of the IPR outlined in Table 6.
5. Note the contents of this report.

Key

Improvement in Performance	↑
Deterioration in Performance	↓
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating November 2020 – October 2021

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

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

Key

Improvement in Performance	
Deterioration in Performance	
Static Performance	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating November 2020 – October 2021

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

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

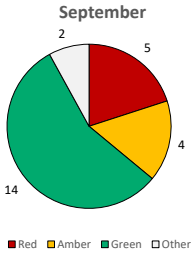
*RAG rating is based on previous month's validated position for these indicators.

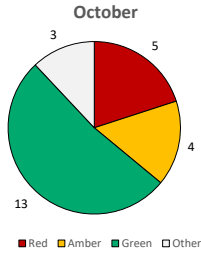
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Integrated Dashboard - October 2021

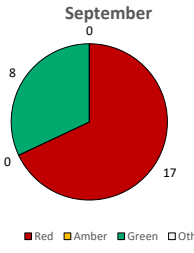
Appendix 2

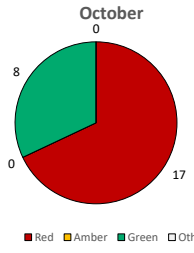
Quality Improvement



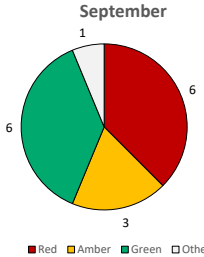


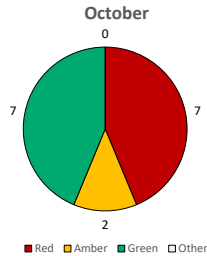
Access & Performance



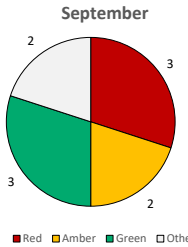


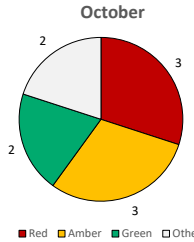
Workforce





Finance





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)?

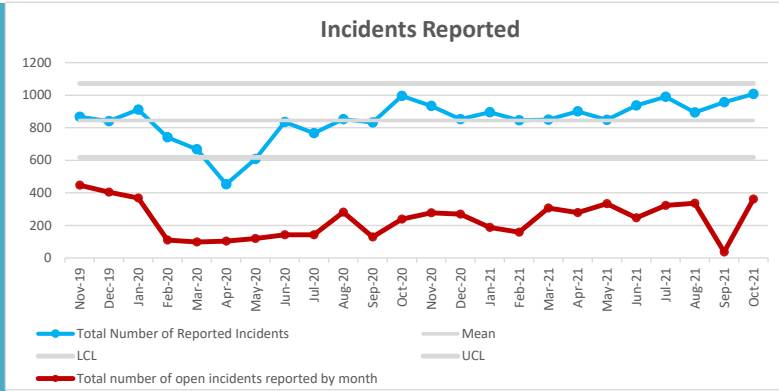
Patient Safety

SOF CQC

Incidents

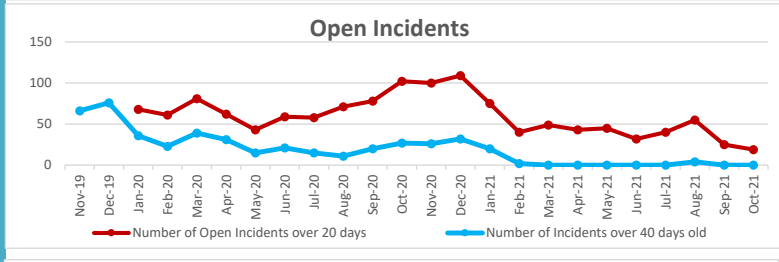
Red: Open incidents outside 40 day timeframe
Amber: Open incidents between 20 - 40 days old.
Green: Open incident within timeframe of 20 days.

The 0 incidents over 40 days. The Governance Managers are working closely with the CBU's to keep overdue incidents on a downward trend.



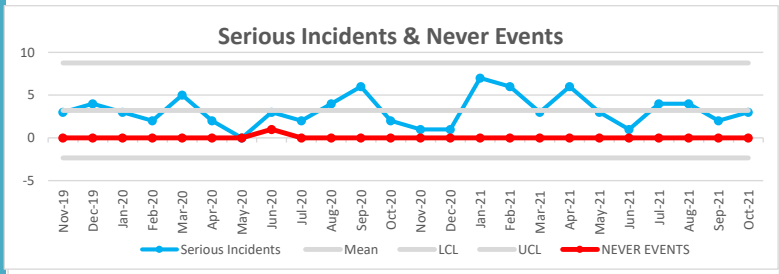
Incident reporting remains stable - within expected range.

Weekly monitoring of incident reporting at CBU and specialty level with escalation to Deputy Director of Governance is in place. Learning sessions from incidents have commenced with Junior Doctors to support reporting and learning as part of their training. This will be implemented Trust wide for all disciplines in 2022. Assurance of accurate incident reporting with reference to the level of harm identified is achieved by weekly sampling by the Patient Safety Manager and Associate Director of Governance.



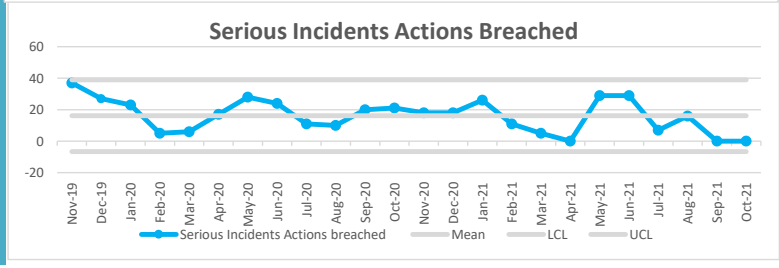
There are 0 overdue 40-day incidents.

Plans are in place to work toward a position of 0 incidents over 20 days old and maintain the previous 0 incidents over 40 days. This will provide assurance of full compliance. The Patient Safety Manager will meet with CBU's weekly with timely escalation to the Associate Director of Governance as required.



There were 3 serious incidents reported in October 2021.

To ensure lessons are learnt across the organisation, findings are shared via the Trust Safety Brief, speciality and CBU Governance meetings. Learning is also shared in the format of newsletters. This is triangulated with learning following inquests. Themes are monitored weekly by the Governance Team with escalation to the Deputy Director of Governance. Specific governance sessions have commenced to support medical trainees.



There were 0 breached serious incident actions in October 2021.

A breached actions position is now provided to the Deputy Director of Governance with weekly appropriate escalation to the CBU leads.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:

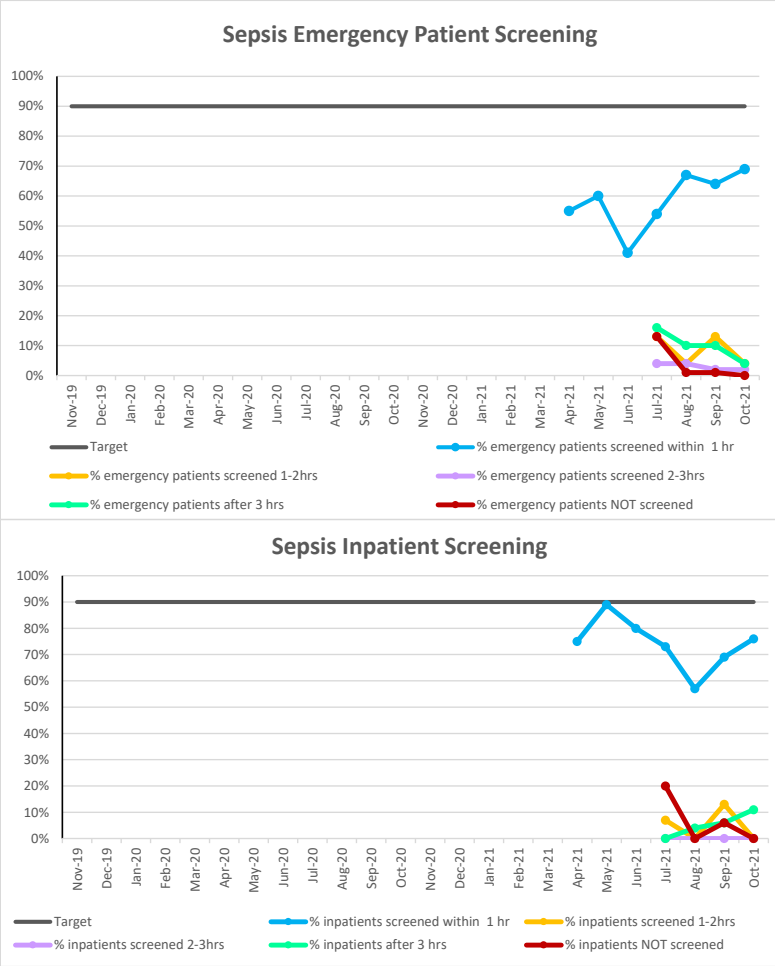
System Oversight Framework — SOF

Care Quality Commission — CQC

Risk Register — RR116

Trust Strategy — S

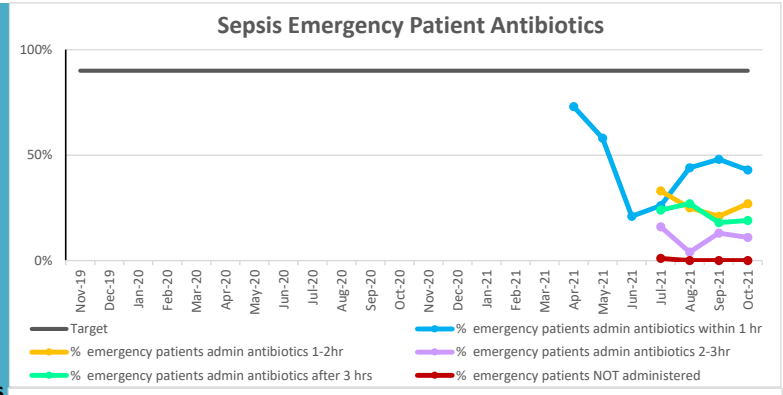
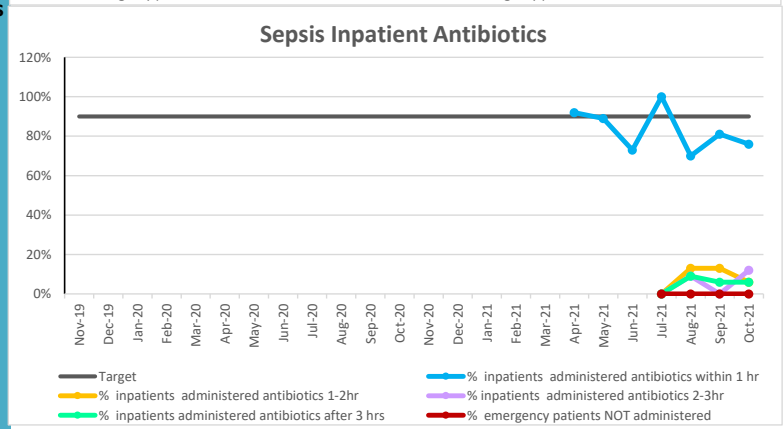
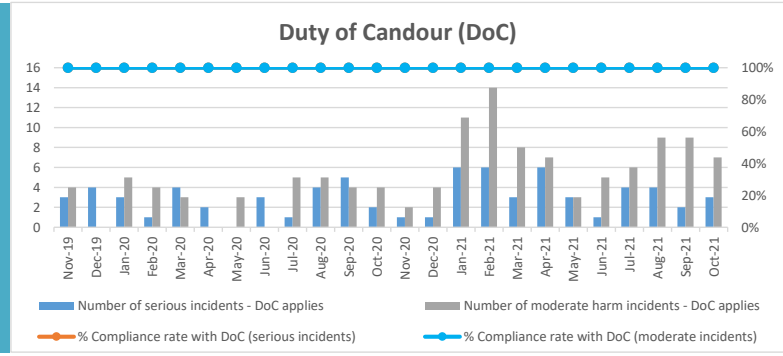
Quality Improvement - Trust Position

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)?
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:** **• 69.00% (66/95) Sepsis screening for all emergency patients with suspected sepsis within 1 hour.** **• 76.00% (13/17) screening for all inpatients with suspected sepsis within 1 hour.**	**Pre made antibiotics are now stocked in the Emergency Department to support improvements. To address the variance in screening, a named clinician for the deteriorating patient is identified each shift, and upskilling of HCA staff is underway.**	**The Task and Finish Group meetings continue to monitor progress against the Trust wide Sepsis Action Plan. Prioritising sepsis has been discussed with all clinicians individually with support from the Trust Clinical Leads. The Patient Safety Nursing Team are present in the Emergency Department weekly to support with sepsis education and are also visible across the Trust to support the use of the new electronic screening tool. Sepsis awareness training remains a priority with an updated training video/e-learning package being created. Sustainability of improvements will be supported by the Quality Academy and collaboration with the Advancing Quality Alliance (AQUA).**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

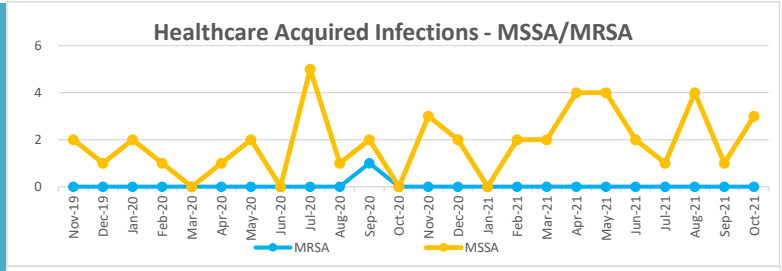
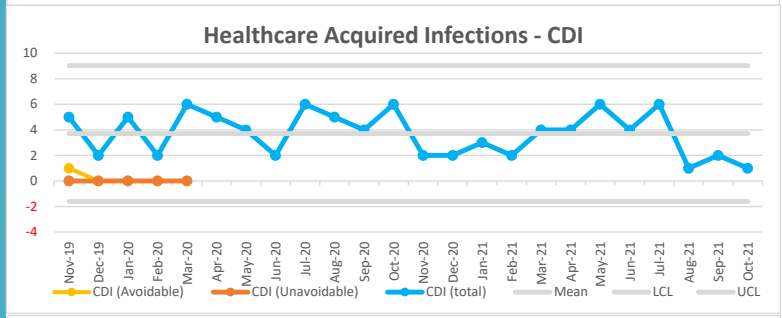
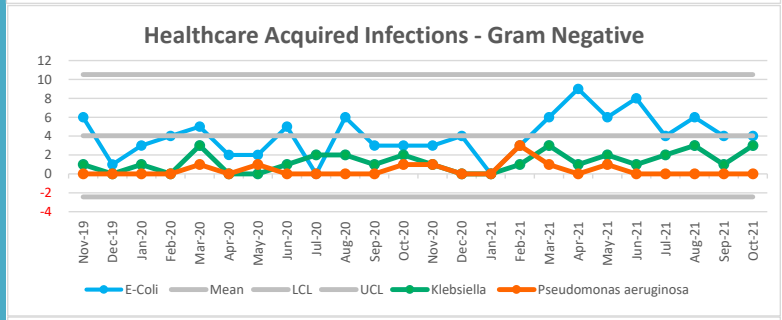
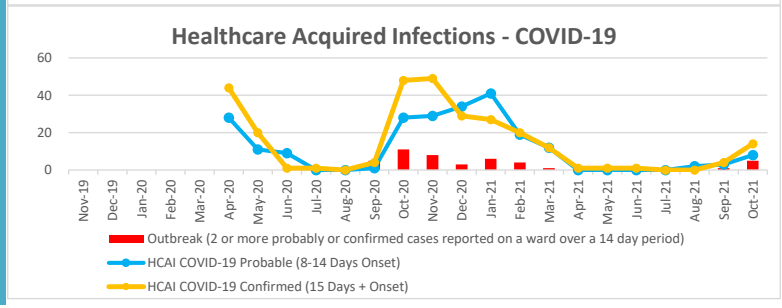
Quality Improvement - Trust Position

	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)?
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:** **• 43.00% (41/95) of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** **• 76.00% (13/16) of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.**	 	**Pre made antibiotics are now stocked in the Emergency Department to support improvements. A named clinician for the deteriorating patient is identified each shift to ensure antibiotics are prescribed in a timely manner.**	**The Task and Finish Group meetings continue to monitor progress against the Trust wide Sepsis Action Plan. Prioritising sepsis has been discussed with all clinicians individually with support from the Trust Clinical Leads. The Patient Safety Nursing Team are present in the Emergency Department weekly to support with sepsis education and are also visible across the Trust to support the use of the new electronic screening tool. Sepsis awareness training remains a priority with an updated training video/e-learning package being created. Sustainability of improvements will be supported by the Quality Academy and collaboration with the Advancing Quality Alliance (AQUA).**
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.**	**Weekly scrutiny and monitoring is in place by the Patient Safety Manager and a Duty of Candour Policy has been ratified.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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)?
Healthcare Acquired Infections MRSA Red: 1 or more Green: 0	In October 2021, the following HCAI were reported: CDI – 1 case - 24 Cases YTD: 1 case under trajectory and 3 cases considered unavoidable by CCG review panel. E-Coli – 4 cases - 41 cases YTD: 6 cases under trajectory. Klebsiella – 3 cases - 13 cases YTD: on trajectory. MRSA - nil cases and 12 months since last reported case. MSSA – 3 case - 19 YTD no threshold set. Pseudomonas aeruginosa - nil cases - 1 case YTD and 1 case under threshold. Covid-19 - 15+ days - 14 cases definite healthcare associated and 8 cases detected 8-14 days probable healthcare associated case 5 Covid-19 outbreaks reported in October		The change in the apportionment standard has increased the number of GNBSI (Gram Negative Bloodstream Infection) cases apportioned to the Trust.	Action plans are in place for the prevention of all HCAIs. The GNBSI Reduction Group is established with 8 wards engaged in phase 1. Focus areas include hydration, continence management, care of urethral catheters, hand hygiene and UTI detection and management. The Catheter Passport has been launched at a series of meetings across the Trust.
Healthcare Acquired Infections C-Difficile Red: 44+ per annum Green: Less than 44 per annum				
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			Continuing global COVID-19 pandemic with high local prevalence per 100,000 / 7 day rate. Missed admission screening has been identified as a contributing factor.	Learning for COVID-19 RCA investigations has been shared at QAC, Medical Cabinet and CBU level with learning shared with the individual wards. Action plans are in place to address findings including missed screening, length of stay, multiple ward moves, environmental hygiene, IPC training compliance and PPE compliance. Robust processes are in place for COVID-19 admission, day 3 and day 5 testing with Infection Prevention and Control (IPC) guidance on isolation and Personal Protective Equipment (PPE).
Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	RR1275			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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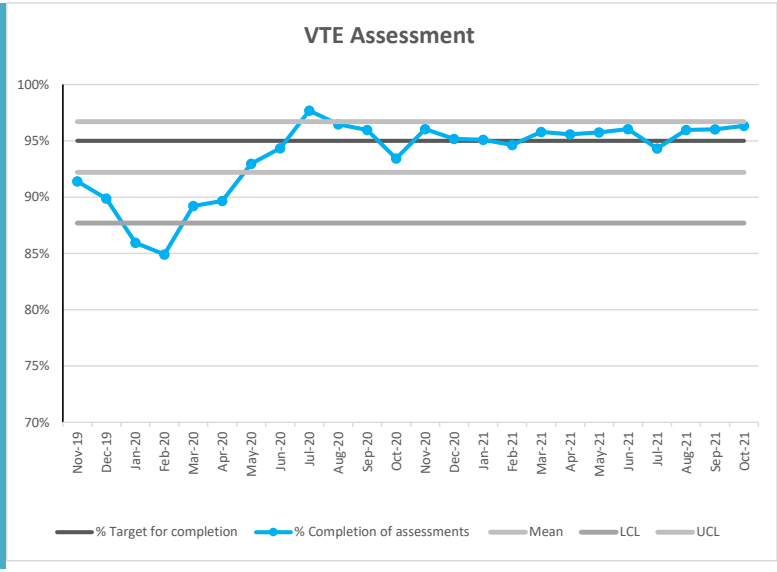
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
VTE Assessment Red: <95% Green: 95% or above based on previous months' figures due to timescales for validation of data	SOF S The Trust achieved 95.30% for VTE assessments YTD 2021/22 from April - October 2021.		The Trust achieved 96.33% for VTE assessments in October 2021. The quality standard has been achieved this month. There has been a stable and consistent trend > 95% with one off isolation in the month of July 2021.	Current systems in place to improve VTE compliance include: 1. Use of CDC forms on clerking & post take ward round (PTWR) will encourage the compliance of WHH VTE risk assessment (RA) within the required 14 hours from admission. Current systems in place 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 in future. 3. To continue to promote the consistent use of ward round CDC forms to improve VTE compliance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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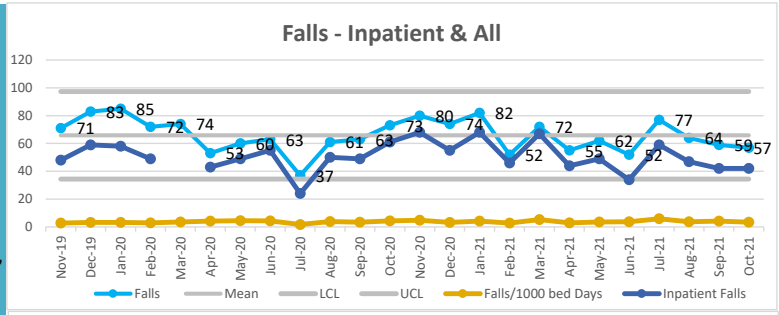
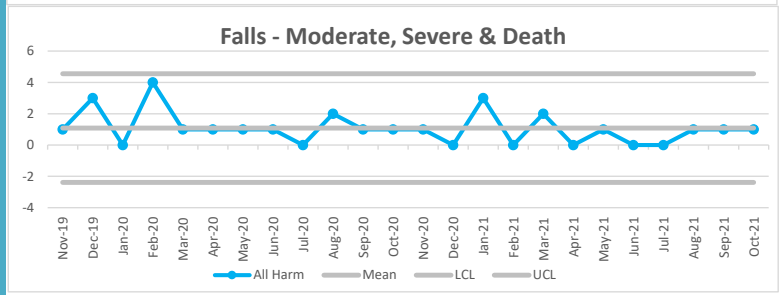
Total number of Inpatient Falls & harm levels Red: <10% decrease from 19/20 Amber: 10-19% decrease from 19/20 Green 20% or more decrease from 19/20	57 total falls were reported, 42 of those were inpatient falls, 1 fall resulted in moderate harm.	 	The number of low/no harm falls remains within normal variation. A full root cause analysis is underway to determine lessons learned from the fall with harm.	The Quality Improvement Programme to support falls prevention has launched the change package to help spread and sustain improvements. Weekly falls meetings continue to reinforce preventative measures to address immediate issues. The Trust falls audit was completed in September which included a review of bed rail usage, results will be available in November. The Trust Wide Safety Brief highlights falls awareness and learning.

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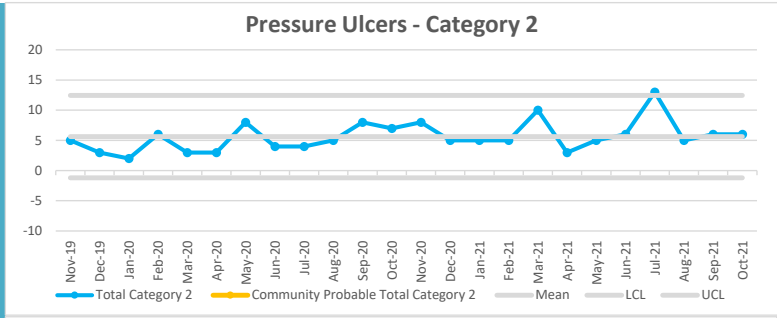
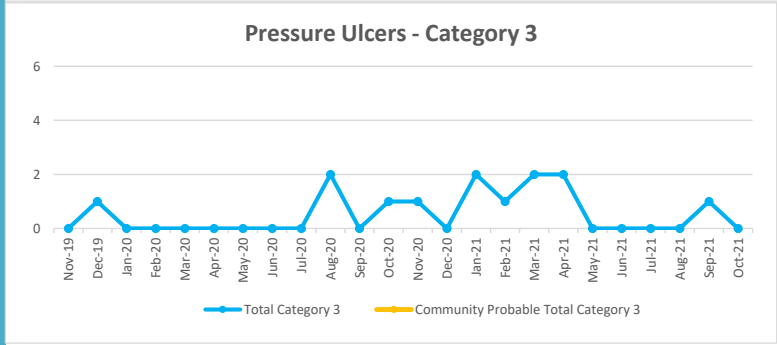
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

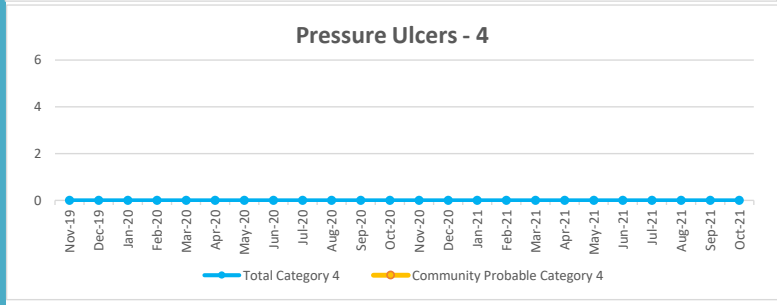
Pressure Ulcers
Based on 65 in 2019/20
Red: 4% reduction or below
Amber: 5%-9% reduction
Green: 10% reduction or above.

CQC

There were 6 hospital acquired category 2 pressure ulcers in October.







2 of the 6 category 2 pressure ulcers in October were as a direct consequence of proning a patient with COVID-19.

New pressure reducing trolley toppers are now in use in the Emergency Department to reduce skin damage. The Quality Improvement Programme to support the prevention of pressure ulcers has launched the change package to spread and sustain improvements. Mattress champions have been identified and awareness sessions held twice weekly throughout October. Face to face general pressure ulcer prevention and specific device training has recommenced.

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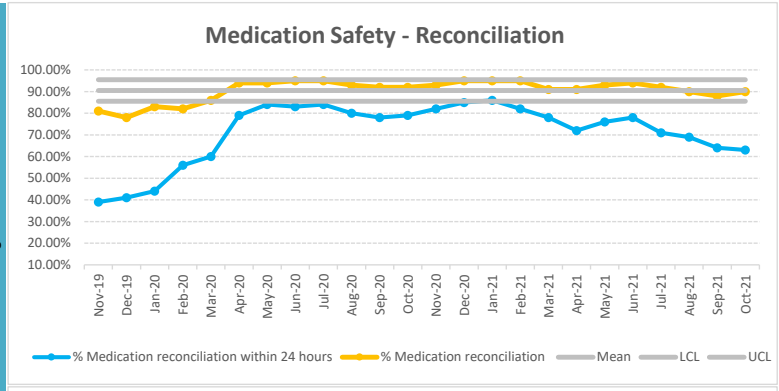
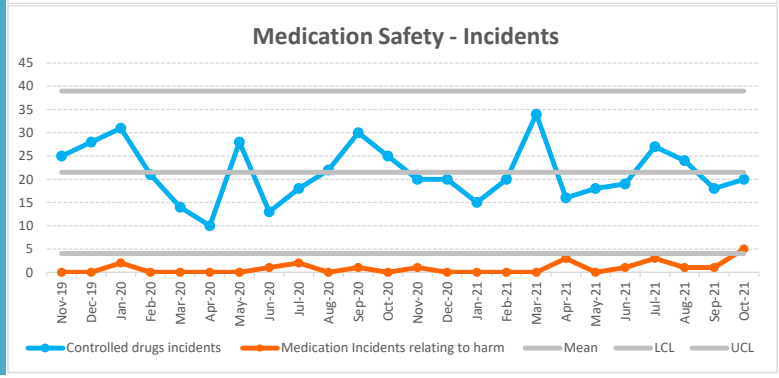
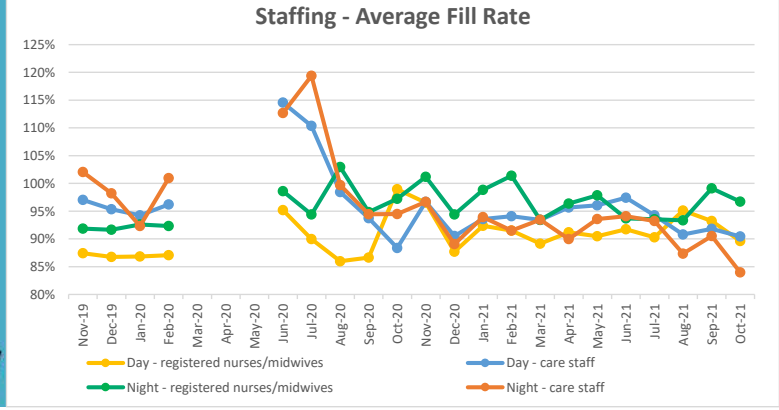
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Medication Safety Reconciliation within 24 hours Red: below 60% Amber: 60% - 79% Green: 80% or above	The Trust achieved 63.00% for medicines reconciliation within 24 hours and 90.00% for overall medicines reconciliation. There were 5 incidents relating to medicines reporting harm. This is above usual variance. There were 20 controlled drug incidents, this is within usual variance.	 	Medicines reconciliation is below 80.00% within 24 hours (63.00%) and achieving 90.00% across the inpatient stay. This is due to vacancy level within junior pharmacist and ward based technician services. There have been unsuccessful attempts to recruit to remaining pharmacist vacancies. There were 5 incidents relating to medicines reported in month. Of these, 2 were reported by the Trust but were attributable to external care providers. There were no identifiable trends in the remaining 3 incidents.	Recruitment is ongoing to fill existing gaps in the technician team. Recently recruited pharmacists will be fully trained by mid November. Remaining vacancies will be skill mixed to enable recruitment and to deliver a robust, sustainable clinical service as a result of review of Pharmacy establishment. Investigations will be undertaken to review incidents and learning will be shared as appropriate.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	In October 2021, the average staffing fill rates were: Day (Nurses/Midwife) 89.61% Day (Care Staff) 90.46% Night (Nurses/Midwife) 96.71% Night (Care Staff) 83.97% RR1108 RR115		12 of the 23 wards reported staffing levels over 90% in October 2021. Additional beds in use across the Trust and increased staff absence due to COVID-19 related reasons remains a driver for variation.	Staffing is reviewed twice daily by the senior nursing team and acuity and activity are monitored to ensure safe patient care at all times. All wards have senior nurse oversight by a matron and lead nurse.

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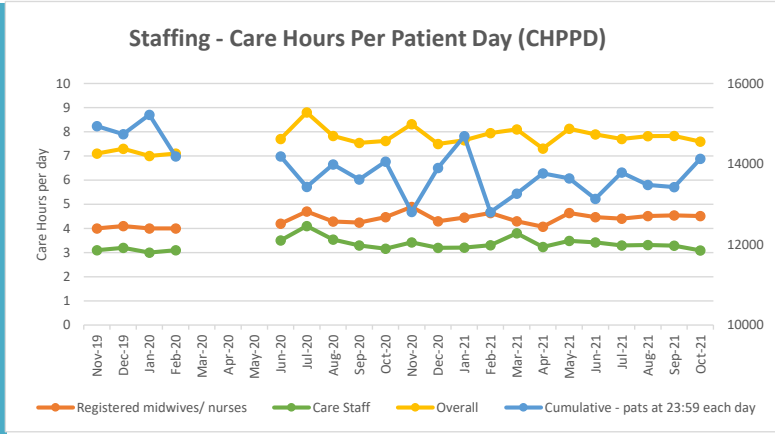
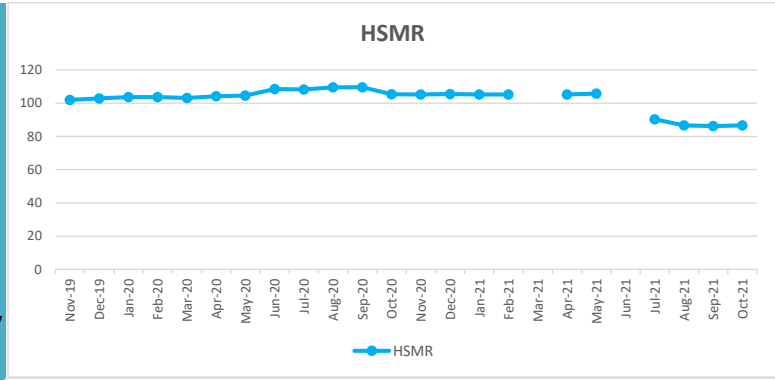
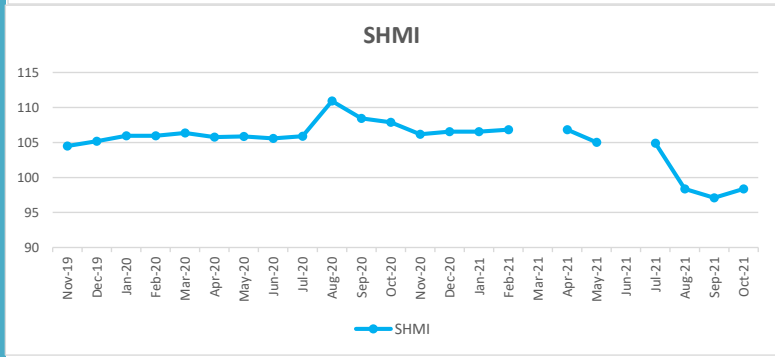
Staffing - Care Hours Per Patient Day (CHPPD) Red: Below 6.0 Amber: 6.0 - 7.8 Green: 7.9 or More	RR115 RR1108 In October 2021, the average CHPPD were: Nurse/Midwife: 4.5 hours Care Staff: 3.1 hours Overall: 7.6 hours		A small decrease is noted in CHPPD for October.	Ward staffing levels continue to be systematically reviewed, which includes planned versus actual staffing levels and overall staffing plans are on track. A Trust wide SOP is in place to support the return of COVID-19 exposed staff following risk assessment.
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 86.67. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 98.36	 	No variation. HSMR and SHMI remain within expected range.	Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning. The Trust's Mortality Lead post has now been recruited to in order to support with the learning from deaths agenda.

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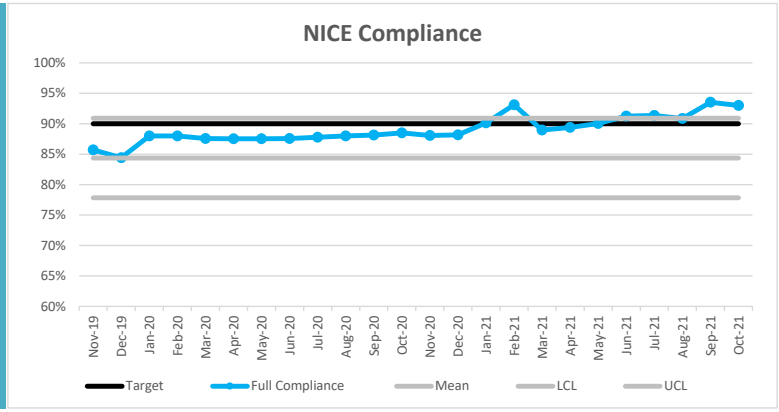
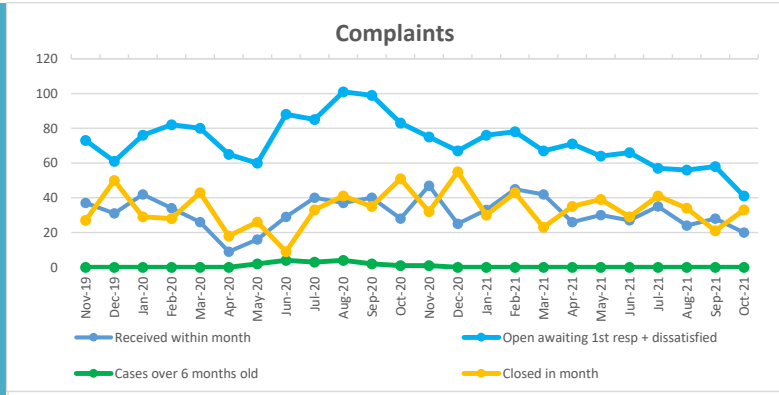
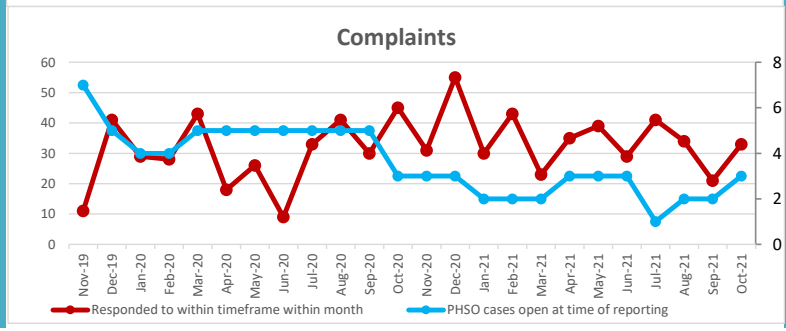
NICE Compliance Red: Below 75% Amber: 75% to 89% Green: 90% or Above	The Trust achieved 93.02% in month.		The Trust has maintained compliance against the Trust's target of over 90.00%.	The position is monitored and reviewed at CBU governance meetings. Clear escalation processes are in place.

Patient Experience

Complaints Red: Complaints over 6 months old/69% or less responded to within the timeframe Amber: No complaints over 6 months old, 70% - 89% responded to within the timeframe Green: No backlog, 90% responded to within the timeframe.	In October 2021, 20 new complaints were received by the Trust which was a decrease of 8 from the previous month. There was 1 dissatisfied response received, which has decreased by 2 when compared to the previous month. This is a continued decreased since April 2021 (4 noted in April).	 	The Trust continues its performance in the timeliness of responding to complaints. There continue to be no complaints over 6 months old, and all complaints are within timeframe.	The complaints position is the best that it has been since data capture on the IPR began in November 2019. In addition, the new Head of Complaints, PALS and Legal Services has started in post. A complaints training package is being developed for implementation across each of the CBUs.

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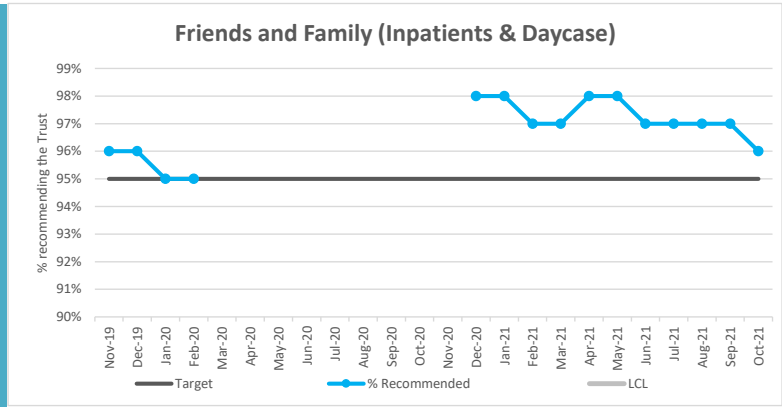
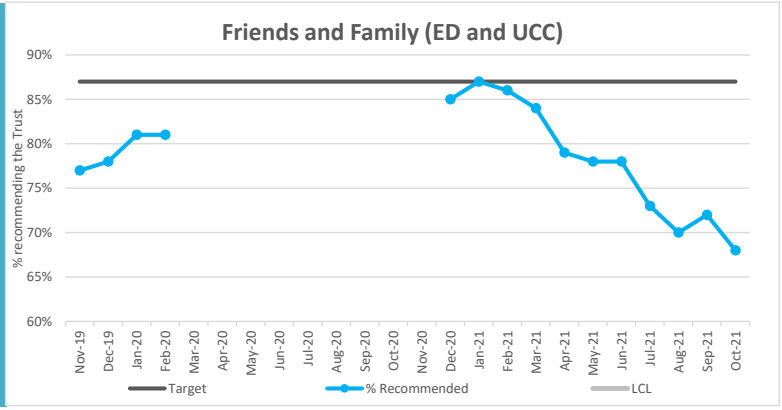
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	CQC S The Trust achieved 96.00% in month.		The Trust achieved 96.00% positivity rate in October 2021.	The Trust continues to receive positive responses through the FFT (Friends & Family Test). Any variation is addressed locally and monitored through the Patient Experience Sub-Committee.
Friends and Family (ED and UCC) Red: Less than 87% Green: 87% or more	CQC S The Trust achieved 68.00% in month.		The Trust achieved 68.00% positive feedback in friends and family test results. The reason for the variance against the target is largely related to patients experiencing longer waits in the Emergency Department.	An Emergency Department Response Group has been developed to improve flow and patient experience within the Emergency Department and subsequent inpatient stay across the organisation. It is pertinent to highlight the reduction in positive recommendations is similar with other hospitals within the Cheshire and Merseyside footprint with the same themes in feedback noted. The best position is 84.00% and worst is 55.00% against a national average of 75.00% as noted in latest data published (September 2021).

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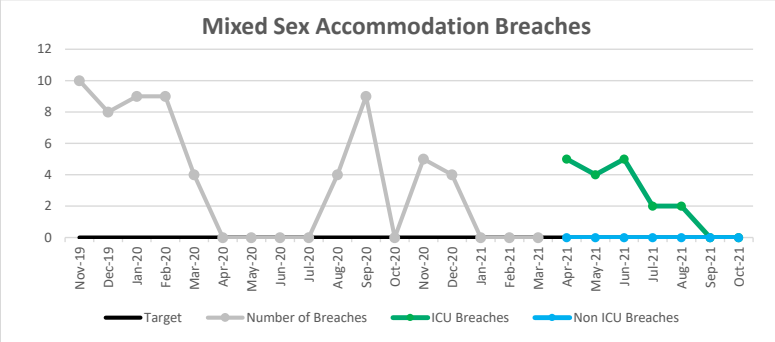
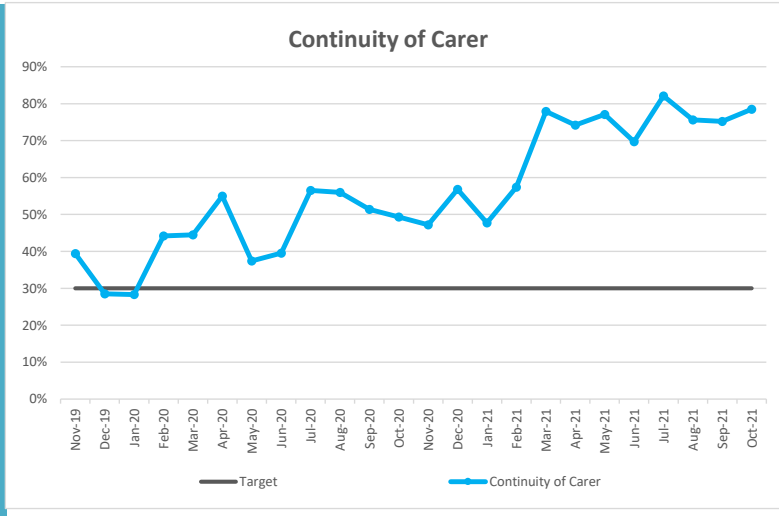
Mixed Sex Accommodation Breaches (Non ITU Only) Red: 1 or more Green: Zero	There were 0 mixed sex accommodation incidents during October 2021.		There were 0 mixed sex accommodation incidents during October 2021.	Patients are cohorted within the Intensive Care Unit to minimise breaches. Patients who are due to step down from the Intensive Care Unit are tracked and prioritised in the regular patient flow meetings. Any delays are escalated via silver command.
Continuity of Carer Green: 51% or Above Amber: 35% - 50% Red: below 35%	In October 2021, 100% of Warrington women are booked onto such a pathway, if 'out of area' bookings are included the figure is 78.50% as we cannot provide the postnatal aspect of the pathway. SOF		The Trust achieved 78.50% onto a Continuity of Carer (CoC) pathway (including intrapartum care) in October 2021. 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. To meet the criteria of Better Births (which includes limits on team size and considerably lower caseload numbers than the traditional model of community midwifery), the requirement for additional staffing was identified and a business case was approved. Staff are now in post and completing their supernumerary and orientation period.

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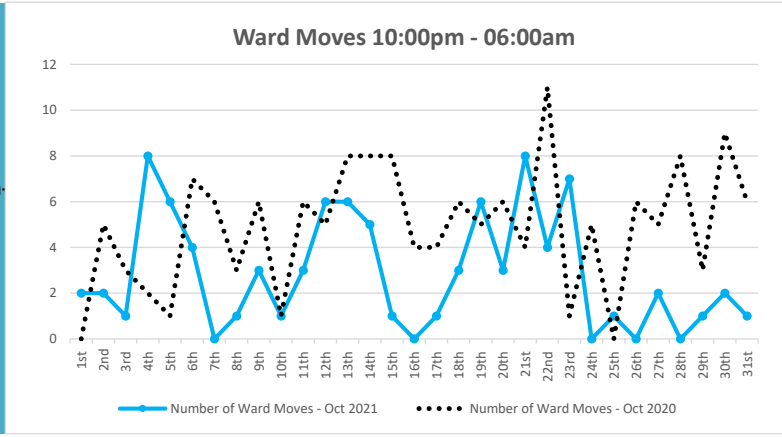
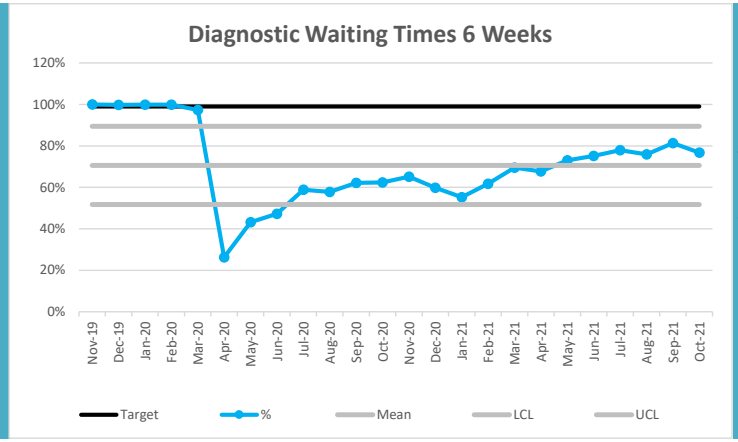
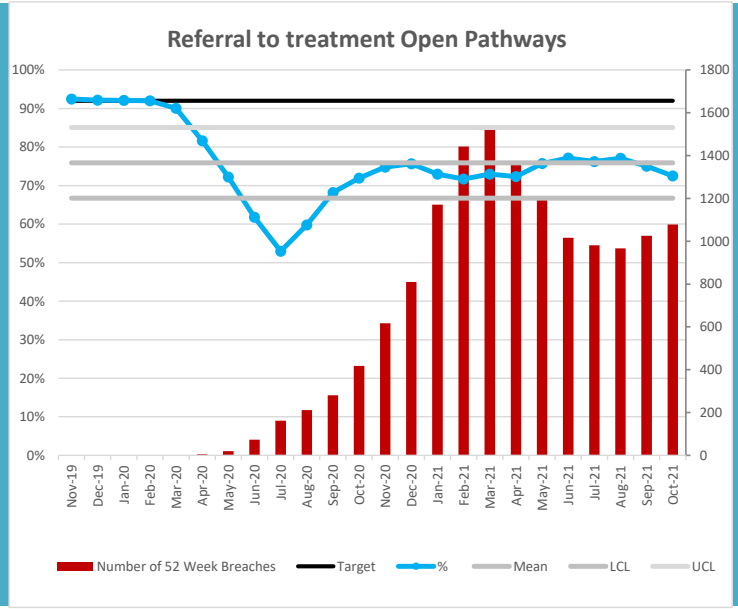
Ward Moves between 10:00pm and 06:00am	There was a total of 88 ward moves between 10pm-6am in October 2021 compared to 152 in October 2020.		The reason for the reduction on ward moves after 10pm for this reporting period compared to last year is as a result of the out of hours patient flow and senior 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.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

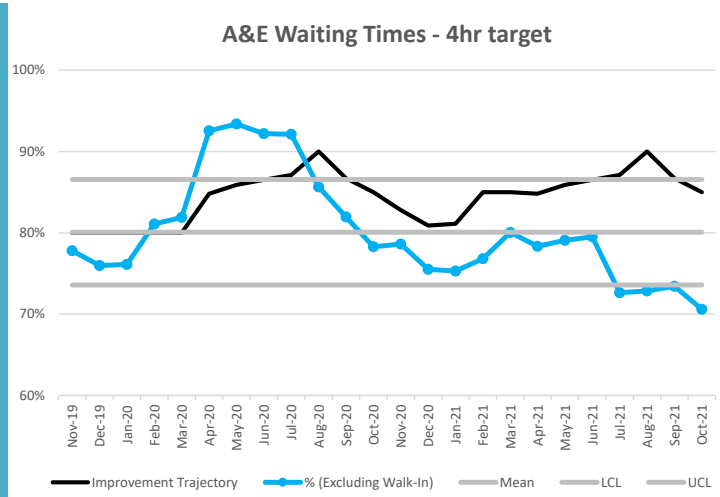
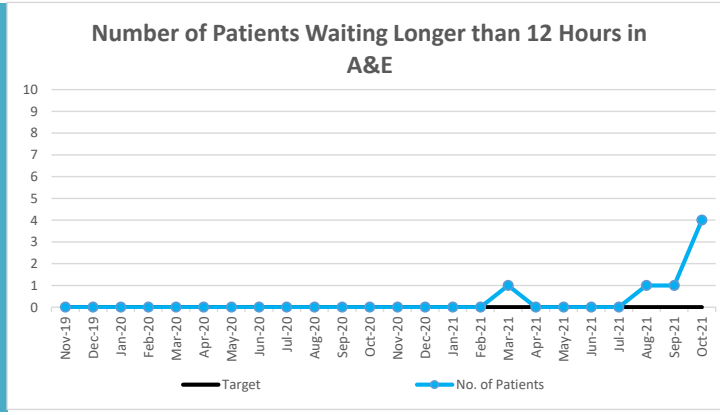
Access & Performance - Trust Position

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)?
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above		The diagnostic standard was not achieved in October 2021, 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 now been agreed and patients are being clinically prioritised accordingly in line with national guidance. The recovery plan is demonstrating that the actions agreed are delivering recovery with fewer breaches recorded as services are brought back on-line. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although there has been good progress in radiological modalities, challenges remain in Endoscopy, Cardiorespiratory, Cystoscopy and CT.
SOF CQC The Trust achieved 76.72% in month. RR1215 RR1125			
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or above		RTT performance in October achieved 72.50%, which is slightly behind the recovery trajectory for this year. RTT recovery for H2 was submitted on the 16th November 2021.	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 Captain Sir Tom Moore Centre. • The Trust continues to utilise Independent Sector Capacity. • Restoration and recovery plans for 2021/22 have been drawn up in line with H1 and H2 Operational Planning Guidance.
RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red			
SOF CQC The Trust achieved 72.50% in month. There were 1078, 52 week breaches in October 2021. RR1215 RR1125			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

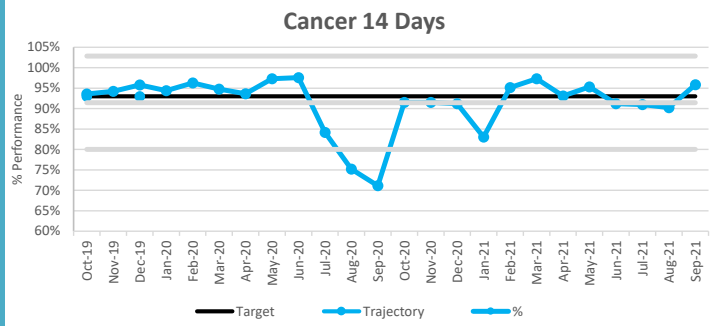
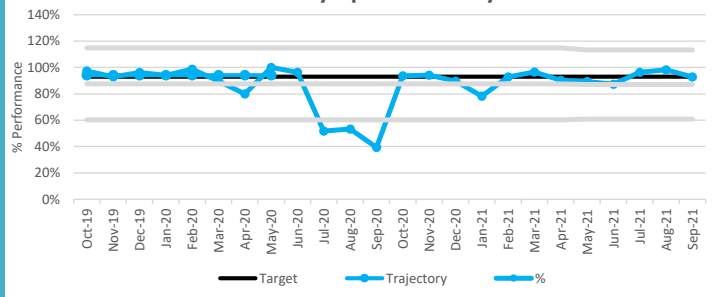
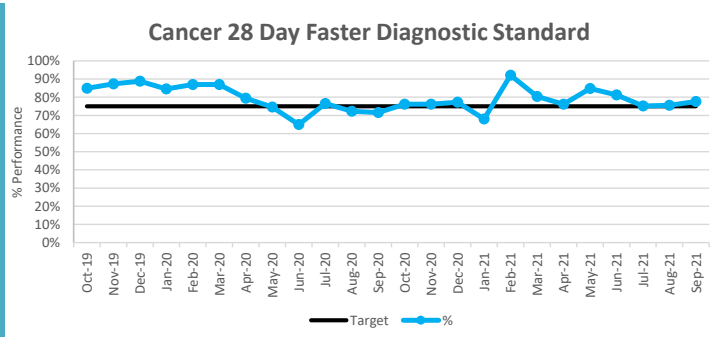
Access & Performance - Trust Position

	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)?
Four Hour Standard - National Target Red: Less than 95% Green: 95% or Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory	CQC The Trust achieved 70.59% excluding widnes walk ins in month. RR224		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%, impacting flow and 4 hour 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. • The Trust has started the SDEC Capital build, due for completion by April 2022.
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 4 patients waiting longer than 12 hours in A&E in month.		There were 4 patients who waited longer than 12 hours in the Emergency department and declarable under the national rules in October. The key themes for the breaches is the continuing high urgent care attends and high occupancy restricting flow through A&E. The rise in breaches of the 12 hour standard across this period is a trend through the North West region.	The Trust will continue to monitor and manage compliance around the 12 hour standard.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

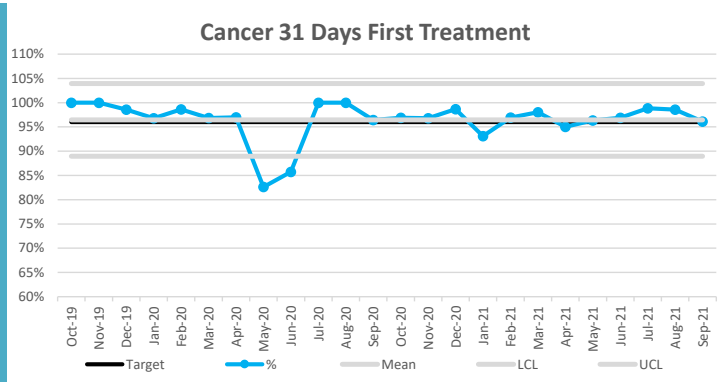
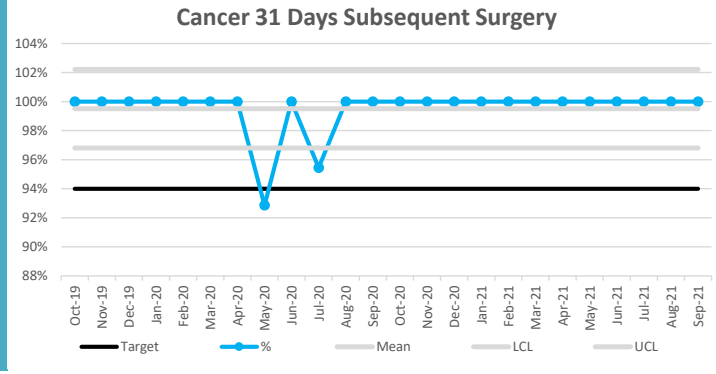
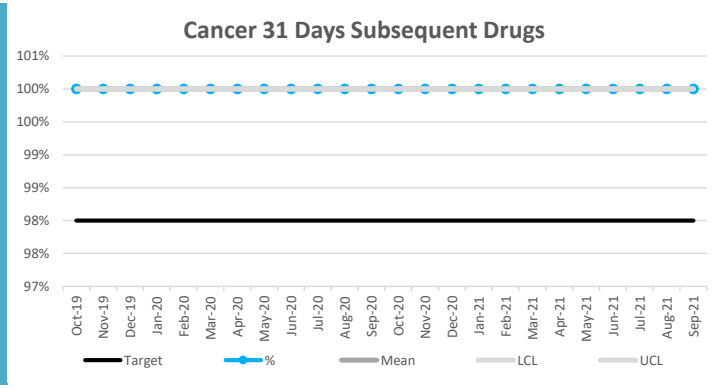
Access & Performance - Trust Position

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 14 Days Red: Less than 93% Green: 93% or above SOF CQC **The Trust achieved 95.86% in September 2021.** RR1125		**The Trust achieved the 2 Week Wait standard in September 2021.**	**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).**
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above SOF CQC **The Trust achieved 92.86% in September 2021.** RR1125			
28 Day Faster Cancer Diagnosis Standard Red: Less than 75% Green: 75% or above SOF **The Trust achieved 77.58% in September 2021.**		**The Trust achieved the standard in September 2021 with 77.58% against a target of 75.00%.**	**The Trust will continue to monitor and review performance of this standard via PRG and KPI Sub Committee.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

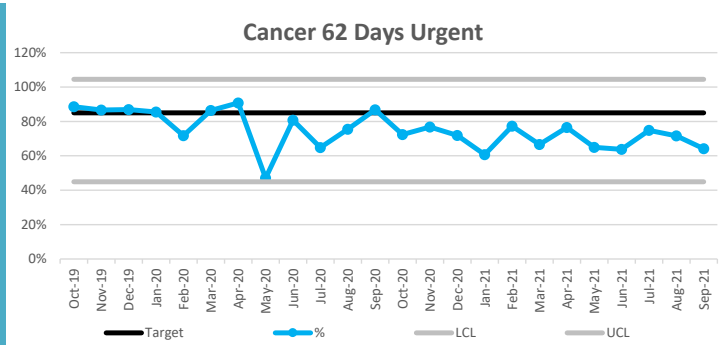
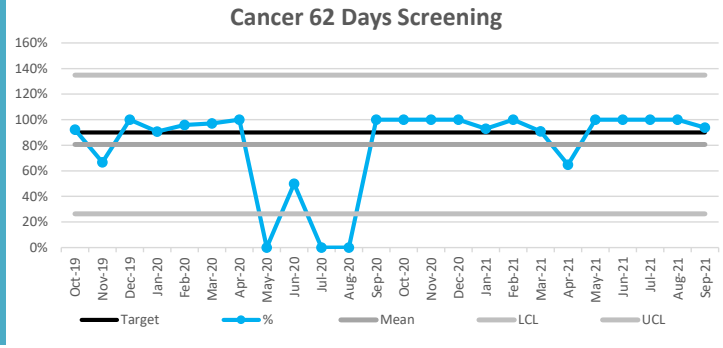
Key:
Risk Register RR116
System Oversight Framework SOF
Care Quality Commission CQC

	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)?
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	SOF CQC The Trust achieved 96.10% in September 2021. RR1125		The 31 day cancer target was achieved in September 2021. 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.
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	SOF CQC The Trust achieved 100% in September 2021. RR1125			
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	SOF CQC The Trust achieved 100% in September 2021. RR1125		The Trust achieved 100% in September 2021.	Maintain compliance against the 31 day subsequent treatment (drug) standard.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

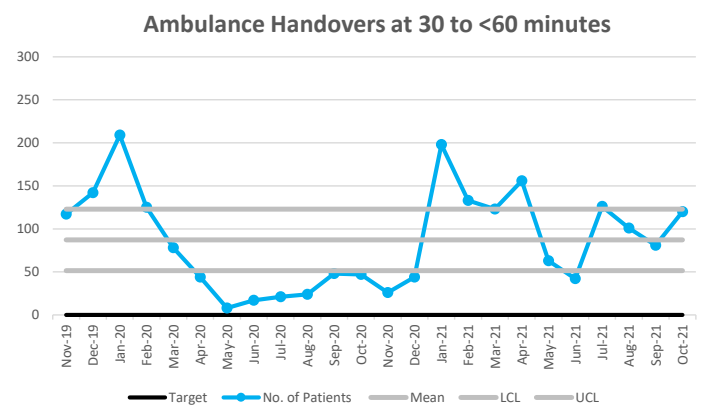
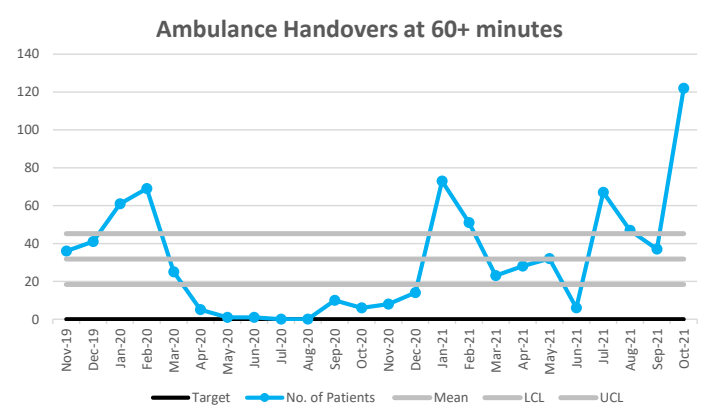
Access & Performance - Trust Position

	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**	SOF CQC **The Trust achieved 64.17% in September 2021.** RR1125		**The 62 day urgent target was not achieved in September 2021 at 64.17%. The Trust is meeting the agreed trajectories for improvement as agreed by the Cheshire and Merseyside Cancer Alliance. The Trust has achieved the 62 day screening standard.**	**There remains a risk for performance due to the impact of the pandemic.**
Cancer 62 Days Screening **Red: Less than 90%** **Green: 90% or above**	SOF CQC **The Trust achieved 93.75% in September 2021.** RR1125			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

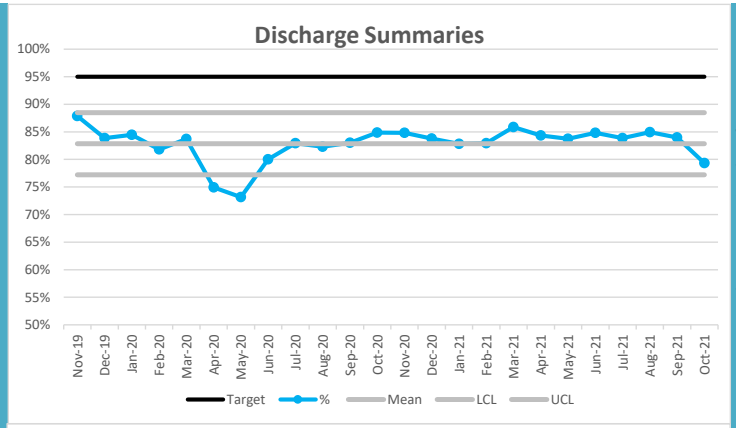
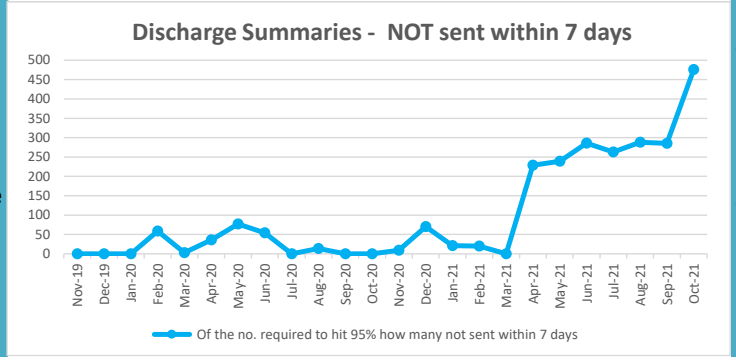
Access & Performance - Trust Position

	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)?
Ambulance Handovers 30 to <60 minutes Red: More than 0 Green: 0	SOF There were 120 patients who experienced a delay in Ambulance Handovers between 30 to 60 minutes in month.		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.
Ambulance Handovers at 60 minutes or more Red: More than 0 Green: 0	SOF There were 122 patients who experienced a delay in Ambulance Handovers over 60 minutes in month.			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

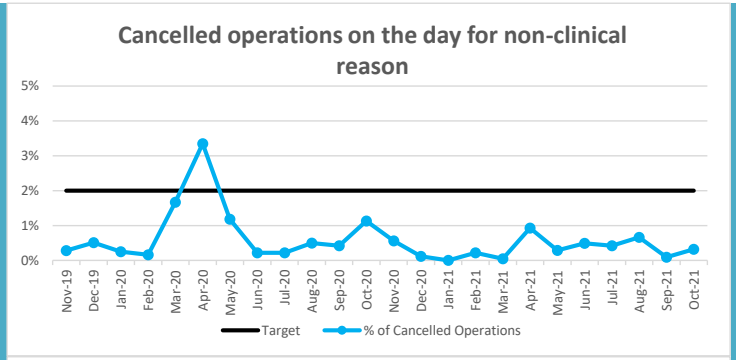
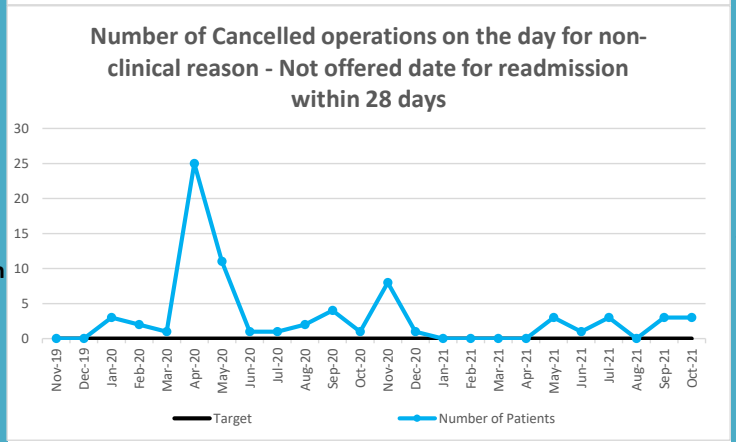
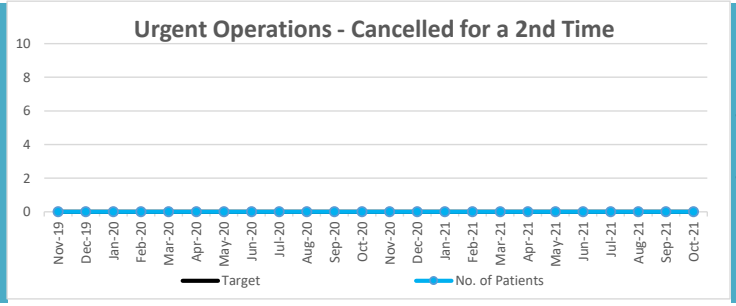
Access & Performance - Trust Position

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**		**There has been a sustained improvement in the number of discharge summaries sent within 24 hours. The dip in performance is being investigated as being a process issue, not a completion issue, at the time of writing this report the investigation is ongoing.**	**The Performance Review Group (PRG) continues to monitor this standard to support improvements.**
The Trust achieved 79.35% in month.			
Discharge Summaries - Number NOT sent within 7 days **Red: Above 0** **Green: 0**		**The step change in compliance from April 2021 was as a result of a review and update of the specialties included in the report. Care Groups are reviewing compliance with a request for recovery plans to be put in place. The dip in performance in October is being investigated as being a process issue, not a completion issue, at the time of writing this report the investigation is ongoing.**	
There were 476 discharge summaries not sent within 7 days required to meet the 95.00% threshold.			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

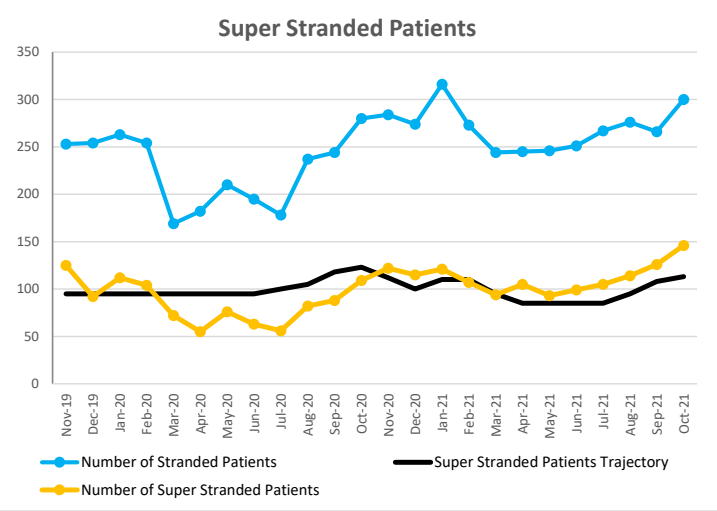
Access & Performance - Trust Position

	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)?
Cancelled Operations on the day for a non-clinical reason Red: > 2% Green: < 2%	CQC 0.32% of operations were cancelled on the day for non clinical reasons in month.		Compliance against this standard remains below the monitored threshold of 2.00% (positive).	Recovery of elective activity continues to be monitored via the Clinical Services Recovery Oversight Group (CSOG).
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	There was 3 cancelled operations on the day for non clinical reasons in month, where the patient was not re-booked in within 28 days.		Compliance against this standard remains at the monitored threshold.	
Urgent Operations - Cancelled for a 2nd Time Green = 0 Red = > 0	There were 0 urgent operations cancelled for a second time in month.		This is an additional standard to enhance monitoring of cancelled operations. The Trust continues to maintain this standard.	Maintain the standard that no urgent operations are cancelled for a second time.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

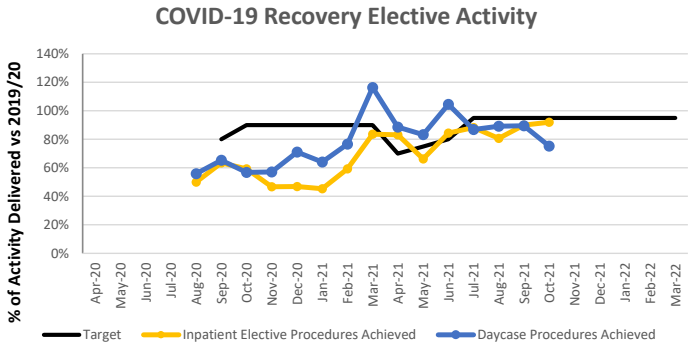
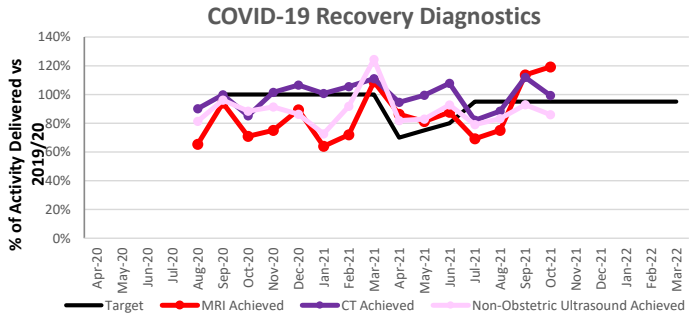
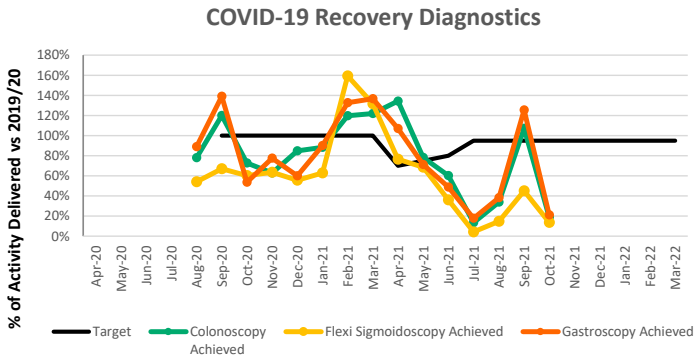
Access & Performance - Trust Position

	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 300 stranded and 146 super stranded patients at the end of October 2021.		The number of Stranded and Super Stranded patients in the organisation is increasing, almost back to 2018 levels. This is significantly impacted by delays and shortages in domiciliary care and intermediate care at home capacity in the Borough. This continued rise is also impacting the Trusts ability to remain compliant against the 12 hour ED standard.	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.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

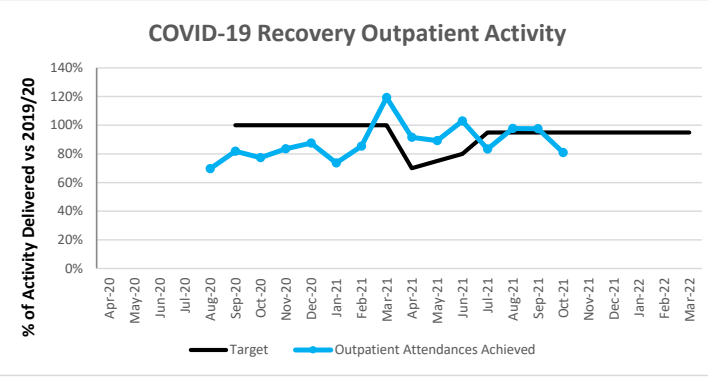
Key:
Risk Register RR116
System Oversight Framework SOF
Care Quality Commission CQC

	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 October 2021, the Trust achieved the following % of activity against October 2019 (plan adjusted). This included 75.28% of Daycase Procedures and 91.98% of Inpatient Elective Procedures. RR1125		The Trust didn't meet the aggregated elective activity recovery trajectories for October 2021.	The Trust monitors progress weekly via PRG and 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 RR1125 In October 2021, the Trust achieved the following % of activity against August 2019 (plan adjusted). This included: 119.18% of MRI 99.41% of CT 85.91% of Non Obstetric Ultrasound 13.69% of Flexi Sigmoidoscopy 18.88% of Colonoscopy	 	The Trust did not meet the diagnostic activity recovery trajectories for October 2021. 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)?
COVID-19 Outpatient Activity RED = Below Elective Recovery Target Green = Elective Recovery Target % activity is against activity in the same month in 2019/20	**In October 2021, the Trust achieved 80.89% of Outpatient activity against August 2019 (plan adjusted).** Please note: M1-6 (H1) Outpatient, Daycase & Elective Activity has been provided in relation to ERF achievement. From Month 7 (H2) ERF is not determined by % of activity against 2019/20 and is therefore not adjusted against plan. SOF RR1125		**The Trust didn't meet the Outpatient activity recovery trajectories for October 2021, which were a very high level based on 2019/20. Compliance against this standard is forecast to recover in November.**	**The Trust continues to restore clinical services in line with the national operating guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance

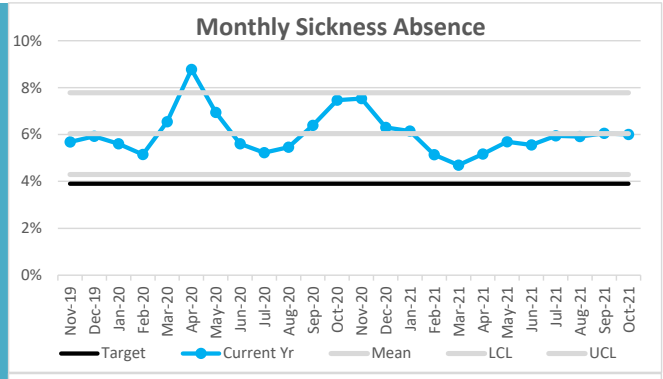
UoR SOF S RR200 RR1134 RR1108

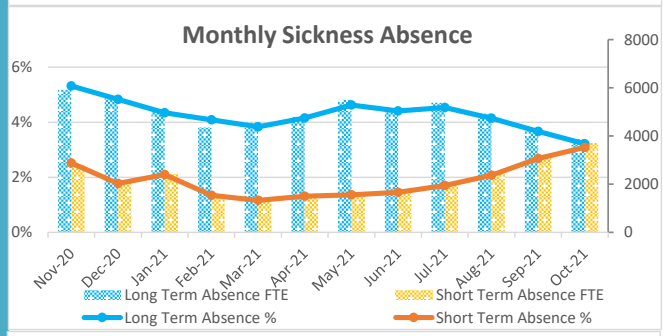
Sickness Absence

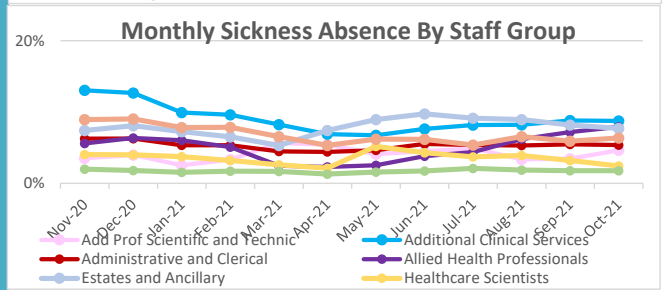
Red: Above 4.5%
Amber: 4.2% to 4.5%
Green: Below 4.2%

The Trust's sickness absence rate was 6.30% in month.
SPC - There is evidence of special cause variation for sickness absence.

Trend







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

Sickness absence was 6.30% in October 2021.

Short term absence was 3.10% and long term absence was 3.20%.

Sickness absence in October 2020 was 7.76%.

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

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

The Trust continues to work in partnership with NHSE/I to explore and implement the findings of the NW Deep Dive into Sickness Absence. Activity to date includes benchmarking against best practice and collation and analysis of other Trust's Absence Policies to inform drafting of revised WHH Policy.
Priority recommendations from NHSE/I Deep Dive have been identified for further exploration and action planning as part of the Supporting Absence Task and Finish Group that will be meeting in December 2021.
The Trust has secured £22.5k of funding from NHSE/I to be used to deliver a 4 month project to launch the WHH Absence Policy to all areas and audit implementation within a pilot area to support best practice in attendance management amongst managers. Learning from this pilot will seek to reduce sickness absence within the pilot area and recommendations will be available in April 2022 and will inform the organisational approach in 2022/23.
The HR Business Partner Team are providing ongoing support to operational managers in managing sickness absence. This includes advisory support in relation to policy and attendance at welfare and sickness stage meetings/hearings. In response to workforce need, existing resources have been realigned with additional HR Advisory support for employees and managers to be available from mid November 2021.
KPI's continue to be monitored through Operational People Committee, where operational colleagues are required to provide assurance on key metrics (incl. Sickness Absence), provide plans for improving KPI's as required and sharing of best practice.

Preventative measures continue to be implemented including Occupational Health and Wellbeing interventions, the COVID-19 Booster and Flu Vaccination Campaigns and Asymptomatic staff testing.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

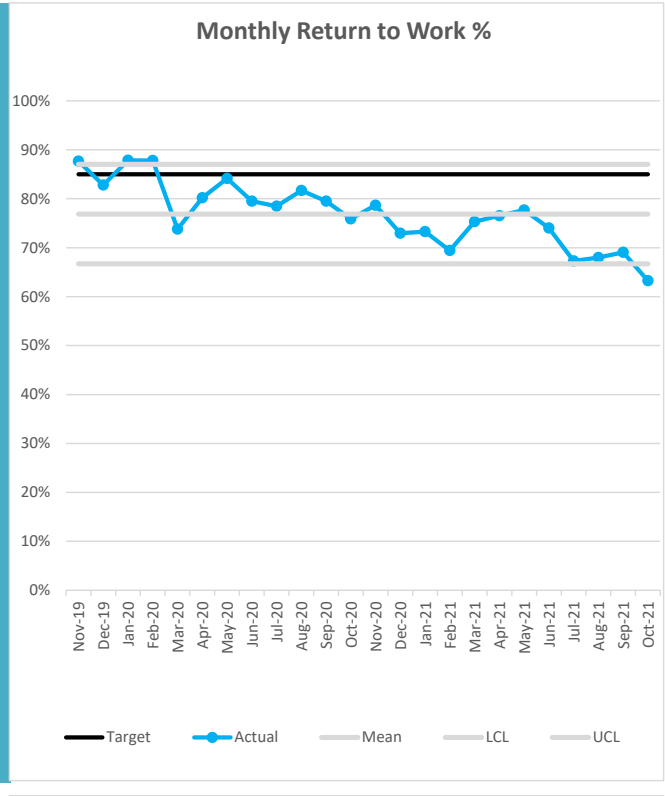
Key:
System Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR200)

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

Return to Work

Red: Below 75%
Amber: 75% to 85%
Green: Above 85%

The Trust's return to work compliance was 63.25% in month.
SPC - There is evidence of special cause variation for Return to Work compliance.



Return to work interview compliance is 63.25% in October 2021.

Its worth noting that previous months RTW compliance has increased, as managers input historic RTWs that occurred, but were not recorded on the system. The 12 month RTW compliance figure is therefore is 71.80%.

Bespoke Manager training has been undertaken in pilot areas with high levels of return to work non-compliance. This will contributed to an increase in compliance in these areas that will be evident within the November reporting.
Evaluation of this training has been undertaken to assess the effectiveness in changing manager practice. Results are currently being analysed with recommendations to follow.
Priority areas have been identified for a return to work data validation exercise to establish if return to works have been undertaken and if so, have they then been recorded. Immediate support will be provided to input return to work dates if completed or if the interviews have not taken place, managers will then be contacted with the offer of bespoke manager training.
As part of continued work with NHSE/I NW Sickness Absence Deep Dive, best practice RTW documentation has been sourced with a meeting to be scheduled in December for the further sharing of best practice. The Operational People Committee continues to request plans/trajectories to demonstrate improving compliance for each CBU and shares best practice as available.
In addition, the Workforce Systems teams are arranging monthly drop-in sessions (an expansion to what is currently delivered), part of this offer is will include RTW data input demo in both ESR and E-Rostering.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

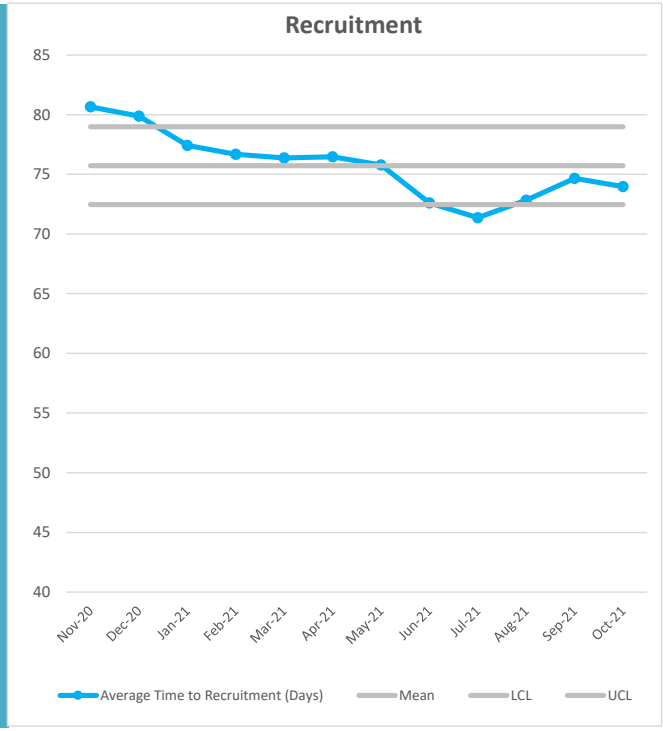
Key:
System Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR200)

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

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 74 days, based on the last 12 months average.
SPC - Recruitment time is within common cause (expected) variation.



Recruitment time to hire for October 2021 is 74 working days compared to 81.4 working days in October 2020. This includes notices periods.

The recruitment team has refined their communications to recruiting managers to both manage expectations, but also support them to proactively consider their recruitment timeline. This has supported the reduction in time to hire despite the significant increase in recruitment activity (7.4% increase in the number of adverts placed, leading to a 36% increase in new starters).

To support this further, the Trusts recruitment and selection training has been refreshed but not yet delivered. This will embed inclusive recruitment and support managers to reduce their time to hire. This will be launched Trust wide as part of the new Line Management Development Programme in January 2022.

E-forms are still in development for the candidates to complete which will allow them to upload copies of their ID documents, this will utilise SharePoint Online, something the Trust is planning to launch late 2021/early 2022.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

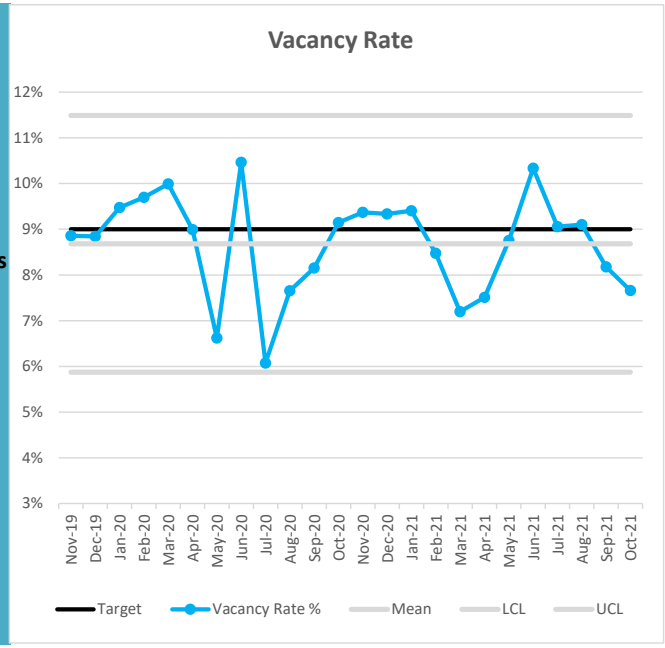
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Vacancy Rates

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

UoR

The Trust vacancy rate was 7.66% in month.
SPC - there is evidence of special cause variation for Vacancy Rates.



The vacancy rate is just above the 9.00% target, at 9.10% in August 2021.

The reduction in the Trusts vacancy rate is in part due to the successful recruitment of international nurses and the HCA recruitment drive.
The Trust has been invited to submit an application to access part funding for international nurses, via both the Nurse refugee programme and CIRC international recruitment for 2022.
The Trust's headcount is currently 4,532 and in September 2021 it was 4,537, the highest on record. This is due to a direct result of a 36% increase in the number of new starters and a reduction of 22.00% of leavers.
The Trust has launched an Inclusive Recruitment action plan following a review, this will impact on candidate attraction. The HR Team is working on developing a suite of additional supporting information, in various formats, designed for NHS Jobs and other platforms.
The H2 Workforce Submission for Health Education England identified a potential (maximum) increase in established FTE (dependent on a number of investments being agreed by the Trusts Executive Team) of 87 FTE, which will increase the vacancy rate, whilst the Trust recruits into the roles.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

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

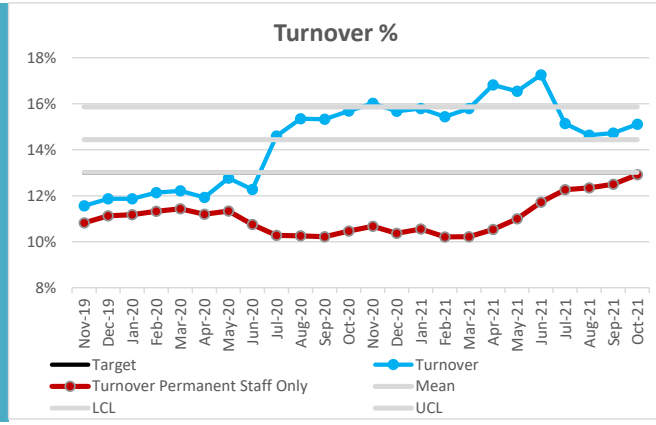
Turnover

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

CQC UoR

The Trust Turnover was 15.11% in month.
SPC - There is evidence of special cause variation for Turnover.

S SOF

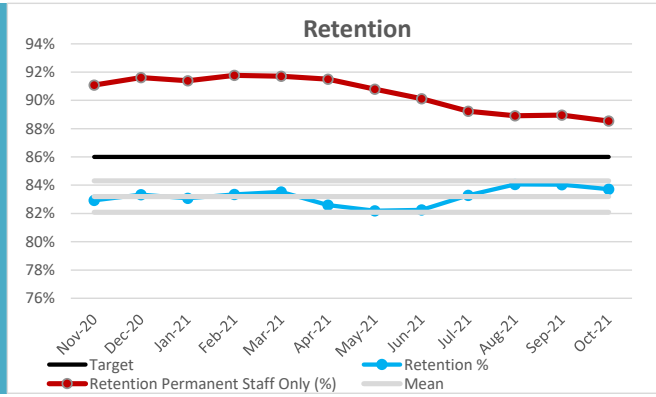


Retention

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

UoR

Trust Retention was 83.72% in month.



Turnover in October 2021 is above target at 15.11%. Turnover of Permanent staff is 12.91%.
Retention in October 2021 is just below Trust target at 83.72%. Retention of Permanent staff is 88.54%
For permanent staff only, the Trust is performing at Trust Target for both Turnover and Retention.
However, because of the response to COVID-19, the Trust engaged 270 fixed term temporary staff that have both joined and left the Trust since January 2020 – therefore our overall Turnover and Retention is lower than the Trust target.
Work-life balance is the number one reason people leave WHH and therefore the Trust has joined the NHSE/I Flex for Future programme and have established an Agile Working Task and Finish Group to develop the strategic approach to agile working and oversee any recommendations for implementation.
This is supplemented by the Trust's reward and benefit scheme, which has been benchmarked with regional and national colleagues via NHS Employers and Health & Wellbeing leads across C&M. WHH are leading the way, however areas for further improvement have been identified and are developing a proposal for consideration.
A range of work is on-going as part of the WHH People Strategy and the NHS People Plan support retention of staff, including:
- **Development and implementation of a line manager development programme in readiness for a January 2022 rollout.**
- **Implementation of a career development programme pilot with staff networks, to be rolled out Trust wide in January 2022.**
- **Supporting 40 of the Trusts leaders through the Compassionate Leadership Development Programme.**
- **Team development offers include bringing teams back together, leadership offers, and leadership circles.**
- **146 development requests have been responded to, in the last 12 months, compared to 50 in the previous 12 months.**
- **Identification and implementation of a Talent Management framework for WHH, which will be Scope for Growth the NHSE/I Talent management approach.**
- **Staff Facilities task and finish group has been established to review the current Staff Facilities based national recommendations and develop a strategic plan to improve.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
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Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR200)

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

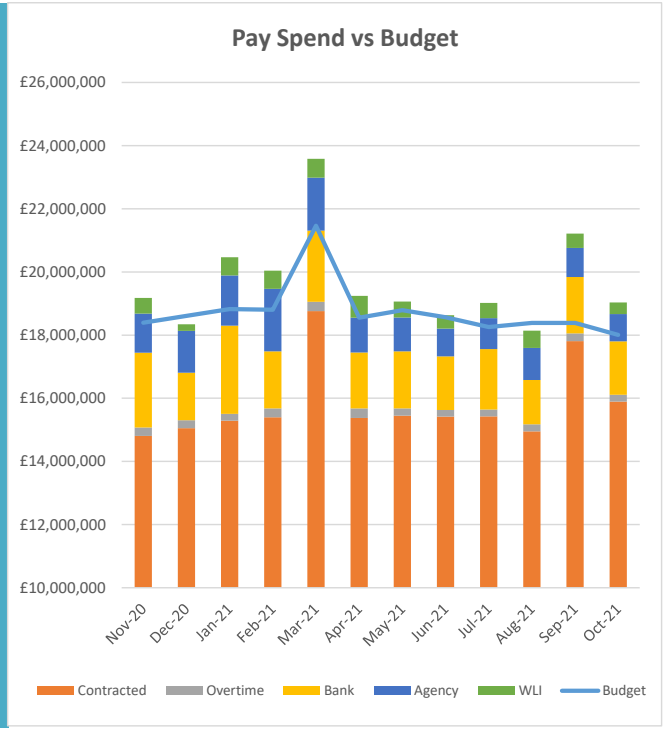
Pay

Red: Greater than Budget

Green: Less than Budget

UoR

Total pay spend in August 2021 was £19m against a budget of £18m.



Total pay spend in October 2021 was £19m against a budget of £18m.

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

- **£15.9m Contracted Pay (i.e. substantive staff)**
- **£1.7m Bank Pay**
- **£0.8m Agency Pay**
- **£0.4m Waiting List Initiative (WLI) Pay**
- **£0.2m Overtime Pay**

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**

A new medical bank rate card has been implemented from 11/10/2021. Since the launch, further work has been identified to develop sign off processes for escalations. A new weekly escalation panel is being setup to review all medical bank rate escalations.

In addition, through the Finance and Sustainability Committee, compliance against our processes and rate cards is being monitored.

Currently, the central bank and agency team are reviewing the end to end processes which will include; sessions from system providers to ensure best practice adoption and utilisation, review of current SOPs and processes, frameworks review and high fill agencies to be contacted for meetings regarding their rates.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

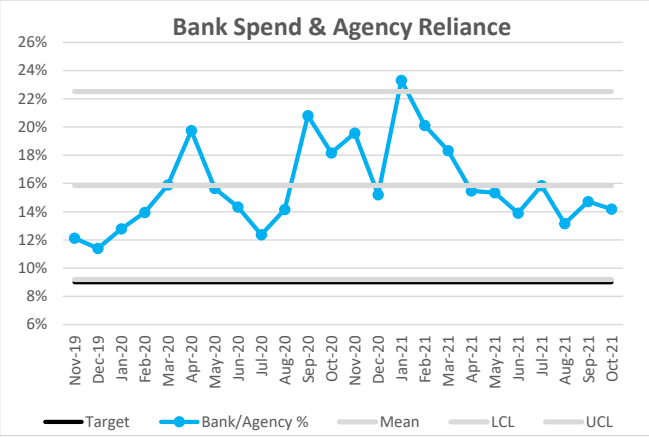
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Bank and Agency Reliance

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

UoR

Bank and Agency Reliance was 14.18% in month. SPC - Bank/Agency reliance is within common cause (expected) variation.



Bank and Agency reliance peaked at 23.30% in January 2021 and there has been a continued reduction since. In October 2021, reliance is 14.18%.

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

With the introduction of the new medical bank rate card; any rate escalations will be required to outline long term recruitment plans.

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)

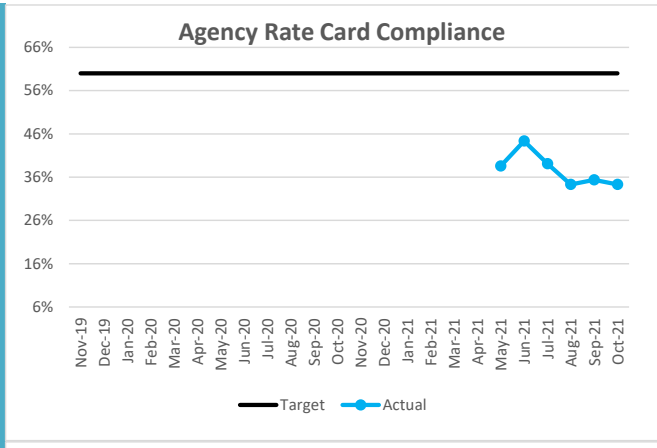
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Agency Rate Card Compliance

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

UoR

Agency Rate Card Compliance was 34.31% in month.



Compliance with the NHSEI rate card was 22.75%. In October 2021, non-compliance was highest amongst the following staff groups:

- **Medical and Dental: 99.00% above price cap**
- **Nursing and Midwifery: 89.00% above price cap**
- **AHPs: 44.00% above price cap**

Compliance with the Cheshire and Merseyside rate card was 34.31% in October 2021.

The central bank and agency team continue to support CBUs in relation to the booking of medical and dental staff and to attempt negotiate rates down towards the Cheshire and Mersey Rate Card and the NHSI Price Cap compliance.

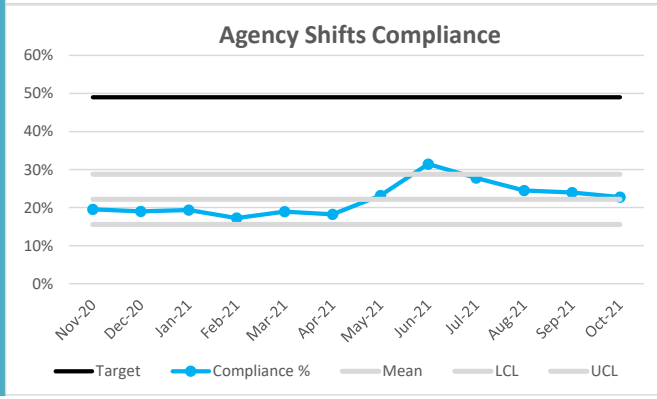
The C&M rate card has recently been amended to consider inflation, which has been implemented from April 2021.

Agency Shifts Compliant with the Cap

Red: below 49%
Green: above 49%

UoR

22.75% of shifts were compliant with the NHSI Price Cap.
SPC - There is evidence of special cause variation within Agency Shift Compliance.



Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

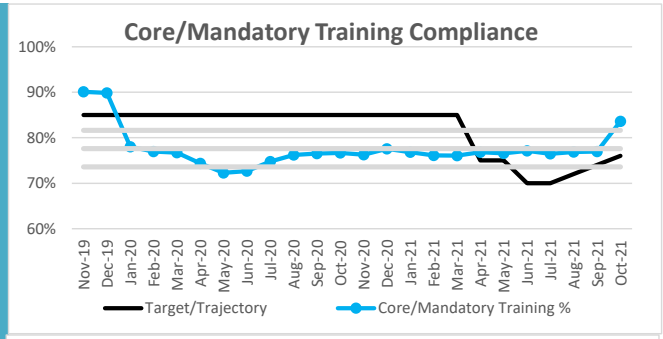
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Core/Mandatory Training

Red: Below Trajectory
Green: Trajectory

CQC

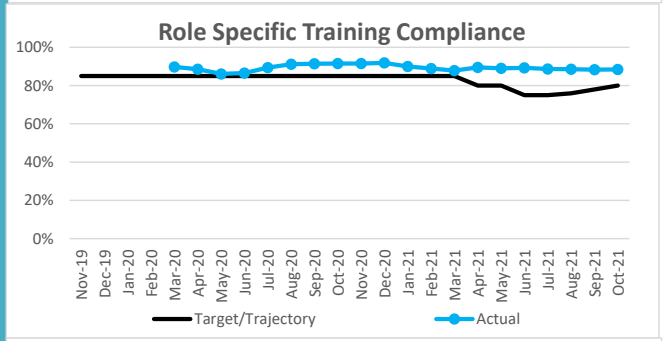
Core/Mandatory training compliance was 83.61% in month.
SPC - there is evidence of special cause variation.



Role Specific Training

Red: Below Trajectory
Green: Trajectory

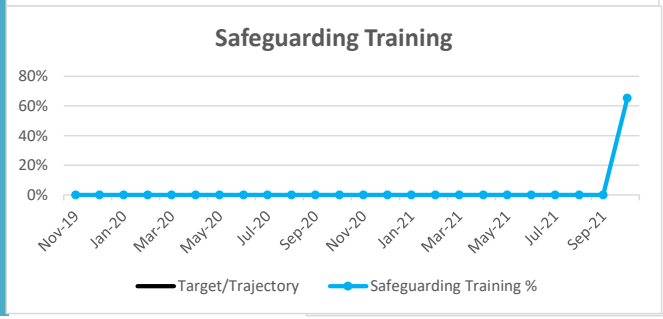
Role Specific Training compliance was 88.47% in month.



Safeguarding Training

Red: Below Trajectory
Green: Trajectory

Safeguarding Training compliance was 65.21% in month.



In October 2021, Core Skills/Mandatory Training compliance was 83.61%, this now excludes Safeguarding Training (Children's and Adults). Safeguarding compliance was 65.21%, and Role Specific Training compliance was 88.47%.

Currently Core Skills/Mandatory Training, Safeguarding Training and Role Specific Training are above their agreed trajectories (positive).

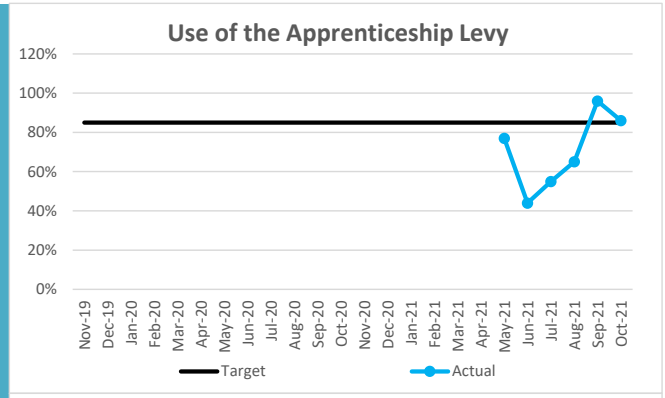
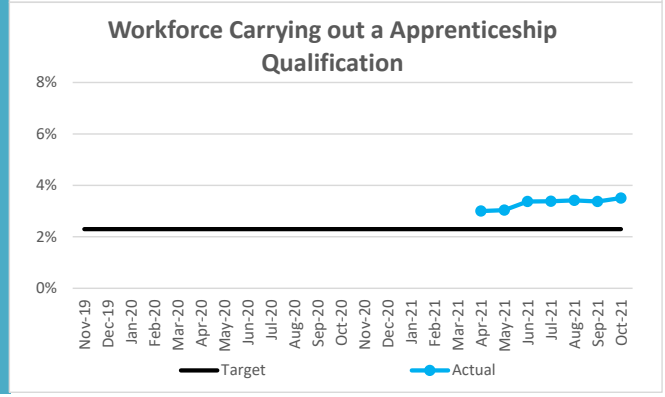
The Mandatory Training compliance is now split by Mandatory, Safeguarding and Role Specific Training.

The CBUs and Subject Matter Expert have been supported to develop trajectories to improve compliance, these are to be monitored through the Operational People Committee.

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)?
Use of Apprenticeship Levy Red: below 50% Amber: 50-84% Green: 85% or above	**Use of the Apprenticeship Levy was 86.00% in month.**		**Utilisation of the apprenticeship levy is 86.00% is October, above target in month (positive). 3.51% of staff are carrying out a qualification, which is above target in month (positive).**	**Use of the apprenticeship 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	**The percentage of the workforce carrying out a qualification was 3.51% in month.**			

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)

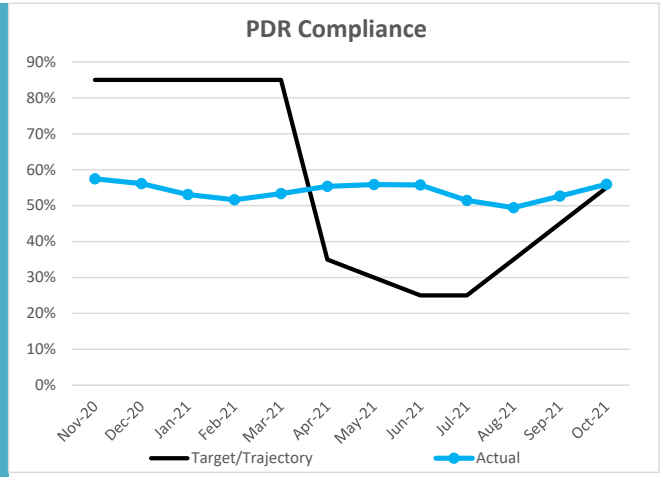
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

PDR

Red: Below Trajectory

Green: Trajectory

PDR compliance was 55.91% in month.



In October 2021, PDR compliance was 55.91%.

Currently, PDR rates are above the agreed trajectories (positive).

An improvement trajectory to return to above target compliance of 85.00% has been in place since July 2021.

The CBUs have been supported to develop trajectories to improve compliance including use of the Wellbeing Check In Conversations where appropriate. These are monitored through the Operational People Committee.

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)?

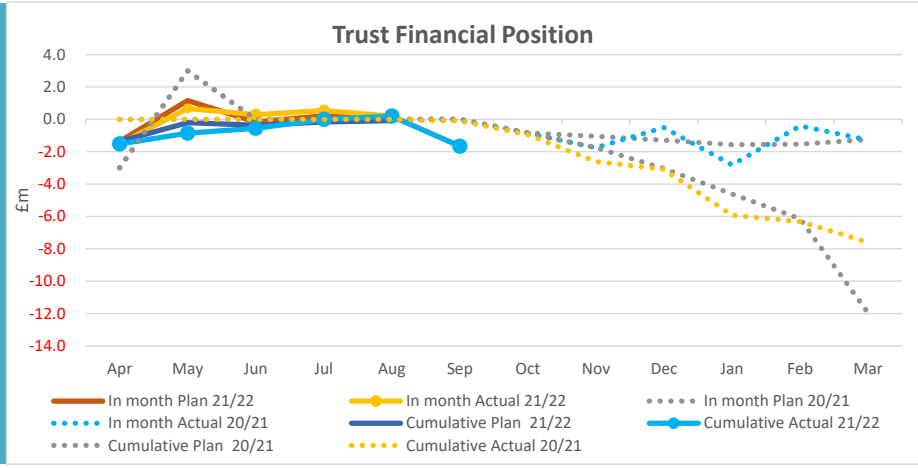
Trust Financial Position

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 £1.7m as at 31 October. The plan for H2 has not been finalised.

RR134



For the period ending 31 October 2021, the Trust has recorded a deficit of £1.7m. The position includes an overspend on COVID-19 partly offset with underspends in other areas of the organisation.

The Trust is applying national guidance as this emerges in relation to financial planning for H2.

System Financial Position

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

Warrington & Halton System reporting is currently on hold.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
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)?

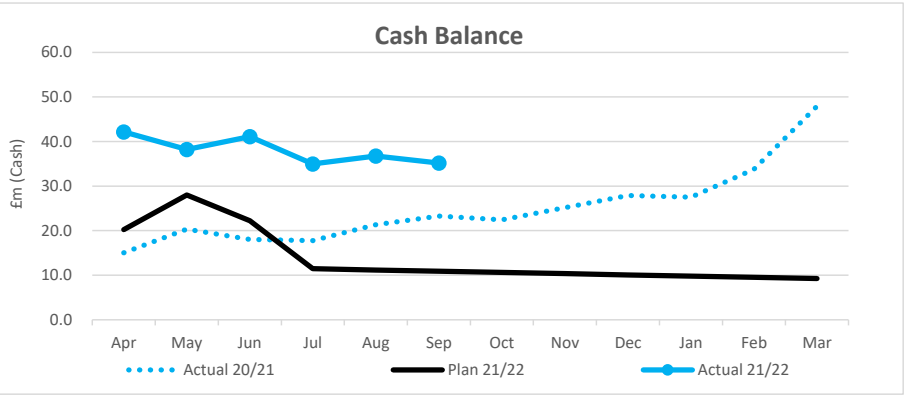
Cash Balance

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

UoR

The current cash balance is £35.2m.

RR134



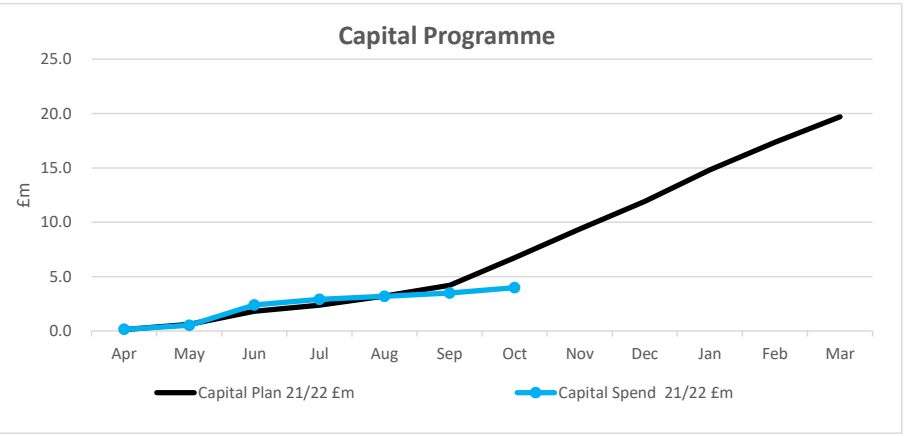
A revised forecast cash position was produced in August 2021 with a planned cash level at Month 7 of £27.9m against an actual balance of £35.2m. The key factors that have impacted the cash in month are the receipt of HEE funds of £3.4m and £5.2m COVID-19 top up.

Capital Programme

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

UoR

The actual capital spend in month 7 was £0.3m. There are £7.9m committed orders on the system.

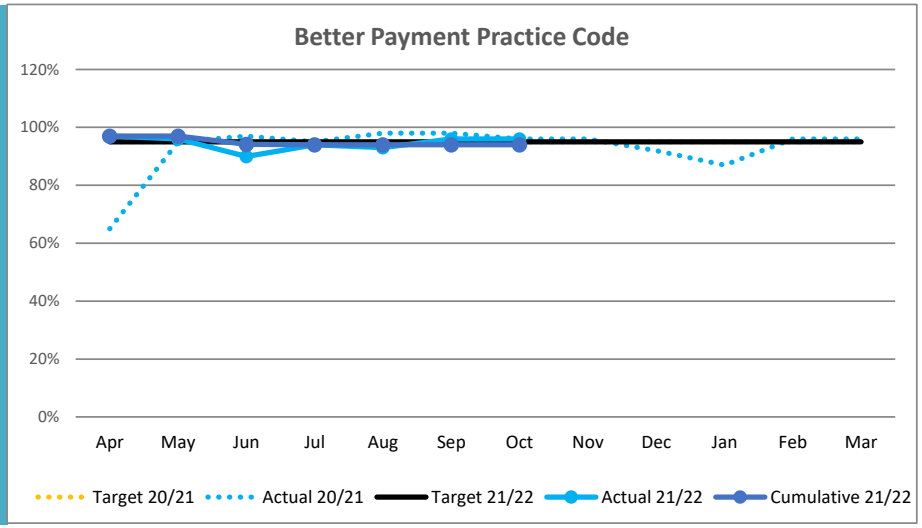


The Trust Board approved a capital plan is £19.6m. There has been a increase of £0.1m due to donated equipment which brings the plan to £19.7m. The actual spend year to date is £3.9m which is £2.7m below the planned spend of £6.7m. However, the Trust has committed orders of £7.9m.

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)?
UoR **In month, the Trust has paid 96.00% of suppliers within 30 days.**		**Cumulative performance is 94.00% 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.**

Better Payment Practice Code

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

UoR

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

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

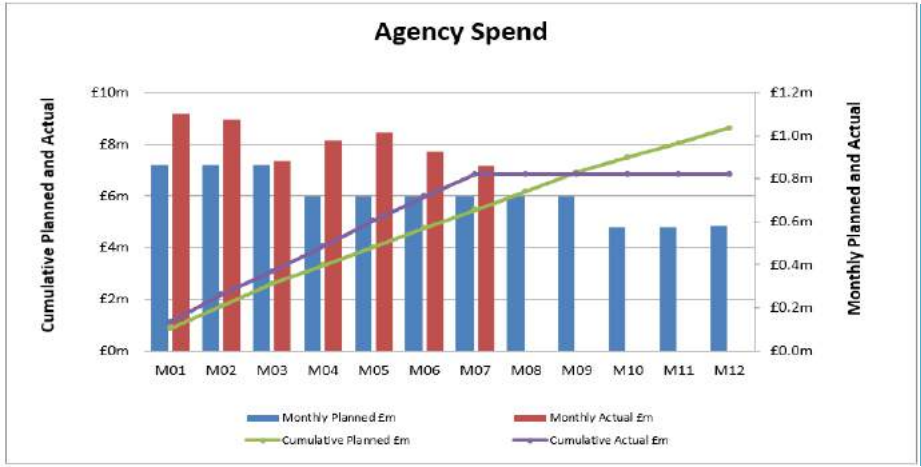
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

Agency Spending

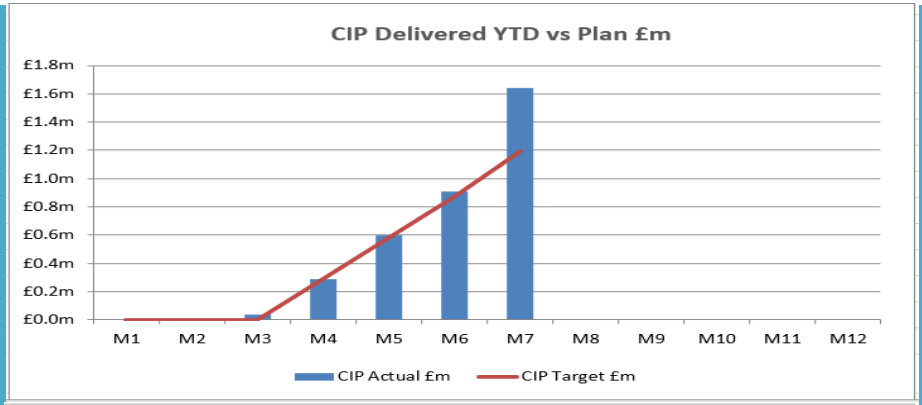
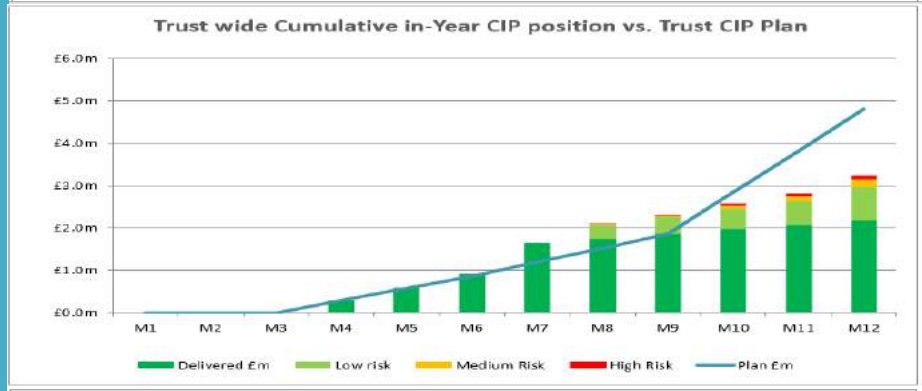
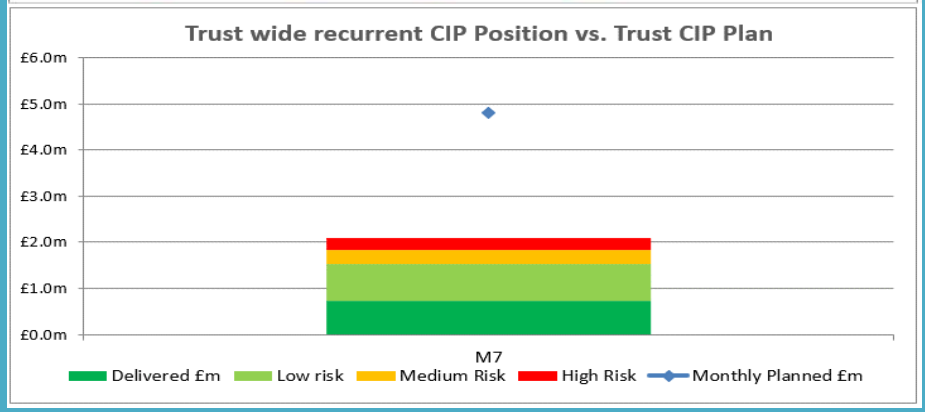
Red: More than 105% of ceiling
Amber: Over 100% but below 105% of ceiling
Green: Equal to or less than agency ceiling.

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR **The actual agency spend in month is £0.9m.**		**The year to date spend of £6.8m is £1.4m above the plan of £5.5m**	**The Trust continues to monitor and report the use and spend on agency as well as the use of efficiency models to reduce costs. The Trust is part of a Cheshire & Merseyside collaborative that has established a standard rate card across all staff groups and specialties to reduce rates and is enhancing processes and controls to ensure appropriate and best use of agency staff. The rate card has been reviewed to consider inflation.**

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)?
Cost Improvement Programme - In year performance to date Red: 0-70% Plan delivered YTD Amber: 70-90% Plan delivered YTD Green: >90% Plan delivered YTD	UoR **The year to date savings are £1.6m.**		**The year to date savings are £1.6m against a plan of £1.2m**	**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 £2.1m, against a plan of £4.8m.**		**There was no CIP target in Q1 2021/22. The Trust has a target of £4.8m for the year and schemes are being developed with CBU and Corporate Services to deliver the CIP.**	**To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT is being used. Further work to increase identification of CIP schemes continues across the Trust.**
Cost Improvement Programme - Plans in Progress - Recurrent Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	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.

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?

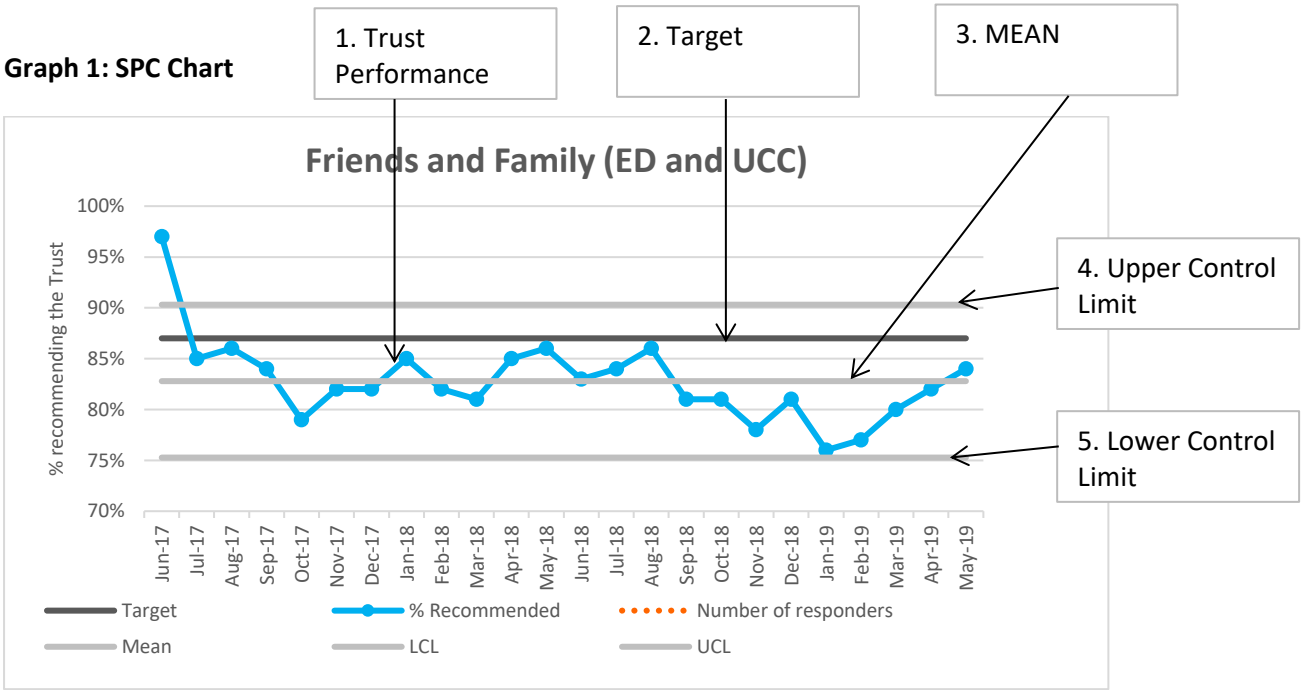
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

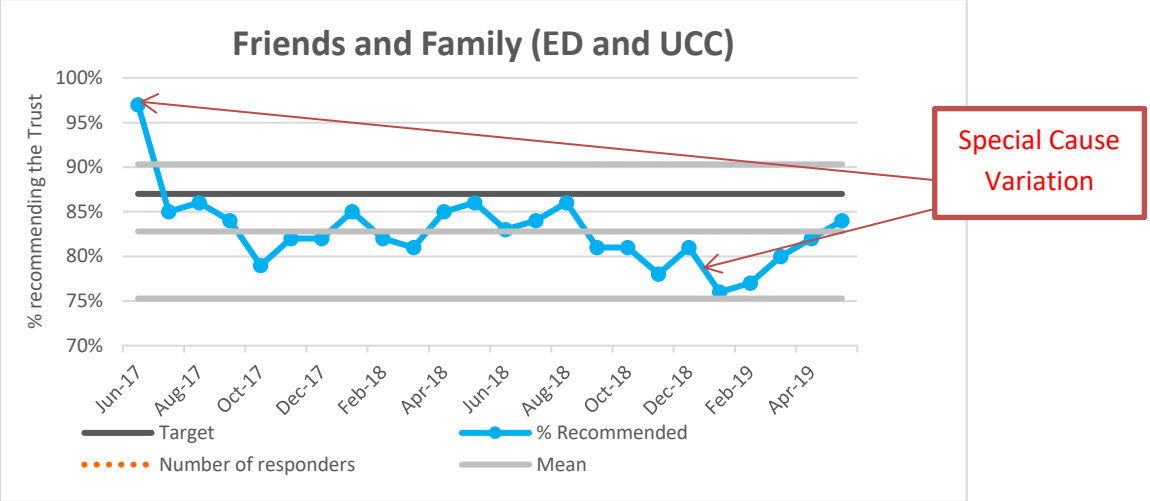
Graph 1: SPC Chart



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 31st October 2021

Income Statement	As at 30th September £000	As at 31st October £000	Variance £000
Operating Income			
NHS Clinical Income			
Elective Spells	2,250	2,656	406
Elective Excess Bed Days	1	17	16
Non Elective Spells	5,420	6,429	1,009
Non Elective Bed Days	305	-7	-313
Non Elective Excess Bed Days	44	100	57
Outpatient Attendances	3,658	3,342	-316
Accident & Emergency Attendances	1,789	1,777	-12
Other Activity	6,016	4,544	-1,472
COVID Top up Income (Liverpool CCG)	4,760	4,021	-738
Sub total	**24,242**	**22,879**	**-1,363**
Non NHS Clinical Income			
Private Patients	28	41	13
Non NHS Overseas Patients	0	0	0
Other non protected	91	52	-39
Sub total	**119**	**93**	**-26**
Other Operating Income			
Training & Education	683	683	0
Donations and Grants	0	132	132
Miscellaneous Income	1,113	1,322	209
Sub total	**1,796**	**2,137**	**341**
Total Operating Income	**26,157**	**25,109**	**-1,048**
Operating Expenses			
Employee Benefit Expenses	-18,830	-18,818	13
Drugs	-1,453	-1,527	-74
Clinical Supplies and Services	-2,012	-2,183	-170
Non Clinical Supplies	-3,156	-3,264	-108
Depreciation and Amortisation	-451	-628	-177
Net Impairments (DEL)	0	0	0
Net Impairments (AME)	0	0	0
Restructuring Costs	0	0	0
Total Operating Expenses	**-25,904**	**-26,419**	**-516**
Operating Surplus / (Deficit)	**254**	**-1,310**	**-1,564**
Non Operating Income and Expenses			
Profit / (Loss) on disposal of assets	21	-144	-166
Interest Income	0	0	0
Interest Expenses	0	0	0
PDC Dividends	-447	-90	357
Total Non Operating Income and Expenses	**-426**	**-234**	**191**
Surplus / (Deficit) - as per Accounts	**-172**	**-1,545**	**-1,373**
Adjustments to Financial Performance			
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0
Less Donations & Grants Income	0	-132	-132
Add Depreciation on Donated & Granted Assets	19	17	-1
Total Adjustments to Financial Performance	**19**	**-115**	**-133**
Adjusted Surplus / (Deficit) as per NHSI Return	**-153**	**-1,659**	**-1,506**

Activity Summary	Sep-21 Actual	Oct-21 Actual	Variance
Elective Spells	13,307	15,876	258
Elective Excess Bed Days	282	329	0
Non Elective Spells	17,089	19,698	123
Non Elective Bed Days	2,989	3,487	-184
Non Elective Excess Bed Days	3,317	3,879	1
Outpatient Attendances (PBR Only)	167,133	198,630	-1,192
Accident & Emergency Attendances	59,236	68,989	461

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/155 (a i)**			
SUBJECT:	**Safe Staffing Assurance Report – August and September 2021**			
DATE OF MEETING:	24th November 2021			
AUTHOR(S):	Ellis Clarke, Lead Nurse for Nurse Staffing & Workforce Improvement			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.			
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	*		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper details ward staffing data for the months of August and September 2021. Ward staffing data continues to be systematically reviewed to ensure the wards and departments are safe. Mitigation was provided and associated actions put in place when a ward was below 90% of planned staffing levels. Registered nurse and midwife sickness absence in the month of August was recorded at 5.83. Sickness data in September details an increase to 6.83%. In the month of August, it was noted that 16 of the 21 wards were above the 90% target during the day, in September 14 of the 21 wards were above the 90% target. In order to ensure safe staffing levels, mitigation and responsive plans were implemented daily to ensure that the safe delivery of patient care. CHPPD in August was 8.0 and 7.9 in September, with a year to date rate 7.9. This maintains a level of improvement over the last 6 months. This report provides assurance that the Trust is safely staffed and staffing is monitored as appropriate . The report does not cover the analysis of spend and staffing cost.			
PURPOSE: *(please select as appropriate)*	Information *	Approval	To note *	Decision
RECOMMENDATION:	Trust Board asked to receive the contents of this report as discussed and received at the Strategic People Committee.			
PREVIOUSLY CONSIDERED BY:	**Committee**	**Strategic People Committee**		
	Agenda Ref.	**SPC/21/11/101**		

	Date of meeting	17th November 2021
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Safe Staffing Assurance Report – August and September 2021	AGENDA REF:	BM/21/11/155 (a i)

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report – August and September 2021.

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

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

2. KEY ELEMENTS

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

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

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

Care Hours Per Patient Day (CHPPD)

The senior nursing team currently collects and reports CHPPD data on a monthly basis. CHPPD is the total time spent on direct patient care based on the number of occupied beds at midnight. The August and September 2021 Trust wide staffing data was analysed and cross-referenced, with ward level data for validation by the Deputy Chief Nurse and Lead Nurses.

Table 1 illustrates the monthly CHPPD data. In the month of August CHPPD was recorded at 8.0 and September recorded at 7.8 with a 2021/22 YTD figure of 7.9.

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

Table 1 – CHPPD Data 2020/21

	Trust wide			
Month	**Cumulative count over the month of patients at 23:59 each day**	**Registered midwives/nurses**	**Care Staff**	**Overall**
Apr-21	13769	4.4	3.3	7.7
May-21	13645	4.6	3.5	8.1
Jun-21	13134	4.5	3.4	7.9
Jul-21	13964	4.4	3.3	7.6
Aug-21	13479	4.7	3.3	8.0
Sep-21	13428	4.5	3.3	7.8
YTD	81419	4.5	3.3	7.9

Key Messages

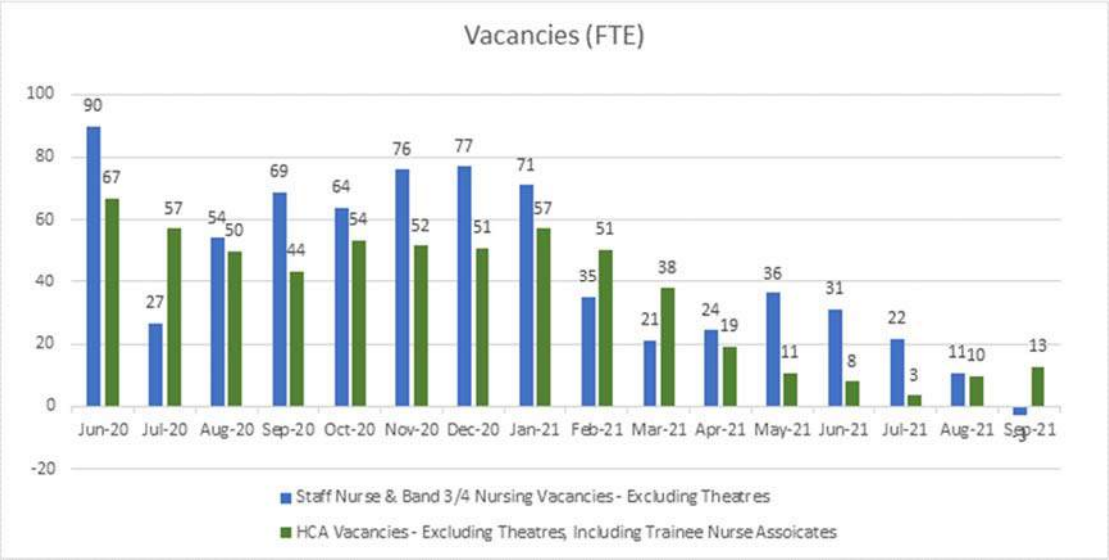
In the month of August, it was noted that 16 of the 21 wards were above the 90% target during the day, in September 14 of the 21 wards were above the 90% target. In order to ensure safe staffing levels, mitigation and responsive plans were implemented daily to ensure that the safe delivery of patient care. Staffing is reviewed twice daily by the senior nursing team and staff are moved based on acuity and activity to ensure safe patient care at all times.

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

Maternity (ward C23) was 87% in August which was lower than previous months. In September though C23 reported 80% planned versus actual. Ward C23 use their responsive staffing plans in the unit to move staff to support if acuity requires additional staffing.

Vacancy Summary

In August 2021 the Trust had 11 registered nurse and 10 health care assistant vacancies at WHH, which required reliance on temporary staffing to ensure safe staffing levels on the wards. In September vacancy levels were no registered nurse and 13 health care assistant vacancies.



Recruitment and retention continue to be priorities for the senior nursing team. WHH are working in collaboration with Wigan, Wrightington and Leigh NHS Trust and Mid Cheshire NHS FT for recruitment of the international nurses. The partnership includes Health Education England (HEE), recognising the need to address the urgent nursing workforce shortages across the region. This approach has utilised the 'toolkit' commissioned by the Department of Health and Social Care produced by NHS Employers (January 2020). A Task and Finish Group has managed the implementation of this programme. Practice educators dedicated to supporting the nurses are in post until April 2022. The nurses have also been accessing support from the Wellbeing team. Through the programme 96 international nurses have been recruited who will join the Trust between January and December 2021. See **Appendix Five** for the Progress Tracker

Recruiting to HCA vacancies has previously been a challenge. However, the Trust received funding from NHSI to enhance HCA recruitment and pastoral support in the clinical areas. In August 2021 we had 10 HCA vacancies. There are 13 vacancies in September, recruitment to these posts is in progress.

Escalation Beds and Costs

In the months of August & September 2021 ward B3 has been open for medically fit patients, the ward is managed by the Unplanned Care Group. Staff are moved from other wards and augmented by temporary staff.

In October K25 was opened as a winter escalation ward. This ward on the Warrington site will mirror the service at Halton on B3 and will be staffed in the same way. More detail of this will be included in the next report.

Off Framework Agency Usage

The Trust continues to manage its bed occupancy and staffing in a responsive and planned way. The use of off framework agency nurses has been minimised. In response to surges in critical care it has been necessary to employ off framework staff who have the required ICU experience. Strict controls are in place and authorisation from the Chief Nurse/DCEO is required. All usage is tracked by the e-rostering team.

Sickness Absence – August & September 2021

Registered nurse and midwife sickness absence in the month of August was recorded at 5.83% showing a slight decrease from the June/July report which was recorded at 5.95%. Sickness data in September details an increase to 6.83%. The cost of bank/agency cover of qualified nursing sickness (at usual bank/agency fill rates) is £244,429 in August and £274,129 for September as detailed in the tables 4 and 5 below;

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

	Aug-21
Contracted Nursing WTE (Band 5 to 7)	961.46
% Sickness	5.83%
WTE Equivalent of Sickness	56.05
NHSP Fill Rate	81%
WTE Covered by Temporary Staffing	45.40
Cost at Average NHSP Rates	***244,429***

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

	Sep-21
Contracted Nursing WTE (Band 5 to 7)	978.10
% Sickness	6.85%
WTE Equivalent of Sickness	67.00
NHSP Fill Rate	76%
WTE Covered by Temporary Staffing	50.92
Cost at Average NHSP Rates	***274,129***

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

Clinically Extremely Vulnerable (CEV) Staff

The number of Clinically Extremely Vulnerable (CEV) staff are a driver behind additional spend on temporary staff in the clinical areas. A significant proportion of CEV staff members continue to work non-clinically or in 'green' pathways. 35 clinical CEV staff have been identified, who are unable to work their substantive role. They have been prioritised for review by Occupational Health & Wellbeing. It

is estimated this will cause an annual additional temporary staffing spend of £1.8 million, however this somewhat offset by £650kdue to the areas the CEV have been redeployed into.

Emergency Department Recruitment

In October we held a recruitment open day for ED nurses. The event held in the Village Hotel following a social media campaign. Interviews were held on the day and a number of RNs were appointed.

Band 5 for Paediatrics in ED

- Two RNs starting in July 2022
- Other paediatric nurses interviewed yielded a further four possible RNs for the ward.

Adult

- One band 5 for Combined Assessment Unit (CAU)
- One band 5 Acute Medical Unit (AMU)
- Thirteen band 5 RNs for ED
    - One qualified now, two in December 2021, one in March 2022, eight in July 2022 and one in September
- Outside of the open day, two were interviewed 26/10/2021 following NHS Jobs applications and successful both start early next year.

Band 6

- Two full time RNs appointed following interview today 1 permanent and 1 temporary contract. One part time RN band 6 offered a post to be confirmed.

Maternity Staffing

- All band 5/6 vacancies have been appointed
- New band 7 Birth Suite coordinator has commenced in post
- New ward manager appointed and will commence in January 2022
- Ockenden funding will recruit a lead midwife for Perinatal Mental Health, Fetal surveillance and 2 advanced midwifery practitioners
- Funding secured to appoint a fixed term contract for a band 7 retention midwife

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

From previous report

Paediatrics - Respiratory Syncytial Virus (RSV) 2021 Preparedness

BW772 Respiratory syncytial virus 2021 ı

In the previous report the above document was shared, the Trust's draft plan in response is in Appendix six.

Action Complete

For October/November report

Provide staffing plan for B3 and K25 escalation wards.

4. RECOMMENDATIONS

The Trust Board is asked to note the content of the report previously discussed at the Strategic People Committee

Appendix 1

Monthly Safe Staffing Data – August 2021																			
		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1782.5	1426	1426	1368.5	80%	96%	1426	1345	1426	1288	94%	90%	1017	2.7	2.6	0.0	0.0	5.4
DD	Ward A5 G	920	931.5	1069.5	1069.5	101%	100%	713	713	1069.5	1035	100%	97%	506.4	3.2	4.2	0.1	0.1	7.6
DD	Ward A5 E	690	720	690	480.5	104%	70%	713	713	690	345	100%	50%	174	8.2	4.7	0.0	0.0	13.0
MSK	Ward A6	1782.5	1612	1782.5	1782.5	90%	100%	1069.5	1541	1782.5	1053	144%	59%	1053	3.0	2.7	0.0	0.0	5.7
MSK	CMTC	1069.5	1276.5	713	897	119%	126%	713	713	713	506	100%	71%	381	5.2	3.7	0.0	0.0	8.9
W&C	C20	1069.333	940.5833	713	723.4167	88%	101%	713	713	0	0	100%	N/A	304	5.4	2.4	0.0	0.0	7.8
W&C	Ward C23	1426	1242	713	575	87%	81%	713	552	713	586.5	77%	82%	713	2.5	1.6	0.0	0.0	4.1
W&C	Birth Suite	2139	1978	356.5	278.5	92%	78%	2139	1943.5	356.5	278.5	91%	78%	336	11.7	1.7	0.0	0.0	13.3
W&C	The Nest	713	437	365.5	285	61%	78%	713	506	365.5	239.5	71%	66%	12	78.6	43.7	0.0	0.0	122.3
W&C	Ward B11	2997	2658.5	892.5	892.5	89%	100%	1682.4	1735.6	322.4	322.4	103%	100%	280	15.7	4.3	1.8	0.1	21.9
W&C	NNU	1782.5	1380.5	356.5	253	77%	71%	1782.5	1265	356.5	310.5	71%	87%	294	9.0	1.9	0.0	0.0	10.9
UEC	Ward A1	1957.67	1969.67	2430	2076.5	101%	85%	1651.42	1258.6	992.75	907.67	76%	91%	999	3.2	3.0	0.0	0.0	6.2
UEC	Ward A2	1438.92	1405.92	1535.5	1339.83	98%	87%	1038.48	936.33	1041.2	853.15	90%	82%	896	2.6	2.4	0.0	0.0	5.1
UEC	ED	6513.08	6727.47	2087.75	1953	103%	94%	4523.6	5329.0	1561.2	1679.4	118%	108%						
MC	ACCU	2495.5	2320	1069.5	1053	93%	98%	1782.5	1771	1069.5	1105	99%	103%	821	5.0	2.6	0.0	0.0	7.6
MC	ICU	4996	4738	1069.5	822.3	95%	77%	4991	4910.5	1069.5	925.8	98%	87%	484	19.9	3.6	0.0	0.0	23.5
MC	Ward A7	1782.5	1973	1426	1499.5	111%	105%	1426	1742	1069.5	1210	122%	113%	1023	3.6	2.6	0.0	0.0	6.3
IM&C	Ward C21	1069.5	1324	1428.5	1515.5	124%	106%	713	724.5	1069.5	1024	102%	96%	773	2.7	3.3	0.0	0.0	5.9
IM&C	Ward B14	1069.5	1046.5	2139	1804.5	98%	84%	713	713.5	1782.5	1725.9	100%	97%	639	2.8	5.5	0.0	0.0	8.3
IM&C	Ward B12	1069.5	1043	2495.5	2173.5	98%	87%	713	713.5	1782.5	1725.9	100%	97%	588	3.0	6.6	0.0	0.0	9.6
IM&C	Ward B19	1276.5	1407	1782.5	1338.667	110%	75%	920	899.5	1426	1282.5	98%	90%	486	4.7	5.4	0.0	0.0	10.1
IM&C	Ward A8	1696.483	1512	1426	1328.667	89%	93%	1,426.00	1,311.50	1426	1311.5	92%	92%	1049	2.7	2.2	0.0	0.0	4.9
IM&C	Ward A9	1782.5	1856.5	1782.5	1564	104%	88%	1069.5	1368.5	1783.5	1449	128%	81%	651	5.0	4.6	0.0	0.0	9.6
	Total	43518.99	41925.64	29750.25	27074.38	96%	91%	31918.9	30896.55	23868.57	21164.24	97%	89%	13479.4	4.7	3.3	0.0	0.0	8.0
		= above 100%			= above 90%			= above 80%			= below 80%								

Appendix 2
August 2021 - Mitigating Actions

	MITIGATING ACTIONS
Ward A4	Vacancy - band 0.19 band 5 0.19 band 2 1.46 Sickness rate - short term 6.32 long term 2.25% Managed in line with policy. Action taken - Use of agency and NHSP to fill gaps . WM filling shortfalls in gaps also. Regular meetings with NHSP.
Ward A5 Gastro	Vacancy - nil Sickness rate - short term 2.41% long term 2.97% Action taken - Use of agency and NHSP to fill gaps . WM filling shortfalls in gaps also. Regular meetings with NHSP.
Ward A5 Elective	Vacancy - band 6 1.0 wte band 5 0.38wte band 2 2.33wte Sickness rate - short term 1.25% long term 0% Action taken - Use of agency and NHSP to fill gaps . WM filling shortfalls in gaps also. Regular meetings with NHSP.
Ward A6	Vacancy - band 7 = 1 pending retirement out to advert, band 5 = 1 WTE, band 2 = 1 WTE vacancies awaiting new starters Sickness rate - 4.93% ST and 7.31 % Lt Action taken - recruitment for vacant posts, sickness abscence policy followed for all staff, occupational health referrals completed and advice sought from HR for complex cases
CMTC	Vacancy - band 5 = 0 WTE NQN commencing September 2021 , band 2 = 0 vacancies, band 3 housekeeper recruited to awaiting start date Sickness rate - 3.19% ST and 2.04 % Lt Action taken - recruitment for vacant posts, sickness abscence policy followed for all staff, occupational health referrals completed and advice sought from HR for complex cases
C20	Vacancy - 0 Sickness rate - 13% Action taken - OH & Wellbeing support in place in line with Trust Attendance Policy
Ward C23	Vacancy - 5.36WTE Sickness rate - 4.11% Action taken - Sickness absence managed according to guidance with OH/HR - Vacancies recruited to awaiting start
Birth Suite	Vacancy - 8.36% Sickness rate - 7.36% Action taken - Sickness absence managed with support from OHWB/HR. Vacancies recruited to awaiting start
The Nest	Vacancy - 0.0% Sickness rate - 6.95% Action taken - Sickness absence managed with OHWB/HR support - Vacancies recruited to/awaiting start
Ward B11	Vacancy - Band 2 (0.33)WTE Band 5 (0.33) WTE Band 6 (0.33) WTE Sickness rate - Long term 3.8 WTE Maternity Leave 3 WTE Action taken - Hours offered to existing staff to increase. Sickness managed in line with trust attendance policy 0.6 WTE resumed. Maternity Leave 1 WTE returned to work 16th August. HDU 12 days.
NNU	Vacancy - 1X Band 4 2X Band 6 2 x band 7 Sickness rate - 1 long term sick Action taken - Recruitment process in place
Ward A1	Vacancy - Band 6 x 2.89 Sickness rate - 12.01% managed in line with policy, ward manager filling shortfalls in staffing. Use of NHSP and agency also where needed Action taken - Awaiting new starters september, ongoing recruitment of band 6. Regular updates with NHSP.
Ward A2	Vacancy - Band 4 x1 Sickness rate - 8.36% managed in line with policy, ward manager filling shortfalls in staffing. Use of NHSP and agency also where needed Action taken - Regular updates with NHSP
ED	Vacancy - band 7 x 1.15 / band 6 x 5.15 / band 5 x 15.22 / Band 2 x 0.74 ongoing recruitment. ED manager organising recruitment drive Sickness rate - 8.90%. Managed in line with policy. Manager and Matrons supporting shortfalls in staffing. Reliance on agancy and NHSP Action taken - Regular meetings with NHSP and ongoing recruitment drive
ACCU	Vacancy - Band 6 2.0 wte Sickness rate - 4.68% Action taken - All managed in line with policy
ICU	Vacancy - 3.49% Sickness rate - 8.35%- health and wellbeing support
Ward A7	Vacancy - Band 6 0.4 wte, band 5 2.81, band 2 3.75 Sickness rate - 9.93% Action taken - Recruitment plans in progress, all sickness managed with HR and Health and wellbeing
Ward C21	Vacancy - Band 5 -0 Band 2 1.0 wte Sickness rate - 3.60% Action taken - attendance & management managed in line with policy 2.0 wte LTS
Ward B14	Vacancy - Band 5 -0 Band 2 2.0 wte Sickness rate - 9.02% Action taken - sickness managed in line with attendance policy 2.0 wte maternity leave band 2 CSWD in place to support ward
Ward B12	Vacancy - Band 5 -0 Band 2 2.0wte Sickness rate - 8.21% Action taken - Band 2 1.0 wte LTS mangaged with support of HR progressing to stage 3 1.0wte redeployed to another area recruitment ongoing being supported with CSWD

Ward B19	Vacancy -Band 5 0 new starters in September x2 1.0wte Band 2 0 Sickness rate - 3.59% Action taken - sickness being managed in line with attendance policy
Ward A8	Vacancy -Band 5 1.0 new starter in September x2 1.0wte Band 2 0 Sickness rate - 10.89% Action taken - sickness being managed in line with attendance policy & supported with HR x2 Band 2 LTS 1.0 supported band 2 with CSWD
Ward A9	Vacancy - Band 5 2.0 wte Band 2 -0 Sickness rate - 6.09% Action taken - recuritment ongoing international nurses to start supported by agency and NHS P wardmanager supporting shortfalls sickness being managed in line with attendance policy band 2 x1 being redeployed to another area supported by HR

Monthly Safe Staffing Data – September 2021

		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1725.0	1489.3	1380.0	1293.8	86%	94%	1380.0	1380.0	1380.0	1311.0	100%	95%	1001	2.9	2.6	0.1	0.0	5.6
DD	Ward A5 G	1000.5	989.0	1035.0	989.0	99%	96%	690.0	690.0	1035.0	1000.5	100%	97%	506	3.3	3.9	0.0	0.0	7.3
DD	Ward A5 E	1000.5	690.0	1000.5	696.0	69%	70%	1035.0	690.0	1035.0	333.5	67%	32%	201	6.9	5.1	0.0	0.0	12.0
MSK	Ward A6	1725.0	1679.0	1725.0	1495.0	97%	87%	1035.0	1115.5	1725.0	1529.5	108%	89%	998	2.8	3.0	0.0	0.0	5.8
MSK	CMTC	1035.0	1243.0	690.0	770.5	120%	112%	690.0	678.5	690.0	356.5	98%	52%	313	6.1	3.6	0.0	0.0	9.7
W&C	C20	1031.8	846.5	795.0	620.5	82%	78%	690.0	690.0	0.0	0.0	100%	NA	145	10.6	4.3	0.0	0.0	14.9
W&C	Ward C23	1380.0	1104.0	690.0	609.5	80%	88%	690.0	517.5	690.0	667.0	75%	97%	662	2.4	1.9	0.0	0.0	4.4
W&C	Birth Suite	2070.0	1932.0	345.0	253.0	93%	73%	2070.0	1874.5	345.0	276.0	91%	80%	316	12.0	1.7	0.0	0.0	13.7
W&C	The Nest	690.0	391.0	345.0	276.0	57%	80%	690.0	425.5	345.0	230.0	62%	67%	12	68.0	42.2	0.0	0.0	110.2
W&C	Ward B11	2907.0	2700.7	950.0	875.0	93%	92%	1564.4	1553.6	312.0	312.0	99%	100%	288	14.8	4.1	1.4	0.5	20.8
W&C	NNU	1782.5	1328.5	356.5	277.5	75%	78%	178.5	1151.5	356.5	299.0	645%	84%	321	7.7	1.8	0.0	0.0	9.5
UEC	Ward A1	2219.8	2367.4	2105.0	2090.0	107%	99%	1591.9	1499.2	1278.3	924.3	94%	72%	922	4.2	3.3	0.0	0.0	7.5
UEC	Ward A2	1392.3	1388.3	1749.7	1486.8	100%	85%	1019.2	910.5	1005.8	866.4	89%	86%	860	2.7	2.7	0.0	0.0	5.4
UEC	ED	6301.9	7132.7	2917.3	2007.8	113%	69%	4379.6	5513.9	1840.7	1629.2	126%	89%						
MC	ACCU	2451.7	2281.4	1035.0	1048.5	93%	101%	1725.8	1706.8	1035.0	1162.5	99%	112%	717	5.6	3.1	0.0	0.0	8.6
MC	ICU	4830.8	4818.5	1035.0	856.8	100%	83%	4830.0	4818.5	1035.0	856.8	100%	83%	537	17.9	3.2	0.0	0.0	21.1
MC	Ward A7	1725.0	1842.3	1473.5	1832.8	107%	124%	1379.0	1765.5	1034.0	1310.0	128%	127%	714	5.1	4.4	0.0	0.0	9.5
IM&C	Ward C21	1035.0	897.0	1380.0	1291.5	87%	94%	690.0	690.0	1035.0	1032.5	100%	100%	750	2.1	3.1	0.0	0.0	5.3
IM&C	Ward B14	1035.0	1018.0	1725.0	1515.0	98%	88%	690.0	690.0	1380.0	1322.5	100%	96%	720	2.4	3.9	0.0	0.0	6.3
IM&C	Ward B12	1069.5	1018.5	2415.0	2153.0	95%	89%	690.0	690.0	1794.0	1817.0	100%	101%	630	2.7	6.3	0.0	0.0	9.1
IM&C	Ward B19	1035.0	1058.0	1598.5	1340.0	102%	84%	690.0	690.0	1207.5	1257.5	100%	104%	720	2.4	3.6	0.0	0.0	6.0
IM&C	Ward A8	1702.0	1472.0	1380.0	1345.5	86%	98%	1380.0	1311.0	1035.0	1058.0	95%	102%	1041	2.7	2.3	0.0	0.0	5.1
IM&C	Ward A9	1725.0	1541.0	1725.0	1616.0	89%	94%	1725.0	1345.5	1725.0	1518.0	78%	88%	1054	2.7	3.0	0.0	0.1	5.8
	Total	42870.22	41227.86	29850.92	26739.38	96%	90%	31503.38	32397.45	23318.74	21069.67	103%	90%	13428	4.5	3.3	0.0	0.0	7.9
		= above 100%			= above 90%			= above 80%			= below 80%								

Ward A4	Vacancy - band 0.19 band 5 0.19 band 2 1.46 Sickness rate - short term 6.19% long term 4.29% Managed in line with policy. Action taken - Use of agency and NHSP to fill gaps . WM filling shortfalls in gaps also. Regular meetings with NHSP.
Ward A5 G	Vacancy - nil Sickness rate -short term 3.66% long term 8.38% Action taken - Use of agency and NHSP to fill gaps . WM filling shortfalls in gaps also. Regular meetings with NHSP.
Ward A5 E	Vacancy - band 6 1.0 wte band 5 0.38wte band 2 2.33wte Sickness rate - short term 6.17% long term 1.29% Action taken - Use of agency and NHSP to fill gaps . WM filling shortfalls in gaps also. Regular meetings with NHSP.
Ward A6	Vacancy - band 7 = awaiting start date, band 5 = fully established , band 2 = 3 WTE vacancies awaiting start dates and 2 WTE awaiting recruitment approval Sickness rate - 2.76% ST and 7.95 % Lt Action taken - recruitment for vacant posts, sickness abscence policy followed for all staff, occupational health referrals completed and advice sought from HR for complex cases
CMTC	Vacancy - band 5 = 0 vacancies , band 2 = 0 vacancies, band 3 housekeeper recruited to awaiting start date, ward clerk out to advert Sickness rate - 4.30% ST and 1.13 % Lt Action taken - recruitment for vacant posts, sickness abscence policy followed for all staff, occupational health referrals completed and advice sought from HR for complex cases
C20	Vacancy - 0 Sickness rate - 14% Action taken - OH & Wellbeing support in place in line with Trust Attendance Policy
Ward C23	Vacancy - 2.16WTE Sickness rate - 20.8% Action taken - Absence managed in line with HR/OHWB. All vacancies out to recruitment
Birth Suite	Vacancy - 3.06WTE Sickness rate - 7.2% Action taken - Absence managed through HR/OH. Recrutiment to vacancies in progress
The Nest	Vacancy - 2.79WTE Sickness rate - 7.9% Action taken - Sickness managed with HR/Oh. Vacancies out to recruitment.
Ward B11	Vacancy - (0.33 WTE Band 2) (0.93 WTE Band 5) (0.33 WTE Band 6) Maternity Leave 2 WTE HDU 27 days Sickness rate - Long term 2 WTE Action taken - Vacancies out to recruit to post Band 5 Sickness carried out in line with Trust Attendanace Policy 2 WTE due to resume October
NNU	Vacancy - 1X Band 4 2X Band 6 2 x band 7 Sickness rate - 1 long term sick Action taken - Recruitment process in place
Ward A1	Vacancy - Band 6 x2.89 vacancy. Fully established in band 5, band 4 vacancy funding being used for band 5 overspend Sickness rate - 13.90%. Managed in line with policy. WM filling any shortfalls in staffing. Use of NHSP and agency Action taken - Daily staffing meetings, regular finance meeting and meetings with NHSP
Ward A2	Vacancy - Fully established Sickness rate - 7.35% Managed in line with policy Action taken - Daily staffing meetings. regular meetings with NHSP and finance team
ED	Vacancy - 6.33% Ongoing recruitment Sickness rate - 4.99% managed in line with policy Action taken - Daily staffing meetings, escalation of staffing concerns to senior team. Matrons working clinically, use of agency and NHSP
ACCU	Vacancy - Band 6 2.0 wte Sickness rate - 2.74% Action taken - All managed in line with policy
ICU	Vacancy - 1.53% ongoing recruitment Sickness rate - 5.28% health and wellbeing support. Action taken -
Ward A7	Vacancy - Band 6 0.4 wte, band 5 2.81, band 2 3.75 Sickness rate - 9.93% Action taken - Recruitment plans in progress, all sickness managed with HR and Health and wellbeing
Ward C21	Vacancy - band 5 Band 2 on going recuritment Sickness rate - 5.70% Action taken - sickness managed as per policy band 5 vacancy supported with Nhs p and agency
Ward B14	Vacancy - Band 2 x 3.0 wte Sickness rate - 10.25% STS in month x2 1.0wte on Maternity leave Action taken - sickness being managed in line with attendance policy with HR and OH support recuritment ongoing
Ward B12	Vacancy - Band 2 2.0 wte Sickness rate - 6.88% Action taken - recruitment ongoing sickness LTS x2 all sickness being managed in line with attendance policy & OH & HR support
Ward B19	Vacancy - fully established Sickness rate - 10.25% Action taken - sickness managed as per policy with support from HR & OH
Ward A8	Vacancy - Band 5 x 2.0wte Band x2 2.0wte Sickness rate - 10.9% LTs x2 HCA being managed as per policy Action taken - ongoing recuritment supported by nhs p and agency
Ward A9	Vacancy - Band 5 ongoing recuritment Sickness rate - 4.10% Action taken - Vacancy for Band 5's supported by Nhs p and agency sickness managed as per policy

Warrington and Halton Hospitals International Nurse Recruitment Summary – August 2021

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

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

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

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

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

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

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

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

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

	Arrival (approx)	OSEC Training	OSEC Exam	Arrival to Trust	Booked in WHH accommodation until…	Notes
WWL Cohort 1	December 2020 - 9 nurses arrived in the UK	Commenced early Dec-20	03/02/2021	05/02/2021	04/03/2021	8 of the 9 successfully completed their OSEC Examination; one resit on the 12/02/2021 candidate was successful. All currently on the wards as of 1st March 2021 • Ward A9 x2 • Ward A8x 2 • Ward A5 x2 – moved to K25 due to skill mix on ward • A&E x2 • ICU x1
WWL Cohort 2	January 2021 -9 nurses arrived in the UK	Commenced early Jan-21	25/02/21 x 3 10/03/21x 1 11/03/21 x 4	15/03/2021	2/4/21	OSEC Examination on different dates due to arrivals and availability. All now out on wards from the 5/4/21 • ICU x 2 • Theatres x 3 • A7 x 1 • Ward A6 x2 2 from theatres moved to ICU at their request.
WWL Cohort 3	February 2021 - 12 nurses arriving	Commencing in February/March	20/03/21 x 3 27/03/21 x 2 31/03/12 x 5 09/04/21 x 1	06/04/21	30/04/21	1 nurse arrived in the UK 27/4/21 awaiting OSCE date she will join Cohort 1 of MC for induction. On ward 26/4/21 Wards allocated: • A&E x1 • A1 x2 • A2x 2 • ICU x3 …….2 nurse to follow after OCSE • Theatre x 1 • A4 x 1

	Arrival (approx)	OSEC Training	OSEC Exam	Arrival to Trust	Booked in WHH accommodation until…	Notes
CIRC Cohort 1	26th February 2021 - 13 nurses arrive in the UK	Commencing 08/03/2021	21/04/2021	24/04/21		100% OSCE pass On Wards W/C 17/05/21 Wards Allocated: • A7 x 2 • A6 x 2 • B19 x2 • B4 Day case Halton x1 • Neonate x 2 • A2 x1 • A3 x1 • A8 x1 • A&E x1
CIRC Cohort 2	26th March 2021 - 17 nurses arrive in the UK	05/04/2021	18/05/21 and 20/05/21	22/05/21		16 nurses passed OSCE first attempt. 1 nurse has re-sit 1/6/21 Ward Allocation: • A9x1 • K25 x2 • A&E x1 • ICU x1 • Theatres x1 • B4 Halton x 2 • CMTC Ward x1 • A4 x1 • Endoscopy x2 • C21 x 2 • B12 x 1
The arrival of Cohort 1 and 2 nurses meet the terms of the NHSI funding (30 nurses in the UK by April 2021) which will secure the 210k funding to support the recruitment of these nurses. Weekly programme Board in place to monitor progress and action any changes during the COVID-19 Pandemic and possible delays.						
CIRC Cohort 3	21st May 2021 -8 nurses arrived in the UK	02/06/2021	13-15/07/2021	19/07/21		8 nurses have arrived in the UK - 4 nurses from India are postponed.
CIRC Cohort 4	23rd September 2021 – 12 + nurses arrive in the UK	02/08/2021	09/09/2021	TBC	23 September x 12	As per comments on page 1
CIRC Cohort 5	10TH September 2021 -12 +	20/09/2021	01/11/2021	TBC		As per comments on page 1

	nurses arrive in the UK					

The arrival of the 36 nurses in cohort 3-5 will take place before the NSHI deadline of arrival (end of Nov 21) – all progress monitored at the weekly CIRC programme Board. 1/6/21 this deadline has been expended to December 31st, 2021 due the Covid situation in India.

PROPOSED STAFFING MODEL FOR EXTREME PRESSURES IN PAEDIATRIC SERVICES

The following essential principles for safe staffing levels must always be adhered to:

- Maintaining a consistent staffing level pro rata across all wards and departments. No one ward would be at Red (extreme pressures) status whilst others are Green (low pressures); staff would be redeployed to ensure consistent staffing levels
- Must ensure a Clinical Co-ordinator/Nurse in Charge is assigned to every shift:
  - Wards that do not have a funded supernumery co-ordinator must still ensure a nurse is allocated to this role;
  - Where staffing is at Amber or Red level the Clinical Co-ordinator must be supernumery to provide leadership and supervision to the team
- Must always have the minimum specified number of Registered Nurses (RN) with specialist knowledge of the patient cohort per shift (Ward profile).
- Must record the agreed patient acuity and dependency score every shift for every patient in line with the pre-determined criteria
- Divisions must try to move staff within their own divisions before escalating to the safe staffing huddle and requesting staff from other areas.

6. Ward and Departmental Optimal and Minimum Staffing Levels: Green, Amber and Red staffing models

At all times, the Trust will strive to maintain safe and appropriate staffing levels on all wards and departments in line with the national standards. However it is acknowledged that at times of local, regional or national pressure that staffing levels may need to be reviewed and reduced to lower than the usual optimal level to aim to **keep all beds open** and accessible to children and young people.

The senior nursing team (Ward Managers, Matrons, Heads of Nursing across Cheshire and Mersey Region have been consulted and agreed the optimal and minimum staffing levels. Directors of Nursing are asked to review and agree these optimal and minimum staffing levels that may be employed as outlined in Section 5.1 It is recognised that the minimum staffing model will result in a reduced RN to patient ratio and / or different skill mix compared to national standards. It is recognised that adjusted staffing levels are in response to anticipated or predicted staffing challenges and as such only apply in extreme cases for the winter period, in the event of a pandemic, or in the event of an actual or predicted surge in patients for example RSV. Amber and Red staffing levels should not be considered as the norm and accepted practice.

It is essential to recognise that any specific acuity and dependency has not been accounted for in the Green, Amber and Red staffing models therefore professional judgement must be made at the daily Safe Staffing Huddle - this should increase in frequency when under pressure Whilst acuity is taken into consideration in the funded establishments of some wards, for example a proportion of patients requiring specialist 1:2 or 1:3 care, it is not provided for in all funded establishments. Every inpatient must have a documented assessment of their acuity and dependency on every shift utilising the trusts agreed evidence based workload measurement tool.

Professional judgement and risk assessment will preside over whether staffing levels can remain at the optimal level, whether staff additional to the usual optimal level are required to take account of acuity, or whether any additional mitigation is/can be put in place to reduce staffing to the minimum Amber or Red level. Where beds are not all occupied, staffing levels will be adjusted accordingly pro rata.

The Red minimum staffing model will result in a reduced RN to patient ratio and / or different skill mix where other RN's or Allied Health Professionals (AHP's) are redeployed to inpatient areas. The organisational lead of the Safe Staffing Huddle will authorise staff movement from other wards as required to maintain safe staffing levels. However the requirement to commence redeployment of other staff to wards and departments (for example Clinical Nurse Specialists or Allied Health Professionals) will be invoked following escalation to the Chief Nurse or Director of Nursing and Daily Operational meeting / Gold Command. Staff will be redeployed as much as possible in order to maintain optimal staffing levels albeit a different skill mix and keep beds open and accessible to children and young people.

There may be occasions when despite invoking Red minimum staffing levels and / or deploying staff, that nurse staffing is, or is predicted to be lower that the agreed Red minimum staffing level and skill mix on a ward or wards.

In such circumstances, ward staffing will be reviewed at the Safe Staffing Huddle by the lead and the appropriate Ward Manager and / or Matron.

However in some circumstances it may be risk assessed as **acceptable to tolerate a level of staffing lower than the minimum staffing level agreed for that shift only** to keep all beds open **based on the professional judgement and risk assessment of the senior nurses**, taking account of acuity, skill mix and the presence of other staff (for example Student Nurses, HCA's, AP's ,PA's ANPs).

As any such action would reduce staffing to lower than the agreed Red minimum staffing level, **the proposed reduced staffing level must be discussed with and authorised by the Chief Nurse or Deputy in hours.**

In the event that reduced staffing levels are proposed out of hours, **the on-site senior nurse who has used professional judgement and assessed the risk to inform this proposal must discuss with, and seek authorisation from, the second on call Executive to proceed to lower staffing levels.** It is anticipated that this will be an unusual occurrence as robust staffing plans and associated decision making will take place in hours at the Safer Staffing Huddle. **Where there is any doubt regarding the safety of reducing staffing levels below the agreed Red minimum staffing level then this should not be authorised** and alternative action (for example the closure of beds) would be taken in line with the Action Card, section 5.1.

5.1 Ward / Departmental Staffing Pressures Action Card

The table below outlines the scenarios, triggers, actions and authorisation to be undertaken in response to low, moderate, severe or extreme staffing pressures.

Ward / Departmental Staffing Pressures Action Card		
Low pressure (GREEN)		
Trigger and impact	**Actions**	**Staff responsible**
Ward staffing numbers: Optimal staffing numbers per ward; or a minimal reduction in staffing compared to the number and acuity of patients and / or the planned duty roster and **Patient acuity & dependency:** Within usual expected range for the area(s) **Overall Trust position:** Shortfall **adult pressures** **Situation:** Business as usual; short term staffing pressure predicted for 1-2 shifts that can be actioned to resolve. Staffing available **considered sufficient to maintain patient safety** and services in line with national standards. **All beds open** **Trust staffing level: Green staffing model**	1. Nurse in Charge (NiC) allocated to act as shift co-ordinator; NiC is not allocated patients to care for directly (only exception is small wards / units as per Appendix x)	Nurse in Charge
	2. Ensure the acuity and dependency of every patient is scored and recorded (SCAMP)	
	3. Review of nursing rota to ascertain whether staff shifts can be changed to accommodate the need for additional staffing where there is a shortfall (for example due to short term sickness)	
	4. Review NHSP and request shifts as appropriate	
	5. Forward look at staffing for next 48 hours at least	
	6. Staffing reviewed at daily Safer Staffing huddle: staff deployed from another ward as appropriate	Safer Staffing lead
	7. Welcome, orientation, local induction, handover and support to staff deployed to assist on the ward	Nurse in Charge
	8. Forward look at staffing for at least next 7 days	Ward Manager
Moderate pressure (YELLOW)		
Trigger and impact	**Actions**	**Staff responsible**
Ward staffing numbers: A moderate reduction in staffing compared to the number and acuity of patients and / or the planned duty roster **and /or** **Patient acuity & dependency:** Increased from that usually expected	1. Actions as per Low Pressures plus:	Nurse in Charge
	2. Ensure any ward / departmental staff on a non-clinical day are deployed to clinical duties in the "numbers" eg staff undertaking management time	
	3. Review the nurse to patient ratio is appropriate in line with Trust standards, patient acuity and	

e.g. requiring increased clinical observation levels or other staff intensive interventions **Overall Trust position:** Shortfall **affecting 2 areas – may include neonatal or ED or** adult pressures - net impact of invoking levelled staffing across the Trust equals moderate pressures across the Trust **Situation:** Predicted short to medium term increase in pressures. Lower levels of staff available but are **considered sufficient to maintain patient safety** and services through the application of professional judgement and risk assessment although **not compliant with national standards. All beds open** Critical skills deficit – eg IV competent **Trust staffing level**: If resolved in line with Low Pressure: **Green staffing model.** If unresolved: **Amber staffing model**	dependency, and the presence and impact of parents assisting in care	
	4. Ensure student nurses and HCAs are appropriately allocated to the care of patients under the supervision of a registered nurse	
	5. Review the skill mix requirement for example whether a RN shift can be safely covered by a Nurse Associate / Assistant Practitioner / HCA – CONSIDER B AND C STAFFING GROUPS	
	6. Identify possible discharges and work with the medical team to expedite	
	7. Inform the Ward Manager / Matron of situation and actions taken and escalate any unresolved issues	
	8. Request additional NHSP bank shifts; Consider shorter or unusual shifts to cover hours of peak activity (eg IV administration), twilight shifts or to fit in with staff availability (eg school hours).	Ward Manager
	9. Postpone / cancel non-essential activities until situation is resolved. Review and consider cancelling study leave as appropriate	
	10. Effective communication of the staffing plan to Daily Operational meeting; site manager and on-call team. Safer Staffing leads and Clinical Site Co-ordinator remain responsible for co-ordinating safe staffing plan and any deployment of staff	Safer Staffing lead
Severe pressure (AMBER)		
Trigger and impact	**Actions**	**Staff responsible**
Ward staffing numbers: A reduction in staffing compared to the number and acuity of patients and / or the planned duty roster which cannot be met in the short term by deployment of staff from other areas or by Bank staffing Significant reduced staffing numbers in areas where this causes increased pressure on patient flow and / or bed availability	1. Actions as per Low / Moderate Pressures plus:	Ward Manager / Nurse in Charge Ward Manager
	2. All non-essential tasks are suspended – specifics agreed by Ward Manager / Matron / Nurse in Charge.	
	3. Ensure all clinical staff are in the numbers	
	4. Review and cancel study leave as appropriate	
	5. Review the staffing model on the ward and consider allocation of tasks ie the RN allocated is	

Staff absence 10-17.5% of establishment **and/or** **Patient acuity & dependency:** Significantly increased from that usually expected – HDU surge	supported to deliver care by student nurses and HCA's	
	6. Practice Educator works clinically supporting student nurses and ward staff	
	7. Ward Manager works clinically supporting the team	
Overall Trust position: Shortfall **affecting 2 areas or wards – may include neonatal or ED or** net impact of invoking levelled staffing across the Trust equals severe pressures across the Trust	8. Staffing reviewed at daily Safer Staffing huddles: Review of overall dependency and acuity of patients across the Trust and skill set required to safely nurse all patients across the Wards - can staff be deployed from another ward area to either increase the nurse staffing number on shift; or improve the skill mix on shift (staff exchange)	Safer Staffing lead
	9. Deploy specialist teams to undertake clinical tasks as appropriate for example IV team assist with IV medications	
Situation: Predicted medium term increase in pressures. Significantly lower levels of staff available but are **considered sufficient to maintain patient safety** and services in line with the Amber staffing model and through the application of professional judgement and risk assessment although **not compliant with national standards. All beds open**	10. Remove the Golden Key from NHSP to escalate shifts to agency providers	
	11. Review supportive measures in order that beds remain fully open and accessible across the Trust based on predicted demand and activity. For example this may mean that staffing and beds are flexed within a shift particularly at night where escalation beds may be required and / or the staff follow the patient	
Trust staffing level: Amber staffing model	12. **Invoke of Amber staffing model:** Where the actions above do not resolve the staffing issues, review the staffing levels in line with the Ward and Departmental Optimal and Minimum Staffing Levels of staffing levels **IMPORTANT:** • Must escalate situation to the Chief Nurse / Deputy and that Trust activating Amber staffing model • Must escalate situation to daily Operational Meeting inclusive of Hospital Manager of the Week; 1st on call manager; Associate Chief Operating Officers; clinical site co-ordinator • Must ensure that the essential staffing principles are adhered to • The application of professional judgement must be applied • Must review the minimum staffing level in line with the documented acuity of individual patients which may not be accounted for in the model	

	14. Where Trust-wide Amber staffing is predicted to or actively continues for longer than 48 hours this must be formally reviewed by the Chief Nurse or Director of Nursing to review patient safety, quality of care, staff health and wellbeing and sustainability and formally agree that the Trust can safely continue at Amber staffing. A Quality Impact Assessment must be completed daily	Chief Nurse
Extreme pressure (RED)		
Trigger and impact	**Actions**	**Staff responsible**
Ward staffing numbers: A significant reduction in staffing compared to the number and acuity of patients and / or the planned duty roster which cannot be met in the short term by deployment of staff from other areas or by Bank staffing Significant reduced staffing numbers in areas where this causes increased pressure on patient flow and / or bed availability Staff absence >17.5% of establishment **and/or**	1. Actions as per Low / Moderate / Severe Pressures plus:	Ward Manager / Matron / Nurse in Charge
	2. Cancel all study leave if not already done so	
	3. Matron works clinically supporting the team	
	4. Review the effectiveness of the nursing model and consider whether task allocation safe and appropriate	
	5. Individual patient acuity/dependency will be reviewed by MDT and care plan amendments or onward referral agreed where required	
Patient acuity & dependency: Significantly increased from that usually expected across majority of wards	6. Dynamic reviews and robust action planning of local situation with ACN to address predicted medium to longer term staffing pressures	Associate Chief Nurse / Safer Staffing lead
Overall Trust position: Affecting **more than 3 wards or areas including neonatal and ED** net impact of invoking levelled staffing across the Trust equals extreme pressures across the Trust **Situation:** Predicted medium term increase in pressures. Significantly lower levels of staff available but are **considered sufficient to maintain patient safety** and services in line with the Red staffing model and through	7. Staffing reviewed at daily Safer Staffing huddles: Review and deploy additional nursing support as available and appropriate from CNS's and ANP's	Safer Staffing lead
	8. **Invoke Red staffing model:** Where the actions above do not resolve the staffing issues, review the staffing levels in line with the Ward and Departmental Optimal and Minimum Staffing Levels and activate the Red staffing model Trust-wide to ensure parity of staffing levels **IMPORTANT:** • Must escalate situation to the Chief Nurse / Deputy in hours or Executive on call out of hours to inform that Trust activating Red staffing model and gain authorisation to proceed	

the application of professional judgement and risk assessment although **not compliant with national standards. All beds open. Where extreme staffing pressures are predicted to continue for longer than 24 hours, activity and bed availability must be reviewed** **Trust staffing level: Red staffing model**	• Must escalate situation to daily Operational Meeting inclusive of Hospital Manager of the Week; 1st on call manager; Associate Chief Operating Officers; clinical site co-ordinator • Must ensure that the essential staffing principles are adhered to • The application of professional judgement must be applied • Must review the minimum staffing level in line with the documented acuity of individual patients which may not be accounted for in the model • Must ensure consistent staffing level pro rata across all wards and departments. **No one ward would be at extreme pressure whilst others are at moderate pressure**	
	9. Where Trust-wide Red staffing is predicted to continue for longer than 24 hours this must be formally reviewed by the Chief Nurse or Director of Nursing to review patient safety, quality of care, staff health and wellbeing and sustainability and formally agree that the Trust can safely continue at Amber staffing. A Quality Impact Assessment must be completed	Chief Nurse
	10. Where staffing is reviewed at the Safer Staffing Huddle by the Chair and the appropriate Ward Manager and / or Matron, and it is risk assessed and agreed that the set Red minimum staffing level can be reduced further **for that shift only** based on professional judgement, acuity, presence of other staff (for example Student Nurses; ANPs) then the proposed further reduced staffing level must be discussed and authorised by the Chief Nurse	Chief Nurse / Safer Staffing lead
	11. Escalate the situation and predicted timescale of pressure to the Chief Operating Officer. Review of planned elective activity and bed capacity is undertaken in line with the Trust Escalation Scenario and Response Framework. Sustained requirement to remain on the Red staffing model may result in the closure of beds based on dynamic Risk Assessment of local and system pressures and Quality Impact Assessment	Chief Nurse / Chief Operating Officer
	12. Deploy staff from other services in line with Divisional plans to reduce services in response to Trust Escalation Scenario and Response Framework for example Research nurses and AHPs; seek	Chief Nurse / Chief Operating Officer / Divisional Triumverates

	agreement and authorisation to redeploy staff from other services in liaison with Divisional leadership team	
	13. Escalate to Gold Command and activate regional mutual aid arrangements	Chief Nurse / Chief Operating Officer

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/155 a**	
SUBJECT:	**Safe Staffing Report**	
DATE OF MEETING:	23 November 2021	
AUTHOR(S):	Ellis Clarke, Lead Nurse for Nurse Staffing & Workforce Improvement	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	 *
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	BAF2.2: Nurse Staffing BAF2.5: Right People, Right Skills in Workforce BAF2.1: Engage Staff, Adopt New Working, New Systems	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper details the October 2021 review of nurse staffing in line with the commitment requested by the National Quality Board in 2016 and more recently in the Improvement Resource for Adult Inpatient Wards in Acute Hospitals January 2018. The report provides transparency and assurance with regard to the management of the nursing and midwifery staffing response at Warrington and Halton Teaching Hospitals (WHH). • The report provides an overview of the current nurse staffing workforce data, including numbers of staff in post, turnover of staff, recruitment initiatives such as the international nurse recruitment programme and investment in Emergency Department nurses. • The report represents the review data from the SafeCare acuity and dependency system • The report demonstrates that our budgeted nurse staffing WTE (whole time equivalent) is comparable to the safe care census data requirements. Improvements have been made in the overall nurse staffing establishments enabling the Trust to meet the SafeCare acuity requirement. • There has been a significant reduction in the number of registered nurse vacancies in 2021. • Care Hours per Patient Day (CHPPD) is the national reporting metric for safe staffing levels. The average CHPPD between April and Septmeber 2021 is 7.9. • The report includes a detailed analysis of the paediatric and maternity staffing review for the last 6 months. • The report demonstrates the progress that continues to be made across the organisation in nursing and midwifery staffing.	

PURPOSE: ***(please select as appropriate)***	Information *	Approval	To note *	Decision
RECOMMENDATION:	It is recommended that the Trust Board review the progress to date and receive the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	**Quality Assurance Committee**		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Safe Staffing Review – October 2021	AGENDA REF:	BM/21/11/155 a

1. INTRODUCTION

Nurses, Midwives and Allied Health Professionals (AHPs) are the largest collective workforce in the Trust. The unique contribution of these highly specialised professionals is delivered through a shared vision which when combined with our Trust values and our pride and professionalism is what makes Warrington and Halton's Nurses, Midwives and AHPs outstanding. This paper describes the safe staffing governance currently in place. This review of nursing and midwifery staffing is in line with the commitment requested by the National Quality Board (NQB) document, 'Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time – safe and sustainable staffing ' (2016) in response to the Francis Enquiry (2013). The NQB guidance has been further refreshed, broadened and re issued in January 2018 with the provision of 'An Improvement Resource for Adult In-patient Wards in Acute Hospitals' which recommends that Boards should carry out a strategic staffing review at least annually. At this Trust, a staffing review is carried out every year, with meetings between the Ward Managers, Chief Nurse and Deputy Chief Executive to discuss and sign off all establishments. The acuity data is taken from the SafeCare system, this year we reviewed data from June and October.

All ward sisters/charge nurses, matrons and lead nurses participate in the acuity and dependency review process. The consistency of the census data has been confirmed with the ward teams by the Lead Nurse for Nurse Staffing.

2. WORKFORCE INFORMATION

2.1 Staff in post

Chart 1 below illustrates the total number of budgeted registered nursing and midwifery staff in post by month from October 2020 to September 2021. Chart 1 indicates the number of staff in post which has shown an increase in the overall whole time equivalent in the last year with the highest whole time equivalent of 1053 nurses and midwives in post in September 2021.

Chart 1

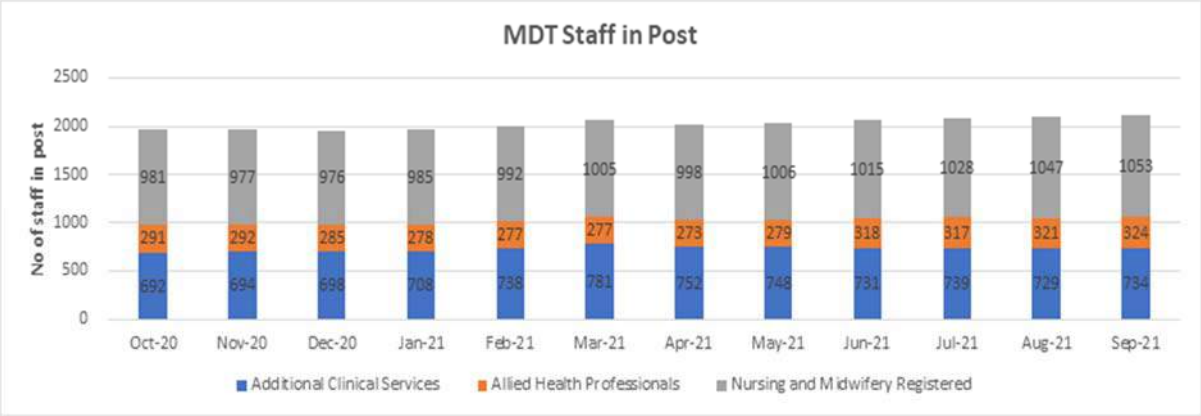
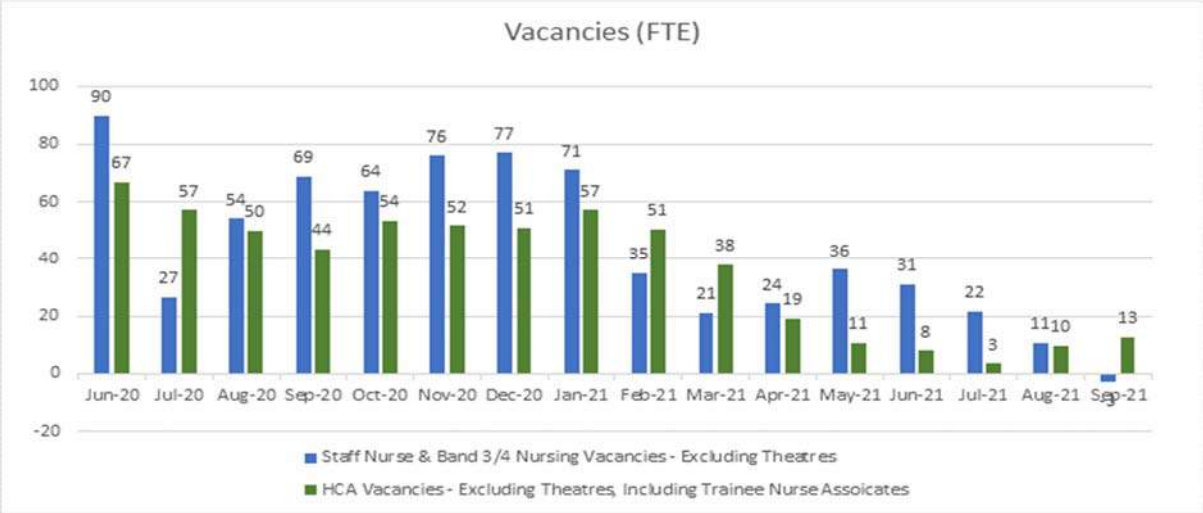


Chart 2 identifies the number of band 5 Registered Nurse (RN) and band 2 Health Care Assistant (HCA) vacancies based on the funded establishments against the number of staff in post (excluding operating department practitioners in Theatres). We have seen a gradual reduction in the number of nursing vacancies over the last year. September 2021 reports a negative vacancy figure of 3 whole time equivalents which is the lowest registered nurse vacancy number in the last 12 months. This was achieved by the recruitment of international nurse and the September 2021 cohort of student nurses. There was a brief period with an excess of RNs this was consumed with turnover. In October we have a small number of vacancies on the general wards and have opened an escalation ward for the winter period. Note: Following investment additional staffing in the Emergency Department and the Acute Respiratory Unit on B18 the vacancy figure will rise in October. These developments is being supported by a significant recruitment campaign for experienced staff.

Chart 2



Vacancies in Theatres are separated from the chart, this is because they are for Operating Department Practitioner (ODP) staff. At the time of the report there are 8 vacancies for Band 5/6 staff and 3 vacancies for HCAs.

The Trust reported a consistent number of HCA vacancies for the year up to February 2021. At this point the Trust received funding from NHSI to enhance HCA recruitment and pastoral support in the clinical areas. In April 2021 we had zero band 2 HCA vacancies following a successful campaign to fill all posts by the end of March 2021. There is further work now to maintain this low vacancy position with additional funding already identified. A smaller recruitment campaign is in progress to fill the 13 vacancies identified in September plus any further staff lost to turnover since then.

2.2 Staff turnover

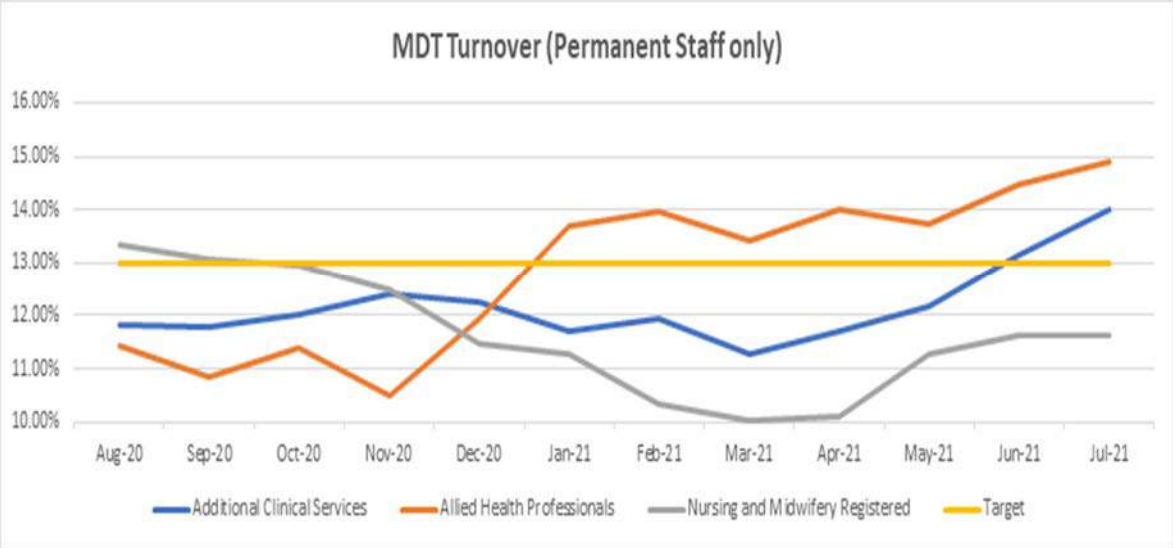
Chart 3 illustrates nursing and midwifery turnover which saw a gradual improvement from August 2020 to a low of 10% in March followed by a small increase in May. In September the turnover figure for RNs was 12.59%

Additional clinical services turnover includes health care assistants and is noted to show a significant increase in July 2021 to 14% compared to 11% in March, however it should be noted that in June 2020

we saw a turnover rate in this group of 23%. As turnover data is recorded as a 12 month average it will take some months before we see an overall reduction in the additional clinical services line.

Monthly progress updates on staff turnover reduction continue to be provided to the workforce a review group chaired by the deputy chief nurse.

Chart 3



2.3 Recruitment and Retention

The Nursing Recruitment and Retention Strategy is being delivered alongside a programme for international nurse recruitment. An innovative recruitment campaign continues with flexible working plans as one of the initiatives on offer.

A small waiting list of registered nurses was created this summer. These staff have been interviewed and as soon as a vacancy became available they were offered the post. The Trust continues to work with local universities to offer posts to nurses in training as much as 2 years from qualification. As previously reported in September we were able to report that all Band 5 RN vacancies had been filled.

2.3.1 International Nurse Recruitment

Warrington and Halton Hospitals are part of two International Nurse recruitment collaborations to recruit a total on 96 nurses by October 2021. The collaborations are summarised below.

Wigan Wrightington and Leigh (WWL) – After a successful Business Case and agreement to recruit 30 nurses as part of this collaboration. WHH were also successful in receiving £47k in NHSI funding to support the recruitment of these 30 nurses.

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

All the nurses arrive at their accommodation at the Crewe University Campus or in one of the designated government quarantine hotels, for arrivals from red zone countries, where they spend the first 2 weeks in quarantine and then commence their OSCE training (in their bubbles). Following the successful completion of their OSCE examination they can apply to be registered with the NMC. We have accommodation available for the nurses on the Halton site for the period that they are undertaking their clinical induction and information on local rental providers to help secure them accommodation in the Warrington area ready for them joining the ward teams. Accommodation across our region is challenging at this time, but with support of HR support all of our nurses at this time have found accommodation or have short term accommodation within the hospital.

Between 30th April and July 2021 the UK Government put a hold on all international recruitment from India, due to the ongoing crisis of the Covid-19 pandemic in that country. This affected Cohort 3 of CIRC with only 8 nurses arriving in May 2021. Following the lifting of the restriction numbers for the next 2 cohorts were increased to 14, to ensure WHH recruited the required number of nurses.

2.3.2 International Nurse Recruitment Pastoral Support

We have a designated practice educator and a matron who lead on the WHH welcome and pastoral support for these new nursing recruits. Pastoral support is recognised as a really important part of the international nurse recruitment process in order to help the nurses settle into the UK and their local Trust / community. As such we are currently working with colleagues across the Trust to ensure that we have everything in place for their arrival which includes some of the following:

- Welcome pack
- Health and Well-being pack
- Local information including accommodation, community groups, transport links and amenities.

The team are organising a treasure hunt around Warrington to help them find key places of interest and bring some light hearted fun on their arrival.
- The BAME network chair is also going to visit the nurses in Crewe and offer the network support on their arrival in the Trust.

2.3.3 Emergency Department Service Development

The Emergency Department is increasing nursing staff by 10.52 WTE to support the care of patients in the Majors 2 and Ambulatory Care areas.

This staffing increase will enable majors 2 to continue to be staffed safely with 2 registered nurses per shift in the day and 1 registered nurse and 1 healthcare assistant per shift in the night.

Additional nursing staff within the ED will support the existing substantive staff to manage the increased demand and the acuity of patients. This will reduce some of the pressure existing staff are facing, improving the health and wellbeing of the workforce and ensure the pateints are safe in our care.

In September and October we are encouraging nurses to join their best ever work family with a recruitment drive for the new posts as well as existing vacancies. An open recruitment day at the Village Hotel is going ahead onThursday 28th October alongside a raft of publicity in the press and on social media.

2.4 Escalation Beds and Associate Costs

B3 at Halton has been open throughout 2021, this ward for medically fit patients, whilst funded does not have substantive staff in place. The patients are cared for by Trust staff moved from other wards, both short and long term, alongside temporary staff from NHS Professionals and other agencies.

Following the opening of the new respiratory unit on B18 in October, there has been a reconfiguration within the Integrated Medicine and Community Care wards. This has meant increased capacity and the wards have initially not required an uplift in staffing. This will be reviewed in the next report.

Critical Care have escalated their capacity throughout 2021. They have utilised the beds in the Unit, escalating the level of care for patients flexibly to accommodate surges in the critically ill affected by COVID and other emergency cases. The recovery programme for elective patients has meant that there are also post operative patients requiring critical care. 10 international nurses have been recruited for ICU and they have also managed to fill all other vacancies with newly qualified preceptees. All are supported by a structured induction programme led by the ICU Practice Educator. It has also been necessary to augment staffing with temporary nurses from NHS Professionals and all agencies. A robust process is in place for usage of any off framework nurses in this area.

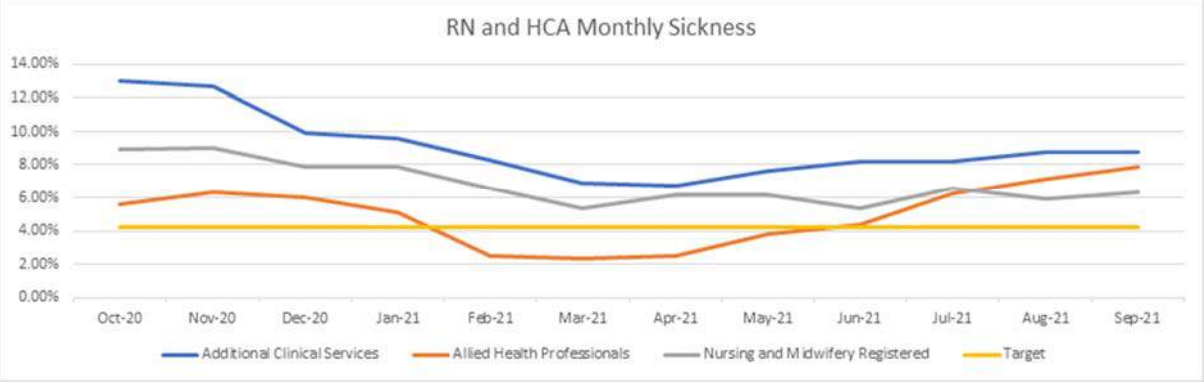
The Emergency Department has expanded their capacity to include Majors 2 and overnight in Ambulatory. These areas will be staffed substantively going forward, however during 2021 this has been managed with temporary staffing.

There are also a number of areas that are used at times of increased demand. These include rooms wards A4 and A5 for treatments such as dressings or wound drains, as well as the discharge lounge.

2.5 Sickness Absence

Sickness absence levels for registered nurses and health care assistants has been above the Trust target of 4.2% during the year which impacts on the overall staffing available in the Trust.

From the chart below it is clear that sickness absence has remained above the threshold during 2021. The level did improve from the peak in October 2020 but remains at 8% for HCAs and just below 7% for RN & RM. Any shortfalls in staffing are reviewed and managed daily at the operational staffing meetings chaired by a Lead Nurse to ensure all wards and departments have sufficient staff to meet the acuity and activity needs of the wards. The estimated cost of sickness absence for nurses is reported each month in the Safe Staffing Board Report.



3. EVIDENCE BASED STRATEGIC WORKFORCE PLANNING

There must be sufficient and appropriate staffing capacity and capability on inpatient wards to provide safe, high quality care to patients at all times. Nurse staffing levels are determined by using a range of metrics. Warrington and Halton Foundation Trust use four factors as follows:

- Using systematic evidenced based acuity data utilising the Safe Care data from the e-rostering system
- Benchmarking with Peers for example Care Hours per Patient Days (CHPPD) through the Model Hospital.
- NICE Guidance and 1:8 minimum staffing: patient ratios
- Professional judgement

Each of the above methodologies are used to ensure that we have consistent evidence based approach to determining the required establishments for each ward.

3.1. Evidence Based Acuity Data

The Trust operationally utilises the SafeCare function within the Allocate E-Rostering system to collect acuity and dependency data twice daily for all wards. SafeCare uses the same dependency scoring as the Safer Nursing Care Tool (SNCT). This is an evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a 'staffing multiplier' to ensure that nursing establishments reflect patient needs in acuity/dependency terms. The data has previously been manually collated for a two week period twice a year; however we are now able to access the information on a daily basis from the SafeCare module in the electronic system. The data is inputted twice daily. The senior nursing team review the data twice daily to ensure appropriate escalation plans are in place to support staffing decisions to meet the needs of the operational demands so that high quality care can be provided on inpatient wards.

3.2 Acuity Data

It should be noted that the SafeCare tool does not differentiate between qualified and unqualified staffing hours and as such requires a very good understanding of the patient groups and nursing requirements. Professional judgment is also an important and essential factor to be considered when making decisions about staffing establishments.

Overall the SafeCare results demonstrates the acuity of the patients at the time of the survey indicated we required 651.41 WTE against a budgeted nursing staff wte of 669.95. This represents a difference of 18.54 WTE. The survey is an average of the acuity and dependency of the patient group over the month of June 2021. It is important to note that B3 – 27 beds at Halton which were open at the time of the data collection did not have a fully funded establishment for nursing staff. Staffing requirements for ward B3 were achieved by a combination of transferring substantive nurses from other wards as well as the use of temporary staff from NHS Professionals. Some wards are showing a positive staff position however there are a number of other considerations that impact on staffing which is detailed below.

3.2.1 Variance

Three wards entering data during the census showed as having more staff than required when viewing the data.

Acute Medical Unit (AMU) – this ward is an assessment area, the acuity/dependency test provided by SNCT does not reflect the patient profile. The patients are in the earliest phase of their stay and the instability cannot be quantified into Care Hours Per Patient Day accurately with the general ward assessment.

B4 and Capt Sir Tom Moore Ward – B4 is currently caring for day case patients and CSTM ward has mixed patient profile of day cases and inpatients. The SNCT cannot adequately measure the required CHPPD for these patients.

A6 – During June it was noted that this ward had been recording their patient levels incorrectly. At the time the ward manager was absent (long term). When the data was reviewed the ward staff were advised of the mistake and this was addressed. In June it appeared that the ward required an extra 30 WTE. With a corrected approach to the levels of care the data now reflects the staffing establishment.

3.3 Ward Changes – Move to Safer Nursing Care Tool

In February 2021 there was a reconfiguration of the planned care wards. This was followed by the staff groups in 5 medical wards. The changes to patient numbers and acuity will be assessed using the formal Safer Nursing Care Tool (SNCT) in 2022.

3.4 Staffing Escalation Assurance

Twice a year there is an audit of the staffing escalation process. The aim of the audit is to ensure that the staffing escalation plans are utilised effectively, are fit for purpose and determine the awareness and impact of the current Trust process at ward and departmental level

An action identified by the Care Quality Commission (CQC) in their 2017 inspection of the Trust was to ensure that there were staffing escalation plans in place across the Trust and that these are audited to assess effectiveness and compliance.

The Trust has a duty to ensure that all wards and departments are staffed with the appropriate number and skill mix of nurses. Nurse staffing levels have been set using nationally recognised methodologies and the Trust is committed to ensuring that there are the right number and skill mix to care for our patients safely, and to effectively utilise our workforce through efficient resource allocation.

Where shortfalls in nurse staffing are identified, the Trust has a staffing escalation process for assessing and managing and recording nurse staffing levels across the Trust on a shift by shift basis.

The National Quality Board paper, Safe Sustainable and Productive Staffing (2018) recommends that organisations should ensure that they have appropriate staffing escalation processes in place as part of their expectations and framework for nurse staffing in adult inpatient wards in acute hospitals.

The most recent audit was February 2021, for the 3rd time the results demonstrated a high level of assurance for the escalation process.

Following the recent changes to medical wards the next audit will take place in November.

4. WORKFORCE DEVELOPMENT

4.1 COVID-19:

On the 14th January 2021, the Nursing and Midwifery Council (NMC) released a statement advising that in response to a request from the Secretary of State, the NMC had agreed to reintroduce emergency education standards for final year nursing students, so that they can support the response to Covid-19. The emergency standards enabled final year nursing students to opt in to undertake a paid clinical placement while the emergency standard is in place. The placements counted towards the clinical hours required for their programme of education however, students did not retain their supernumerary status. Thirty-four final placement student nurses responded, bringing their skills and experience to support the Trust during the last wave of the pandemic.

In December 2020, the Trust commenced the COVID-19 Vaccine Clinic. In total at the 30 June 2021, 127 vaccinators have completed the training required to undertake the role which includes six vaccination specific e-learning modules, anaphylaxis training and resuscitation training.

4.2 New roles:

The table below provides an overview of developments relating to new roles:

Programme	Update
Advancing Practice	we have received confirmation from Health Education England that we have been allocated training grant funding to support 6 Trainee Advanced Clinical Practitioners (4 across Acute Medical Unit and Combined Assessment Unit, 2 for Haematology).
Specialist Community Public Health Nursing	we have received confirmation from Health Education England that we have been allocated training grant funding to support one Specialist Community Public Health Nursing - Occupational Health trainee commencing September 2021.
Trainee Nursing Associates	we are currently recruiting for the next cohort of eight Trainee Nursing Associates to commence programmes in September 2021.

4.3 Health Education England Continuing Professional Development Funding:

We have received confirmation of the 21/22 allocation that we will receive in line with the announcement of £150m increased investment in continuing professional development (CPD) for nursing associates, nurses, midwives, and allied health professionals (AHPs). Our final allocation for 21/22 is £470,666 and we are required to submit an investment plan to HEE by the 30 July 2021. The allocation is calculated upon workforce headcount data (Dec 2020). This funding is an investment solely for CPD and cannot be used for funding backfill or mandatory training. We are currently undertaking a training needs analysis to support the development of the investment plan.

4.4 International Nurse Recruitment Induction and Preceptorship

Warrington and Halton Hospitals are part of two International Nurse recruitment collaborations to recruit a total on 96 nurses by October 2021. At the 30 June 2021, 62 international nurses have arrived at WHH. The Clinical Education teams have been supporting this initiative by providing a 3-week preceptorship induction programme (5 x 3 week programmes have been facilitated to date. We have also planned development days for their first 12 months in the Trust as part of their continued preceptorship. Two Clinical Educators have been recruited utilising NHSI funding to provide ward based support to the new recruits and their wards/departments.

4.5 Health Care Support Worker (HCSW) Induction

NHSE/I funding was made available to the Trust from which we have developed targeted recruitment campaigns and pastoral support with the aim of reducing the number of HCA vacancies. The overarching objective was met with the Trust reporting 0 Band 2 vacancies in April 2021 and a reserve list of new starters was initiated. As part of this process the induction programme for HCSWs was redesigned to more effectively prepare our HCSW's for their new roles and to support their retention.

Week 1	
Day 1 Monday	Introduction In Hospital Life Support Moving & Handling – People Moving Falls prevention and management Riverside apprenticeship sign-up Smartcards and ID badges E-Learning Time
Day 2 Tuesday	Basic PPE Fundamental skills of patient care Last Offices
Day 3 Wednesday	Infection Control Level 2 Video Palliative Care E-Learning Time Vaccinations if appts available
Day 4 Thursday	Patient documentation HCSW Skills Passport New Starter Buddy Form Smartcards & ID badges (if not yet received) Practice introduction day
Week 4	
Day 5 Thursday	Clinical Skills Day Physiological Observations Catheter Removal Cannula Removal Competency Booklets

Day 6 Friday	Counselling Service Session Resilience NHSP Career Development Clinical Supervision Programme evaluation

5. WOMEN AND CHILDREN

5.1. Paediatrics

Nurse staffing levels for Paediatrics, including Paediatric Emergency Department, are based on Royal College of Nursing (RCN) Standards from the document 'Defining Staffing Levels for Children and Young People's Services: RCN Standards for Clinical Professionals and Service Managers (July 2013)'. This supports assessing acuity with numbers of staff on shift, patient acuity and dependency needs. Paediatrics use an adapted acuity tool from the Shelford model. Patient acuity levels are monitored at 3 different time points through a 24 hour period against staffing levels on the main ward B11. Acuity and dependency of the patients on the Paediatric wards was monitored over a 4 week period in June 2021 (appendix 6).

During the 4 week monitoring period there were shortfalls of qualified nursing staff identified on the ward at the specific monitoring times. Appropriate action was taken on all occasions with the co-ordinator or ward manager stepping into the clinical numbers during the day. Unfortunately last minute sickness prior to the night shift and a rise in admissions of young people requiring a mental health assessment meant an increase of acuity on the unit overnight, this was escalated appropriately and staffing levels were increased the following nights. Therefore during the monitoring period the paediatric department was safe and had appropriate escalation processes in place to manage the peaks in activity and acuity. Following a recent staffing review, the department now ensures a band 6 is allocated to each shift ensuring an appropriate skill mix.

5.2 Neonatal Unit (NNU)

The Neonatal Unit is commissioned as an 18 cot Local Neonatal Unit supporting intensive care, high dependency and special care baby unit cots.

In January 2021 the NNU opened it's Transitional Care bay on C23. The transitional care environment provides additional support for the newborn at the mother's bedside by the neonatal and midwifery team and aims to avoid the unnecessary separation of mothers and babies.

The criteria for suitability for TC has now changed to include babies from 35 weeks gestation and babies weighing ≥1.8kg.

The guideline for "Transitional Care of the Newborn" has been updated to support the unit and to reflect the changes, this includes staff responsibilities, flowchart of the process and training needs analysis for all staff involved.

Number of Neonatal Unit Cots	18
Intensive Care	3
High Dependency	3
Special Care Baby Unit	8
Transitional Care Cots	4

Neonatal unit capacity is planned in coordination with maternity services and the operational delivery network (ODN). This approach anticipates individual care needs and in utero and neonatal transfers within the region.

Neonatal Unit (NNU) staffing levels are defined by British Association of Perinatal Medicine (BAPM) guidance. BAPM staffing recommendations are assessed at two points during a 24 hour period and recorded on the BadgerNet system, a database that determines workload based on acuity.

The actual number of cot days from 01/04/20 – 31/03/2021 was 2792. This is determined from the number of babies and their category of care in each 24 hour period. It is monitored shift by shift.

Annual Care Level Days April 20 – March 21	BAPAM Criteria 2001	BAPAM Criteria 2011
NICU	270	210
HDU	446	595
SBU	2186	2097

Capacity is planned on an average 80% occupancy to meet the demands of the unpredictable nature of neonatal admissions and intensity of care required.

Neonatal Staffing Requirements are detailed below:

- Special care staffing ratio 1:4 (registered nurses : infants requiring special care)
- High dependency care 1:2(registered nurses : infants requiring high dependency care)
- Intensive care 1:1 (registered nurses : infants requiring intensive care)
- A minimum of 70% of nursing staff should be Qualified in Specialty
- A supernumerary shift leader should be available.

Neonatal Unit Staff: Providing Direct Care Only		
	WTE BUDGET	WTE IN POST
BAND 7	5.78	4.37
BAND 6	10.28	5.68
BAND 5 / Band 5 QIS	10.55	4.94 (QIS)
		5.53 (Band 5)
BAND 4	5.22	5.52

- A minimum of 3 registered nurses (+1 band 6 shift leader) are on duty at any one time
- There is a supernumerary shift leader in addition to those providing clinical care
- 2 Advanced Neonatal Practitioners (ANNP) support the paediatric medical staff during resuscitation situations on Labour Ward and stabilisation of sick infants on the neonatal unit. ANNP provide additional support to medical staffing rota and are not part of the direct care nursing establishment.

In May 2021, utilising an endorsed neonatal nurse staffing tool (Dinning), a staffing review was completed which assisted in calculating neonatal staffing establishment based on 12 months of historical activity workloads according to BAPM's categorisation of care. The review period was 01/04/20 – 31/03/201

The Dinning Tool looks at clinical activity only; a separate professional judgement review is required for staffing numbers for specialist roles, mangers and community outreach teams etc.

Utilisation of both the Dinning Tools and professional judgement has facilitated a small change in establishment to facilitate a band 8a matron post in replacement of a band 7 ward manager. Unfortunately despite advertising this post on numerous occasions the unit have been unsuccessful in recruitment into this post, following discussions with the Neonatal Network it is evident that recruitment within Neonatal Units has been challenging across the region. Following a staffing review in May 2021 it was decided to advertise for a NNU Ward Manger, this is currently out to advert. This role is required to represent the Trust within the Cheshire and Mersey Neonatal Network and at ODN meetings. The ward manager will further support the development of transitional care services which has a separate staffing requirement.

The ODN also use BadgerNet data to monitor and benchmark activity on the ODN dashboard

Dinning Tool Review April 2020– March 2021

Suggested skill mix: total nursing establishment available to provide direct care only.			
	BAPM Recommendations 2011 activity based Includes all staff available to give hands on care. This would include specialist roles		Calculation using Dinning. Clinical staff only providing care Band 7 with specialist role excluded from calculation Dinning calculation for direct care
BAND 7	1.85		-4.43
BAND 6	9.80		-0.48
Band 5 QIS	8.17		3.31
BAND 5	5.86		0.17
BAND 4	3.36		-1.86

The service has taken on board recommendation 22 from the MA Desktop Review and will ensure that this is embedded in practice as per the evidence in this report. In addition recruitment processes have been reviewed and will be strengthened to support ongoing rectuitment.

The NNU staffing establishment ensures compliance with commissioned activity and BAPM guidance making us one of the only units in Cheshire and Merseyside to achieve this standard.

5.2.1 Covid-19 Impact and Response (Paediatrics)

As in other areas of the trust the COVID-19 pandemic has had an impact on Paediatric and Neonatal staffing through sickness absence, redeployment and self-isolation. However, the most significant impact has been as a result of our more clinically vulnerable staff and staff with underlying medical conditions meaning 40% of our workforce on Ward B11 are undertaking restricted duties or being unable to be in a clinical environment. This has also had an impact, along with current vacancies, of the number of QIS (Qualified in Speciality) neonatal nurses.

During the Covid Pandemic the Paediatric staff supported our adult colleagues in many areas of the hospital including the NNU, ITU and the Emergency Department. The Paediatric Emergency Department was relocated to Ward B11 in January 2021 for a period of 4 months to enable the main ED department to utilse the space as an Ambulatory area during the third wave of the pandemic. The Child Health team have utilised staff working from home to support administration duties, developing and updating guidlines and policies and have worked closely with workplace health and wellbing in order to support our more vulnerable staff working from home due to the impact of isolation on individuals mental health.

5.3 Midwifery Workforce Position

The Midwifery staffing report provides a review of midwifery and midwifery support worker staffing levels from 1st November 2020 to 30th April 2021 in relation to the safety and quality of care provided.

5.3.1 Safe Staffing Reviews

The recommended ratio of midwives to women in a maternity service nationally is one midwife per every 28 women (Safer Childbirth, RCOG 2007) and notes that this number should flex dependant on acuity. A full maternity workforce planning review using the nationally recognised Birthrate Plus® workforce planning tool in in progress funded by the Local maternity System. This full review follows the desktop review and audit submission undertaken as part of the Ockenden work programme. Birthrate Plus considers clinical complexity, the number of births, the location of birth and the number of women cared for by Warrington and Halton Teaching Hospitals staff as well as those women who receive care from other providers but who choose to give birth at Warrington and Halton Teaching Hospitals. An additional percentage is added for specialist roles and managers within the service.

The recommended Birthrate Plus® midwifery staffing levels for Warrington and Halton Teaching Hospitals is currently 1:29. The midwife to birth ratio is monitored through the Maternity Internal Dashboard. The maternity service continues to meet the recommended midwife to birth ratio of 1:29 for one to one care in labour.

5.3.2 Monitoring of the Maternity Workforce

Daily staffing review meetings evaluate staffing levels within the department and support redeployment in anticipation of increased capacity or reduced staffing levels.

Matrons, birth suite coordinators and Ward Managers discuss staffing levels daily as part of the Daily Matron Walkaround. A review of unit capacity and acuity is completed to identify risks from women or babies requiring additional monitoring or 1:1 care and the overall staffing: acuity ratio.

Monthly midwifery staffing numbers are reported to NHS England for the inpatient areas; Birth Suite, The NEST (MLU) and Maternity Ward C23.

5.3.3 NHS England Figures Nov 2020 – April 2021

Birth Suite	**Day**				**Night**				
	Registered Midwives		**Care Staff**		**Registered Midwives**		**Care Staff**		**patients**
	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours	patient count at 23:59
Total	**12834.0**	**12196.0**	**2081.5**	**1897.5**	**12834.0**	**12240.0**	**2081.5**	**1854.5**	**1483**

Birth Suite reported an average 95.0% fill rate against planned midwifery staffing levels for day shifts during the 6-month period Nov 2020 to April 2021 and an 95.3% fill rate for nights.

There was an average 91.1% fill rate against planned Health Care Assistant staffing levels during the 6-month period Nov 2020 to April 2021 for day shifts and an 89.0% fill rate for nights.

Maternity Ward C23	**Day**				**Night**				
	Registered Midwives		**Care Staff**		**Registered Midwives**		**Care Staff**		**patients**
	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours	patient count at 23:59
Total	**8326.0**	**7606.0**	**4163.0**	**3835.5**	**4163.0**	**3806.5**	**4163.0**	**3809.5**	**1872**

Maternity Ward C23 reported an average 91.0% fill rate against planned midwifery staffing levels during the 6-month period Nov 2020 to April 2021 for day shifts and an 91.0% fill rate for nights.

There was an average 92.0% fill rate against their planned Health Care Assistant staffing levels during the 6-month period Nov 2020 to April 2021 for day shifts and a 91.5% fill rate for nights.

The NEST	Day				Night				
	Registered Midwives		Care Staff		Registered Midwives		Care Staff		patients
	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours	patient count at 23:59
Total	**3473.0**	**3116.5**	**1736.5**	**1529.5**	**3473.0**	**3070.5**	**1736.5**	**1552.5**	**130**

The NEST (MLU) opened on 1st December 2021. The NEST reported an average 89.7% fill rate against planned midwifery staffing levels for days for the **5-month** period Nov 2020 to April 2021 and an 88.4% fill rate for night shifts.

There was an average 88.0% fill rate against the planned health care assistant staffing levels for days during the **5-month** period Dec 2020 to April 2021 with an 89.4% fill rate for the night shifts.

5.3.4 Sickness and Absence

Sickness and absence within the maternity department is monitored through the internal maternity dashboard

- Birth Suite (including the NEST) sickness absence rate ranged from 1.57% – 9.35% from Nov 2020 to April 2021.
- Maternity Ward C23 sickness absence rate ranged from 5.23% – 12.08% from Nov 2020 to April 2021.
- Reasons for sickness and absence included maternity leave, long term sickness and the requirement to shield or self-isolate staff following Covid-19 recommendations.

Shortfalls in staffing were supported using flexible workers from the NHS Professionals Bank and external Agencies. This had a positive impact on the shortfall of midwifery hours required to support care provision.

5.3.5 Supernumerary Status for Birth Suite Coordinator

The Birthrate Plus® acuity tool is also used to monitor the supernumerary status of the Birth Suite Coordinator every 4 hours. If there is an occasion when the Birth Suite Coordinator does not have supernumerary status this is escalated to the Matron and mitigating action is taken to address the issue. A red flag is recorded on the acuity tool.

5.3.6 Midwifery Red Flag Reporting

Monitoring staffing red flags is recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' (2015). Staffing red flags are recorded in the Safe Care module of the Trust's Health Roster. Midwifery Red Flags include:

- Delay in induction of labour
- Delay in administration of analgesia
- Delayed or cancelled time critical activity
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)
- Missed medication during an admission to hospital or midwifery-led unit
- Delay of more than 30 minutes in providing pain relief
- Delay of 30 minutes or more between presentation and triage
- Full clinical examination not carried out when presenting in labour
- Delay of 2 hours or more between admission for induction and beginning of process
- Delayed recognition of and action on abnormal vital signs
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour

Although the effects of reduced staffing or increased capacity were recorded on the Birthrate plus acuity tool they did not clearly describe specific red flags and a clearer process of describing midwifery red flags was required. Recording the midwifery red flags in the Safe Care system was introduced and implemented at the beginning of June 2021. When a red flag is raised in the Safe Care module of the Health Roster it prompts an immediate response from a senior member of the midwifery management team (in-hours) to review staffing and acuity across the maternity footprint to ensure safe care for women and their families is maintained. Out-of-hours midwifery red flags are acknowledged as soon as is reasonable and reviewed within the senior management team for learning and sharing. If staffing is compromised during this time escalation would also occur as documented in the Maternity service escalation policy

Staff also use professional judgements to complete electronic incident forms in response to safety concerns impacted by staffing levels and acuity. Where incidents are reported a review by senior managers is completed and concerns addressed in near or real time wherever possible.

5.3.7 Maternity Unit Closures

The Cheshire and Mersey Maternity Escalation and Policy (2017) contain comprehensive information on reasons why a maternity service would be closed to admissions and the process to be followed to ensure the continued safety of women and babies. During the period 01.11.20 – 30.09.21 there have been 3 maternity unit closures. All Maternity diverts are STEIS reported and investigated through the Serious Incident governance process and reported to Trust Board.

5.3.8 National Maternity Transformation

The national midwifery workforce strategy is outlined in 'Better Births' (2017) and sets out clear recommendations for the rollout of Continuity of Carer (CoC) to support women's choice and improve safety and better birth outcomes. Implementation of CoC is mandated and linked to WHH achieving the requirements of Clinical Negligence Scheme for Trusts (CNST).

To support the future development of the safe and sustainable workforce including those required to implement an effective CoC model, a full Human Resource staff consultation programme was completed focussing in particular on rostered model and set working hours. This you said we did approach fostered staff engagement/involvement in the changes to working practices as we moved

to an integrated teams' model. All midwives were asked to complete a Learning Needs Analysis to identify and facilitate any skills/training needs in areas of actual or perceived knowledge/competence and skill deficit.

The consultation and skill mix review identified an investment in midwifery staffing was required. A midwifery recruitment process was completed in September 2020 when 10.2 WTE band 5 and 6 midwives were recruited to support the implementation of the six CoC teams.

The continuity of carer (COC) project is now well established with six teams in place and includes a homebirth team (Team Lunar), a team focussing on women with additional vulnerabilities (Team River) and four mixed risk team (Teams Venus, Ocean, Clover and Meadow). Team Lunar are currently work within a traditional community midwifery model with on-call element to support homebirth. All other Teams work within a rostered model providing 50% of their care in the intrapartum hospital setting and 50% within the community setting. This meets the standards and national trajectory of CoC. The rostered model was preferred by staff as part of the initial consultation process.

5.3.9 Support for Vulnerable, Black Asian and Minority Ethnic Women and Families

As part of the CoC project, there is a requirement that priority be given to women with additional vulnerabilities and to women from a Black Asian and Minority Ethnic (BAME) backgrounds, the latest census indicates that this represents 7% of Warrington and Halton residents. Both groups are at increased risk of health inequalities and associated poor outcomes. The WHH model has prioritised our most vulnerable women and they are already cared for within the CoC model via Team River. Women from minority ethnic background with additional vulnerabilities (e.g. non-English speaking, asylum seekers) are also cared for via Team River.

The WHTH CoC project lead continues to meet with all teams regularly to ensure staff feel supported working within the new model of care. In addition, staff from Team River receive regular support and safeguarding supervision from the Named Midwife for Safeguarding.

5.3.10 Covid-19 Impact and Response

The current pandemic has had an impact on maternity staffing through sickness absence, self-isolation and quarantine requirements. However, the most significant impact has been as a result of our more vulnerable staff shielding/undertaking restricted duties. In total 22 staff have been identified as requiring adjustments to their role due to the pandemic. These have been considered on a case by case basis with the assistance of both Human Resources and our Occupational Health & Wellbeing Service to ensure staff are appropriately protected and supported both physically and emotionally.

The effect of 22 staff unable to fulfil clinical patient-facing care has resulted in 293.25 intrapartum midwifery clinical hours per week (22.5 shifts). The maternity team have also used the pandemic as an opportunity to look at how hospital and community services can be provided and completed in a more agile way. This has included the provision of virtual antenatal education and hypnobirthing services as well as utilising staff working from home to support administration of the elective section list, maternity telephone bookings and other non-patient facing care and audits

By working in this way, we have been able to release capacity for staff able to work clinically as well as ensuring those who are unable to complete their normal duties feel able to contribute to the service. This is significant in view of the impact the pandemic has already been shown to have in exacerbating feelings of isolation and in impacting on individual mental health.

In addition, we have increased the number of staff who support the unit from National Health Service Professionals (NHSP) , this has included giving temporary contracts to some as well as long term shift booking to ensure resilience of the rotas. We have worked closely with NHSP to ensure their staff are able to train alongside the maternity services team and feel a valued and respected part of the workforce.

5.3.11 Assurance of an Effective System of Midwifery Workforce Planning.

In summary there is an effective system of workforce planning in place to ensure safe staffing levels which incorporates:

- Daily staffing review and monitoring of safe staffing levels
- Proactive management of sickness and absence
- Embedded National Red Flag alerts to alert senior team to review, redeploy and prioritise where staff are needed to support safe care in relation to clinical activity
- Cheshire and Mersey Maternity Escalation and Divert Policy followed to reduce variation and improve the standardisation of the escalation pathway. Only 3 unit closures in this time period and during pandemic
- Corporate investment to increase midwifery workforce to develop 100% Continuity of Carer model which improves clinical outcomes and experience of women throughout the pregnancy continuum.
- WHH awaiting review of maternity staffing using national acuity tool Birth Rate Plus which will provide external benchmarking to national midwifery staffing standards

6. MONTHLY STAFFING RETURN

Nursing and Midwifery staffing data is published on a daily basis at entrances to WHH wards along with submission of data on a monthly basis through the Unify system to NHSE, in addition to publication on the Trusts website and reporting to the Board of Directors. A review of the 'ward staffing boards' has been undertaken to ensure that staffing levels are displayed on all ward entrances and to support patient understanding of ward staffing.

The Trust is required to submit a monthly staffing return as part of the Strategic Data Collection Service (SDCS) detailing planned v's actual staffing fill rates. In line with recommendations from the NQB (2016) the staffing data return is presented to the Board of Directors on a bi monthly basis highlighting areas where fill rates fall below 90%. Although the 90% standard has not been constantly achieved during the day time there have been mitigating actions taken with senior nurse escalation, and an increase in HCA fill rates to support the ward teams. Matrons and lead nurses support the ward managers with ward risk assessments and staffing plans to ensure safety is maintained.

6.1. Comparing staffing levels with peers – Care Hours per Patient Day (CHPPD)

Care Hours per Patient Day (CHPPD) was developed following Lord Carter's review in February 2016, it has been tested and adopted to provide a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatients wards. CHPPD monitoring and tracking can be facilitated alongside E-Rostering systems and supports the daily assessment of operational staffing requirements. NHS Improvement (NHSI) Model Hospital portal now makes it possible to compare CHPPD metrics with comparable peer Trusts.

Chart 4 illustrates the reported CHPPD figures for the Trust from June 2020 to September 2021 which gives us an overall CHPPD for the current financial year of 7.9.

Chart 4

inyear	Month	Cumulative count over the month of patients	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2020/21	June	14189	4.2	3.5	7.7
	July	13433	4.7	4.1	8.8
	August	13990	4.2	3.5	7.8
	September	13616	4.2	3.3	7.5
	October	14058	4.5	3.2	7.6
	November	13774	4.5	3.2	7.7
	December	13902	4.3	3.2	7.5
	January	14691	4.4	3.2	7.6
	February	12805	4.6	3.3	7.9
	March	13262	4.7	3.5	8.2
2020/21 Total		137720	4.4	3.4	7.8
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
2021/22 Total		81419	4.5	3.3	7.9

7. ASSURANCE

This report provides an overview of the current position in the nursing workforce, including data from the evidence based staffing review (SNCT) and comparative benchmarking data from CHPPD. It is positive to report that the staffing escalation process continues to provide a high level of assurance.

The report demonstrates that our budgeted nurse staffing WTE (whole time equivalent) is comparable to the safe care census data requirements. Improvements have been made in the overall nurse staffing establishments enabling the Trust to meet the SafeCare acuity requirement. The actual number of staff in post has increased in the last 12 months. Nursing recruitment and retention remains a priority with improvements continues to be made in registered nurse vacancies resulting in the lowest number of registered nurse vacancies below zero being recorded in September 2021. The International Nurse Recruitment Programme has made a significant contribution to this position. We have welcomed 96 nurses to the Trust in 2021 from overseas.

CHPPD is the national reporting metric for safe staffing levels. NHS Choices has recently replaced planned versus actual staffing levels. WHH ended 2020/21 with a CHPPD rate of 7.8. The year to date average for 2021/22 is 7.9. This improvement from the previous 12 months continues to be monitored monthly.

The report demonstrates the progress that continues to be made across the organisation in Nursing and Midwifery staffing.

8. RECOMMENDATIONS

It is recommended that the Trust Board review the progress to date and receive the contents of the report.

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 21/11/155 b i	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	24 November 2021

Date of Meeting	5 October 2021
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/21/10 /236	**Matters Arising**	QAC/21/0LeDeR Mortality Report – It was reported that LD data is to be included in Mortality Review Quarterly report to QAC. Assurance provided of escalation process in place to escalate any concerns, incidents of LD patients reviewed as part of the Mortality Review Group (MRG) process and Harm Review meetings. Action closed.	**The Committee noted the update and received significant assurance**	**QAC 02.11.2021**
QAC/21/10 /236	**Matters Arising** - **Deep dive ED Attitudinal Complaints**	The Committee received a presentation following a review of attitude and behaviours within ED over the past 3 years and included actions in place and learning. The Committee notes: - 08/2018-08/2019- 37 complaints in relation to attitude and behaviours. - 08 2019- 08/2020- 44 complaints in relation to attitude and behaviours. - 08 2020 – 07/2021- 48 to date. - Improvement in the number of staff attitudinal related complaints in August and September 2021, designated support in place to support resolution of complaints in real-time. - Marginal increase in attitudinal in this period, assurance provided of plans in place to improve patient experience including support to ED staff, increased	**The Committee discussed the presentation and received good assurance concerning the response and actions in place following the review. Improvement will continue be monitored through reports to QAC which will include Complaints and Patient Experience.**	**n/a**

		counsellor support in ED Department, increased support from Security Staff in ED day and evening, resilience and conflict resolution training for staff, First Impressions initiative in ED. - Exploring increase in current number of Security Staff overnight to support increase in assaults in ED and additional overnight support. - Assurance provided of support measures from team and senior teams to support Doctors and staff to support improvement		
QAC/21/10/ 237	**ED Response Group update**	The Committee received an update on the ED Response Group, specifically on Key elements, learning and actions of the work to date of the ED Response Group and further planned improvements. - weekly monitoring of objectives, 5 key workstreams and associated action plan. Challenges increased ED attendances, high occupancy, IPC regulations and primary care capacity. - Senior Doctor at Triage Monday-Friday to support identification of patients in ED, early referral to specialty areas and improve flow. Exploring options to this support at weekends and out-of-hours at ED Response Group 6 October 2021. - Progressing Test of Change for Urgent Care Treatment model in Minors with GP presence, linking with Acute Medicine to directly stream appropriate patients to be seen. - Cross-site working in place with nurses, ACPs, ANPs, nurses attending minor illness training models to support Doctors in Triage to ensure and support having correct staff and skill mix in place. - Data metrics to be agreed including decision to admit, number of patients, time in ED, appropriate attends and time in ED, dashboard to be developed.	**The Committee noted the progress to date of the ED Response Group and monitoring in place and received moderate assurance.** **It was agreed high-level summary to be shared at each QAC.**	**QAC 02.11.2021**
QAC/21/10/ 238	**Hot Topic – nosocomial Learning update**	The Committee received a comprehensive update including background, context and overview provided of processes put in place following COVID-19 Pandemic declaration and associated learning and improvement plans put in place. Key learning across 5 areas highlighted: - Screening, Organisation, COVID exposure, Patient Factors and IPC Factors.	**The Committee discussed the presentation and received good assurance.**	**n/a**

		- Next steps alongside learning - continued robust screening programme, RCA reviews, reinforcement of IPC and PPE Champion refresher training. - Weekly screening put in place variance in how COVID exposure and outbreaks managed across different Trusts. Assurance provided of robust screening in place in ED, since March to date, 1 outbreak due to mis-testing. - WHH completing RCAs of all patients. Assurance provided of support and mechanisms in place to support teams for 3- and 5-day swabbing including continued daily review of data by AK. - Internal assurance and external assurance as part of national inquiry and from legal perspective of full compliance in application of Duty of Candour through RCAs. - MRG will review sample of 30 SJR case note reviews as per the last Nosocomial Deep Dive and report through the Learning From Deaths report to this committee.		
QAC/21/10/ 240	**Deep Dive Patient Equality, Diversity & Inclusion overview**	The Committee were provided with an overview of background, context, learning, actions in place and next steps following the deep dive into the strategy's two patient objectives (1) Better Health Outcomes for all and (2) Improved Patient Access and Experience. Of particular note was: - improving data analysis, collection and recording to evidence 'due regard', increased education relating to regulatory reporting for Patient EDI; - improving patient experience and access through improved Interpretation and Translation provision for improved patient experience and access, Accessible Information Standards and embedding of Learning and Disability Strategy; - 'seeing the person' ensuring that Patient experience at the heart, sharing lived experience stories of patients with digital stories being launched. - Strengthened collaborative working with partner organisations and stakeholders. - First Impressions initiative progressing	**The Committee discussed the presentation and received good assurance.** **Going forward reporting will be strengthened through quarterly reports to QAC.**	
QAC/21/10/ 244	**Maternity Safety Champion Report**	The Committee received the Maternity Report and Ockenden Review update report. No issues were escalated, and the following matters were noted:	**The Committee noted the updates and received good assurance.**	**QAC 02.11.2021**

		Maternity Voices Partnership (MVP) activities work progressing through local governance framework reporting. Better Births Continuity of Carer, 100% achieved for in area women since March 2021, new Team Clover launched 6 September 2021. M2O - four key action plans, Ockenden, Aubury, CQC Mock Inspection Framework and M2O all on track. Maternity Incentive Scheme Year Four - Safety Action 2 MSDS Data submission MSDS submission for May data due 31 July 2021. Issues uploading data, requests to NHS Digital to rectify have not allowed further submission. WHH quality rating indicates WHH did not submit this data. Discussions continue to resolve, if no resolution, second paper may need to be produced with Executive sign-off to submit missing data with notification to QAC as appropriate. Saving Babies Lives (SBL v2) – work progressing on the 5 elements of SBL. - WHH positive outlier regionally and nationally and shortlisted for HSJ Patient Safety Awards 2021 (b) Maternity SI Report - High level summary of Maternity Serious Incidents (SIs) noted.		
QAC/21/10/ 245	**Management of Sepsis review – outcome of review of 15 cases requiring MRG Review**	The Committee received a further update following review of 15 cases requiring MRG Review, identified in the previous review. The report provided an update on the outcomes and measures in place the improve practice of Management of Sepsis. It was noted that: - Limited improvement noted in patients not waiting over 2 hours for assessment. Improvement work continues to improve Sepsis screening patients not waiting over 2 hours, slight improvement from previous week of 62% to 67%. - Antibiotic screening within 1 hour at 50%, action plan to achieve improvement at pace. Consultant support in ED to identify and support staff and patients in	**The Committee noted the update and received moderate assurance. A further update was requested in the next meeting**	**QAC 02.11.2021**

		early identification, reduce delay in antibiotic administration and/or completion of appropriate documentation whilst dealing with patient. - Key areas of focus 'intentional rounding' in ED, increase team in ED for clinical walk round to assess, screening, bloods carried out in a timely manner - Significant increase in ED attendances. Deputy Chief Nurse located in ED to support colleagues to carry out ward rounds with the increased attends. - Work continues to support triage, rounding and daily briefings to CEO, Executives and NEDs as appropriate. - E Obs data will provide E-Outcome information and ensuring Ward Manager focus on Sepsis management. **MRG Review of case notes** - 13 patient case notes reviewed with Sepsis on part 1a or 1b of death certificate. - 8 cases – diagnosis of Sepsis made/suspected. Six displayed red flag for Sepsis, however red flags could have been caused by other co-morbidities, high on frailty index. - Out of the 8 cases, 1 patient had full Sepsis screening within 1 hour, 3 had antibiotics within 1 hour and 1 had blood cultures antibiotics within 1 hour. - Following conclusion of the review, assurance provided that none of the patients who had died were negatively impacted by not receiving the Sepsis Care Bundle. - Sepsis Care Bundle to form part of MRG process. - Quality process in place, Medical Examiner reviewing all death certificates. Reassurance provided the Trust is not an outlier for other septicemia mortality relating to HMSR and SHMI data. - Sub-optimal care and Sepsis management identified as part of SJR and referred to MRG process as appropriate. - The Committee acknowledged assurance provided of actions taken to date and that further improvement plans need to be progressed at pace to achieve Sepsis Gold Standard		

The Committee also received and discussed:

- Updates to the Strategic Risk Register & BAF
- Key discussion points from the Clinical Recovery Oversight Committee (CROC)

The Committee received and noted the following

- Quality Dashboard
- Dementia Strategy
- Learning Disabilities – Learning From Inquests, Learning Outcomes update report

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

- Patient Safety and Clinical Effectiveness Sub Committee
- Infection Control Sub-Committee
- Safeguarding Committee
- Patient Experience Sub Committee

- Health and Safety Sub Committee
- Complaints Quality Assurance Group
- Quality Academy Committee
- Patient Equality, Diversity & Inclusion Sub Committee

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 21/11/155 b ii	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	24 November 2021

Date of Meeting	2 November 2021
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/21/11 /265	**Hot Topic – Acute Kidney Injury (AKI)**	The Committee received a presentation providing an overview on Acute Kidney Injury (AKI) and highlighted the following key points: - Prior to August 2020 inpatient Nephrology cover was provided by RLUH – phone advice and transfer if needed. - Information from trainees on this site 2018 highlighted a number of difficulties experienced. Work has been taking place to reduce the inequality in healthcare for kidney patients admitted outside of tertiary centres. This has so far led to: - Development of local referral service with more accessible phone advice, continuity and face to face local reviews. Reducing need for transfer (cut down by 23.5%); reducing the wait for those that need transferring (this has dropped from a mean of 4.95 days to 0.57 days) - Monday to Friday Nephrology reviews on site. - Changing the mindset of junior doctors through education - Integration of follow up system.	**The Committee noted and discussed the presentation and received moderate assurance.** **The Committee requested a further presentation in six months to report on next steps**	**QAC May 2022**

		- Improved care for existing renal patients and those severely ill with AKI. - Having identified gaps and areas for improvement additional possible service developments to support improved patient outcomes were presented.		
QAC/21/11/266	**Deep Dive – 72 hour Fracture Clinic Review (verbal update)**	The Committee received a verbal update concerning the ongoing 72 hour Fracture Clinic Review. It was advised that the 200 patients who formed the backlog have now all been seen in clinic and there has been no harm reported. An action plan had been presented to the Executive Team and a report would be received at the Patient Safety & Clinical Effectiveness Sub-Committee in November 2021 followed by a presentation to the Quality Assurance Committee in December 2021	**The Committee noted the update and received good assurance**	**QAC 07.12.2021**
QAC/21/11/267	**ED Response Group update**	The Committee received an update on the ED Response Group, specifically on Key elements, learning and actions of the work to date of the ED Response Group. An update was provided on Senior Doctor Triage and the agreed roles and responsibilities. It was agreed that future reports would include monthly comparisons on key metrics such as ambulance turnaround times and trolley waits.	**The Committee noted the progress to date of the ED Response Group and monitoring in place and received good assurance.**	**QAC 07.12.2021**
QAC/21/11/268	**Sepsis screening update**	The Committee received a further update following review of 15 cases requiring MRG Review, identified in the previous review. The report provided an update on the outcomes and measures in place the improve practice of Management of Sepsis. It was noted that: - Sepsis screening in ED has improved; however, administration of antibiotics has not shown a significant improvement. This will be specifically reviewed in the Task and Finish Group. - The key focus of the T&F Group was the use of pre-made antibiotics in ED, and bleep for deteriorating patients. - % of inpatients screened within 1 hour had fallen to 38%. This data is taken from MET calls. The patient safety improvement nurses are working with Acute	**The Committee noted the update and received moderate assurance. A further update was requested in the next meeting**	**QAC 07.12.2021**

		Care Team to establish a way of gathering data daily through E-obs to hopefully provide a clearer picture.		
QAC/21/11/272	**Maternity Safety Champion Report**	The Committee received the Maternity Report and Ockenden Review update report, following matters were highlighted: - Maternity Incentive Scheme Year Four - Safety Action 2 MSDS Data submission. NHSR updated MIS guidance on 12th October 2021 with extended interim deadlines for safety actions 1,2,3,6, 8 and 9. - Data submission challenges escalated to NHS Digital - Work progressing with new maternity EPR system.	**The Committee noted the updates and received good assurance.**	**QAC 07.12.2021**
QAC/21/11/275	**The Management of Oxygen Supply Update**	The Committee received an update report following the original report received by the Committee in March 2021. It was noted that: - Medical Gasses Committee set up - meeting every 3 months initially until fully established and then move to 6 monthly meetings. - Alerts on medical gasses now managed through the Health & Safety Department and circulated to Pharmacy or Estates Manager as appropriate. - Supply and demand of oxygen to bedheads reported daily to NHSEI - Commissioned a survey of the medical gas system across both sites. Assurance was received that all the recommendations from the report had been actioned and any future HSIB reports with actions and recommendations will be taken through the Medical Gasses Committee and then through the appropriate governance.	**The Committee noted and discussed the report and received good assurance.**	**n/a**

The Committee received a Digital Patient Story explaining the work being done to support young people who have diabetes and detailed the therapeutic and engagement activities in place to support them in the community.

The Committee also received and discussed:
- Updates to the Strategic Risk Register & BAF
- Key discussion points from the Clinical Recovery Oversight Committee (CROC)
- DNACPR 6-month position report
- DIPC Infection Control BAF Bi-Monthly Report
- Patient Safety Strategy

- Moving to Outstanding report

The Committee received and noted the following
- Quality Academy Summit update report
- Fit Testing Compliance Bi-Monthly Report
- DIPC Infection Control Q2 Report
- SI and Complaints Q1 & Q2 Report
- Quality Improvement Q2 Progress Report
- Enabling Strategy Alignment 6 month progress report
- Learning From Deaths Q2 Report

The Committee received the High-Level Briefing Reports from the following Sub Committees:
- Patient Safety and Clinical Effectiveness Sub Committee
- Infection Control Sub-Committee
- Palliative Care and End of Life Steering Group:
- Risk Review Group
- IG and Corporate Records Sub Committee
- Patient Equality, Diversity and Inclusion Sub Committee

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/21/11/155 c		TRUST BOARD OF DIRECTORS	DATE OF MEETING	24th November 2021

Date of Meeting	17th November 2021
Name of Meeting + Chair	Strategic People Committee
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
SPC/21/11/89	**Navajo Chartermark**	**Navajo Chartermark Presentation, Equality, Diversity & Inclusion Manager** The Navajo LGBTQ+ Charter Mark is an equality mark sponsored by In-Trust Merseyside and Cheshire and supported by the LGBTQ+ community networks across Merseyside.	**Decision** The Navajo LGBTQ+ Charter Mark is an equality mark sponsored by In-Trust Merseyside and Cheshire and supported by the LGBTQ+ community networks across Merseyside. Presentation outlines Navajo Charter mark, application process and subsequent action plan The application includes six distinct elements to analyse and address: • Consultation • Practices and Policies • Training	

			• Staff Recruitment and Engagement • Monitoring • Service Users and LGBTQ+ Engagement Full action plan and application to be shared with SPC members following meeting for noting. The Strategic People Committee (SPC) was asked to receive and approve the contents of the Trust's Navajo application and action plan as presented prior to submission to In-trust Merseyside and Cheshire. **Action:** **SPC approved the application and action plan for submission and noted that it was to be presented to Quality Assurance Committee from a patient and service user perspective in December 2021 and would be formally submitted to In-trust Merseyside and Cheshire following this in December 2021.**	
SPC/21/11/92	**Workforce Race Equality Standard**	**Workforce Race Equality Standard, Deputy Chief People Officer** This paper provides a follow up summary of the one specific employee relations case relating to BAME staff, following findings of a detailed review into the 2020 WRES Data Indicator relating to formal disciplinary processes	**Assurance** Strategic People Committee were asked to note that there are no concerns in relation to the case and are asked to support the completion of this detailed review. Analysis to be picked up as part of Employee Relations report going forward to ensure continued oversight related to assurance around the implementation of Improving People Practices, Just and Restorative Practice and WRES Indicator 3 Action Plan. SPC Chair asked how SPC would assure themselves that the work of the DCPO was cognisant of all EDI, Improving People Practices and Just Culture standards with appropriate independence whilst maintaining confidentiality of employees concerned. **Action:**	

			CPO agreed to review the assurance oversight of all WRES (3) related Employee Relations Casework and to make a proposal within the January 2022 - Employee Relations report.	**January 2022**
SPC/21/11/93	**BAF & Risk Register** - **Staff**	**BAF & Risk Register,** **Trust Secretary** Workforce risks on the Board Assurance Framework (BAF) and Corporate Risk Register (CRR)	**Assurance** No new risks, no risks deescalated. Proposal to amend the risk title 1207 was **approved**. New Risk title (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 manager 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.*	
SPC/21/11/94	**Attendance Management and Return to Work**	**Attendance Management and Return to Work – Hot Topic,** **Deputy Chief People Officer**	**Assurance** Update provided on the Supporting Attendance work being undertaken and also the work specifically around improving the Return to Work interview (RTWI) compliance. The report also gives assurance around the CQC Workforce Red Flag report of which there are 3 items relating to absence. Key updates were as follows: ▪ Update on performance data and impact of covid related absence ▪ Focus on supporting attendance ▪ Supporting Attendance T&F Group to commence next month ▪ Additional support from NHSE/I Bid to commence 1st December 2021 ▪ Focus upon nursing absence	

			▪ New Supporting Attendance Policy to be launched and audited ▪ Continue with RTWI focus ▪ Continue to monitor progress at OPC	
SPC/21/11/95	**Moving to Outstanding Red Flags**	**Moving to Outstanding Red Flags, Chief People Officer** This paper provides Strategic People Committee an update on 7 CQC Indicators, which have been flagged by the CQC on the Insight report.	**Assurance** SPC noted the request for the Committee Workplan to be amended to remove the Moving to Outstanding (People) update and replace with the Moving to Outstanding CQC Red Flag Report (workforce) items. In addition, members noted the link to the Hot Topics presentation earlier in the agenda and that future Hot Topic presentations would link to CQC Red Flags (Workforce). Updates were provided on the 7 Red Flags from the CQC Insight Report. SPC noted the format of the report and that as the CQC Red Flags would change with each Insight Report, the content would evolve to meet the assurance needs of the committee. For this first report, SPC members received an update on: • W3 Whistleblowing alerts • W3 Sick days for nursing and midwifery staff (%) • W3 Immediate managers - PICKER - NHS staff survey themes and questions • W3 Sick days for non-clinical staff (%) • W3 Sick days for other clinical staff (%) • W3 Team Working - PICKER - NHS staff survey themes and question • W3 Turnover rate for other clinical staff (%) **<u>Action:</u>** **Trust Secretary asked to amend the SPC Workplan and close the Action Log item: SPC/19/07/67 Moving to Outstanding**	**January 2021**

SPC/21/11/96	**Policies and Procedures Report**	**Policies and Procedures Report, Deputy Chief People Officer** The document sets out the review of a number of HR and OD policies, for approval.	**Decision** The following policies have been reviewed and developed within the Policies and Procedures group and received approval for submission to SPC by the Joint Negotiating and Consultative Committee and Operational People Committee on the 11th November 2021: • Adoption Leave Policy • Agile Working Policy • Apprenticeship Policy • Flexible Working Policy • Maternity Policy • Organisational Change Policy • Overtime Policy • Paternity and Partner Leave Policy • Payment of Travel and Expenses Policy • Recruitment and Selection Process • Retirement and Long Service Policy • Resolving Workplace Issues Policy • Supporting Performance Improvements Policy • Temporary Staffing Policy • Work Experience Policy All the polices were approved for ratification • MHPS – extension to the review of this policy to March 22 • Pay Progression - extension to the review of this policy to December 22, following national pause of pay progression Both extensions were approved	
SPC/21/11/97	**Chief People Officer Report**	**Chief People Officer Report, Chief People Officer** The Chief People Officer updated the Committee on:	**Assurance** **COVID-19 Workforce Risk Assessments** – maintained high compliance levels; for assurance reports are provided daily to managers and in late October 2021 a letter was sent out to all staff who have not completed the self-risk assessment in a timely	

		• COVID-19 Workforce Risk Assessments • Self-Isolation SOP • Asymptomatic Testing • Flu Campaign • Annual Staff Survey Update • The Brathay Trust First Impressions • Bottles to Poppies Project • Flex for Future • Staff Facilities	manner (the number of outstanding self-risk assessments reduced by 43%). **Self-Isolation SOP** – 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. To date implementation of the SOP has saved the Trust a total of 1610 days, with 215 staff members having been approved by OH to proceed with the approach. **Asymptomatic Testing** – The Executive team have approved that the organisation will remain with LAMP testing as the primary method of asymptomatic testing, however this will be further supported by staff being encouraged to report their Lateral Flow Test. **Flu Campaign** – Currently the vaccine has been administered to patient facing staff only. This has been delivered in the Flu/COVID HUB and in 'pop-up' clinics on both sites. The percentage of patient facing staff vaccinated is 62%. As of the 10th November 2021, the Trust has utilised all Flu Vaccinations that were delivered and allocated for staff use. We have therefore fully maximised Flu Vaccinations for patient facing staff based on the delivery schedule dictated to us by external bodies. **Annual Staff Survey** - The 2021 Annual NHS staff survey approaches, it will close on Friday 26 November 2021. **The Brathay Trust** is a staff offer from a psychological and wellbeing perspective, SPC were updated about the initial outcomes and evaluation of the programme for participants are currently being analysed, but a supportive measure after the event is that all	

			participants have setup a Whatsapp group to continue their journey together. **Bottles to Poppies Project** - The Trusts Inaugural Remembrance & Dedication Service & Parade will take at Warrington on Thursday 11th November 2021 at the Poppy Field & River in the Wellbeing Courtyard **Flex for Future** - The NHS Flex for Future is a joint initiative from NHSE/I and Timewise. WHH are taking an active role within the national group, included being selected as one of five Trusts to take part in a related pilot. The initiative aims to enhance flexible and agile working across the NHS. To support this an Agile Working Task and Finish Group **Staff Facilities** - Project Wingman at WHH comes to a close after a relationship and partnership of 19 months. The existing area will transition to the Staff Health, Wellbeing and Engagement (HW&E) team, ensuring the health and wellbeing offer continues to exist, protecting the legacy of the Project Wingman ethos. To support this the organisation has also set up a Staff Facilities Task and Finish Group.	
SPC/21/11/98	**People Strategy & Equality, Diversity and Inclusion Strategy (Workforce) Update**	**People Strategy & Equality, Diversity and Inclusion Strategy (Workforce) Update, Deputy Chief People Officer** The People Strategy and the Equality, Diversity and Inclusion (EDI) Strategy set out the strategic objectives relating to our workforce.	**Assurance** SPC received an update of the following Work Programmes, which encompass the People and Equality Diversity and Inclusion Strategies. Focus and update on: • Inclusion Strategy • Benchmarked against reward and recognition - benchmarked very well • OD responded to 146 across the Trust as opposed to 50 pervious year • Line manager development programme • Career development programme	

			• HRBP's supporting CBU 's workforce plans on a page - would increase establishment by 87 WTE if approved. • Kindness, Civility and Respect - Anti Bullying Week • Working towards Level 3 Disability Confident Employer - committee asked to note • SCOPE for GROWTH - selected as an early adopter from NHSE/I • Update taking HCA pay work through OPC – C&M ICS Nursing and Midwifery workstream but may have pay and resourcing implications for SPC and Finance and Sustainability Committee in 2022	
SPC/21/11/101	**Trust Board Monthly Staffing Report**	**Trust Board Monthly Staffing Report, Chief Nurse & Deputy CEO** This paper details ward staffing data for the months of August and Sept 2021	**Assurance** SPC received the report that highlighted an increase in Nursing sickness absence, and a slight reduction of the CHPPD. The Nurse vacancy information was also highlighted, which demonstrated a significant reduction in the number of Nursing vacancies, and the ongoing work with Finance colleagues to realign the budgets to reflect the number of nurse staffing changes.	

We are WHH & We are PROUD to make a difference

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/20/11/154 d		TRUST BOARD OF DIRECTORS	DATE OF MEETING	24 November 2021

Date of Meeting	**20 October 2021**
Name of Meeting + Chair	**Finance and Sustainability Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
FSC/21/10/167	Corporate Performance Report	The Committee considered and reviewed the report noting: - • September A&E performance 73.42%. Emergency attendances increased by 361 in September (4.9% increase since last month) and 11% higher than pre pandemic levels • All beds now open on the Warrington site • Super stranded patients totalled 122 at the end of September • Number of Covid-19 positive patients increasing in the hospital • Expectation of a new contract with Spire	The Committee **noted** the updates	FSC November 2021
FSC/21/10/168	Pay Assurance Report	The Committee considered and reviewed the report noting: - • Following national guidance 206 CEV staff have been seen by Occupational Health and allocated work in green areas or home working. 9 non-clinical staff to be reviewed further and may need to be redeployed • All international nurses have been recruited and are in the UK and retention is good with just 1 nurse leaving due to family issues	The Committee **noted** the update.	FSC November 2021

FSC/21/10/169	Monthly CIP	The Committee considered and reviewed the monthly CIP noting: - • On plan at the end of H1 with £0.9m delivered • Greater CIP challenge in H2 with the current risk of £1.7m	The Committee **noted** the CIP report	FSC November 2021
FSC/21/10/170	COVID-19	The Committee noted the COVID-19 update, noting: - • A further reduction in expenditure again in September • Agreed to receive this report on a quarterly basis rather than monthly subject to expenditure continuing to reduce	The Committee **noted** the update and agreed to change in reporting frequency	FSC January 2022
FSC/21/10/171	Capital Plan – stocktake/deep dive outcomes	The Committee considered and reviewed the capital update, noting: - • Schemes over £0.5m were reviewed, specifically the breast relocation and ED plaza schemes • Internal review of estates capital has been completed with the external review by MIAA nearing completion	The Committee **noted** the update.	FSC November 2021
FSC/21/10/172	Digital Services Board Report	The Committee considered and reviewed the report noting: - • Comprehensive report received • Dedalus (formerly DXC) Vendor management. Moderate assurance. Patch implemented to resolve CDC form issue and post-migration performance issues resolved (RCA led to anti-virus settings). Clarity still required on Microsoft Silverlight extended support arrangements. • Strategic Electronic Patient Record (including tactical solution). Moderate assurance. Work to update the Outline Business Case following feedback from NHSEI and NHS Digital is progressing to plan with additional work on benefits identification and delivery planning (e.g. ward closure). Final preparations being made for launch of procurement process end of October. The revised business case for the tactical Lorenzo contract extension was approved by Trust Board end of September.	The Committee **noted** the update.	FSC November 2021
FSC/21/10/173	C&M System Finance Report M5	The Committee noted the update, noting:- • Report including the month 5 position and a verbal update for the month 6 position	The Committee **noted** the update.	FSC November 21

		• Cheshire & Merseyside achieved Breakeven for H1 with the NW achieving £14m surplus		
FSC/21/10/174	H2 Guidance	The Committee considered and reviewed the H2 draft plan noting: - • The draft plan was discussed at length • The importance of progressing the decision on the IMC & Respiratory business cases is required	The Committee **noted** the update.	FSC November 2021
FSC/21/10/175	Benefits realization Q2 report	The Committee noted the benefits realisation Q2 report noting: - • Disappointment in the lack of progress made in some areas • Expectation that progress is made over the next month and link outstanding reviews to the budget setting and plan on a page process	The Committee **noted** the update.	FSC January 2022
FSC/21/10/176	Monthly Finance report	The Committee considered the report and capital proposals. Key points to note included: • H1 achieved break even position as per plan • There were no items for escalation by the Financial Resources Group (FRG) or the Capital Planning Group (CPG) • Note the change in the capital contingency	The Committee **noted** the update.	FSC November21
FSC/21/10/178	Risk Register	The Committee noted the update noting: - • There are no new risks or changes to the current risks	The Committee **noted** the update	FSC November 2021
FSC/21/10/179	6 month Committee Effectiveness Survey outcomes	The Committee considered the 6 month Committee effectiveness survey, noting:- • 5 individuals had responded • The Chair welcomed any further feedback	The Committee **noted** the results	FSC April 2022

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/11/155 d		TRUST BOARD OF DIRECTORS	DATE OF MEETING	17 November 2021

Date of Meeting	**17 November 2021**
Name of Meeting + Chair	**Finance and Sustainability Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
FSC/21/11/185	Corporate Performance Report	The Committee considered and reviewed the report noting: - • October A&E performance 70.59% • Super stranded patients totalled 142 at the end of October • 4 declarable trolley wait breaches during October • Emergency attendances at the Warrington site increased by 89 in October	The Committee **noted** the updates	FSC December 2021
FSC/21/11/186	Pay Assurance Report	The Committee considered and reviewed the report noting: - • Estimated FTE lost through Sickness Absence was 244.5 • The Trust was successful with a bid for sickness absence reduction, Chief Executives across C&M looking at incentive schemes and therefore more expected to follow on this • MIAA audit on WLI waits concluded but work ongoing on management responses, paper due to Committee in December • WHH rate card introduced at the beginning of October with 93% compliance against it	The Committee **noted** the update.	FSC December 2021

		• Links with University of Chester continue to strengthen, review of Model Hospital undertaken which demonstrates low spend on staffing and agency compared to peers and comparable sickness rates		
FSC/21/11/187	Monthly CIP	The Committee considered and reviewed the monthly CIP noting: - • CIP target of £4.8m remains, 2.5% target per C&M HCP • £1.56m of unidentified CIP, ongoing work with the Operations Team to identify schemes	The Committee **noted** the CIP report	FSC December 2021
FSC/21/11/188	PACU	The Committee considered and reviewed the PACU update, noting: - • 11 of 12 metrics reported as being met • 1 metric not met – 'Reduction of emergency transfer from Halton' due to the data being difficult to measure	The Committee **noted** the update.	
FSC/21/11/189	Capital Plan – stocktake/deep dive outcomes	The Committee considered and reviewed the capital update, noting: - • £19.7m plan (inclusive of donated assets) • £3.9m spend to date at month 7, £2.8m underspend against rephased plan mainly due to Cardiac Catheterisation Suite which hasn't started yet but now profiled for later in the year • Schemes over £0.5m were reviewed, specifically the Cardiac Catheterisation Suite, ED plaza and breast relocation schemes • National meeting regarding capital requesting declaration of underspend in the current year and requesting of Treasury if this can be rolled over to next year. The ICS is requesting the same information with a deadline of this week • Delay on Shopping City due to landlord change and asbestos being found, due to finish work in April 2022 • MIAA has completed the estates review and this will be reported to Audit Committee	The Committee **noted** the update.	FSC December 2021
FSC/21/11/190	Digital Services Board Report	The Committee considered and reviewed the report noting: - • Moderate assurance relating to issues with responsiveness of the system and users navigating through the system, further investigations continue	The Committee **noted** the update.	FSC December 2021

		• IT Services update. Moderate Assurance. A new version of the IT Service Desk Solution went live in October. KPIs now need to be developed, working towards formal SLA targets from April 2022 including both benchmarking and performance analysis • EPCMS business case. Moderate assurance. Pending reapproval of the updated OBC by FSC and Trust Board. Launched procurement process which will continue in parallel with review and approval of the OBC.		
FSC/21/11/191	Strategy & Sustainability 6 month report	The Committee noted the update, highlighting:- • New Hospitals – EOI submitted, initial feedback received but no confirmation of the next stage of the process yet but expecting to hear in Spring next year • New Health & Wellbeing Centre (Warrington Town Deal) – lease negotiations continue, supported by Warrington Borough Council to ensure the Trust receives the best value from donated income. The full business case has been through all approvals both at the Trust and the Council • Shopping City – looking to sign agreement to lease while asbestos cleared and then will move to full lease contract	The Committee **noted** the update.	FSC May 22
FSC/21/11/192	H2 update	The Committee considered the update, noting:- • Requirement is to achieve breakeven • October submitted plan of £9.5m deficit • Revised deficit of £5m at 11 November due to successful bids for recovery along with the associated expenditure, full commitment of 2.5% CIP target, deferral of prioritisation schemes not yet commenced until January 2022, position also includes not yet confirmed ED flow bids • Revised deficit of £3.4m at 17 November due to additional ICS funding, diagnostic reduction and extra ERF calculated by the System. It was noted that ERF funding is dependent on the rest of the System but has been included as advised by ICS	The Committee **noted** the update and **supported** the £3.4m deficit submission.	FSC December 21

		• Risk included in the plan (ERF System based, bids not yet approved), request for support of the £3.4m deficit and further work to achieve break even continues		
FSC/21/11/193	Monthly Finance report	The Committee considered the report and capital proposals. Key points to note included: • £1.7m deficit, no plan yet for H2 or confirmation of income yet therefore comparison to September • RTT activity fell below the threshold for achievement of ERF • Work being undertaken to address pay overspends • Noted the change in the capital contingency and supported use of £11k of capital contingency • Items for escalation from Financial Resources Group (FRG) and Capital Planning Group (CRG) were discussed elsewhere on the agenda	The Committee **noted** the update and **supported** use of £11k of capital contingency.	FSC December 21 Capital to be approved at Board November 21
FSC/21/11/194	EPCMS	This item was postponed to the December meeting awaiting letter of support from ICS		FSC December 21
FSC/21/11/195	Draft Green Plan	The Committee considered the update, noting:- • Three key elements being 1. Reducing our carbon emissions; 2. Reducing our contribution to air pollution; 3. Reducing our generation of waste • Feedback provided and additional Board session requested to review	The Committee **noted** the update	
FSC/21/11/196	Proposal for amendments to Access & Performance KPIs	The Committee considered the update, noting:- • New indicators were agreed to be escalated for review at Trust Board for inclusion in the Trust IPR	The Committee **noted** the update and **supported** for review at Trust Board	
Additional item	Changes to the Capital Programme for Urology Investigation Unit (UIU) and Paediatric	The Committee considered the update, noting:- • Increased costs for both schemes (£184k and £150k, £334k in total) to be funded by capital contingency which has increased due to underspends on ICU and Cardiac	The Committee **noted** the update and **supported** for review at Trust Board	

	Outpatient developments - Estates	• Concern raised that revised contingency on the schemes is low but supported for review at Trust Board		
FSC/21/11/197	Risk Register	The Committee considered the update, noting: - • There are no new risks or changes to the current risks	The Committee **noted** the update	FSC December 2021
FSC/21/11/198	Trust Overseas charging policy	The Committee considered the policy, noting:- • Complete rewrite of the policy required based on the regulation changes required following the end of the EU transition period • Approved by Clinical Policy Review Group • Further information requested regarding engagement and communication prior to final approval under Chairs Action	The Committee **noted** the update and once query resolved Chair to **approve** the changes under Chairs Action	

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/11/155 e		TRUST BOARD OF DIRECTORS	DATE OF MEETING	24th November 2021

Date of Meeting	**12th October 2021**
Name of Meeting + Chair	**Clinical Recovery Oversight Committee (CROC) Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
CROC/2021/10/115	Harm Profile update	Update on focussed assurance piece • As of 29/09/21 there are 3 harm reviews to be completed to close the assurance piece. • There has been a total of 1 patient identified as moderate harm ENT - Matron linking in with nursing home. Patient and nursing home have agreed TCI date for 15/10/21 Harm Reviews Outstanding • 360 reviews outstanding	The Committee **noted** the update	CROC November 2021
CROC/2021/10/116	Waiting List update	RTT update: • Total RTT Waiting list size 22060(this does not include ASI, RAS patients) higher than the submitted estimate 20512) Including ASI, RAS Total WL size 24300	The Committee **noted** the report.	CROC November 2021

		• Additional activity requirements are being reviewed as part of H2 planning September Position 74.94%(Not fully finalised position) which is a decrease of 2% on Aug Position. This is below the estimated Trajectory 76.77%. <u>52 ww Restoration non-admitted pathway</u> October will be slightly over 52-week trajectory, Teams are trying to address this issue: • The October is currently estimated at 1073 against a trajectory of 945 work is currently underway to try and recover this position • Once the P2 backlog hits the end trajectory in October 21, an additional 40-50 theatres slots will be redirected to support reductions in 52 week breaches <u>P2 Patients – Restoration</u> • July and August trajectories are achieved <u>Priority code update:</u> • The month end position for September was 113 against a trajectory of 102 <u>Priority code update: Key Issues</u> • There is a national steer to ensure there are no patients waiting >104 weeks by the end of March 2022. • Consideration is being given to elective recovery during winter and will form part of the Trust and wider Cheshire and Mersey/ICS winter plan.		

		<u>Cancer: Key Issues</u> • Trajectories for >62 and >104 day being achieved in line with the Cancer Alliance trajectories • Colorectal and Prostate noted as the most challenged pathways • Continued increase in 2ww referrals over and above pre pandemic levels. In the last 2 weeks referral rates have been 31% above pre pandemic levels with particular increases in Breast and Lower GI referrals which will represent a challenge in October. 2ww has struggled in the last 2 months but September performance has recovered the standard at 95.5% • Diagnostic waiting times contributing to the under-performance –particularly Endoscopy <u>Diagnostics</u> *i. Radiology: Key Issues* • Delay in the opening of the new MRI department offset with mobile MRI scanner until end of October 2021. Handover of new build area expected end of October 2021 • Pressures in Ultrasound due to staffing –leavers x 3 plus 2 Mat Leave *ii Endoscopy: Key Issues* • In line with national guidance, all overdue surveillance patients will need to be added to an active waiting list • Continued difficulties in staffing additional capacity due to WHH staff working at other NHS and Private Endo units for increased pay out of hours		

		Iii Cardio-Respiratory: Key Issues • Main concern is echoes and stress echoes. Capacity and Demand modelling shows deficit of 12 sessions per week. Increase in 2 WTE required to meet current demand <u>Outpatients key issues:</u> • September target for OPFA attendances is just short (272) of 95% of 19/20 position. Additional therapy activity has been identified that should uplift this to target • September target for OPFU attendances is expected to achieve despite a 222 shortfall • Delays but action being taken in respect of Fracture Clinic		
CROC/2021/10/117	Items escalated from FSC	• Overdue follow ups • DNA Rates • Incomplete Pathway Trajectory	The Committee **noted** the update	CROC November 2021
CROC/2021/10/120	Access to recovery fund Update	• JH reported that further guidance, in addition to what has already been received week commencing 4th October 2021, is awaited	The Committee **noted** the update	CROC November 2021

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/11/155 e		TRUST BOARD OF DIRECTORS	DATE OF MEETING	24th November 2021

Date of Meeting	**16th November 2021**
Name of Meeting + Chair	**Clinical Recovery Oversight Committee (CROC) Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
CROC/2021/11/128	Harm Profile update	• 431 patients who have a 52+ week wait requiring a harm review • 1304 patient requiring a harm review who have a wait of less than 52 weeks • To pilot the AI tool all 337 patients will have a clinical harm review undertaken o The large number of Urology patients was noted and should be triangulated through QAC Urology service updates. • Initial focus of harm reviews will be on urology and T/O	The Committee **noted** the update	CROC December 2021
CROC/2021/11/129	Waiting List update	<u>RTT update:</u>	The Committee **noted** the report.	CROC December 2021

		October Position 72.50 which is a decrease of 2.55% on Sept Position. This is now below the estimated Trajectory 78.41%. Work is ongoing with the CBU's to recover this position. The size of the overall incomplete pathway waiting list was noted as growing. Total RTT Waiting list size 22326(this does not include ASI, RAS patients) higher than the submitted estimate 20512) Including ASI, RAS Total WL size 24500. <u>52 ww Restoration non-admitted pathway</u> • The October position was 1078 against a trajectory of 945 – achieved. • A new trajectory for H2 submitted. <u>P2 Patients – Restoration</u> The October position was 87 against a trajectory of 57 The Use of . <u>Priority code update: Key Issues</u> • There is a national steer to ensure there are no patients waiting >104 weeks by the end of March 2022 – H2 submitted plans achieved this. <u>Cancer: Key Issues</u> • Trajectories for >62 and >104 day being achieved in line with the Cancer Alliance trajectories • Continued increase in 2ww referrals over and above pre pandemic levels. October has seen a significant rise in Breast referrals in line with the national campaign.		

		Diagnostics Radiology has achieved the 99% standard as forecasted by end of October for all modalities aside from Ultrasound *ii* *Endoscopy: Key Issues* • End of October position of 622 patients a reduction of 62 patients on the previous month. • Surveillance patients to be added to the WL in line with national guidance. *Iii* *Cardio-Respiratory: Key Issues* • Main concern is echoes and stress echoes. Continued high referrals. Outpatients key issues: • October slightly behind target for OPFA attendances 95% of 19/20 position. November on track to recover. • Virtual activity remains above 25%		
CROC/2021/11/131	H2 Planning	• The indicative H2 activity numbers have been submitted. The final version to be circulated after 16th November.	The Committee **noted** the update	CROC December 2021
CROC/2021/11/132	Items escalated from Finance and sustainability	Overdue Follow ups • Performance will be managed via CSOG and PRG on a weekly basis. Reported into QAC and PSCE • The size of FU waiting list for consultant follow up in 19/20 was 56,158 and the position now is 64,939. This is indicating	The Committee **noted** the update	CROC December 2021

		an overall increase of 16% for consultant led FU's against the position prior to the pandemic • The non-consultant led FU's has seen an increase from 19/20 figures with Orthoptics and cardiac rehabilitation having the highest backlog • Number of actions being taken, including validation and Patient initiated follow up. This work is being linked to the harm review ongoing works.		
CROC/21/11/133	BAF Update	Risk **#1125** escalated from the Corporate Risk Register at a rating of **20**	The Committee **noted** the update	CROC December 2021

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/156**	
SUBJECT:	**Moving to Outstanding and Red Flags Bi-monthly Report**	
DATE OF MEETING:	24th November 2021	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
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. **#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 **#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. **#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. **#1331** Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	Following the completion of the CQC's post-inspection action plan, the Moving to Outstanding Steering Group has a refreshed focus that includes: • The Red Flags report, linked to CQC's Insight report • Oversight of CQC enquiries (6 received to date) • Oversight of the mock inspection programme including Clinical Business Units action plans for 'Moving to Outstanding' • Progress updates on: o RCEM action plan o Progress towards ACSA accreditation o Progress towards JAG re-accreditation o Use of Resources • Regulatory Updates This paper provides high-level updates across each of these areas.

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

RECOMMENDATION:	The Board of Directors are asked to note the contents of this paper.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/21/11/276 b
	Date of meeting	2nd November 2021
	Summary of Outcome	Accepted for Information at Quality Assurance Committee.
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 Flag Bi-monthly Report	AGENDA REF:	BM/21/11/156

1. BACKGROUND/CONTEXT

The Moving to Outstanding Steering Group continues to focus on:

- The Red Flags report, linked to CQC's Insight report
- Oversight of CQC enquiries (6 received to date)
- Oversight of the mock inspection programme including Clinical Business Units action plans for 'Moving to Outstanding'

Progress updates on:

a. RCEM action plan
b. Progress towards ACSA accreditation
c. Progress towards JAG re-accreditation
d. Use of Resources

- Regulatory Updates

2. KEY ELEMENTS

2.1 Red flags report

The Red Flags report presented at the Moving to Outstanding Steering Group in October 2021, noted that:

- CQC monitored 72 indicators in September 2021.
    - 84% (60/72) of the Trust's indicators were in line with the national average. 7% (5/72) were better than the national average.
    - 7% (5/72) were below the national average.
    - 1% (1/72) was much better than the national average.
    - 1% (1/72) was worse than the national average.
- All indicators that are declining or below the national average are monitored through the Red Flags report. In September 2021 there were 28 indicators in total outstanding that are being monitored through the Red Flags report, an increase of 3 when compared to August 2021.
- The new indicators relate to the number of whistleblowing concerns received from the CQC (2 Trust wide), a 12-hour breach (UEC) and Ambulance Turnaround times over 60 minutes (UEC). The Ambulance Turnaround indicator is performing above national average. Further assurance for these indicators is outlined at 2.1.1 below.
- A summary overview of all indicators is below in Appendix 1. Key points are:
    - 43% of indicators (12/28) are improving, compared to 36% (8/25) in September 2021.
    - 57% of indicators (16/28) are declining which is a positive position, an improvement from 60% (15/25) in September 2021.

- 4% (4/28) of the declining indicators are above or in line with the national average. These are ratio of ward managers to staff, immediate managers, team working and ambulance turnaround times.

2.1.1 New indicators

- The Trust have had two whistleblowing concerns raised with the CQC (August 2021 and September 2021). Work is underway to help develop staff awareness of the role of the CQC whilst highlighting the internal escalation processes available.
- Ambulance Turnaround times are much better than the national average (6.7% vs 14.4%)
- In relation to the 12-hour breach, operational pressures due to activity levels have impacted on the ED. The case has had a rapid incident review with no harm identified.

2.1.2 Existing indicators

- Existing Indicators with decline are:
  - Sickness absence
  - Turnover of clinical and non-clinical staff
  - Elements of operational performance.

  In relation to sickness, the HR and the OD team have established a programme of work to focus upon improving attendance with consideration for employee Health and Wellbeing . The HR and OD team have participated in an NHSE/I regional absence management deep dive and the Trust is currently awaiting the outcome of this.

- Operational performance is being supported by the patient flow programme with oversight provided at the Clinical Services Oversight Group and Performance Review Group. The ED steering group have commenced piloting initiatives recognised by the CQC as good practice.

There are plans in place to monitor CQC red flags across all executive agendas.

2.2 CQC Enquiries

From 17 September 2021 the Trust has received 6 new CQC enquiries. The Deputy Director of Governance oversees responses to these enquiries and there are no concerns to escalate to this Committee.

2.3 Oversight of the mock inspection programme

- At the October Moving to Outstanding Steering Group the Maternity team provided an update of the actions agreed following their mock inspection This action plan will be monitored through the CBU governance process and the Moving to Outstanding Steering Group.
- The Urgent and Emergency Care inspection has been completed. An initial compliance action plan will be implemented followed by a moving to outstanding action plan. These action plans will be monitored through the CBU governance process and the Moving to Outstanding Steering Group.
- The unannounced mock inspection for Outpatients is underway. Further inspections are scheduled/ proposed throughout Q3 and Q4 2021/22.
- Mock inspections have been intermittently due to operational pressures.

2.5 Oversight of the RCEM action plan

There are 38 indicators in the RCEM report, from which the Trust had 119 individual actions. There are 2 Amber (on track) actions outstanding:

- IPC 06 – Nursing for Escalation areas – A business case has been approved and a recruitment event is scheduled for the 28th October 2021.
- IPC09 – ED Plaza – The contractor is scheduled to commence work on 18th October 2021.

2.6 Oversight of progress towards ACSA accreditation

- The next ACSA virtual visit is scheduled for 21 October 2021 with all actions on track. A final accreditation on-site visit is scheduled for 22 March 2022.

2.7 Oversight of progress towards JAG accreditation renewal

- JAG accreditation is expected in January 2022 following data submissions due early in November 2021. This is being supported by the Associate Director of Compliance with trajectory on track.

2.8 Updates on Use of Resources

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

2.9 Communications

The Director of Communications and Engagement outlined three key elements required under the CQC Responsive and Well Led domains that are being addressed jointly by the Patient Experience and Communications & Engagement teams:

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

The Communications and Engagement team is supporting awareness around the requirements of an 'Outstanding' organisation and culture change within the organisation. This is underpinned by awareness and education through the deployment of the CQC M2O 'toolkit' where 'We are WHH and we are Proud to…' is the campaign thread – linked directly to the Trust's mission 'To be OUTSTANDING' for our patients, our communities and each other'.

Assurance was offered that this will be delivered through five key workstreams:

- The production of patient information (PINFO)
- Compliance with the accessible information standard
- Patient and Public Participation and Involvement (PPP&I)
- Communications and Engagement
- Freedom of Information Act Information requests (FOI)

A further update will be provided to the next Moving to Outstanding Steering Group and subsequently to the Quality Assurance Committee.

2.10 Regulatory Update

2.10.1 New Assessment Frameworks

The CQC are developing new assessment frameworks, which they are planning to introduce during Q4 2021/22 a further update will be provided.

2.10.2 Maternity Report: Safety, Equity and Engagement in Maternity Services

The CQC have published a report that sets out concerns regarding the varied quality and safety of maternity services. The report makes recommendations in four areas (Leadership; Voices and choices; Engagement; Data and risk) working alongside system partners. The CQC's report has been shared with the Women's and Children's CBU. An update will be provided to the next Moving to Outstanding Steering Group meeting and Quality Assurance Committee. There are no concerns to escalate to the Board of Directors.

3. ASSURANCE COMMITTEE

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

4. RECOMMENDATIONS

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

Appendix 1

Summary position

Of the 28 Red Flags identified, the following are categorised as:

Area	Trend	Current position	Previous position (based on 25 indicators)
Overall Trust	↑	12 (43%%) are improving	8 (36%) are improving
Overall Trust	↓	16 (57%) are declining	15 (60%) are declining
Overall Trust	⇦⇨	0 (0%) has stayed the same	1 (4%) has stayed the same
Overall Trust	* It should be noted that 4 (14%) of the declining indicators are currently better or the same as the national average position		
Surgery	1 (3.5%) red flag metric is for surgery we no longer undertake and is on the list to monitor that CQC remove it		

	Inproving	Declining	Same
Trust wide	**S2** - Ratio of occupied beds to nursing staff	**S2** - Ratio of ward manager nurses to senior and staff nurses	
	W3 - Sick days for nursing and midwifery staff - Electronic Staff Record	**W3** - Whistleblowing alerts	
	W3 -Turnover rate for other clinical staff (%)	**W3** - Immediate managers	
		W3 - Sick days for non-clinical staff (%)	
		W3 - Sick days for other clinical staff (%)	
		W3 - Team Working	
		W3 - GMC Enhanced Monitoring	
		W3 - Turnover rate for nursing and midwifery staff (%)	
UEC	**R3** - Patients spending less than 4 hours in (any type of) A&E (%)	**R3** - A&E Attendees spending more than 12 hours from decision to admit to admission	
	R3 - Patients spending less than 4 hours in majors A&E	**R3** - Ambulances remaining at hospital for more than 60 minutes (%)	
	R3 - Admissions waiting 4-12 hours from the decision to admit (%)	**R3** - Waiting time from arrival to examination by doctor or nurse	
Medicine	**E2** - Emergency readmissions: Urinary tract infections	**E2** - In-hospital mortality: Fractured neck of femur	
	E2 - In-hospital mortality: Acute bronchitis	**E2** - In-hospital mortality: Urinary tract infection	
	R3 - Referral to treatment, on completed admitted pathways in Medicine, within 18 weeks (%) NHS England - RTT Admitted		
Surgery	**E1** - Crude proportion of patients having perioperative medical assessment (%)	**R3** - Referral to treatment, on completed admitted pathways in Surgery, within 18 weeks (%) NHS England - RTT Admitted	
		E2 - Risk-adjusted 90-day post-operative mortality rate (%)	
Cancer		**R3** - First treatment in 62 days of urgent GP/dentist referral (%)	
Outpatients	**R3** - Patients waiting over 6 weeks for diagnostic test		
	R3 - Referral to treatment, on incomplete pathways, within 18 weeks (%		

Key	
	Monitoring for removal by CQC
	Above or in line with national average

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/157**	
SUBJECT:	**COVID-19 Overview Report**	
DATE OF MEETING:	24th November 2021	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#224** Failure to meet the emergency access standard, Caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to Trust reputation, financial impact and below expected Patient experience. **#1207** Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and	

	welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component. **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The COVID-19 pandemic has brought unprecedented challenge for all healthcare providers to ensure the timely delivery of safe care. At WHH, this has been underpinned by robust governance processes to ensure that decisions have been made collectively with appropriate oversight from Ward to Board. This paper will describe the Trust approach to the management of the pandemic with each wave (1-3) noted alongside phases referenced as 'gateways'. Each gateway will describe the work undertaken to provide assurance of safety throughout the pandemic for both patients and staff. This is evidenced in a number of ways including: • Risk assessments. • Pathways. • Policies. • Standard Operating Procedures (SOPs). The Trust response to the COVID-19 pandemic has been underpinned by a robust governance framework ensuring that decisions have been made collectively across a range of senior disciplines including: • Medical Team • Nursing & Midwifery Team • Allied Health Professionals • Infection Prevention & Microbiology Teams • Operational Management Teams

<table>
<tr><td></td><td colspan="4">

- Governance, legal and Statutory Teams
- Occupational Health & Human Resources Teams
- Finance & Procurement Teams
- Palliative Care Team

This has enabled timely escalation to the Strategic Oversight Group as necessary with oversight at the at modified Board as part of robust governance arrangements, as described in the paper.
</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval</td><td>To note
x</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Board of Directors are asked to note the report.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Trust Board</td></tr>
<tr><td></td><td colspan="2">Agenda Ref.</td><td colspan="2">BM/21/07/94</td></tr>
<tr><td></td><td colspan="2">Date of meeting</td><td colspan="2">July 2021</td></tr>
<tr><td></td><td colspan="2">Summary of Outcome</td><td colspan="2">Noted</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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REPORT TO BOARD OF DIRECTORS

SUBJECT	COVID-19 Overview Report	AGENDA REF:	BM/21/11/157

1. Background

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

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

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

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

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

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

This has enabled timely escalation to the Strategic Oversight Group, with additional oversight provided within a modified Board governance structure.

2. Identification of Waves

2.1 Identification of Waves

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

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

Table 1

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

2.2 Initial Considerations of WHH Response

2.2.1 Governance

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

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

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

- Governance in relation to service changes including the recovery of services with accompanied PPE forecasting documents to ensure adequate PPE provision at all times.
- An Incident Management Team and control room was established from the beginning of the pandemic to coordinate the Trust response to COVID19.

The Chief Executive Officer and Executive(s) as appropriate, have reported to a bespoke Non Executive Director Assurance Group in addition to the Board of Directors which continued to hold governance committee meetings throughout the pandemic in a modified form. These measures ensured that appropriate oversight was maintained.

2.2.2 Capacity Arrangements: ED Footprint

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

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

2.2.3 Fit Testing and PPE Provision

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

3.0 Covid-19 Response Timeline

From the beginning of the pandemic the Trust identified an Accountable Emergency Officer (AEO) in accordance with the NHS England Emergency Preparedness, Resilience and Response Framework (EPRR). This was the Chief Operating Officer.

3.1 Wave1: Gateway 1ST March 2020 – May 2020

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

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

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

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

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

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

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

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

Following the peak in mid-April, the number of COVID-19 inpatients reduced and continued to steadily decline until 9th September 2020, marking the beginning of the second wave and gateway 2. NHSE/I notified Trusts of work to be undertaken and part of the recovery plan in April 2020 and WHH responded to this promptly in May 2020. This referenced the 'recovery phase' whereby the Tactical Group was reduced and replaced with Recovery Board temporarily (Tactical twice weekly, recovery three times per week), chaired by the Chief Operating Officer. This was further supported by a service change and recovery proforma detailing all changes to services, ratified at the Tactical Group. A bespoke Non Executive Director Assurance Group was established to ensure oversight from ward to board and the frequency of the Quality Assurance Committee was increased from bi-monthly to monthly in July 2021. This period represents wave 1, gateway 2 with the following undertaken:

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

COVID19 and to ensure that appropriate risk assessments were in place. This was actioned and included:

- Pregnant women
- NHS returnees
- Black and ethnic minority staff
- Staff with underlying health conditions.

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

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

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

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

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

- The daily COVID19 SITREP process

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

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

Screening patients prior to discharge to care homes was introduced on 16th April 2021 following PHE Care home Guidance. The guidance stated that:

- inform the care home of any COVID related issues for patients being discharged to care homes. This includes patients being admitted to the care home for the first time rather than returning to a home they came from.
- It is not necessary to have a negative test result for patients being discharged to care homes.
- Any exposed persons who have been in a bay with a COVID-19 case in hospital should isolate on return to the care home for the remaining 14-day period.

Palliative Care support was provided throughout the pandemic with additional support provided by WHH staff that were temporarily redeployed into the Palliative Care Team, thus increasing the size of the team. The Family Liaison Team linked into the Palliative Care Team to ensure that relatives and loved ones were kept informed and up to date with regard to treatment and individual plans of care. Visiting, whilst restricted was in place for those at the end of their life following appropriate risk assessment, in addition to patients with dementia, mental health diagnosis and learning disabilities. A medical ethics committee was also established with legal support though there was no requirement for this to be enacted during the pandemic.

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

Table 3: Inpatient Covid Status May – August 2020

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

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

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

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

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

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

During this time WHH expanded the work on the Trust environmental safety plan which has continually been updated throughout the pandemic and 'Staying Covid Secure in 2020' advice was issued to all corporate and clinical teams. There were updates on staff shielding in response to falling community rates of COVID-19 and staff continued to work flexibly in accordance with the agile working policy. Staff were provided with equipment to enable them to work from home.

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

Executive Director (Vice Chair of the Trust Board). This information is also shared with the Clinical Commissioning Group.

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

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

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

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

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

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

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

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

Recovery Board continued to take place twice weekly and there were no Tactical meetings. Assurance around limiting crowding in ED was completed. Work towards completing the

gateway 3 response continued. Other aspects undertaken in this time included (this list is not exhaustive).

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

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

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

Environmental plan in place to provide assurance of social distancing, access egress to entrances and IPC measures. This included analysis of capacity for bed spacing with a full risk assessment of every ward to identify compliance or challenges in meeting this requirement as per ward risk assessment. Clear curtains were provided to all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains.

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

Table 3: Inpatient Covid Status September – November 2020

	Number of COVID related deaths (inpatient)	Tier status	Peak inpatient number	Outbreaks
September 2020	4 (+1 in ED)	n/a	33	5 outbreaks 2 Inpatient (ACCU, A6,) 3 Staff (Discharge Planning Team,

				Endoscopy Halton, CSTM Theatre staff)

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

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

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

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

- Completion and submission of the phase 3 return.

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

October 2020

- Clinical validation of surgical waiting lists: framework and support tools communicated by NHSE on 1st October 2020, along with the National Elective Clinical Validation Programme - Exemption Process commenced.
- An updated FFP3 strategy was communicated through Tactical Board.
- Guidance on ICU and winter consumables were reviewed in preparation for the predicted surge and winter pressures.
- Test and trace Information for people working in healthcare was released and communicated.
- The ICU team reviewed the escalation plan determining escalation into Theatre Recovery and Theatre Pods to support surge pressures. It was determined that the unit would care for patients with COVID and the Theatre pods would support non-

COVID ICU patients. Theatre Recovery would support Level 2 COVID patients if ICU was escalated to full capacity.

- A review of staff rest areas took place with a number of locations identified to allow for social distancing on breaks. All break areas across the Trust, corridors, stairwells etc have been risk assessed since the beginning of the pandemic with regular daily senior spot checks undertaken daily.
- The asymptomatic testing pilot was coordinated by the Finance Team and involved the testing of asymptomatic patient facing staff for green pathway patients.
- The Winter Plan for Critically ill Children in the North West Management of Capacity and Demand Pressures for Winter 2020/21 and COVID19 Potential Surge were shared through the regional network.
- The COVID19 visitors trigger tool was released by NHSE, along with updated advice on visiting. Visitor guidance was updated nationally and locally.
- The Redeployment Hub was re-established to support the surge pressures.
- Weekend exemption reporting occurred with NW Trusts completing additional weekend situation reports for 11 weeks, with returns before 9am on Saturday and Sunday.
- The Gold Command daily data collection reviewing cancellations started on 23d October 2020.
- The Palliative Care referral process was recirculated to support surge and the associated impacts of this.
- IPC shared a Checklist and Monitoring Tool for the Management of suspected and known COVID19 cases.
- COVID19 Escalation occurred into C21 and K25, beyond A7, A8 and A9.
- Additional staff communication was shared around car sharing, social distancing on breaks and reassessing environments to ensure COVID-secure.
- On 11th October 2020 Ward B3 was opened as an escalation area to support surge pressures.
- Draft ward escalation plans to support surge were created by Clinicians, identifying the appropriate pathways and medical cover to support escalation. Emergency management SOP and discharge processes were updated to support this escalation.
- The Trust Full Capacity Protocol was enacted on 22nd October 2020.
- NHS Nightingale North West was reopened on 26th October 2020 with the appropriate admission criteria established.

3.4 Wave 2; Gateway 2

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

- Asymptomatic testing using the Lateral Flow Testing (LFT), with patient facing staff being issued LFT home testing kits and agreeing to test twice weekly.

- On 2nd November 2020 Increased admissions prompted the instruction for the reduction in urgent elective activity through the Cheshire and Merseyside Gold Command.
- A ward escalation plan was developed to support up to 240 COVID19 patients.
- There was additional guidance shared to support Clinically Extremely Vulnerable staff.
- The internal winter plan was devised with priorities shared at Tactical Board.
- The COVID19 visitors trigger tool was updated by NHSE.
- National guidance 'Your COVID-recovery' released.
- Learning Disability Emergency Department Care Pathway COVID update shared by NHSE.
- The clinical prioritisation programme update was shared at Tactical Board on 11.11.20.
- Initial plans to develop a Continuous Positive Airway Pressure unit on ward A7 were communicated through Tactical Board.
- Version 1 of the Urgent and Emergency Care, Royal College of Emergency Medicine action plan was shared at Tactical Board on 11.11.20.
- The Danish mink variant was detected, and a triage process was identified on 12.11.20.
- COVID Oximetry work commenced with the initiation of oximetry at home on 12.11.20.
- The vaccination team was established, and deployment information was received.
- Flu vaccination uptake reminders occurred.
- Guidance from NHSE around Wave 2 Service Protection support guide for Specialised Services was released.
- De-escalation of COVID19 wards started to occur by 20th November 2020 with reduced pressure of COVID19 inpatient numbers.
- The IPC Board Assurance was updated and shared on 23.11.20.
- The trial of Tocilizumab was supported by Pharmacy, along with and update to the Recovery Trial SOP.
- The instruction for admission, day 3 and day 5 screening was initiated by NHSE on 17th November 2020 with which the Trust was compliant. The Trust had initiated day 2 screening ahead of the release of this guidance on 16th November 2020.

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

Table 4: Inpatient Covid Status December – February 2020

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

				(A5, A8, B3)

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

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

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

- The vaccination programme commenced with the use of the Pfizer BioNTech vaccine and groups were prioritised in accordance with the cohorting identified by the JVCI. A range of SOPs were approved to support the operational, logistical and clinical processes associated with the vaccination programme.
- New COVID19 variants were discovered in parts of London and the South East.
- Clinically Extremely Vulnerable advice was updated to support this group of staff through the tier system.
- The Home for Christmas campaign was implemented on 10th December 2020, before the launch of Where Best Next? following the Christmas period.
- Prioritisation letters for the waiting lists were approved through Tactical group.
- The wards were de-escalated in the reverse order of the October / November 2020 escalation plan – K25, C21, A9, A8 and A7 were utilised for COVID19 capacity.
- Cheshire and Merseyside Gold Command shared some modelling to support preparation for a third wave. The operational managers reviewed escalation plans in Intensive Care and on the wards to plan for this.
- Additional advice to support pregnant women was released by NHSE.
- NHSE communicated additional funding availability to support winter workforce pressures.
- The self-isolation policy was reviewed by the Planned Care Team and Microbiology. This was approved through the Tactical Group.

- The mortuary refurbishment commenced mid-December 2020 with mitigation to utilise space at the Halton site.
- Updates to the Acute Sitrep and reporting processes were communicated by NHSE.
- All business-as-usual reporting occurred over the Christmas period and a detailed Christmas Plan was communicated for assurance of staffing and operational teams.
- NHSE communicated operational priorities for winter and 2021-22 on 23rd December 2020.
- Lateral Flow guidance for ED and Maternity was issued with subsequent action plans being implemented in departments.
- The Trust received guidance on the LAMP testing for staff to replace LFT home testing in the Local community rates peaked on 12th January 2021. On 15th January 2021 the Trust experienced a peak of 243 COVID19 inpatients.
- The Prime Minister announced the third national lockdown on 4th January 2021.
- Staff redeployment was reviewed to support the increased demand on Intensive Care and COVID19 escalation wards at the start of January 2020.
- Ward escalation followed the previous plan, with A7, A8, A9, C21 and K25 established for escalation. Reconfiguration of surgical wards meant B18 was also available for ward escalation.
- National updates on patient visiting were communicated by NHSE, with no significant changes to current practices.
- Oxygen issues emerged with alarms triggered due to the increased use of oxygen in wave 3. The SOP to support the safe deployment of oxygen was devised and there was increase monitoring of the flow of oxygen through Tactical group meetings. Mutual aid supported the increased demand on CPAP and NIV machines.
- Paediatric ED relocated to B11 to ensure adequate assessment space for surge pressured in ED.
- Medical student deployment was extended.
- The Oxford Astra Zeneca Vaccine was deployed for patient and staff vaccinations.
- Inpatient vaccinations commenced on both the Warrington and Halton sites.
- Enhanced Respiratory Care Ward - A7 was stepped up as additional ICU / HDU. support with patients receiving CPAP and NIV on the ward.
- The COVID Virtual ward was established.

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

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

4.0 Risk Management

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

5.0 Health and Safety

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

- Environmental action plan
- Health and Safety Report
- Legal Paper
- Nosocomial paper
- Numerous standard operating procedures
- Meeting minutes from:
    - Tactical Group
    - Recovery Board
    - Strategic Oversight Group
    - Patient Safety and Clinical Effectiveness Sub Committee
    - Risk Review Group
    - Health and Safety Sub Committee
    - Infection Prevention Silver Command
    - Covid Learning exercise, wave 1 (Appendix 1)
    - Service Change Proforma log
    - Silver COVID19 Group

• 6.0 Finance

All COVID-19 expenditure both revenue and capital was reviewed and approved by Executive colleagues during the pandemic. Paperwork was completed and monitored before purchases made so that the expenditure could be tracked and coded to COVID-19 and claimed back from NHSE/I. The Trust was chosen to be audited by Deloitte and expenditure was checked and verified. A full report from Deloitte was shared with the Audit Committee and the Finance and Sustainability Committee was appraised on the process and outcome. The report showed that a robust process had been followed with only one overstatement and a small number of coding errors highlighted in the findings.

7.0 Summary

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

Reports:

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

8.0 Recommendations

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

Appendix 1

Ratification of Standard Operating Procedures

Month	Standard Operating Procedures
April 2020	Medicines Policy - Proposed Policy Changes during COVID19 Escalation SOP for Health Care Workers SOP for Resuscitation of adults Visiting the dying and care after death SOP for Isolation of Vulnerable Patients and Infection during COVID19 Oxygen and NEWS guidance Contact a patient SOP

	Standard Operating Procedure for the Deployment of Oxygen Concentrators During COVID19 Pandemic Operation Shield SOP Discharging SARS-CoV2 Positive Patients / Stepping Down Infection Control Precautions while in the Hospital Clinical ethics committee TOR and escalation process RIDDOR and COVID19 - Safe Operating Procedure Updated SOP for Management of COVID19 Patient Placement During COVID19 Pandemic Testing Healthcare workers for COVID19 Estates Use of high flow Oxygen therapy devices Vulnerable Patients Update SOP for Isolation of Vulnerable Patients Caring for people at high risk during Covid 19 Criteria for Admission for Suspected COVID Patients from 08th April 2020 Clinical guide for the management of surge Nightingale Hospital North West Reusable Personal Protective Equipment Decontamination and Maintenance SOP
May 2020	A report was produced by AQUA summarising the response to the first wave of the pandemic. Waiting list process COVID19 Medical Care Recovery Plan V 1.0 SOP for Fit Testing of Respiratory Protective Equipment using the Qualitative (taste) Method Use of black box risk assessment Pilot Testing of Asymptomatic Staff Service recovery for Endoscopic procedures in Halton Theatre and Spire during COVID 19 Cancer pathways Laparoscopic Surgery Patient Placement during COVID19 Pandemic Service Change Protocol v2 Prescribing of paracetamol for staff in staff accommodation self-isolating Operating framework for urgent and planned services in hospital settings during COVID19 Respiratory Follow Up of Patients with COVID19 Pneumonia SOP for Testing Healthcare workers V7 WHH SOP NHS On Loan Equipment 2.docTrack and Trace of Loaned Medical Devices during COVID19 V.1 Testing Healthcare workers for COVID19 Staff Antibody SOP V1.1 Revised Elective Surgery during COVID19 Pandemic SOP Women's and Children's CBU COVID19 Recovery Plan v1.0 Recovery board action plan ~ Halton Elective Centre Recovery Board Action plan DD.docx RCEM - COVID 19 Action Plan Service recovery for Endoscopic procedures in Halton Theatre and Spire through COVID 19 v3

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

	Testing and advice for healthcare workers Virtual MDT SOP Corticosteroids in COVID -19 PACU SOP Elective paediatric surgery low prevalence Elective paediatric surgery high prevalence Standard Operating Procedure for Management of Novel Coronavirus (COVID19) in Adults and Children version 14092020 A4 WHH SOP exclusion 03.8.2020 Transfer of Covid-patient
October 2020	Treatment escalation plans and communication Staff clinical screening - non swabbing Remdesivir SOP Combined HFNO Ward Admissions SOP Local Anaesthetic Administration SOP V2 Ward Admissions SOPv2 Healthcare workers return from shielding v2
November 2020	Version 4 WHH Pharmacy SOP Recovery Clinical Trial 26-11-2020 SOP Conscious Proning WHH SOP Safety Huddle and Briefing COVID19 Patient Screening SOP 2.1 NOV 2020 SOP for Testing and advice for Healthcare workers using LFD - OH additions - 18.11.2020 SOP for Remote Working
December 2020	Tactical - SOP for Testing and advice for Healthcare workers relating to COVID19 V10 • SOP Ordering Pfizer BioNtech Covid- 19 Vaccines • SOP Monitoring Freezer Temperature • SOP IT support for receipt of COVID vaccines sites • SOP Covid Vaccines Clinic Appointments • SOP Covid Vaccines in OPD • SOP Mortuary Refurbishment OOH Temp Failure at WHH • SOP Covid -19 vaccines governance • SOP MS35 Receipt of Standard bulk deliveries into pharmacy • SOP Moving PFizer BioNtech Covid -19 Vaccine • SOP Issuing, Checking, delivering supplies of Vaccines • SOP Mortuary Refurbishment Site Manager at WHH • COVID19 Patient Screening SOP 2.3 Dec 2020 • WHH OPD SOP
January 2021	Tocilizumab ICU SOP B18 SOP V4 Jan 2021

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

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

Headlines on capturing learning fro

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/158**	
SUBJECT:	**Use of Resource Assessment (UoRA) Update – Q2 2021/22**	
DATE OF MEETING:	24th November 2021	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer and Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1273 Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. #1289 Failure to deliver planned elective procedures caused by the Trust's decision to pause some elective procedures in order to ensure safe staffing and critical care capacity during the COVID-19 pandemic, resulting in potential delays to treatment and possible subsequent risk of clinical harm #115 Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. #134 Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust continues to progress improvement in its Use of Resources both internally and in collaboration with system wide partners, however COVID-19 has impacted progress. This paper outlines the current status of the Use of Resources Dashboard, however it should be noted that a number of the indicators have not been updated on the Model Hospital.	

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

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

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

REPORT TO THE BOARD OF DIRECTORS

SUBJECT	Use of Resource Assessment (UoRA) Update – Q2 2021/22	AGENDA REF:	BM/21/11/158

1. BACKGROUND/CONTEXT

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

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

2. KEY ELEMENTS

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

The following movements have taken place on the UoRA Dashboard since Quarter 1:

- Radiology Cost Per Report – the Trust has moved from Red to Green (the last update to this indicator prior to this quarter was in March 2018). The Trust's radiology team has repatriated a number of modalities including Vascular which has resulted in a lower cost per report.
- Costs per WAU (Nursing, Medical & AHP) – These metrics have been moved to the "legacy" area of the Model Hospital which means these are no longer being updated. Therefore, these metrics have been removed from the UoRA dashboard.

National Corporate Benchmarking

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

3. RECOMMENDATIONS

The Board of Directors is asked to:

1. Note the contents of this report.

Andrea McGee
Chief Finance Officer and Deputy Chief Executive
17th November 2021

Appendix 1 – Benchmarking Performance against the National Median

KLOE Indicator	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22
KLOE 1 - Clinical													
Pre-Procedure Elective Bed Days	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22
Pre-Procedure Non-Elective Bed Days	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22
Emergency Readmission (30 Days)	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22
Did Not Attend (DNA) Rate	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22
KLOE 2 - People													
Staff Retention Rate	June 2018	September 2018	December 2018	December 2018	December 2018	December 2018	March 2020	March 2020	June 2020	Sept 2020	December 2020	March 2021	March 2021
Sickness Absence Rate	May 2018	August 2018	November 2018	November 2018	June 2019	October 2019	March 2020	March 2020	June 2020	Sept 2020	January 2021	March 2021	June 2021
KLOE 3 – Clinical Support Services													
Top 10 Medicines - Percentage Delivery of Savings	March 2018	March 2018	March 2018	March 2018	September 2019	November 2019	March 2020	March 2020	August 2020	November 2020	February 2021	May 2021	July 2021
Pathology - Overall Costs Per Test	Q4 2017/18	Q4 2017/18	Q2 2018/19	Q2 2018/19	Q4 2018/19	Q2 2019/20	Q3 2019/20	Q3 2019/20	Q3 2019/20	Q1 2020/21	Q3 2020/21	Q4 2020/21	Q4 2021/22
Radiology Cost Per Report	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	2020/21
KLOE 4 – Corporate Services													
Finance Costs per £100m Turnover	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19
Human Resource Costs per £100m Turnover	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19

Procurement Process Efficiency and Price Performance Score Clinics	Q4 2016/17	Q4 2017/18	Q3 2018/19	Q3 2018/19	Q4 2018/19	Q4 2018/19	Q4 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q2 2019/20	Q2 2019/20	Q2 2019/20
Estates Costs Per m2	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2019/20	2019/20	2020/21

KLOE 5 - Finance													
Capital Services Capacity*													
Liquidity (Days)*													
Income & Expenditure Margin*													
Agency Spend - Cap Value*													
Distance from Financial Plan*													

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

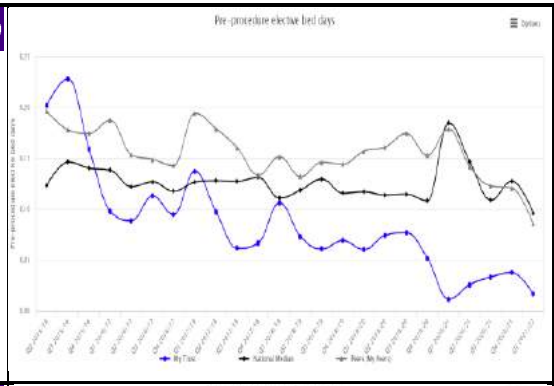
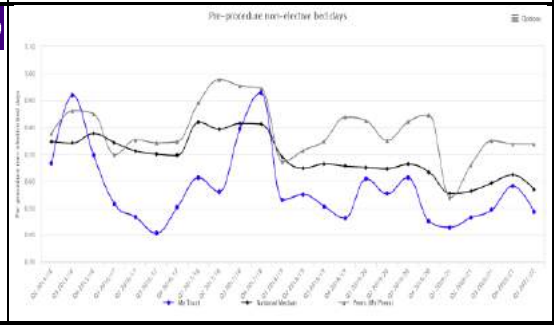
Green on the Model Hospital (Better than the National Median)
Red on the Model Hospital (Worse than the National Median)
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q2 2021/22

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

KLOE 1: Clinical/Operational

KLOE Operational Lead: Hilary Stennings

Pre Procedure Elective Bed Days - The number of bed days between the elective admission date and the date that the procedure taken place.	**National Median: 0.10 days** **Q1 2021/22** **Peer Median: 0.9 days** **Target: Maintain** **Best Quartile: 0.05 days** **WHH Position:** **0.02 days** **Ranking:** **2/9 Peer Group** **Quartile:** **1 (Best)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	UoR		**The Trust is performing in the best quartile for this metric and is performing better than the national and peer medians.** The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme supported the reduction in theatre cancellations and in improving productivity and efficiency. The position has been sustained throughout the COVID-19 pandemic and continues to be monitored.
Pre Procedure Non Elective Bed Days - The number of bed days between an emergency admission date and the date the procedure taken place.	**National Median: 0.57 days** **Q1 2021/22** **Peer Median: 0.74 days** **Target: Maintain** **Best Quartile: 0.40 days** **WHH Position:** **0.49 days** **Ranking:** **03/09 Peer Group** **Quartile:** **2 (2nd Best)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	UoR		**The Trust is performing better than the national and peer medians**. The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme supported the reduction in theatre cancellations and in improving productivity and efficiency. The position has been sustained throughout the COVID-19 pandemic and continues to be monitored.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

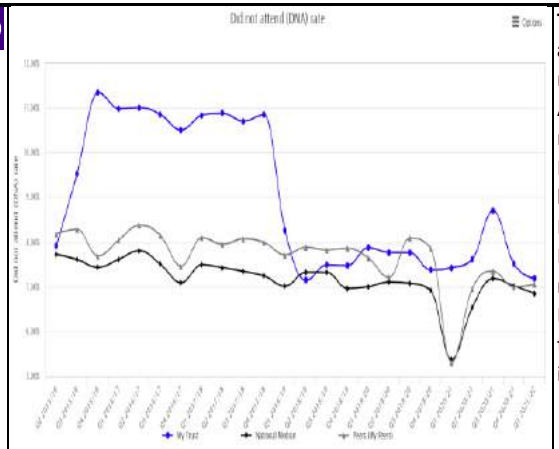
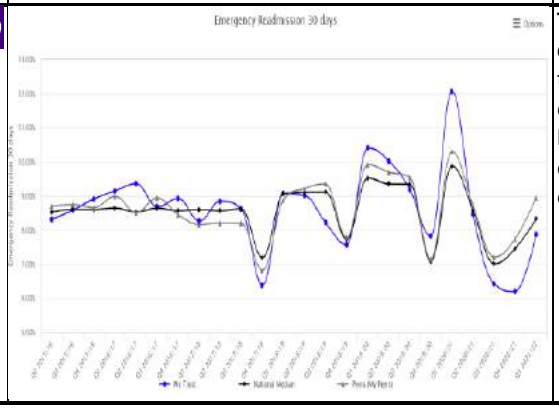
Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

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

Use of Resources Assessment Dashboard - Q2 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Did Not Attend Rate - Rate of patients not attending their outpatient appointment	**National Median: 6.85%** Q1 2021/22 **Peer Median: 7.05%** Target: National Median **Best Quartile: 5.80%** **WHH Position:** 7.18% **Ranking:** 06/09 Peer Group **Quartile:** 3 (2nd Worse) **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		**The Trust is performing slightly worse than the national and peer medians, although improvement has been seen this quarter.** The Trust reintroduced a text reminder service which resulted in a significant improvement in the DNA (Did Not Attend) rate. Further improvements have been made to the text message reminder and a communications campaign took place (Don't Let Me Down). During the COVID-19 pandemic, the use of virtual and telephone appointments has been rapidly expanded. The Trust has established the Outpatient Recovery Improvement Group incorporating 5 workstreams; Risk Stratification, Workforce, Performance & KPIs, Operational and Access Policy. DNA performance is monitored through the Performance & KPI workstream. The Access policy and the DNA policy have been reviewed and individual CBUs are monitoring frequent DNAs to ensure that these patients are clinically reviewed for potential discharge. Patient initiated follow ups are also being used and will reduce DNAs.
Emergency Readmission Rates (30 Days) - This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay. Admissions for cancer and obstetrics are excluded as they may be part of the patient's care plan.	**National Median: 8.32%** Q1 2021/22 **Peer Median: 8.95%** Target: Maintain **Best Quartile: 7.87%** **WHH Position:** 6.20% **Ranking:** 3/09 Peer Group **Quartile:** 2 (2nd Best) **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		**The Trust is performing better than national and peer medians and is in the best quartile for this metric.** Every effort is made when discharging patients to ensure that the discharge is appropriate. Readmissions are reviewed by the clinical directors to understand any inappropriate discharges and to ensure lessons are learned. The Trust is fully engaged with GIRFT (Getting It Right First Time) and continues to use intelligence to make improvements in efficiencies and the quality of services.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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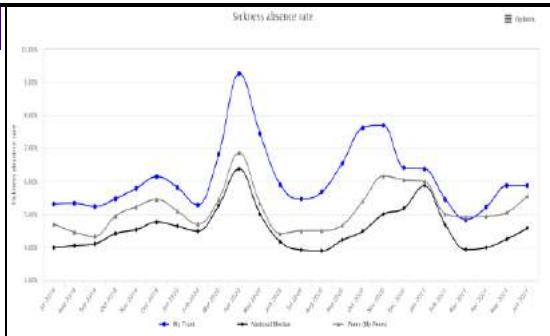
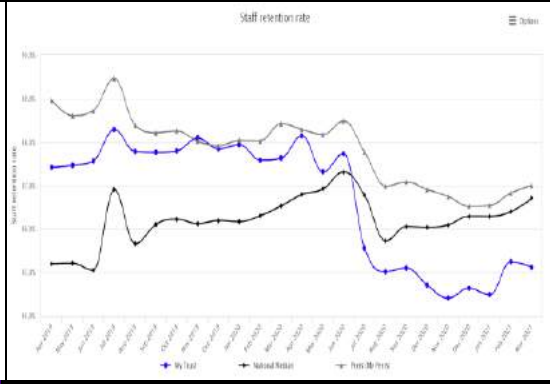
Use of Resources Assessment Dashboard - Q2 2021/22

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

KLOE 2: People

KLOE Operational Lead: Carl Roberts

Staff Sickness - Percentage of staff FTE sick days.	**National Median: 4.58%** **June 2021** **Peer Median: 5.57%** **Target: 4.2%** **Best Quartile: 3.28%** **WHH Position:** **5.88%** **Ranking:** **6/10 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: Trust Board, SPC** **Source: HSCIC - NHS Digital iView Stability Index**		**The Trust is performing worse than the national and peer medians.** Significant strategic and operational work has been undertaken to improve this position. The position includes COVID-19 and Non COVID-19 related sickness but does not include shielding/medical suspensions as a result of COVID-19. A deep dive review was undertaken from which a series of recommendations and actions were developed. The HR Directorate is working with clinical and corporate services to implement these recommendations and actions.
Staff Retention Rate - The percentage of staff that remained stable over 12 months period.	**National Median: 86.7%** **March 2021** **Peer Median: 87.0%** **Target: National Median** **Best Quartile: 89.2%** **WHH Position:** **85.10%** **Ranking:** **9/10 Peer Group** **Quartile:** **3 (2nd Worse)** **Monitoring: SPC** **Source: HSCIC - NHS Digital iView Stability Index**		**The Trust is performing worse than the national and peer median.** The Trust has previously performed well with regards to staff retention and turnover which has demonstrated the success of the work undertaken in line with the NHSE/I nursing retention programme. However, performance has been impacted by the significant number of temporary staff who supported the Trust during the pandemic and whom have now left their post. This indicator is a rolling 12 month period and performance is expected to improve as the Trust returns to normal operations. For example retention of permanently contracted staff in October 2021 was 88.54%.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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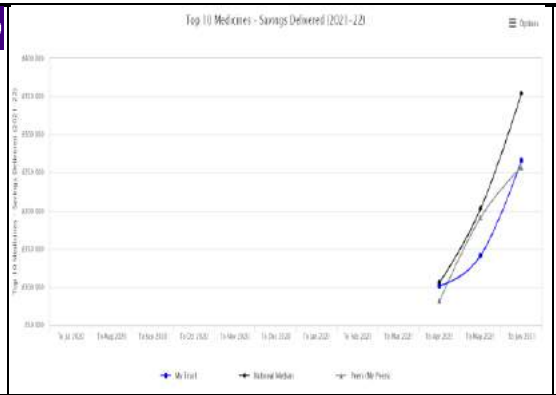
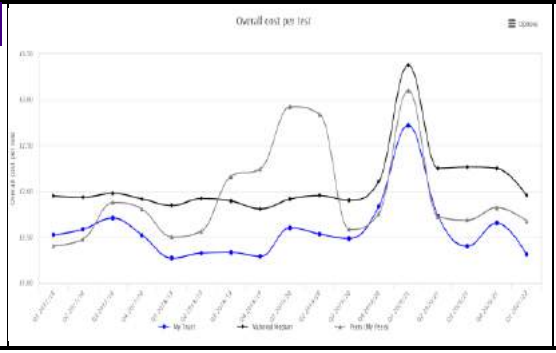
Use of Resources Assessment Dashboard - Q2 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
KLOE 3: Clinical Support	UoR		KLOE Operational Lead: Diane Matthew KLOE Operational Lead: Neil Gaskell KLOE Operational Lead: Mark Jones

Top 10 Medicines - Percentage Delivery of Savings (Pharmacy)	**Benchmark: £125k** **Peer Median: £356k** **Best Quartile: N/A** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: Medicines Governance Committee** **Source: Rx-Info Define© (processed by Model Hospital)**	**July 2021** **Target: Benchmark** **£311k** **N/A**	UoR		**The Trust is performing better than the national benchmark.** The Trust is exceeding the national benchmark and has achieved savings of £311k as of July 2021. Medicines optimisation remains a prioritised workstream. Processes continue to be aligned between the Trust, CCGs/ICS and the Pan Mersey Area Prescribing Committee. Collaboration is ongoing to ensure opportunities for further improvements are identified. WHH is engaged in a ICS level medicines optimisation workstream which will look to collaborate on medicines efficiencies across the network.
Pathology - Cost Per Test - The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items.	**National Median: £1.96** **Peer Median: £1.68** **Best Quartile: N/A** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: Pathology Business Meeting** **Source: NHSI Q Pathology Data Collection 20/21**	**Q4 2021/22** **Target: Maintain** **£1.31** **1/4 Peer Group** **1 (Best)**	UoR		**The Trust is performing better than the national and peer medians.** Overall the Trust's pathology service is efficient with the use of streamlined processes, technology and procurement opportunities. The Trust continues to perform well with regards to overall cost per test during the recovery period following the COVID-19 pandemic. Data collections have now resumed and the Trust has submitted up to date data including the annual position for 2019/20 and Q4 2020/21. Q1 2021/22 is due to be submitted in October 2021.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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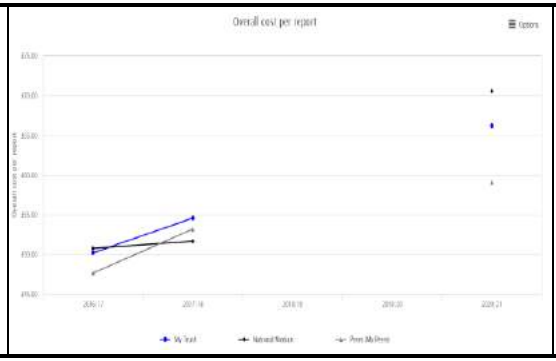
Use of Resources Assessment Dashboard - Q2 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Imaging - Cost Per Report - Total cost of reporting one image, irrespective of modality	**National Median: £70.59** **2020/21** **Peer Median: £68.15** **Target: Maintain** **Best Quartile: £55.93** **WHH Position:** **£66.19** **Ranking:** **8/10 Peer Group** **Quartile:** **2 (2nd Best)** **Monitoring:** **Source: NHS Imaging Productivity Data Collection (Annual)**		**The Trust Imaging Cost Per Report is lower than the national and peer median.** This metric has been updated for the first time in 3 years and shows the Trust is cheaper than the national median for the overall cost per report. The Trust has invested significantly in diagnostic equipment which has enabled the Trust to reduce its outsourcing of radiology including vascular.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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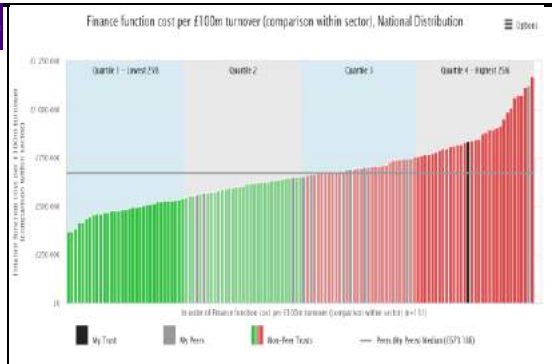
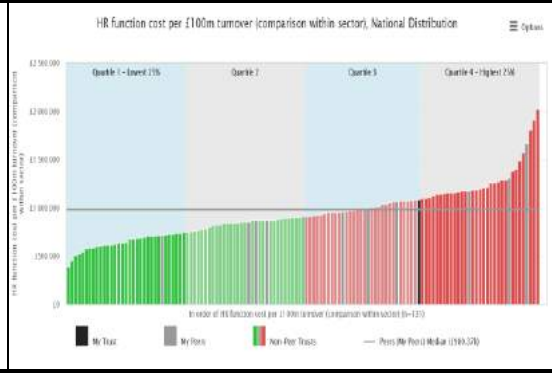
Use of Resources Assessment Dashboard - Q2 2021/22

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

KLOE 4: Corporate Services

Finance — KLOE Operational Lead: Jane Hurst
Procurement — KLOE Operational Lead: Alison Parker
HR & OD — KLOE Operational Lead: Carl Roberts
Estates & Facilities — KLOE Operational Lead: Ian Wright

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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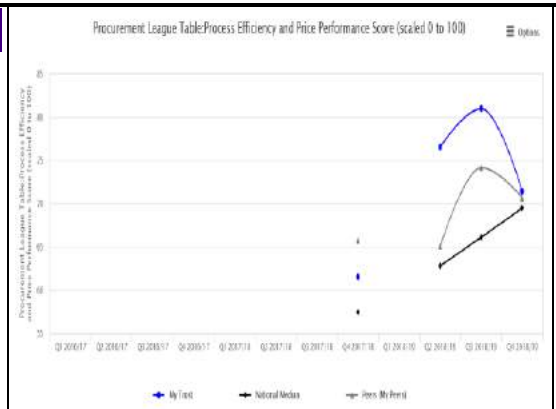
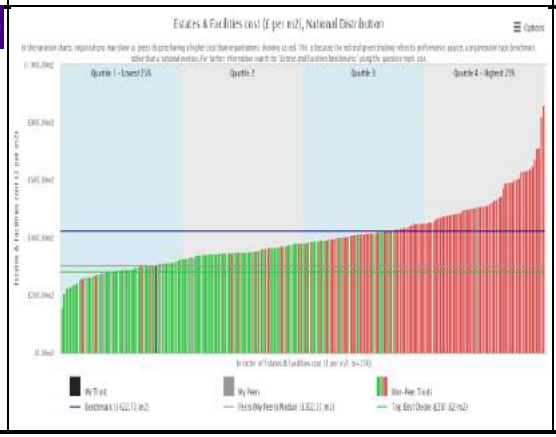
Use of Resources Assessment Dashboard - Q2 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Procurement Process Efficiency and Price Performance Score - This measure provides an overall view of how efficient and how effective an NHS Provider is in it's procurement process and price performance, respectively, when compared to other NHS providers.	**National Median: 56** **Q2 2019/20** **Peer Median: 44.7** **Target: 72** **Best Quartile: 72** **WHH Position:** **61** **Ranking:** **4/11 Peer Group** **Quartile:** **3 (2nd Best)** **Source: Purchase Price Index and Benchmark (PPIB) tool**		**The Trust is performing better the national and peer median for the Procurement Process Score.** Pre COVID-19 the Trust was engaged to move to Edge for Health, SBS has suspended new clients with no date for resuming. Edge for Health is an intelligent way to streamline process between suppliers and the Trust and supports performance in a number of ways. Suppliers are responsible for updating their catalogues electronically (subject to Trust approval) reducing error and orders raised are 'flipped' to become an invoice for automatic matching. This also improves the number of invoices transacted via EDI as they become system generated. The Trust will engage with Edge for Health once SBS are accepting new clients. This will further improve the Electronic Transfer of Order and Invoices metric and therefore contribute to the Procurement League Table ranked position.
Estates & Facilities Costs (£ per m2) - The total estates and facilities running costs is the total cost of running the estate in an NHS trust including, staff and overhead costs. In-house and out-sourced costs, including PFI costs, will be included.	**Benchmark: £422** **2020/21** **Peer Median: £302** **Target: Maintain** **Best Quartile: £321** **WHH Position:** **£308** **Ranking:** **5/9 Peer Group** **Quartile:** **1 (Best)** **Monitoring: Estates and Facilities Operational Group** **Source: ERIC 2018-19 Total Estates and Facilities Running Costs**		**The Trust Estates and Facilities costs are better than the national Benchmark.** The Trust has invested year on year to reduce backlog maintenance. The Trust has had the opportunity in 2020/21 to significantly invest in backlog maintenance and this should be reflected in 2021/22 data. The Trust is awaiting the outcome of its ERIC (a national estates benchmarking report) return due in Q3 2021/22.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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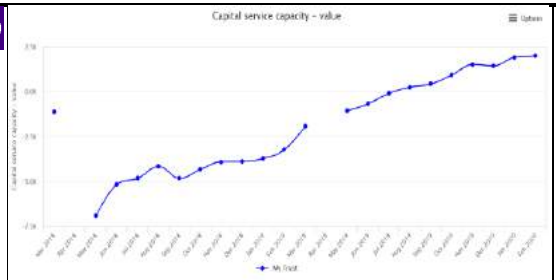
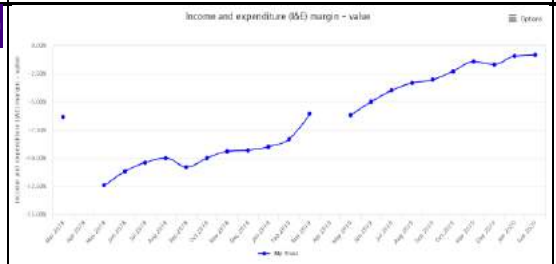
Use of Resources Assessment Dashboard - Q2 2021/22

KLOE 5: Finance

KLOE Operational Lead: Jane Hurst

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Capital Services Capacity - The degree to which the provider's generated income covers its financial obligations	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 1.99 (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		Use of Resource (Finance) reporting has been suspended since March 2020, therefore the information on the model hospital is out of date. The financial position has significantly changed since April 2020 due to the COVID-19 pandemic under the new financial regime. The Trust achieved the target of break even in H1 (months 1 - 6). The Trust is currently developing plans for H2 and whilst the challenge from the system is to break even, the first submission was a £9.5m deficit. This is mainly due to a reduction in income, inability to access ERF and a shortfall in funding for the national pay award.
Income & Expenditure Margin - The income and expenditure surplus or deficit, divided by total revenue.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital -0.85% (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		For 2020/21, the Trust delivered a deficit of £11.3m with an adjusted deficit of £6.8m. The Trust achieved breakeven for H1 2021/22. The Trust is working with the system towards developing a plan of breakeven for H2, however the first submission was a deficit of £9.5m.
Liquidity (Days) - Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital -66.53 (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		The Trust liquidity days are 21.61 as of M6 2021/22. This is positive and means that the Trust can promptly pay suppliers. As at M6, the cumulative Trust performance against the Better Practice Payment Code was 94%.

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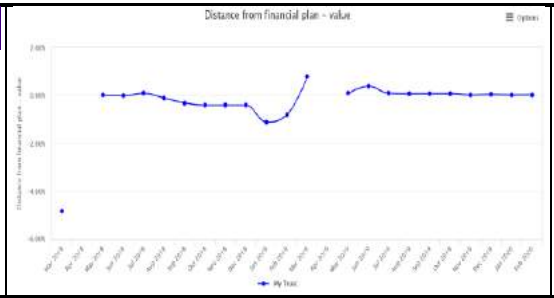
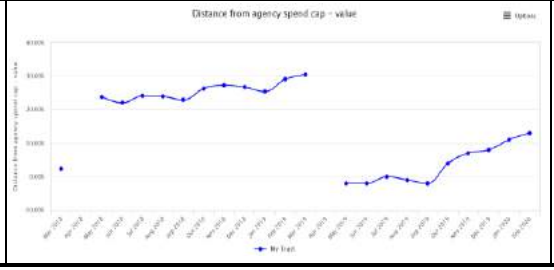
Use of Resources Assessment Dashboard - Q2 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Distance from Financial Plan - Year-to-date actual I&E margin in comparison to year-to-date plan I&E margin. I&E margin calculated on a control total basis. Measure is in percentage points.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 0.04% (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		As at month 6 the Trust was on plan finishing H1 with a breakeven position. The ongoing COVID-19 costs and increase in drug costs have been offset by slippage on schemes and underspends on some budget lines.
Agency Spend - Cap Value - The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 13.00% (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		There is no agency cap for 2021/22, however the Trust continues to closely monitor agency spending for both business as usual and COVID-19 requirements. The agency costs are £6.0m as at month 6, of which £1.5m relates to COVID-19.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q2 2021/22

KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
Clinical/ Operational - Operational Efficiency	**Hilary Stennings**	**Operational Efficiency** • Deep Dive Reviews • Theatre Transformation • A&E Improvements • Maternity Improvements • Ward Reconfiguration – programme re-configure the Warrington site resulting in improvements in flow, patient experience and care. Ward B18 has been opened as a Respiratory and Enhanced Care co-located with Critical Care to ensure operational efficiency. This will allow escalation of critical care capacity at times of surge. • Re-designing the Community ECG pathway – redesign of ECG pathway providing ECG in community settings. • Hospital Handover Improvement Project with NWAS – project to review ambulance handover times and improve flow in ED. • Focus on Flow – programme of work to improve discharges, improving flow, ensuring patients are at the most appropriate point of care. • Breast Service Reconfiguration – the Trust has completed the reconfiguration of breast screening and surgery service, the building work is complete and the new unit has now opened. This will improve patient experience and efficiency. **DNA Rate** • DNA - Communications Campaign "Don't let us down" • Review of alternative appointment methods such as telephone and virtual clinics rapidly expanded during the COVID-19 pandemic. • Use of Technology – optimisation of text message reminder service. Introduction of Virtual appointments and Patient Initiated Follow Ups. **Emergency Readmissions – 30 Days** • Improvements in Discharge Planning are underway, this has been impacted by capacity within social care to transfer the patient onto their next point of care. **COVID-19** • Virtual COVID-19 Ward - early supported discharge by monitoring COVID-19 patients at home. • Investment in Diagnostics Equipment - CT/MR £4.5m, 3 x X-ray Rooms including within A&E £0.4m. This has support patient flow and COVID-19 recovery. The new MR scanner will open in November 2021 and will give the Trust the ability to carry out Cardiac MR. The new CT scanner and X-ray rooms are now open.	• Progression of collaboration opportunities through mutual aid/SLAs to maximise use of assets e.g. Walton Centre Pain service and support recovery. • Virtual Enhanced Care – review and re-design of processes to improve patient care/experience. Expansion of the use of virtual clinics. All CBUs are creating SOPs where appropriate. • Patient Transport Services – review and reprocurement of patient transport services including capacity/demand management to improve patient flow. • ED plaza development - phase 1 (ED Ambulatory Assessment Service) to be delivered 2021/22. Building work is now underway. • COVID-19 Recovery – recovery programme for the Trust to achieve the elective activity and outpatients. • DNA - Patient Initiated follow up is live in T&O, Cardiology, Ophthalmology, Gastroenterology and Gynaecology. Other specialties are being scoped.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q2 2021/22

KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
People - Sickness	**Carl Roberts**	**Sickness Programme of Work:** In order to improve sickness absence and also in response to COVID-19 related sickness, the Trust has implemented a number of initiatives including: COVID-19 nursing advice line, Occupation health call centre, Enhanced 7 day occupational health service, Enhanced health & wellbeing options, Mental Health wellbeing drop in sessions, Facilitated conversations within impacted clinical areas, Face to Face on site counselling, Alternative therapies, Additional support for BAME staff, A real-time workforce information hub, Support for shielding staff, Processes around antigen and antibody testing, Self-compassion at work programme, Bringing teams together bespoke development package and the Launch of the Disabled Staff Network. • The Trust is working with other Trusts across the North West to improve sickness absence - utilising lessons learned and how these can be applied in the future with analysis and deep dive reviews. • Undertaken a programme of engagement and training with line managers to promote education and understanding of the Occupational Health Service, strengthening links and joint working between line managers and the service.	**Sickness:** The Trust undertook a deep dive review into sickness absence and attendance management following request by the Trust Board in November 2020. Recommendations which are in the process of being implemented are: • Supporting Absence Task and Finish Group established and will meet in December 2021. Continued focus on employee Health and Wellbeing. • Focus on interventions for staff living in Halton and Warrington, working with local community partners. • The HR Business Partner Team are providing ongoing support to operational managers in managing sickness absence. This includes advisory support in relation to policy and attendance at welfare, and sickness stage meetings/hearings. • Review 'Supported Early Return' pilot and roll out Trust wide. • Undertake a full and thorough review Attendance Management Policy. The Trust has secured funding from NHSE/I for a project to launch the Absence Policy as a pilot. • Preventative measures continue to be implemented including Occupational Health and Wellbeing interventions, the Covid Booster and Flu Vaccination Campaigns and asymptomatic staff testing.
People - Retention	**Carl Roberts**	**Retention:** Improving work/life balance by reviewing policies/procedures and promotion of offerings, Support for staff to pursue career progression, Develop and empower line managers to retain staff, Development of recruitment and retention champions, Improvement of retire and return options and pre-retirement courses, Launch of new PDR framework and the Introduction of the flexible working actions set out within the NHS People Plan. • A programme of Workforce Recovery to maintain the current focus on employee Health and Wellbeing, this is being lead by the Workforce Recovery Steering Group. Bespoke programmes were developed for ED, Theatres and ITU.	**Retention:** • A line manager development programme is being implemented - in progress, a task and finish group has been set up to share proposed development programme and will seek feedback. Implementation of career development programme pilot with staff networks, to be rolled out Trust wide in Q4. • Launch of a kindness, civility and respect campaign - in progress. • Working with NHSE/I "Flex for the Future" programme to look at how we can improve both agile and flexible working throughout the organisation. • Supporting 40 of the Trusts leaders through the Compassionate Leadership Development Programme • Team development offers include bringing teams back together, leadership offers, and leadership circles. Identification and implementation of a Talent Management framework for WHH, which will be Scope for Growth the NHSE/I Talent management approach. • Staff Facilities task and finish group has been established too review the current Staff Facilities based national recommendations and develop a strategic plan to improve.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q2 2021/22

KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
People - Staff Costs per WAU	**Carl Roberts**	**Staff Costs per WAU:** Ongoing development of workforce plans which will flex as required, Review of vacancies in hard to recruit roles and understand what can be done differently, Monthly deep dives supported by NHS professionals, Enhanced ECF processes for non-clinical vacancies, Expanded ECF processes for temporary staffing, Implementation of the Cheshire & Mersey rate card, Implementation of consistent hourly rates for Medical staff, Introduction of patchwork medical bank system, Review of all long term locums by the COO and Review and action of pay elements within NHSI/E Grip and control checklist. • Recruitment of International Nurses - the Trust embarked on a programme to recruit 96 International Nurses to support the Nursing workforce and fill the vacancies. The programme consists of working with both WWL NHS Trust and Mid Cheshire Hospitals NHS Trust to support the 94 Nurses through their OSCE (Objective Structured Clinical Examination) to enable them to receive their NMC Registration. The Trust has embedded a comprehensive induction which includes a supernumerary period on the wards. The Trust has recruited a number of International Nurses (80 are working on the Wards, 0 are on the Trusts Induction, 14 are studying towards their OSCE) as of September 2021. The Trust has also addressed vacancies within the Healthcare Assistant staff group from 63 vacancies in January 2021 to 0 in March 2021 as of September 2021 there are 13 vacancies due to turnover. • Identify the gaps within the Medical Workforce based on the analysis, developing innovative solutions to fill the gaps. • Implementation of a refined WHH Medical Bank Rate Card. • Deep dive review undertaken to understand nursing vacancies across the wards - the outcome of the review shows that there are a small number of nursing posts which have not got a candidate recruited to with the majority of vacancies recruited to and are in the employment checks/notice period.	**Staff Costs per WAU:** • The workforce review group Terms of Reference will be reviewed to include the assessment of high vacancies/high temporary staffing spend and will develop action plans to address. • Expansion of the International Recruitment Programme so it covers Medics, AHPs, Operating Department Practitioners and Nurses - no further opportunities have been identified at this time. • Analysis of the established medical model and the proposed effective establishment within the context of RCP Safe Medical Staffing Guide. The Medical Staffing Review has now been completed and a series of actions are now being progressed.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q2 2021/22

KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
Clinical Support - Pharmacy	**Diane Matthew**	**Savings on Medicines:** The Trust delivered £1.7m of savings on medicines in 2019/20 and £1.7m in 2020/21 which was better than the national benchmark in both years. The Trust has continued to exceed the benchmark throughout 2021/22. **Pharmacy Efficiencies:** 7-day clinical pharmacy services are now embedded across the Trust, with the service intelligently deployed based upon targeted medicines reconciliation data across the bed-base daily. This has resulted in medicines reconciliation rates (completed within 48 hours) increasing to 92%, from a baseline of 44% in 2018. **Missed Dose Report:** Introduction of daily electronic report highlighting any missed medicine administration slots, alerting clinical pharmacy and wider teams for further investigation and action. **Critical Care Service Resilience:** Throughout the COVID-19 pandemic, the pool of clinical pharmacists and technicians trained and proficient in critical care has been increased, with a robust, integrated clinical pharmacy service provided 7 days per week. Enhanced specialist service provision remains on-going, with work to support the wider B18 reconfiguration. **ePMA Part 1 & 2:** The Trust went live on ITU in October 2021	• **Savings on Medicines:** Further action and focus on Homecare services and Biosimilar switching. • **Job Planning:** Undertake internal review of job plans within pharmacy establishment. • **GP Connect:** Implementation of GP connect, enabling the Trust to see a list of medication prescribed by the GP which links into the Trust EPR, reducing the risk of selection errors when prescribing medication in hospital which also improves safety. **TCAM:** Transfer of medication prescription details to the patients nominated community pharmacy to inform of discharge prescription details. • **e-Exchange:** Increase integration and use of e-Exchange facility into clinical pharmacy activities, to better access and utilise relevant patient information. Requirement to formally include in the current processes. • **ePMA 1 & 2:** The Trust continues to implement ePMA with the last speciality scheduled for go live: Neonatal to be scoped by the end of 2021/22. • **ePMA Part 3:** Dose Range Checking - Testing and planning of rollout anticipated by the end of Q4 2021/22. • **ePMA: Part 4:** Integration with JAC system (Stock Control) upgrade released in Q2 2021/22 and progression of testing is underway and will be completed by the end of Q3 2021/22. • **Missed Dose Report:** this has been developed and has been through governance sign off process. Use of the report is in the process of being embedded at ward level. • **Clinical Research Network:** Exploring options around how pharmacy resource can be shared across the research network to deliver clinical trials.
Clinical Support - Radiology	**Mark Jones**	**Radiology Efficiencies:** • The Trust no longer outsources Vascular Ultrasound at a cost saving of £140K per year. • Due to COVID-19 recovery, the Trust has had to increase its external reporting capacity. There has been a increase in MDT and rapid incident reviews requiring consultant attendance which has reduced the Trusts reporting capacity. • Lung cancer easy diagnosis – the pilot has been completed and this is now being rolled out so that patients who require CT scans for a lung cancer diagnosis have the x-ray first then CT within 2 days if required. • Trial of hot reporting completed by reporting radiographers. This provides a report for the ED clinicians within 1 hour which increases flow in the ED department with a more accurate diagnosis. • Maintenance – the department has worked with the Trusts procurement team to reprocure the maintenance contract for X-ray equipment with a saving of £200k annually.	**Radiology Efficiencies:** • The Trust has installed a new MRI machine which will mean the Trust is able to repatriate cardiac MRI and reduce the use of outsourced mobile MRI – this is due to be operational from November 2021. These works have reduced the capacity of the department due the encroachment of the working area. • Cheshire & Mersey ICS is carrying out a review of how data is recorded and reported across the network to ensure like for like comparisons. This has been paused due to COVID-19. • The Trust has been asked to share good practice with the C&M network around the allocation of reporting to consultants.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q2 2021/22

KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
Clinical Support - Pathology	**Neil Gaskell**	**Pathology Network:** The overarching business case was agreed by the network and participating organisations to rationalise pathology services across Cheshire & Mersey. A Project Initiation Document (PID) and Project Plan was developed. The Trust is awaiting overarching financial principles to be agreed which all Trusts will adhere to. **Implementation of NPEX:** As part of COVID-19 response in Q1 (2020/21), the Trust received funding to implement NPEX which supports joint working across the Network with electronic requests, removing the requirement for manual intervention. The Trust is looking how NPEX can be used to expand out of area tests connected to NPEX whilst there is a review from the Pathology network on the repatriation of out of area referred work. The Trust is working with a number of NHS Trusts to maximise the use of NPEX including Lancashire Teaching Hospitals NHS Foundation which will improved Test Turn Around Time and potentially reduce staffing time. **Pathology Procurement:** The Trust continues to look for opportunities to reduce costs by utilising procurement processes. For example the Trust has switched providers for HBA1C diabetes tests reducing the contract price from 77p to 32p per test with overall savings of c£45k. The network is reviewing potential procurement savings of c£44m influenceable spend, consolidating into 1 maintenance contract with a potential of c£7m savings across the network over the next 6/7 years due to the alignment of contracts. **Collaborative Working:** The Pathology Team is working in collaboration with 2 other Trusts and the Cancer Alliance to deliver FIT Testing as part of the national pilot. Due to COVID-19, this has been extended to provide tests for patients awaiting endoscopy which reduces the overall risk whilst providing additional income via a service level agreements. **COVID-19:** The Trust has supported the regional response to COVID-19 and has developed a web form for patients who require anti-body testing. In addition, a simple e-booking system for patients who need vaccinations, swabs or blood tests has been developed. The pathology team has implemented a point of care rapid test in the Urgent Care and in Maternity which allows the department to carry out their own initial screening, which had reduced the pressure on the pathology lab, however due to the delta variant, duplicate testing has been implemented to ensure patient safety and reduce the infection control risk.	**Pathology Network:** The Trust continues to work with the Pathology Network and specifically with STHK around the future of pathology services across Cheshire & Mersey. A number of options are being explored. A second review of the PID (WHH & STHK) has taken place and the Trust is awaiting a response. A number of risks have been identified around Finance, Logistics and Operations. Further detail has been requested from the network to understand how these risks can be mitigated. Process mapping of the current service is underway. **Digital Pathology:** The Pathology Network has funded the implementation of a digital pathology solution that allows the scanning and visualisation of microscopic tissue slides for diagnosis. The solution works similarly to tried and tested PACS technology and has been developed by Philips. The network is looking at using the Trust system (Molis) for Cellular Pathology as it is more digitally mature than other LIMS in C&M. A second version of the bid has been submitted by the network and the outcome is awaited. **Pathology Efficiency & Quality:** • The Trust will pilot the phlebotomy and transfusion application, this will improve patient safety by taking the sample at bedside using the electronic identification system which matches the patient request to the wrist band reducing the risk of taking the wrong blood from the wrong patient and therefore issuing the wrong results. Future options around efficiencies relating to the Phlebotomy application will be explored. • The Pathology Team will carry out a review of cost per test and benchmark against the actual costs - Q4 2021/22. • The Trust has engage with Simplybook and Halton CCG to electronically book patient appointments for Phlebotomy which will reduce paper and improvement patient experience and referrals. A project manager has been assigned with monthly project meetings in place. This is part of the Trust's Digital Operational Group's agenda. • E-Task management system – the Trust utilises its e task management system out of hours to inform acute clinical areas of critical abnormal pathology results. This utilises a interfaces between the Trust pathology systems and e-task management providing real-time alerts which improves efficiency and patient safety. Currently this is only used in Acute services out of hours, however future options to expand in other areas.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q2 2021/22

KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
Corporate - Estates	**Ian Wright**	**Strategic Cost Reduction** • The Estates & Facilities team conducts rolling reviews of costs and identifies opportunities to reduce costs through procurement and standardisation. The Trust continues to explore collaboration opportunities. The Trust continuously benchmarks estates and facilities efficiency through ERIC returns and the Model Hospital and implements action plans around the results of PLACE assessments. ERIC returns were submitted in June 2021 (for 2020/21) and it is anticipated the report will be received in Q3 2021/22. The Trust has signed up to a Domestic Waste contract as part of the Cheshire & Mersey collaboration at scale project. The Trust is in the process of signing up to a clinical waste contract. • Investment in backlog maintenance in 2020/21 to improve the critical risk infrastructure. Impact on critical infrastructure risk costs as a result of backlog maintenance spend will be recognised in Q3 2021/22 when NHSE report is received by the Trust. • Energy Saving Schemes: Procurement of an energy infrastructure upgrade (CHP) which saved; carbon, energy, money and future investment (savings of £140k in 2019/20 on the contract cost). The Carbon Energy Fund (CEF) provided replacement of 4000 halogen bulbs with more cost effective LED lighting. All new capital developments are now fitted with energy saving lightbulbs. **COVID-19** • Significant effort to support the Trust during the COVID-19 response. This includes additional requests e.g. screens, laundry, capital spending, security transfers of COVID-19 patients. • Establishment of a furniture swap in order to reduce expenditure on new furniture, anticipated return in Q4 2021/22. • Streamlined capital project processes to improve the response times whilst also including stakeholders in the design process.	**Strategic Cost Reduction:** • Explore and develop further collaboration opportunities (impacted by COVID-19). • Review of Facilities Management Contracts at Cheshire & Mersey Level (Energy, Linen, Post and Decontamination). A plan has been developed for a collaborative approach across C&M as current contracts expire. Opportunities to tender collaboratively to reduce costs. • Progression/Expansion of agile working to reduce floor space (this has been accelerated by COVID-19, however due to social distancing requirements, the ability to remove desks has been affected). **Energy Saving Schemes:** • Internal replacement of emergency lighting to improve efficiency is an ongoing programme within capital developments. • Cost neutral proposal for electric car charging points - this is currently out to a procurement mini competition. • Capital spend on projects that will reduce critical infrastructure risk and long term estates maintenance costs. **Collaboration & Sustainability:** • Monitoring of critical infrastructure risk and how this has had an impact on estates maintenance costs. • Development and publication of the Trust's Green Plan - approved by the Strategy & Sustainability Sub-Committee. To be presented at the Finance & Sustainability & Trust Board in November 2021. • The Trust has commissioned a deep dive review in the CHP contract to ensure the Trust is gaining value of money and expert advice - the Estates team will review the report and progress recommendations.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q2 2021/22

KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
Corporate - Procurement	**Alison Parker**	**Procurement Service Collaborative** • The Trust is providing procurement services on behalf of Bridgewater via Service Level Agreements. • Bridgewater has an approved Procurement Strategy and Procurement Policy. Bridgewater is moving towards the "Good" NHS Standards of Procurement. • A highlight report has been developed for Chief Finance Officers detailing collaborative procurement progress and opportunities. • An ICS Task & Finish Group has been established for the delivery of the ICS Based Procurement plan. A business case has now been approved for the ICS procurement lead and a data analytics platform. • Further work is being undertaken to develop a collaborative contract register. • The Trust implemented the Cheshire & Mersey agency rate card (with estimated savings of £0.8m) in November 2019. A new SRO needs to be identified at ICS level from the HR Network to develop the next phase of this project (benchmarking and adherence to rate metrics). • The Trust has re-engaged with Category Tower 10 – Food as procurement lead to develop a C&M wide strategy for the purchase of food. • The Trust as re-engages with Supply Chain Co-ordination Ltd (SCCL) to develop a C&M wide savings strategy presented to the C&M Procurement Committee in July. **Procurement Efficiency** • The Trust is fully engaged with SCS (Spend Comparison Service) participating in training, webinars and events. Further training is taking place as new members of staff are appointed to the team. • E-Catalogue Transactions - regular reviews of items used which are suitable for cataloguing with analysis of non-pay spend and usage establishing catalogues where appropriate. • The Trust went live with "Punch Out" in November 2019 which improves the loading of the NHS Supply Chain catalogues and streamlines processes. • The Trust has implemented additional monitoring and weekly review meeting to oversee the capital programme. **COVID-19** • The Trust took the lead on the COVID-19 Response Procurement Group supported by MIAA, facilitating mutual aid, driving the PPE agenda with a structured to move to a 7- day service. • The Trust represented C&M organisations on the NW PPE forum established in response to COVID-19	**Procurement Efficiency** • Development of a high-level ICS Procurement Plan to deliverable actions. PTOM Steering Group in place to develop plans. • Re-engage with SBS regarding the implementation of Edge for Health. This has been placed on hold by SBS, the Trust is awaiting next steps. • Re-engage on the development of a strategy for the Category Tower 10 (Food) to deliver potential savings of c£0.8m. This has commenced, currently awaiting a strategy from Foodbuy. The Trust is currently analysing the data. • The Trust has re-engaged with Supply Chain Co-ordination Limited (SCCL) to develop a C&M wide strategy for the delivery of savings from the category towers which was presented to the C&M procurement committee in September 2021. Additional development is required. • Monthly monitoring of the tracker to report against the 34 point action plan for procurement for NHSE/I. The ICS has developed a procurement tracker to look at opportunities. Development of a highlight report of schemes on the capital programme and the progress in terms of on track and mitigations/management of delivery and on budget. • Re-commence data analytics re the Spend Comparison Service, a plan has been developed. *Six Monthly Basis* - Every six months the top 500 purchased products based on the total spend of the Trust (% Variance for Top 500 Product Metric) will be run comparing the data to the; lowest floor price, C&M Trusts, NHSE/I Peer Group. This will serve two purposes; support the delivery of savings and support work required in line with model hospital requirements. Saving opportunities will reviewed on a monthly basis focusing on those with the highest opportunity until all 500 opportunities have been exhausted. This exercise will then be repeated. *Catalogue Benchmarking* - The Trust has 309 catalogues in place covering 42,471 product lines. Catalogue Benchmarking to be undertaken on a rolling monthly basis comparing our catalogue prices to those prices paid across the NHS.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q2 2021/22

KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Action Plan
Finance	**Jane Hurst**	**Financial Planning, Sustainability & Controls:** • Strengthening of Treasury Management processes. • Close monitoring of COVID-19 Capital and Revenue spend with new governance processes implemented. Positive report received from external audit of COVID-19 spend. • Close monitoring of COVID-19 vaccination hub spend. • Improvement of Better Payment Practice Performance to 90% cumulatively in 2020/21. Improved BBPC to 94% cumulatively as at M6 2021/22. • Delivered CIP in 2020/21. Delivered CIP for H1 2021/22. • Delivered financial position in 2020/21. Delivered the Financial position of breakeven for 2021/22 H1. Overachieved access to ERF in H1. • Secured CDEL (Capital Departmental Expenditure Limit) funding for ED Plaza and Paediatric capital schemes. • Training for non-finance colleagues regarding Finance and Procurement. • Secured £1m to deliver community maternity in Halton and £0.4m long COVID-19 service and additional commercial opportunities through the Halton Clinical Research Unit which contributes to the sustainability of the organisation.	**Financial Planning, Sustainability & Controls:** • The Trust will continue to monitor and assess emerging guidance to ensure compliance. Financial performance is closely monitored and variation from plan is addressed in a timely manner. • Continue to monitoring COVID-19 schemes due to cease. • Continued scrutiny and governance on capital schemes over £0.5m. • The Trust is working with the system to deliver a breakeven position in 2021/22. The Trust will work with the system to understand the gap left by reduced income, gap in pay award and inability to access ERF in H2. • Delivery of CIP of £4.8m in 2021/22 and monitoring of Quality Impact Assessments. • Delivery of £19.6m Capital Programme in 2021/22. • Support and monitor the plans to deliver activity to achieve Elective Recovery Fund in H2. • Increased monitoring of cashflow. • Increased review investment proposals and benefits realisation. • Increase scrutiny and governance over retrospective waivers. • Action plan to achieve level 3 Future Focused Finance accreditation. • Support the Mersey Internal Audit Review of WLIs.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/159**	
SUBJECT:	**Healthy, Happy and Thriving Communities**	
DATE OF MEETING:	24 November 2021	
AUTHOR(S):	Kelly Jones, Head of Strategy and Partnerships	
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.	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)***	**#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.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	• This document builds on the Healthy, Happy and Thriving Communities baseline presentation that was shared with the Board in June 2021 and outlines how WHH will structure our change journey as an anchor institution around the three pillars of social value, green agenda and health inequalities. • The domains through which WHH can align interventions to grow organisational maturity as an anchor institution and achieve social value, deliver the NHS Green Plan objectives and/or address health inequalities are proposed, along with ten core objectives to underpin WHH's journey as an anchor institution. • The work already underway (which has previously been shared) has now been translated into tangible actions and anticipated outcomes. Additionally, work has progressed to develop actions for advancing the Trusts work as an anchor institution. • Three delivery plans are emerging, which when successfully implemented over the coming months, will mark a step change in the Trusts role as an anchor institution. • It should be noted that some activities, an example being procurement, can only be achieved through collaboration with region and the emerging ICS structure, while others can be progressed at place or independently by the Trust. These distinctions will be made within delivery plans and interdependencies will be appropriately monitored. Timescales for delivery will need to reflect what can be done with autonomy and what will require wider collaboration and therefore less direct control while the wider system reforms.	

PURPOSE: ***(please select as appropriate)***	Information x	Approval	To note	Decision
RECOMMENDATION:	Since June 2021, progress has made to advance the Trusts position as an anchor institution. However, health inequalities across the country have worsened as a result of Covid-19 and we have an obligation to address			

	this. Whilst it is right that work continues across a broad spectrum of initiatives, it is recommend the Trust prioritise first 1000 days and alcohol/substance misuse as strategically important priorities for the Trust that merit concentrated effort across the organisation.	
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	

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Healthy, Happy and Thriving Communities

Lucy Gardner, Director of Strategy and Partnerships

Update: Warrington and Halton Teaching Hospitals' role as an anchor institution and an organisation with social value at its core to address health inequalities.

November 2021

1. Summary

Warrington and Halton Teaching Hospitals NHS Foundation Trust

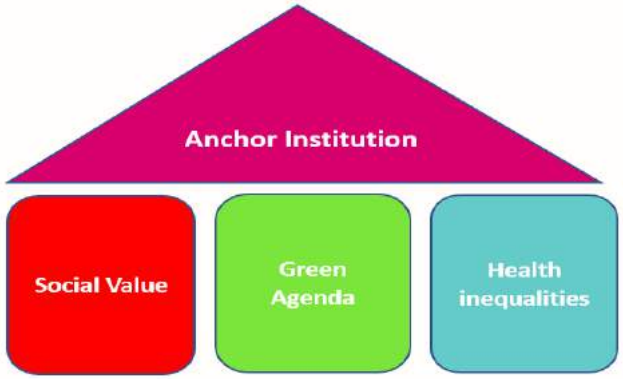
- This document builds on the Healthy, Happy and Thriving Communities baseline presentation that was shared with the Board in June 2021 and outlines how WHH will structure our change journey as an anchor institution around the three pillars of social value, green agenda and health inequalities.
- The domains through which WHH can align interventions to grow organisational maturity as an anchor institution and achieve social value, deliver the NHS Green Plan objectives and/or address health inequalities are proposed, along with ten core objectives to underpin WHH's journey as an anchor institution.
- The work already underway (which has previously been shared) has now been translated into tangible actions and anticipated outcomes. Additionally, work has progressed to develop actions for advancing the Trust's work as an anchor institution.
- Three delivery plans are emerging, which when successfully implemented over the coming months, will mark a step change in the Trust's role as an anchor institution.
- It should be noted that some activities, an example being procurement, can only be achieved through collaboration with region and the emerging ICS structure, while others can be progressed at place or independently by the Trust. These distinctions will be made within delivery plans and interdependencies will be appropriately monitored. Timescales for delivery will need to reflect what can be done with autonomy and what will require wider collaboration and therefore less direct control while the wider system reforms.

2. A way to structure the change

Warrington and Halton Teaching Hospitals has a role as an anchor institution and an organisation with social value at its core of addressing health inequalities.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Pillars of an Anchor Institution



Domains through with anchor organisations can grow their maturity and align interventions to achieve social value, deliver against NHS Green Plan objectives and/or address health inequalities*.

- Patients and Public
- Governance
- Culture
- Finance and Contracting
- Information and Technology
- Workforce
- Place Based Care
- Partnerships
- Leadership

** Based on Aqua's Anchor Institution Framework (2021)*

3. An alternative approach

- The Social Mobility Pledge is linked to the Government's Levelling Up agenda.
- Driven by a coalition of cross-sector businesses and universities, it encourages organisations to be a force for good by putting social mobility at the heart of their purpose. It speaks to the aims of an anchor institution and is underpinned by 14 Levelling Up Goals.
- The pledge was considered as a vehicle through which change could be structured but is still embryonic.
- The 14 Levelling Up goals will none-the-less be considered in programmes of work and learning continued to be monitored for transferability.

4. Defining what the terminology means to WHH

To ensure collective understanding and alignment of objectives, there is a need to define what the terms anchor institution, social value, green agenda and health inequalities mean to us at WHH.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Definition of term	What the term means to WHH
Anchor Institution	The term 'anchor institution' is used to refer to o**rganisations which have an important presence in a place**, usually through a combination of **being large scale employers; being the (or one of the) largest purchasers of goods and services in the locality; controlling large areas of land and/or having relatively fixed assets**. Anchor Institutions can be seen as organisations that are tied to a particular place by their mission, histories, physical assets and local relationships	As an anchor institution, WHH has an opportunity to positively influence the health and wellbeing of the patients we service and the local communities we are part of. We will use our position and influence to work with others in responsible ways, to have an even greater impact on the wider factors that create happy, healthy and thriving communities.
Green Agenda	The NHS green agenda is encapsulated by the Greener NHS programme, which aims to work with staff, hospitals and wider partners to **tackle climate change by reducing NHS emissions to 'net zero' by 2045.**	Through the green agenda, WHH will step up action to address the adverse impacts we have on public health and the environment, helping prevent illness, reducing pressure on A&E and tackling climate change as part of a system wide approach.
Social Value	A process whereby **organisations meet their needs for good, services and works and utilities in a way that achieves value for money** on a whole life basis in terms of generating benefits not **only to the organisation but also to society and the economy, whilst minimising damage to the environment**.	Social value will play a vital role in creating a fair and green WHH. It will be used to address health inequalities and is a vehicle through which we have the opportunity to make the economy more socially just by leveraging support towards local economic and environmental goals.
Health inequalities	Health inequalities are **unfair and avoidable differences in health across the population, and between different groups within society**. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and shapes our mental health, physical health and wellbeing. Health inequalities have been documented between population groups across at least four dimensions: Socio-economic status and deprivation, Protected characteristics, Vulnerable groups of society, Geography: e.g. urban, rural	For some people in Warrington and Halton there are still unfair and avoidable inequalities in their health and in their access to and experiences of NHS services. Through a focus on health inequalities, we will proactively and systematically work to reduce these inequalities, working in partners with others to do so where it adds value.

5. Our overarching objectives as an anchor institution

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Anchor Institution

Social Value

1. To purchase more locally when possible and for social benefit. Local businesses create jobs and wealth and will be offered the opportunity to work with the Trust

2. To use WHH buildings and spaces to maximise support to local communities.

3. To working more closely with local partners, learning from others, spreading good ideas, modelling civic responsibilities and collaborating in the interest of patients and local communities.

4. To promote skills and employment, focusing on growth and development and ensuring that all communities are offered the opportunity to develop new skills and gain meaningful employment.

5. To create healthier, safer and more resilient communities by building stronger and deeper relationships with the voluntary and social enterprise sector whilst continuing to engage and empower citizens.

Green Agenda

6. To reduce our environmental impact. Ensuring the places where people live and work are cleaner and greener, promoting sustainable procurement and protecting the long-term future of our planet.

Health inequalities

7. To reduce unfair and avoidable differences in health across Warrington and Halton and different groups across society.

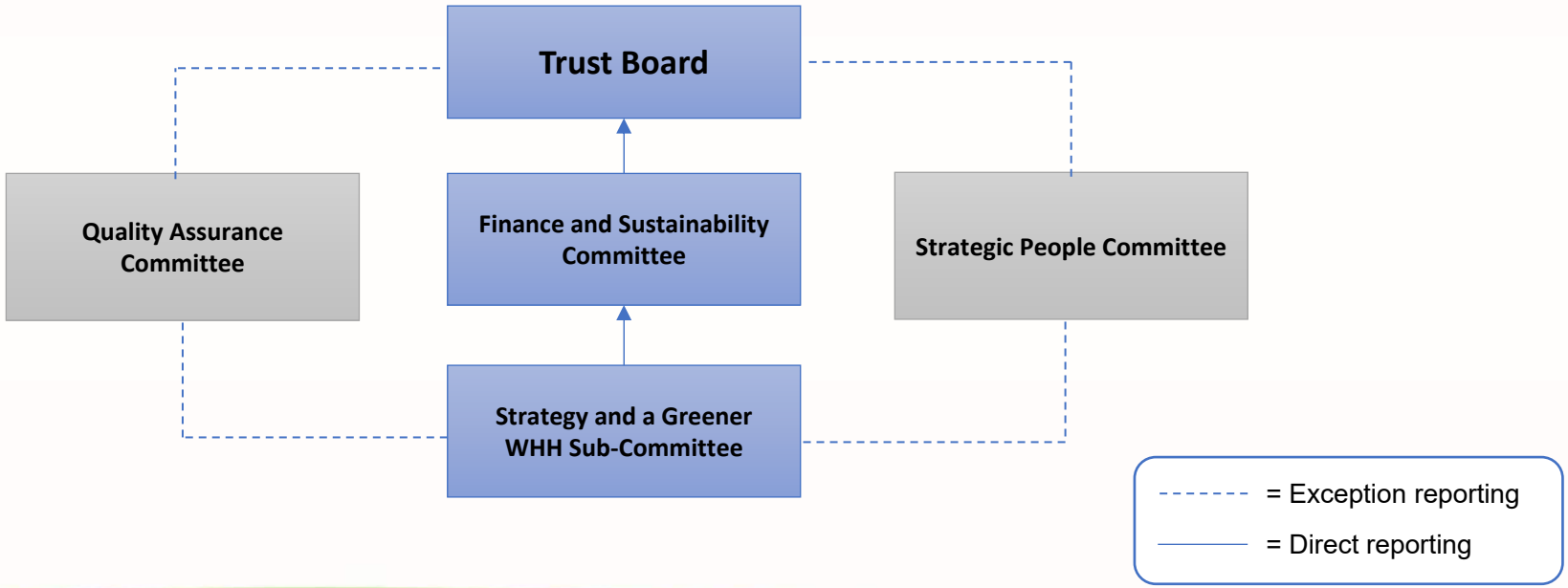
8. To promote new ideas and innovation to solve old and new social problems

9. To widen access to quality work

10. To work with partners to understand the health needs of the population of Cheshire and Mersey and assets within each place and taking action to address identified needs.

6. Governance

Warrington and Halton Teaching Hospitals' journey as an anchor institution is monitored through the following governance route:



7. Examples of the breadth of work already underway

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Digital Inclusion Cafe

Digital Inclusion Cafes are being delivered to patients accessing services at WHH. These cafes are hosted on site, with the intent of getting patients familiar with logging onto the Wi-Fi, accessing health care apps/appointments and feeling digitally oriented on site. At the same time, cafes are an opportunity to support patients to use iPad, laptops, phones etc, that they may have purchased or been given but not necessary shown how to use. They are also a social and networking opportunity.

Individual action supporting NHS Green Plan

Service generated initiatives addressing social value

Strategic projects addressing health inequalities

Zero Carbon Patient

Dr Ahmed Farag is mapping the carbon footprint of a typical patient journey for two procedures in the Catheter Laboratory. This will be used to inform ways to reduce the carbon footprint of the patient journey.

CarbonZero

Warrington Town Deal Health and Wellbeing Hub

Towns Fund

With an investment of £3.1m, the Health and Wellbeing Hub will provide local residents with drop-in access to a range of services targeted at families and children and those living with early signs of frailty. The Hub will be located in the town centre, making it central to, and easy to reach from, the most deprived areas of the borough.

8. Connecting our offer – Asset rich

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Focus on early intervention, ill-health prevention, self-care and community-led support.

How well do we really understand our local communities on a micro level?

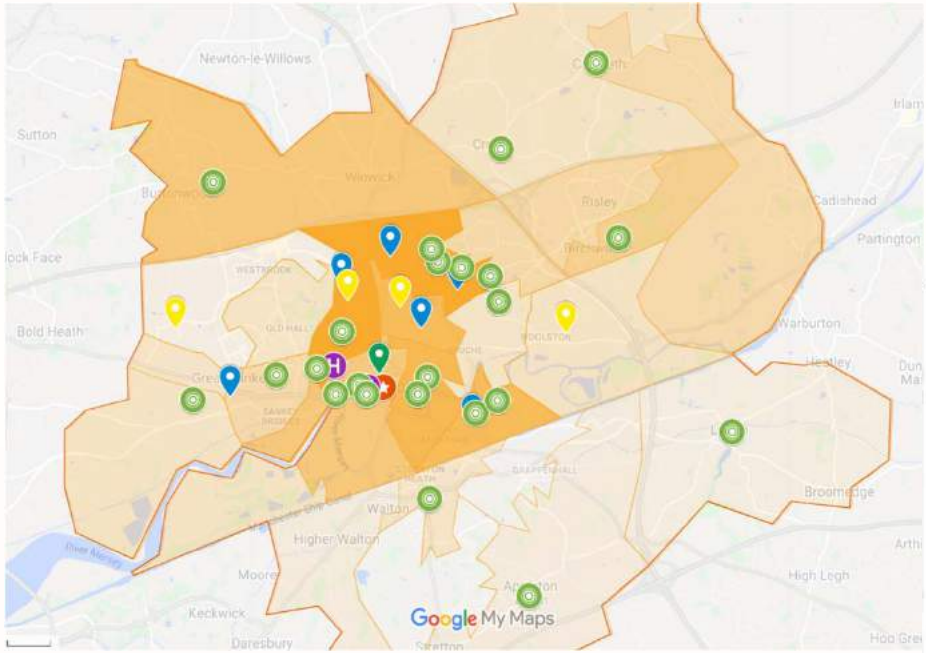
How do people access services?

What assets exist in these communities and how are they utilised?

Are there any gaps in provision?

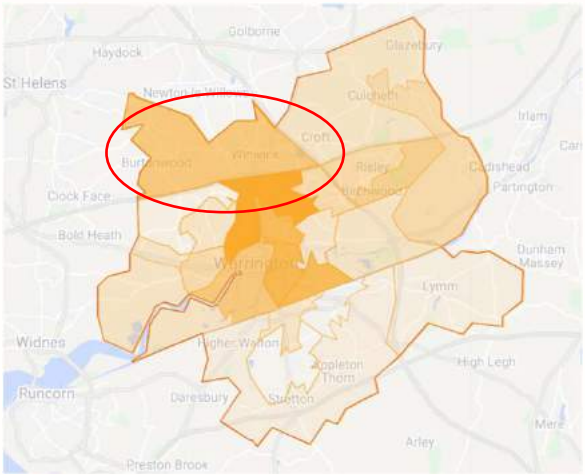
How do people find out what is going on in their local communities?

Progressing from national and regional baselining to macro level analysis using service level data to support targeted work on health inequalities…



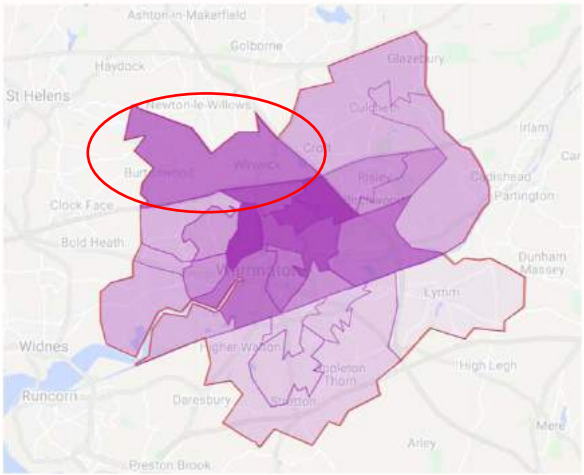
9. Burtonwood & Winwick - A tale of 3 metrics

Warrington and Halton Teaching Hospitals NHS Foundation Trust



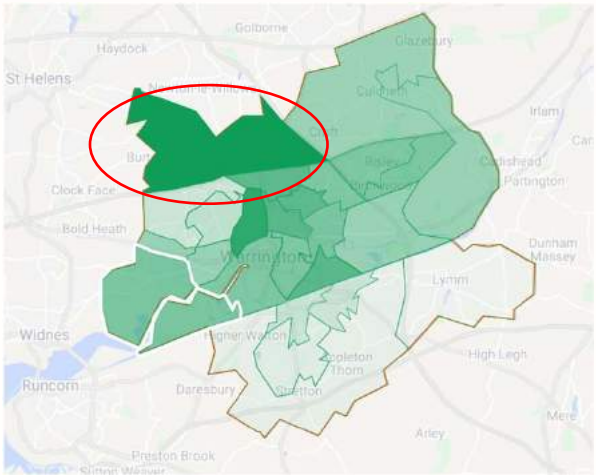
Index of Multiple Deprivation

Burtonwood and Winwick = 7th most deprived area of the borough



Prevalence of Depression (% of population)

Burtonwood and Winwick = 6th highest in the borough



Prevalence of COPD (% of population)

Burtonwood and Winwick = Highest in the borough

10. Directing impact

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Initial baselining identified work already underway, current status, gaps and potential next steps.
- From this, work has commenced on structuring a programme of improvement to advance the Trust's commitment to tackling health inequalities and boosting opportunities to make a positive social impact.
- Delivery plans are emerging for each pillar. These currently contain variable levels of detail, ranging from delivery of agreed projects, exploration of potential opportunities and enhanced baselining activities.
- Notably, progress has been made with clear milestones outlined for achieving the requirements of the NHS Green Plan.
- Progress is as follows ……..

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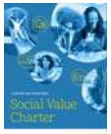
Social Value

11. Policy and legislative requirements to be reflected in plans

Warrington and Halton Teaching Hospitals NHS Foundation Trust



The Public Services (Social Value Act) 2012
The Act requires public sector services to consider how they could improve the economic, environmental and social wellbeing of their local area through their procurement activities. The Act is a tool to help get more value for money out of procurement.

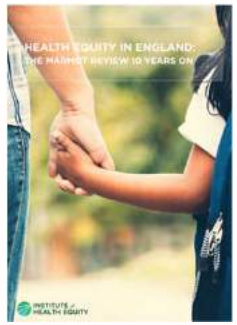
Social Value Award Criteria
WHH was successfully awarded the Social Value Award in December 2020. Compliance against the social value award criteria

Cheshire and Merseyside Social Value Charter
The Cheshire & Merseyside Social Value Charter sets out five key social value themes based on the Marmot priorities, which include best start in life, healthy lifestyles, employment, sustainable places and preventing ill health.

Upcoming requirements

Indicators for Cheshire and Merseyside Marmot Community
Work has recommenced across Cheshire and Merseyside with a focus on what organisations across the partnership and local area can do to address inequalities. A set of indicators are expected in Q4 of 2021-22 for ongoing monitoring of inequalities and key social determinants of health. Although targeted towards health inequalities, there are likely to be implications for social value.

Procurement – contract allocation weighting
From April 2022 all NHS organisations will be required to take social value into account when procuring goods and services. A mandatory 'social value' weighting of **10%** is requirement across for all NHS procurement.



12. Social Value – Existing programme of work

Ref	Project	Overview and progress made since June 2021	Domain delivered against	Objective/s supported	Delivered by	Lead/s
S1	Institute of Technology Bid	**Developing an Institute of Technology** WHH are proactively supporting Cheshire and Warrington's bid to be designated an Institute of Technology. Successful selection would attract c.£13m funding for local partners to further develop technology education and training. Cheshire and Warrington's bid has been shortlisted.	Information & Technology Partnerships Workforce	1, 3, 4	Emerging	System project Internal links: Lucy Gardner Viviane Risk
S2	Patient Experience and Inclusion Calendar	**Inclusion Calendar** Introduction of the Patient Experience and Inclusion Calendar to celebrate events and create an environment of acceptance and cultural celebration	Patients and Public Workforce Culture	3	In place and activities ongoing	Adam Harrison
S3	Carers Passport	**Reintroduction of Carer Cafes** Delivered in partnership with local organisations, Carer Cafes are an opportunity for carers to come together and chat with other carers, swap tips on caring, make new friends and find out about other avenues of support.	Patients and Public Culture Partnerships	3, 5	In place and activities ongoing	Adam Harrison
S4	Warrington wider estates review	**Warrington Public Sector Estates Review** WHH, CCG and WBC combined programme to review public sector estate across Warrington and identify opportunities for utilisation. Supplier partner to be appointed in Nov 21 with work to commence in Dec 21.	Partnerships	2	March 2022	Lucy Gardner Viviane Risk Ian Wright

13. Social Value – Existing programme of work

Ref	Project	Overview and progress made since June 2021	Domain delivered against	Objective/s supported	Delivered by	Lead/s
S5	Growing a future workforce	**Education and employment** Through partnership working with Warrington & Vale Royal College as part of the development of the Warrington Health & Social Care Academy, a programme of training and development focussed on hard to recruit or new and emerging roles in both health and social care is being developed. The outcome of this is likely to improve employment opportunities for local people and help address known workforce challenges across the borough. Since June, capital funding has been made available to the college and a lead for the academy has been appointed. Next steps are: • Input into development of the syllabus for the academy. • Explore ways in which the Health and Social Care Academy and Warrington Health and Wellbeing Hub can collaborate to enhance the value to the system of the separate projects.	Workforce	4	June 2022 October 2022	Nichola Newton – Principal – Warrington & Vale Royal College Trust Links: Debbie Howard, Steve Bennett and Caroline Lane
S6	Elective Hub @ Halton	**Halton Elective Hub** Project to position and develop Halton as a central elective hub for the Cheshire and Merseyside region. If successful this will attract inward investment to develop the Halton site in Halton Lea and increase economic activity in the area.	Patients and public Partnerships	2, 8, 10	Emerging	Val Doyle Nikhil Pradhan Steve Bennett

14. Social Value – Existing programme of work

Ref	Project	Overview and progress made since June 2021	Domain delivered against	Objective/s supported	Delivered by	Lead/s
S7	Central 6 Masterplan	**Improving Health and Wellbeing in Centre 6** A wide-reaching programme of work led by WBC to improve the quality of life for residents in the "central 6" neighbourhoods of Warrington, which are widely regarded to be the most deprived areas of the borough. Next steps are to identify further collaboration opportunities for WHH to input into programme of work and agree specific deliverables.	Partnerships	3	February 2022	Eleanor Blackburn - Head of Inclusive Growth and Partnerships - WBC Trust links – Lucy Gardner Steve Bennett
S8	Warrington and Halton's Health & Wellbeing Strategies	**Health & Wellbeing Strategies** Working across the health and care system to deliver improvements to health and wellbeing for residents. WHH have actively inputted into the strategies to influence direction and ensure WHH priorities are reflected. Next steps:- Progress conversations to collaboratively develop a high-impact network of connected health and wellbeing spaces tailored around the needs of the local communities and aligned to local plans.	Place Based Care Partnerships Leadership	2, 3, 5	Emerging	Thara Raj (WBC) Ifeoma Onyia (HBC) Trust links: Lucy Gardner Steve Bennett

15. Social Value – Existing programme of work

Ref	Project	Overview and progress made since June 2021	Domain delivered against	Objective/s supported	Delivered by	Lead/s
S9	Employment	As an anchor institution, WHH is a significant employer across Warrington and Halton. Our approach to employment can have a defining effect on the employment prospects and incomes of local people, stimulate social improvements and reduce inequalities. In response to the COVID-19 pandemic and the ongoing impact that this has and will continue to have on the workforce, the organisation has committed to provide ongoing recovery support to equip staff with the skills to look after their own health, wellbeing and resilience in a variety of ways. Since June, Dr Cliff Richards, Non-Executive Director, has been appointed as the organisation's Wellbeing Guardian. A wellbeing sanctuary has been implemented on the Warrington site and investment made into a wellbeing sanctuary space on the Halton sit. Two on-site counsellors have been appointed until August 2022. A range of wellbeing initiatives have been delivered, some in partnership with other anchors and a stocktake has been undertaken on the staff wellbeing offer utilising the national Health and Wellbeing Framework and the Greater Manchester Health and Wellbeing Framework.	Workforce	3, 4, 7	In place	Laura Hilton

16. Social Value – Next steps

Warrington and Halton Teaching Hospitals NHS Foundation Trust

To further progress our work around social value, the following actions will be delivered.

Ref	Action	Domain delivered against	Objective/s supported	Delivered by	Lead/s	Notes
S10	**Procurement** ICS are developing procurement initiatives around ethical procurement and evaluation of environmental and social value in procurement. This will drive a wider programme of work. Specific actions the Trust will take while ICS plans are emerging are: • Assess WHH spend on goods and services with SMEs and understand what this is as a % of our total influenceable spend on goods and services. • Implement initiatives from the NW Sustainability Group in terms of single use plastics, recycled goods etc. • Continue to measure and report Trust performance against the Procurement Target Operating Model (PTOM) 34 point action plan that includes a range of actions around sustainability. • Develop a procurement strategy to include approach to sustainability and social value	Finance and Contracting	1, 3, 6	January 2022 Set per initiative January 2022 April 2022	Alison Parker	
S11	**Academic Collaboration (University of Chester)** Formalise programme of work to deliver on identified opportunities and establish work streams to deliver agreed objectives.	Partnerships Workforce Leadership Information & Technology		Emerging	Kimberley Salmon-Jamieson Paul Fitzsimmons Michelle Cloney Lucy Gardner	High level objectives established Work plan in development Supported by Viv Risk

17. Social Value – Next steps

To further progress our work around social value, the following actions will be delivered.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Ref	Action	Domain delivered against	Objective/s supported	Delivered by	Lead/s	Notes
S12	**Baseline work** Assess existing projects against the domains for an anchor organisation, identifying gaps in progress against each domains and seek opportunities to maximise social value, whereby growing organisational maturity.	Governance Leadership	1, 2, 3, 4, 5	January 2022	Steve Bennett	
S13	**Measuring impact** Work is required to ensure projects delivering social value have baseline metrics and mechanisms in place to measure benefits with clear timescales for benefits realisation identified.	Information and technology Governance	1, 2, 3, 4, 5	January 2022 – initial assessment	Kelly Jones	Where metrics are unclear or difficult to establish, proxy measures will be considered.
S14	**Develop an estates – value maximisation plan** Develop a plan to ensure our estate and assets are used in ways that address resource gaps in communities and support residents to live healthy lives	Partnerships	2	February 2022	Ian Wright	May help address environmental and economic disparities

18. Social Value – Next steps

To further progress our work around social value, the following actions will be delivered.

Ref	Action	Domain delivered against	Objective/s supported	Delivered by	Lead/s	Notes
S15	**Hospice Partnership work – St Rocco's** Develop programme of partnership working alongside local Hospice as another local Anchor Institution to raise quality of care and also support some operational challenges faced by the Hospice. Partnership working workshop held in early October to identify common areas for improvement between the two organisations. Next steps: Define programme of work with St Rocco's and identify key deliverables for projects.	Patients and public Partnerships Place Based Care	3	February 2022	Chris Barlow Jude Raper Steve Bennett	Formal programme of work will be formulated over coming months, to include a wider project to develop a single place-based End of Life Strategy that includes a broader group of stakeholders.
S16	**Influencing underlying causes of crime to reduce hospital admissions** Baseline data highlighted high levels of youth offending, with figures for Halton and Warrington both above the England average. Additionally, high rates of hospitalisation due to violent crime were identified. Opportunities to work with system partners to address underlying causes of crime, such as poverty, poor education, alcohol abuse and drug misuse, need to be explored. The Trust can proactively impact crime while working to prevent substance misuse health related conditions. • Explore partnership opportunities that will have a positive impact on tackling underlying cases of crime. • Analyse service level data to link work to health inequalities and agree programme of work to address.	Patients and public Leadership Culture Place Based Care Partnerships	3, 4, 5	Emerging	TBC	This will need to be influenced through Place and place-based leads once appointed

19. Social Value – Next steps

To further progress our work around social value, the following actions will be delivered.

Ref	Action	Domain delivered against	Objective/s supported	Delivered by	Lead/s	Notes
S17	**Implement WHH Charity Strategy** A key pillar of WHH's emerging charity strategy will be to support the Trust's ambition to be an anchor institution by building social value through: • Continuation of the community hub • Use of estate to reduce isolation, improve awareness and increase education on key health issues affecting our population • Building mutually beneficial partnerships • Outreach (schools programmes) The strategy will be developed with clear metrics in place to measure success	Patients and public Partnerships	1, 2, 5	December 2021	Pat McLaren	
S18	**Employer of choice** Building progression routes, committing to paying the living wage and recruiting from lower income areas are all actions WHH are progressing as an anchor to create a positive impact. To progress this agenda,	Workforce			Laura Hilton Carl Roberts	
	• Implement a physical activity offer for staff • Workforce plans and initiatives will be mapped against anchor pillars in order to be fully articulated in plans. • Workforce plans will be reviewed and assessed to ensure actions are in place to advance the workforce domain of anchor institutes. Underpinning action plan to be developed where gaps are identified.		7 4, 7 4	December 2022 January 2022 April 2022		

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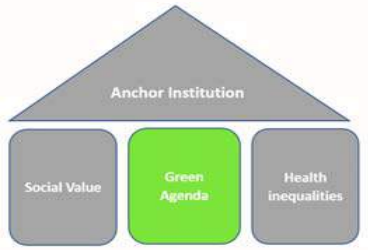
Green Agenda



20. Policy and legislative requirements to be reflected in plans

- The Climate Change Act 2008 - mandatory target for UK to reduce carbon emissions to net zero by 2050
- 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
- "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 January 2022

21. Trust Green Plan

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Green Plan has been developed and comprises of:

Trust's Carbon Baseline

Action Plan

Emissions Monitoring

Focus on:

- Reducing our carbon emissions;
- Reducing our contribution to air pollution;
- Reducing our generation of waste.

117 actions identified

10 areas of focus

22. Trust Green Plan

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Reduction in emissions to be achieved moving forward, against 2013 baseline emissions of 13,997 t/CO2e per annum:

Year	Percentage Reduction in Emissions	Required Reduction in Emissions (t/CO2e per annum)
2021	32	9472
2022	37	8865
2023	41	8259
2024	45	7652
2025	50	7046
2026	54	6439
2027	58	5833
2028	63	5226
2029	67	4620
2030	71	4013
2031	76	3407
2032	80	2799
2033	82	2450
2034	85	2100
2035	87	1820
2036	90	1400
2037	92	1120
2038	95	700
2039	97	420
2040	100	0

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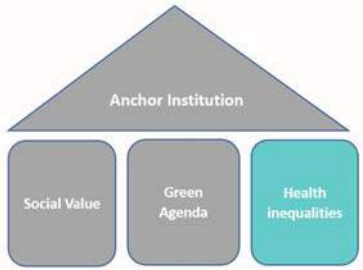
Health Inequalities



23. Policy and legislative requirements to be reflected in plans

Warrington and Halton Teaching Hospitals NHS Foundation Trust

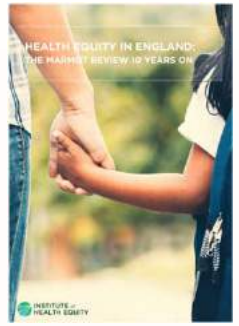
Public Sector Equality Duty
Advancing equality and tackling health inequalities represents a values based commitment. Alongside this, sit legal duties to promote equality as required by the Equality Act 2010 and to address health inequalities, as required by the Health and Social Care Act 2012. The public sector Equality Duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Prevention Pledge
WHH is one of the first two Trusts piloting the Cheshire and Merseyside Health & Care Partnership Prevention Pledge, focused on developing and coordinating programmes to support and improve staff and patient wellbeing and working with primary care and local organisations to help facilitate early interventions. The pledge will enable WHH to work towards becoming an anchor institution and system leader in prevention, and offers the opportunity to provide a coordinated and consistent approach to addressing prevention within secondary and tertiary care.

Upcoming requirements

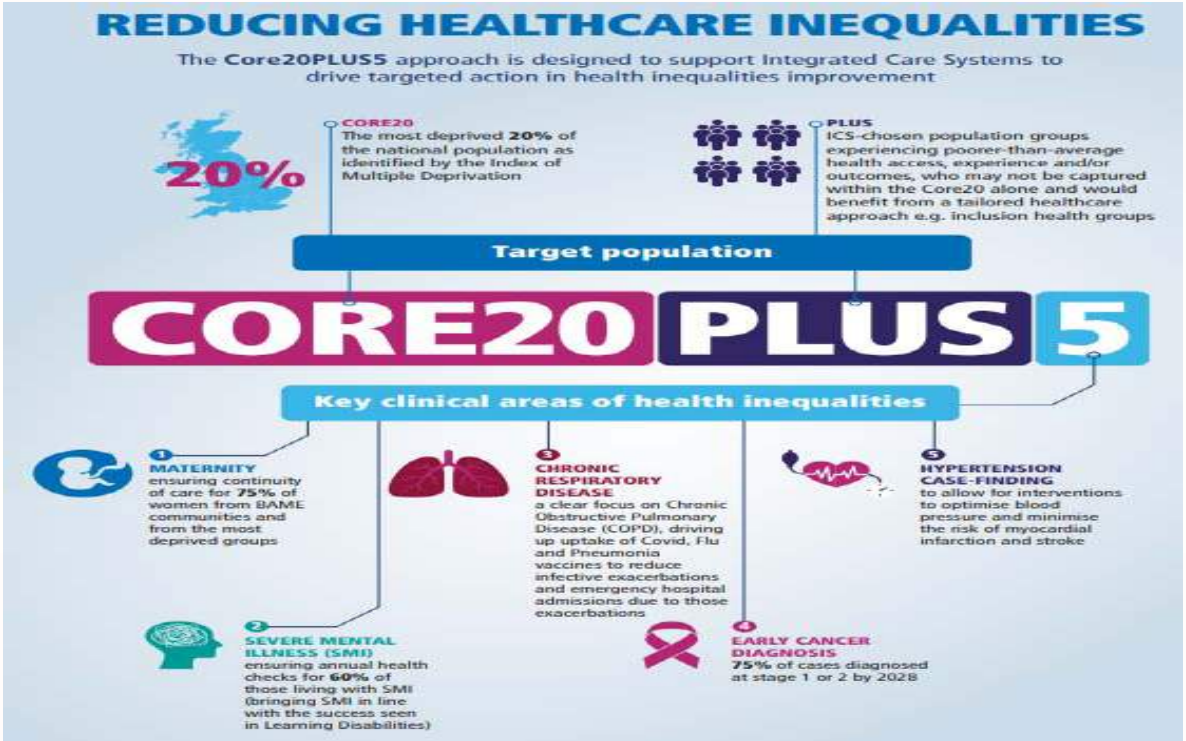
Indicators for Cheshire and Merseyside Marmot Community
Work has recommence across Cheshire and Merseyside with a focus on what organisations across the partnership and local area can do to address inequalities. A set of indicators are expected in Q4 2021-22 for ongoing monitoring of inequalities in health and key social determinants of health. Two specific indicators likely to impact the Trust are requirements to identify the amount of procurement with local companies and the number of local people employed.



24. Requirements to be reflected in plans

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Upcoming requirements



25. Health Inequalities – Existing programme of work

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Below is a list of existing projects the Trust is involved in at regional or local level that will support delivery of our Health Inequalities objectives

Ref	Project	Overview and progress made since June 2021	Domain delivered against	Objective/ supported	Delivered by	Lead/s
HI1	Warrington Town Deal Health and Wellbeing Hub	**Anchoring hospital services into communities** As part of the Warrington Town Deal, WHH has secured funding to create a Health and Wellbeing Hub in Warrington Town Centre. With an investment of £3.1m, the Health and Wellbeing Hub will provide local residents with drop-in access to a range of services targeted at families and children and those living with early signs of frailty. The Hub will be located in the town centre, making it central to, and easy to reach from, the most deprived areas of the borough. Since June, the Full Business Case for the Hub has been supported/approved by all system partner organisations and is now awaiting approval from central Govt. before project mobilisation commences in full.	Patients and public Place based care Partnerships Leadership	7, 8, 9, 2, 3, 5	Final approval from DLUHC Dec 21. Release of funds from DLUHC Mar 22. Doors open Autumn 22 (est)	Lucy Gardner Steve Bennett Caroline Lane
HI2	Runcorn Shopping City	**Anchoring hospital services into communities** WHH has identified forward thinking solutions to delivering clinical services to realise maximum benefits for the local community. This project will see key services including audiology, ophthalmology and dietetics provided from Runcorn Shopping City. It will ensure Halton residence have access to services locally and in a convenient location. The movement of services will create an additional 3,000 outpatient appointments each year and will help to regenerate local retail space. Since June, the Trust has agreed a Heads of Terms agreement with the Centre landlord. A formal lease will be signed following completion of some remedial works in November 2021. Contractors have been selected via a competitive tendering process to deliver the refurbishment with a completion date anticipated in early 2022. The Trust's clinical governance team have worked closely with all services involved to submit a location change form to CQC in October 2021.	Patients and public Place based care Partnerships Leadership	7, 8, 9, 2, 3, 5	Phase 1 construction to complete Spring 2022. Planning for Phase 2 underway	Lucy Gardner Carl Mackie

26. Health Inequalities – Existing programme of work

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Below is a list of existing projects the Trust is involved in at regional or local level that will support delivery of our Health Inequalities objectives

Ref	Project	Overview and progress made since June 2021	Domain delivered against	Objective/s supported	Delivered by	Lead/s
HI3	Runcorn Town Deal	**Anchoring hospital services into communities** As part of the Runcorn Town Deal, WHH has secured funding to create a Health and Education Hub in Runcorn Old Town. With an investment of £2.85m, the Health and Education Hub is planned to deliver women's and children's services, including antenatal and postnatal care, a range of diagnostic services, alongside a comprehensive education offer delivered via Riverside College. The Runcorn Town Deal Board confirmed the successful award of funding to the project in September 2021. Governance for managing the project has been agreed. Initial conversations regarding the service model are underway.	Patients and public Place based care Partnerships Leadership	7, 8, 9, 2, 3, 5	Estimated completion Autumn 2023 Business Case due to be presented at Town Deal Board in June 2022	Lucy Gardner Carl Mackie
HI4	Diabetes Prevention	**Prevention** A Youth Worker post has been established and appointed between the Diabetes service and Paediatrics. The post is working with those aged 14 to 25 with a specific focus on engaging younger people in our communities in the prevention agenda, including diet, physical activity, alcohol and drugs. Links have also been forged between the Diabetes service and the Universities of Edge Hill and Chester on initiatives related to Diabetes care in the community. Next step: - Agree mechanisms to review impact of engagement	Patients and public	3, 5, 7, 8, 9, 10	Post in place June 2022	Paula Chattington

27. Health Inequalities – Existing programme of work

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Below is a list of existing projects the Trust is involved in at regional or local level that will support delivery of our Health Inequalities objectives

Ref	Project	Overview and progress made since June 2021	Domain delivered against?	Objective/s supported	Delivered by	Lead/s
HI5	Prevention Pledge	**Prevention Pledge** Adoption of the Cheshire and Merseyside Prevention Pledge, consisting of the implementation of 14 commitments to reduce health inequalities and improve the social value of the Trust. The Trust, alongside Liverpool University Hospitals, was a pilot site for adoption. An action plan has been created to monitor the Trust's progress and many of the commitments are addressed through projects identified within this presentation. The Trust was awarded the Cheshire and Merseyside Social Value Award in 2021, partly in recognition of its work in adopting the 14 commitments. Next step will be to review progress against the original action plan	Patients and Public Workforce Culture Partnerships Leadership	2, 3, 4, 5, 7, 8, 10	Action plan developed and signed off April 2021 April 2022	Carl Mackie
HI6	Carers Strategy	**Focus on carers** The Trust is working in partnership with local organisations to develop a carers strategy to support the communities of Warrington and Halton	Patients and Public Partnerships	7, 8, 10	Emerging	Adam Harrison Patient Experience & Inclusion Manager

28. Health Inequalities – Existing programme of work

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Below is a list of existing projects the Trust is involved in at regional or local level that will support delivery of our Health Inequalities objectives

Ref	Project	Overview and progress made since June 2021	Domain delivered against?	Objective/s supported	Delivered by	Lead/s
HI7	Children and Maternity services	**First 1000 days** A number of initiatives are underway within Children's and Maternity services including, • The introduction of 'Wellbeing Wallets' in order to hold pregnancy notes and support the reduction of stillbirth by up to 50%. • The Saving Babies Lives Care Bundle which sees a range of initiatives (reduced smoking, risk assessment tools, surveillance for foetal growth restriction etc.) • The Continuity of Carer project which, aimed at reducing stillbirths, puts addressing health inequalities at the heart of maternity provision. • The River Pass project for Women whose first language is not English Next steps: Child and Maternal Health are key areas with a range of poor metrics across indicators. A review of existing initiatives is required, alongside a plan to address gaps.	Patients and public Partnerships	3, 5, 7, 8, 9, 10	April 2022	Catherine Owens Deborah Carter

29. Health Inequalities – Next Steps

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Actions required to progress our Health Inequalities work.

Ref	Action	Domain delivered against	Objective/s support?	Delivered by	Lead/s	Notes
HI8	**Delivery plan** Develop a full delivery plan to guide the Trusts Health Inequalities Programmes	Leadership	7, 8, 9	June 2022	Kelly Jones	Delivery plan to incorporate mechanisms and metrics for evaluating impact and to link with regional priorities
HI9	**Improved integration of care across Mental Heath and alcohol services** The Trust signed up to an agreement at clinical network to improve coordination of care for patients who present with alcohol and mental health issues. The ensuing actions and their impact need to be understood.	Patients and Public Partnership		December 2021	Kelly Jones Clinical and operational leads to be identified	
HI10	**Prevention** - Sign up to the Cheshire and Merseyside 'Prevention Concordat for Better Mental Health for All' and embed the Concordat across health and care policies and practices - Devise a programme of work that prioritises a long-term focus on well-being, prevention and early intervention across services and pathways.	Patients and Public Partnership Patients and public	7, 10, 3 7	Timescales are emerging – ICS initiative	Kelly Jones Operational lead will also be required.	Requirements have been drafted and are pending approval. Specific actions to be determined as identified. Supports implementation of prevention pledge

30. Health Inequalities – Next Steps

Actions required to progress our Health Inequalities work.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Ref	Action	Domain delivered against	Which objective/s does this support?	Delivered by	Lead/s	Notes
HI11	**Assess scope of existing projects against anchor framework** Assess existing projects against the domains for an anchor organisation, identifying gaps in progress against each domains and seek opportunities to reduce health inequalities.	Leadership	7, 8, 9, 10	January 2022	Kelly Jones	
HI12	**Prevention focused collaboration** Identify partnership opportunities to collaborate on common prevention pathways across Trusts, supporting secondary and tertiary prevention that reduces the impact of established disease	Leadership	7, 8, 9, 10	Assessment for inclusion in delivery plan June 2022	Kelly Jones	Supports implementation of prevention pledge
HI13	**Alcohol** Baseline data has identified alcohol-related mortality is higher than the national average across both boroughs and alcohol-related admissions to hospital are 64% higher than the national average in Halton. There is a need to analyse this further at service level and develop a targeted programme of work. Opportunities emerging to work with third sector partners to use physical activity as an intervention to reduce alcohol related issues.	Patients and Public	7	Emerging	Kelly Jones James Higgins	Supports implementation of prevention pledge. To be aligned to business planning.

31. Health Inequalities – Next Steps

Actions required to progress our Health Inequalities work.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Ref	Action	Domain delivered against	Which objective/s does this support?	Delivered by	Lead/s	Notes
HI14	Obesity levels in children are high across a range of metrics in Halton. A plan to address this is needed.	Patients and public	7, 8, 10	June 2022	Kelly Jones Clinical lead to be identified	

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Summary and next steps

32. Next Steps

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Ref	Action	Delivered by	Suggested discussion at Board development session in December 2021
1.0	**Harness the passion of individuals and teams** WHH has a passionate, skilled and values driven workforce who as individuals and teams can make a difference to our patients and communities and advance the work of WHH as an anchor. A framework will be developed to support staff to take forward their ideas, while capturing learning, outputs and impacts.	April 2022	✓
2.0	**Strategy and Implementation plan development** Green plan approval Development of strategies: Procurement, charity, people, place based health and wellbeing	December 2021 April 2022	✓
3.0	**Continue to progress existing programmes** E.g. Patient experience and inclusion, carers support, estates review, Town deal hubs, Shopping City provision, diabetes prevention	Set by individual programme as outlined in previous slides	
4.0	**Commence new priority programmes** E.g. Alcohol, obesity, violent crime	Plans delivered by April 2022	✓
5.0	**Monitoring progress** A reporting schedule will be developed to track progress of action plans through the outlined governance structure	January 2022	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/159**			
SUBJECT:	**Warrington and Halton Teaching Hospitals NHS Foundation Trust Green Plan**			
DATE OF MEETING:	24th November 2021			
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 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. WHH has worked in partnership with WRM Sustainability to assess the Trust's current position and develop an implementation plan to achieve our emissions targets.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note	Decision x

RECOMMENDATION:	It is recommended that the Trust Board reviews and provides comments on the 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/21/11/159**

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.

WHH has worked in partnership with WRM Sustainability to assess the Trust's current position and develop an implementation plan to achieve our emissions targets.

2. KEY ELEMENTS

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.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Trust Board is requested to provide any comments on the report.

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.*

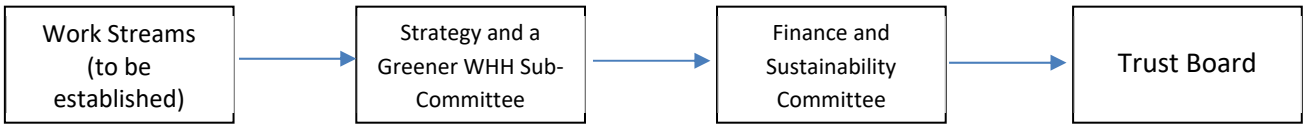
Emissions will be calculated annually using the Trust's annual energy return to NHSE/I.

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.

Implementation leads for the actions are being identified and will be detailed in the action plan when presented to Finance and Sustainability Committee and Trust Board for final approval in December 2021.

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. It is anticipated that 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.

7. TIMELINES

Implementation leads for the actions are being identified, and will be detailed in the action plan.

Following incorporation of comments from both Finance & Sustainability Committee and the Trust Board, and inclusion of implementation leads the Green Plan will be presented to Finance and Sustainability Committee and Trust Board for approval in December 2021.

The plan will be launched across the Trust in January 2022.

8. RECOMMENDATIONS

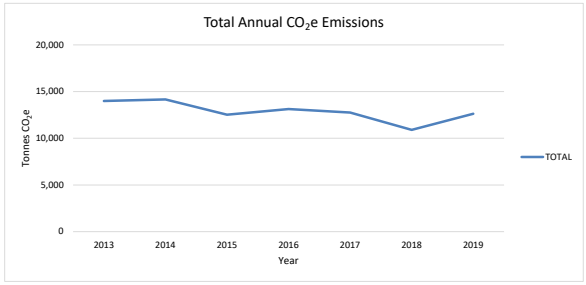
It is recommended that the Trust Board reviews and provides comments on the Green Plan.

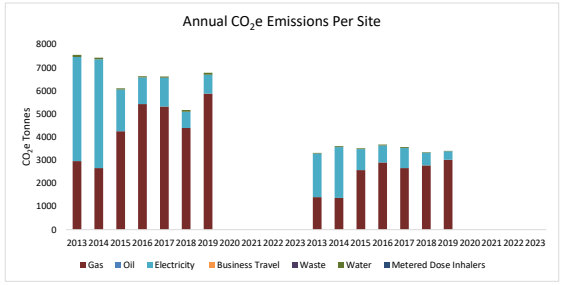
CARBON FOOTPRINT ANALYSIS

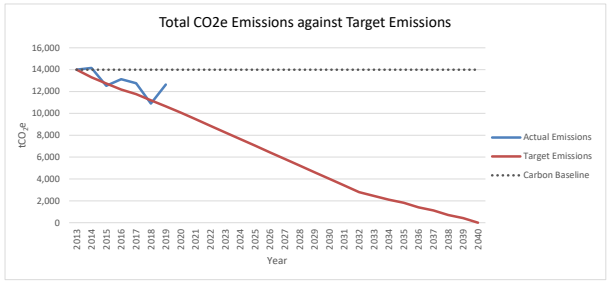
tCO2e/annum

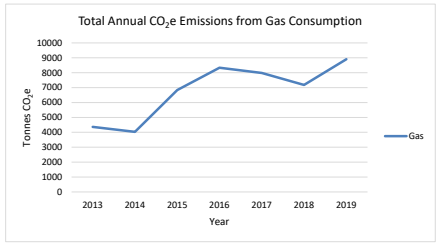
			Gas	Oil	Anaesthetics	Electricity	Business Travel	Waste	Water	Metered Dose Inhalers	TOTAL
		2013	2963.13	0		4,501			94		4,501
		2014	2660.27	0		4,706			65		4,706
		2015	4256.58	0		1,799			51		1,799
		2016	5427.83	0		1,154			52		1,154
		2017	5322.37	0		1,243			56		1,243
		2018	4395.57	0		702			74		702
		2019	5883.21	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	1404.27	0		1,884			31		1,884
		2014	1371.9	0		2,196			44		2,196
		2015	2576.08	0		907			32		907
		2016	2904.52	0		735			38		735
		2017	2664.49	0		865			38		865
		2018	2779.9	0		547			18		547
		2019	3021.97	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	4367.4	0	2,933	6,385	103	56	124.52	28	13,997
		2014	4032.17	0	2,933	6,902	101	52	109.56	28	14,158
		2015	6832.66	0	2,743	2,706	99	23	83.23	34	12,521
		2016	8332.35	0	2,512	1,889	100	163	89.50	37	13,123
		2017	7986.86	0	2,425	2,108	86	26	93.36	35	12,760
		2018	7175.47	0	2,229	1,249	88	26	92.09	40	10,899
		2019	8905.19	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

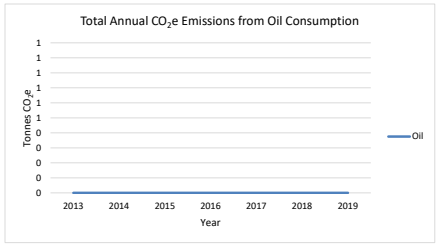
NHS Emissions Targets						
	Year	Baseline	Percentage Reduction	Actual Emissions	Required Reduction
Total	2013	13997	0	13,997	13997
	2014	13997	5	14,158	13297
	2015	13997	9	12,521	12737
	2016	13997	13	13,123	12177
	2017	13997	16	12,760	11757
	2018	13997	20	10,899	11198
	2019	13997	24	12,632	10638
	2020	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

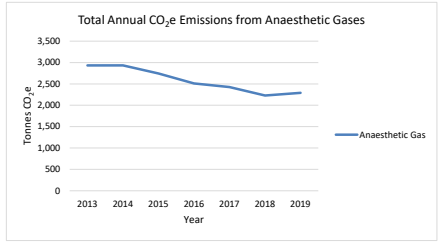

Total Annual CO_2e Emissions
Tonnes CO_2e
20,000
15,000
10,000
5,000
0
2013
2014
2015
2016
2017
2018
2019
Year
TOTAL

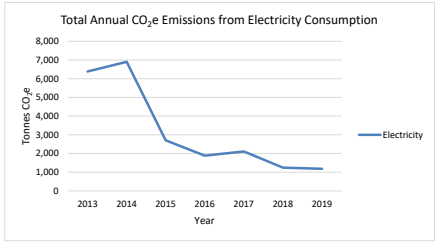

Annual CO_2e Emissions Per Site
CO_2e Tonnes
8000
7000
6000
5000
4000
3000
2000
1000
0
2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023
Gas
Oil
Electricity
Business Travel
Waste
Water
Metered Dose Inhalers

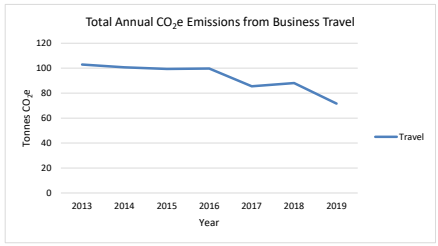

Total CO2e Emissions against Target Emissions
tCO_2e
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040
Year
Actual Emissions
Target Emissions
Carbon Baseline

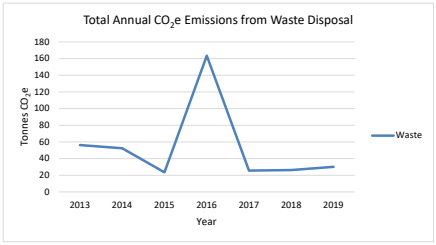

Total Annual CO_2e Emissions from Gas Consumption
Tonnes CO_2e
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
2013
2014
2015
2016
2017
2018
2019
Year
Gas

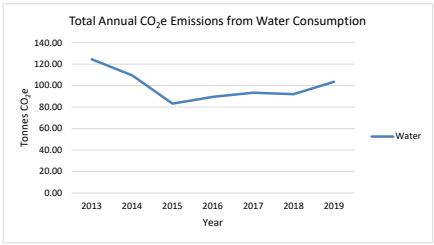

Total Annual CO_2e Emissions from Oil Consumption
Tonnes CO_2e
1
1
1
1
1
0
0
0
0
0
2013
2014
2015
2016
2017
2018
2019
Year
Oil

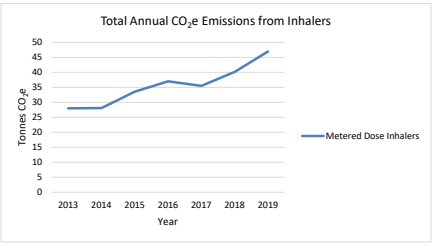

Total Annual CO_2e Emissions from Anaesthetic Gases
Tonnes CO_2e
3,500
3,000
2,500
2,000
1,500
1,000
500
0
2013
2014
2015
2016
2017
2018
2019
Year
Anaesthetic Gas

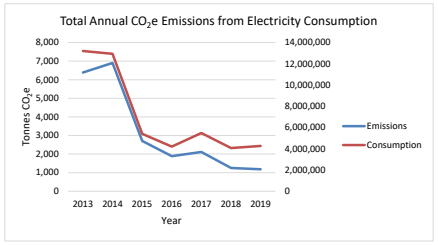

Total Annual CO_2e Emissions from Electricity Consumption
Tonnes CO_2e
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
2013
2014
2015
2016
2017
2018
2019
Year
Electricity

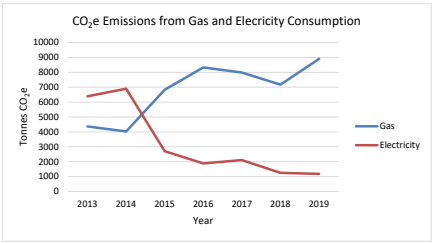

Total Annual CO_2e Emissions from Business Travel
Tonnes CO_2e
120
100
80
60
40
20
0
2013
2014
2015
2016
2017
2018
2019
Year
Travel

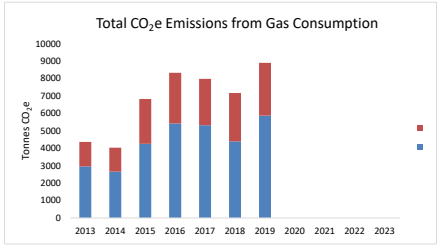

Total Annual CO_2e Emissions from Waste Disposal
Tonnes CO_2e
180
160
140
120
100
80
60
40
20
0
2013
2014
2015
2016
2017
2018
2019
Year
Waste

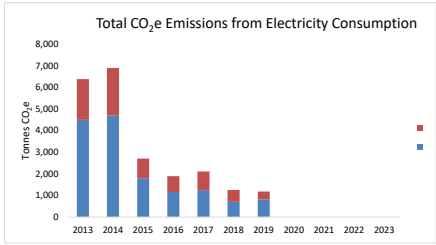

Total Annual CO_2e Emissions from Water Consumption
Tonnes CO_2e
140.00
120.00
100.00
80.00
60.00
40.00
20.00
0.00
2013
2014
2015
2016
2017
2018
2019
Year
Water


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


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

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

2021-22

Fuel	Unit	kg CO_2e		
Natural Gas	kWh (Net CV)	0.20297		kgCO_2e/kWh
	kWh (Gross CV)	0.18316	Total CO_2e	0.18316

2022-23

Fuel	Unit	kg CO_2e		
Natural Gas	kWh (Net CV)			kgCO_2e/kWh
	kWh (Gross CV)		Total CO_2e	0

2023-24

Fuel	Unit	kg CO_2e		
Natural Gas	kWh (Net CV)			kgCO_2e/kWh
	kWh (Gross CV)		Total CO_2e	0

2024-25

Fuel	Unit	kg CO_2e		
Natural Gas	kWh (Net CV)			kgCO_2e/kWh
	kWh (Gross CV)		Total CO_2e	0

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

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

2020-21

Fuel	Unit	kg CO_2e		
Gas Oil	kWh (Net CV)	0.2731		$kgCO_2e/kWh$
	kWh (Gross CV)	0.25672	Total CO_2e	0.25672

2021-22

Fuel	Unit	kg CO_2e		
Gas Oil	kWh (Net CV)	0.27318		$kgCO_2e/kWh$
	kWh (Gross CV)	0.25679	Total CO_2e	0.25679

2022-23

Fuel	Unit	kg CO_2e		
Gas Oil	kWh (Net CV)			$kgCO_2e/kWh$
	kWh (Gross CV)		Total CO_2e	0

2023-24

Fuel	Unit	kg CO_2e		
Gas Oil	kWh (Net CV)			$kgCO_2e/kWh$
	kWh (Gross CV)		Total CO_2e	0

2024-25

Fuel	Unit	kg CO_2e		
Gas Oil	kWh (Net CV)			$kgCO_2e/kWh$
	kWh (Gross CV)		Total CO_2e	0

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	

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		
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			

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

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

2020-21

Fuel	Unit	kg CO_2e		kgCO_2e/kWh
Petrol	miles	0.2805	Total CO_2e	0.28052

2021-2022

Fuel	Unit	kg CO_2e		kgCO_2e/kWh
Petrol	miles	0.2805	Total CO_2e	0.28053

2022-23

Fuel	Unit	kg CO_2e		kgCO_2e/kWh
Petrol	miles		Total CO_2e	0

2023-24

Fuel	Unit	kg CO_2e		kgCO_2e/kWh
Petrol	miles		Total CO_2e	0

2024-25

Fuel	Unit	kg CO_2e		kgCO_2e/kWh
Petrol	miles		Total CO_2e	0

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

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		$kgCO_2e/m^3$
Treatment	cubic metres	0.7085	Total CO_2e	1.0526

2014-15

Type	Unit	kg CO2e		
Supply	cubic metres	0.3441		$kgCO_2e/m^3$
Treatment	cubic metres	0.7085	Total CO_2e	1.0526

2015-16

Type	Unit	kg CO2e		
Supply	cubic metres	0.344		$kgCO_2e/m^3$
Treatment	cubic metres	0.708	Total CO_2e	1.052

2016-17

Type	Unit	kg CO2e		
Supply	cubic metres	0.344		$kgCO_2e/m^4$
Treatment	cubic metres	0.708	Total CO_2e	1.052

2017-18

Type	Unit	kg CO2e		
Supply	cubic metres	0.344		$kgCO_2e/m^3$
Treatment	cubic metres	0.708	Total CO_2e	1.052

2018-19

Type	Unit	kg CO2e		
Supply	cubic metres	0.344		$kgCO_2e/m^3$
Treatment	cubic metres	0.708	Total CO_2e	1.052

2019-20

Type	Unit	kg CO2e		
Supply	cubic metres	0.344		$kgCO_2e/m^3$
Treatment	cubic metres	0.708	Total CO_2e	1.052

2020-21

Type	Unit	kg CO2e		
Supply	cubic metres	0.344		$kgCO_2e/m^3$
Treatment	cubic metres	0.708	Total CO_2e	1.052

2021-22

Type	Unit	kg CO2e		
Supply	cubic metres	0.149		$kgCO_2e/m^3$
Treatment	cubic metres	0.272	Total CO_2e	0.421

2022-23

Type	Unit	kg CO2e		
Supply	cubic metres			$kgCO_2e/m^3$
Treatment	cubic metres		Total CO_2e	0

2023-24

Type	Unit	kg CO2e		
Supply	cubic metres			$kgCO_2e/m^3$
Treatment	cubic metres		Total CO_2e	0

2024-25

Type	Unit	kg CO2e		
Supply	cubic metres			$kgCO_2e/m^3$
Treatment	cubic metres		Total CO_2e	0

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

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

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 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**					
		A standing section on sustainability will be added to our board papers.	**All**					
		The Trust will adopt an invest to save approach to projects.	**All**					
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**					
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**					
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**					
		We will work with volunteers and other members of the local community in the delivery of our sustainable development objectives.	**All**					
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**					
		We will evidence which products pose a high ethical and labour standards risk and will implement mitigation processes.	**N/A**					
		We will report on the value/volume of goods that we procure ethically.	**N/A**					
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**					
		We will develop a sustainability specification and evaluation criteria that can be effectively incorporated in to our procurement contracts.	**All**					
		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**					
		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**					
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**					
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**					
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**					

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**					
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**					
		We will install occupancy sensors in appropriate locations on all new future refurbishments and new builds.	**C**					
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**					
AMU-04	**The Trust shall switch to a renewable energy tariff.**	*We will procure 100% renewable electricity.*	**C**					
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**					
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**					
AMU-07	**The Trust shall work with suppliers to improve efficiency.**	*We will work with our on-site contractors and suppliers to ensure they help reduce our waste and energy usage where relevant.*	**All**					

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**					
		We shall work with the council to provide electric shuttle buses.	**C & A**					
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**					
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**					
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**					
		We will monitor the environmental impacts including CO2e and air pollution associated with the transport and logistics from our supplier.	**C & A**					
		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**					
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**					
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**					
		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**					
		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**					
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**					

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**					
		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**					
		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**					
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**					
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**					
		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**					
		The adaptation plan shall be approved by the Board.	**C**					
		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**					
		Training is provided to staff relevant to their role, to ensure they understand their roles and responsibilities in relation to adaptation planning.	**C**					
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**					
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**					
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**					
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**					
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**					

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**					
		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**					
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**					
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**					
		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**					

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**					
		We will ensure that sustainability is factored into the design process of all new capital projects.	**All**					
		The Trust shall explore how consideration of sustainability can be factored into contracts for new capital projects.	**All**					
		All tenders for new capital projects, including refurbishments and new buildings shall include sustainability as a technical question.	**All**					
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**					
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**					
		We will consider adaptation to climate change when designing new buildings to ensure they are resilient.	**N/A**					
		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**					
		We will prioritise efficiency when designing new buildings and refurbishments to reduce energy consumption.	**C**					
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**					
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**					
CP-06	**The Trust shall consult key stakeholders including staff, patients, visitors and the local community when embarking on a new capital project.**	*The opinions of staff, patients, visitors and the local population shall help guide the design process of key capital projects.*	**All**					
		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**					

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**					
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**					
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**					
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**					
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**					
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**					
		The Trust shall provide an induction for staff upon occupation of a new building so it can be utilised efficiently.	**All**					

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.*						
GB-02	**The Trust will work to improve local biodiversity.**	*The gardens team will work with local organisations to improve biodiversity on our estate.*						
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.*						
		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					
		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					
		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					
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					
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					
		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					
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					
		We will communicate our strategy to staff, patients and stakeholders.	n/a					
		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					
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					
		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					
GB-08	**The Trust shall integrate wellbeing schemes with our greenspace and biodiversity plans to maximise the health**	*We will provide staff with opportunities, and encourage engagement in, local volunteering activities in maintenance of green spaces and biodiversity.*	n/a					
		We shall promote the health benefits of green space to our staff, patients and the wider community.	n/a					
		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					
GB-09	**The Trust shall provide green space for food cultivation on our estate and encourage, staff, patient and community engagement.**	*We will engage staff and patients in food growing onsite or at home and/or local sustainable food sourcing.*	n/a					
		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					

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**					
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**					
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**					
		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**					
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**					
		We shall work to identify which groups should receive large quantities of medicines to their homes, to reduce waste.	**All**					
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**					
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**					
		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**					
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**					
SCM-08	**The Trust will ensure that staff are adequately trained to develop and**	*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**					

	implement sustainable care models.	*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**					
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**					
		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**					
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**					
		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**					
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**					
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**					
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**					
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**					
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**					
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**					
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**					

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**					
		We will ensure that all suitbale 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**					
		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**					
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**					
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**					
OP-04	**The Trust will run a communications programme to publicise our sustainbility ageneda and targets**	*We will run a communications piece alongside the publication of our Green Plan to engage our workforce with our sustainability agenda and ecourage behavioural*	**All**					
		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**					
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**					
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**					
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**					
OP-08	**The Trust will seek to incorperate social responisibility clauses in procurement policices.**	*We will work to develop our understnaning of social responsibility within procurement and idenity the most effective ways to incorperate this into our procurement policies.*	**n/a**					
OP-09	**The Trust will provide relevant training for staff to promote sustainable behaviour change at the Trust.**	*We will assess the training needs of our workforce and produce talent maps to identify potential to upskill staff and support succession planning.*	**All**					
		We will agree an awareness raising programme focusing on increasing knowledge and understanding of sustainability and social value amongst our staff.	**All**					
OP-10	**The Trust shall develop a communications plan to highlight the importance of sustainability at the Trust and enocurgae**	*We will develop an active communications strategy linked with the Green Plan to raise awareness about sustainability at every level of the organisation.*	**All**					
		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**					
OP-11	**The Trust will develop an engagement programme to encourage staff to make more sustianable**	*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**					
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**					

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					
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					
		Where appropriate we will ask prospective suppliers to confirm that they comply with the Modern Slavery Act 2015.	n/a					
OP-14	The Trust will work to improve employment oppourtunites.	*We will develop schemes to help long-term unemployed people into work.*	n/a					
		We will work with our local strategic partnership and other key partners to plan improved access to employment opportunities in our organisation.	n/a					
		We will seek tobecome a living wage empoloyer.	n/a					

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.*						
		We will compact cardboard packaging onsite to reduce the frequency of collection and improve recycling rates.						
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.*						
		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 minimisaitn targets for each area.						
		We will engage with staff across all departments to identify high waste areas and identify specific solutions.						
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.*						
		We shall review the use of single use PPE and explore reusable alternatives and greener waste treatmetn options where resuable options are not viable.						
		We will explore ways to recycle disposbale curtains, such as the Sterimelt system.						
		We will carry out a review of the single use products used within the Trust and work to identify alternative products.						
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.*						
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.*						
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.*						
		We will set all printers across the Trust to print in black and white and double sided as the default setting.						
		We will review the efficiency of our printers and look to uprgrade printers to more efficient models as required.						
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.*						
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.*						
SR-09	**The Trust will reduce reliance on the Expedia system.**	*We shall move towards patients bringin gtheir own devices for entertainment whilst in hospital to improve the patient experince and improve efficiency.*						
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.*						
		We will commit to using original pack dinspensing where clincally appropriate to reduce cardboard.						
		We will explore options to collect metered dose inhalers for suitable disposal to reduce emissions from landfill.						
		We will use recylable paper bags instead of plastic bags for medicines.						
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.*						

SR-12	**The Trust will engage with suppliers to improve sustainability throughout the supply chain.**	*We will work with our suppliers to*						
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.*						
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.*						
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 twoels.*						
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					
		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					
		We will work with our onsite contractors to ensure they also help reduce our use of hazardous/toxic chemicals.	n/a					
		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					
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					
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					
		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					
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					
		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					
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					
		We will communicate the benefits of sustainable products and services to our employees, to encourage staff to maximise similar benefits at home.	Waste					
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					
		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					
		We will work with external stakeholders to encourage greater provision of healthy and sustainable food choices more widely in the local area.	Waste					
		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					

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**					
		We will encourage the use of low flow rates, where clincally appropriate, to improve efficiency and reduce emissions.	**C**					
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**					
		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**					
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**					
GHG-04	**The Trust shall develop a communications plan to raise awareness of the importance of sustainability and encourage behaviour change.**	*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**					
		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**					
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**					
		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**					
		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**					
		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**					
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**					
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**					

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**					
GHG-09	**The Trust shall expand the scope of the Carbon Baseline.**	*We shall imporve reporting of emissions from agregate sites and work to include these emissions inour carbon baseline.*	**C**					
		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**					
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**					

Green Plan

Issue 1.0

Produced for **Warrington and Halton 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 FOREWORD

To be provided by CEO or Deputy CEO

3.0 INTRODUCTION

3.1 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.

3.2 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.

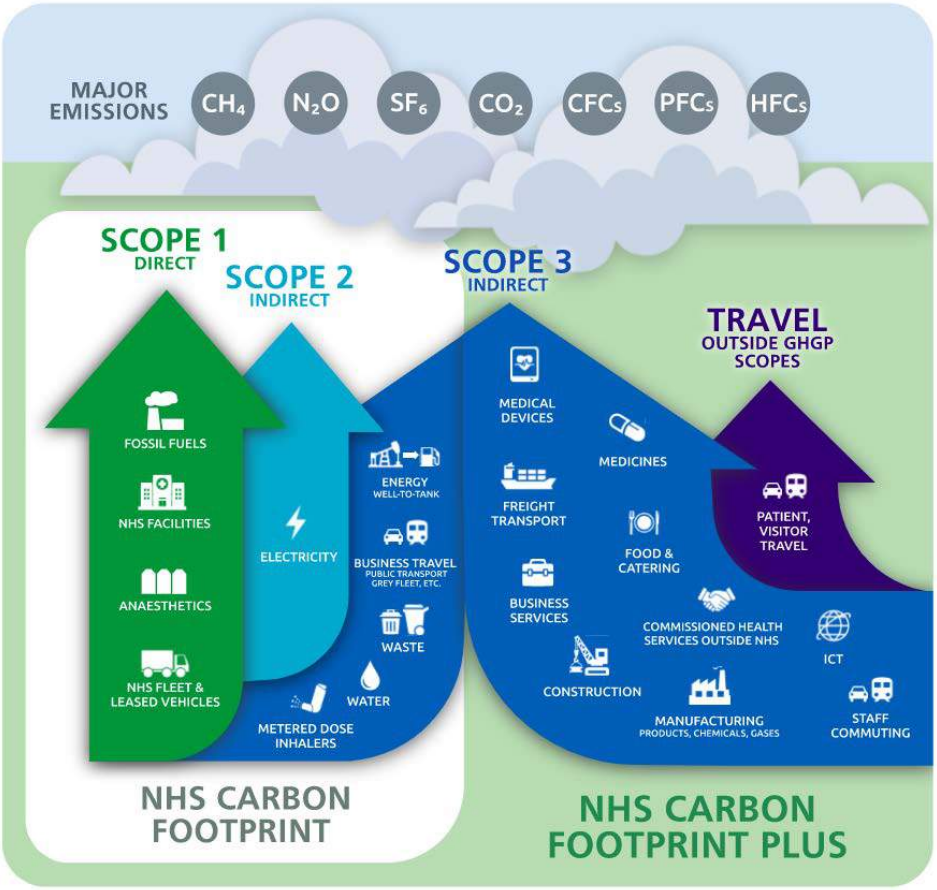

Figure 1 - NHS Carbon Footprint and NHS Carbon Footprint Plus with scope classifications

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.

3.3 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.

3.4 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.

3.5 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.

3.6 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.

3.7 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.

4.0 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.

4.1 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

4.2 Our Commitment and Targets

In line with national and local drivers the Trust will adopt the following targets:

4.2.1 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.

4.2.2 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.

4.2.3 Waste

- We will sign and adopt the Single-Use Plastic Pledge.
- We will adopt a Zero to Landfill policy by 2021.

5.0 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.

5.1 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.

5.1.1 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 Figure 1 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.

5.2 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

5.3 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.

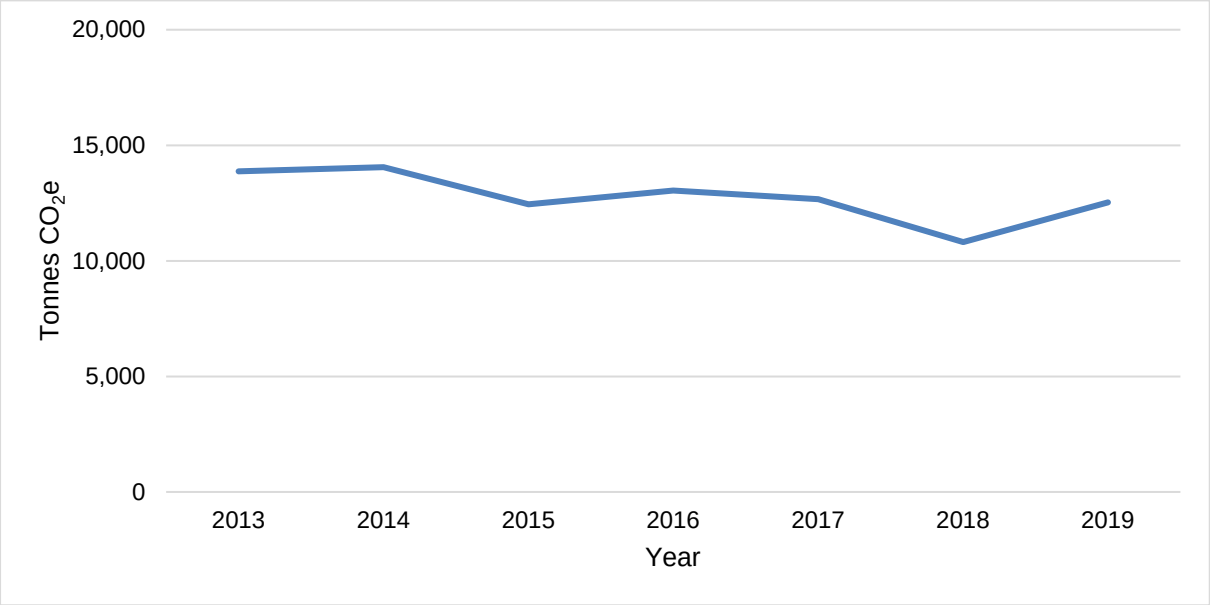

Figure 3 - Total annual CO2e emissions from the Trust

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	28	13,997
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

5.4 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.

5.5 Scope 1

5.5.1 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.

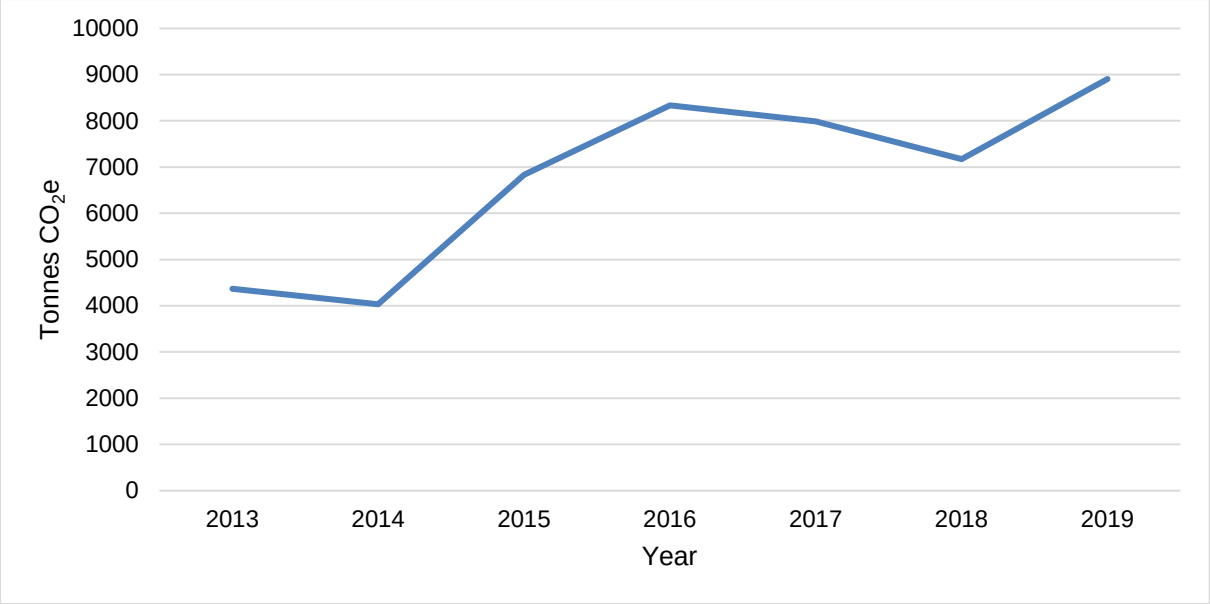

Figure 4 - Total CO_2e emissions from gas consumption at the Trust

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.

5.5.2 Oil

As shown in Table 2 - Comparison of CO_2e 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.

5.5.3 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.

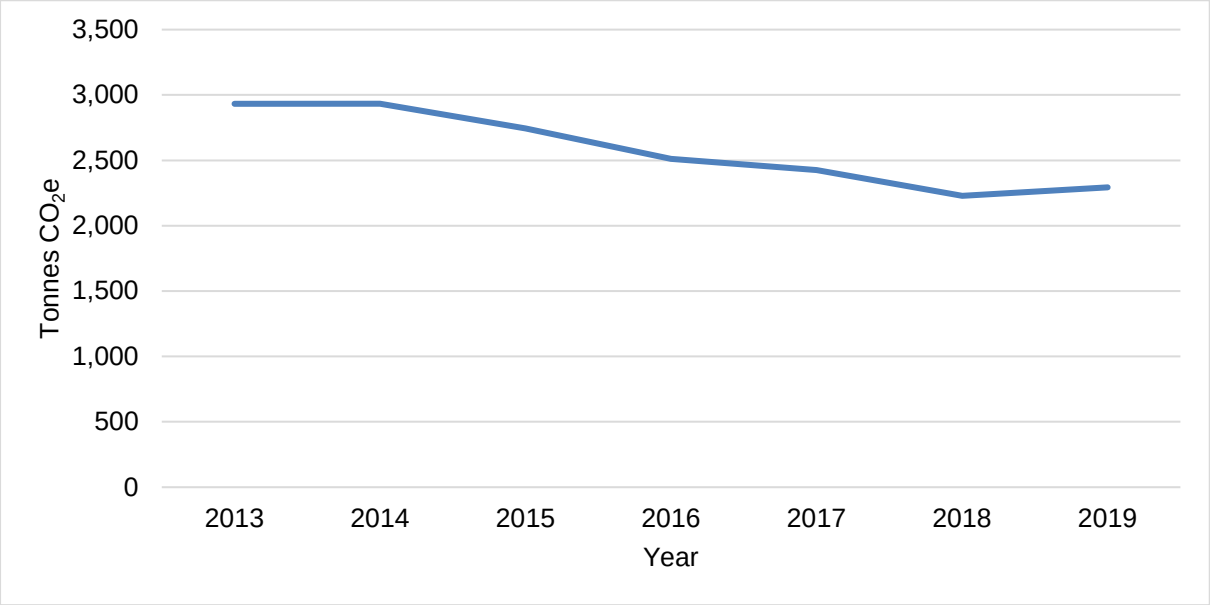

Figure 5 - CO_2e emissions from anaesthetic gas use at the Trust

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.

5.6 Scope 2

5.6.1 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.

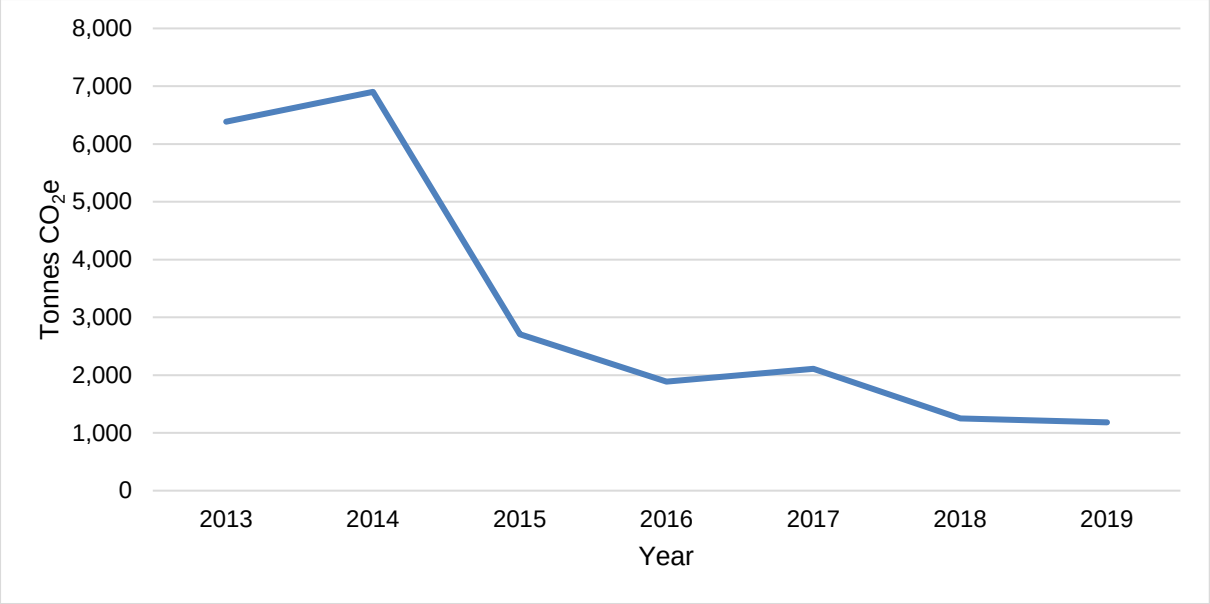

Figure 6 - Total annual emissions from electricity consumption at the Trust

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.

5.7 Scope 3

5.7.1 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.

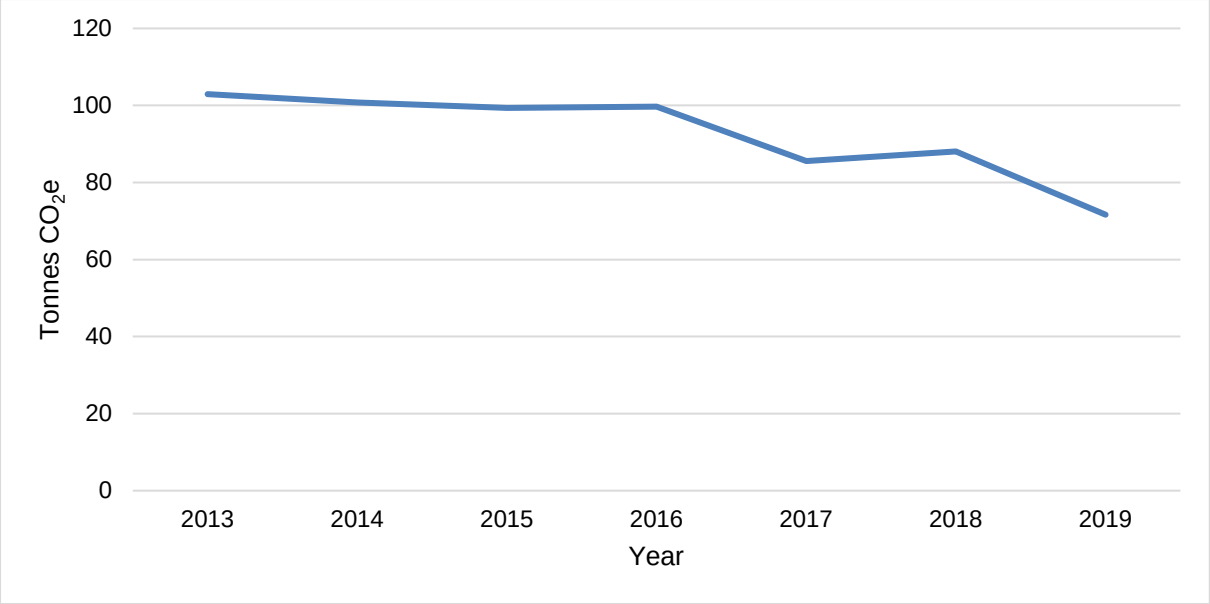

Figure 7 - Total CO_2e emissions from business travel at the Trust

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.

5.7.2 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.

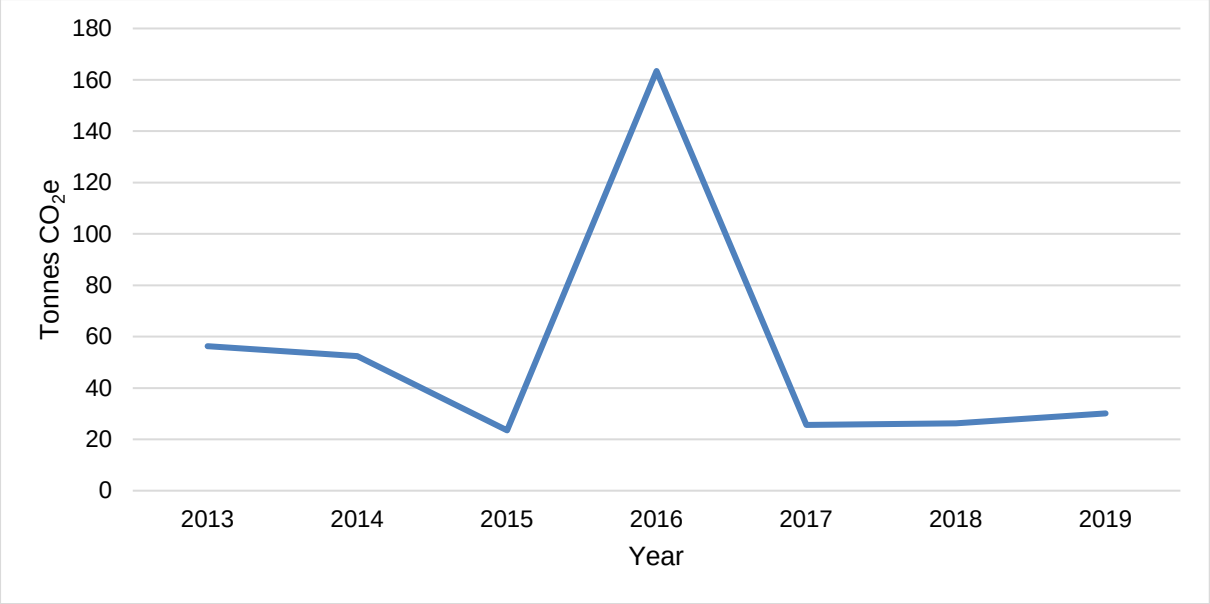

Figure 8 – Total CO_2e emissions from waste at the Trust

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.

5.7.3 Water

As shown in Figure 9, the Trust achieved a 17% reduction in emissions from water consumption.

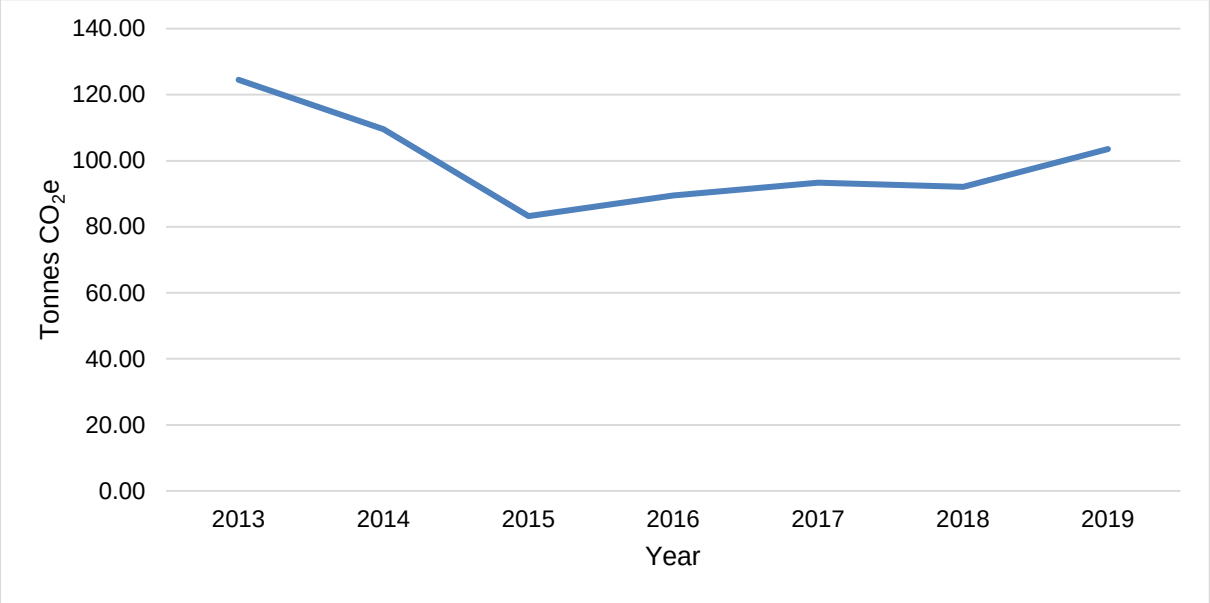

Figure 9 - Total CO_2e emissions from water at the Trust

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.

5.7.4 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.

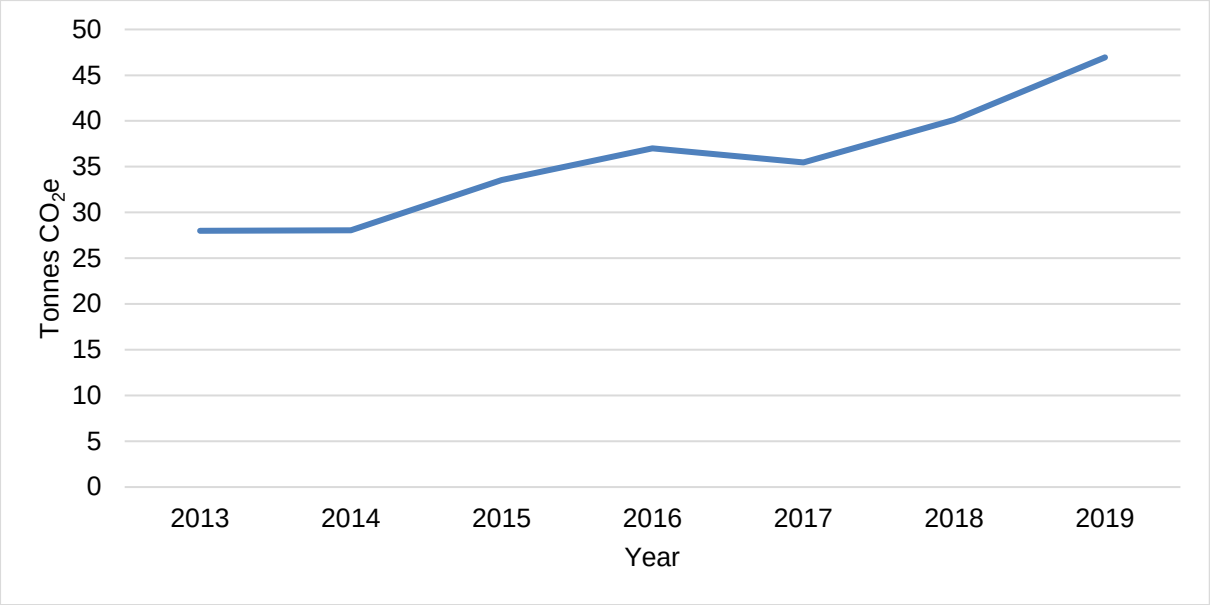

Figure 10 - CO_2e emissions from metered dose inhalers at the Trust

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.

6.0 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

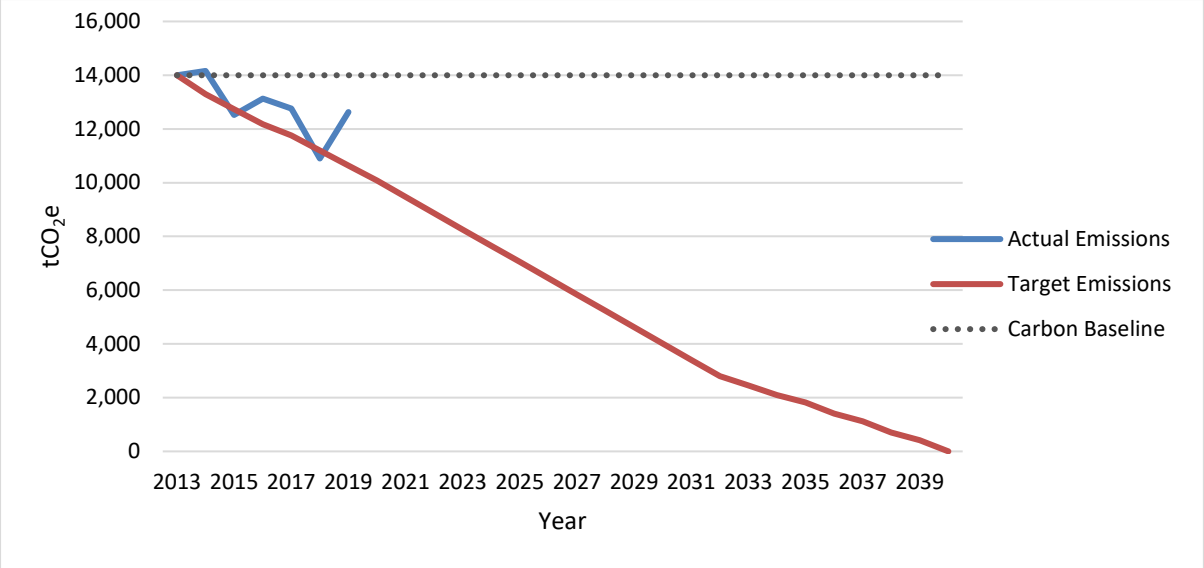

Figure 11 - Trust emissions against the NHS CO2e emissions targets

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.

6.1 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.

6.1.1 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.

6.1.2 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.

6.2 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.

6.2.1 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.

6.2.2 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.

6.2.3 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.

7.0 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

7.1 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.

7.2 Sections of the Sustainable Action Plan

7.2.1 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.

7.2.2 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.

7.2.3 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.

7.2.4 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.

7.2.5 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.

7.2.6 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.

7.2.7 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.

7.2.8 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.

7.2.9 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.

7.2.10 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

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/160**	
SUBJECT:	Engagement Dashboard Q2 Report	
DATE OF MEETING:	24 November 2021	
AUTHOR(S):	Pat McLaren, Director of Communications & Engagement	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications & Engagement	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X X X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Engagement Dashboard is for the period Ju-Sept 2021 inclusive (Q2) and addresses: • Level of success in managing the Trust's reputation in the media and across digital and social platforms • Our engagement with patients, staff and public via our social media channels • The Trust's website and levels engagement with this key platform • Patient enquiries via our website • Patient/public feedback on the independent platforms **Media** 1. Covid-19 data from our hospitals remains a key item of interest among our local and regional media. We continue to publish key Covid-19 stats on our website at 1pm daily which are reported on weekly in local outlets. 2. Media sentiment continued neutral, ie where media reported on Covid statistics etc, however the Trust pressed ahead with key projects which drew positive media attention. **Social Media** 1. Twitter – Followers have grown sharply in the quarter to circa 17K with engagements in the period reaching 499K 2. Facebook reach in the period was 592K as expected over the summer months 3. Instagram – this platform is extensively used by younger users and we are working on building a following on this medium, achieving 4.4k reach in the period To note that are social media channels carried extensive messaging around Covid vaccination and appropriate use of ED and UTCs in the period.	

<table>
<tr><td></td><td colspan="4">Website
• Website visits reached an all time high in January at 70K but did decline over the summer months – however there were 150K visits which is nearly double the same period last year. Nearly two thirds of visitors arrived by mobile phone.
• Patient/visitor enquiries through the website totalled 660 for the period which is reflective of both summer and the fact that we have put much more content onto the website making visitor experiences richer. Work continues on the introduction on our ‘Virtual Assistant’ and we are conducting the final stages of user testing ahead of a pilot launch. The virtual assistant supports visitors to find the information they require through a single search term. As well as offering a significantly better visitor experience, it will also reduce pressure on Switchboard and the Communications teams.

Patient Feedback
There were 29 patient reviews on the three main external channels: NHS Choices, Care Opinion and I Want Great Care of which 8 were negative.
Healthwatch continues to collect ratings on healthcare services in each borough, Halton Hospital is at 5* from 61 reviews, RUCC is at 4.5* from 8 reviews and Warrington Hospital is at 3* based on 15 reviews
Google Reviews We now collate Google reviews, an increasingly popular ratings system and which are present when the user searches for an organisation or establishment. Warrington Hospital is at 3.3 down from 3.4 in the quarter with A&E, ambulance and car parking most highly mentioned. Halton General is at 3.9* with users most often mentioning ‘professional, nurse, treatment and triage’ CSTM now showing 5* up from 4.9 – there are stillinsufficient ratings to review these comments.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information
X</td><td>Approval</td><td>To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4"></td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3">Choose an item.</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="3"></td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="3"></td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="3"></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">None</td></tr>
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NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WHH Engagement Dashboard

2021 Q2

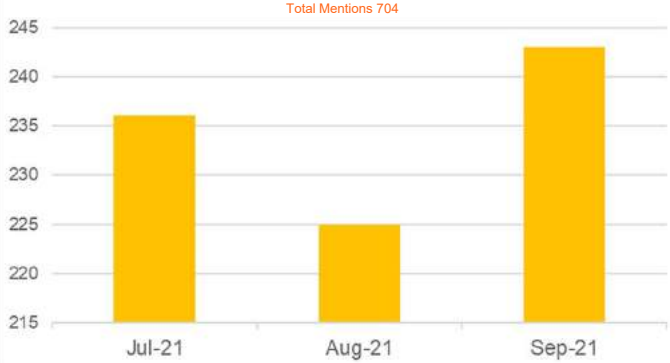
July 2021 – September 2021

Media Dashboard

Warrington and Halton Teaching Hospitals NHS Foundation Trust

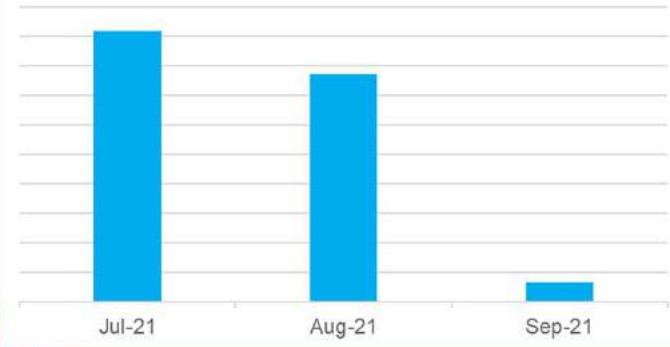
Media Mentions

Total Mentions 704



Media Reach

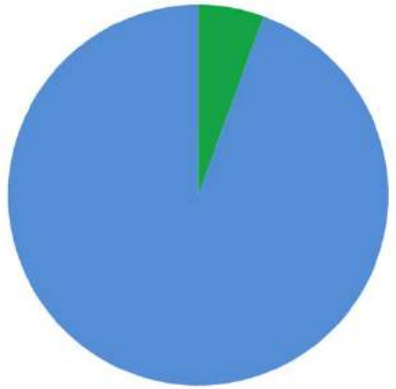
Total Reach 87M



Top Articles

HEADLINES	OUTLET	REACH
Warrington Hospital intensive care and maternity teams honoured by awards shortlist	Warrington Guardian	40,037
		
Warrington Hospital surgeon smashes gruelling challenge cycling the length of the UK	Warrington Guardian	40,037
Hospital surgeon smashes 1,035 cycling challenge raising over £4,000	Warrington Worldwide	11,800

Media Coverage Sentiment by mention

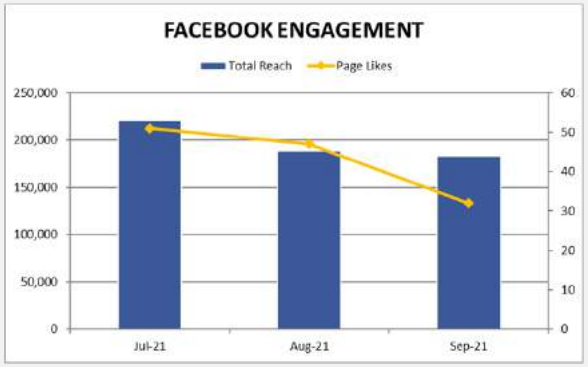


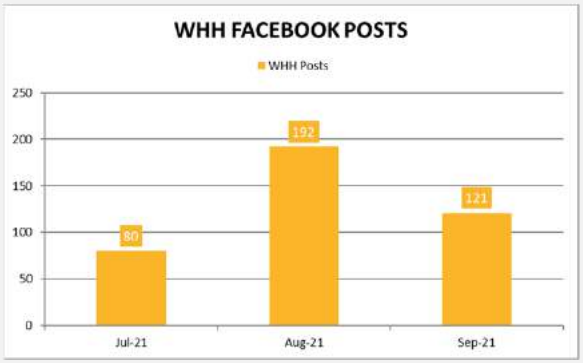
Neutral 94% Positive 5.99% Negative 0.01%

WHH Social Media

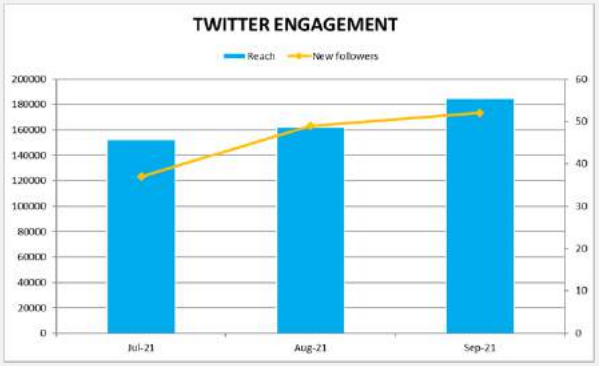
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

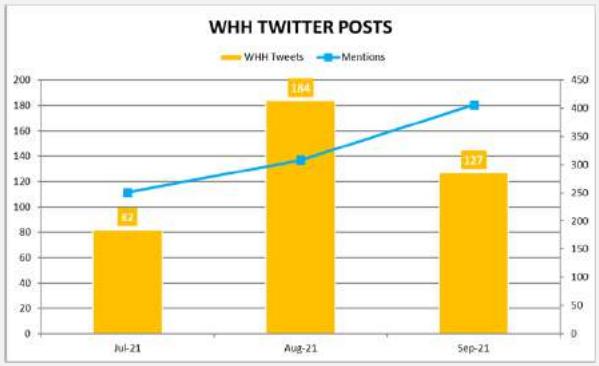
FACEBOOK
Total Reach 592K



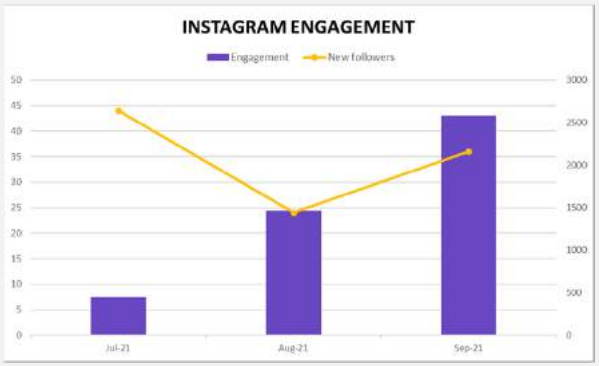


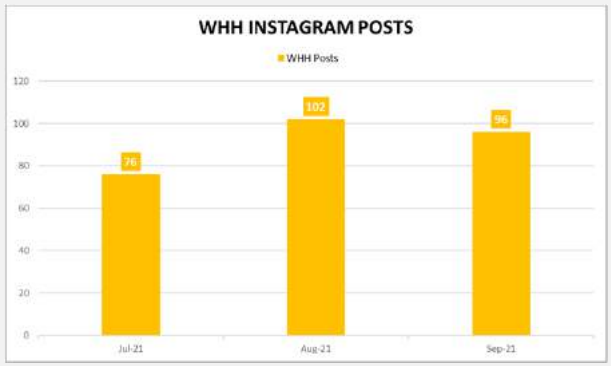
TWITTER
Total Reach 499K





INSTAGRAM
Total Engagement 4.4K





WHH Website

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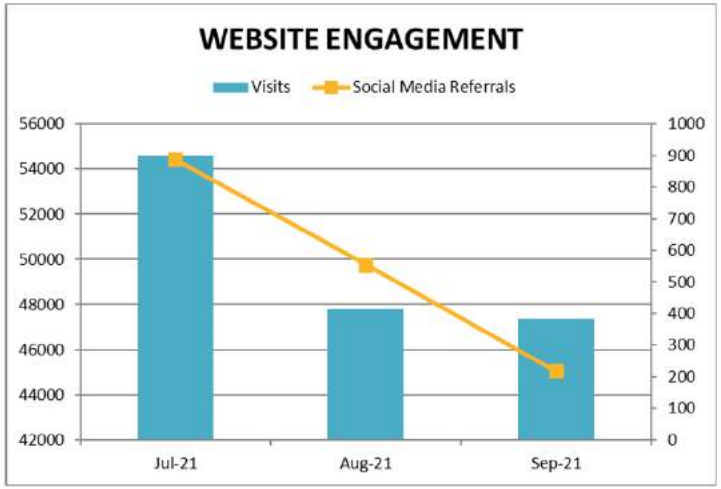
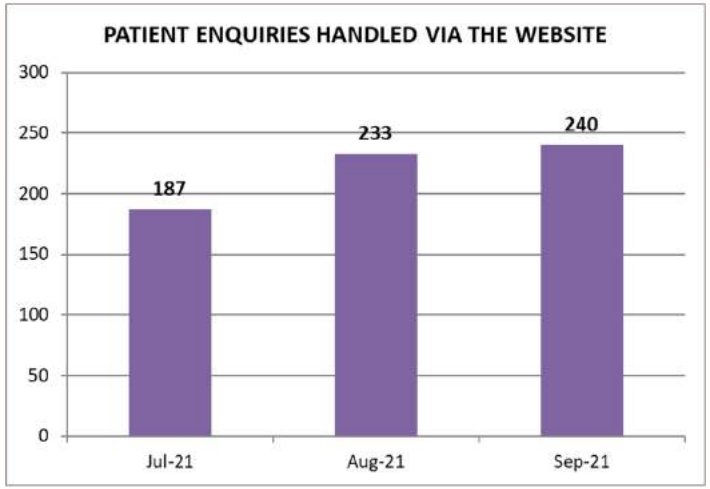
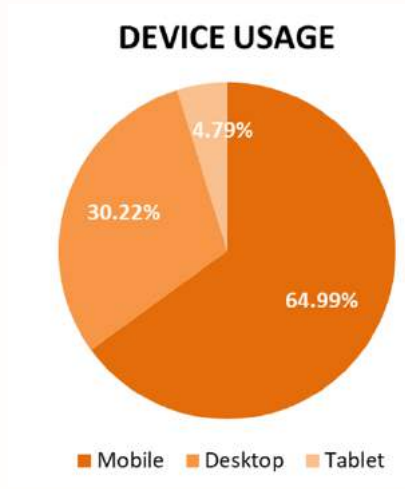


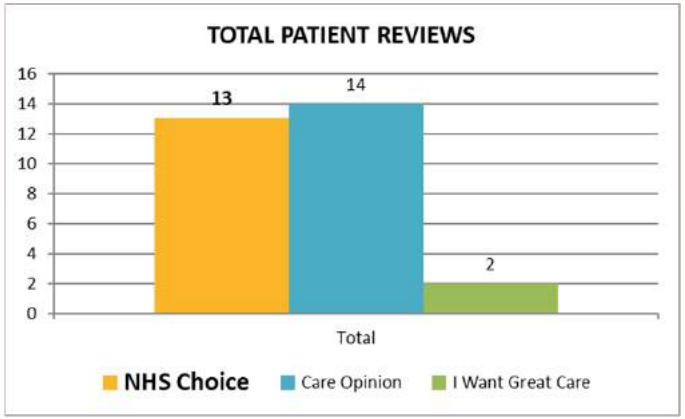


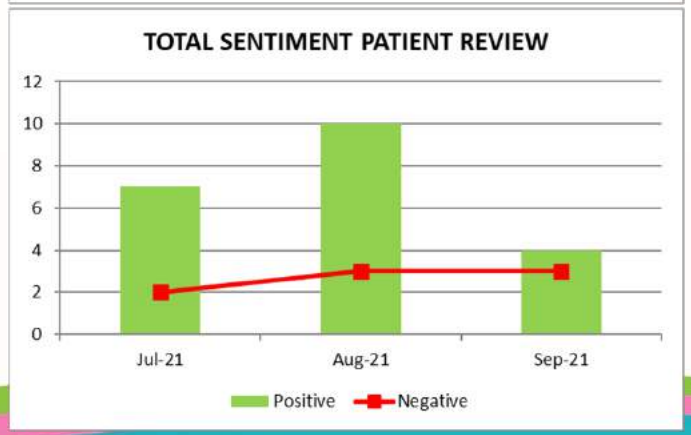


Total website sessions: 149,736 ↑ 43% from the same period last year

Total patient enquiries handled: 660 ↓ 25% from the same period last year

Patient Experience - Third party website feedback





"I had an unexpected stay in hospital due to fall - nurses, carers, physios etc made me feel comfortable- short staffed most of time - called to other bays to help - then get moaned at - being a shop worker I understand how deflating it can be - I have no complaints about my care. No complaints about food - good choice of menu. Thank you for caring"

"Taken into A&E on Saturday then to the Acute ward and on to Cardiology. Exceptional in all area. All staff are amazing, committed and caring, kept me fully informed and as comfortable as possible. Facilities excellent Well done and a sincere Thank You to all"

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

Google Reviews

NHS
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REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/161**			
SUBJECT:	**Board Assurance Framework**			
DATE OF MEETING:	24th Novmeber 2021			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	✓		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Since the last meeting: • No new risks have been added to the BAF. • There have been no amendments to the ratings of any risks. • The description of one risk on the BAF have been amended. • No risks have been de-escalated from the BAF since the last meeting. Notable updates to existing risks are also included in the paper.			
PURPOSE: ***(please select as appropriate)***	Information	Approval ✓	To note	Decision
RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC 21/11/270		
	Date of meeting	02.11.2021		
	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/21/11/16 1

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 has been added to the BAF.

2.2 Amendment to Risk Ratings

Since the last meeting there have been no amendments to the ratings of any risks.

2.3 Amendments to descriptions

Following discussion at the Risk Review Group on 4th November 2021, and subsequent approval at the Quality Assurance Committee on 5th November 2021, it was agreed that the description of risk **#224** should be amended as follows to provide greater clarity and be reflective of the current circumstances:

Previous: *Failure to meet the emergency access standard, caused by system demands and pressures 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.*

Current: *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.*

2.4 De-escalation of Risks

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

2.5 Existing Risks - Updates

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

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
224	Failure to meet the emergency access standard, caused by system demands and pressures. Resulting in potential risks to the quality of care and patient safety, staff health and wellbeing, Trust reputation, financial impact and below expected Patient experience.	• Monthly Focus on Flow weeks scheduled every month until July 2022	No impact on risk rating
1215	Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm	• H2 Planning Guidance submission – October 2021 • Elective Recovery Plan Business Case under development to support waiting list recovery for outpatients, cancer and electives in H2	No impact on risk rating
1273	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.	• 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.	No impact on risk rating
1272	Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 meters apart, resulting in reduced capacity to admit patients and a potential subsequent major incident.	• Bioquell Pods now in place in B18 • In October 2021 and increase in community prevalence noted. • Increase in formally declared nosocomial infection	No impact on risk rating
1275	Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks	• Bioquell Pods now in place B18 • Cohorting of COVID-19 positive patients recommenced • Non-adherence to Trust Staff isolation policy	No impact on risk rating
1289	Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres,	• B18 opened in October 2021 • Respiratory nursing business case approved to support step down of respiratory patients from ICU to B18	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm	earlier in their care pathway thus creating ICU capacity to support planned care	
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.	• The Trust will be placing 96 International Nurses by Dec 21. • In September 21 we have 0 wte band 5 vacancies. • Recruitment campaign for ED staffing is active, open day 28th October • There are currently 13 Health Care Assistant vacancies within the Trust. All vacancies are being recruited into during November. • WHH Nursing retention plan to be refreshed for 2022 • Increase staffing pressure due to ongoing use of temporary winter wards (B3 & 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 • 11.59% nursing turnover	No impact on risk rating
134	Risk: Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	• Achieved Break Even H1 2021/22 • Phase 3 of the Health Infrastructure Programme (HIP) announced. WHH submitted an Expression of Interest (EOI) in September 2021 • Additional PDC Capital bids still to be confirmed • New revenue request received that were not included in budget setting, currently undergoing a prioritisation exercise. • 2021 cost pressures supported by Trust Board. Business cases being developed to secure required levels of funding. There are 9 are in progress, 5 are complete, 2 have been closed as the funding is in budget. These are expected to be completed by 28th February 2022 • WHH judged by Cheshire & Merseyside Health & Care Partnership as the top priority for the	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		New Hospital Build Programme in C&M	
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	• 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%. • 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 • 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. • In Sept 2021 overall vacancy rate is 8.18% 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 Sept 2021 reliance on bank and agency staff increased slightly to 14.72% 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	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		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. • 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.	
1207	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	Trust compliance as at 9th November 2021 • Have you offered a Risk Assessment to all staff? - Yes • What % of all your staff have you Risk Assessed? – 95.04% • What % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary? – 95.52% • What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary? – 92.44% In late October 2021 at letter was sent out to all staff who have not completed the self-risk assessment in a timely manner, the letter reinforced the message that the self-risk assessment tool is one of a series of safety measures that the Trust has introduced, to ensure the safest possible working	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		environment for all of our staff and patients whilst we continue to respond to the Covid-19 pandemic and healthcare needs of our community. The number of outstanding self-risk assessments reduced by 43%. A second letter will be sent late Nov-2021 outlining a formal process that will be followed should the self-risk assessment not be completed. At 9th September 2021: •131 staff members yet to complete self-assessment (reduced from 231 in September 2021, demonstrating the impact of the letter) •0 Management Risk Assessments (required when an individual identifies as having a COVID Vulnerability) have been outstanding since at least March 2021 •5 Management Risk Assessments (required when an individual identifies as having a COVID Vulnerability) have been outstanding since at least Apr 2021 • 91 Management Risk Assessments have been outstanding since Jul 2021	
125	Failure to provide a safe, secure, fit for purpose hospitals and environment caused by the age and condition of the WHH estate and limited availble resource resulting in a risk to meeting compliance targets, staff and patient safety, increased backlog costs, increased critical infrastructure risk and increased revenue and capital spend.	• 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	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 extremely vulnerable, those who are assessed as only able to work on a green	• 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	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	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. • 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 sick rate IRO 8%	
1274	Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.	• LAMP testing introduced across the Trust and actions in place to increase uptake • Updated guidance in place to support staff return to work • Review of CEV staff continue to support returns to work	No impact on risk rating
1331	Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.	• Opening of B18 in October 2021 & approval of Respiratory Business case supports provision of bed capacity for ICU patients	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	• The subgroup continues to meet bi-monthly to monitor national changes, including the current logistical challenges associated with EU exit.	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	delay in the flow of these supplies.		

3 RECOMMENDATIONS

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

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/162**	
SUBJECT:	**Formal Public Consultation Outcomes Report – Runcorn Shopping City**	
DATE OF MEETING:	24th November 2021	
AUTHOR(S):	Pat McLaren, Director of Communications + Engagement	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications + Engagement	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	X
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	X
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 Financial Sustainability a) Failure to sustain financial viability, #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. #145 a. Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In July 2019, Halton Borough Council (HBC) secured £1m through the Liverpool City Region Town Centre Commission to develop schemes to further regenerate Halton Lea. The Trust has worked in partnership with HBC to develop a scheme as part of this bid to create an out of hospital health hub within Runcorn Shopping City. The Trust proposed relocating its Audiology and Ophthalmology outpatient service from Halton Hospital to this health hub and relocate its Dietetics service from Halton Hospital AND St Paul's to this hub also. As this was a significant service change – ie cease provision at current location and commence provision at Runcorn Shopping City formal public consultation was required in line with the Gunning Principles. The Trust worked in partnership with Commissioners NHS Halton and NHS Warrington CCG to conduct a period of pre-consultation engagement and preparation work before carrying out formal public consultation. The Halton Health Performance Board (scrutiny) received and approved the consultation plans.	

	The outcomes of the consultation follow in this report. A comprehensive equality impact assessment was also carried out and is included in the appendices. We are grateful to the 569 respondents who took the time to share their views which have been incorporated in the further design and development of the service.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note	Decision
RECOMMENDATION:	It is recommended that the Board note the outcomes of the recent public consultation.			
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

AGENDA REFERENCE:	**BM/21/11/163**	
SUBJECT:	**Breast Services Reconfiguration Phase 2**	
DATE OF MEETING:	23/11/21	
AUTHOR(S):	Caroline Lane, Strategy Programme Manager	
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.	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)***	**#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 **#125** Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. **#145 a**. Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Warrington, Halton, St. Helens and Knowsley Breast Screening Service (WHSKBSS) provides routine breast screening, diagnostic and onward referral services to a population of approximately 92,000 from across the four boroughs. The current service is provided from Warrington, Halton, and St Helens and Knowsley. The cost of the capital programme is estimated to be £1.8m and has been approved in the capital programme for 2021/22. In July 2021 works were completed at CSTM creating the new breast unit. The final phase of this project, subject to consultation outcomes, is to enable the co-location of screening services in Warrington in a single location, Bath Street, enabling delivery of the Trusts estates priority to remove all clinical services from the Kendrick Wing of Warrington Hospital. Public Consultation for this final phase is due to commence in January 2022.	

PURPOSE: ***(please select as appropriate)***	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: Note the intention to go to public consultation for consolidation and expansion of breast screening services at Bath St, Warrington and relocation of breast screening services from Kendrick Wing Warrington Hospital.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			

	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Breast Services Reconfiguration Phase 2	AGENDA REF:	BM/21/11/163

1. BACKGROUND/CONTEXT

WHSKBSS provides routine breast screening, diagnostic and onward referral services to a population of approximately 92,000 from across the four boroughs. Breast Screening is offered to all women aged 50 - 70 (up to their 71st birthday), in line with national programme/guidance where screening is conducted once every three years. Patients over the age of 70 able to self-refer for screening.

In 2019/20 the service invited over 28,000 people for screening and performed a mammogram on around 22,000. The WHSKBSS service is currently provided from the following locations, and women may choose any of these locations to have their mammograms:

- Warrington (Kendrick Wing Warrington Hospital and Bath St. Health & Wellbeing Centre (c.33k eligible)
- Halton Hospital (c.20k eligible patients)
- St Helens Hospital (c.29k eligible patients)
- Knowsley Whiston Hospital (c.9k eligible patients)
- Mobile Units (numbers counted in locations above)

In the summer of 2021 the Breast Assessment and Symptomatic clinics relocated from Warrington Hospital to Halton Hospital's Captain Sir Tom Moore building, where a new Breast Centre has been created on the ground floor of the Trust's flagship estate.

A comprehensive formal public consultation and engagement process was carried out in the first half of the year which informed the Trust's decision to consolidate its diagnostic service and the specialist staff required to offer both diagnostics and onward referral to the co-located Breast teams if required. See consultation outcomes report here https://whh.nhs.uk/application/files/4716/3120/2269/Reconfiguration_of_Breast_Services_-_Public_Consultation_Outcomes_Report_July_2021.pdf

At the time of the public consultation the future of the screening service at Kendrick Wing was not consulted upon although a future consolidation of the service one mile away at Bath St Health Centre was described.

The Trust is now in a position to move forward with the expansion of screening services at Bath St and the relocation of the screening service at Warrington Hospital.

2. KEY ELEMENTS

Currently approximately 5.3K patients attend for mammography at Bath Street and 3K at Warrington Hospital Kendrick Wing per annum. The number of patients screened each year by the service has doubled over the last 20 years. However, the service provided from the base at Warrington Hospital's Kendrick Wing has retained the same basic estate footprint, which is no longer fit for purpose and has no opportunity for obvious expansion. The current split site nature of Warrington's screening service creates inefficiencies in use of estate, equipment and workforce. Additionally, the

workforce challenges are significant with a local and national shortage of mammographers making recruitment into crucial posts challenging.

Benefits

- There are real opportunities to create a significantly enhanced patient experience and improve access, create a more efficient service and support the longer-term sustainability of the service by relocating to single modern and fit for purpose location.
- Significantly enhanced accessibility in the modern Bath Street facility in comparison to the current service at Kendrick Wing which has deteriorated over the years as it is a first-floor service requiring movements through multiple doors, steep stair access and a small lift which has multiple service issues.
- Car parking facilities at Bath Street are easier to access than those at Warrington due to lower volume of patients attending and close access to the building.
- Removing the need to attend at Warrington hospital reduces the risks associated with attending an environment with known Covid-19 positive patients.
- As well as expanding screening with the consolidation, the service is future-proofed at Bath Street with still further scope for expansion if necessary.
- The move maximises utilisation of Public Sector Health Estate at Bath Street.

Consultation

NHS commissioning organisations have a legal duty under the National Health Service Act 2006 (as amended) to 'make arrangements' to involve the public in the commissioning of services for NHS patients ('the public involvement duty'). For CCGs this duty is outlined in Section 14Z2 (and Section 13Q for primary care services) of the Act to fulfil the public involvement duty, the arrangements must provide for the public to be involved in (a) the planning of services, (b) the development and consideration of proposals for changes which, if implemented, would have an impact on services and (c) decisions which, when implemented, would have an impact on services.

Objectives of consultation

- To ensure the local population is made aware of the proposal to consolidate breast screening services in Warrington at Bath St (augmented by mobile screening programmes as usual) and provided with a number of platforms to engage and participate
- To ensure that the local population is made aware of the impact of the consolidation in terms of the cessation of screening at Kendrick Wing, Warrington Hospital
- To ensure the local population is able to make alternative recommendations and suggestions relating to the proposed consolidation of the breast screening service at WHHNHS
- To ensure any emerging issues and themes are taken into account and any potential mitigating actions are considered
- To inform the Public Consultation documentation, questions and answers using initial feedback from the first round of engagement and formal consultation in the first half of 2021
- To prepare consultation outcomes reports for the appropriate stakeholder and advisory groups.

Methodology

Having undertaken considerable engagement and formal consultation around the reconfiguration of breast services across all four boroughs in the first half of this year it is proposed that consultation is undertaken as follows:

- Updating the comprehensive communications plan already in place for the Reconfiguration of Breast Services under 'Phase 2 consolidation of breast screening services in Warrington'
- Production of an information document, FAQs and questionnaire in partnership with commissioners
- Development of Easy Read, Additional Language and other format materials
- Local engagement with patients attending breast screening and assessment sessions at both Bath St and Warrington Hospital's Kendrick Wing
- Promotion of the proposed consolidation, hosted on WHHNHS and Commissioner website
- Media release
- Briefing to MPs and other key stakeholders
- Collation of feedback, analysis to inform Warrington Breast Screening Consultation Outcomes report
- Collection of respondent data for Equality Impact Assessment will be in standard NHS Consultation format.

Report on the consultation outcomes addressing any concerns raised during the consultation.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Board is asked to endorse the public consultation phase for Phase 2 of the Breast Screening reconfiguration project which involves the consolidation and expansion of breast screening services at Bath St, Warrington and relocation of breast screening services from Kendrick Wing Warrington Hospital.

4. IMPACT ON QPS?

Quality- The patient experience will be improved by increasing services at Bath street due to the newer more accessible estate being utilised.
People- The newer building, improved car parking and proximity to the Town centre location of Bath Street will create a positive workplace environment for staff.
Sustainability the move to Bath Street aligns with the strategic direction of the Trust by offering services in the community within a partnership setting.

5. MEASUREMENTS/EVALUATIONS

Collation of feedback, analysis to inform Warrington Breast Screening Consultation Outcomes report.
Collection of respondent data for Equality Impact Assessment will be in standard NHS Consultation format.
Report on the consultation outcomes addressing any concerns raised during the consultation.

6. MONITORING/REPORTING ROUTES

- Consultation outcomes report to Commissioners (NHS England Specialist Commissioning and NHS Warrington)
- Warrington Health Scrutiny Committee

- Internally, progress will be reported through Capital Planning Group, the Executive Team, Finance and Sustainability Committee and Trust Board.

7. TIMELINES

7.1 Proposal to Health Scrutiny Committee

- Warrington Health Scrutiny Thursday 4th November 2021

7.2 Preparation of communications and consultation materials

- 15-29 November 2021

7.3 Formal Public Consultation commences (6 working weeks)

- 3rd January 2021 – 14th February 2022

7.4 Consolidation of outcomes and production of consultation outcomes report

- 11th -21st February 2022

7.5 Reporting to Commissioners (NHS England Specialist Commissioning and NHS Warrington)

- 22nd February 2022

7.6 Health Scrutiny Committee

- 28th April 2022

7.7 Relocate screening service from Kendrick Wing to Bath St

- Approximately October 2022

8 RECOMMENDATIONS

The Board is recommended to endorse the public consultation phase for Phase 2 of the Breast Screening reconfiguration project which involves the consolidation and expansion of breast screening services at Bath St, Warrington and relocation of breast screening services from Kendrick Wing Warrington Hospital.

Trust Board

DATES 2022-2023

All meetings to be held in the Trust Conference Room

Date of Meeting	Agenda Settings	Deadline For Receipt of Papers	Papers Due Out
2022			
Wednesday 26 January	Thursday 6 January (EXECS)	Monday 17 January	**Wednesday 19 January**
Wednesday 30 March	Thursday 10 March (EXECS)	Monday 21 March	**Wednesday 23 March**
Wednesday 25 May	Thursday 5 May (EXECS)	Monday 16 May	**Wednesday 18 May**
Wednesday 27 July	Thursday 7 July (EXECS)	Monday 18 July	**Wednesday 20 July**
Wednesday 28 September	Thursday 8 September (EXECS)	Monday 19 September	**Wednesday 21 September**
Wednesday 30 November	Thursday 10 November (EXECS)	Monday 21 November	**Wednesday 23 November**
2023			
Wednesday 25 January	Thursday 22.12 or 5.1.23	Monday 16 January	**Wednesday 18 January**
Wednesday 29 March	Thursday 9 March	Monday 20 March	**Wednesday 22 March**