We are WHH & We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WHH Board of Directors Meeting Part 1

Wednesday 31 MARCH 2021
10.00am-12.30pm
VIA MS Teams

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

Wednesday 31 March 2021 time 10.00am -12.30pm

Via MS Teams

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

Purdah –a period of purdah starts from 15th March, 2021 until local elections on 6th May, 2021*. With this in mind, the Board agenda and papers have been reviewed and have been confined to matters that need a Board decision or require Board oversight.*

REF BM/21/03	ITEM	PRESENTER	PURPOSE	TIME	
BM/21/03/25	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	10.00	Verb
BM/21/03/26 PAGE 8	Minutes of the previous meeting held 27 January 2021	Steve McGuirk, Chairman	Decision	10:02	Encl
BM/21/03/27 PAGE 19	Actions & Matters Arising	Steve McGuirk, Chairman	Assurance	10:05	Encl
BM/21/03/28PAGE 21	Chief Executive's Report – *to follow* - Vaccination Position statement – PPT	Simon Constable, Chief Executive	Assurance	10:10	Encl
BM/21/03/29	Chairman's Report	Steve McGuirk, Chairman	Information	10:20	Verb

Quality People Sustainability

BM/21/03/30 PAGE 32	COVID-19 Performance Summary Report and Situation Report	Simon Constable, Chief Executive	Assurance	10:25	Enc
BM/21/03/31 ai PAGE 59	Integrated Performance Dashboard and Assurance Committee Reports	All Executive Directors	To note for assurance	10:35	Enc
	- Quality & Performance Dashboard including	Daniel Moore Chief Operating Officer			Enc
(a) ii	- Monthly Nurse Staffing Report (12/20 & 01/21)	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO			
(b)	- Key Issues report Quality and Assurance Committee (01.02.2021 and 02.03.2021)	Margaret Bamforth, Committee Chair			Enc
	People Dashboard	Michelle Cloney, Chief People Officer			Enc
(c)	- Key Issues Strategic People Committee (24.03.2021)	Anita Wainwright, Committee Chair			
	- Sustainability Dashboard	Andrea McGee Chief Finance Officer & Deputy CEO			
(d)	- Key Issues Finance and Sustainability Committee (17.02.2020 and 24.03.2021)	Terry Atherton Committee Chair			
(e)	- Key Issues Audit Committee (25.02.2021)	Ian Jones Committee Chair			

Quality

BM/21/03/32 PAGE 178	WHH Maternity Services - Compliance with Ockenden	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	To discuss and note for assurance	11.15	Enc
BM/21/03/33	Spinal Services Update	Daniel Moore Chief Operating Officer/Alex Crowe, Executive Medical Director	To discuss and note for assurance	11.20	PPT

Sustainability

BM/21/03 35 PAGE 188	Annual Capital Programme 2021-2022	Andrea McGee Chief Finance Officer & Deputy CEO	To discuss and approve	11.40	PPT

People

BM/21/03 37 PAGE 195	BAME Assembley Strategic Priorities and WHH Response	Chief People Officer	To discuss and note for assurance	11.55	Enc
BM/21/03/38 PAGE 216	National Staff Opinion Survey	Chief People Officer	To discuss and note for assurance	12.05	Enc

GOVERNANCE

BM/21/03/39 PAGE 227	Strategic Risk Register & BAF	John Culshaw Trust Secretary	To note for assurance	12.15	Enc
BM/21/03/40 PAGE 283	Clinical Oversight Recovery Committee (CORC) Terms of Reference	John Culshaw Trust Secretary	To discuss and approve	12.20	Enc
BM/21/03/41 PAGE 288	Partnership Agreement with University of Chester	Lucy Gardner Director Strategy & Partnerships	To discuss and approve	12.25	Enc

MATTERS FOR APPROVAL – Included in Supplementary Binder

	ITEM	Lead (s)				
BM/21/03/42 PAGE 2	Performance Assurance Framework (PAF) and Integrated Performance Indicator Review 2020-2021	Andrea McGee Chief Finance Officer & Deputy CEO	Committee Agenda Ref. Date of meeting Summary of Outcome	 FSC/21/03/52 24.03.2021 Supported		Enc
BM/21/03/43 PAGE 16	Trust Board Cycle of Business 2021-2022	John Culshaw Trust Secretary	Committee Agenda Ref. Date of meeting Summary of Outcome	N/A 		Enc
BM/21/03/44 PAGE 20	Cycles of Business: - Audit Committee A*pproved Audit Commttee 25.02.2021* - Strategic People Committee *Approved SPC 24.03.2021* - *Finance & Sustainability Committee approved FSC 24.03.2021*	John Culshaw Trust Secretary	Committee Agenda Ref. Date of meeting Summary of Outcome	See cover report See cover report See cover reoort See cover report		Enc
BM/21/03/45 PAGE27	Amendment to the Trust Standing Financial Instructions (SFIs)	John Culshaw Trust Secretary	Committee Agenda Ref. Date of meeting Summary of Outcome	Finance + Sustainability Committee FSC/21/03/56 24.03.2021 Supported		Enc

BM/21/03/46	**Delegation of Authority for Annual Report**	**John Culshaw Trust Secretary**	**Committee**	N/A		**Verb**
			Agenda Ref.			
			Date of meeting			
			Summary of Outcome			
BM/21/03/47 PAGE 30	**Amendment to the Constitution – for Ratification**	**John Culshaw Trust Secretary**	**Committee**	Council of Governors		**Enc**
			Agenda Ref.	COG/21/02/12		
			Date of meeting	18.02.2021		
			Summary of Outcome	Approved		
BM/21/03/48 PAGE 36	**Strategic People Committee Chairs Annual Report**	**Anita Wainwright Committee Chair**	**Committee**	Strategic People Committee		**Enc**
			Agenda Ref.	SPC/21/03/21		
			Date of meeting	24.03.2021		
			Summary of Outcome	Approved		

MATTERS FOR NOTING FOR ASSURANCE

	ITEM	**Lead (s)**				
BM/21/03/49 PAGE 95	**Learning from Experience Q3 Report & Slides**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	QAC/21/03/68		
			Date of meeting	02.03.2021		
			Summary of Outcome	Noted		
BM/21/03/50 PAGE 142	**Infection Prevention and Control Q3 report**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	QAC/21/03/71		
			Date of meeting	02.03.2021		
			Summary of Outcome	Noted		
BM/21/03/51 PAGE 159	**Maternity SI Monthly Report**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	QAC/21/03/64		
			Date of meeting	02.03.2021		
			Summary of Outcome	Noted		
BM/21/03 52 PAGE 164	**Hospital Volunteer Report**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Strategic People Committee		**Enc**
			Agenda Ref.	SPC/21/01/07		
			Date of meeting	20.01.2021		
			Summary of Outcome	Noted		
BM/21/03/53 PAGE 172	**Moving to Outstanding (M2O) Report**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	QAC/21/03/59		
			Date of meeting	02.03.2021		
			Summary of Outcome	Noted		
BM/21/03/54 PAGE 177	**Safe Staffing Report – 6 monthly review (May 2020 – October 2020)**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	QAC/21/03/69		
			Date of meeting	02.03.2021		
			Summary of Outcome	Noted		
BM/21/03/55 PAGE 211	**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/21/03/72		
			Date of meeting	02.03.2021		
			Summary of Outcome	Noted		

BM/21/03/56 **PAGE 259**	**Freedom To Speak Up Bi-Annual Report**	**Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO**	**Committee**	Strategic People Committee		**Enc**
			Agenda Ref.	SPC/21/03/34		
			Date of meeting	24.03.2021		
			Summary of Outcome	Noted		
BM/21/03/57 **PAGE 264**	**Mortality Review Q3 Report**	**Alex Crowe Executive Medical Director**	**Committee**	Quality Assurance Committee		**Enc**
			Agenda Ref.	QAC/21/03/65		
			Date of meeting	02.03.2021		
			Summary of Outcome	Noted		
BM/21/03/58 **PAGE 274**	**Digital Update Report**	**Alex Crowe Executive Medical Director**	**Committee**	**N/A**		**Enc**
			Agenda Ref.			
			Date of meeting			
			Summary of Outcome			

BM/21/03/60	**Any Other Business**	**Steve McGuirk, Chairman**	**N/A**		**Ver**
	Date of next meeting: Wednesday 26 May 2021				

Conflicts of Interest

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

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

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

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

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

Interests fall into the following categories:

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

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

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 27 January 2021, MS Teams

Present	
Steve McGuirk (SMcG)	Chairman
Simon Constable (SC)	Chief Executive
Terry Atherton (TA)	Deputy Chair, Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
Alex Crowe (AC)	Executive Medical Director & Chief Clinical Information Officer
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director,
Andrea McGee (AMcG)	Chief Finance Officer & Deputy Chief Executive
Daniel Moore (DM)	Chief Operating Officer
Cliff Richards (CR)	Non-Executive Director
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse & Deputy CEO and Director of Infection Prevention & Control (DIPC)
Anita Wainwright (AW)	Non-Executive Director
In Attendance	
Michelle Cloney (MC)	Chief People Officer
Lucy Gardner (LG)	Director of Strategy & Partnerships
Phillip James (PJ)	Chief Information Officer & Senior Information Risk Officer
John Culshaw (JC)	Trust Secretary
Julie Burke	Secretary to The Trust Board
Apologies	Pat McLaren, Director of Communications & Engagement
Observing N Holding, Lead Governor Members of the public (4)	P Bradshaw, K Keith, S Fitzpatrick, S Hoolachan, C Fitzpatrick, C Jenkins, L Mills C McKenzie, A Robinson Public Governors, D Birtwistle Staff Governor

BM/21/01/01	**Welcome, Apologies & Declarations of Interest** The Chairman welcomed all to the meeting. No declarations made in relation to the agenda. The agenda had been streamlined to focus on key pertinent issues ensuring governance process and evidence remains robust whilst not constraining discussions. The Chairman congratulated Daniel Moore on his appointment to the role of Chief Operating Officer.
BM/21/01/02	**Minutes of the meeting held 25 November 2020** P 4 4th paragraph to read dedicated Board session about the methodology of nurse staffing….. delete reference to financial challenges. With this amendment, the minutes of 25 November 2020 were agreed as an accurate record.
BM/21/01/03	**Actions and Matters Arising. Action log and updates noted and recorded.** The Chairman referred to BM/20/11/122 Legal Considerations of Governance during COVID-19. He had met with KSJ, JC and LA to agree additional risks to the BAF to accurately reflect pandemic challenges. He felt very assured following the meeting, that risks assessments would be required to articulate the unprecedented situation as it is not always possible to proceduralise all decisions.
BM/21/01/04	**Chief Executive's report** The report was taken as read, the CEO highlighted: The Trust had 93 COVID-19 patients on Christmas Day which had increased at the end of December and in January 2021, particularly critical care areas with a significant number

	of patients (30) as well as patients receiving non-invasive ventilation support on respiratory ward. The increase trend is in line with Cheshire & Mersey and the North West position, however the increase is greater than the England average. Current position provided, 7am 27 January 2021, a total of 216 inpatients with COVID-19, midday 26 January 2021 232 inpatients; on 25 January 2021 227 inpatients. Highest number of deaths recorded in one week at WHH (31), in the week of 18 January 2021. Stabilising position, slow decrease in community prevalence, however anticipated to be 2-3 weeks before this transfers into a decrease in hospitalisation. Wave 3 continues to be managed alongside successful roll out of Vaccination Programme which commenced 22 December 2020 with 1000 vaccinations taking place before 25 December 2020. This involved a major logistical and administration challenge, all managed in line with the Joint Committee on Vaccines and Immunisation (JCVI) guidance and priority list. The Trust continues its working with system partners to support top 4 priority groups being immunised by the middle of February. Questions were invited. AW congratulated Daniel Moore on behalf of the Board on his appointment to Chief Operating Officer and echoed SC's comments recognising the many team and individual staff awards. AW referred to recent media reports and potential one third reduction of vaccines to the North West and if this would impact on the Trust's vaccination programme. SC explained it might not impact on current plans but may impact on plans to escalate capacity in the coming months. LG concurred that it would not impact on first vaccination of the four priority groups, plans are being developed to increase capacity for second appointments and to continue first appointments. LG anticipated further guidance at regional call on 28 January 2021 and will update the Board accordingly. CR enquired relating to reference to Palliative Care and work with American Universities and of further detail. SC explained this referred to the Serious Illness Care Programme for which the Trust is the national lead, an evidence based programme to support Clinicians to have difficult end of life care discussions with family and patients. More detailed information of the Programme to be shared to Non-Executives. **The Board noted the report.**
BM/21/01/05	**Chairman's Report** The Chair reported that a successful virtual Governor Induction had taken place in January to welcome newly elected Pubic, Partner and Staff Governors. He commended The Chair commended the efforts of staff to support the successful first virtual Staff Awards event in December 2020. The Chair recognised efforts of all staff involved in the Vaccination Programme and the progress made since its launch. The Chair referred to recent media reports relating to process to offer vaccinations to the 4 priority groups reaffirming that the Trust had followed all guidance from the Health Protection Board and JVCI in this respect.

	He recorded congratulations to the Finance Team on receiving Finance Team of the Year award and their part in supporting the Trust in the Vaccination Programme. Also recognised was the Trust's achievement winning the London Business School (LBS) Innovation Awards as inaugural winners of a new 'Innovating in Adversity' award and the opening of the Post Anaesthetic Care Unit (PACU) at the Sir Captain Tom Moore Building at Halton. The Chair continues with internal and external meetings including with Non-Executives (NED) with NED Assurance Committee meetings, Board, Council of Governors, Governor Briefing meetings and 1:1 meetings with the Lead Governor. External meetings continue with Local Authority CEOs, NW Chairs, local partners and stakeholders. Chairman had Chaired the recent C&M Health & Care Partnership Board **The Board noted the update**
BM/21/01/06	**COVID-19 Performance Summary and Situation Report** The CEO referred to the situation report and Elective Recovery plans. All data is submitted through Emergency Planning Resilience Reporting to NHSE/I and provides headline figures and outcomes data from a regional, national and local perspective. The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily COVID-19 Executive Summary which outlines key information pertinent to the command and control of the situation. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where possible and forms part of the continuing development of understanding of demand, capacity and outcomes that will determine future strategic planning. Data up to 23rd January 2021 was highlighted, which is shared with NEDs at their weekly meetings to provide assurance and reassurance of plans in place. SC highlighted: Comparative Crude mortality in December 2020 was 2.5% compared with 1.5% in December 2019. Crude mortality was 2.1% in Wave 1 and 2.3% in Wave 2 with Crude mortality for COVID-19 patients 25.1% in Wave 1 and 20.1% in wave 2 reflecting some of the learning since the start of the Pandemic. AC referred to Crude Mortality data and complexities of recording death of a patient with COVID-19 positive diagnosis as opposed to definite cause of death due to COVID-19. SMcG referred to number of people in hospital, the high numbers at WHH surpassing Wave 1 and the significant impact on critical care capacity for WHH compared to other Acute Trusts in the NW. CR referred to emergency admissions data December 2019 to December 2020 showing 64% activity compared to previous year, and potential reasons, was this flu, or perception of pubic coming to hospital for treatment during the Pandemic. CR enquired if outpatient attendances had been virtual, face to face or a mixture SC explained data describes 4 hour performance in Urgent Treatment Centre and Emergency Department, emergency attendances circa 90%, similar to last year, and that

	reduction in admissions primarily reflects alternative care pathways to manage patients through assessment and care pathways, the Combined Assessment Unit, Ambulatory Care Unit etc. Out-patients data reflects both virtual and face to face consultations. Future data will be able to show trends for these attendances and movement in the last few months with the offer of virtual appointments TA added that the Trust had taken part in a Pilot last year encouraging the public to contact NHS 111 for advice for the best care pathway to avoid unnecessary attendance at Emergency Departments. AW enquired of difference in data for patients who had passed away and patients tested positive and passed away. AC explained further clarity on definitions to record this data had been raised and discussed at North West Structured Judgement Review (SJR) Cell to understand how to annotate death certificates and interpretation of laboratory results to provide a clearer picture as patients may have other co-morbidities. • **The Board noted the report.**
BM/21/01/07	**IPR Dashboard and IPR Key Issues** The CEO introduced the report and invited questions to focus on key issues within the IPR, Committee Assurance Reports, relevant to each Portfolio area. SMcG commented that a number of the KPIs included in the IPR dashboard were irrelevant to a degree currently as a consequence of the pandemic. MB - no matters of escalation from the Quality Assurance Committee (QAC). Agenda had been streamlined to focus on key governance and matters for discussion with continued receipt and robust monitoring of assurance through a number of assurance reports. CR asked how pressures are being managed, ie Endoscopy, flexoscopy as no indication of growth in Waiting List, was this due to decrease in patients not being referred in, and diagnostic procedures. DM provided assurance that Waiting Lists are reviewed weekly to ensure patients receive their required treatment. Endoscopy patients are clinically triaged according to urgent and cancer pathways categories, patients not in the high priority groups with longer waits continue to be reviewed alongside options to scale up activity at Warrington. Further mitigations, full Endoscopy services to be offered at Spire Cheshire throughout February and March 2021 and a fourth room opened on Warrington site. The Trust is also part of Endoscopy and Diagnostics Network in C&M with mutual aid agreements in place if patients move to one of the high priority groups for treatment. SMcG referred to Mortality Review Report in QAC Assurance Report and for clarification relating to small percentage of BAME COVID-19 related deaths and prevalence in Warrington Community. AC explained nationally demographics in community recognised as important component which impacts on prognosis and other important co-morbidities, ie hypertension. Members of BAME community lower in Warrington reflected in the small percentage of BAME deaths.

	SMcG asked for assurance that the 4 cases deemed Poor following Structured Judgement Reviews (SJRs) that Duty of Candour had been followed. AC assured the Board it had and referred to supporting Appendices in the report detailing how the Trust has implemented a lessons learned process through Medical Cabinet, Clinical Governance meetings and daily Tactical Group to share learning following SJRs which had identified key learning of clearer communication, allergy management. Referring to the Attendance Management Deep Dive in the Strategic People Committee (SPC) Assurance Report and feedback received from Line Managers of the long process to apply the Policy, SMcG concurred, and that a streamlined process be put in place as soon as possible. MC advised the matter had been discussed at the SPC on 20 January 2021 to progress at pace prior to next SPC in March. A proposal to be shared with Chair of SPC in February 2021 for Chair approval with formal ratification at the March SPC. SMcG referred to the Finance and Sustainability IPR and the overspend of the Midwifery Led Unit reporting that internal meetings had taken place to review position, a report presented to Finance and Sustainability Committee following which TA had briefed the Board. No other questions/comments were raised in relation to the IPR.
BM/21/01/07 (a)	**Monthly Safe Staffing Reports, October 2020 and November 2020** The reports were taken as read. No issues were highlighted for escalation to the Board.
BM/21/01/07 (b)	Quality Assurance Committee (QAC) Assurance Report 01.12.2020 & 12.01.2021 see above.
BM/21/01/07 (cii)	Strategic People Committee (SPC) 20.01.2021 see reference to Attendance Management above, no further questions / matters escalated. • **The Board approved the amendment to the change of KPI Turnover and Retention and additional information to be included.**
BM/21/01/07 (dii)	**Sustainability** – AMcG highlighted the following proposals for the Board to consider and approve, in respect of the Capital Programme, all which had been discussed and supported at the Finance and Sustainability Committee (FS) on 20 January 2021: **The Board:** • **Noted, reviewed and discussed the report.** • **Noted the OCT machine scheme approved as emergency capital by the Chief Finance Officer & Deputy Chief Executive using capital contingency funds.** • **Approved the additional capital spend in relation to the MRI adjustments, utilising £43k from capital contingency funds.** • **Approved the additional capital spend in relation to the X-Ray quotes, £4k due to higher quotes than originally received.** • **Approved the increase in the capital contingency budget due to the availability of alternative funding streams, £167k and £17k for Anaesthetics and ENT scope increasing contingency to £403.8k.** • **Approved the proposed change in the reporting logic for the Discharge Summary**

	KPI to be implemented from Q1 2021/22. Additionally the Board were asked to approve: (a) increase to the Capital Plan by £186k (to £26.325m) following a successful bid for capital to replace Mammography kit. A small sum would be required for enabling works (est £10k) which would come from the contingency; (b) any changes to the capital plan be delegated to the FSC for the remainder of the financial year. TA reported that he had discussed the additional requests with AMcG and fully supported these proposals as Chair of FSC. • **The Board approved additional requests (a) and (b) above.** Finance & Sustainability Committee (FSC) 23.12.2020 & 20.01.2021 No further matters escalated or questions raised.
BM/21/01/08	**Nosocomial COVID-19 Infection Report** The report was taken as read, providing an overview of nosocomial Covid-19 cases and actions in place to reduce the risk of transmission within the Trust. KSJ highlighted key points to note: - Table one showing COVID-19 results and LOS at the time of sampling. - 1461 patients admitted into hospital already positive for COVID-19 (patients in the community acquired or indeterminate categories). - 169 possibly contracted COVID-19 in the hospital given the length of incubation (probable category). - 222 patients in the definite category making a total of 391 probable or definite transmission from 1852. - Rate of WHH transmission between 12-16%. The Trust is within the top five Acute providers in C&M but not the highest. - Wards affected, as expected, had been more in Integrated Medicine CBU and two surgical wards affecting patients with longer length of stays. Unfortunately due to requirements with patient flow, managing patients who had tested positive for COVID-19, patients who had been in contact with patients with COVID-19 and the remaining patients, is constantly reviewed, moving patients throughout the day to move patients around bays and wards to ensure hospital flow. - WHH had reported 31 outbreaks, 6 clusters; - 25 definite outbreaks, 13 staff, 3 patient, and 15 for both staff and patients. - Further introductions to be explored / made include Pop-Up Beds/Ward, looking at evidence of effectiveness before proceeding, increase the update of LPF and the vaccination programme. KSJ further assured the Board that SJRs are carried out for all patients who had sadly died following nosocomial transmission. - No incidences required reporting to RIDDOR, this only related to staff. - The Trust is compliant with and has implemented the national ten key actions. - Further work on one sub section of one of the actions regarding the requirements for two negative tests before a patient is moved. - The Trust continues with the environmental action plan and Health Air trial. - Following a number of root cause analysis, reviews had been reviewed, further implementation of the recommendations within the paper will continue to be

	reviewed weekly as a priority at Silver Infection Control meeting. KSJ assured the Board of assurance processes in place with constant review of learning and sharing of the main points of learning. Additionally, a number of challenges experienced had also been shared, as well as challenges difficult to manage, ie old Estate of the Trust, side rooms and recurrence of missing day 5 swabs. Questions invited. TA referred to the data being received in various reports and challenge to triangulate to show impact of the Pandemic, ie patients sadly died in hospital and those shortly after leaving hospital. KSJ referred to earlier reference to rate of WHH transmission between 12-16% and the difficulty to compare like for like with all C&M organisations as some are Community or Mental Health Trusts, Mental Health Trusts transmission rate at 20%-30%. KSJ assured the Board that full SJRs are undertaken for all patients sadly died as a result of nosocomial transmission and all learning shared. MB referred to (1) two negative tests before a patient is moved and difficulties to manage and maintain patient flow; and (2) Orthopaedic patients presenting with fractured hips and if this included patients presenting, then testing positive and how these patients are managed. KJS explained (1) two swabs, sometimes taken at the same time, difficult to manage risk of patient flow and not undertaking the second swab to ensure patients are safely managed on wards. Sometime wards and bays may need to change which sometimes outweigh risk of carrying out two swab tests. The situation is monitored constantly. (2) Fractured hip patients cared for on surgical unit. If outbreaks on surgical wards patients moved to other wards but moved back as quickly as possible to surgical footprint. SC commented the Trust is not an outlier despite high figures, information is triangulated for reporting of outbreaks by, staff and patients affected by outbreaks, staff with positive tests, daily summary of positive results, those that fall in greater than 8 days, all reported to daily Tactical Group and Executives. Referring to ageing estate discussions and impact on patient care, bed capacity, lack of side rooms and infection control challenges, AMcG asked for early indication of any capital or revenue costs that may be required. KSJ explained a number of options being explored including Pop-Up beds, whilst dealing with ageing estate challenges outside of COVID to ensure sufficient side rooms, adequate size of wards and bathroom facilities AC added caution to Nosocomial infections, its definition, which is being discussed regionally as false negative swabbing circa 30% needs to be taken into account. AW enquired of reasons of non-compliance of second test. KSJ explained 12 missed day 5 swabs , deemed COVID on next 8-14 day sample. Of the 12 samples, 1 due to patient move in late evening, system in place for flagging when swabs are due on electronic ward boards in addition to paper system. Vaccination for in-patients had also commenced.

	SMcG thanked KSJ for the comprehensive report and assurances provided that WHH is doing everything it can to meet COVID and other challenges as discussed. The Trust is to explore recycling of some PPE. • **The Board reviewed, noted and discussed the report.**
BM/21/01/09	**WHH Maternity Services – Compliance with Ockenden** The report was taken as read, KSJ highlighted key points to note which provided an update to Ockenden, the Trust current position and background to NHSE/I request in December 2020. - Ockenden Review identified 7 immediate actions and additional 12 urgent clinical priorities. - 3 actions were reported to NHSI/E from WHH as partial compliance, detailed in the report. - Labour Ward Medical cover action fully compliant. - Compliant with the Serious Incident action, which is in two parts, Local maternity System (LMS) element to be completed. - Third action relates to risk assessment completion at every contact and with the implementation of the new EPR the Trust will have full compliance by Summer 2021. CR referred to statement in the report of baby deaths sighted but not been seen, the difficulty to quantify against recommendations to try to mitigate if it became embedded in an organisation from a behavioural and cultural aspect. KSJ explained the governance process in place to triangulate patient, quality and safety to mitigate at WHH. MB concurred referring to the strengthened governance in place with named Maternity Safety Champions at Board, Executive and operational level, regular listening events, comprehensive assurance reporting to QAC SIs and maternity. KSJ referred to the externally commissioned review, that she had commissioned, into Neonatal Still Births at the Trust in 2018, to understand the fluctuation and variance in still birth rates of 20 still births at the Trust. The review did not find any major failings on the part of the Trust in this cluster review. **<u>Kirkup Report</u>** KSJ provided brief background and summary and actions that had been taken by WHH: - NHSI/E requested a Trust update on the Kirkup report, following the Morecambe Bay Independent Investigation (Kirkup Report) from 2015. - WHH provided a response to Kirkup (presuming this was led by previous Chief Nurse and Head of Maternity in 2015, 2016 and 2017. WHH had reported compliant on each submission. - December 2020 request to update Kirkup from NHSE/I WHH re-reviewed the submission and reported as compliant with exception of two areas which the Trust reported as partially compliant. (1) Process in place for auditing transfers from and to NICU room Labour Ward (2) Audit of transfer of patients into and out of hospital (in utero transfers and transfer of women into hospital from a home birth setting). Following audit of the two partially complaint elements WHH will be fully compliant.

	- KSJ summarised key recommendations of the Kirkup Report which included broadly transactional recommendations with the exception of dysfunctional team working. Kirkup major challenges reported: - (1) Substandard clinical competence of clinicians involved (Midwifery, Paediatrics and Obstetrics). - (2) Pursuit of normal birth at any cost with insufficient recognition of risk. - (3) Inadequate clinical investigations over several years including reliance on poor quality internal governance systems. - (4) External oversight which was deemed inadequate at Morecambe during the process of seeking Foundation Trust status and a development approach was used. This included CQC Monitor, PHSO and NW SHA. - The cross over from Kirkup for WHH had been some of the clinical leadership issues, behaviour of clinical colleagues and dysfunctional team working. - The Board had received previous evidence of poor interdisciplinary working relationships but not substandard care. - In 2018/19 some negative working relationships between Midwives and Obstetricians led to commissioning of external work through PROSPECT who carried out some focused work in 2018 followed up by the Trust internal organisational development work, led by HR Department. - Management instability and professional disciplines issues continued. Further external support by GLOBIS in form of mediation commenced and overall diagnosis of dysfunctional teams noted. Parallel and inter-related allegations led to an investigation following a Safeguarding training session. - KSJ described this against a backdrop of a double CQC Requires Improvement (RI) department with worsening results from 2017 – 2019. Maternity Improvement Committee established, Chaired by Chief Nurse. - KSJ referred to previous reports that Board had received following a comprehensive improvement plan with 56 actions, specifically for W&Cs. The Department moved to Good in 2019 and Medical Obstetric leadership had changed during this time frame. - 2019 – a further catalyst for departmental relationship issues was the Community Midwifery consultation and further changes in leadership. - The collapse of One to One and recruitment of One to One Midwives created further issue within the Midwifery team. Some Midwives employed at WHH cited unpleasant experience with one Midwife from One to One resigning due to this. - Historical cultural issues continued. A number of Freedom to Speak Up contacts made and, again with the back drop of Kirkup, this (with the leadership and community consultation) led to a series of team leader and listening events, all which had been shared with Board members previously. - The Trust appointed Senior Midwifery Advisor to the Department to support from a Midwifery perspective with dedicated Organisation Development support from HR Department. - More recently, 2020 and the Kindness Collaboratives have been taken forward. Experienced Advisory and Senior Manager appointments had been made to support the unit. SMcG thanked KSJ for the comprehensive report and assurance provided that the identified cultural and behavioural had been discussed and debated at the Quality Assurance Committee and previous Trust Board meetings. Whilst progress had been made, further work is required to ensure full cultural change in Maternity with full

	support of the Trust Board. • **The Board noted the report and assurance provided relating to:** • **WHH response to the 'Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NS Trust (Ockenden Report) 11 December 2020.** • **Progress against the Kirkup Report Action Plan.** • **High level thematic review of SI's in the last two years** • **Update of review of compliance of maternity services with NICE guidance.**
BM/21/01/10	**Strategic Risk Register and Board Assurance Framework (BAF)** The report was taken as read and JC highlighted the following for the Board to review and consider the following proposals for the BAF since the last meeting and the rationale: Since the last meeting: - One new risk had been added to the BAF Risk #1126 supported at the Risk Review Group on 11 January 2021 and approved at the Quality Assurance Committee on 12 January 2021 at a risk rating of 25. - The Board were asked to consider a proposal to add two additional risks, both supported at the Risk Review Group on 11 January 2021, and the Quality Assurance Committee on 12 January 2021, (1) Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the increase in critically unwell COVID-19 positive patients resulting in potential harm and - (2) Failure to provide a suitable patient environment caused by the rapid creation and opening of additional capacity/wards resulting in potential harm, both at a risk rating of 25. - The rating of two risks had been amended, Risk #1124: from 25 to 15 and Risk #1274 from 25 to 15 due to significant mitigations put in place. - The descriptions of one risk on the BAF had been amended Risk #1114. - The Board were also asked to consider a proposal to amend the description of one further risk, Risk #134 as detailed in the report, supported at Finance and Sustainability Committee on 20 January 2021. - No risks had been de-escalated from the BAF since the last meeting. - Notable updates to existing risks are also included in the paper. Also included in the report were notable updates to existing risks #1124; #1215; #1272 #1273; #1274; #1289; #115; #134; #1114; #1079; #1207; #1108; #1290. • **The Board reviewed and noted the BAF and Strategic Risk Register and assurance provided of oversight and scrutiny of strategic and corporate to ensure risks are being managed and escalated appropriately.** **The Board <u>approved:</u>** • **The addition of one new risk to the BAF # and proposal for the addition of two further risks as above.** • **The amendment of two risks as above.** • **The amendment to the description of one risk and the proposal to amend the description of one further risk as above**.
MATTERS FOR APPROVAL/RATIFICATION	
BM/21/01/11	**Quality Assurance Committee Cycle of Business 2021-22** The Board **<u>ratified</u>** the Quality Assurance Committee Cycle of Business which had been approved at the Quality Assurance Committee on 12 January 2021.

BM/21/01/13	**Amendment to the Constitution – Appointment of Additional Non-Executive Director** The Board **ratified** this amendment to the Constitution which had been virtually approved by the Council of Governors on 8 January 2021.
BM/21/01/14	**Amendment to the Constitution – Update to the Governor Code of Conduct** The Board **ratified** this amendment to the Constitution which had been virtually approved by the Council of Governors on 8 January 2021.

MATTERS FOR NOTING FOR ASSURANCE	
BM/21/01/15	**DIPC Q2 Report** This report had been reviewed and discussed at the Quality Assurance Committee on 12 January 2021. **The Board noted the report.**
BM/21/01/16	**Learning from Experience Q2 Report** This report had been reviewed and discussed at the Quality Assurance Committee on 1 December 2020. **The Board noted the report.**
BM/21/01//17	**Maternity Monthly SI Report** This report had been reviewed and discussed at the Quality Assurance Committee on 12 January 2021 and provided detail of the number of SIs reported at WHH in the last 12 months with learning identified. **The Board noted the report**
BM/21/01/18	**COVID-19 Mortality Review Report** This report had been reviewed and discussed at the Quality Assurance Committee on 12 January 2021. **The Board noted the report.**
BM/21/01/19	**Moving to Outstanding (M2O) Report** This report had been reviewed and discussed at the Quality Assurance Committee on 12 January 2021. **The Board noted the report.**
BM/21/01/20	**Use of Resources Q3 Report** This report had been reviewed and discussed at the Quality Assurance Committee on 12 January 2021. **The Board noted the report.**
BM/21/01/21	**Guardian of Safeworking Q3 Report** This report had been reviewed and discussed at the Strategic People Committee on 20 January 2021. **The Board noted the report.**
BM/21/01/22	**Digital Update report** The Board reviewed and noted the updated formatted report. • **The Board noted the report and assurance provided relating to:** • **EPR Procurement status;** • **Maternity EPR status including delayed contract award;** • **National Infrastructure Incident – 13th/14th January 2021.**
BM/21/01/23	**Infection Prevention and Control COVID-19 and Orthopaedic Trauma Cases** The Board reviewed and noted the report.
	The Chairman on behalf of the Board conveyed their appreciation and thanks to Executive colleagues for all their efforts and support during the Pandemic and the importance of their own 'down-time'. **Next meeting to be held: Wednesday 31 March 2021**

Signed …… Date ……

Chairman ……

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

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE	BM/21/03/27	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	31 March 2021

1. ACTIONS ON AGENDA

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

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/07/57	26.05.2020	Junior Doctor/Trainee Engagement update Trello)	6 mth update presentation.	**Executive Medical Director + CCIO**	**Paused nationally 2020, date TBC**		14.01.2019. Deferred to March 27.03.2019. Deferred to future BTO 29.05.2019. Update to September Board to include results from GMC survey. 06.09.2019. Deferred to November Board due to deferred HEE visit. 18.11.2019. Deferred to January Board due to HEE visit. 13.01.2020 Date of HEE visit still to be confirmed. 9.03.2020 HEE visits cancelled on 3 occasions. HEE visit confirmed for 22.5.2020. Verbal update to May Board 27.05.2020 Visit cancelled. HEE visits paused due to COVID, future date to be confirmed 29.07.2020. Visit confirmed for Autumn 2020. 30.09.2020. Virtual HHE GMC	

							assessment anticipated Nov/Dec 2020. 25.11.2020 Notification of potential visit in February 2021.	
BM/20/11/117ac	25.11.2020	Nurse Staffing challenges	Dedicated session be held with Trust Board on Nurse Staffing by the Chief Nurse.	**Chief Nurse & Deputy CEO**	**28.04.2021**			
BM/20/11/117c	25.11.2020	People IPR - Attendance Management Policy	Review of shared learning from the C&M Symposium	**Chief People Officer**	**Paused**		C&M symposium paused due to pandemic	
BM/20/11/118	25.11.2020	M2O Report – Hospital Food National Review	Board sample of patient menu at a future Board meeting.	**Chief Nurse & Deputy CEO**	**Paused**		On hold due to Pandemic	

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/20/11/114	25.11.2020		Armed Veterans Action Plan to future Board meeting	**Chief Nurse & Deputy CEO**		**11.02.2021**	Action plan circulated to Board members.	

RAG Key

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

We are WHT & We are PROUD to make a difference

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/28**			
SUBJECT:	**Chief Executive's Briefing**			
DATE OF MEETING:	31st March 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 through high quality, safe care and an excellent patient experience.	✓		
	SO2 We will…Be the best place to work with a diverse, engaged workforce that is fit for the future.	✓		
	SO3 We will...Work in partnership to design and provide high quality, financially sustainable services.	✓		
LINK TO BAF RISK:	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

SUBJECT	Chief Executive's Briefing	AGENDA REF:	BM/21/03/28

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 27th January 2021, some of which are not covered elsewhere on the agenda for this meeting.

2) KEY ISSUES

2.1 Current COVID-19 Situation Report

As at the time of writing we have a total of 52 inpatients with COVID-19 at WHH; the week before it was 63. This is a COVID-19 demand that we have not seen since the first week of October. There is no doubt that our figures are relatively slow to come down in comparison with other acute trusts. Out of the 52 COVID-19 positive patients, 32 have a length of stay greater than 21 days (the so called 'super-stranded'). Of those 32 patients, 17 are 'medically-fit'. COVID-19 is a relatively long length of stay illness.

Positively, our overall super-stranded position for patients with a length of stay greater than 21 days is at 85, the lowest it has been for some months outside of a Home For Christmas programme.

The slow decline in hospitalised COVID-19 patients locally is at least partially explained by the 'dial not shifting' much in terms of community prevalence. In the latest 7 days fully published (15th March – 21st March) in Warrington there were 84 cases per 100,000 people (the average area in England had 44); 177 new cases were reported in that week, up 37 compared with the previous week. In Halton, there were 64 cases per 100,000 people; 83 new cases in that week, up 6 compared with the previous week.

The latest R number for the North West, updated on Friday 19th March, is at 0.7 – 0.9, the UK as a whole is at 0.6 – 0.9.

Since March, we have performed over 74137 COVID-19 tests and 5266 have been positive in total. We have discharged a total of 1897 patients with COVID-19 to continue their recovery at home. Sadly, a total of 488 patients with COVID-19 have died in our care.

2.2 Executive Team Changes

Phill James, Chief Information Officer, left the organisation at the end of February. The Digital Service portfolio has subsequently been split: executive leadership for IT services has transferred to the Executive Medical Director, Dr Alex Crowe, and for Information services to the Chief Finance Officer & Deputy Chief Executive, Andrea McGee, effective from 1st March 2021. The specific Board-level (non-voting) role of Chief Information Officer is therefore disestablished, although the recruitment of a new Chief Information Officer to support Dr Crowe is underway.

The rationale to do this at this point follows on from a direction of travel at WHH in recent years – significantly, an important component of IT being the Patient Administration System (PAS) and Electronic Patient Record (EPR) being fundamentally a clinical tool with clinical implications for patients and staff. The Executive Medical Director is also currently the Board-level Chief Clinical Information Officer and Caldicott Guardian. Moreover, the importance of data becoming information and intelligence with analytics is an area of recent investment that has consequences across all QPS objectives. This aligns well with the finance portfolio and there are many areas of synergy.

2.3 WHH COVID-19 Vaccination Programme

Our vaccination programme as a hospital hub continues to go from strength to strength. At the time of writing, we have performed over 24000 COVID-19 vaccinations. We have also vaccinated 90.27% of WHH staff – the highest staff uptake of any trust in the North West. This is a credit to everyone involved including the staff who have been so ready to take up the offer when presented to them. It is good to be at the top of such an important league table.

We are well on they way with our second doses of vaccine now.

Our WHH Neighbourhood Champion Scheme for vaccination for those within the JCVI 1-9 groups has continued. It works really well in terms of bringing people forward for vaccination, sponsored by members of staff, so that we continue to make best use of our capacity. DNA rates are very low.

2.4 National and Regional Developments

There has been confirmation that the Cheshire and Merseyside Health and Care Partnership has now been formally designated as an Integated Care System (ICS) and will work towards becoming a statutory organisation from April 2022. There are ongoing discussions with all partners around the development of provider collaboratives as well as integrated care partnerships at place (borough) level.

Effective 25th March 2021, the national incident has been reduced from level 4 to level 3, as occurred during the summer of 2020. The national incident infrastructure will be maintained, but the incident management will move to a regional level.

We have today also received the operational and financial/contracting guidance for 2021-2022. This timing of this means that we will be working with an interim budget for 2021-2022 until this is presented to the Trust Board next month.

2.5 Captain Sir Tom Moore

We were all saddened to learn of the death of Captain Sir Tom Moore in February. He was a truly remarkable and inspirational man, in the truest sense of the word, embodying a positive spirit of 2020. Somebody doing something over and above – something they didn't need to do, but did anyway to help others, and demonstrate hope in the process. There have been countless examples of that kind of thought and action in this Trust and across our communities over the last year too.

Sir Tom's connection to WHH is indirect, through the massive amount of money he raised for NHS Charities Together, of which we are a beneficiary. The money has been used to fund staff health and wellbeing initiatives including our Sanctuary Staff Health and Wellbeing Hub, support for the Project Wingman Lounge and other initiatives that will support improvements in staff welfare and development, and ultimately patient care.

It is entirely fitting and consistent with WHH that the renaming last summer of our Cheshire and Merseyside Treatment Centre at Halton Hospital as the Captain Sir Tom Moore Building will be a lasting tribute to him. It was the popular choice from the online poll we did last summer. His legacy will therefore be seen tangibly in our most modern building (and all that goes on within it) as well as felt throughout our Trust through the impact of all of the above which are a direct result of his fundraising efforts.

2.6 Halton Clinical Research Unit

In another low-key ceremony (a reflection of the time we find ourselves in), on 4th March we formally opened the Halton Clinical Research Unit (HCRU) with our partners from Liverpool University Hospitals NHS Foundation Trust and the NIHR North West Coast Clinical Research Network.

This last year been an extraordinary time for clinical research, especially clinical research in the United Kingdom, and particularly the North West. The sheer speed and application of clinical trials, most notably the RECOVERY trial and of course the national COVID-19 vaccination programme has captured the imagination and interest of our wider population. It is therefore significant that we are bringing a piece of that excitement and interest to our part of Cheshire and Merseyside, and giving greater access to clinical research to our local population, as well as greater possibilities to our clinical teams and those individuals who want to do research but have been needing a platform to do this. This is beyond COVID-19 and gives something tangible and with legacy potential way in to the future.

In the lead-up to the formal opening, over the last few months, a multi-disciplinary project team has been established, created from this new and exciting partnership. Our partnership has provided expertise in research and enabled us to apply for our very first clinical trial from the HCRU.

Crucially we have received investment from the CRN (nearly £200,000) to set up the unit which will create a fantastic legacy for the Trust. The project team has worked quickly to set up the unit, and I am pleased to say that we have received approval for our first clinical trial in the HCRU for a new COVID-19 vaccine. The trial is planned to start in April.

Medical and nurse staffing, recruitment, research and development, training, pharmacy, infection prevention and control, haematology, estates and facilities, operations, IM&T, communications, procurement and finance are all a part of making this happen and I cannot thank everyone involved enough for their energy, enthusiasm and ability to make things happen. Signs are now up in the Trust to guide us to the unit in the Nightingale Building. The unit has been set up to provide flexible accommodation and staffing to support different types of clinical research and trials, as this is very much only the beginning.

We will be placing the unit under the stewardship of our Quality Academy, a flagship of our commitment to a future where our ambition for research becomes part of what we do every day for the benefit of our local communities, our patients and absolutely for our staff.

2.7 Other developments at Halton Hospital

In addition to the opening of the Halton Clinical Research Unit described above, there is a lot of other development work going on in Halton at the moment, including:

- Movement of Breast Services, in line with Halton as the Trust's location for providing this service, including the expansion of Breast Surgery lists at Captain Sir Tom Moore Building and the creation of a Breast Screening and Assessment unit, relocating this service from Warrington's Kendrick Wing (due for completion this year).
- Development of the Post-Anaesthetic Care Unit (PACU) at Captain Sir Tom Moore Building, enabling the elective surgery expansion.
- Utilisation of Captain Sir Tom Moore Building for COVID recovery, including the addition of sessions for a number of new specialties from this location, including General Surgery, Urology, ENT and Ophthalmology.
- Shopping City Programme with approximately £1m investment from Liverpool City Region and the Trust, including the novel relocation and expansion of Ophthalmology, Audiology and Dietetics outpatient services (due to open September 2021).
- Proposed £3m health and education hub in Runcorn town centre included in Runcorn's Town Investment plan – awaiting Government feedback on the overall plan.

We continue to seek national funding for the redevelopment of the whole hospital site to provide services in a modern estate in a way that is complementary to the new Warrington Hospital proposals.

2.8 Urgent and Emergency Care

It has been a difficult few weeks more recently from a UEC point of view. Attendances have been significantly up, both at the Warrington Emergency Department but also at the Halton Urgent Treatment Centre. As ever, attendances are rarely smoothly profiled throughout the day. Whilst our super-stranded position has been improving in terms of patient flow (although there is always more to be done) we have also been thwarted by bedded assessment areas which further impacts our ability to make best use of assessment capacity and keep patients out of hospital. It is also related to the constraints brought about by COVID/non-COVID flow separations.

As at the time of writing our super-stranded position is at 84 patients, the best situation we have had for many weeks outside of a Home For Christmas programme and the historical favourable Christmas Eve bed situation.

2.9 Anaesthesia Clinical Standards Accreditation (ACSA)

At the beginning of March I was very pleased to join our Anaesthetics and Theatres teams in welcoming a virtual review team from the Royal College of Anaesthetists (RCoA) as the first stage on our path to Anaesthesia Clinical Standards Accreditation (ACSA). It is a journey I started as medical director a little while ago now and has been slowed for over a year by the

pandemic. However, the RCoA are now trying to do as much as they can virtually before visiting us when some of the public health restrictions are lifted.

For me its is absolutely fitting that this is happening now given the crucial role played by anaesthetics and theatres in the COVID response, both at WHH and across the country. The review team was extremely complimentary already about the positive departmental attitude and organisation, as well as the high quality policies including the systematic follow up of patients who had had any sort of problem with anaesthesia. We know that we have some work to do around training, alarm systems in theatres and patient satisfaction surveys but we are well on the way to being where we need to be in terms of meeting the required standards. Well done to the entire team led by Drs Dan Edwards, Ruth Cowen and Andy Langdon alongside Gemmell Johnston, Mark Rigby and Guy Hanson.

2.10 Car Parking

Car parking continues to be a major issue, particularly at Warrington. This is despite the national lockdown and normal 'foot-fall' being suspended for over a year. It is not helped by the number of spaces we have lost temporarily because of all the very important (but equally beneficial) estates work going on at the present time. It is obviously an unsustainable situation as parking demand increases year on year, and significantly impacts on our patients' experience as well as being very frustrating for staff, especially those arriving later in the day for late shifts.

There is no quick fix to this and we continue to explore all options, including a multi-story car park. In this regard, we also need to have a clearer idea of any new hospital development within the wider town master plan before we commit to anything.

However, we do have to regulate car parking and make the best use of what we have got, including the off-site spaces that we have invested in. Last year we carried out an extensive survey of staff car park users and we have reviewed this feedback. In summary, this involves us switching the cameras back on 1st April, protecting patient/visitor spaces as much as we can and reinstating charges for patients, visitors and the general public (albeit with an increased number of concessions available) in line with most other trusts. We will introduce a new criteria-based permit system – all staff will be required to apply for a new permit between April and June via a new system. Staff will be issued with passes assigned to a specific car park on site or at one of the four offsite car parks (Wellfield St, Basfords, Poundstretcher, Froghall Lane).

There are no plans to reintroduce charges for staff parking either on or offsite. This is consistent with the NHS People Plan and national directives.

2.11 National Day of Reflection

Tuesday 23rd March marked one year since the first national lockdown, and as part of a national day of reflection there was a minute's silence at noon. This was observed by individuals and teams throughout the trust, alongside a series of reflective pieces in Good Morning WHH, my daily message.

2.12 Warrington Guardian Lockdown Heroes Awards

The Warrington Guardian plans to honour community heroes who have gone above and beyond over the past 12 months. The awards are being held in association with Warrington Borough Council and WHH – in recognition of the support and efforts of our amazing local community for our hospitals during the pandemic. The event will be hosted by TV medic Dr Hilary Jones and will hail NHS staff, shop workers, volunteers and young people. The event is virtual and everyone can join live on Friday, April 30th.

The Communications Team are assisting with nominations. Both the Chairman and I are chairing panels for two of the 12 awards.

2.13 WHH Armed Forces & Military Veterans Network

WHH is currently developing our WHH Armed Forces/Military Veterans Network for those with a connection to the Armed Forces and who wish to be involved in that community. In addition, we are also seeking a Chair and Vice Chair(s) for the network with protected time to undertake the role.

2.14 Maternity Services

We opened The Nest on 1st December 2020 in a very low-key ceremony. The Nest is our Midwifery-Led Unit (MLU) and the latest addition to the birth options available to the women of the Warrington and Halton area. The Nest offers four ensuite birth rooms, each with its own birthing pool and two having outside access to the garden area (still under development as the weather improves). The state-of-the-art rooms have been designed to promote active, upright labours in a calm and relaxed environment.

From opening until the end of February the team have cared for 102 women in labour and welcomed 78 babies into the world; the remaining 24 women will have, for one reason or another, had to transfer to our main Delivery Suite/Labour Ward. That is a transfer-in-labour rate of 23.5%, when the national average for units like this is 26.4%.

There have been 49 waterbirths on The Nest; a waterbirth rate of 62.8%.

The Nest is just one of a series of capital and revenue investments in Women's and Children's Health within the last year, that also includes us investing over £450K in staffing for the important continuity of care agenda, as well as in leadership for the team.

2.15 COVID-19 LAMP Testing

In November 2020 WHH agreed to be one of three 'early adopter sites' in the North West for the role out of Lateral Flow Device Testing to asymptomatic front line staff across the workforce, alongside North Care Alliance (Oldham Site) and East Lancashire Hospitals NHS Trust. The programme has since been rolled out to all acute trusts and extended to Mental Health, Community Trusts and Ambulance Services. More recently we have begun using Lateral Flow devices on patients in the Emergency Department and on patients and family members in the Maternity Unit.

In February 2021 it was recommended that they all trusts in the North West explore moving to LAMP (Loop Mediated Isothermal Amplification) testing instead of Lateral Flow testing. LAMP testing detects the presence of RNA of the SARS-CoV-2 virus from a fresh saliva sample

provided by staff. LAMP testing is self-administered and takes only a few minutes to complete. Testing is carried out at home before eating or brushing teeth to prevent the potential interference with the sample. For some sub regions access to LAMP is not universally available, however for Cheshire and Merseyside the Health & Care Partnership has developed plans to transfer.

LAMP testing is more comfortable than a nose or throat swabs – the test is saliva-based and has enough sensitivity to mean confirmatory PCR tests are not needed. Test outcomes are automatically reported through the laboratory. Unlike lateral flow testing, asymptomatic testing under the LAMP regime only needs to take place once per week and takes around five minutes for the individual to carry-out. It currently can take around 30-40 mins for a staff member to carry out a Lateral Flow Test, twice per week.

LAMP is simple to start, supported by well-developed digital technology. Staff taking part in the LAMP testing programme register their data online, resulting in readily available data. Unlike Lateral Flow, LAMP is not a 'rapid' test. However, it can be processed much more quickly than PCR tests, and turnaround is less than 24 hours. Because samples must be sent to laboratories, the LAMP regime lends itself much more easily to hospital sites, where large numbers of staff can efficiently access sample drop-off points. There is considerable lab capacity for LAMP testing (Liverpool Clinical Laboratories are doing this for us).

2.16 Special Days/Weeks for professional groups

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

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

LGBT+ Month – February 2021
Time To Talk Day – 4th February 2021
International Mother Language Day – 21st February 2021
World Sleep Day – 19th March 2021

2.17 Local political leadership communication

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

2.18 Employee Recognition

During the COVID-19 pandemic the WHH employee recognition scheme (*Employee of the Month and Team of the Month)* has been temporarily suspended.

Chief Executive Award (February 2021): Ward A8 and Ward A9

Both of these wards have been operating in an extremely challenging environment thoughout the pandemic, but have continued to deliver high standards of care with countless examples of positive patient and family feedback. Kindness and compassion have frequently been words used to describe the care given on these wards.

Chief Executive Award (February 2021): Communications Team

Deferred from January, this award was made for the extra hard work and success in delivering the Thank You AwArds in December 2020 at very short noice. This successful event occurred, virtually, despite the pandemic and involved the team being innovative and flexible in equal measure.

Chief Executive Award (March 2021): Olivia King

One of our midwives, Olivia King, was traveling as second-on-call to a homebirth in Warrington when she saw a young woman sat on a bridge. Olivia circled back to the girl and called the police. We understand the girl's intention was to commit suicide. Olivia stayed with the woman until the police and other services arrived. Cheshire Police have said Olivia undoubtedly saved her life and will be nominating Olivia for a commendation.

Chief Executive Award (March 2021): Critical Care

Our critical care team have been at the very forefront of COVID-19 care throughout waves 1, 2 and 3 of the pandemic, and over the last two waves have been one of the busiest and most escalated critical care units in the North West. They have my utmost admiration for all that they have done and the way that they have done it.

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

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

- Mel Thompson, Ward Manager A7
- Jennie Myler, Executive Assistant
- Veronica Brash, Medical Secretary - Digestive Dieases
- Dr Anna Vondy, Consultant, Urgent & Emergency Care
- Mr Hemal Raja, Consultant ENT Surgeon
- Matthew Rogers & Team, COVID-19 Vaccination Programme
- Dr Alex Crowe, Executive Medical Director
- Katie Nixon & Team, Ward Manager - B12
- Mr Noaman Sarfraz, Consultant Surgeon
- Erin Schofield, Student Nurse - Women's & Children's Health
- Joanna Thomas, Clinical Specialist Physiotherapist - Critical Care Unit
- Elena Evans-Guillen, WHH Charity Fundraiser
- Ruben Evans-Guillen, WHH Charity Fundraiser
- Mr Azher Shafiq & Team, Consultant Surgeon and Breast Screening Team
- Dr Mark Forrest & Team, Clinical Director - Medical Care

- Mr Mark Tighe & Team, Consultant Surgeon - Digestive Dieases
- Dr Bharathi & Team, Consultant Gastroenterologist/Endoscopy Unit
- Renee Roberts, Senior Domestic Supervisor - Estates and Facilities
- Barbara Kelly, Waiting List Clerk - Endoscopy Unit
- Dr Prakash Mathew, Associate Specialist Ophthalmology
- Mark Hampson, Head of Resuscitation
- Karen Johns, Medical Secretary - Specialist Surgery
- Deborah Owens, Medical Records Clerk
- Andrea McGee, Chief Finance Officer & Deputy CEO
- Val Doyle, Associate Director, Elective Care
- Claire Grice, Ward Manager - PACU
- Sally Proffitt, Associate Director of Finance
- Joanne Nolan, Healthcare Assistant - Ward K25

2.19 Signed under Seal

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

- Underlease of the Reception Desk area at Warrington Hospital
- Deed of Variation to the property at the Entrance Concourse at Warrington Hospital
- Licence for alterations at the Reception Desk area at Warrington Hospital
- Project Agreement for a pathology equipment service

3 MEETINGS ATTENDED/ATTENDING

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

- North West Coast Vaccine Alliance Steering Group (Monthly)
- Clinical Reseach Network North West Coast Partnership Board (Quarterly)
- NHSE/I COVID-19 System Leadership (Weekly, now biweekly)
- C&M CEO Provider Group Calls (Weekly)
- C&M Medical Directors Clinical Prioritisation & Mutual Aid meeting (Weekly)
- NHS 111 Oversight Group (Monthly)
- Update calls with our local MPs: Andy Carter MP, Charlotte Nichols MP, Derek Twigg MP, Mike Amesbury MP
- Steve Broomhead, Chief Executive, Warrington Borough Council
- David Parr, Chief Executive, Halton Borough Council
- Dr Andy Davies, Clinical Chief Officer, NHS Warrington and Halton CCG
- Colin Scales, Chief Executive, Bridgewater Community Health NHSFT
- Warrington Health Scrutiny Committee (March 2021)
- Warrington Health and Wellbeing Board (March 2021)
- Halton Health Policy and Performance Board (March 2021)
- C&M Hospital Cell (Weekly)

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

4) RECOMMENDATIONS

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

We are WHH & We are PROUD to make a difference

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Report to the Board of Directors

AGENDA REFERENCE:	BM/21/03/30		
SUBJECT:	**COVID-19 Performance Summary and Situation Report**		
DATE OF MEETING:	31st March 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 through high quality, safe care and an excellent patient experience.	x	
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	x	
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate*)	1126 – Failure to provide the required levels of oxygen for ventilators caused by system constraints, resulting in a lack of adequate oxygen flow at outlets. 1134 – Failure to provide adequate staffing caused by absence relating to COVID-19, resulting in resource challenges and an increase within the temporary staffing domain.		
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily COVID-19 Executive Summary which outlines key information pertinent to the command and control of the situation. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where possible. This is the tenth iteration of this report which is part of the continuing development of understanding of demand, capacity and outcomes that will determine future strategic planning. Data up to 27th March 2021 is included.		
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**			
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO THE BOARD OF DIRECTORS

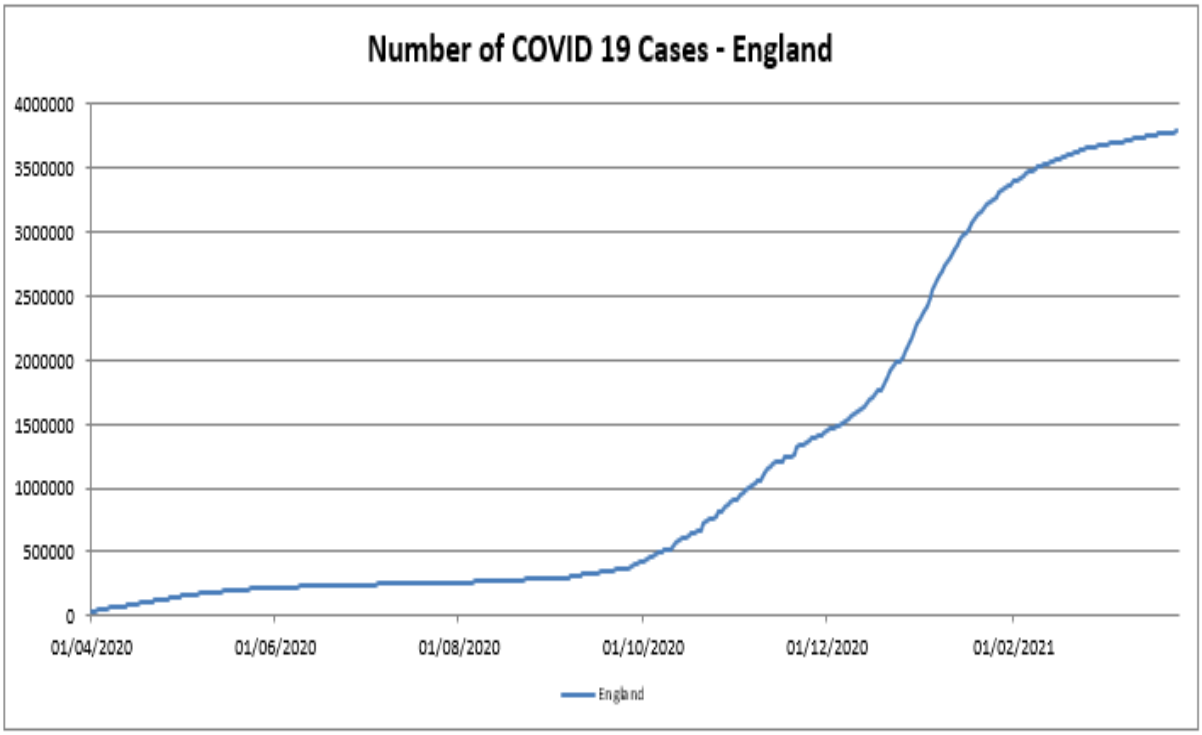
SUBJECT	COVID-19 Performance Summary and Situation Report	**AGENDA REF:**	BM/21/03/30

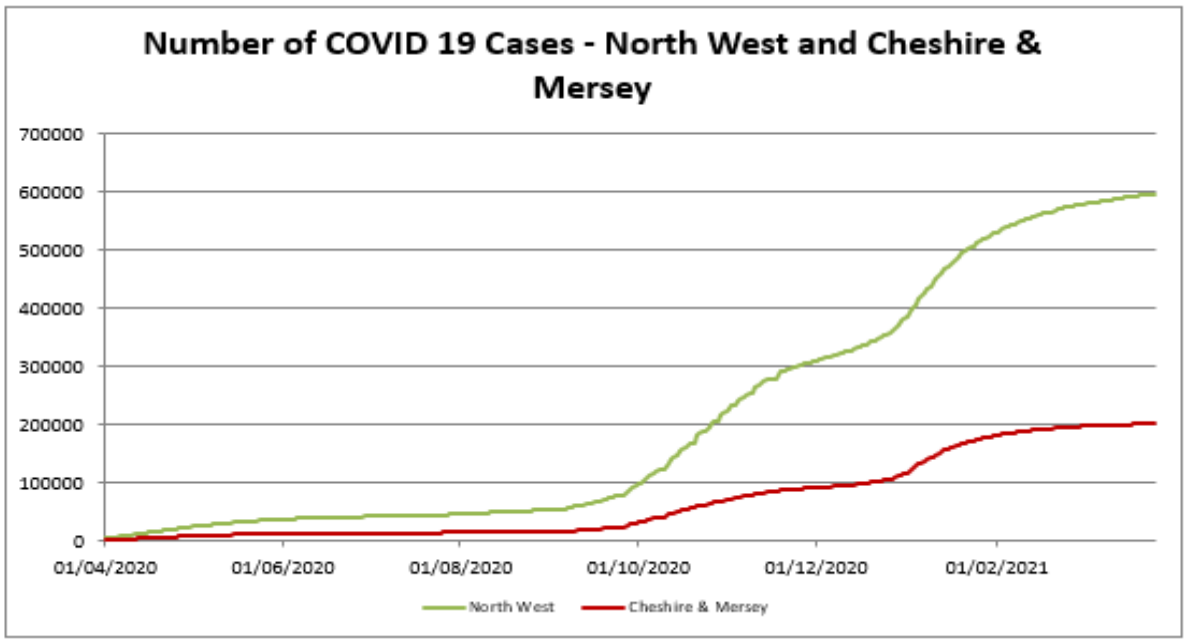
1. BACKGROUND/CONTEXT

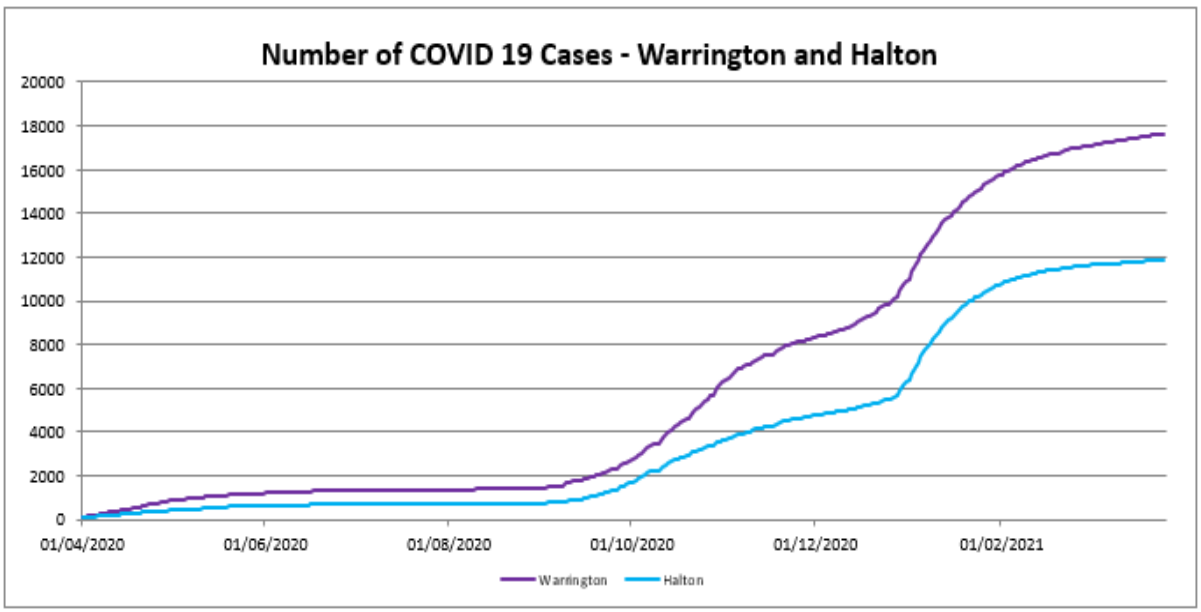
The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily COVID-19 Executive Summary which outlines key information pertinent to the command and control of the situation. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where possible. This is the tenth iteration of this report which is part of the continuing development of understanding of demand, capacity and outcomes that will determine future strategic planning. Data up to 27th March 2021 is included.

2. KEY ELEMENTS

2.1 Number of Reported Cases

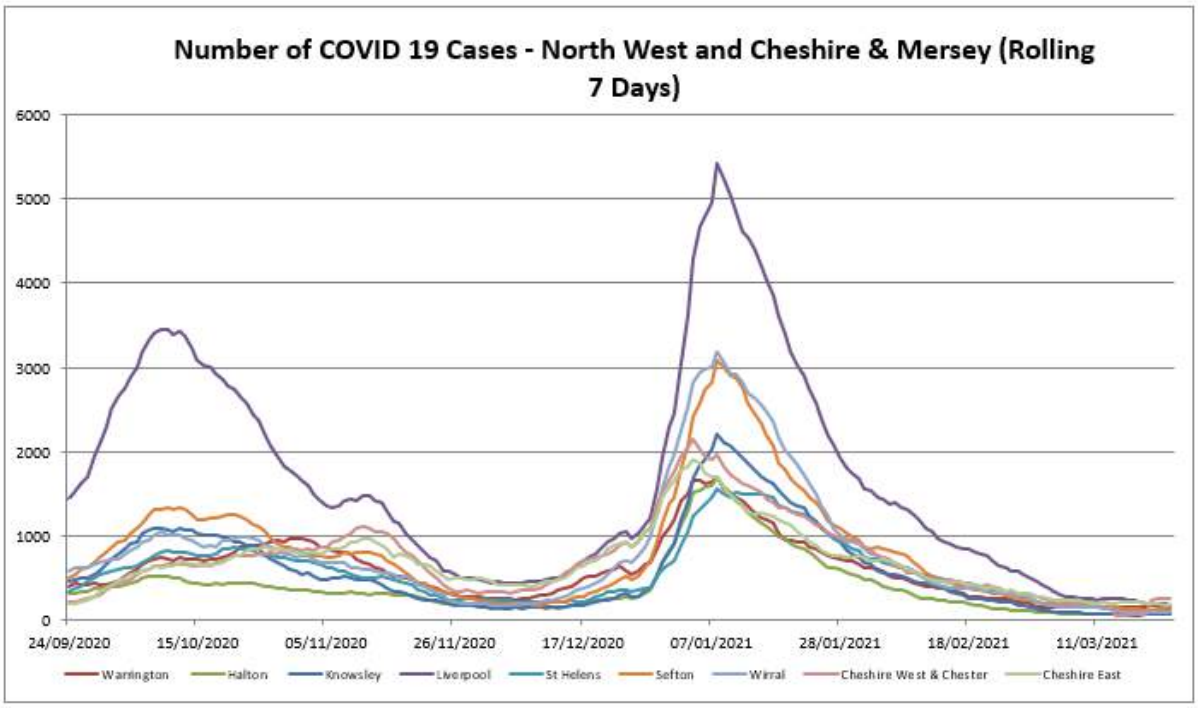


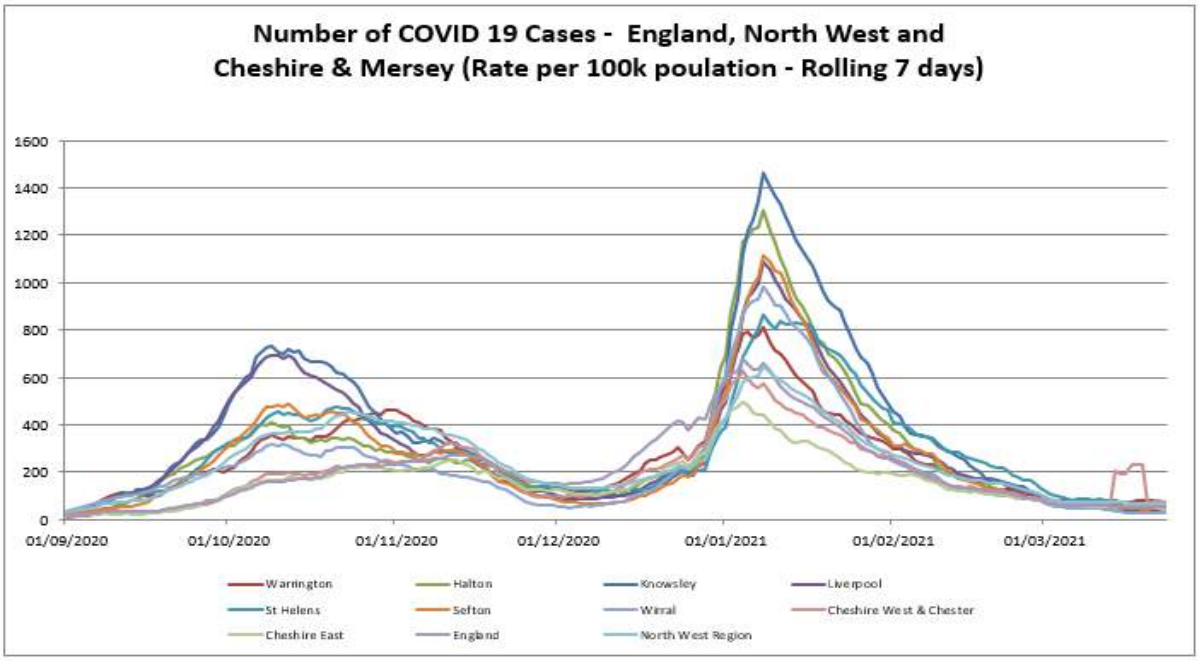




Narrative: As of 27/03/2021, there were 17,621 cases (from 16,767 on 20/02/2021) of confirmed COVID-19 reported in Warrington and 11,867 (from 11,439 on 20/02/2021) cases reported in Halton. The Trend is in line with the England, Cheshire & Mersey and the North West positions.
Source: https://coronavirus.data.gov.uk/

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

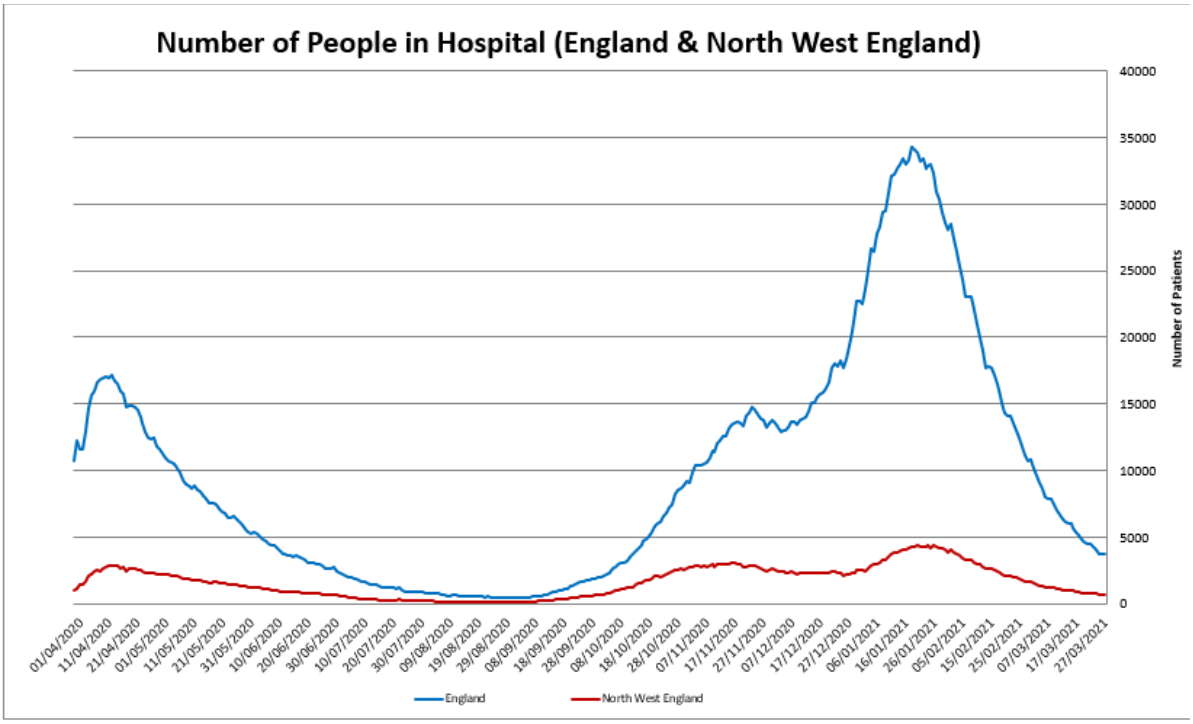


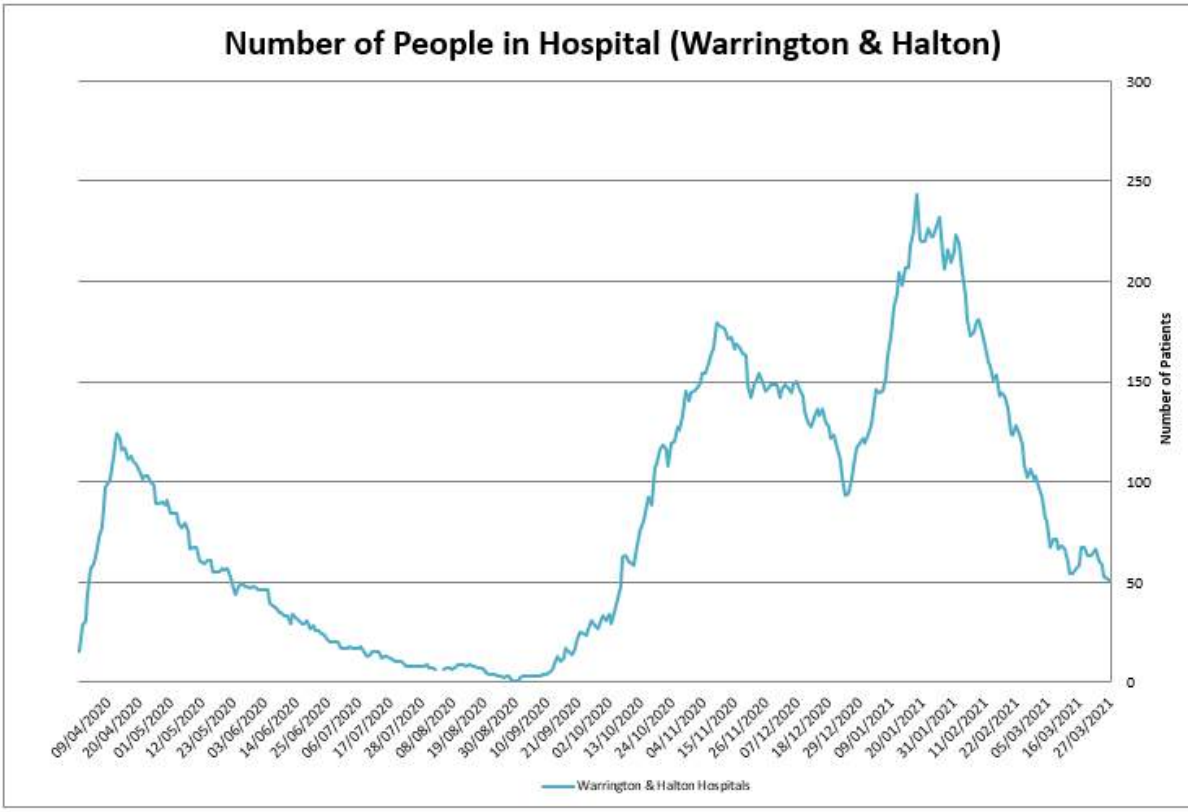


Narrative: The graphs show the infection count and rates per 100k population over a rolling 7 day period. This is a fairer comparison than total number of cases due to the different populations. The data continues to show a significant declined in the number of infections since the peak on 08/01/2021. As at 23/03/2021 (the latest data period for this indicator) Warrington had 78.1 cases per 100k population and Halton had 61.8 cases per 100k population which is in line with the North West position (68.5 cases/100k population) but above the England position (56 cases/100k population).

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

2.3 Number of People in Hospital

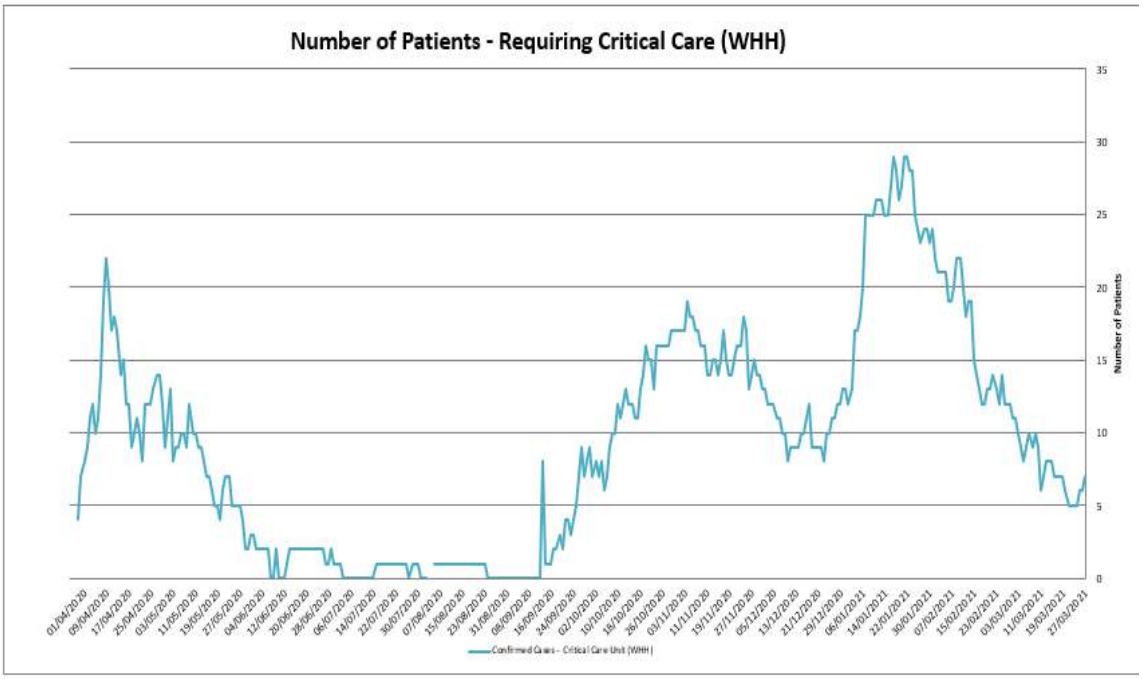




Narrative: As 27/03/2021, there were 50 inpatients being treated by the Trust with confirmed COVID-19 (from 124 on 20/02/2021). The peak of the 3rd wave was on 18/01/2021 with 243 inpatients receiving treatment, this was followed by a period of small peaks and waves. The number of inpatients has continued to decline since early February.

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

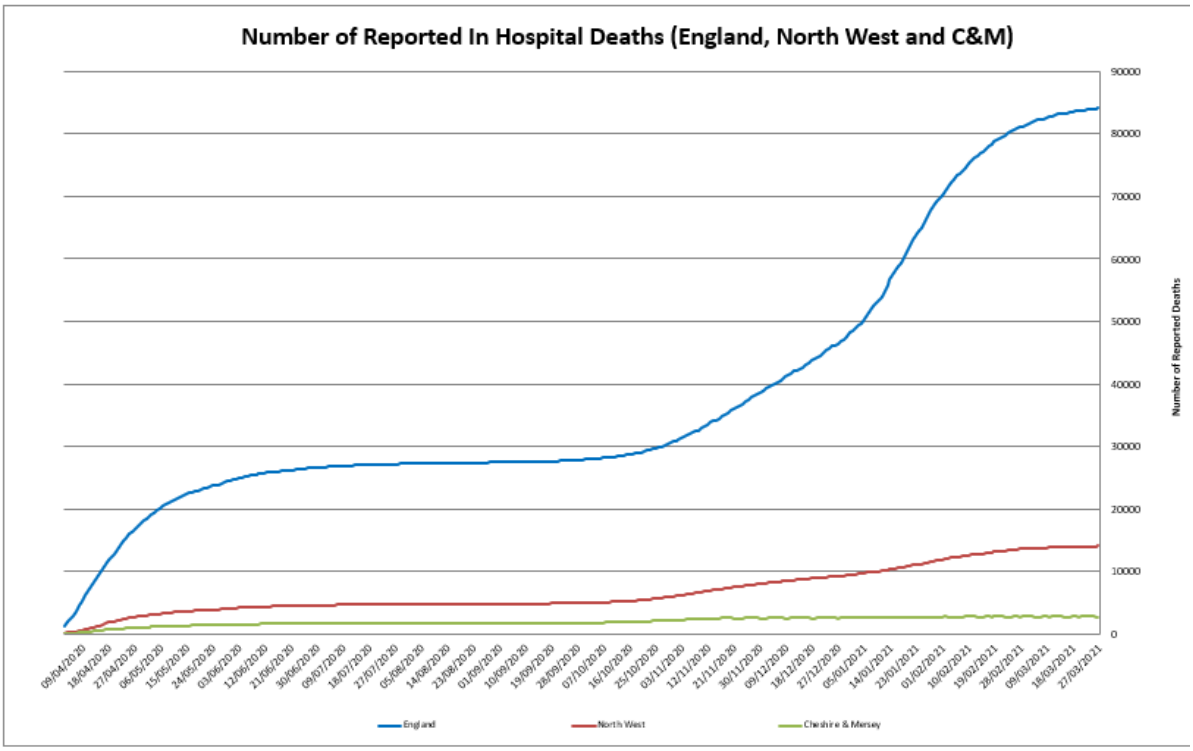
2.4 Number of Patients Requiring Critical Care

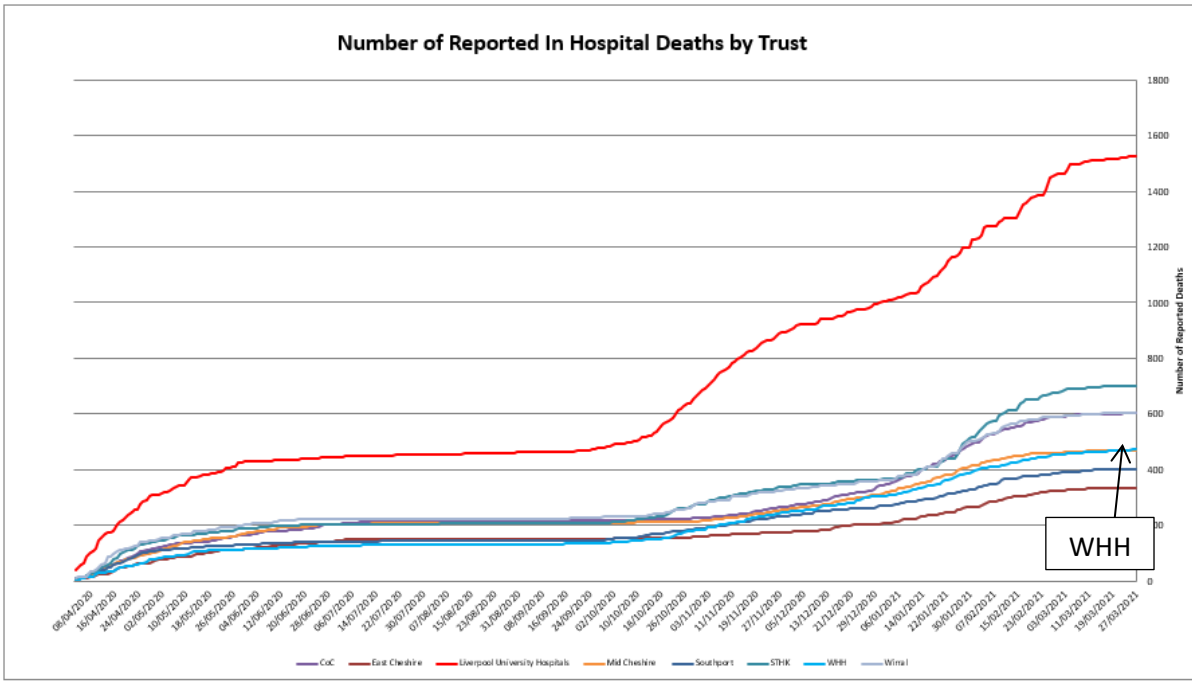


Narrative: As of 27/03/2021, there were 7 inpatients with confirmed COVID-19 and 1 inpatient with suspected COVID-19 in critical care (from 13 confirmed cases and 0 suspected cases on 20/02/2021). The peak of the 3rd Wave came on 22/01/2021 with 29 patients in critical care.

Source: National SITREP data (England & North West) and Trust Data (Warrington & Halton).

2.5.1 Number of In-Hospital Deaths





Narrative: As of 27/03/2021, the Trust had reported 488 deaths of inpatients with confirmed COVID-19 (from 453 on 20/02/2021). The trend is in line with the North West and Cheshire & Mersey positions.

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

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

2.5.2 Crude Mortality

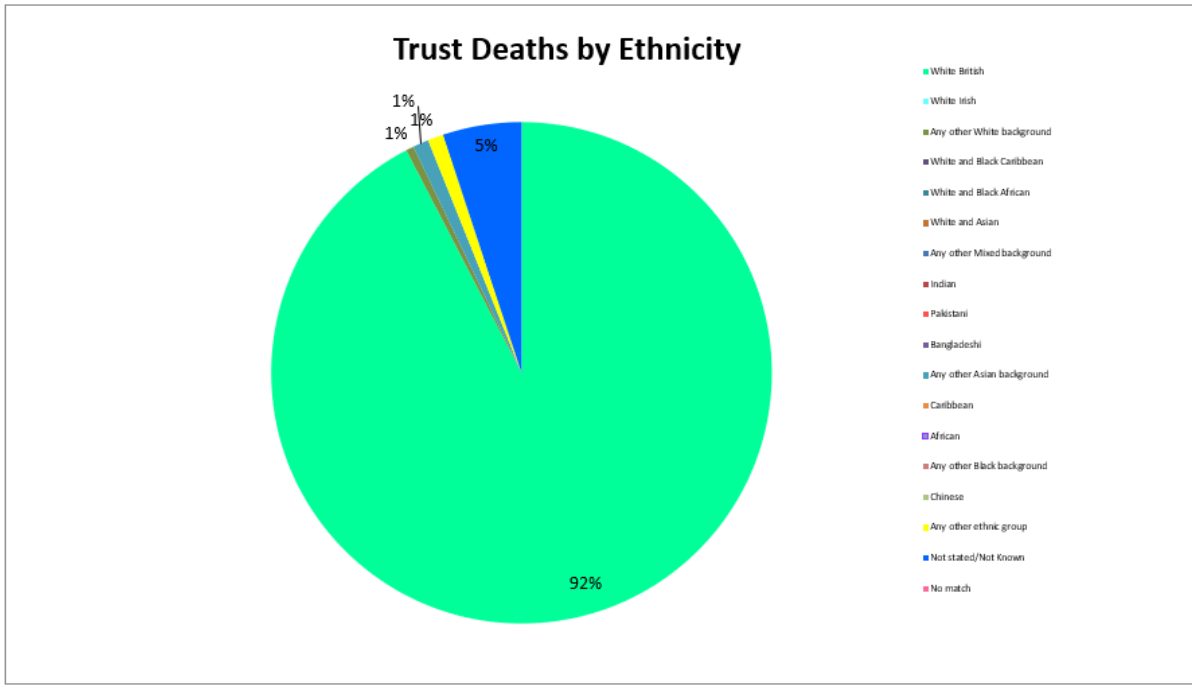
	2020	2021
February (All Deaths)	86	103
February (Non COVID)	86	42
February (COVID)		61
% COVID Deaths (of all deaths)		59.2%
Discharges	6353	4275
Crude Mortality (deaths divided by deaths+discharges)	1.4%	2.4%

	Wave 1 Apr-Aug 2020	Wave 2 Sept-Dec 2020	Wave 3 Jan 2021 - Present
All Deaths	405	402	306
Non-COVID	272	228	135
COVID	133	174	171
% COVID Deaths (of all deaths)	32.8%	43.3%	55.9%
Discharges	19328	17240	11406
Crude Mortality (deaths divided by deaths+discharges)	2.1%	2.3%	2.7%
Crude Mortality COVID-19 (COVID-19 deaths divided by COVID-19 deaths+ COVID-19 discharges)	25.2%	20.2%	18.2%

Narrative: Crude mortality in February 2021 was 2.4% compared with 1.4% in February 2020. Crude mortality was 2.1% in wave 1 and 2.3% in wave 2 and 2.7% in wave 3 (to date) with Crude mortality for COVID-19 patients 25.2% in wave 1, 20.2% in wave 2 and 18.2% in wave 3 (to date).

Source: Trust Data.

2.5.3 Number of In Hospital Deaths (Ethnicity)

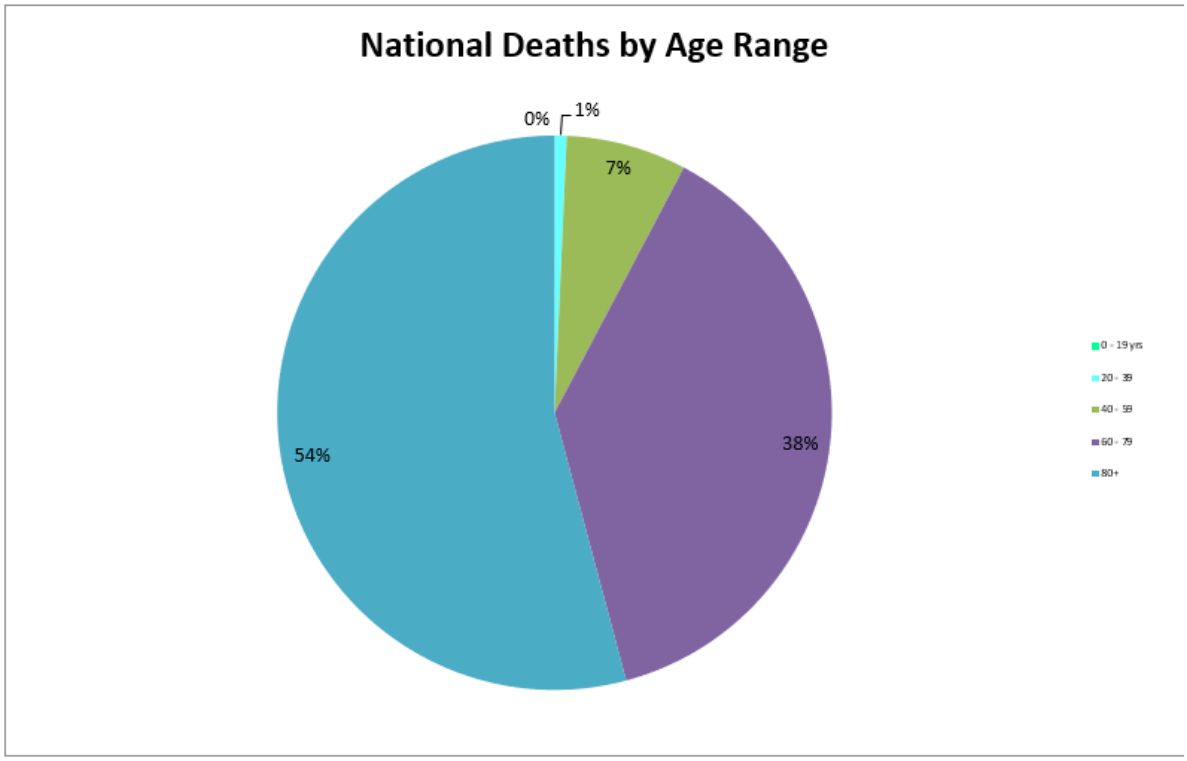


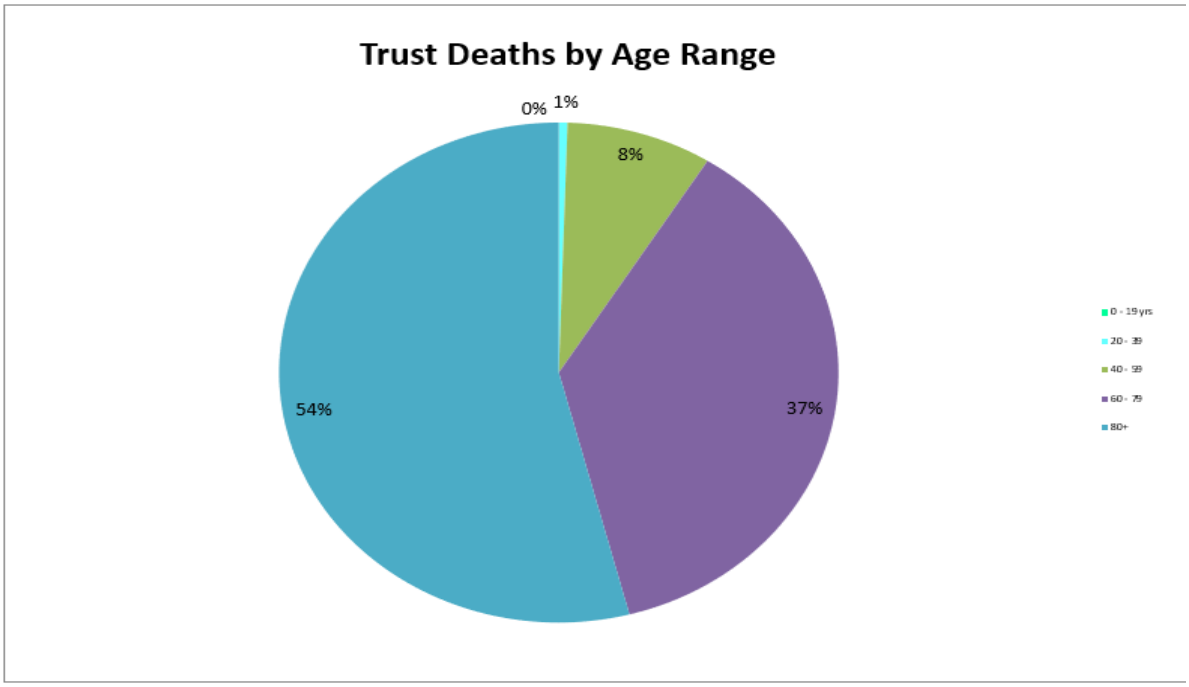
Narrative: As of 27/03/2021, 92% of reported deaths were patients who identified as "White British", with 5% patients' ethnicity "Not Stated/Not Known", <1% patients' ethnicity stated as "Any Other Ethnic Group", <1% patients stated as "Asian" or "Asian British" and <1% patient identified as "White Any Other Background". The proportion of White British patient deaths is greater than the national position, however this is as expected when comparing the population of Warrington (96.00% White British) & Halton (98.00% White British).

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

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

2.5.4 Number of In Hospital Deaths (Age Range)



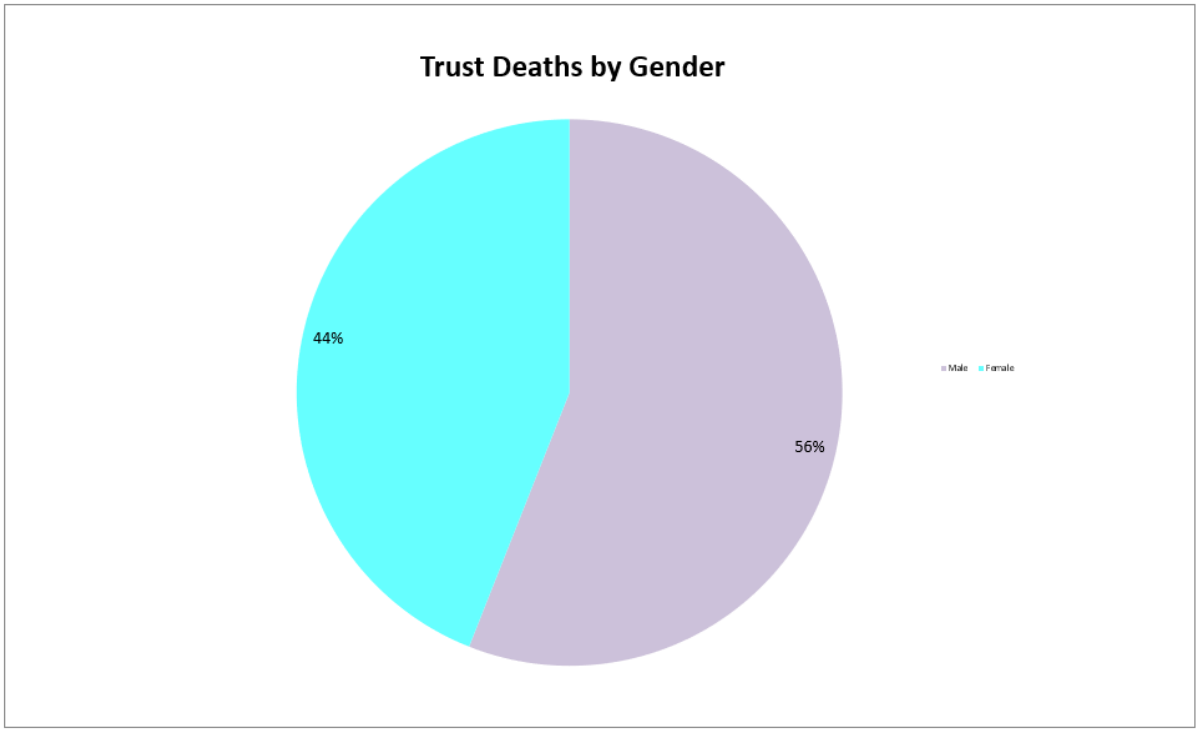


Narrative: As at 27/03/2021, 91.0% of COVID-19 related deaths were inpatients over the age of 60, which is line with the national position. The average age of death was 78 years.

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

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

2.5.5 Number of In Hospital Deaths (Gender)

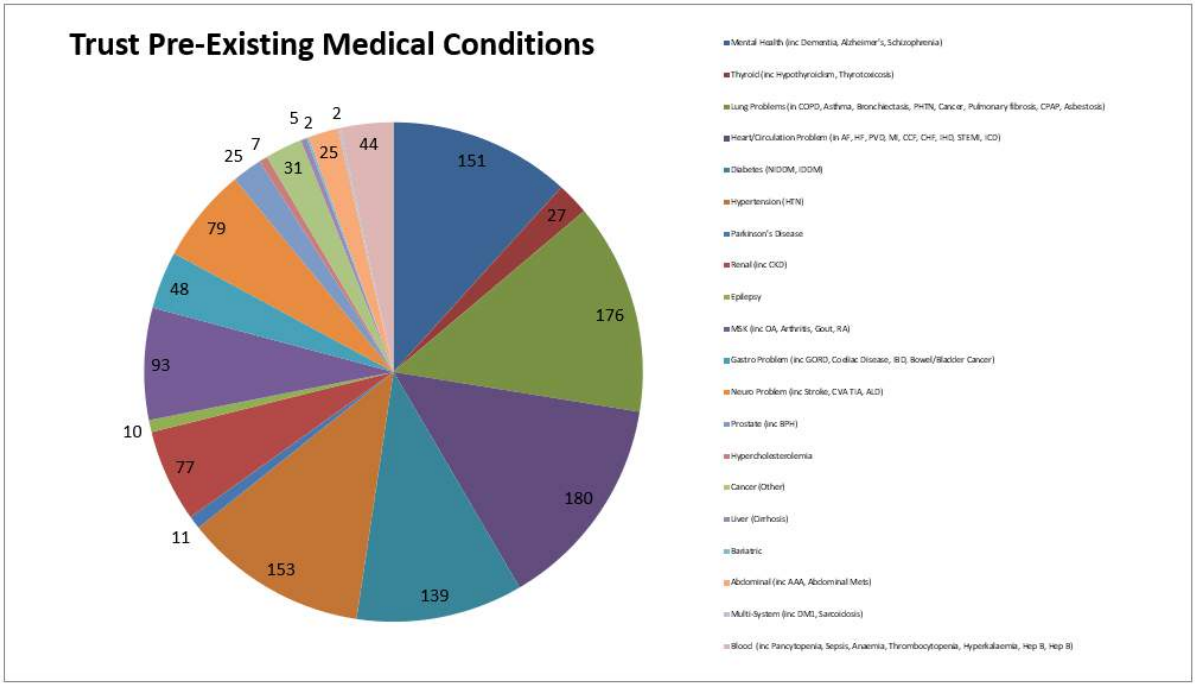


Narrative: As at 27/03/2021, 56% of COVID-19 deaths were male patients and 44% of deaths were female patients.

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



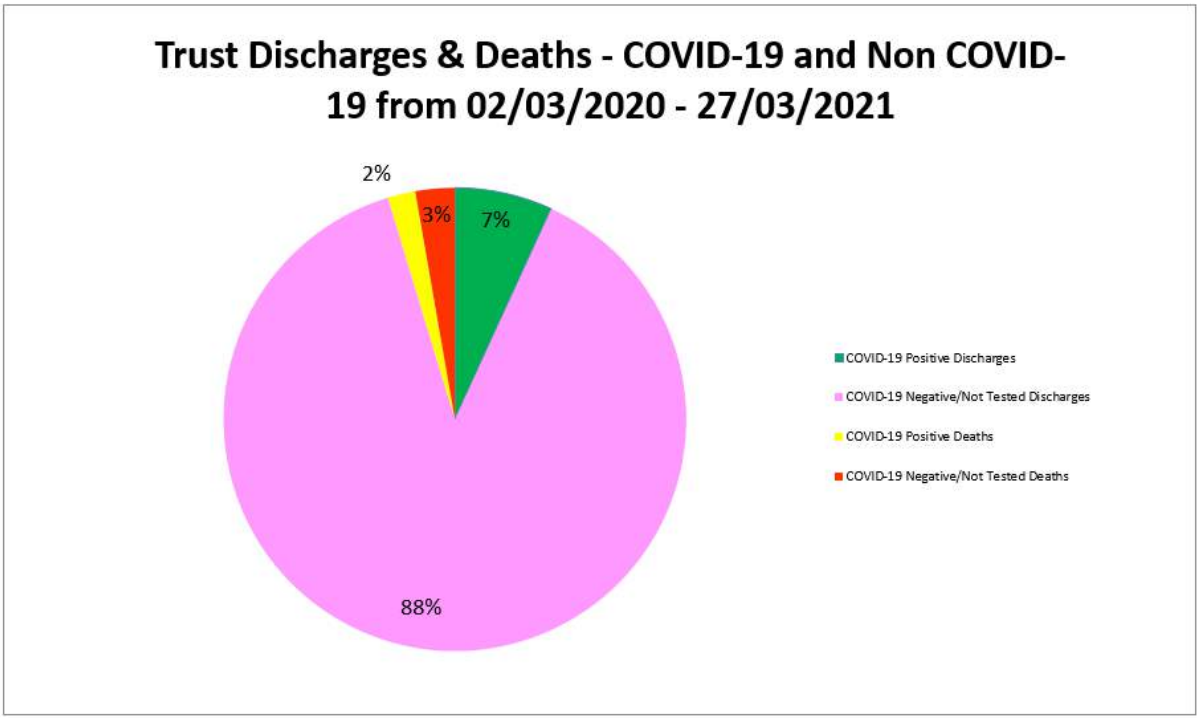
Narrative: As at 27/03/2021, 89% of Trust inpatients who have died as a result of COVID-19 had a pre-existing medical condition recorded. The most common of these were Heart and Lung conditions in additional diabetes and organic mental health conditions such as Dementia and Alzheimer's.

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

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

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

2.6 Trust Outcomes

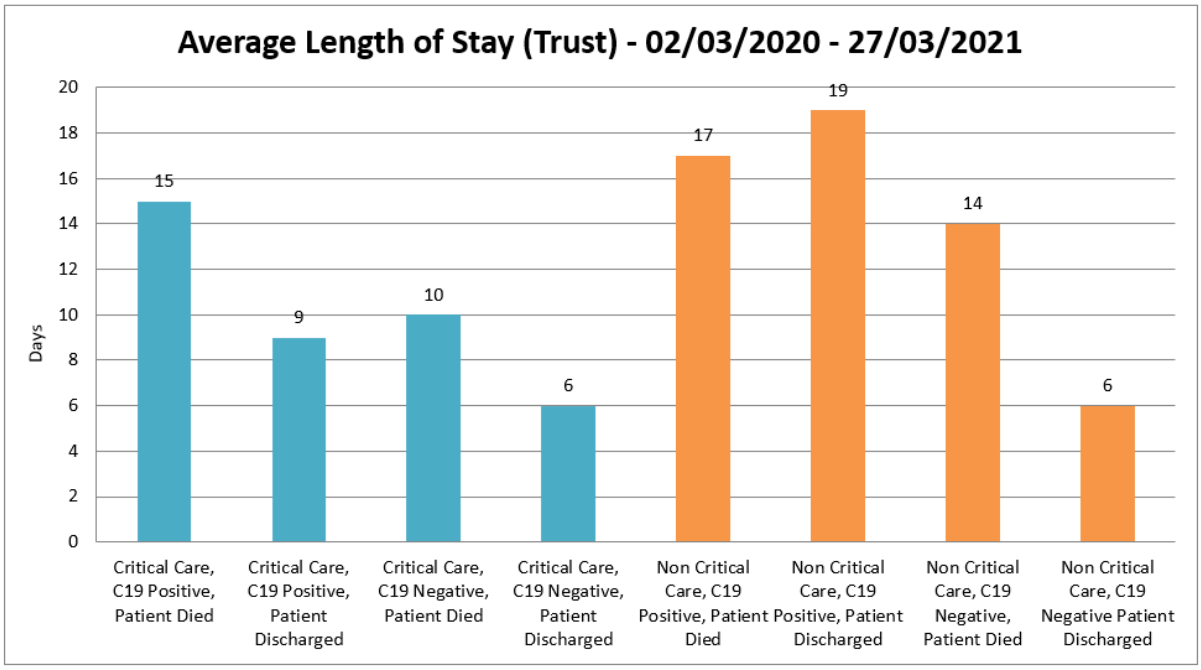


Narrative:

- Between 02/03/2020 – 27/03/2021, the Trust treated 25,950 inpatients (any patient with at least 1-night stay).
- 2,293 (8.83%) inpatients had tested positive for COVID-19.
- 95.38% of all patients were discharged from hospital.
- There was a total of 1,197 inpatients (all causes) who have died; this represents 4.61% of all inpatients.
- 488 inpatient deaths were related to COVID-19 which represented 1.88% of all inpatients.
- 92 patients who have died and who had tested positive for COVID-19 were admitted from a care home, 5.53% of all COVID-19 positive inpatients.

Source: Trust Data

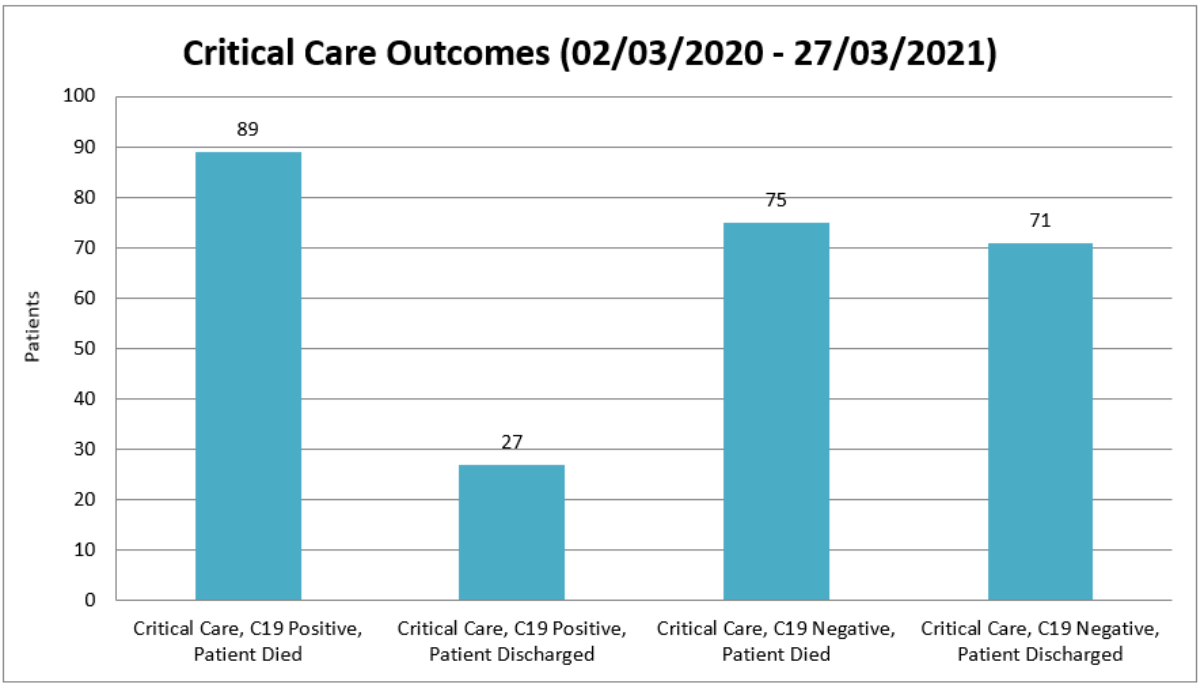
2.6.1 Average Length of Stay



Narrative: From 02/03/2020 - 27/03/2021, the average length of stay for patients who had tested positive for COVID-19 was 13 days in critical care and 18 days in non-critical care.

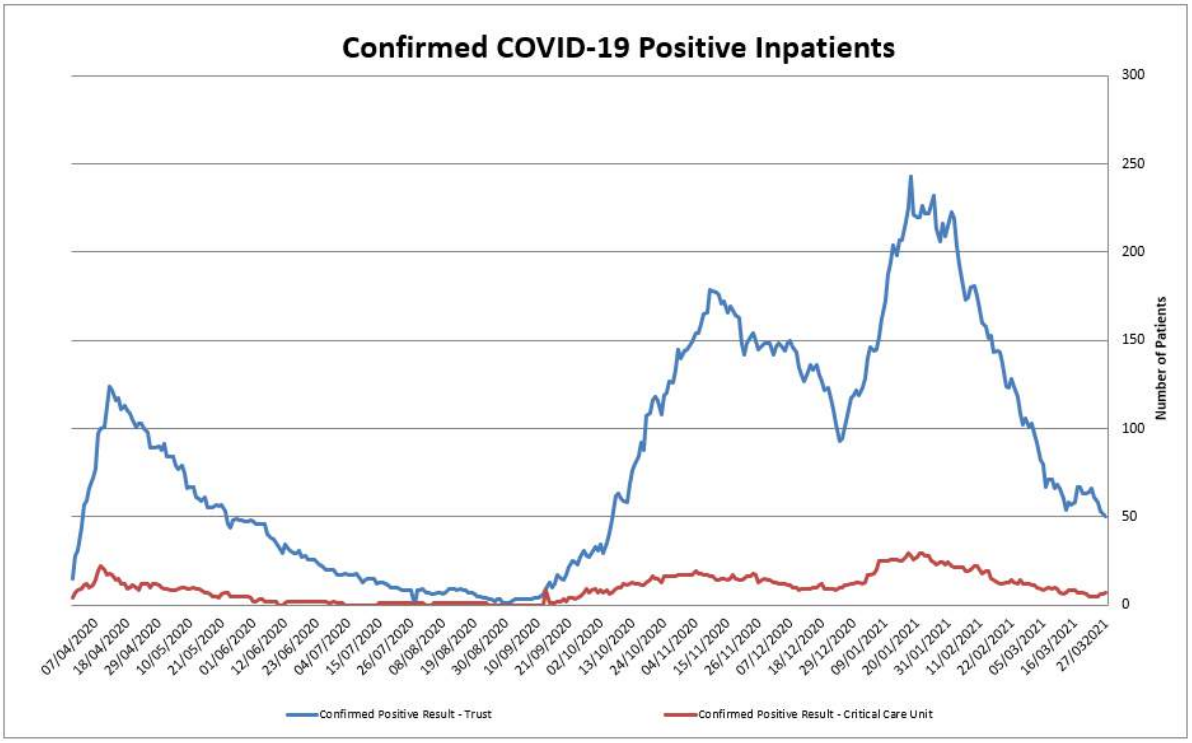
Source: Trust Data

2.6.2 Critical Care Outcomes



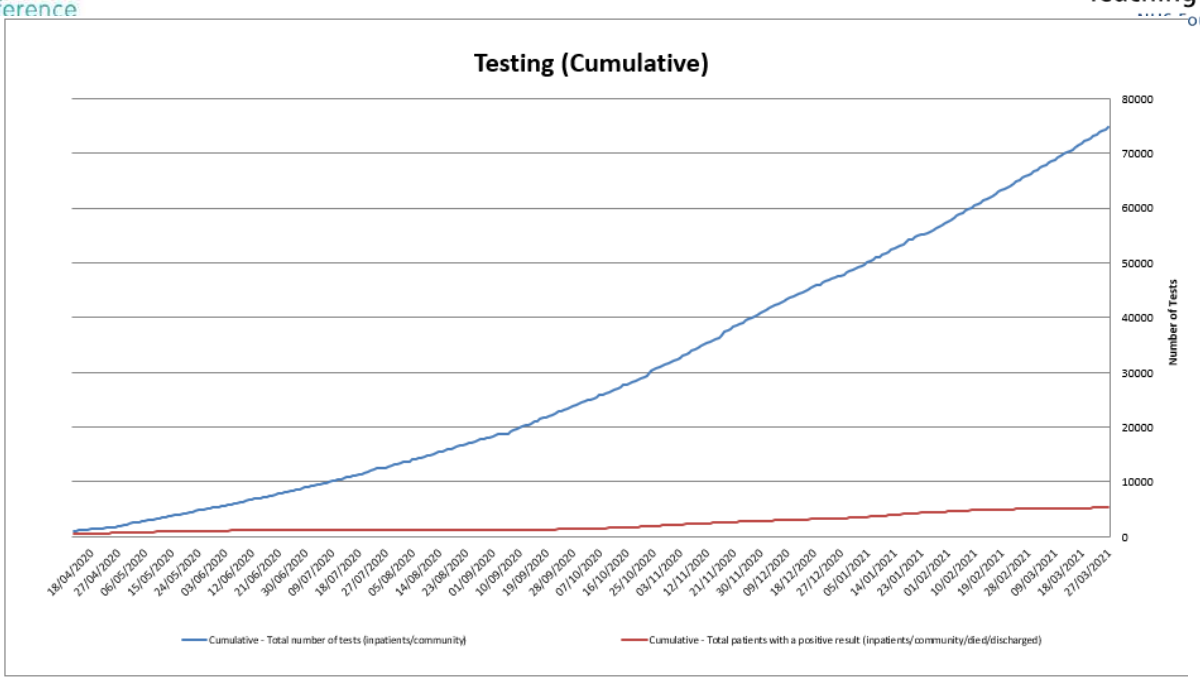
Narrative: From 02/03/2020 – 27/03/2021, there were 164 critical care inpatient deaths (89 COVID-19, 75 Non-COVID-19) and 98 critical care inpatient discharges (27 COVID-19, 71 Non-COVID-19).
Source: Trust Data

2.7 Confirmed Positive COVID-19 Patients



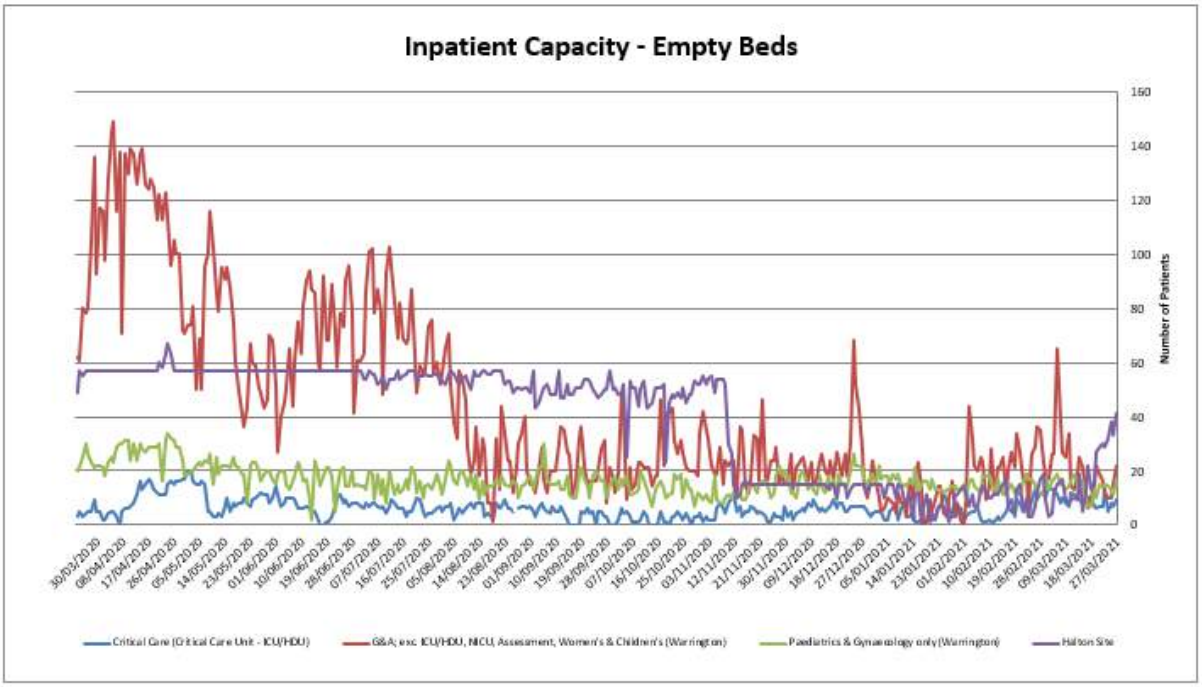
Narrative: As of 27/03/2021, there were 50 confirmed COVID-19 positive inpatients with 7 patients in critical care. The position is reducing in line with the regional and national positions and the reduction in infections.

2.8 COVID-19 Testing



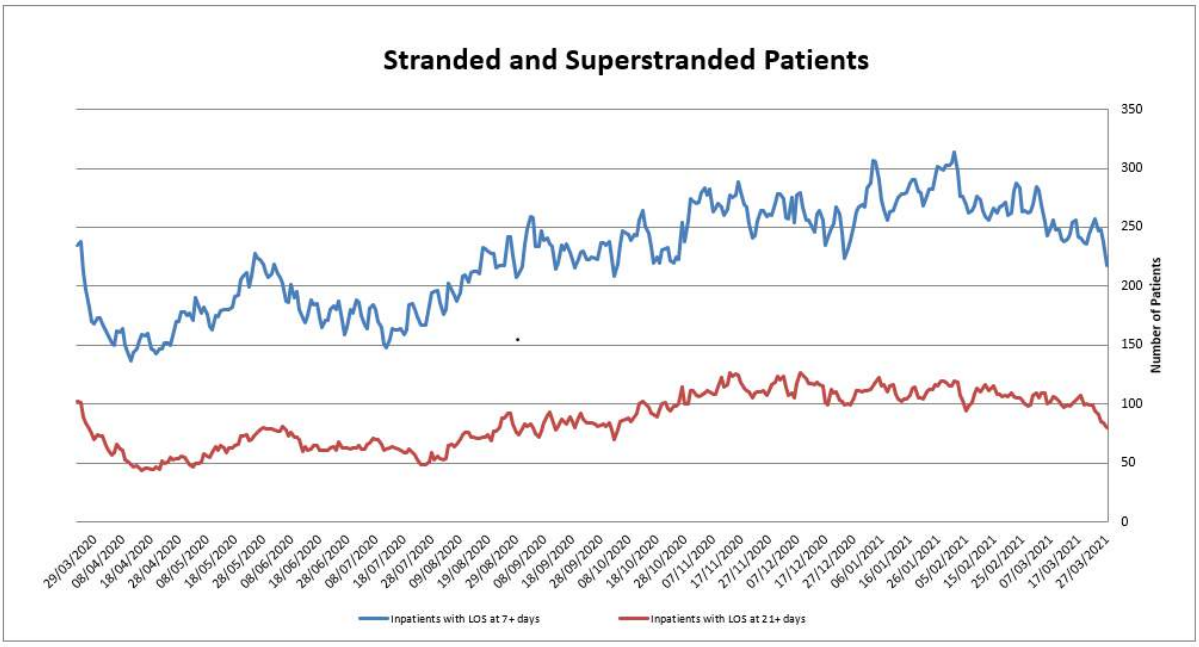
Narrative: As of 27/03/2021, 74,713 patients' tests (inpatients & community) have been carried out and 6,977 staff tests have been carried out (internally). Of the 74,713 patient tests carried out, 5280 (7.06%) patients have tested positive.
Source: Trust Data

2.9 Capacity/Empty Beds



Narrative: Since the last report on 20/02/2021, there has been at least 3 beds available at all times in critical care.
Source: Trust Data

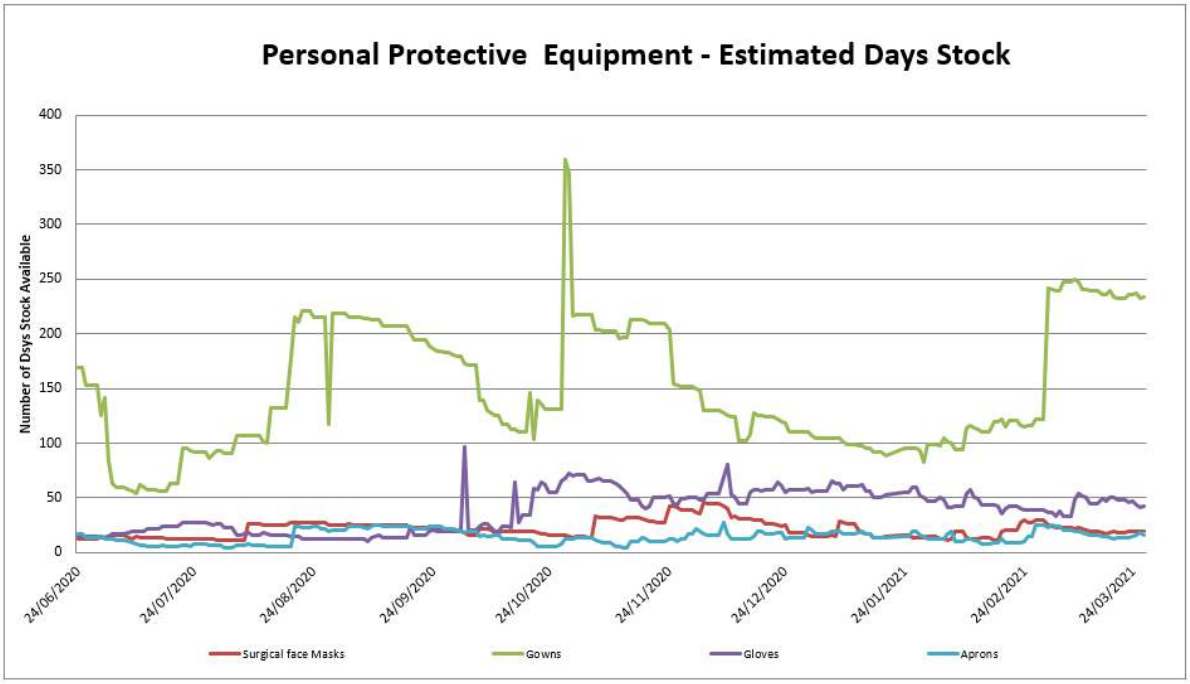
2.10 Stranded/Super Stranded Patients



Narrative: On 27/03/2021, there were 218 Stranded and 80 Super Stranded patients.

Source: Trust Data

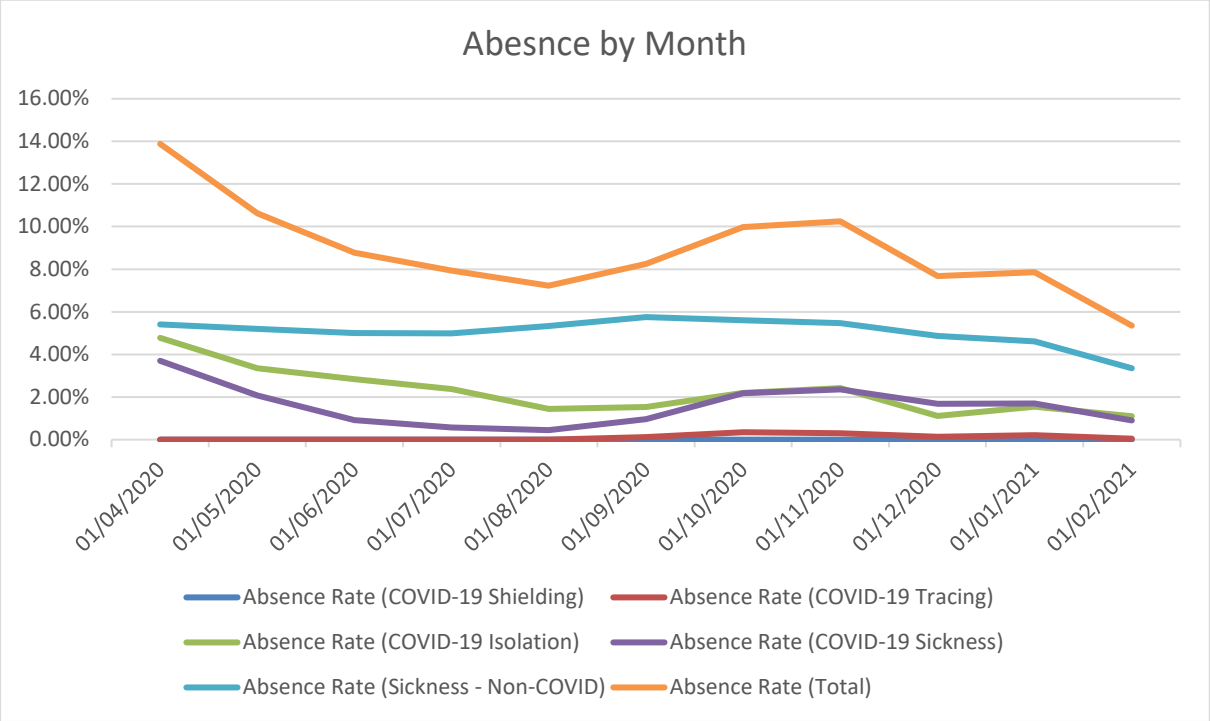
2.11 Personal Protective Equipment (Stock Days)



Narrative: The Trust had a minimum stock level of 16 days for all items of PPE as of 27/03/2021.

Source: Trust Data

2.12 Staff Sickness

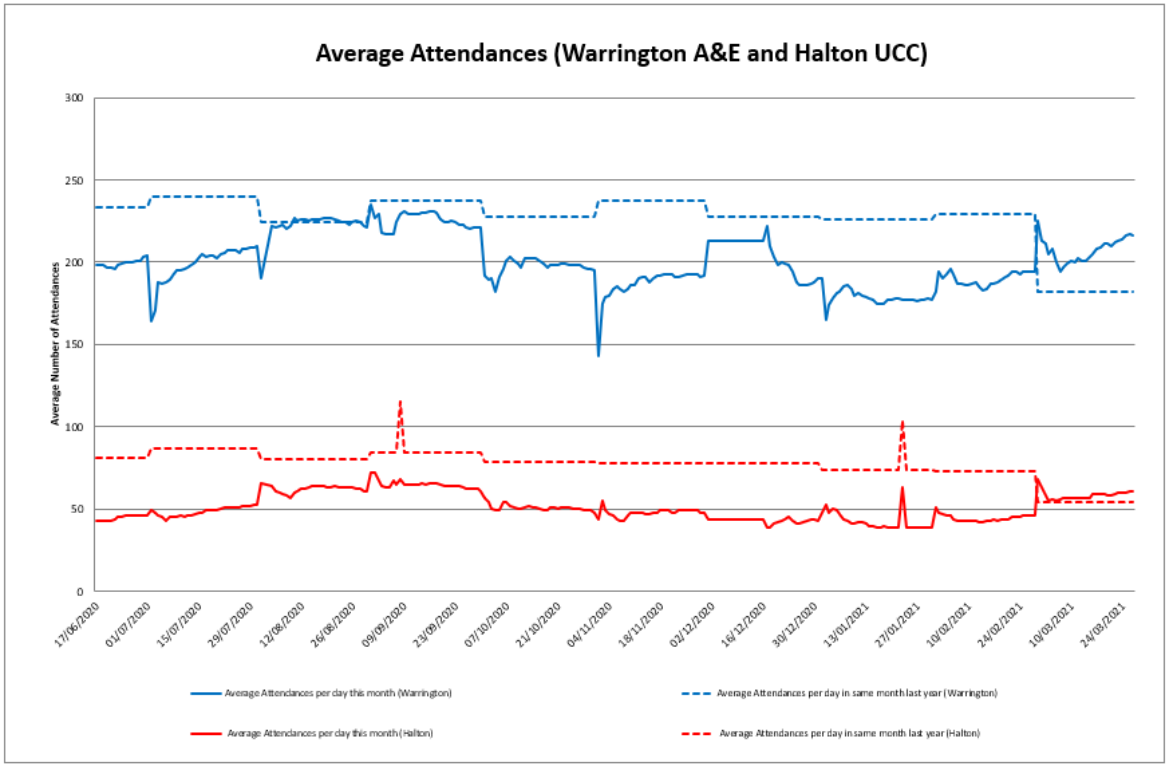


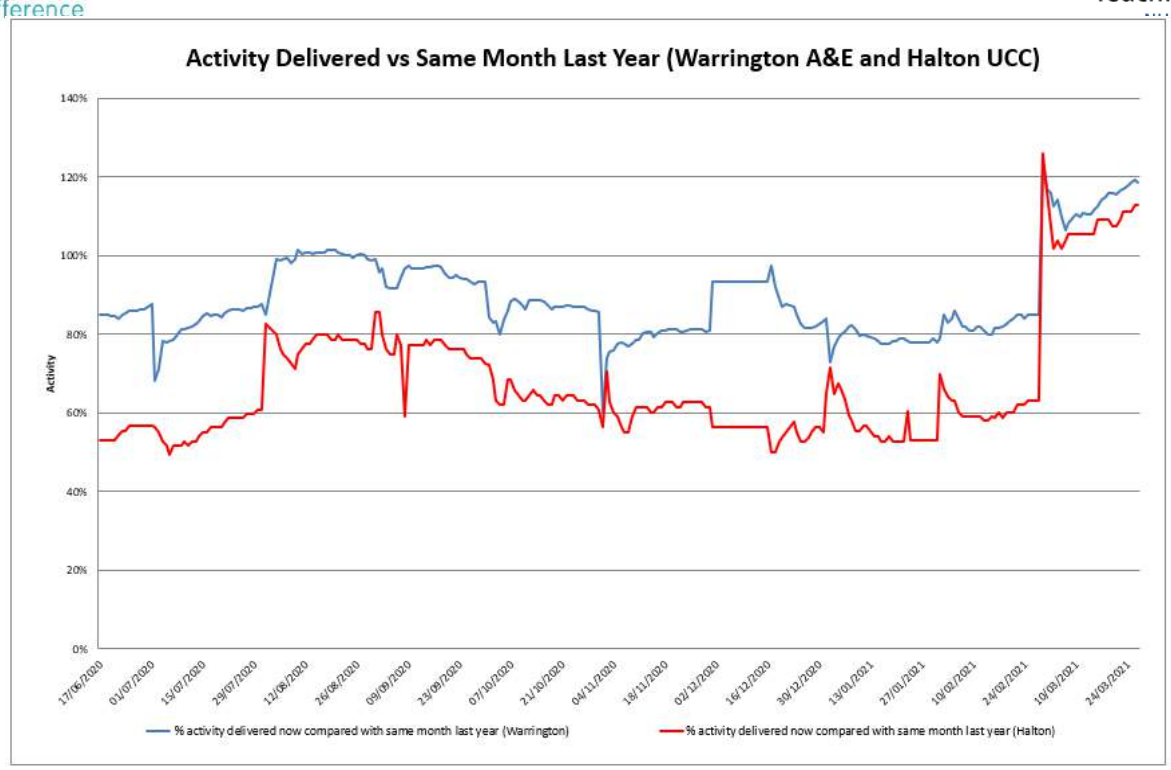
Narrative: Non COVID-19 related sickness absence has reduced to 3.35%. COVID-19 related sickness absence has decreased to 0.9%, and isolation (through either tracing or CEV isolation) has also decreased. Technology is enabling more individuals to work from home, where this is the case, they do not count towards the isolation numbers and the Trust continues to

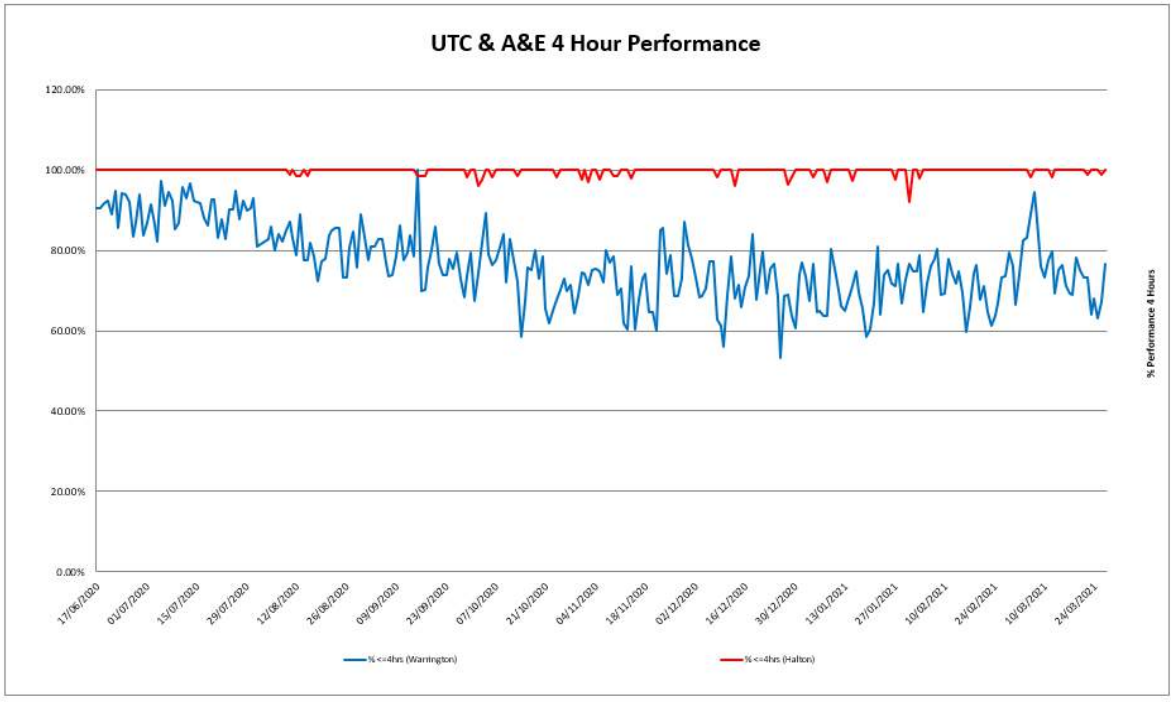
support Clinically Extremely Vulnerable staff back into the workplace when Risk Assessments are approved.

Benchmarking information has not been available for the past month.
Source: Trust Data

2.13 Urgent Care

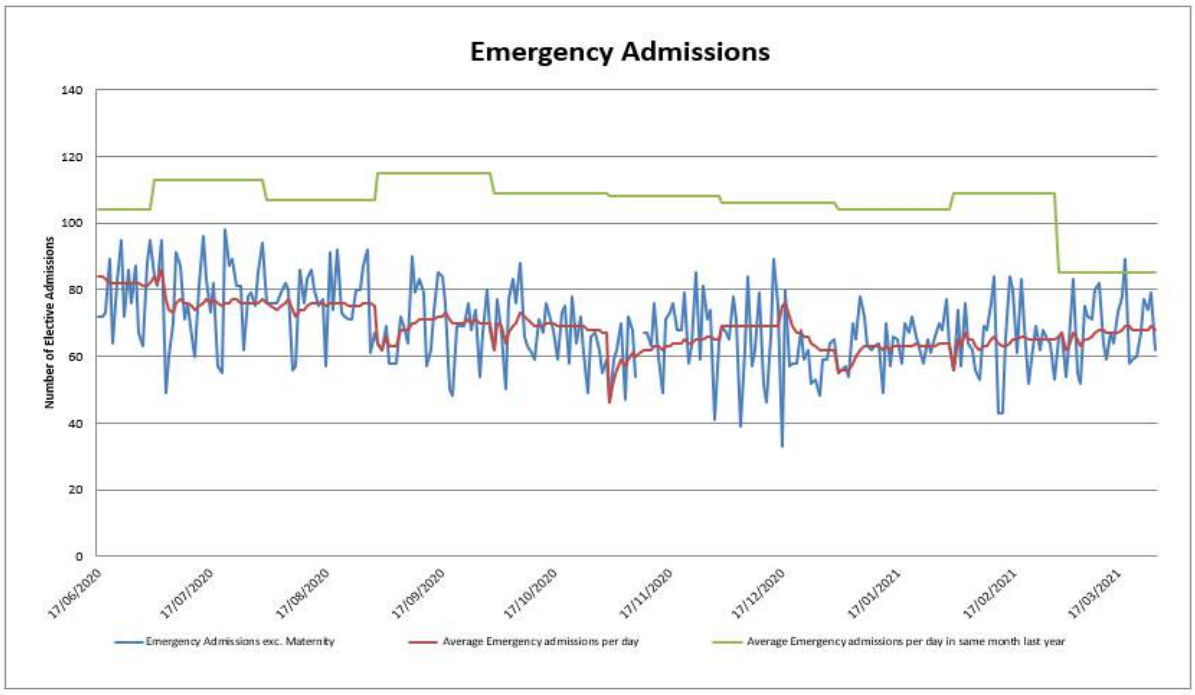



Activity Delivered vs Same Month Last Year (Warrington A&E and Halton UCC)
140%
120%
100%
80%
60%
40%
20%
0%
Activity
17/06/2020
01/07/2020
15/07/2020
29/07/2020
12/08/2020
26/08/2020
09/09/2020
23/09/2020
07/10/2020
21/10/2020
04/11/2020
18/11/2020
02/12/2020
16/12/2020
30/12/2020
13/01/2021
27/01/2021
10/02/2021
24/02/2021
10/03/2021
24/03/2021
% activity delivered now compared with same month last year (Warrington)
% activity delivered now compared with same month last year (Halton)


UTC & A&E 4 Hour Performance
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
% Performance 4 Hours
17/06/2020
01/07/2020
15/07/2020
29/07/2020
12/08/2020
26/08/2020
09/09/2020
23/09/2020
07/10/2020
21/10/2020
04/11/2020
18/11/2020
02/12/2020
16/12/2020
30/12/2020
13/01/2021
27/01/2021
10/02/2021
24/02/2021
10/03/2021
24/03/2021
% <=4hrs (Warrington)
% <=4hrs (Halton)

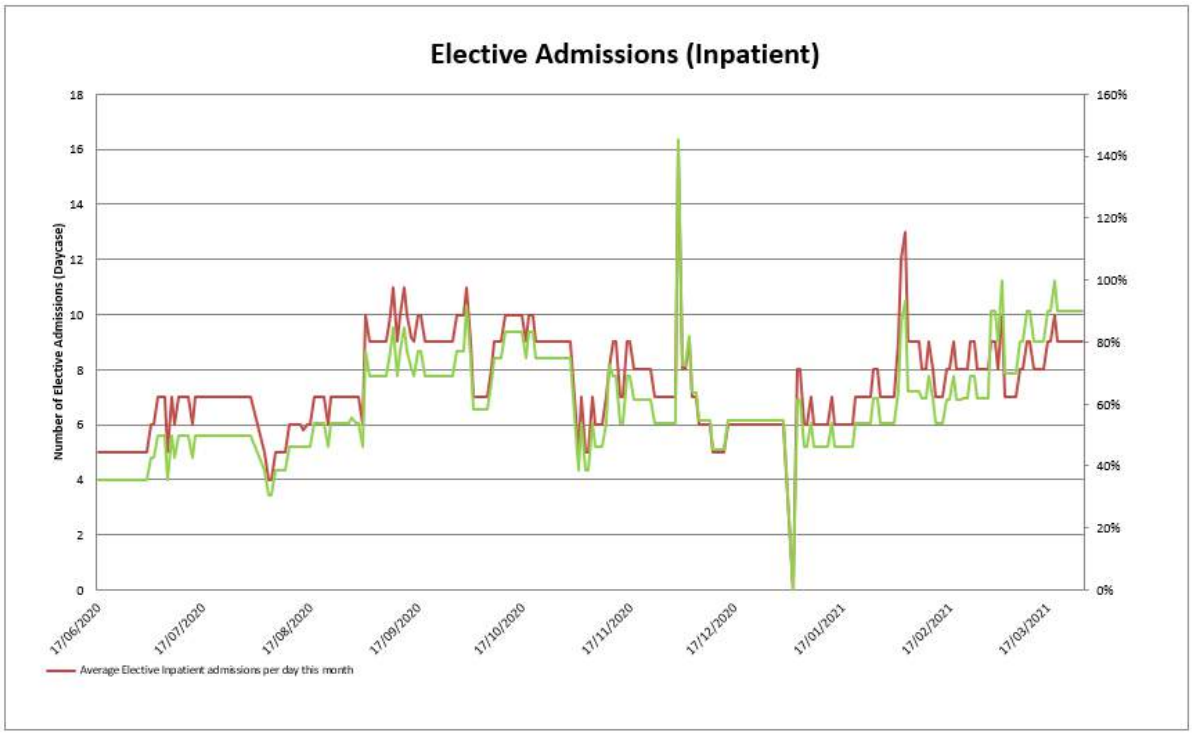
Narrative: Activity in February 2021 in Warrington A&E has averaged 82.91% of activity in February 2020. Activity in February 2021 at the Halton UTC has averaged 61.13% of activity in February 2020.
Source: Trust Data

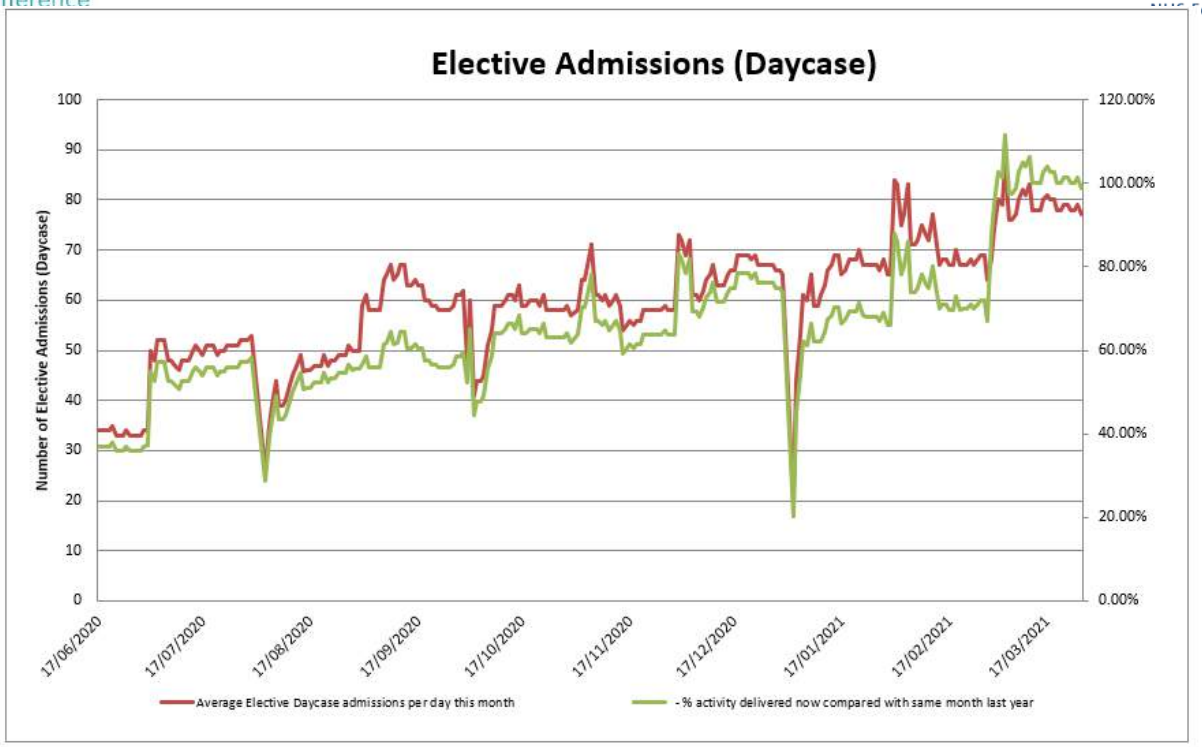
2.14 Emergency Admissions



Narrative: The average number of emergency admissions in February 2021 was 59.14% of the average number of emergency admissions in February 2020.
Source: Trust Data

2.15 Elective Admissions



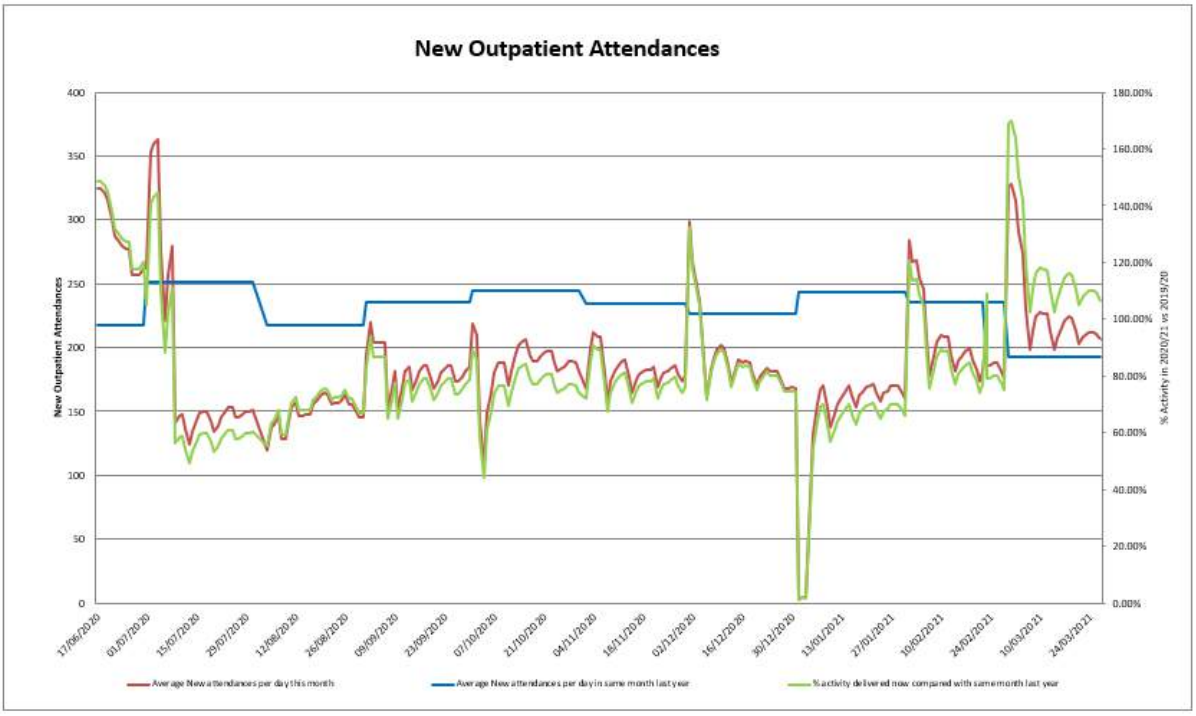


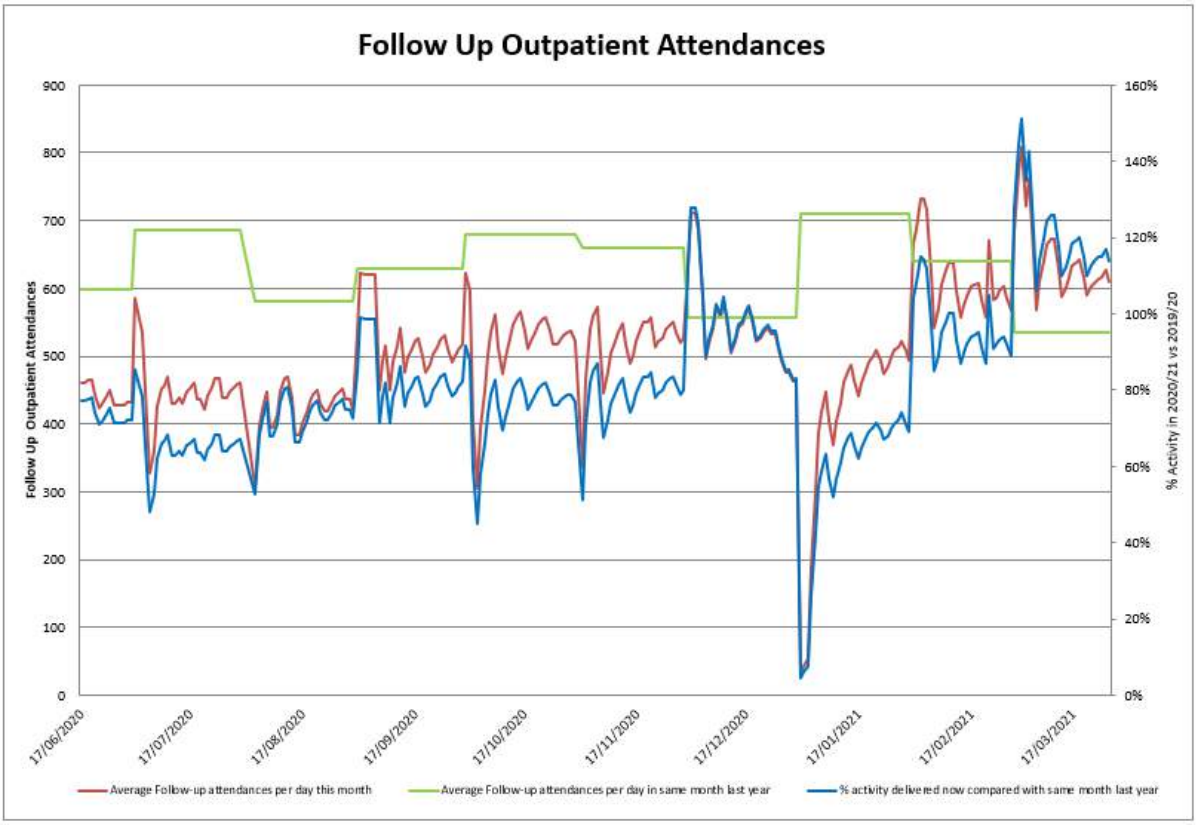
Narrative: The average number of elective inpatient admissions in February 2021 was 64.12% of the average number of elective inpatient admissions in February 2020.

The average number of elective daycase admissions in February 2021 was 74.39% of the average number of elective daycase admissions in February 2020.

Source: Trust Data

2.16 Outpatient Attendances



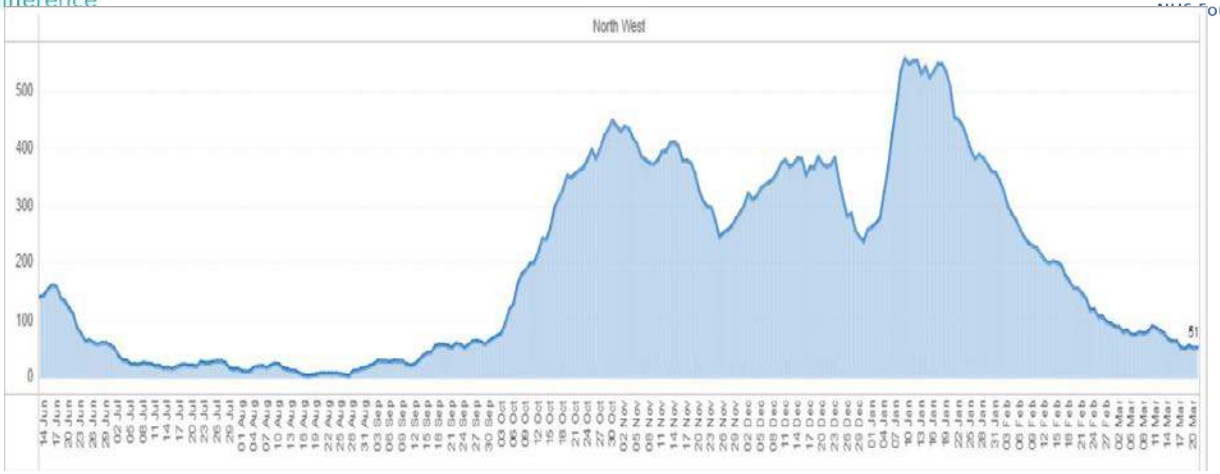


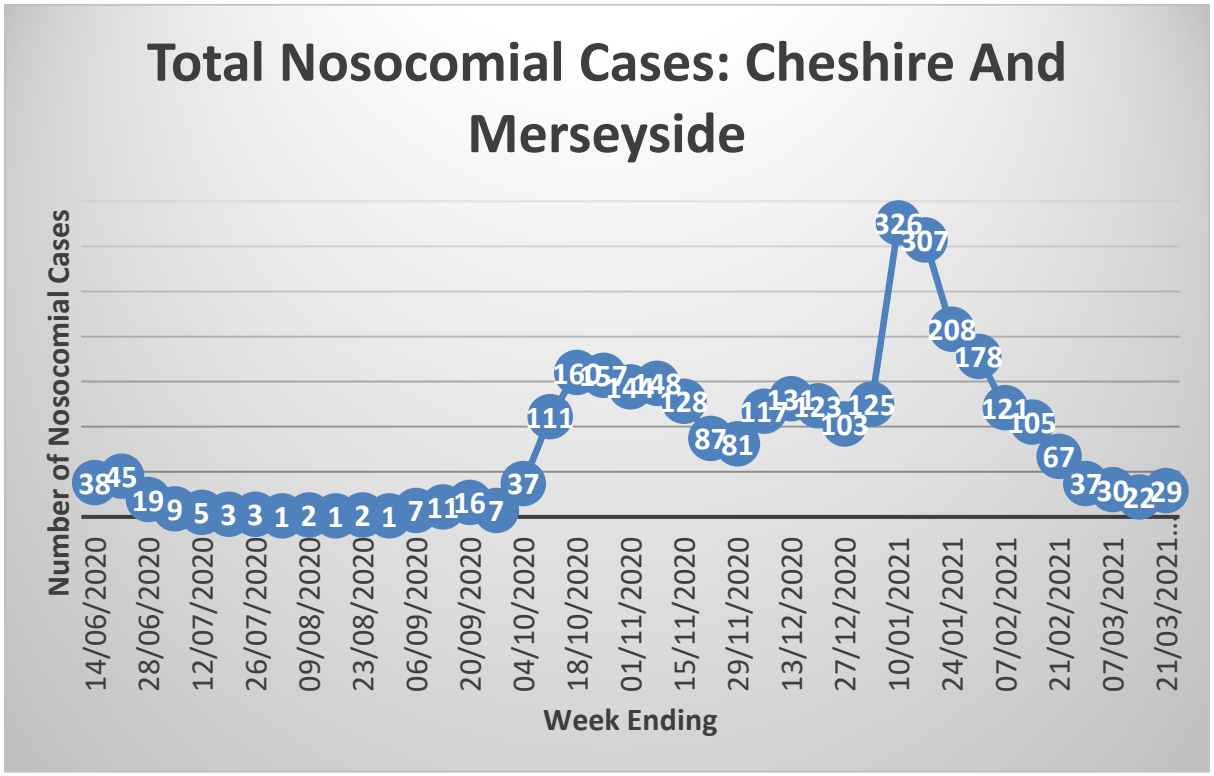
Narrative: The average number of new outpatient attendances in February 2021 was 86.88% of the average number of new outpatient attendances in February 2020.
The average number of follow up outpatient attendances in February 2021 was 96.33% of the average number of follow up outpatient attendances in February 2020.
Source: Trust Data

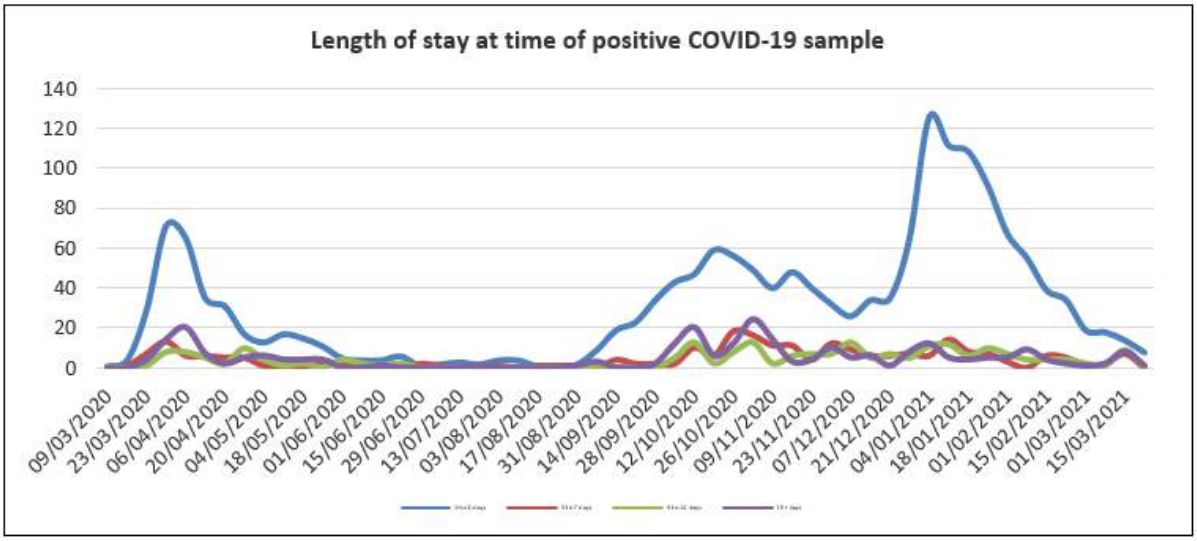
2.17 Nosocomial Infection

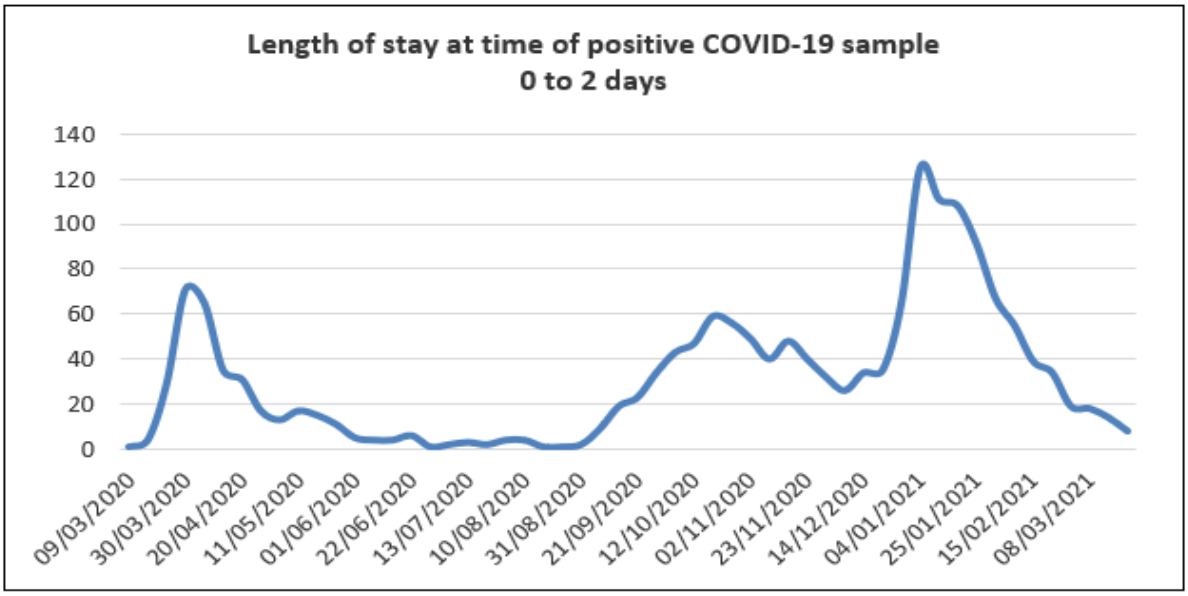
Nosocomial infections are defined as:

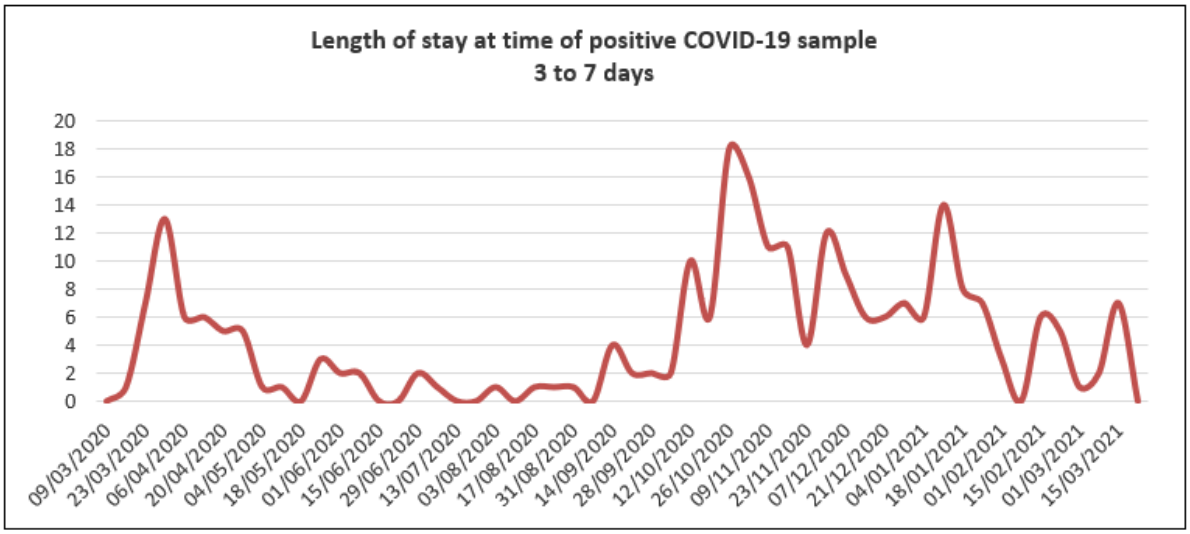
- Length of Stay at the Time of Positive COVID Sample 0-2 Days – Community Acquired
- Length of Stay at the Time of Positive COVID Sample 3-7 Days – Hospital Onset Indeterminable Hospital Associated
- Length of Stay at the Time of Positive COVID Sample 8-14 Days – Hospital Onset Probable Hospital Acquired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

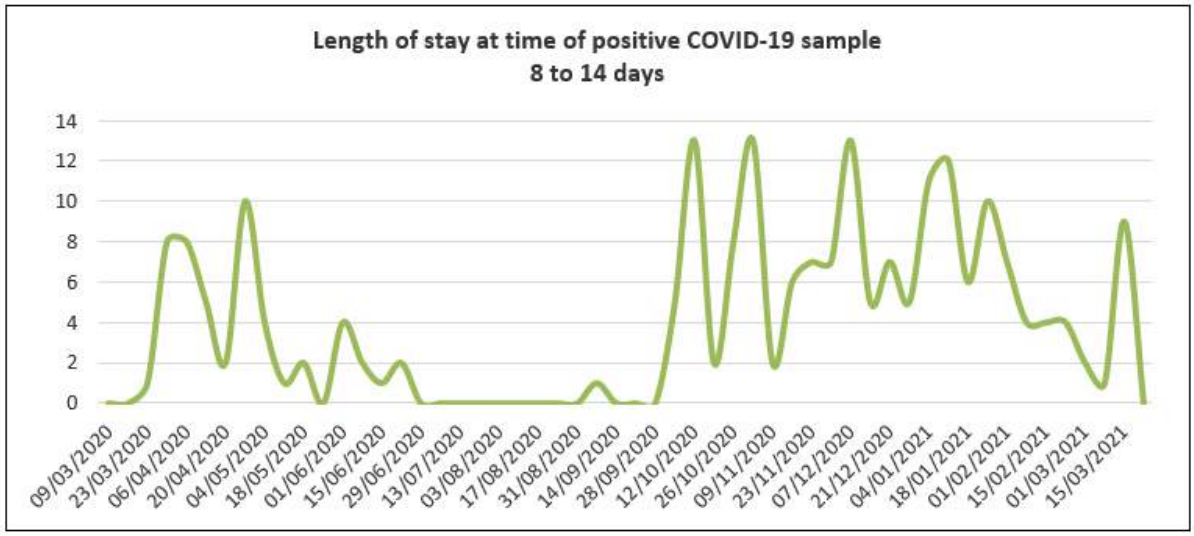

North West
500
400
300
200
100
0

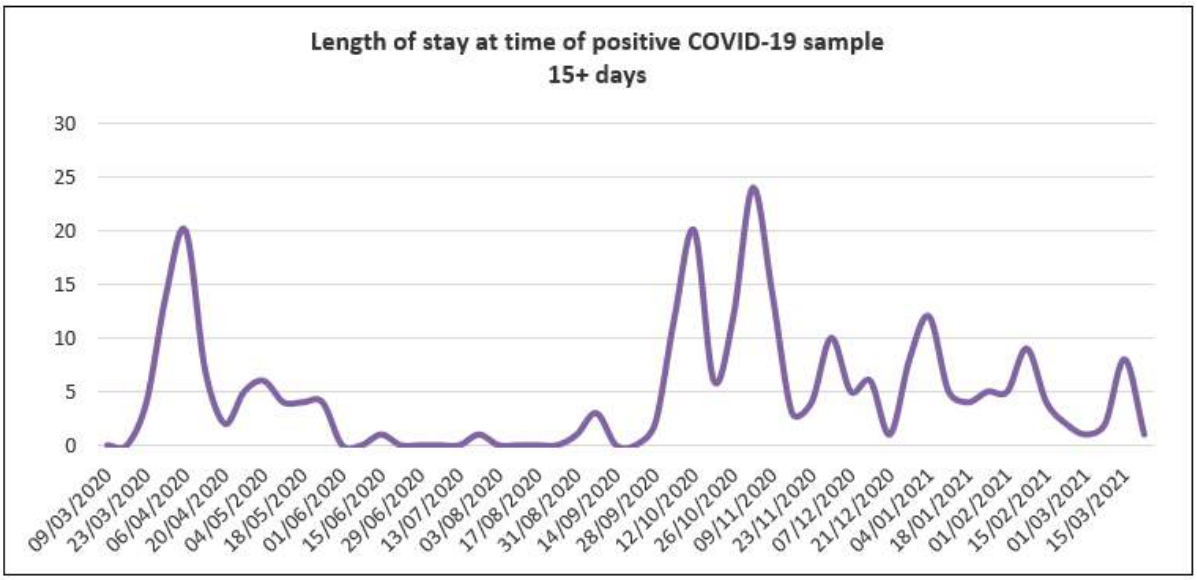

Total Nosocomial Cases: Cheshire And Merseyside
Number of Nosocomial Cases
Week Ending
14/06/2020
28/06/2020
12/07/2020
26/07/2020
09/08/2020
23/08/2020
06/09/2020
20/09/2020
04/10/2020
18/10/2020
01/11/2020
15/11/2020
29/11/2020
13/12/2020
27/12/2020
10/01/2021
24/01/2021
07/02/2021
21/02/2021
07/03/2021
21/03/2021...
38 45 19 9 5 3 3 1 2 1 2 1 7 11 16 7 37 111 160 157 144 148 128 87 81 117 131 123 103 125 326 307 208 178 121 105 67 37 30 22 29


Length of stay at time of positive COVID-19 sample
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


Length of stay at time of positive COVID-19 sample
0 to 2 days
140
120
100
80
60
40
20
0
09/03/2020
30/03/2020
20/04/2020
11/05/2020
01/06/2020
22/06/2020
13/07/2020
10/08/2020
31/08/2020
21/09/2020
12/10/2020
02/11/2020
23/11/2020
14/12/2020
04/01/2021
25/01/2021
15/02/2021
08/03/2021


Length of stay at time of positive COVID-19 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



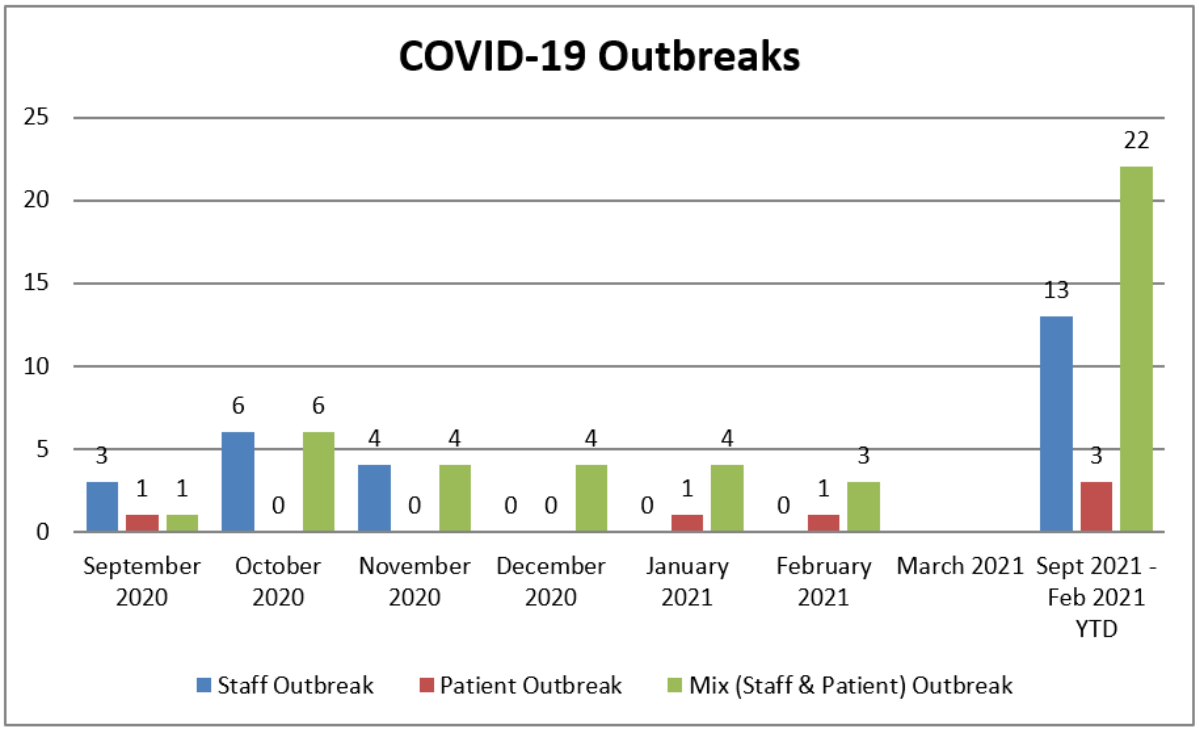


Narrative: The graphs show that the majority of the positive tests come within 2 days of admission or between 3-7 days of admission which suggest these infections were probably picked up in the community and brought into hospital. However, in the last 7 days, 0 infections were detected within 8-14 days which indicates probable hospital onset infection and 1 infection were detected after 15 days which suggests definite hospital onset infection.

Source: Trust Data

2.18 Outbreaks

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



Narrative: In February 2021, there were 4 outbreaks, 3 which were a mix of staffing and patient areas and 1 area was a patient only outbreak.

Source: Trust Data

3. CONCLUSION

The Executive Team will continue to monitor this data and will take immediate action as appropriate where concerns are noted in any area.

4. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/21/03/31a	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	31st March 2021	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Andrea McGee - Chief Finance Officer and Deputy Chief Executive Dan Moore - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #224 Failure to meet the emergency access standard.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has 72 IPR indicators which have been RAG rated in February as follows: Red: 31 (from 27 in January) Amber: 4 (from 6 in January) Green: 29 (from 31 in January) Not RAG Rated: 8 (from 8 in January) As a result of the COVID-19 pandemic, the Trust has not met the RTT 18 week, RTT 52 week, Diagnostics 6-week, Cancer 14 day, Cancer 31 day or Cancer 62-day urgent standards. Prior to COVID-19, the Trust had consistently met these standards. The Trust has established robust recovery plans in line with phase 3 planning guidance and clinical prioritisation is in place. The Trust will continue to utilise independent sector support and will engage in system conversations to seek out mutual aid in an effort to address the backlog. The Trust has ensured that processes remain in place to monitor and improve quality during the COVID-19 pandemic. Open Incidents are monitored and have significantly reduced by 90% with progress tracked weekly via	

	the Trust Meeting of Harm. CBUs continue to be supported to ensure the timely closure of incidents. There were no complaints open over 6 months old. For the period ending 28 February 2021 performance against the original £10.3m deficit plan is £0.2m from plan (adverse variance). The forecast plan of £16.6m deficit includes the impact of COVID-19 wave 2 and wave 3. The Trust has recorded a year to date deficit position of £6.3m against a deficit forecast of £6.4m. A revised forecast of £11.9m deficit has now been submitted in the month 11 NHSE/I financial return. The improvement from the previous forecast of £16.6m relates to additional income of £4.6m to support the income shortfall in the calculation of income top ups. As at 28 February 2021 the cash balance was £33.7m. PDC of £33.67m has been drawn down in March 2021 to support the cash position.			
PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Approve the expenditure and funding arrangements regarding the COVID-19 vaccine service. 2. Note the capital schemes approved as an emergency by the Chief Finance Officer & Deputy Chief Executive. 3. Note the capital schemes approved by the Finance & Sustainability Committee within its delegated limit in Table 3. 4. Note the increase in the underspend / contingency in Table 4 due to the availability of alternative funding streams, underspends and potential non-delivery of goods by 31 March 2021. The current forecast is c£1.9m under spend. 5. Approve the recommended changes to the Key Performance Indicators on the IPR for 2021/22. 6. Note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee Quality Assurance Committee Finance & Sustainability Committee		

	Agenda Ref.	SPC/21/01/05 QAC/21/03/63 FSC/21/02/33
	Date of meeting	SPC – 20th January 2021 QAC – 2nd March 2021 FSC – 17th February 2021 **FSC Capital Approval:** 22/02/2021 (Virtually) 03/03/2021 (Virtually) 12/03/2021 (Virtually) 24/03/2021
	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/21/03/31a

1. BACKGROUND/CONTEXT

The RAG ratings for all 72 IPR indicators from March 2020 to February 2021 are set out in **Appendix 1**. The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the Board with assurance in relation to the delivery of all Key Performance Indicators (KPIs) across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

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

Table 1: RAG Rating Movement

	January	February
Red	27	31
Amber	6	4
Green	31	29
Not RAG Rated	8	8
Total:	72	72

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

Due to the impact of COVID-19, 6 indicators cannot be RAG rated in month as the data is not available or not reportable. These are:

Access & Performance

- Ambulance Handovers 30-60 Minutes – data from the North West Ambulance Service was unavailable for February 2021.
- Ambulance Handovers 60 Minutes Plus – data from the North West Ambulance Service was unavailable for February 2021.

Finance

- Use of Resource Rating – UoR rating is not currently reportable. The Trust is awaiting further guidance from NHSE/I.
- CIP x 2 (In Year & Recurrent Plans in Progress) – CIP was suspended nationally during the pandemic. However, the Trust is now reporting CIP performance against plan and will recommence the reporting of the in year and recurrent plans in progress indicators in 2021/22.

- System Financial Position – system reporting across the Warrington & Halton system is currently on hold.

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

Quality

Quality KPIs

There are 4 Quality indicators rated Red in February, an increase from 2 in January.

The 2 indicators rated Red in January, which have remained rated Red in February are as follows:

- Incidents - There were 2 open incidents over 40 days old at the end of February, an improvement from 20 incidents at the end of January, against a target of 0. There was a 90.00% improvement in the number of open incidents over 40 days between January and February with continued oversight by the Head of Clinical Effectiveness. Performance has been impacted by the COVID-19 pandemic as clinical areas have been required to focus on providing direct patient care. All areas continue to be supported by the Governance Department and virtual meetings continue.
- Healthcare Acquired Infections (MRSA) – there was 1 case of MRSA reported in September, therefore this indicator will remain Red for the rest of 2020/21. No MRSA cases were reported in February.

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

- Pressure Ulcers – there were 5 category 2 and 1 category 3 pressure ulcers reported in February from 5 category 2 and 2 category 3 pressure ulcers reported in January. Therefore, year to date, the Trust has reported 63 category 2 pressure ulcers and 7 category 3 pressure ulcers which exceeds the 65 pressure ulcer baseline from 2019/20.
- Friends and Family Test (ED) – the Trust achieved 86.00% in February, a decrease from 87.00% in January, against a target of 87.00%.

Access and Performance

Access and Performance KPIs

There are 15 Access and Performance indicators rated Red in February, increased from 14 indicators in January. Performance against Access & Performance indicators has been significantly impacted by the COVID-19 pandemic.

The 13 indicators which were rated Red in January and remain rated Red in February are as follows:

- Diagnostic 6 Week Target – the Trust achieved 61.77% in February, an improvement from 55.24% in January, against a target of 99.00%.
- Referral to Treatment Open Pathways – the Trust achieved 71.71% in February, a deterioration from 72.73% in January, against a target of 92.00%.

- Referral to Treatment 52+ Week Waiting – there were 1,442 patients waiting over 52 weeks in February, a deterioration from 1,171 patients in January, against a target of 0. RTT and Diagnostic performance is as a result of the reduction in the elective programme, suspension of services and the associated backlog during the initial phases of the pandemic. The Trust has robust recovery plans with clinical prioritisation; however, these have been impacted by wave 2 and 3.
- A&E Waiting Times 4-hour National Target – the Trust achieved 76.82% (excluding Widnes Walk ins) in February, an improvement from January's position of 75.30%, against a target of 95.00%.
- A&E Improvement Trajectory – the Trust did not achieve the improvement trajectory of 85.00% in February.
- Cancer 14 Days – the Trust achieved 83.03% in January, a deterioration from 91.17% in December, against a target of 93.00%.
- Breast Symptomatic – the Trust achieved 78.26% in January, a deterioration from 89.66% in December, against a target of 93.00%.
- Cancer 62 Days Urgent - the Trust achieved 57.83% in January, a deterioration from 71.28% in December, against a target of 85.00%. This is due to patient choice and limited green operating capacity in January due to COVID-19 wave 3.
- Discharge Summaries % sent within 24 hours – the Trust achieved 83.21% in February, an improvement from 82.90% in January, against a target of 95.00%.
- Discharge Summaries not sent within 7 days – there were 7 discharge summaries not sent within 7 days in February, an improvement from 17 at the end of January, against a target of 0.
- COVID-19 Recovery Elective Activity – the Trust achieved 62.73% of inpatient elective activity and 75.89% of day case activity in February, against the target of 90.00% of activity in the same period in 2019/20.
- COVID-19 Recovery Outpatient Activity – the Trust achieved 84.79% of outpatient activity in February, against the target of 100% of activity in the same period in 2019/20.
- COVID-19 Recovery Diagnostic Activity – the Trust achieved 71.91% of MRI Activity, 105.44% of CT Activity, 91.88% of Non-Obstetric Ultrasound Activity, 119.69% of Colonoscopy Activity, 159.30% of Flexi Sigmoidoscopy Activity and 132.60% of Gastroscopy Activity in February, against the target of 100% of activity in the same period in 2019/20.

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

- Cancer 28 Day Faster Diagnostic - the Trust achieved 68.01% in January, a deterioration from 77.22% in December, against a target of 75.00%. This is attributed to availability of capacity for CT colon and Endoscopy over the period.
- Cancer 31 Days First Treatment - the Trust achieved 93.10% in January, a deterioration from 98.65% in December, against a target of 96.00%.

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

- Super Stranded Patients – there were 107 super stranded patients at the end of February, an improvement from 121 patients at the end of January against a trajectory of 110 patients.

The 2 Ambulance Handovers indicators (30-60 Minutes and 60 minutes+) have not been RAG rated in month as the information is unavailable from the North West Ambulance Service. The data has not been available since December 2020.

PEOPLE

Workforce KPIs

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

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

- Sickness Absence – The Trust's sickness absence was 5.47% in February, an improvement from 6.40% in January, against a target of less than 4.20%.
- Return to Work Compliance – interview compliance was 52.20% in February, a deterioration from 62.12% in January, against a target of 85.00%.
- Recruitment – the average time to recruit was 77 days over the last 12 months as of February, the same as January against a target of less than 65 days.
- Bank/Agency Reliance – The Trust's reliance was 19.15% in February, an improvement from 21.44% in January, against a target of less than 9.00%.
- Agency Shifts Compliant with the Cap – 19.86% of agency shifts were compliant with the cap in February, a deterioration from 21.52% in January, against a target of 49.00%.
- Agency Rate Card Compliance – 19.65% of agency shifts were compliant with the rate card in February, a deterioration from 22.31% in January, against a target of 60.00%.
- Monthly Pay Spend – monthly Trust pay spend was £1.3m above budget in February, reduced from £1.6m above budget in January.
- PDR Compliance – The Trust's PDR compliance was 52.11% in February, a deterioration from 54.94% in January, against a target of 85.00%.

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

- % Use of the Apprentership Levy – the Trust achieved 49.00% in February, a deterioration from 78.00% in January, against a target of 85.00%.

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

- Vacancy Rates – the Trust's vacancy rate was 8.44% in February, an improvement from 9.41% in January, against a target of less than 9.00%.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 3 Finance & Sustainability indicators rated Red in February, the same as January.

The 3 indicators which were rated Red in January and remain rated Red in February are as follows:

- Trust operating surplus / (deficit) – The year to date position is a deficit of £6.3m against a deficit plan of £6.1m. The position includes a retrospective top up of £20.1m to support COVID-19 expenditure and income loss of £26.4m year to date. It should be noted that the position is £0.1m better than the forecast deficit. The forecast deficit has been adjusted at the end of the month to include £4.6m non NHS income that is being awarded by NHSE/I in recognition of income the Trust was unable to receive this year. The deficit forecast has improved from £16.6m to £11.9m.
- Capital Programme – The actual spend year to date is £10.6m which is £6.0m below the planned spend of £16.6m. However, the Trust has committed orders of £9.0m. The Trust is forecasting an under spend of c£1.9m on the programme.
- Agency Spending – The agency spend in February was £2.0m which is £1.4m above plan. Year to date expenditure is £13.6m of which £7.9m relates to COVID-19.

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

During February, £3.3m of COVID-19 costs were incurred which is an average month. These were partly offset by underspends on recovery plans and the reduction in elective activity.

Vaccination Service

The COVID-19 Vaccination Service at Warrington Hospital will continue to run from 1 April 2021 to 30 September 2021 at an estimated cost of £1,029,983. The detailed costings have been presented to and supported by SEOG on 1 March 2021. The expenditure incurred in providing this service will be monitored by the Management Accounts team who will submit monthly returns to NHSE/I to enable full reimbursement of costs and therefore no financial impact on the Trust.

The Trust Board is asked to approve the expenditure and funding arrangements regarding the COVID-19 vaccine service.

Capital Programme

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

Table 2 - Capital plan and spend year to date

Capital	Annual Plan	Plan To Date	Expenditure to Date	Variance	RAG
	£000	£000	£000	£000	
Core Programme (1-5, 14, 15)	8,887	5,135	5,003	132	
MRI (PDC)	875	0	0	0	
Non COVID-19 Loan Programme	4,851	4,174	2,046	2,128	
Critical Infrastructure Risk (CIR) Funding	2,410	2,082	564	1,518	
A&E Plaza	1,000	800	301	499	
Phase 1 COVID-19	2,802	2,841	2,577	264	
Endo	592	444	12	432	
Critical Care	1,422	1,002	25	977	
Breast Screening	186	0	0	0	
Workforce Deployment Systems	133	0	0	0	
Critical Care	145	0	0	0	
Total Approved Capital Programme as at 17th February 2021	**23,303**	**16,478**	**10,528**	**5,950**	
Critical Care main programme (6)	(452)	0	0	0	
Critical Care – additional (7) Approved 22/2/21	116	0	0	0	
Phase 1 COVID-19 – additional (8)	39	0	0	0	
Phase 2 COVID-19 (9) Approved 22/2/21 and 12/3/21	2,883	0	0	0	
EPR In the Community (10)	39	0	0	0	
Rapid Testing (11)	30	0	0	0	
iPads (12)	15	0	0	0	
Vaccine Clinical Trials (13)	183	76	58	18	
Total Planned Capital Investment	**26,156**	**16,554**	**10,586**	**5,968**	

*In addition to the expenditure, there are also committed orders of £9m.

Changes to the capital budget approved as an emergency by the Chief Finance Officer and Deputy Chief Executive and by the Finance & Sustainability Committee as delegated by the Trust Board are noted in **Table 3.**

Table 3 – Changes to the Capital Budget

Changes approved as an emergency by the Chief Finance Officer & Deputy Chief Executive	**£000**
Halton Shopping city (1)	**11**
MRI knee coil (2)	**7**
Ultrasound transducer (3)	**8**
Resusitaire (4)	**10**
Cheshire House ramp (5)	**7**
Changes approved by the Finance & Sustainability Committee virtually on 22/02/2021, 03/03/2021 & 12/03/2021 as delegated by the Trust Board	
Critical Care MRI monitoring systems and pump (funded by MOU) (7)	**116**
COVID-19 phase 2 (funded by MOU) (9)	**2,883**
Halton Shopping city (15)	**72**
Changes approved by the Finance & Sustainability Committee on 23/03/2021 as delegated by the Trust Board	
Critical care reduction to the programme, which will be completed in 2021/22 (6)	**(452)**
Additional COVID-19 phase 1 (funded by MOU) (8)	**39**
EPR in the Community (funded by MOU) (10)	**39**
Rapid Testing kits (funded by MOU) (11)	**30**
Additional iPads (funded by MOU) (12)	**15**
Vaccine Clinical Trials (13)	**183**
CSTM Doors (14)	**13**

At month 10, it was assumed £0.4m would be the forecast underspend based on the remaining capital schemes being on plan. The changes shown in **Table 4** have been approved by the Finance & Sustainability Committee as delegated by the Trust Board and the revised estimate is £1.241m underspent, which equates to 4.00% of the total capital plan.

Table 4: Changes to the capital plan giving revised estimated underspend

Capital Movements	**£000**
February 2021 Forecast Underspend	**440**
Underspend on items ordered COVID-19 Phase 2	248
Ormis unable to spend in 2020/21	60
Labour screens unable to spend in 2020/21	100
Increase contingency from various underspends	118
Revised underspend	**966**
Modular expenditure (FSC approval)	(223)
Shopping City (FSC approval)	(72)
Revised underspend	**671**
Items on order classed as RED RISK TO DELIVERY	570
Estimated Underspend	**1,241**

The procurement team continues to chase suppliers to ensure delivery by 31 March 2021.

The Trust Board is requested to:

1. Approve the expenditure and funding arrangements regarding the COVID-19 vaccine service.
2. Note the capital schemes approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.
3. Note the capital schemes approved by the Finance & Sustainability Committee within its delegated limit in Table 3.
4. Note the increase in the underspend / contingency in Table 4 due to the availability of alternative funding streams, underspends and potential non delivery of goods by 31 March 2021. Current forecast c£1.9m under spend.

The Trust capital programme is attached in **Appendix 6**.

3. ANNUAL KEY PERFORMANCE INDICATOR REVIEW

2021/22 Key Performance Indicator Review

The Contracts & Performance Team has met with Executive and Operational leads to review current indicators and to ascertain requirements for new indicators. In addition, the 2021/22 draft NHS Standard Contract has been reviewed to understand changes which may affect performance monitoring. The recommendations outlined have been supported by the relevant committees as follows:

Indicators to be Removed

KPI	Rationale
Quality	
CQC Insight Composite Score	The CQC Insight Composite score has been retired by the CQC.
CAS Alerts	The Trust has maintained compliance with no CAS alert actions having breached the timescale in the two years since this indicator was introduced to the IPR. Therefore, it is recommended that this indicator is removed from the IPR. If the Trust does breach a timescale in the future, this will be reported to the Quality Assurance Committee and escalated to the Trust Board.
Access & Performance	
None.	
Workforce	
None.	
Finance	
None.	

Indicators to be Updated

KPI	Proposed Change	Rationale
Quality		
Inpatient Falls & Harm Levels	The RAG rating criteria is currently based on a 20% reduction from the number of falls in 2019/20. This is usually updated to the following year; however, it is recommended the reduction continues to be based on 2019/20 levels in 2021/22.	This is due to the impact of COVID-19. Benchmarking against 2020/21 would not be an accurate comparison due to the different inpatient profile.
Pressure Ulcers	The RAG rating criteria is currently based on a 10% reduction from the number of pressure ulcers in 2019/20. This is usually updated to the following year; however, it is recommended the reduction continues to be based on 2019/20 levels in 2021/22.	This is due to the impact of COVID-19. Benchmarking against 2020/21 would not be an accurate comparison due to the different inpatient profile.
Complaints	Removal of the "backlog" line from the graph.	The Trust no longer has a backlog and already monitors complaints over 6 months old.
Mixed Sex Accommodation Breaches	It is recommended this indicator is modified to split mixed sex accommodation breaches into ICU and non-ICU with the RAG rating amended to only include non-ICU related breaches.	The guidance states that exceptions to the Mixed Sex Accommodation Breaches standard is: • In the event of a life-threatening emergency. • Where critically ill patients need one-to-one nursing care in ICU. • Where a nurse must be physically present in the room/bay at all times e.g. in level 2 (high dependency care). Therefore, these patients should be excluded from the standard. All mixed sex accommodation breaches that the Trust has reported in the last 12 months have occurred in ICU.
Continuity of Carer	RAG rating to be amended to: Green: 51% or above (from 35% or above in 2020/21) Amber: 35%-50% (from 25%-34% in 2020/21) Red: Below 35% (from below 25% in 2020/21)	The national target set by NHS England was to achieve 35% by March 2021 and 51% by March 2022. The RAG rating has been updated to reflect the new standard. It is anticipated further national guidance will be provided to outline future milestones.
Access & Performance		
None.		

Workforce		
Turnover & Retention	For both Turnover and Retention, it is proposed to retain the existing standards which measure turnover and retention of all staff (both temporary and permanent). It is proposed to include an additional line on the graph to show turnover and retention of all permanent staff only.	Due to the impact of COVID-19, the Trust has had a significant number of temporary staff join the Trust to support ward/services during these challenging times. However, as these staff leave the Trust; it has a significant impact of retention and turnover. Including the additional information will accurately reflect the change in position of the Trust substantive workforce.
Core Training Role Specific Training PDPs	For 2021/22 only, the target of 85% for all three indicators will be replaced with an agreed improvement trajectory to bring the Trust back up to 85% in March 2022.	In line with National Guidance from NHS Employers (March 2020) and NHSE/I Guidance (January 2021), the Strategic Executive Oversight Group (SEOG) agreed a temporary pause on completion of Mandatory Training and Role Specific Training renewals for existing staff and a temporary pause on PDR completion for new and existing staff, where staff are unable to complete these due to the on-going COVID-19 response.
Finance		
None.		

New Indicators

KPI	RAG Criteria	Rationale
Quality		
Sepsis - % screening for all emergency patients.	Green: 90% or above Red: Less than 90%	To strengthen oversight of sepsis management regarding treatment and screening. Inclusion on the IPR will provide assurance to the Trust Board.
Sepsis - % screening for all inpatients.		
Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag sepsis.		
Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis.		
Access & Performance		
None.		
Workforce		
None.		
Finance		

None.

The proposed changes will result in the increase of the KPIs from 72 to 74 as follows:

	2020/21	2021/22
Quality	22	24
Access & Performance	25	25
Workforce	15	15
Finance	10	10
Total	**72**	**74**

The Trust Board is asked to approve the proposed amendments to the IPR Dashboard for 2021/22.

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
- Trust Operational Board
- Strategic People Committee

6. RECOMMENDATIONS

The Trust Board is asked to:

1. Approve the expenditure and funding arrangements regarding the COVID-19 vaccine service.
2. Note the capital schemes approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.
3. Note the capital schemes approved by the Finance & Sustainability Committee within its delegated limit in Table 3.
4. Note the increase in the underspend / contingency in Table 4 due to the availability of alternative funding streams, underspends and potential non-delivery of goods by 31 March 2021. The current forecast is c£1.9m under spend.
5. Approve the recommended changes to the Key Performance Indicators on the IPR for 2021/22.
6. Note the contents of this report.

Key

Improvement in Performance	↑
Deterioration in Performance	↓
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating March 2020 – February 2021

	KPI		Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21
	QUALITY													
1	Incidents		↓	↑	↑	↓	↑	↑	↓	↓	↑	↓	↑	↑
2	CAS Alerts		↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
3	Duty of Candour		↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
4	Healthcare Acquired Infections - MSRA		↔	↔	↔	↔	↔	↔	↓	↑	↔	↔	↔	↔
5	Healthcare Acquired Infections – Cdiff		↓	↑	↑	↑	↓	↑	↑	↓	↑	↔	↓	↑
6	Healthcare Acquired Infections – Gram Neg		↓	↑	↔	↓	↑	↓	↑	↓	↑	↑	↑	↓
7	Healthcare Acquired Infections – COVID-19 Hospital Onset & Outbreaks													
8	VTE Assessment		↑	↑	↑	↑	↑	↓	↓	↓	↑	↓		
9	Total Inpatient Falls & Harm Levels		↓	↑	↓	↓	↑	↓	↓	↓	↓	↑	↓	↑
10	Pressure Ulcers		↑	↔	↓	↑	↔	↓	↓	↑	↓	↑	↓	↑
11	Medication Safety (24 Hours)		↑	↑	↑	↑	↑	↓	↓	↑	↑	↑	↑	↓
12	Staffing – Average Fill Rate		-	-	-	↑	↓	↓	↑	↑	↑	↓	↑	↑
13	Staffing – Care Hours Per Patient Day		-	-	-	↑	↑	↓	↓	↑	↑	↓	↑	↑
14	Mortality ratio - HSMR													
15	Mortality ratio - SHMI													
16	NICE Compliance		↓	↓	↔	↑	↑	↑	↑	↑	↓	↑	↑	↑
17	Complaints												↔	↔
18	Friends & Family – Inpatients & Day cases		-	-	-	-	-	-	-	-	-		↔	↓
19	Friends & Family – ED and UCC		-	-	-	-	-	-	-	-	-		↑	↓
20	Mixed Sex Accommodation Breaches		↓	↔	↔	↔	↔	↓	↓	↑	↓	↑	↓	↔
21	Continuity of Carer		↑	↑	↓	↑	↑	↓	↓	↓	↑	↑	↓	↑
22	CQC Insight Indicator Composite Score		↓	-	-	-	-	-						

Key

Improvement in Performance	↕
Deterioration in Performance	↕
Static Performance	↔

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Appendix 1 – KPI RAG Rating March 2020 – February 2021

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

Key

Improvement in Performance	
Deterioration in Performance	
Static Performance	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating March 2020 – February 2021

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

Key

Improvement in Performance	↑
Deterioration in Performance	↓
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating March 2020 – February 2021

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

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

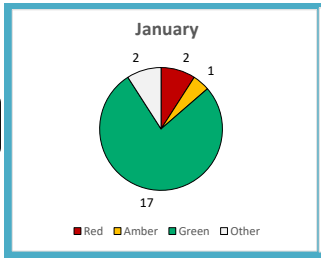
Warrington and Halton Teaching Hospitals NHS Foundation Trust

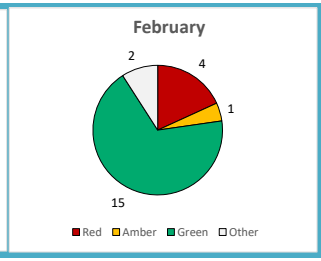
Integrated Dashboard - February 2021

Appendix 2

Key Points/Actions

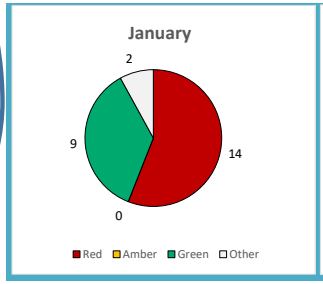
Quality Improvement

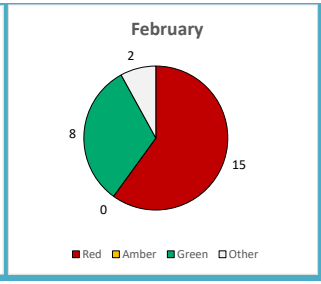




There were 159 open incidents that required review and sign off, of which 2 have been open over 40 days. Compliance in relation to Duty of Candour remains 100% in month. There were 2 cases of CDI (under review), 3 cases of E.coli, 0 cases of MRSA, 2 cases of MSSA, 3 cases of Pseudomonas aeruginosa and 1 case of Klebsiella reported in month. There were 5 category 2 pressure ulcers, 1 category 3 pressure ulcer and 0 category 4 pressure ulcers reported in month. There were 52 falls reported in month, of which 46 were inpatient falls. Medication reconciliation within 24 hours was 82.00% and overall reconciliation was 95.00%. NICE compliance was at 93.10%. There were 0 mixed sex accommodation breaches in month. Care Hours Per Patient Day was at 7.9. Continuity of Carer compliance was 57.40%. There were 0 open complaints over 6 months old.

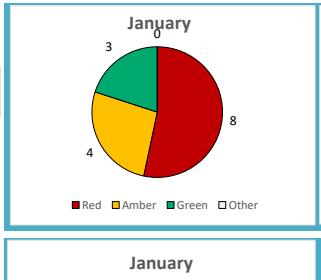
Access & Performance

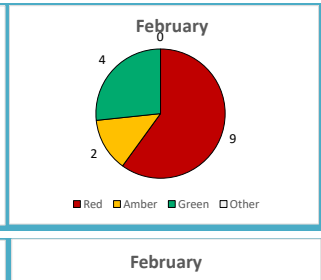




Performance against the Access & Performance standards has been significantly impacted by COVID-19. In February, the Trust did not achieve the RTT (71.71%) or the 6 week Diagnostic standards (61.77%). The Trust did not meet the 4 hour A&E standard (76.82%) or the improvement trajectory in month. The Trust did not meet the Cancer two week wait (83.03%), Breast Symptomatic (78.26%), 28 Day Faster Diagnostic (68.01%), Cancer 31 Day (93.10%) or Cancer 62 Day Urgent Standard (57.83%) in January 2021. The Trust did not achieve the 24 hour discharge summary standard (83.21%) or the 7 day standard. There were 0 patients whose operation was cancelled and not rebooked within 28 days. The number of operations cancelled on the day for non-clinical reasons has met the standard (0.11%). The number of Super Stranded patients (107) is better than the trajectory. The Trust did not meet the COVID-19 Phase 3 recovery plan in month.

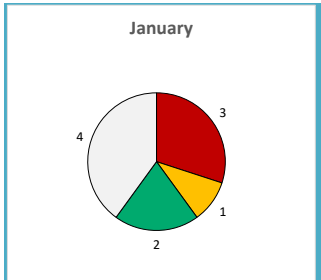
Workforce

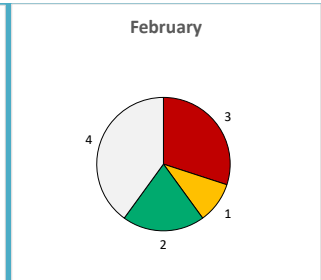




In February 2021, the Trust's sickness absence was 5.47%. Return to work compliance was 52.20%. Average recruitment timeframes over the 12 month rolling period are on target at 77 days. Turnover was at 12.62% and Retention was 87.79%. Vacancy rates were 98.44%. Bank and Agency reliance was 19.15%. Core Skills Training was at 82.43% with Role Specific Training at 82.79%. Agency shift compliance against the pay cap was at 19.86% and compliance against the rate card was 19.65%. Pay spend was £19.7m against a budget of £18.4m. PDR compliance was 52.11%. Use of the apprenticeship levy was 49.00% and the % of staff carrying out an apprenticeship qualification was 2.80%.

Finance





For the period ending 28 February 2021, performance against the original £10.3m deficit plan is £0.2m from plan (adverse variance). The forecast plan of £16.6m deficit includes the impact of COVID-19 wave 2 and wave 3. The Trust has recorded a year to date deficit position of £6.3m against a deficit forecast of £6.4m.
A revised forecast of £11.9m deficit has now been submitted in the month 11 NHSE/I financial return. The improvement from the previous forecast of £16.6m relates to a payment of additional income of £4.6m to support income shortfall due to calculation of income top ups. During February, £3.3m of COVID-19 costs were incurred. These were offset by underspends on recovery plans and reduced elective activity. The actual capital spend year to date is £10.6m which is £6.0m below the planned spend of £16.6m. However, the Trust has committed orders of £9.0m. Year to date agency spend was £13.6m of which £7.9m relates to COVID-19. Better Practice Payment Code was 90.00% in month which is 5.00% below the target of 95.00%, this was due to suppliers providing invalid PO numbers. As at 28 February 2021 the cash balance was £33.7m. PDC of £33.67m was drawn down in March 2021 to support the cash position.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

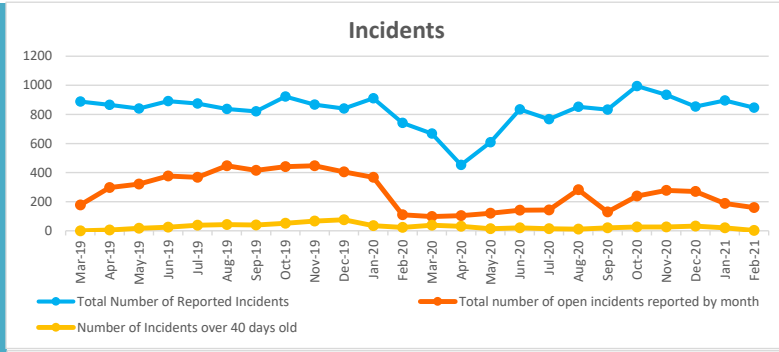
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Patient Safety

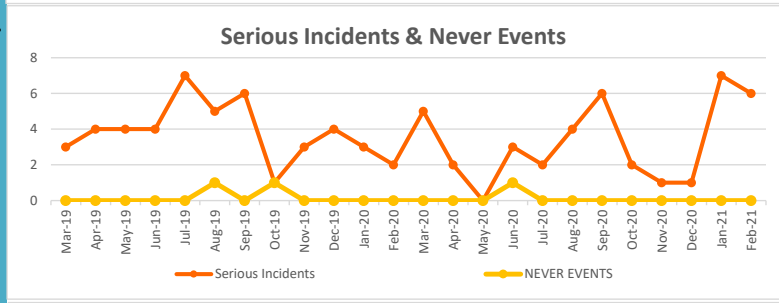
SOF CQC

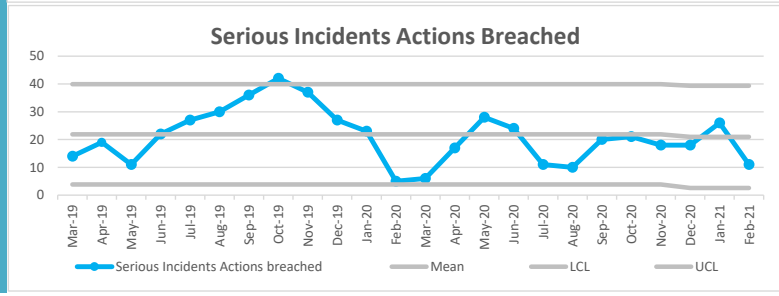
Incidents

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



There were 2 incidents over 40 days old open in February 2021 across the 6 CBUs and Clinical Support Services. This is a decrease of 90.00% compared to the previous month.





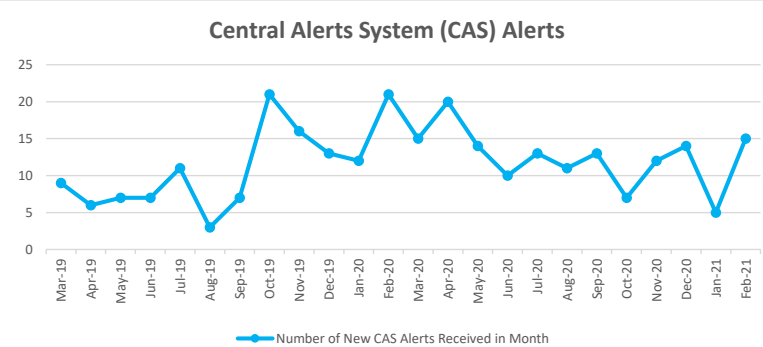
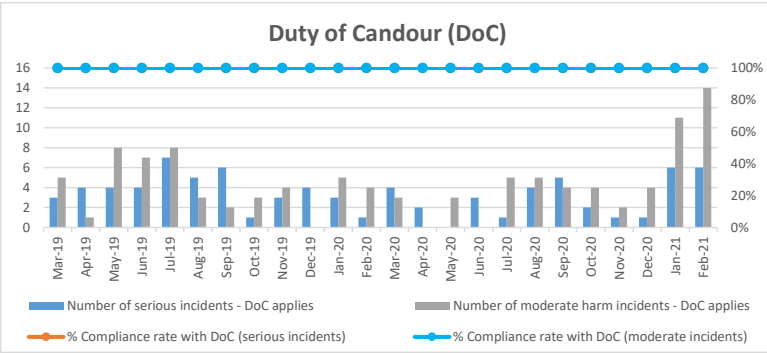
There were 6 Serious Incidents reported in February 2021. This is monitored via the Patient Safety & Clinical Effectiveness Sub-Committee in addition to the weekly Meeting of Harm. Clinical harm reviews are being undertaken.

Governance managers will continue to support the CBUs in reviewing and closing incidents with appropriate actions and evidence. This is monitored by the Patient Safety Manager and Head of Clinical Effectiveness with escalation as necessary to the Deputy Director of Governance. Weekly oversight of incidents and actions is provided at the Meeting of Harm.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

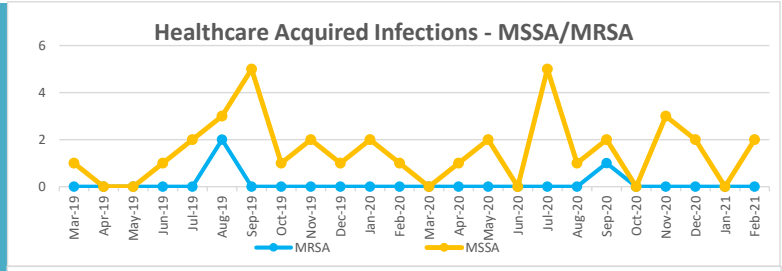
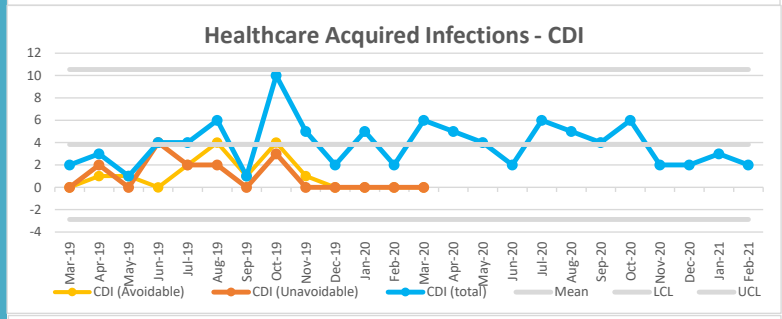
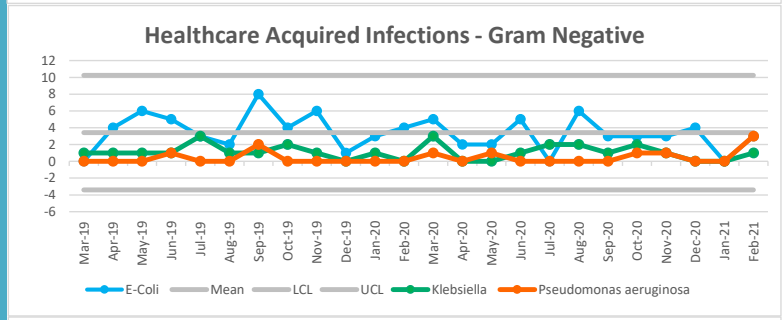
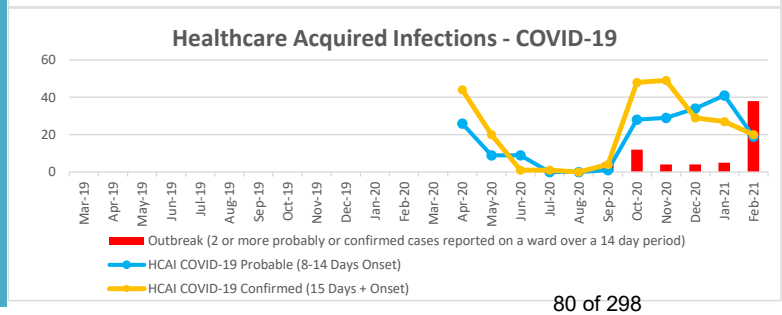
Quality Improvement - Trust Position

	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)?
CAS Alerts - Green - All relevant CAS Alerts actioned within timescales Red - Applicable CAS Alert not actioned within the timescale.	CQC The Trust received 15 CAS alerts in month with no action breaches.		There were 15 new CAS Alerts received in month. There were no CAS alert actions which have breached the timescale in month.	There is ongoing monitoring and oversight at the Health and Safety and Patient Safety and Effectiveness Sub-Committees to ensure the current position is sustained.
Duty of Candour Red: <100% Green: 100%	CQC The Trust achieved 100% for Duty of Candour in month.		Compliance with Duty of Candour remains in line with Trust policy at 100% compliance.	Training for senior managers and clinicians continues as part of clinical governance training, delivered by the Patient Safety Manager. Weekly scrutiny and monitoring is in place by the Patient Safety Manager.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

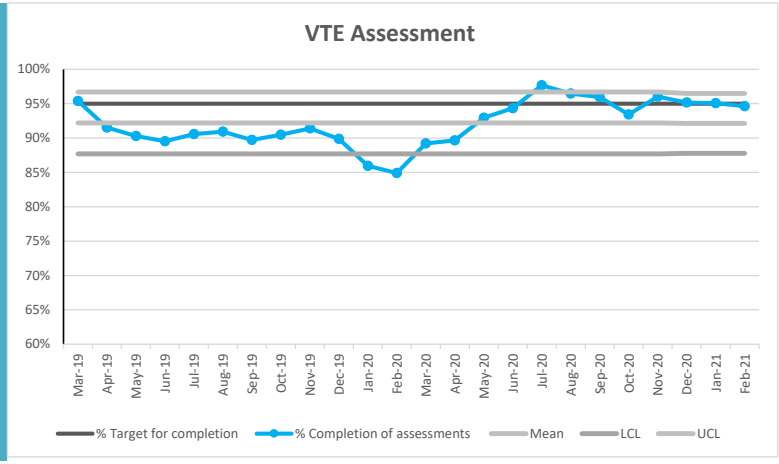
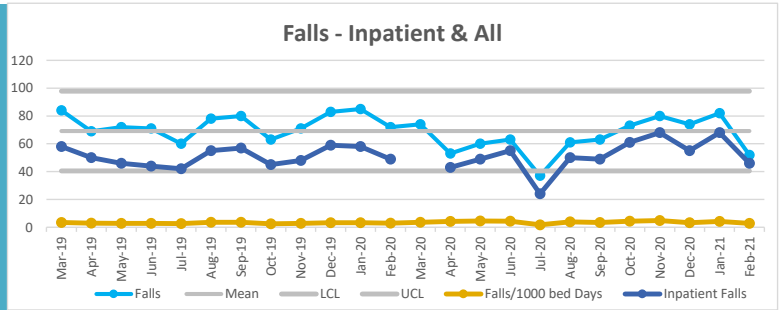
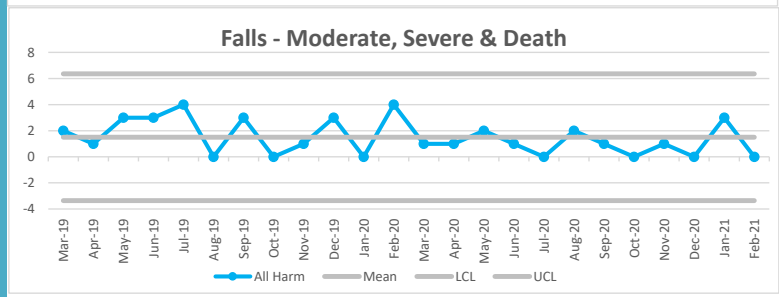
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Healthcare Acquired Infections **MRSA** **Red: 1 or more** **Green: 0**	**Healthcare Acquired Infection (HCAI) objectives have not been published nationally by NHSE/I for Gram Negative bloodstream infection reduction or C. difficile. The current RAG rating is based on 2019/20 thresholds.**		**In February 2021, the following cases were reported:** **MRSA - Nil, 1 reported YTD (in September).** **MSSA – 2 cases, 22 reported YTD** **CDI – 2 cases, 41 reported YTD** **E-Coli – 3 cases, 39 reported YTD** **Klebsiella – 1 case, 12 reported YTD** **Pseudomonas aeruginosa – 3 cases, 6 reported YTD.**	**Action plans are in place for the reduction of all HCAIs and will be applied throughout the COVID-19 recovery period. Plans will be reviewed and adapted according to Root Cause Analysis report findings.** **Robust processes are in place for COVID-19 admission, day 3 and day 5 testing with Infection Prevention and Control (IPC) guidance on isolation and Personal Protective Equipment (PPE).** **Learning for COVID-19 outbreaks is being shared Trust wide.**
Healthcare Acquired Infections **C-Difficile** **Red: 44+ per annum** **Green: Less than 44 per annum**				
Healthcare Acquired Infections - Gram Negative **E-Coli** **Red: 47+ per annum** **Green: Less than 47 per annum** **Pseudomonas aeruginosa & Klebsillea - No Threshold Set**				
Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks				

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

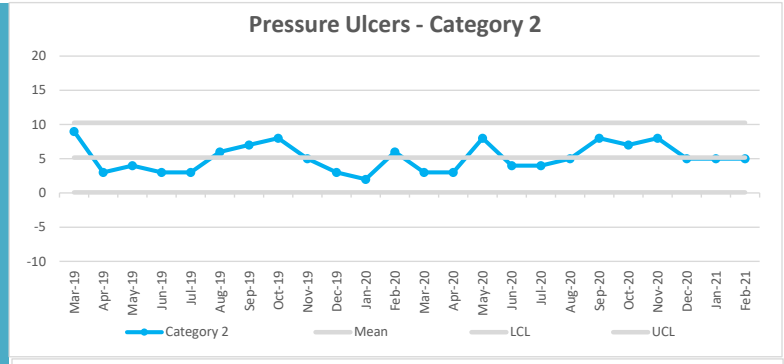
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
VTE Assessment **Red: <95%** **Green: 95% or above based on previous months' figures due to timescales for validation of data**	SOF, S **The Trust achieved 95.90% for VTE assessments on average in Q3 2020/21.** RR128		**The Trust achieved 94.64% for VTE assessments in February 2021. This is just below the quarterly target in month. An average for this indicator is reported quarterly in relation to the National Trajectory of meeting the 95.00% target for VTE.**	**Focused work, "check and challenge" is taking place with clinical teams to improve VTE electronic risk assessment compliance. Daily progress updates are escalated to clinicians, supported by the Associate Medical Director to ensure completion of risk assessments. Outstanding VTE assessments are communicated via the Trust Wide Safety Brief. A Clinical Data Capture (CDC) form on Lorenzo to document ward rounds is currently being piloted. This includes a prompt to complete a VTE risk assessment.**
Total number of Inpatient Falls & harm levels **Red: <10% decrease from 19/20** **Amber: 10-19% decrease from 19/20** **Green 20% or more decrease from 19/20**	CQC, S **There were a total of 52 falls in month; of which 46 were inpatient falls. There were no reported falls with harm.** RR120	 	**The themes identified were; Inappropriate selection of preventative device, Lack of recognition of enhanced care risk for semi independent patients and Increased demand for enhanced care.**	**Weekly falls meetings continue to learn and share themes. Safety messages are reinforced across the Trust via the Trust Wide Safety Brief with daily review of early learning. Falls quality improvement work will relaunch in March 2021 with the identified wards.**

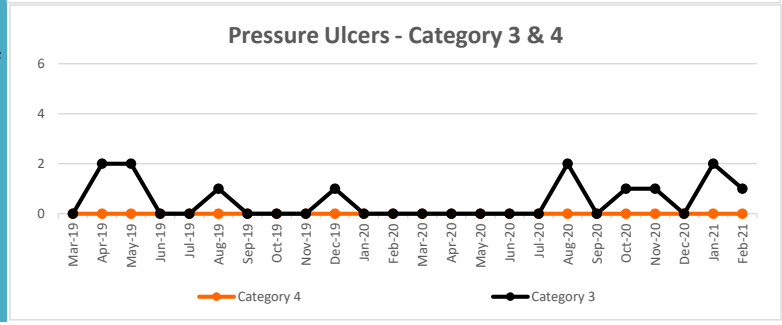
Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
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 5 hospital acquired Category 2 pressure ulcers, 1 Category 3 pressure ulcer and 0 Category 4 pressure ulcers reported in month. The Trust has had a total of 63 Category 2 pressure ulcers YTD, which is an increase of 26.00% compared to the same reporting period in 2019/20.	The Trust has seen an increase in device related pressure ulcers, in particular related to TED Stockings. The COVID-19 pandemic has impacted the number of pressure ulcers due to the increased numbers of critically ill patients that have required proning and non invasive ventilation.	Assessment of educational needs through a survey has been undertaken in the areas noted to have increased prevalence of pressure ulcers (related to TED stockings) with educational sessions arranged. A pilot of a new stocking is underway on A4 and A6. Education continues on the wards for the new mattresses and sessions are being provided by the supplier on Parafricta bootees which reduce the incidence of friction damage to heels. The single point lesson on 'preventing heel pressure ulcers' has been recirculated via Trust Wide Safety Brief. The Deputy Chief Nurse for Patient Safety has met with Lead Nurses from each CBU to provide assurance on measures in place to reduce the incidence of pressure ulcers in their areas. Quality improvement work will recommence in March with the identified wards.

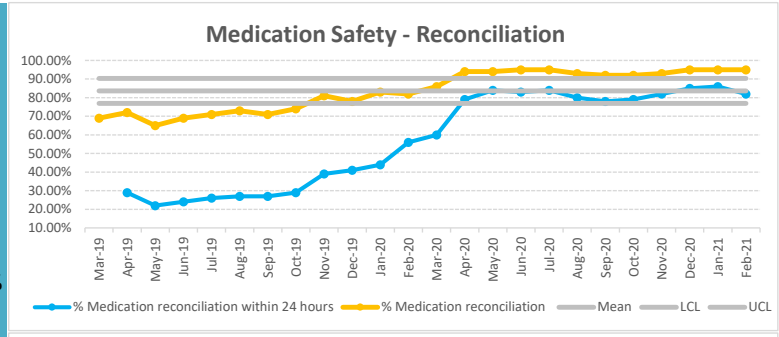
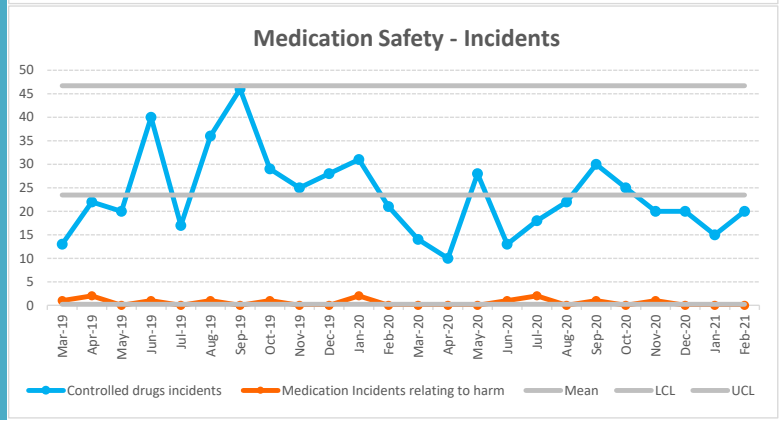
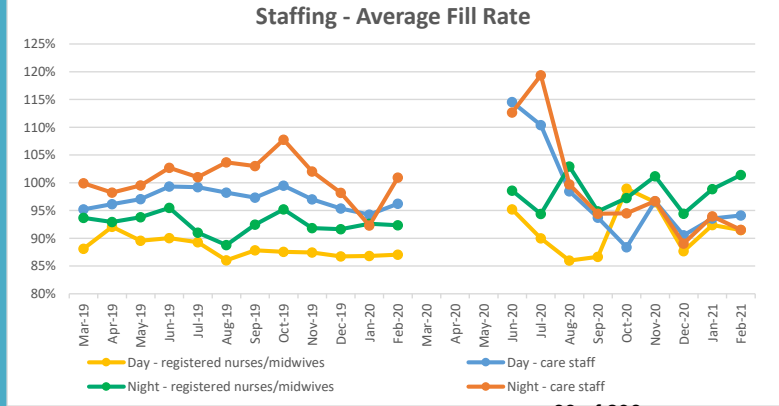




Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

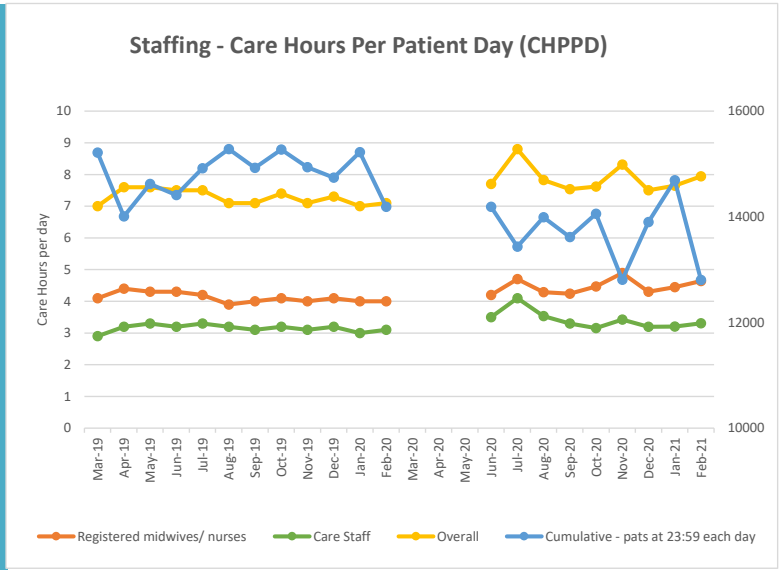
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Medication Safety Reconciliation within 24 hours Red: below 60% Amber: 60% - 79% Green: 80% or above	S, RR415 The Trust achieved 82.00% for medicines reconciliation within 24 hours and 95.00% for overall medicines reconciliation. There were no incidents reporting relating to harm. There were 20 controlled drug incidents.	 	Documentation in controlled drug registers is a key theme, however the roll out of a new controlled drug register may have reduced some documentation issues. The patient's own controlled drugs is an emerging theme. The data includes patients treated by the Independent Sector and more recently patients discharged onto the virtual ward.	2020/21 medicines reconciliation improvements has been achieved by targeting wards with new admissions. In the short term staffing overtime at weekends has been utilised, however a review of staffing to provide a consistent service in the emergency department 7 days per week as well as a weekend service in women's & childrens and pre-op is required. All incidents are reviewed to identify learning and any need for safety communications. Pharmacy controlled drug audits are undertaken 3 monthly to identify themes and actions; tracked by the Medicines Governance Committee. A monthly ward controlled drug check report is presented to the Operational Safety Group.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	RR115 In month the average staffing fill rates were: Day (Nurses/Mwife) 91.50% Day (Care Staff) 94.10% Night (Nurses/Mwife) 101.39% Night (Care Staff) 91.50%		11 of the 21 wards reported staffing levels under 90.00% in February 2021 for registered nurses in the day. On night shifts, this reduced to 3 wards out of the 21. HCA fill rates on days reported 9 wards out 21 under the 90.00% fill rate and 8 wards on nights. The fill rate percentage has shown a slight improvement this month as shift fill improved through bank and agency. Additional beds for the COVID-19 pandemic and increased staff absence remains a factor.	Staffing is reviewed twice daily by the senior nursing team and staff are moved based on acuity and activity to ensure safe patient care at all times. All wards have senior nurse oversight by a Matron and Lead Nurse, who will remain on the ward to support if required.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

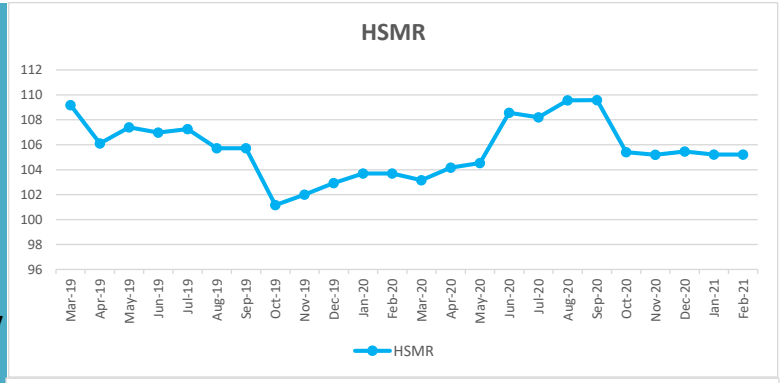
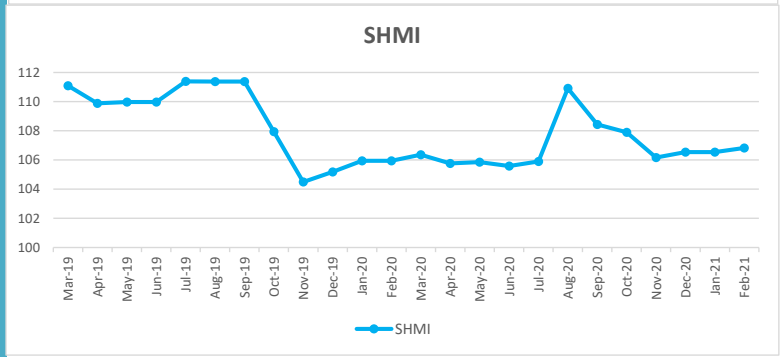
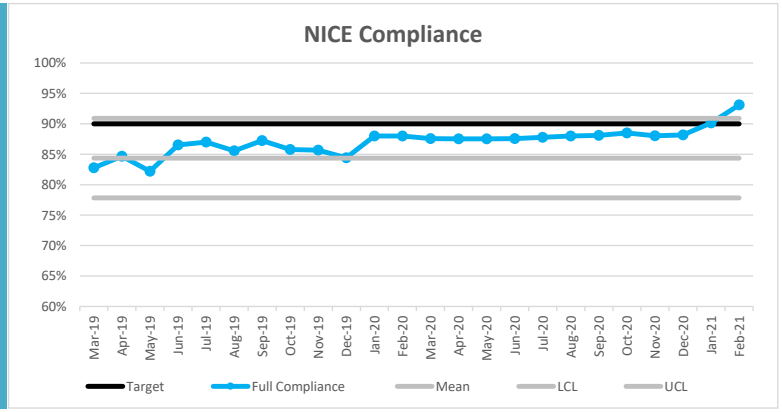
Quality Improvement - Trust Position

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)?
Staffing - Care Hours Per Patient Day (CHPPD) Red: Below 6.0 Amber: 6.0 - 7.8 Green: 7.9 or More	RR115 In month, the average CHPPD were: Nurse/Midwife: 4.6 hours Care Staff: 3.3 hours Overall: 7.9 hours		In February 2021, CHPPD was recorded at 7.9 in month with a 2020/21 YTD figure of 7.8, against the national median rate of 9.1 and peer organisation rate of 8.3.	Ward staffing levels continue to be systematically reviewed, which includes Planned vs. Actual staffing levels. These are reported monthly as part of the Unify submission and any ward that falls below 90.00% provides mitigation to ensure safe, high quality care is consistently being delivered in those areas.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework (SOF) | Risk Register (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)?
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	CQC SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 105.22. The Summary Hospital Level Mortality Indicator (SHMI) ratio in month was 106.83.	 	HSMR and SHMI remain within expected range.	Mortality reviews will continue to be undertaken alongside the governance incident process to ensure triangulation and learning. The Trust Mortality Lead post has now been recruited to in order to support the learning from deaths agenda.
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected				
NICE Compliance Red: Below 75% Amber: 75% to 89% Green: 90% or Above	SOF The Trust achieved 93.10% in month.		The Trust continues to increase compliance against NICE guidance and has robust processes in place to review and address.	The Trust aims to continue to maintain compliance above 90.00%.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

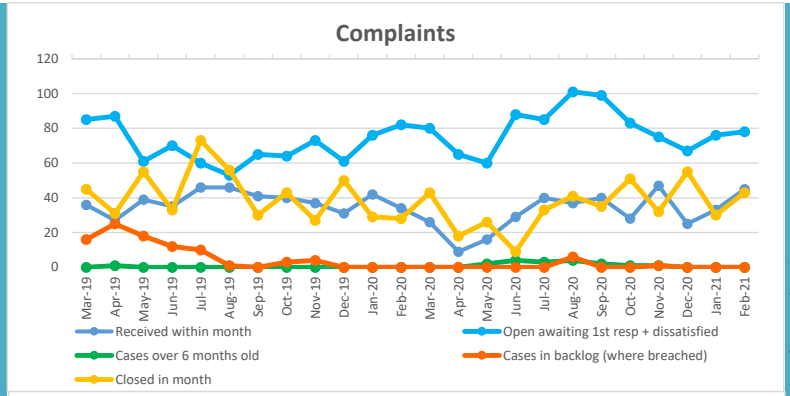
Quality Improvement - Trust Position

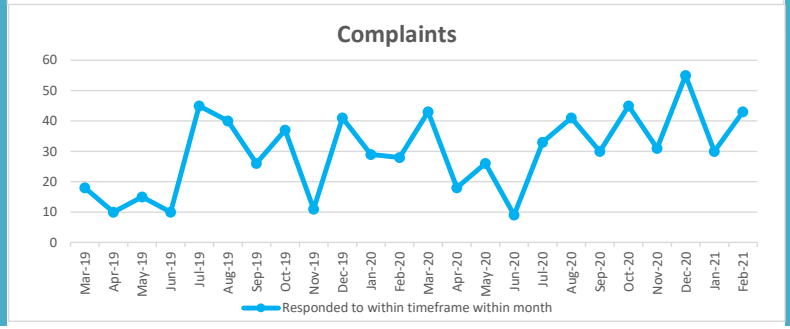
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Patient 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 February, there was a 36.00% increase of new complaints into the Trust. The Trust has maintained the timely closure of complaints, closing 100% within timeframe. There were 78 open complaints, with no complaints open over 6 months old. This is a 2.6% increase in open complaints from January 2021.





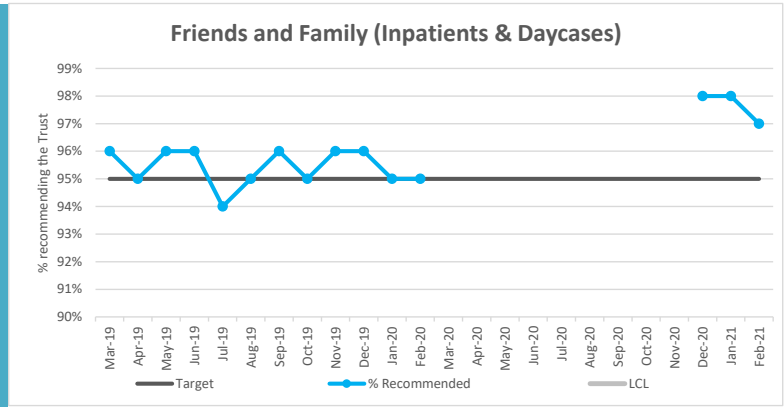
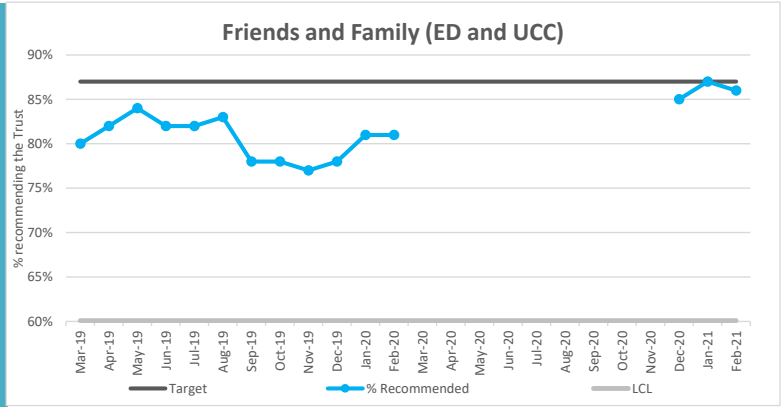
During February 2021, 43 complaints were closed, an increase of 43.00% from January. All complaints were closed within the required timeframes. The Trust maintained performance in the timeliness of responding to complaints. CBUs continue to work closely with the Complaints Team with effective escalation processes in place.

The complaints service continues to be overseen by the Associate Director of Governance and Compliance. Daily complaints progress reports and weekly performance reports are reviewed by the Associate Director of Governance and Compliance with escalation as appropriate to the Deputy Director of Governance. The increase in the number of complaints is carefully being monitored with appropriate plans in place.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

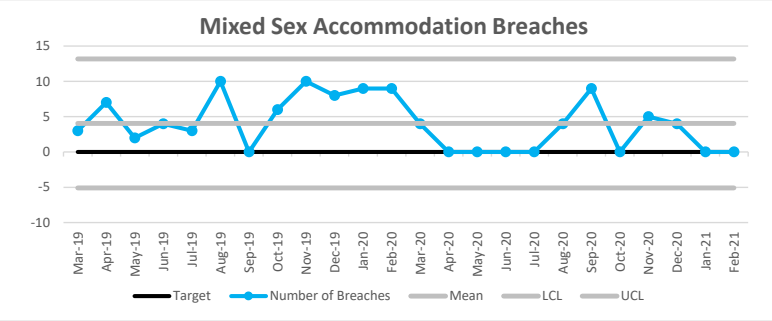
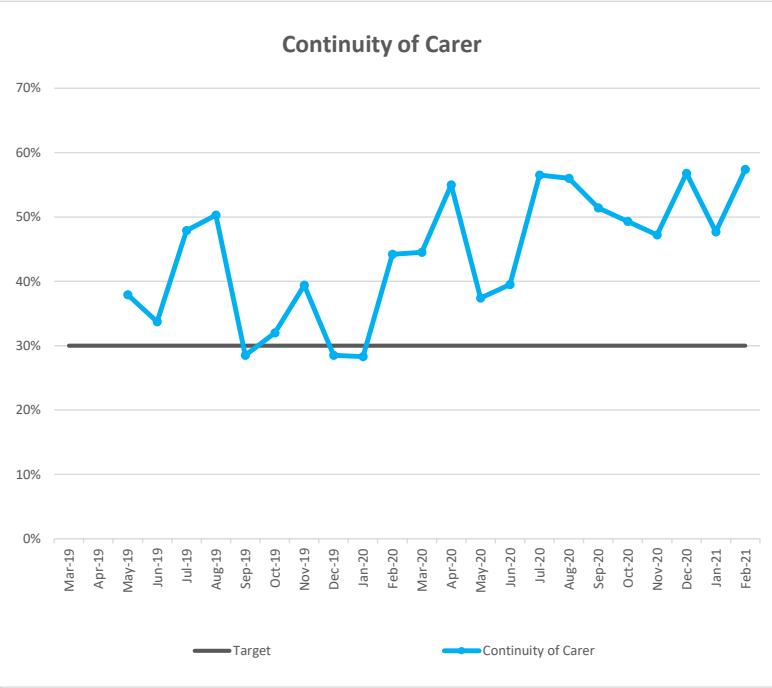
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	SOF CQC S The Trust achieved 97.00% in month.		The Trust has met the standard set of 95.00% recommendation rate. The Trust recommenced FFT surveys in line with national guidance. The Trust achieved 97.00% recommendation rate in February 2021.	CBUs provide a high level briefing paper to the Patient Experience Sub-committee monthly, detailing FFT recommendation rates and FFT feedback response. Recommendation rates continue to be monitored through Quality Metric reports.
Friends and Family (ED and UCC) Red: Less than 87% Green: 87% or more	SOF CQC S The Trust achieved 86.00% in month.		The Trust achieved 86.00% recommendation rate against a target of 87.00%. This is in response to the increased attendance in A&E and an impact on wait times.	Alternative methods of gathering feedback within Urgent & Emergency Care have been implemented, such as online via IPads to increase the chance of real time or near real time feedback.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	SOF There was 0 mixed sex accommodation incidents during February 2021.		There was 0 MSA breaches reported in February 2021. National Trajectory: The Trust met the national target of 0.	Patients are cohorted to minimise breaches and step down is expedited as soon as is practicable.
Continuity of Carer Green: 35% or Above Amber: 25% - 34% Red: below 25%	The NHSE target for women being booked onto a continuity of carer pathway has been amended. By March 2021 the target is for over 35.00% of all women to be on an all pregnancy pathway continuity model by 29 weeks pregnant. In February 68.00% 'in area' women are booked onto such a pathway, if 'out of area' bookings are included the figure is 57.40% as we cannot provide the postnatal aspect of the pathway. The provision of the full pathway to 47.70% of women is a significant increase from the estimated figure in April 2020 of 11.00%.		The Trust achieved 57.40% in February 2021 for all women. The Trust is on target for March 2021.	New care new models have been developed by the CBU to enable the Trust to deliver 100% against the Continuity of Carer standard 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). Accordingly, new models will require investment in staffing for which a business case is being progressed.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

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

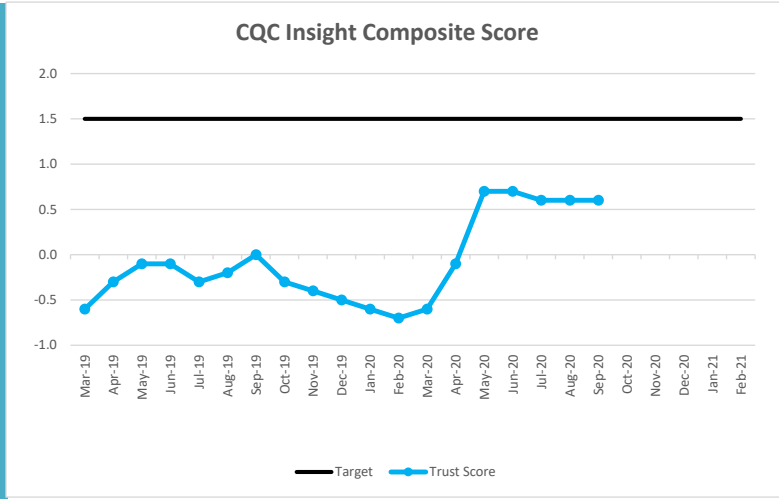
CQC

CQC Insight Composite Score

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

CQC | RR115

The Insight Report has recommenced in January 2021 but recording of the Composite Score has now retired.



A Moving to Outstanding Operational Task & Finish Group has been established to underpin the following six steps agreed by Executives to formulate a refreshed plan for the Trust.

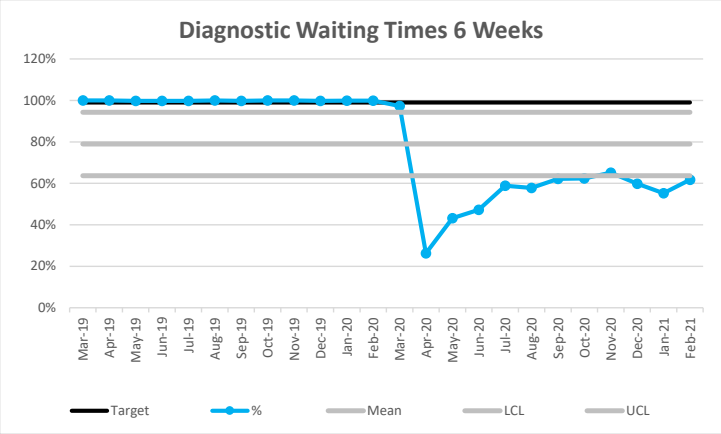
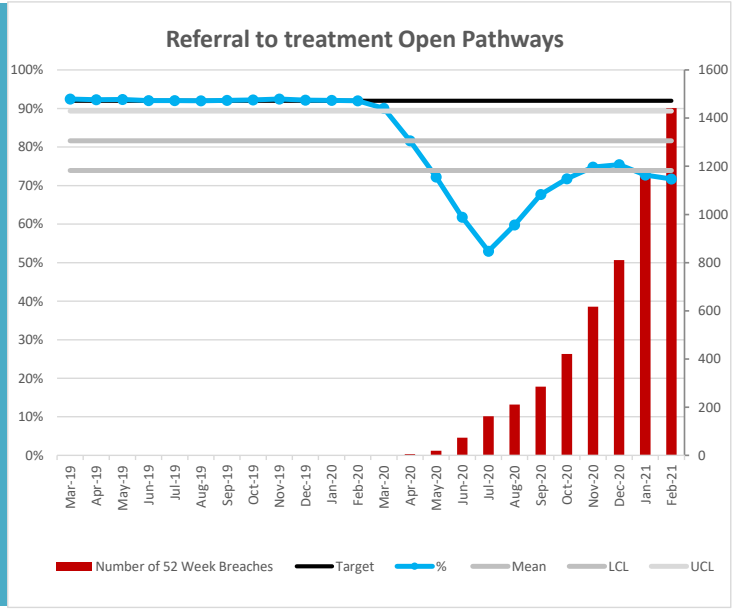
- **Consideration of how CQC's new regulatory approach will impact the Trust**
- **An assessment of where we are now**
- **Identification of steps needed to achieve compliance with linked actions to move WHH to outstanding**
- **Establishment of work streams**
- **Continued monitoring arrangements**
- **Throughout the above five steps consideration needs to be given to staff engagement in the process**

The six steps will support the Moving to Outstanding Steering Group to deliver the Trust's vision for 'Moving to Outstanding'.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

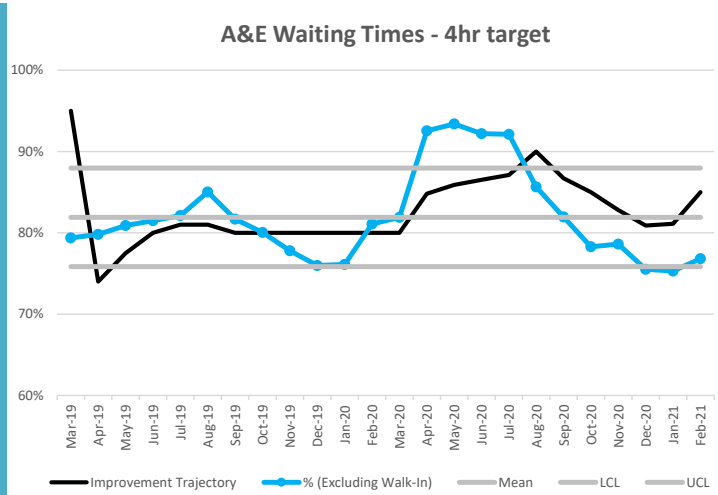
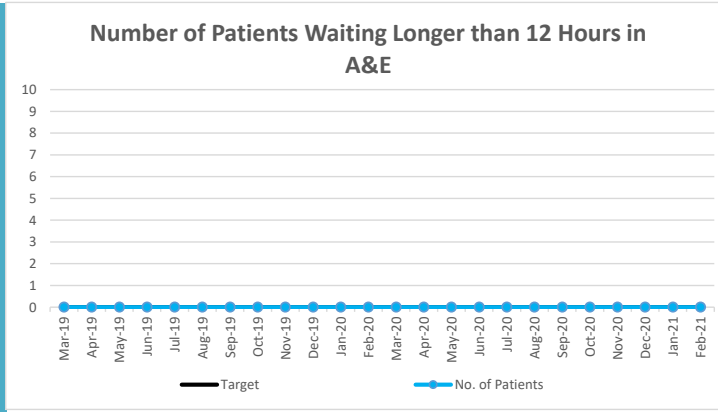
Key:
Risk Register RR116
Single Oversight Framework SOF
Care Quality Commission CQC

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	SOF CQC The Trust achieved 61.77% in month. RR116		The diagnostic standard was not achieved in February 2021, this was due to the impact of the COVID-19 pandemic. The position worsened in January attributable to the impact of wave 3, but has since improved in February.	A recovery plan has now been agreed and patients are being clinically prioritised accordingly in line with national guidance. The recovery plan is demonstrating that the actions agreed are delivering recovery with fewer breaches recorded as services are brought back on-line. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although there has been good progress in radiological modalities, challenges remain in Endoscopy, Cardiorespiratory and Cystoscopy.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or above RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red	SOF CQC The Trust achieved 71.71% in month. There were 1442, 52 week breaches in February 2021. RR116		The restoration of elective activity and clinical services has continued to be impacted by Wave 2 and Wave 3. Elective activity for P1 and P2 patients has been maintained on site and with support from the independent sector. The number of patients waiting 52 weeks + at the end of February was at 1442.	Recovery of the elective programme is taking place with: • Urgent cancer and elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of vulnerable patients. • Elective capacity has been restored at the Halton Elective Centre and Captain Sir Tom Moore Centre. • The Trust continues to utilise Independent Sector Capacity. • Restoration and recovery plans for 2021/22 are currently being drawn up in line with Cheshire & Mersey planning.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

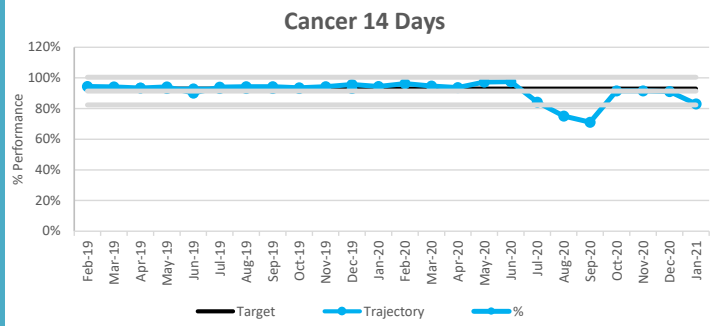
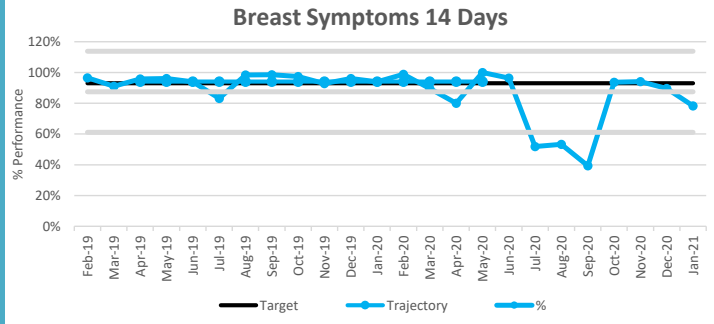
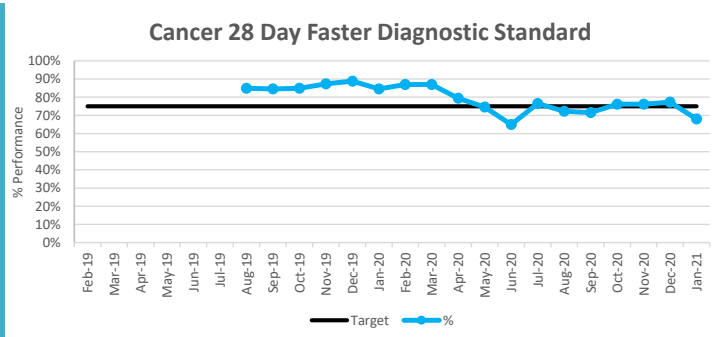
Key:
Risk Register RR116
Single Oversight Framework SOF
Care Quality Commission CQC

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Four Hour Standard - National Target Red: Less than 95% Green: 95% or Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory	SOF CQC The Trust achieved 76.82% excluding walk ins in month. RR224		There was a modest improvement in performance from January to February to 76.82% (excluding Widnes Walk-in activity). This is attributable to the ongoing impact of the pandemic, particularly that of Wave 3 during the month. Additionally, the ED footprint remains impacted by the pausing of the ED plaza works following instruction from NHSE/I.	• System partners have been engaged to support the reduction of Super Stranded patients in the bed base to create capacity to support flow. • The actions developed in response to the Royal College of Emergency Medicine guidance, Resetting Emergency Department Care, continue to be taken forward and monitored. • Additional beds remain open on the Halton site to support bed capacity and flow.
The number of patients who has experienced a wait in A&E longer than 12 hours from the decision to admit. Green = 0 Red = > 0	SOF There were 0 patients waiting longer than 12 hours in A&E in month.		The Trust has achieved the standard of not having any patients waiting longer than 12 hours from the decision to admit in February 2021. This standard has been consistently achieved over time.	Maintain compliance against the 12 hour standard from the decision to admit.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 14 Days Red: Less than 93% Green: 93% or above		The Trust did not achieve the 2 week wait standard in January 2021. This is attributed to a surge in the number of referrals at the end of December that couldn't be accommodated over the festive period. However, it should be noted that there has been significant improvement since the appointment of a new locum in the Breast service at the end of August. The position is impacted by the availability of capacity due to COVID-19.	The Trust will continue to review capacity. Early review of February data indicates an improvement in performance.
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above			
28 Day Faster Cancer Diagnosis Standard Red: Less than 75% Green: 75% or above		The Trust continues to participate as the test site for the 28 day Faster Diagnosis standard as part of the clinical review of all cancer access standards. The Trust failed to achieve the standard in January 2021 with 68.01% against a target of 75.00%. This is attributed to availability of capacity for CT colon and Endoscopy over the period. In addition patient choice associated with the festive period was also a factor.	Continue to maintain improvement against the FDS clinical review of standards pilot. Early review of February data confirms improved compliance against the standard.

The Trust achieved 83.03% in January 2021.

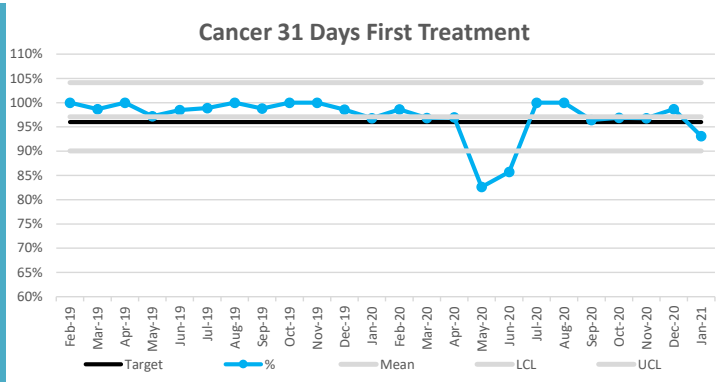
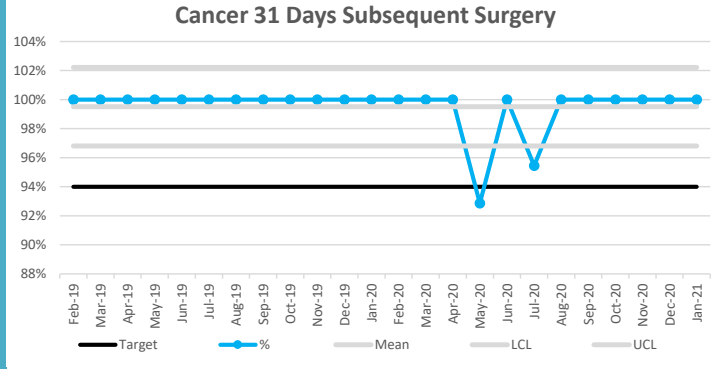
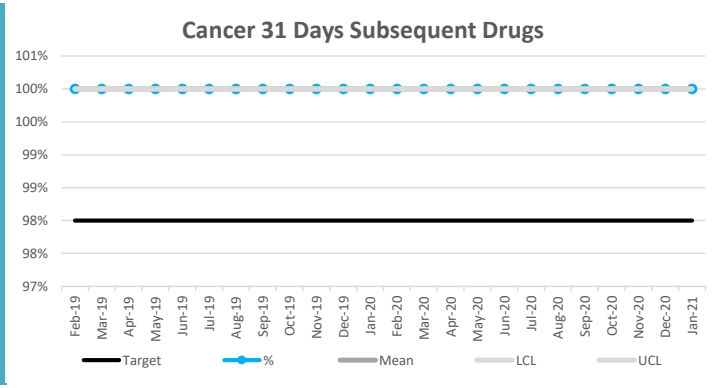
The Trust achieved 78.26% in January 2021.

The Trust achieved 68.01% in January 2021.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

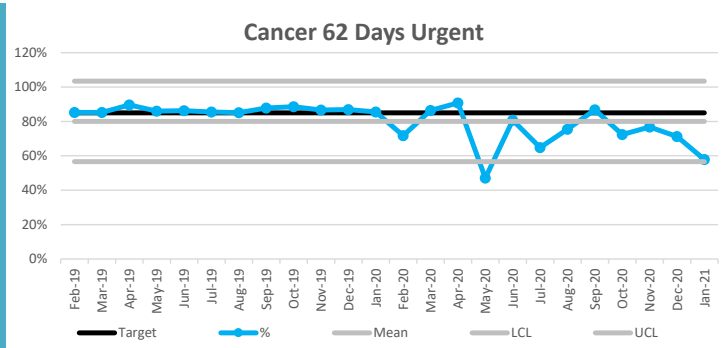
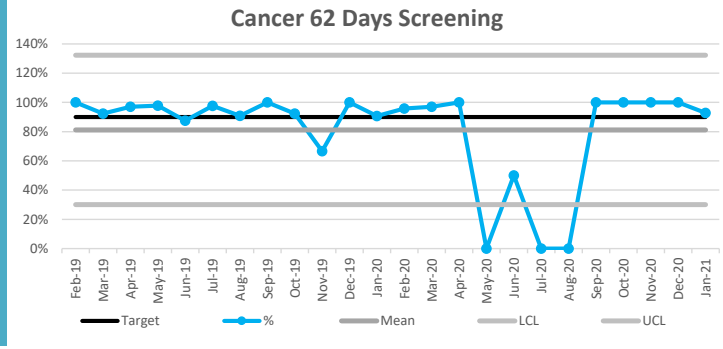
Key:
Risk Register RR116
Single Oversight Framework SOF
Care Quality Commission CQC

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above		The 31 day cancer target was not achieved in January 2021 at 93.10% This was the result of a some patients choosing not to have their procedures over the festive period. In addition, there was limited green pathway operating in January as a consequence of the impact of Wave 3 COVID-19 and B18 being repurposed. In addition, given the rise in community transmission of COVID-19 the guidance for preoperative self isolation was increased. This meant the rescheduling of some procedures.	There remains a risk for performance due to the impact of the pandemic. Early review of February data suggests indicates an improvement on January's performance.
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above			
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above		The Trust achieved 100% in January 2021.	Maintain compliance against the 31 day subsequent treatment (drug) standard.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

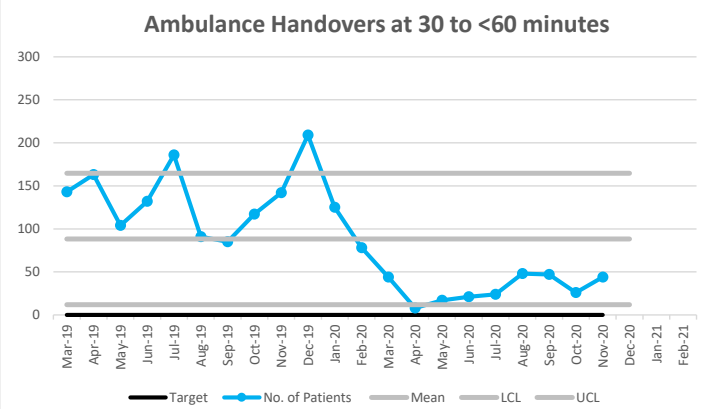
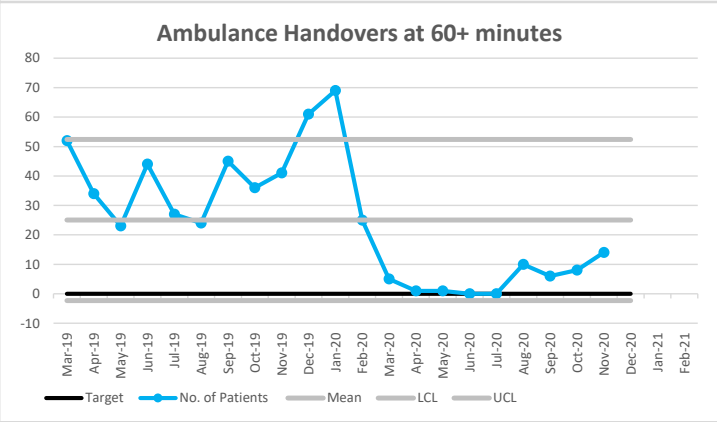
Key:
Risk Register RR116
Single Oversight Framework SOF
Care Quality Commission CQC

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	SOF CQC The Trust achieved 57.83% in January 2021. RR116		The 62 day urgent target was not achieved in January 2021 at 57.83%. This is as a result of patient choice over the festive period and the limited green pathway operating in January because of the impact of Wave 3 COVID-19 and B18 being repurposed. The Trust achieved above target for screening.	There remains a risk for performance due to the impact of the pandemic. Early review of February performance indicates an improvement in compliance.
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	SOF CQC The Trust achieved 92.86% in January 2021. RR116			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

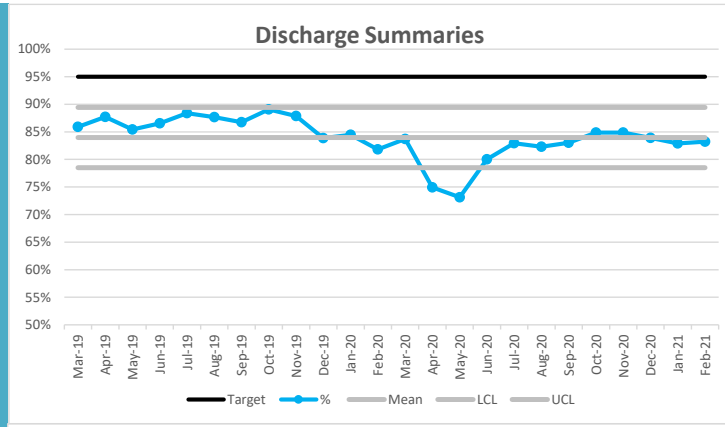
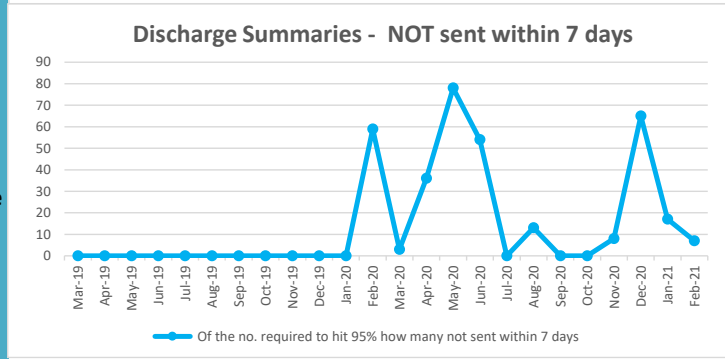
Key:
Risk Register RR116
Single Oversight Framework SOF
Care Quality Commission CQC

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Ambulance Handovers 30 to <60 minutes Red: More than 0 Green: 0	Ambulance handover data was not available in month from the North West Ambulance Service.		Data was unavailable from the North West Ambulance Service at the time of writing this report.	The Trust continues to participate within the regional collaborative aimed at reducing delays during the winter period. The Trust will continue to work in partnership with the North West Ambulance Service to identify and implement improvements. Ambulance waiting times are reviewed daily on the Cheshire and Merseyside Gold Call.
Ambulance Handovers at 60 minutes or more Red: More than 0 Green: 0	Ambulance handover data was not available in month from the North West Ambulance Service.			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

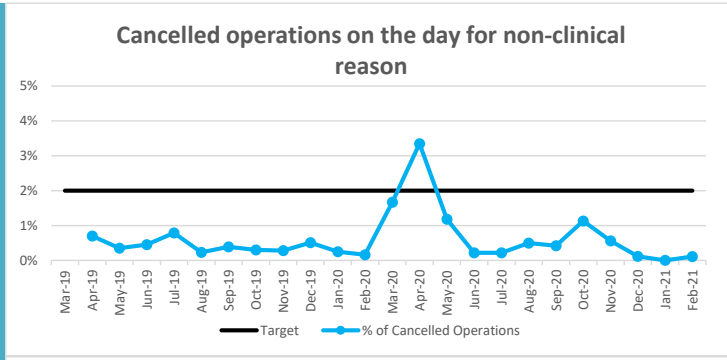
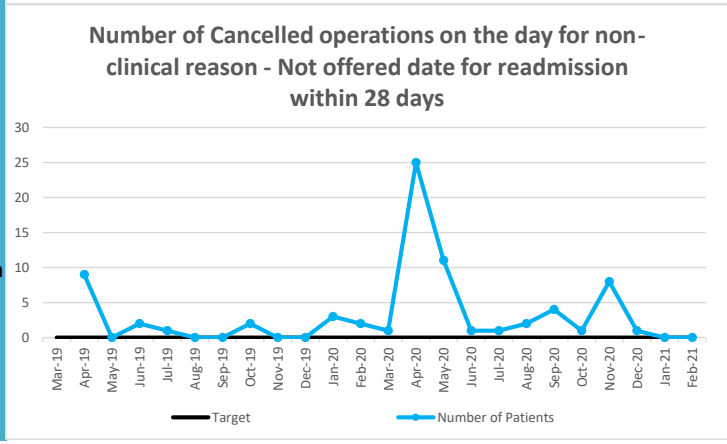
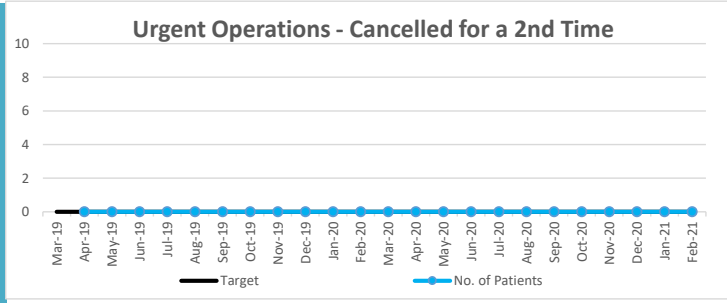
Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Discharge Summaries - % sent within 24hrs **Red: Less than 95%** **Green: 95% or above**	RR123 **The Trust achieved 83.21% in month.**		**There has been a sustained improvement in the number of discharge summaries sent within 24 hours in February 2021. Performance is starting to return to pre COVID-19 levels. However, the standard remains a focus of the CBUs. There is weekly scrutiny at the PRG and monthly at the KPI meeting.**	**The Performance Review Group (PRG) continues to monitor this standard to support improvements.**
Discharge Summaries - Number NOT sent within 7 days **Red: Above 0** **Green: 0**	RR123 **There were 7 discharge summaries not sent within 7 days required to meet the 95.00% threshold.**		**Performance against this standard improved in February 2021.**	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

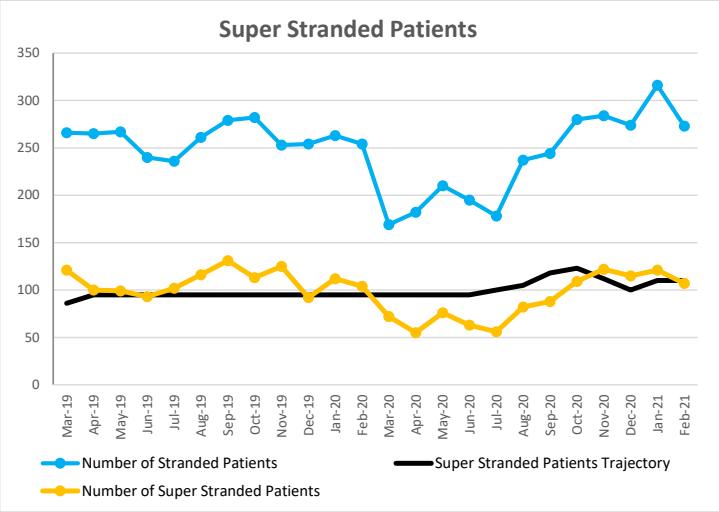
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancelled Operations on the day for a non-clinical reason Red: > 2% Green: < 2%	CQC 0.11% 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%.	Recovery of elective activity continues to be monitored via the Clinical Services Recovery Oversight Group.
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	There was 0 cancelled operation on the day for non clinical reasons in month, where the patient was not re-booked in within 28 days.		Compliance against this standard remains at the monitored threshold.	
Urgent Operations - Cancelled for a 2nd Time Green = 0 Red = > 0	There were 0 urgent operations cancelled for a second time in month.		This is an additional standard to enhance monitoring of cancelled operations. The Trust continues to maintain this standard.	Maintain the standard that no urgent operations are cancelled for a second time.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

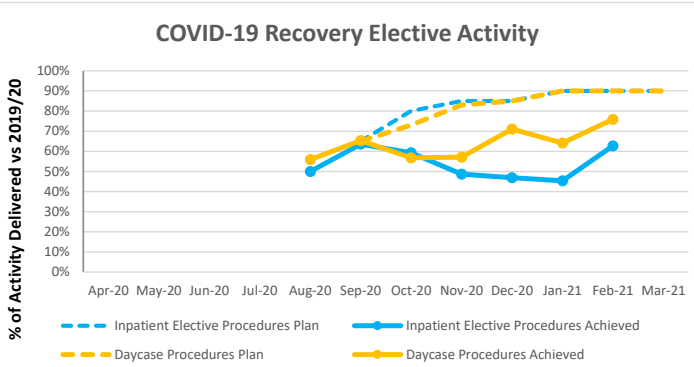
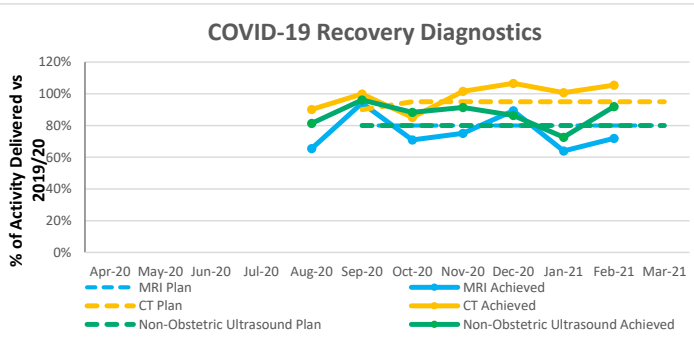
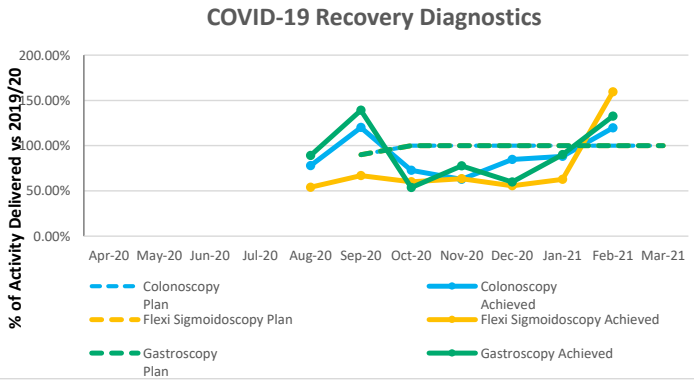
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Super Stranded Patients Green: Meeting Trajectory Red: Missing Trajectory	There were 273 stranded and 107 super stranded patients at the end of the February 2021.		The number of Stranded and Super Stranded patients on the last day of the month decreased in February 2021.	The Trust is working in collaboration with partners from Local Authorities and community providers to ensure community capacity is available throughout the pandemic. The Trust has introduced "Focus on Flow" Length of Stay meetings on a daily basis to support timely discharge.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

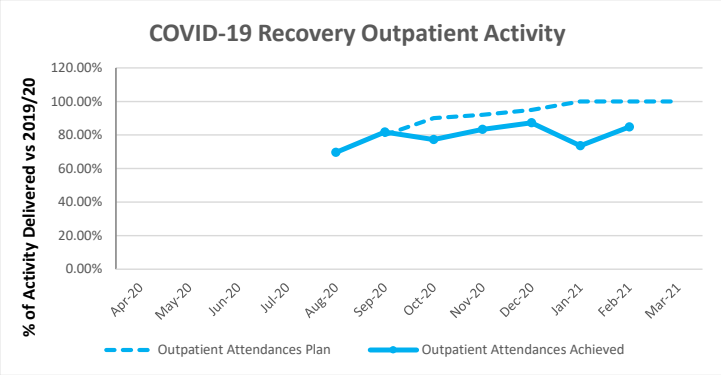
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
COVID-19 Recovery Elective Activity RED = Below 90% of 2019/20 Activity Green = 90% or greater of 2019/20 Activity	In February 2021, the Trust achieved the following % of activity against February 2020. This included 75.89% of Daycase Procedures and 62.73% of Inpatient Elective Procedures.		Progress against Elective activity recovery as per the Phase 3 submission has been stalled as a result of the impact of wave 2 and wave 3 COVID-19.	The Trust monitors the impact weekly and will progress measures to switch services back on at the earliest opportunity based on the impact of COVID-19. The Trust actively engages and explores opportunities for mutual aid in the form of staffing, ICU and surgical capacity.
COVID-19 Recovery Diagnostics RED = Below 100% of 2019/20 Activity GREEN = 100% or greater of 2019/20 Activity	In February 2021, the Trust achieved the following % of activity against February 2020. This included: 71.91% of MRI 105.44% of CT 91.88% of Non Obstetric Ultrasound 119.69% of Colonoscopy 159.30% of Flexi Sigmoidoscopy 132.60% of Gastroscopy	 	Progress against Diagnostic recovery as per phase 3 has been stalled as a result of the impact of wave 2 and wave 3 COVID-19. Good progress has been maintained in Radiological modalities however challenges remain in Endoscopy, Cystoscopy and Cardiorespiratory.	The Trust monitors the impact weekly and will progress measures to switch services back on at the earliest opportunity.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
COVID-19 Recovery Outpatient Appointments RED = Below 100% of 2019/20 Activity GREEN = 100% or greater of 2019/20 Activity	In February 2021, the Trust achieved 84.79% of Outpatient activity against February 2020.		Progress against Elective activity recovery as per the Phase 3 submission has been stalled as a result of the impact of wave 2 and wave 3 COVID-19.	The impact remains to be mitigated by the switch from face to face to non face to face methods such as telephone and video appointments.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance

Trend

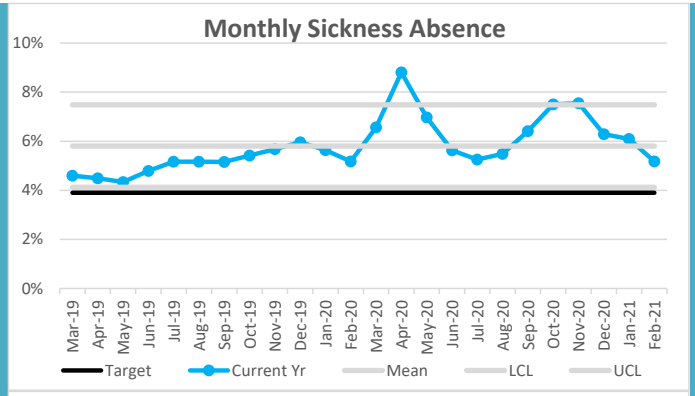
What are the reasons for the variation and what is the impact?

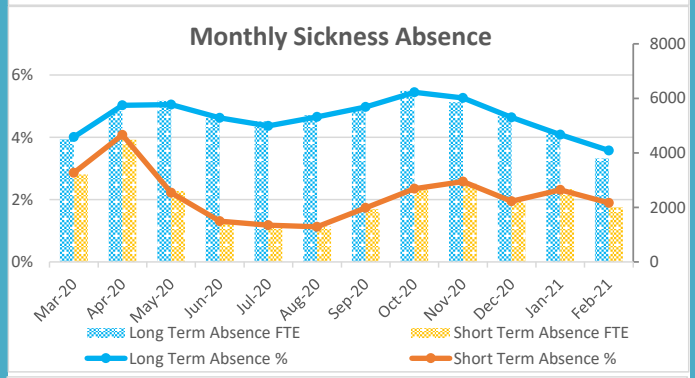
How are we going to improve the position (Short & Long Term)?

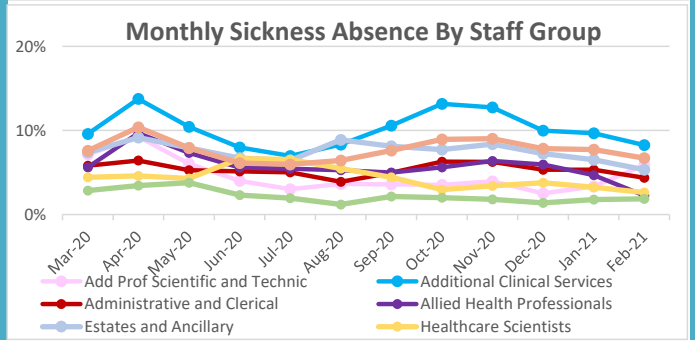
Sickness Absence

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

The Trust's sickness absence was 5.47% in month.
SPC - There is evidence of special cause variation for sickness absence.







Sickness absence has decreased to 5.47% in February 2021. 0.96% relates to COVID-19 sickness absence and 4.5% relates to non-COVID-19 sickness absence. The majority of absence (3.58%) relates to long term absence, although this has continued to decline steadily from November 2020.

Sickness absence in February 2020 was 5.47% (all non-COVID-19 related).

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

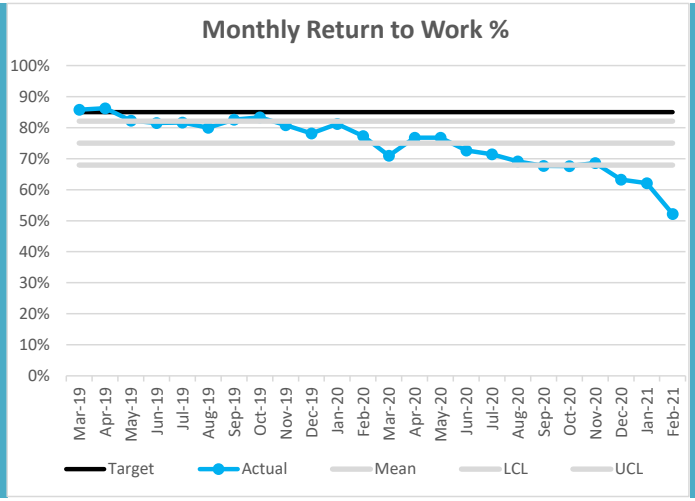
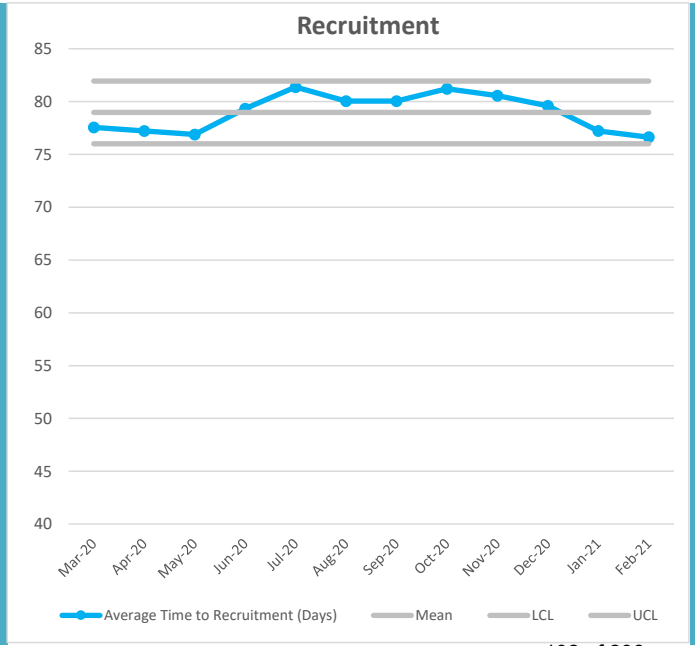
Additional Clinical Services, Nursing and Midwifery and Estates and Ancillary are the most challenged staff groups. Sickness absence declined across all staff groups in February 2021 with the exception of Scientific and Technical staff group, where there has been a sharp increase in recent months. This increase has been driven by an increase in long-term sickness absence related to anxiety/stress/depression. The need for additional support within this staff group is currently being reviewed.

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

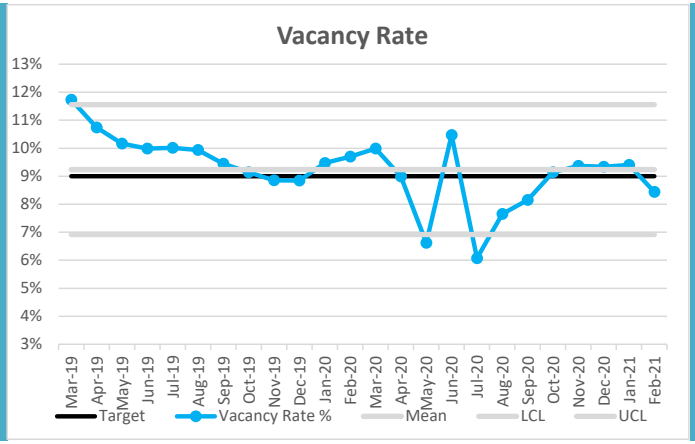
Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	The Trust's return to work compliance was 52.20% in month. SPC - There is evidence of special cause variation for Return to Work compliance.		Return to work interview compliance has reduced significantly due to pressures relating to COVID-19.	Return to work interviews remain a vital part of the support in place for our workforce. The reduction in compliance is in line with the findings of the Attendance Management Deep Dive and will form part of the policy review, as well as Workforce Recovery. The HR Business Partners continue to support the CBUs to improve their compliance through the monthly meetings. Completion of return to work interviews has been highlighted as an issue in the Attendance Management Deep Dive and is addressed within the recommendations.
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 77 days, based on the last 12 months average. SPC - Recruitment time is within common cause (expected) variation.		Recruitment time to hire has seen a reduction based on the 12 month average.	The Trust continues to take advantage of improved national guidance and support, that includes: • Verification of original documents: the Trust is now able to accept scanned and emailed copies of original documentary evidence for urgent appointments. • References and Employment History: the Trust is now able to accept one reference from the individual's current or previous employer (previously had to cover last 3 years). The Trust has also made a number of amendments to keep time to hire to a minimum: • Inductions are now weekly providing much more flexibility with start dates. • Managing expectations of both the candidates and recruiting managers through improved communications. • Contractual change letters are now emailed using the information supplied on the contractual change form (ECF).

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Vacancy Rates Red: 11% or Above Amber: 11% to 9% Green: 9% or Below	UoR **The Trust vacancy rate was 8.44% in month. SPC - there is evidence of special cause variation for Vacancy Rates.**		**Vacancy rates has reduced in February 2021 and is now below target (positive) at 8.44%.**	**Recruitment has continued as per business as usual processes. During the last 12 months the Trusts headcount has increased indicating an ability to both attract candidates and retain it's current workforce. The Trust has recruited 1036 staff compared to 694 in the previous 12 months, a significant increase. Part of this increase in workforce includes 33 international nurses since October 2020 who are at various stages of their journey with WHH either in quarantine, currently training or out on the wards.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

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

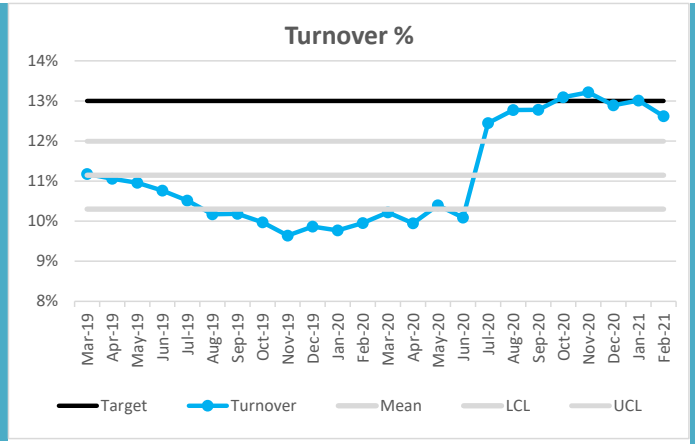
Turnover

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

CQC UoR

Trust Turnover was 12.62% in month.
SPC - There is evidence of special cause variation for Turnover.

S SOF



Turnover has reduced in February 2021 and is now below target (positive) at 12.62%. Similar to turnover, retention has improved in February 2021 and is above target (positive) at 87.79%.

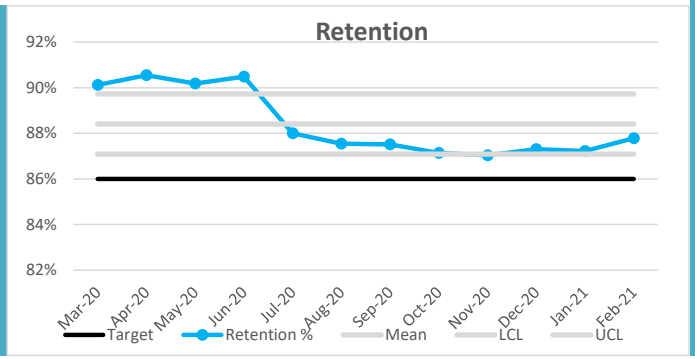
A range of work delivered and on-going as part of the WHH People Strategy and the NHS People Plan support retention of staff, including:
- **Compassionate Leadership Development Programmes**
- **Staff networks and celebrations of diversity**
- **Promotion of flexible working**
- **Review and marketing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

Retention

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

UoR

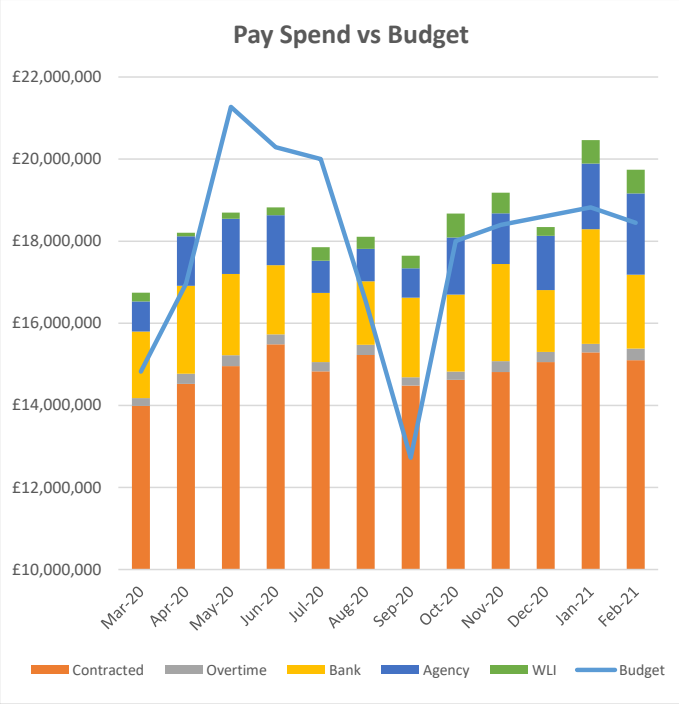
Trust Retention was 87.79% in month.
SPC - There is evidence of special cause variation for Retention.



Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Pay Red: Greater than Budget Green: Less than Budget		The total pay spend is broken down into the following elements: • £15.1m Contracted Pay (i.e. substantive staff) • £1.8m Bank Pay • £2m Agency Pay • £0.58m Waiting List Initiative (WLI) Pay • £0.284m Overtime Pay	Additional controls and challenge around pay spend have been identified in order to support a reduction in premium pay: • Enhanced ECF process for non-clinical vacancies; • Expanded ECF process for some temporary staffing pay spend; • Implementation of Cheshire and Mersey Rate Cards; • Introduction of Patchwork Medical Bank system; • Introduction of +Us Medical Agency System; • Introduction of central bank and agency team Through the Finance and Sustainability committee, compliance against the Trust's processes and rate cards is being monitored. This has enabled the Trust to identify where additional support from the central bank and agency team is required.
UoR SOF RR199 Total pay spend in February 2021 was £19.7m against a budget of £18.4m.			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

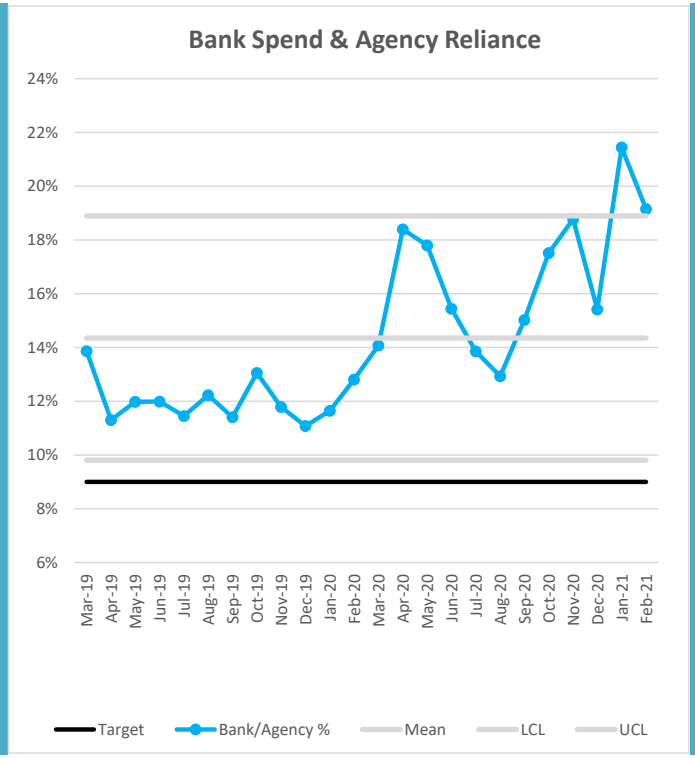
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Bank and Agency Reliance

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

UoR RR199

Bank and Agency Reliance was 19.15% in month. SPC - Bank/Agency reliance is within common cause (expected) variation.



Bank and Agency reliance peaked at 21.44% in January 2021 and although there has been a reduction in February 2021, reliance remains high at 19.15%. Temporary staffing usage has been higher in January and February 2021 in line with the COVID-19 third wave response.

The Bank and Agency Team continue business as usual. Processes are in place to ensure appropriate sign off of the need for temporary staffing, the on-going negotiation of rates, recruitment onto the bank, removing the requirement for an agency worker. Compliance against the process is reported to the Finance and Sustainability Committee and shows on-going improvement:

- **In February 2021 only 1.00% of bookings were advertised straight to agency, with an approved ECF in place. This is an improvement from 14.00% in August 2021.**
- **36.00% of bookings were advertised to bank / advertised on NHS Jobs had a approved ECF in place. This means that 36.00% of bookings were fully compliant with the ECF process and assurance can be provided that value for money has been achieved in terms of engagement method. This has improved from 28.00% in August 2020.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

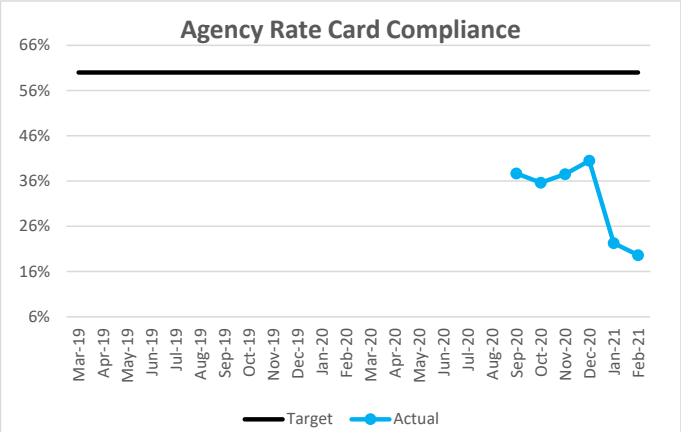
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Agency Rate Card Compliance

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

UoR

Agency Rate Card Compliance was 19.65% in month.

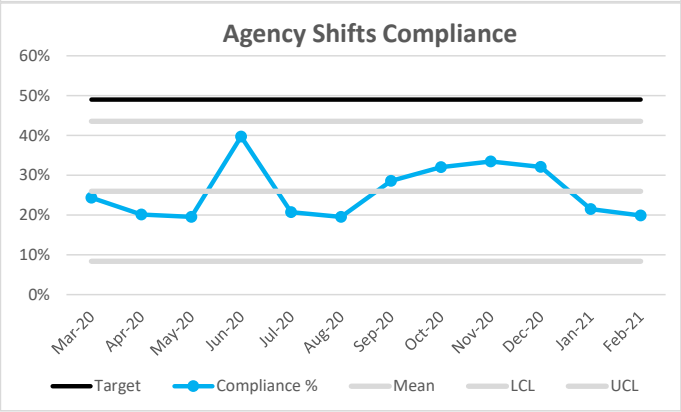


Agency Shifts Compliant with the Cap

Red: below 49%
Green: above 49%

UoR

19.86% of shifts were compliant with the NHSI Price Cap.
SPC - There is evidence of special cause variation within Agency Shift Compliance.



Compliance with the NHSEI price cap was 19.86%. In February 2021, non-compliance was highest amongst the following staff groups:
- **Medical and Dental**
- **Nursing and Midwifery**
- **Scientific, Therapeutic & Technical (AHPs)**

Compliance with the Cheshire and Merseyside rate card was 19.65% in February 2021. This is mostly driven by a decline in compliance in the Nursing and Midwifery staff group, from 37.00% in September 2020 to 9.00% in February 2021.

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

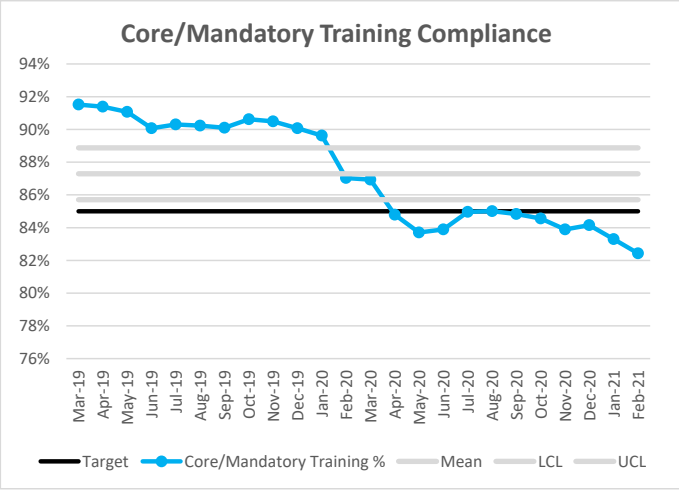
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Core/Mandatory Training

Red: Below 70%
Amber: 70% to 85%
Green: Above 85%

CQC

Core/Mandatory training compliance was 82.43% in month.
SPC - there is evidence of special cause variation.

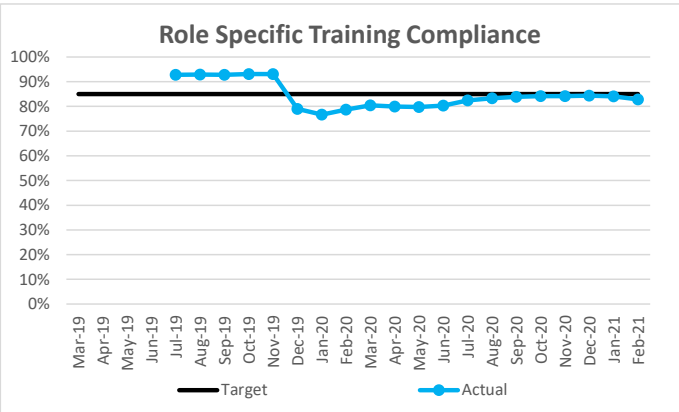


RR153

Role Specific Training

Red: Below 70%
Amber: 70% to 85%
Green: Above 85%

Role Specific Training compliance was 82.79% in month.



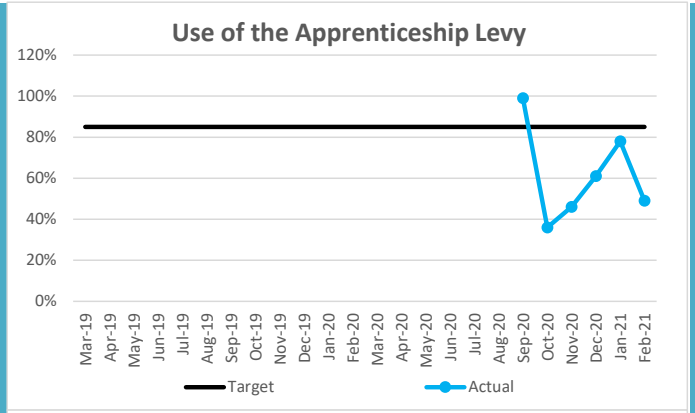
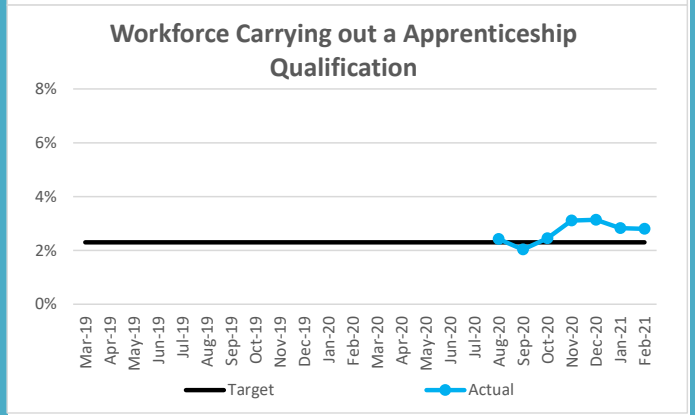
In February 2021 Mandatory Training compliance was 82.43% and Role Specific Training compliance was 82.79%. In line with National Guidance from NHS Employers (March 2020) and NHSE/I Guidance (January 2021), the Strategic Executive Oversight Group (SEOG) agreed a temporary pause on completion of Mandatory Training and Role Specific Training renewals for existing staff and a temporary pause on PDR completion for new and existing staff, where staff are unable to complete these due to the on-going COVID-19 response.

An improvement trajectory to return to above target compliance will be recommended and following implementation, will be monitored via the proposed Workforce Recovery Steering Group.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Use of Apprenticeship Levy Red: below 50% Amber: 50-84% Green: 85% or above		Utilisation of the apprenticeship levy has dipped below target in month, although 2.8% of staff are carrying out a qualification, which is above target (positive).	Use of the levy continues to be challenged for new recruitment and the uptake of formal training using the apprentice levy is regularly promoted.
Workforce carrying out an Apprenticeship Qualification Red: below 1.5% Amber: 1.5% - 2.2% Green: 2.3% or above			

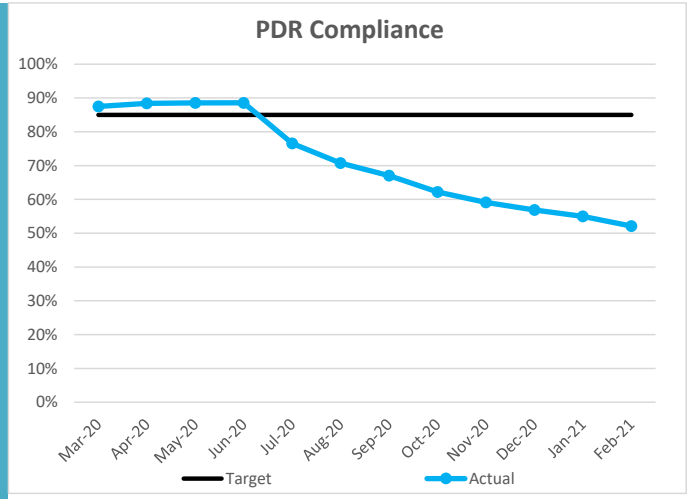
Use of the Apprenticeship Levy was 49.00% in month.

Percentage of the workforce carrying out a qualification was 2.80% in month.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%		In February 2021, PDR compliance was 52.11%. In line with National Guidance from NHS Employers (March 2020) and NHSE/I Guidance (January 2021), the Strategic Executive Oversight Group (SEOG) agreed a temporary pause on completion of Mandatory Training and Role Specific Training renewals for existing staff and a temporary pause on PDR completion for new and existing staff, where staff are unable to complete these due to the on-going COVID-19 response.	An improvement trajectory to return to above target compliance will be recommended and following implementation, will be monitored via the proposed Workforce Recovery Steering Group.

PDR compliance was 52.11% in month.

Sickness Absence Actions

An Attendance Management Deep Dive has been undertaken. An interim report was submitted to Strategic People Committee in January 2021 and a final report has been submitted to the Committee ahead of the meeting on 24 March 2021. The deep dive found that:

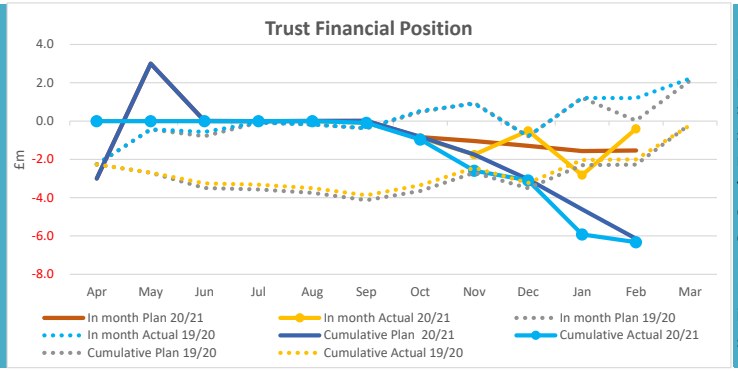
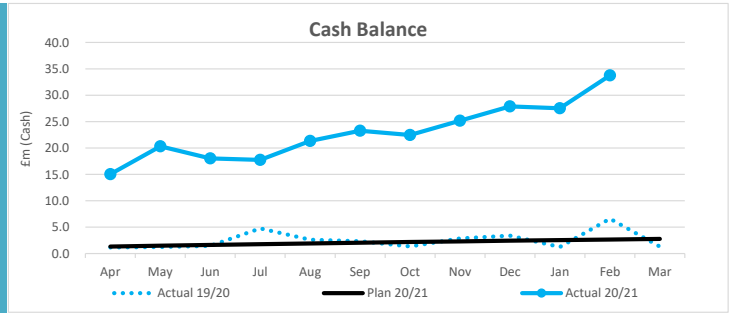
- The Trust scores above average on the Health and Wellbeing theme in the 2020 Staff Survey, across all COVID-19 classifications.
- Sickness absence is higher amongst staff members who live in Halton, where there is significant local deprivation and, to a lesser extent, amongst staff who live in Warrington, where there are several areas of deprivation.
- The North West region, and Cheshire and Merseyside in particular, experience consistently high levels of sickness absence. The Trust was not highlighted as an area of concern for sickness absence in the most recent North West SitRep report.
- The Attendance Management Policy is in line with the legal requirements and with other local Trusts. The policy is not always applied by line managers in a timely and consistent manner.
- Line managers are confident in applying the policy but there is work to be done in terms of the line manager role around supporting wellbeing and promoting attendance.
- The 'Supported Early Return' pilot was well received by managers.
- There is a move amongst neighbouring Trusts towards Attendance Management policies and approaches that are simple, easier for line managers to utilise and more person-centric, in line with Just Culture principles. This includes development for line managers to empower them to realise this significant change in management culture.

Recommendations based on the above have been submitted to the Strategic People Committee, for approval.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

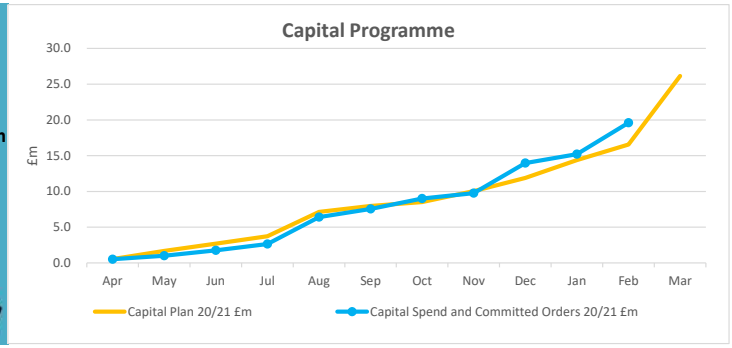
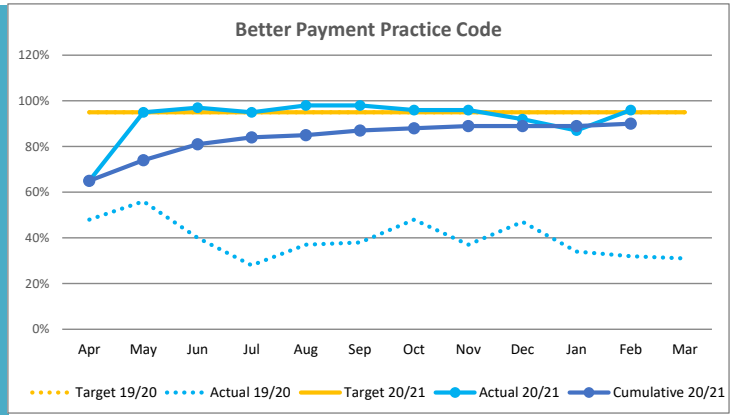
Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR116)
Care Quality Commission (CQC)
Trust Strategy (S)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
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 £6.3m as at 28 February.** RR134		**For the period ending 28 February 2021 the Trust has recorded a deficit position of £6.3m against a deficit plan of £6.1m. The position includes a retrospective top up of £20.1m to support COVID-19 expenditure and income loss of £32.96m year to date. NHSE/I is providing £4.6m non NHS income which will improve the forecast deficit to £11.9m.**	**The Trust is applying national guidance as this emerges in relation to financial planning.**
System Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus	**Warrington & Halton System reporting is currently on hold.**		
Cash Balance Red: Less than 90% or below minimum cash balance per NHSI Amber: Between 90% and 100% of planned cash balance	UoR SOF **The current cash balance is £33.7m.** RR134		**The current cash balance is £33.7m which is £31.1m better than the initial cash plan. As at 28 February 2021 the cash balance was £33.7m. PDC of £33.67m was drawn down in March 2021 to support the cash position. The forecast closing cash position is £8.94m.**	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	UoR SOF **The actual capital spend YTD is £10.6m with £3.2m in month. In addition there are £9.0m committed orders on the system.** RR669		**The Trust Board approved capital plan is £23.3m adjusted in March to £26.2m for the additional COVID-19 PDC. The actual spend year to date is £10.6m which is £6.0m below the planned spend of £16.6m. However, the Trust has committed orders of £9.0m. The Trust is currently forecasting c£1.9m underspend.**	
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or better	UoR SOF **In month, the Trust has paid 96.00% of suppliers within 30 days. This results in a cumulative performance of 90.00%.**		**Performance of 96.00% is slightly above the national standard of 95.00%. The cumulative position is below 95.00% target due to a significant supplier using a invalid purchase order which slowed down payment. Following a meeting with the Finance Planning and Performance Directorate of NHSE/I, it was made clear that prompt payment remains a clear priority.**	**Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
Single Oversight Framework (SOF)
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)?

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

UoR SOF

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

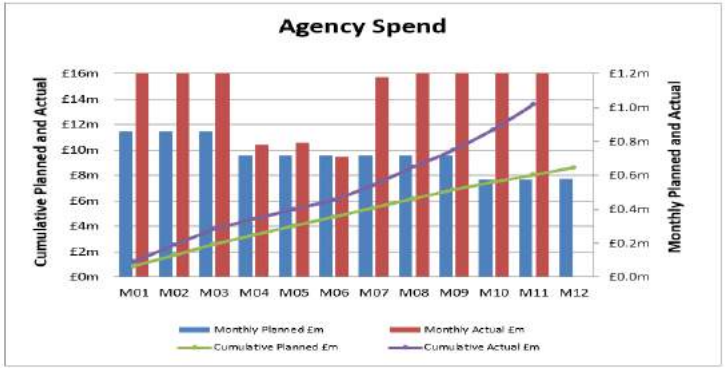
Agency Spending

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

UoR SOF

The actual agency spend in month is £1.98m.

RR199



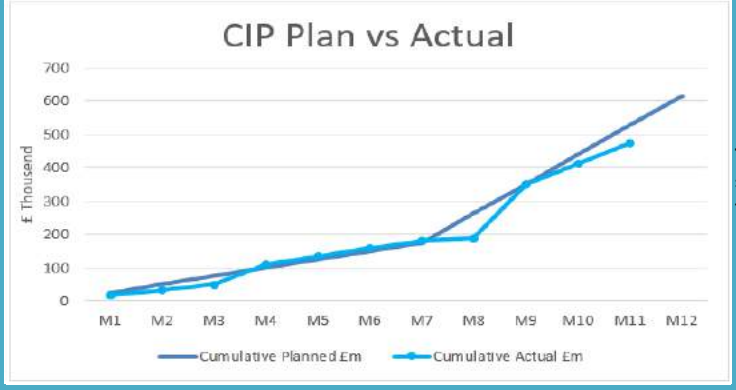
The spend of £1.98m is £1.4m above the plan of £0.6m. Of the total YTD expenditure of £13.6m, £7.9m relates to COVID-19.

The Trust continues to monitor and report the use and spend on agency as well as the use of efficient models to reduce costs. The Trust is part of a Cheshire & Mersey collaborative that has established a standard rate card across all staff groups and specialties to reduce rates and is enhancing processes and controls to ensure appropriate and best use of agency staff.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
Single Oversight Framework (SOF) | 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 **The monthly savings are £0.063m which increases year to date savings at £0.5m.**		**The cumulative savings are £0.5m against a cumulative target of £0.6m.**	**CIP progress is reviewed on a monthly basis. Where possible the Trust seeks to accelerate schemes and is reviewing additional areas to support further cost reductions.**

Cost Improvement Programme - In year performance to date
Red: 0-70% Plan delivered YTD
Amber: 70-90% Plan delivered YTD
Green: >90% Plan delivered YTD

UoR

Cost Improvement Programme - Plans in Progress - In Year
Red: Forecast is less than 50% of annual target
Amber: Forecast is between 50% and 90% of the annual target
Green: Forecast is more than 90% of the annual target

CIP reporting for the in year and recurrent plans in progress indicators will recommence in 2021/22.

UoR

Cost Improvement Programme - Plans in Progress - Recurrent
Red: Forecast is less than 50% of annual target
Amber: Forecast is between 50% and 90% of the annual target
Green: Forecast is more than 90% of the annual target

Appendix 3 – Trust IPR Indicator Overview

Indicator	Detail
Quality	
Incidents	Number of Serious Incidents and actions breached. Number of open incidents is the total number of incidents that we have awaiting review. As part of the 2018 - 2021 Trust Quality Strategy, the Trust has pledged to Increase Incident Reporting to ensure that we don't miss opportunities to learn from our mistakes and make changes to protect patients from harm.
CAS Alerts	The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Timescales are individual dependent upon the specific CAS alerts.
Duty of Candour	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days. Duty of Candour must be completed within 10 working days.
Healthcare Acquired Infections (MRSA, CDI and Gram Negative)	Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to meticillin are termed meticillin susceptible Staphylococcus aureus (MSSA). MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. Clostridium difficule (c-diff) due to lapses in care; agreed threshold is <=44 cases per year. Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections. A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2024.
Healthcare Acquired Infections COVID-19 Hospital Onset and Outbreaks	Measurement of COVID-19 infections onset between 8-14 days and 15+ days of admission. Measurement of outbreaks on wards (2 or more probably or confirmed cases reported on a ward over a 14 day period).
VTE Assessment	Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month.
Total Falls & Harm Levels	Total number of falls per month and their relevant harm levels (Inc Staff Falls).
Pressure Ulcers	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.
Medication Safety	Overview of the current position in relation to medication, to include; medication reconciliation (overall and within 24 hours of admission), controlled drugs incidents and medication incidents relating to harm.
Staffing Average Fill Levels	Percentage of planned verses actual for registered and non-registered staff by day and night. Target of >90%. The data produced excludes CCU, ITU and Paediatrics.
Care Hours Per Patient Day (CHPPD)	Staffing Care Hours per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
HSMR Mortality Ratio	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.
SHMI Mortality Ratio	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on

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

Cancer 31 Days - Subsequent Drug	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%.
Cancer 62 Days - Urgent	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory.
Cancer 62 Days – Screening	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%.
Ambulance Handovers 30 – 60 minutes	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system).
Ambulance Handovers – more than 60 minutes	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system).
Discharge Summaries – Sent within 24 hours	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge. This metric relates to Inpatient Discharges only.
Discharge Summaries – Not sent within 7 days	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge.
Cancelled operations on the day for non-clinical reasons	% of operations cancelled on the day or after admission for non-clinical reasons.
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
Urgent Operations – Cancelled for a 2nd Time	Number of urgent operations which have been cancelled for a 2nd time.
Super Stranded Patients	Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.
COVID-19 Recovery Elective Activity	% of Elective Activity (Inpatients & Day Cases) against the same period in 2019/20, monitored as part of Phase 3 Recovery.
COVID-19 Recovery Diagnostics	% of Diagnostic Activity against the same period in 2019/20, monitored as part of Phase 3 Recovery.
COVID-19 Recovery Outpatients	% of Outpatient Activity against the same period in 2019/20, monitored as part of Phase 3 Recovery.
Workforce	
Sickness Absence	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and peer average.
Return to Work	A review of the completed monthly return to work interviews.
Recruitment	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks.
Vacancy Rates	% of Trust vacancies against whole time equivalent.
Retention	Staff retention rate % over the last 12 months.
Turnover	A review of the turnover percentage over the last 12 months.
Bank & Agency Reliance	The Trust reliance on bank/agency staff against the peer average.
Agency Shifts Compliant with	% of agency shifts compliant with the Trust cap against peer average.

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

Appendix 4 - Statistical Process Control

What is SPC?

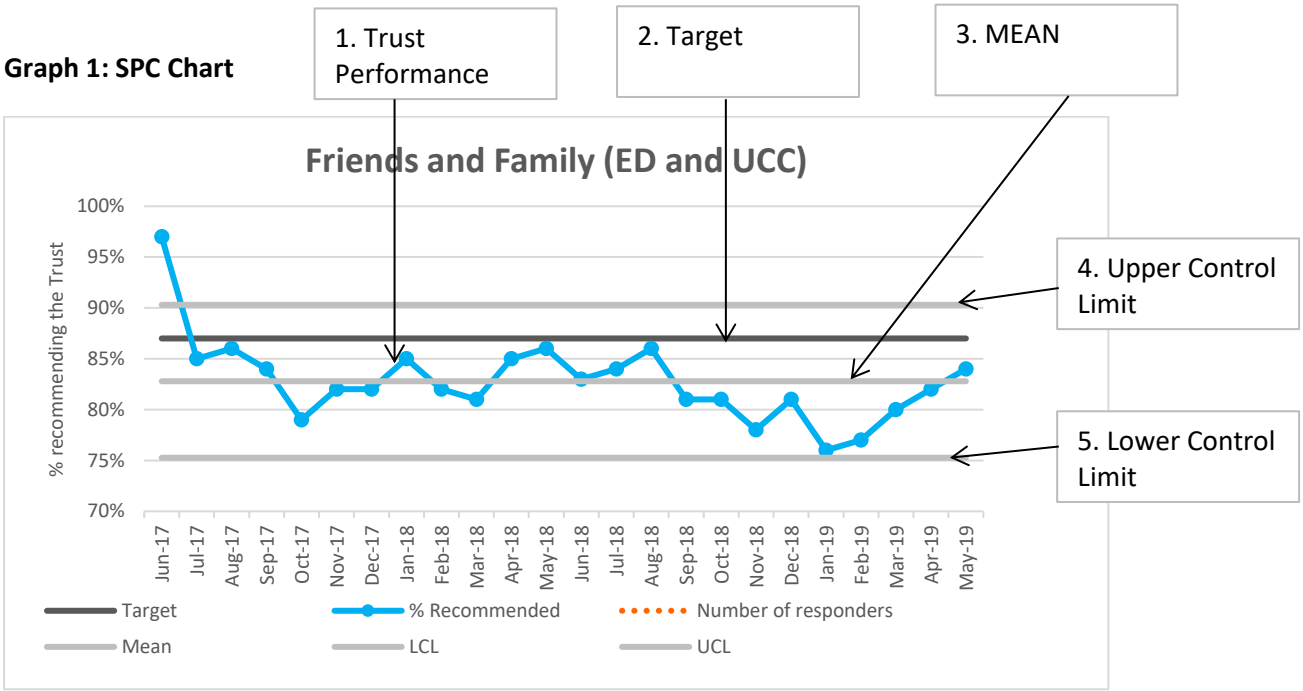
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

SPC Charts

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

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

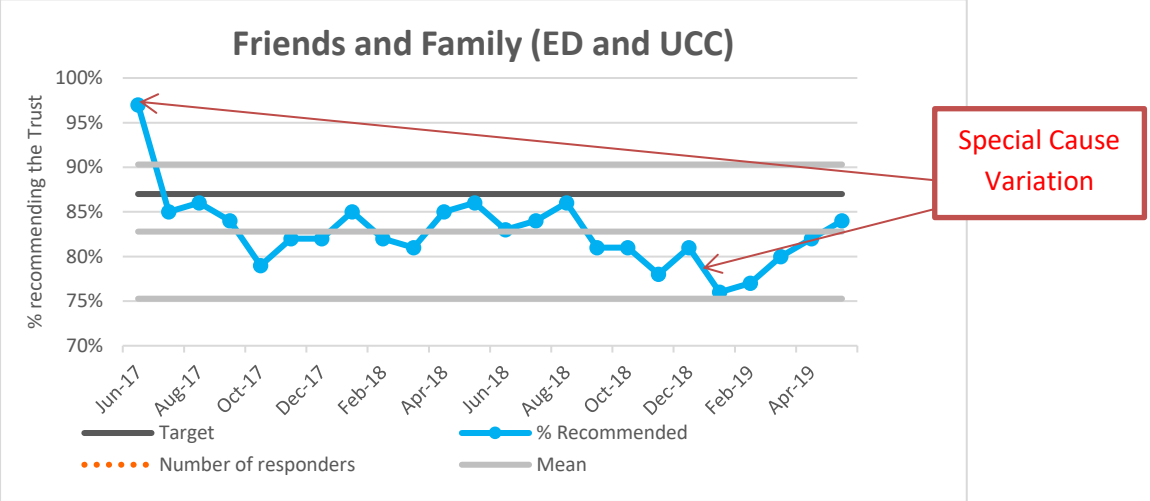
Graph 1: SPC Chart



Interpreting a SPC Chart

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

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



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

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

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

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

Appendix 5

Income Statement, Activity Summary and Use of Resources Ratings as at 28th February 2021

	Month			Year to date			Forecast			
Income Statement	**Budget £000**	**Actual £000**	**Variance £000**	**Budget £000**	**Actual £000**	**Variance £000**	**Original Plan £000**	**Revised Plan £000**	**Actual £000**	**Movement from Revised Plan £000**
Operating Income										
NHS Clinical Income										
Elective Spells	2,357	1,632	-725	28,284	13,904	-14,380	30,916	30,846	30,846	0
Elective Excess Bed Days	18	2	-17	201	27	-175	220	220	220	0
Non Elective Spells	5,220	4,601	-619	65,517	55,960	-9,557	71,484	70,888	70,888	0
Non Elective Bed Days	166	106	-60	1,831	1,806	-25	1,997	1,997	1,997	0
Non Elective Excess Bed Days	105	98	-7	1,155	754	-401	1,260	1,253	1,253	0
Outpatient Attendances	3,011	2,320	-690	34,228	23,472	-10,756	37,440	37,329	37,329	0
Accident & Emergency Attendances	1,305	1,280	-25	15,689	14,179	-1,510	17,153	16,906	16,906	0
Other Activity	6,655	7,459	804	61,483	96,876	35,393	66,757	68,247	67,730	-517
Sub total	**18,837**	**17,499**	**-1,339**	**208,388**	**206,977**	**-1,411**	**227,227**	**227,685**	**227,168**	**-517**
Non NHS Clinical Income										
Private Patients	0	9	9	0	71	71	0	16	16	0
Non NHS Overseas Patients	6	0	-6	55	20	-35	61	50	50	0
Other non protected	30	53	23	417	467	49	447	405	405	0
Sub total	**36**	**62**	**26**	**472**	**557**	**85**	**508**	**471**	**471**	**0**
Other Operating Income										
Covid/Growth/NHS Top Up	3,777	3,652	-124	46,573	46,429	-144	50,350	50,322	54,916	4,594
Training & Education	681	913	232	7,475	8,116	641	8,157	8,910	8,910	0
Donations and Grants	0	134	134	0	134	134	0	0	0	0
Miscellaneous Income	520	4,700	4,180	4,997	12,457	7,460	5,518	9,261	9,261	0
Sub total	**4,978**	**9,400**	**4,422**	**59,045**	**67,137**	**8,092**	**64,025**	**68,493**	**73,087**	**4,594**
Total Operating Income	**23,851**	**26,961**	**3,109**	**267,906**	**274,671**	**6,765**	**291,760**	**296,650**	**300,727**	**4,077**
Operating Expenses										0
Employee Benefit Expenses	-18,804	-19,759	-955	-200,412	-203,395	-2,983	-221,874	-229,235	-228,718	517
Drugs	-1,208	-1,535	-327	-13,312	-13,996	-684	-14,515	-14,847	-14,847	0
Clinical Supplies and Services	-1,802	-1,751	50	-20,154	-20,361	-207	-21,962	-22,129	-22,129	0
Non Clinical Supplies	-2,663	-3,194	-532	-30,093	-32,242	-2,149	-32,760	-35,168	-35,168	0
Depreciation and Amortisation	-609	-664	-55	-6,920	-7,507	-587	-7,528	-8,187	-8,187	0
Net Impairments (DEL)	0	0	0	0	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	-10	-10	0	-10	-10	0
Restructuring Costs	0	0	0	0	0	0	0	0	0	0
Total Operating Expenses	**-25,085**	**-26,903**	**-1,818**	**-270,891**	**-277,510**	**-6,620**	**-298,639**	**-309,575**	**-309,058**	**517**
Operating Surplus / (Deficit)	**-1,234**	**58**	**1,291**	**-2,985**	**-2,839**	**146**	**-6,879**	**-12,926**	**-8,332**	**4,594**
Non Operating Income and Expenses										
Profit / (Loss) on disposal of assets	0	-18	-18	1	-4	-5	1	17	17	0
Interest Income	3	0	-3	17	0	-17	20	0	0	0
Interest Expenses	-46	0	46	-322	-1	321	-367	-1	-1	0
PDC Dividends	-276	-320	-44	-3,035	-3,517	-482	-3,311	-3,837	-3,837	0
Total Non Operating Income and Expenses	**-319**	**-338**	**-19**	**-3,340**	**-3,522**	**-183**	**-3,658**	**-3,821**	**-3,821**	**0**
Surplus / (Deficit)	**-1,553**	**-281**	**1,272**	**-6,325**	**-6,362**	**-37**	**-10,537**	**-16,747**	**-12,153**	**4,594**
Adjustments to Financial Performance										
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0	10	10	0	0	0	0
Less Donations & Grants Income	0	-134	-134	0	-134	-134	0	0	0	0
Add Depreciation on Donated & Granted Assets	17	11	-6	184	164	-21	201	188	188	0
Total Adjustments to Financial Performance	**17**	**-123**	**-140**	**184**	**39**	**-145**	**201**	**188**	**188**	**0**
Adjusted Surplus / (Deficit)	**-1,536**	**-404**	**1,132**	**-6,141**	**-6,323**	**-182**	**-10,336**	**-16,559**	**-11,965**	**4,594**

Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**
Elective Spells	2,569	2,109	-460	30,837	17,592	-13,245	34,481	34,481
Elective Excess Bed Days	68	0	-68	750	99	-651	818	818
Non Elective Spells	2,975	2,024	-951	38,135	23,920	-14,215	41,487	41,487
Non Elective Bed Days	466	270	-196	5,128	5,137	9	5,595	5,595
Non Elective Excess Bed Days	392	0	-392	4,308	2,777	-1,531	4,699	4,699
Outpatient Attendances	25,439	21,716	-3,723	289,218	218,763	-70,455	316,354	316,354
Accident & Emergency Attendances	8,720	6,645	-2,075	106,650	80,259	-26,391	116,646	116,646

Appendix 6

Capital Bid Analysis 2020/21

Scheme Name	Funding Source	Original Value £000's	Risk
Backlog - All Areas Fixed Installation Wiring Testing	Mandated	100	
6 Facet Survey	Mandated	55	
Backlog - HV Maintenance Annual	Mandated	40	
Backlog - Annual Asbestos Management Survey & Remedials	Mandated	30	
Fire - Remove Final Stepped Exits from Kendrick Wing	Mandated	20	
Anaesthetic Machines (ASCA accreditation standards) Was £260k	Mandated	167	
Call Alarms for all Anaesthetic Rooms (ASCA Accreditation standards)	Mandated	60	
MRI Turnkey/Enabling Work (Estimate)	Business Critical	200	Overspend
Devices Replacement (Tech Refresh)	Business Critical	194	
Electronic Patient Record Procurement (£70k for scoping / £180k for procurement)	Business Critical	250	Underspend
E-Outcome Resilience	Business Critical	100	
Additional Network Cabinets	Business Critical	30	
Backup Storage	Business Critical	20	
Replacement for Trackit	Business Critical	30	
EPMA Phase 1 & 2	Board Approved	20	
Balance of Midwifery Led Unit (Building Works)	Board Approved	289	Overspend
Induction of Labour Ward (Building £22k, Equipment £56k)	Board Approved	78	
Workplace Health & Wellbeing Service Development (Building works only)	Board Approved	52	
MRI Estates Work	Board Approved	1,008	Overspend
Estates Capitalisation of Staff Costs	Board Approved	177	
IM&T (current structure) Capitalisation of Staff Costs	Board Approved	316	
Bridgewater Executive Team Relocation	Board Approved	154	
EPMA Phase 1 & 2 (Additional areas)	Board Approved	60	
EPMA Phase 3 & 4	Board Approved	210	
Lorenzo Digital Exemplar plus	Board Approved	285	
Falsified Medicines Directive	Board Approved	83	
Finance & Commercial Development - Refurbishment	Board Approved	400	
Finance & Commercial Development - Office/Kitchen Equipment	Board Approved	50	
Refurbishment of Warrington Education Centre	Board Approved	5	
Contingency Spent ??	Board Approved	170	
Schemes carried forward from 2019/20	Board Approved	1,518	
MRI PDC Funded	PDC	875	
Fire - Replacement of Obsolete 5000 Series Fire Alarm Panels	CIR	600	
Backlog - Electrical Infrastructure Upgrade	CIR	200	
Fire - Halton 30 Minute Fire Compartmentation	CIR	150	
Appleton Wing Circulation Areas 60 Minute Fire Doors	CIR	100	
Warrington and Halton Gas Meter Replacement	CIR	100	
Fire - Thelwall House Emergency Lighting Final Phase	CIR	100	
Backlog - Kendrick Wing Works To Emergency Lighting	CIR	75	
Backlog - Water Safety Compliance	CIR	50	
Pharmacy Fire Doors Sliding Type	CIR	30	
Fire - Alarm System Monitoring	CIR	30	
Halton Residential Blocks 2 & 3 Fire Doors	CIR	25	
Estates Department Fire Doors	CIR	20	
Thelwall House - Improvements to Fire Alarm System	CIR	20	
Backlog - Kendrick Wing Fire Alarms to Portakabin Buildings	CIR	15	
Cheshire House Fire Alarm	CIR	25	
Cheshire House Emergency Lighting	CIR	20	
Replacement Water Tanks : Boiler House 1&2	CIR	280	
Appleton Wing Roof Repairs	CIR	570	
IM&T Digital Refresh	PDC (Loan)	1,048	
IM&T Cardiology Systems Upgrade – CRD	PDC (Loan)	16	
IM&T Health & Wellbeing Workplace	PDC (Loan)	13	
IM&T Labour Ward Bedside Touch Screens and Archiving Software/Licences	PDC (Loan)	101	
IM&T Medisoft diabetic retinopathy module software	PDC (Loan)	14	
IM&T Wi-Fi Upgrade	PDC (Loan)	240	
IM&T Integration of Coagucheks with POCcelerator	PDC (Loan)	12	
IM&T Interface connection of GeneXpert to MOLIS LIMS	PDC (Loan)	6	
IT 'Other'	PDC (Loan)	71	
Radiology - Dexa Scanner	PDC (Loan)	250	
Monitoring Equipment - Carescape Monitors	PDC (Loan)	203	
Ultrasound Machine for Vascular scanning	PDC (Loan)	71	
Microbiology Safety Cabinet	PDC (Loan)	13	
Portable ventilation/ extraction system for CT scanner	PDC (Loan)	15	
ENT Scope	PDC (Loan)	17	
Replacement of Electrocardiogram (ECG) Machines	PDC (Loan)	14	
Portable Echo ITU & CRD	PDC (Loan)	7	
Ebike EL Stress Echocardiogram	PDC (Loan)	11	
Visual Field Analyser - Halton	PDC (Loan)	36	
Optical Coherence Tomographs - Halton	PDC (Loan)	61	
Digital Gonioscope	PDC (Loan)	22	
Wide field non-contact fundus camera combined with ICG, FFA and swept source OCT	PDC (Loan)	174	
CMTC Endo (Estates £600k; Equip £200k)	PDC (Loan)	800	
Kendrick Wing Enhancements	PDC (Loan)	50	
Enhancements 'Other'	PDC (Loan)	120	
Creation of High Care Area on AMU	PDC (Loan)	146	
Install Hand Washing Station	PDC (Loan)	5	
OPD Configuration	PDC (Loan)	65	
X-Ray room 2	PDC (Loan)	250	
Mortuary	PDC (Loan)	1,000	
Plaza reduced by £3.3m	PDC	1,000	Underspend
MRI Additional Equipment costs	BAU	326	
Covid pre 18th May	PDC	2,802	
Halton CMTC	BAU	2,000	Underspend
Contingency	BAU	390	
Endoscopy	PDC (Endo)	592	
Critical Care	PDC (Critical Care)	1,422	Underspend
Breast Screening additional PDC	PDC	186	
Workforce deployment systems (new PDC)	PDC	133	
Critical Care extra PDC	PDC (Critical Care)	145	
Total		**23,303**	
Changes post Feb FSC			
Critical Care main programme (1)		-452	
Critical Care – additional (2) Approved 22/2/21	PDC	116	
Phase 1 covid – additional (3)	PDC (COVID)	39	
Phase 2 covid (4) Approved 22/2/21 and 12/3	PDC (COVID)	2,883	
EPR In the Community (5)	PDC	39	
Rapid Testing (6)	PDC	30	
iPads (7)	PDC	15	
Vaccine Clinical Trials (8)	External funding	183	
Total Planned Capital Investment		**26,156**	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/31 a**			
SUBJECT:	**Safe Staffing Assurance Report – December 2020 and November 2021**			
DATE OF MEETING:	31 March 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 December 2020 and January 2021. Ward staffing data continues to be systematically reviewed to ensure the wards and departments were safe. Mitigation was provided and the action when a ward falls below 90% of planned staffing levels. Sickness absence rates were recorded at 8.93% in December 2020 and 7.65% in January 2021 for nursing and midwifery staff, December was consistent with October & November. In the month of December 2020 it was noted that 15 of the 21 wards were below the 90% target during the day, with a similar position noted in January 2021 with 14 of the 20 wards below the 90% target. In order to ensure safe staffing levels, mitigation and responsive plans were implemented daily to ensure that the safe delivery of patient care. CHPPD in December 2020 was 7.5 and 7.6 in January 2021, with a year to date rate 7.8. WHH have joined Wigan, Wrightington and Leigh NHS Trust to participate in a regional pilot for recruitment of international nurses. Following a successful business case we have recruited 30 registered nurses to join the Trust between the months of February and April 2021.			
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/21/03/33
	Date of meeting	24.03.2021
	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 – December 2020 & January 2021	AGENDA REF:	BM/21/03/XX

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report – December 2020 & January 2021.

The purpose of this report is to provide assurance with regard to the nursing and midwifery ward staffing levels during the months of October and November 2020. The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 and in their recommendations in 2018, that Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability.

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

2. KEY ELEMENTS

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

During the months of October and November 2020 ward staffing data continued to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels.

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

Care Hours Per Patient Day

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

Table 1 illustrates the monthly CHPPD data. In the month of December 2020 CHPPD was recorded at 7.5 and January 2021 recorded at 7.6 with a 2020/21 YTD figure of 7.8. This is in comparison to the national YTD figure of 8.1.

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

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

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

Table 1 – CHPPDD Data 2020/21

		Data			
Finyear	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2020/21	June	14189	4.2	3.5	7.7
	July	13433	4.7	4.1	8.8
	August	13990	4.2	3.5	7.8
	September	13616	4.2	3.3	7.5
	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
2020/21 Total		111653	4.4	3.4	7.8

Key Messages

Although there are areas above the 90% fill rate during this period, it is acknowledged that the percentage of registered nurses/midwives on 15 of the 21 wards in December 2020 and 14 out of 20 in January 2021 reported staffing levels under the 90% for registered nurses. Staffing is reviewed twice daily by the senior nursing team and staff are moved based on acuity and activity to ensure safe patient care at all times.

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

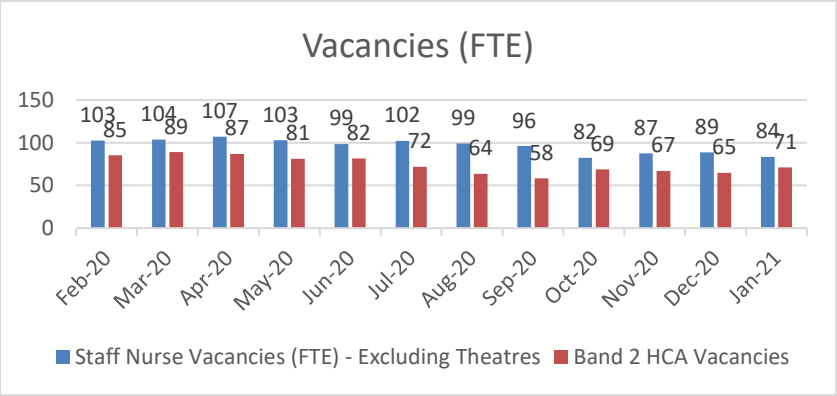
Maternity (ward C23) although showing below the 90% target on the ward in December 2020 at 88% there was an improvement noted in January 2021 at 94%. Ward C23 use their responsive staffing plans in the unit to move staff to support if acuity requires additional staffing.

Following the initial improvement, the Trust continued to run an incentive scheme with NHSP to increase fill rates across all areas in December & January. The NHSP incentive scheme increased registered nurse fill rate by 10.8% in the first 4 weeks of November.

Vacancy Summary

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

Chart 1 - Registered Nurse and Health Care Assistant vacancies Dec 2019 –Jan 2021



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

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

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

Recruiting to HCA vacancies remains a challenge for the Trust and although we have recruited 103 HCA staff since February 2020, we still have 62 HCA vacancies across the Trust. We have adopted a different recruitment approach in order to improve the HCA vacancy position with interviews now taking place on a monthly basis which has resulted in a further 46 staff who have been recruited, who are currently undergoing pre-employment checks. The Trust has recently received funding from NHSI to enhance HCA recruitment and pastoral support in the clinical areas, progress against this will be reported monthly to the Workforce Group. The Trust continues with a rolling advert for HCA's advertised both locally and regionally.

Escalation Beds and Costs

In the months of December 2020 & January 2021 there were two additional wards open, K25 and B3 both of which are currently being managed by the Unplanned Care Group. These areas have had staffing support from the recently displaced staff from ward B1 after it closed in the summer months. Cost associate with these wards are detailed below in table 2 and 3.

Table 1 – Cost associated with additional beds in December 2020

	Dec-20			
Ward	**No. Bed Days**	**Additional Costs £**	**Notional Bed Day Cost £**	**Total Cost £**
B3	611	138,118	0	138,118
K25	431	97,428	0	97,428
Totals	**1042**	**235,546**	**0**	**235,546**

Table 1 – Costs associated with additional beds in January 2021

	Jan-21			
Ward	**No. Bed Days**	**Additional Costs £**	**Notional Bed Day Cost £**	**Total Cost £**
B3	692	156,428	0	156,428
K25	490	110,765	0	110,765
Totals	**1182**	**267,193**	**0**	**267,193**

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

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

Sickness Absence – December 2020 & January 2021

During the month of December registered nurse and midwifery absence rates were recorded at 8.93% showing a slight decrease from the October/November report which was recorded at 9.03%. Sickness data in January 2021 details a similar position of 7.65%. The cost of bank/agency cover of qualified nursing sickness (at usual bank/agency fill rates) is £335,881 in December and £297,437 for January 2021 as detailed in the tables 4 and 5 below;

Table 4 - Registered nurse and midwifery sickness cover – December 2020

Contracted Nursing WTE (Band 5 to 7)	919.29
% Sickness	8.93%
WTE Equivalent of Sickness	82.09
NHSP Fill Rate	76%
WTE Covered by Temporary Staffing	62.39
Cost at Average NHSP Rates	***335,881***

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

Contracted Nursing WTE (Band 5 to 7)	950.28
% Sickness	7.65%
WTE Equivalent of Sickness	72.70
NHSP Fill Rate	76%
WTE Covered by Temporary Staffing	55.25
Cost at Average NHSP Rates	***297,437***

Sickness absence rates were recorded at 8.93% in December 2020 and 7.65% in January 2021 for nursing and midwifery staff, December was consistent with October & November.

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

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

Patient Harm by Ward
In December 2020 we have reported 5 category 2 pressure ulcers on Wards A4,A5, A6, K25 & C20. There have been 0 patients falls with moderate or major harm reported in December.

In January 2021 we have reported 5 category 2 pressure ulcers; 2 on Ward A1 and 1 on Wards A2, A5 & A9. There has been 1 patient fall with Moderate Harm on Ward K25, 1 patient fall on Ward B3 at Halton with Major Harm & 1 patients fall on Ward C21 with Major Harm.

Infection Incidents
In both December 2020 and January 2021 the Trust did not report any cases of MRSA bacteraemia.

Appendix One

Monthly Safe Staffing Data – December 2020																			
		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1690.5	1438	1426	1529.5	85%	107%	1069.5	1035	1069.5	1069.5	97%	100%	858	2.9	3.0	0.3	0.0	6.3
DD	Ward A5	1782.5	1452.5	1426	1452.5	81%	102%	1357	1173	1391.5	1288	86%	93%	971	2.7	2.8	14.3	0.0	19.9
DD	Ward B18	690	759	690	483	110%	70%	713	713	713	310.5	100%	44%	121	12.2	6.6	0.0	0.0	18.7
MSK	Ward A6	1782.5	1472.5	1782.5	1564	83%	88%	1069.5	1046.5	1782.5	1621.5	98%	91%	1027	2.5	3.1	0.0	0.0	5.6
MSK	CMTC	460	268	345	218.5	58%	63%	333.5	230	402.5	115	69%	29%	14	35.6	23.8	0.0	0.0	59.4
W&C	C20	1069.5	884.5	713	432.5	83%	61%	713	713	0	218.5	100%		448	3.6	1.5	0.0	0.0	5.3
W&C	Ward C23	1426	1253.5	713	713	88%	100%	713	644	713	632.5	90%	89%	251	7.6	5.4	0.0	0.0	12.9
W&C	Birth Suite	2139.5	1978.5	356.5	299	92%	84%	2139.5	2036	356.5	276	95%	77%	246	16.3	2.3	0.0	0.0	18.7
W&C	The Nest	713	598	356.5	299	84%	84%	713	586.5	356.5	299	82%	84%	26	45.6	23.0	0.0	0.0	68.6
W&C	Ward B11	3062.5	2872.5	807.3	722	94%	89%	1627.6	1638.4	322.4	322.4	101%	100%	286	15.8	3.7	1.2	0.0	20.6
W&C	NNU	1782.5	1277	356.5	305	72%	86%	1782.5	1207.5	356.5	345	68%	97%	287	8.7	2.3	0.0	0.0	10.9
UEC	Ward A1	2325	2025	2325	2469.45	87%	106%	1616.65	1514.34	1293.32	834.4	94%	65%	1116	3.2	3.0	0.0	0.0	6.1
UEC	Ward A2	1426	1165.5	1782.5	1478	82%	83%	1069.5	1035	1069.5	1104	97%	103%	930	2.4	2.8	0.0	0.0	5.1
MC	ACCU	2495.5	1910.5	1069.5	997	77%	93%	1782.5	1552.5	1069.5	1035	87%	97%	687.25	5.0	3.0	0.0	0.0	8.0
MC	ICU	4991	4830	1069.5	879.8	97%	82%	4991	4939.3	1069.5	1000.5	99%	94%	606	16.1	3.1	0.0	0.0	19.2
MC	Ward A7	1782.5	1941.5	1426	1473	109%	103%	1426	1473	1069	1228.5	103%	115%	928	3.7	2.9	0.0	0.0	6.6
IM&C	Ward C21	1069.5	859.5	1426	1585	80%	111%	713	713	1069.5	1138.5	100%	106%	760	2.1	3.6	0.0	0.0	5.8
IM&C	Ward B14	1069.5	1136.5	1771	1549.5	106%	87%	713	747.5	1069.5	977.5	105%	91%	744	2.5	3.4	0.0	0.0	5.9
IM&C	Ward B12	1069.5	988	2495.5	2206	92%	88%	713	713	1828.5	1667.5	100%	91%	651	2.6	6.0	0.0	0.0	8.9
IM&C	Ward B19	1426	1096.5	2024	1455.5	77%	72%	1069.5	1069.5	1426	1323	100%	93%	837	2.6	3.3	0.0	0.0	5.9
IM&C	Ward A8	1725	1474.5	1725	1456.5	85%	84%	1426	1391.5	1426	980.5	98%	69%	1054	2.7	2.3	0.0	0.0	5.1
IM&C	Ward A9	1782.5	1426	1782.5	1663.5	80%	93%	1069.5	1038	1782.5	1483.5	97%	83%	1054	2.3	3.0	0.0	0.0	5.3
		= above 100%			= above 90%			= above 80%			= below 80%								

Appendix Two

December 2020 - Mitigating Actions

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

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

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

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
Ward A4	85%	107%	97%	100%	Vacancy - band 5 2.3wte band 2 0.57 wte Sickness rate - 9.79% december Action taken - all sickness as per hospital policy
Ward A5	81%	102%	86%	93%	Vacancy - band 6 0.72 wte band 5 2.48 wte band 2 2.51 wte Sickness rate - 7.82% december Action taken - all sickness as per hospital policy
Ward B18	110%	70%	100%	44%	Vacancy - Band 5 1.32 wte band 2 2.0 wte sickness band 2 2.0 wte long term all managerd as per policy Sickness rate - 6.60% Action taken - all managed as per policy
Ward A6	83%	88%	98%	91%	Vacancy - band 6 = 1.25 WTE trauma coordinator post, band 5 = 4 WTE , band 2 = fully established Sickness rate - 9.32% 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	58%	63%	69%	29%	Vacancy - Sickness rate - Action taken -
C20	83%	61%	100%		Vacancy - RN Band 6.20 new starter band 5 (Feb 21) Sickness rate - 3.75 managed in line with policy Action taken -
Ward C23	88%	100%	90%	89%	Vacancy - 0.0WTE Sickness rate - 8.05% Action taken - Sickness absence managed in line with HR/OHWB
Birth Suite	92%	84%	95%	77%	Vacancy - 0.0WTE Sickness rate - Action taken - All action taken in line with HR/OH
The Nest	84%	84%	82%	84%	Vacancy - 0.0WTE Sickness rate - % Action taken - Sickness absence managed alongside in line with HR/OHWB

Ward B11	94%	89%	101%	100%	Vacancy - Band 6 (0.8 WTE) Band 5 (1.4 WTE) Band 2 (0.2 WTE) Sickness rate -Long-term Band 5 (1 WTE) Band 2 (1 WTE) Maternity Leave Band 2 (1 WTE) Band 5 (1 WTE) HDU 9 days Action taken - Trust Attendance Policy followed. both Long-term Sickness employees resumimg Januray 2021. Vacancies out to recruitment January 2021.
NNU	72%	86%	68%	97%	Vacancy - Sickness rate - Action taken -
Ward A1	87%	106%	94%	65%	Vacancy - Band 5 recruitment ongoing ECF x4 raised Band 2 x1.77 vacancy. Using CSWd on NHSP Sickness rate - 8.09% Managed in line with policy Action taken - Ongoing recruitment, use of agency/bank workers. WM filling shortfalls in staffing
Ward A2	82%	83%	97%	103%	Vacancy - Band 5 recruitment ongoing 2.5wte vacancy /Band 4 recruitment ongoing x1 vacancy/ Band 2 vacancy filled with CSWd Sickness rate - 3.57% Managed in line with policy Action taken - Ongoing recruitment. WM filling any staffing shortfalls.
ACCU	77%	93%	87%	97%	Vacancy - band 6 x1 / band 5 x4 / band 2 x1 - ongoing recruitment Sickness rate - 6.07% Managed in line with policy Action taken - Ongoing recruitment. Agency/Bank workers being used to maintain safe staffing
ICU	97%	82%	99%	94%	Vacancy - Band 2 - 0.68wte Sickness rate - RN 16%, HCA 7.8% (Total of 49 staff covid positive) Action taken - 1.0wte band 7 LTS, 1.80wte RN M/L, 1.0wte RN shielding, 1.92wte RN seconded K25, 1.0wte HCA seconded K25.
Ward A7	109%	103%	103%	115%	vacancy 6.3.sickness 5.5%. Managed as per policy
Ward C21	80%	111%	100%	106%	Vacancy - Sickness rate - Action taken -
Ward B14	106%	87%	105%	91%	Vacancy - awiting review of staffing RN and CSWD commening January 21 Sickness rate - Action taken - CSWD in to support band 2's sickness managed in line with attendnace policy
Ward B12	92%	88%	100%	91%	Vacancy - no band 5 vacancies band 2 3.0 wte vacancy Sickness rate - x2 LTS x1 band 2 & 1 band 3 short term sickness low Action taken - CSWD supporting band 2 vacancy sickness managed in line withattendance policy
Ward B19	77%	72%	100%	93%	Vacancy - 2.5 wte band 5 Band 2 4.0 wte Sickness rate - x3 LTS being managed moving to stage 3 with x1 meeting with HR in place short term sickness being managed with HR support x2 band 2 shielding Action taken - Band 2 vacancies supported by CSWD band 5 appointed awaiting start date sickness managed in line with

Ward A8	85%	84%	98%	69%	Vacancy - 1.6 RN wte , 5.4 wte HCA. Sickness rate - 4.0 wte RNs and 2.0 wte band 2 redeployed, Action taken - supported with redeployment from ward B1 staff, use of NHSP and agency to backfill, supported by CBU
Ward A9	80%	93%	97%	83%	Vacancy - 1.6 RN wte , 5.4 wte HCA. Sickness rate -16.64% , 4.0 wte RNs and 2.0 wte band 2 redeployed, Action taken - supported with redeployment from ward B1 staff, use of NHSP and agency to backfill, supported by CBU, CSWD to commence post in Jan 2021
Total Fill Rate (%)	88%	91%	94%	89%	

Appendix Three

Monthly Safe Staffing Data – Jan 21

		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1667.5	1276.5	1426.0	1414.5	77%	99%	1069.5	1104.0	1069.5	1138.5	103%	106%	967	2.5	2.6	0.2	0.0	5.3
DD	Ward A5	1782.5	1403.0	1426.0	1466.3	79%	103%	1426.0	1128.5	1426.0	1150.0	79%	81%	930	2.7	2.8	0.1	0.0	5.8
DD	Ward B18	805.0	947.0	805.0	793.5	118%	99%	782.0	878.0	690.0	801.0	112%	116%	572	3.2	2.8	0.0	0.0	6.0
MSK	Ward A6	1782.5	1426.0	1782.5	1598.5	80%	90%	1069.5	1092.5	1782.5	1644.5	102%	92%	969	2.6	3.3	0.0	0.0	6.0
MSK	CMTC	1069.5	950.5	713.0	586.5	89%	82%	713.0	600.0	713.0	253.0	84%	35%	170	9.1	4.9	0.0	0.0	14.1
W&C	Ward C20	1069.5	839.5	713.0	685.5	78%	96%	713.0	713.0	0.0	253.0	100%		482	3.2	1.9	0.0	0.1	5.3
W&C	Ward C23	1426.0	1345.5	713.0	701.5	94%	98%	713.0	655.5	713.0	575.0	92%	81%	260	7.7	4.9	0.0	0.0	12.6
W&C	Delivery Suite	2139.0	2077.5	356.5	333.5	97%	94%	2139.0	2079.5	356.5	345.0	97%	97%	253	16.4	2.7	0.0	0.0	19.1
W&C	The Nest	713.0	632.5	356.5	287.5	89%	81%	713.0	655.5	356.5	322.0	92%	90%	43	30.0	14.2	0.0	0.0	44.1
W&C	Ward B11	2763.5	2640.0	830.0	807.5	96%	97%	1854.4	1842.7	322.4	322.4	99%	100%	238	18.8	4.7	1.3	0.0	24.9
W&C	NNU	1782.5	1303.0	365.5	322.0	73%	88%	1782.5	1311.0	365.5	310.5	74%	85%	256	10.2	2.5	0.0	0.0	12.7
UEC	Ward A1	2325.0	2016.5	2325.0	2475.5	87%	106%	1616.7	1481.1	1293.3	1011.7	92%	78%	1116	3.1	3.1	0.0	0.0	6.3
UEC	Ward A2	1426.0	1180.5	1782.5	1532.5	83%	86%	1069.5	1058.0	1069.5	1092.5	99%	102%	930	2.4	2.8	0.0	0.0	5.2
MC	ACCU	2495.5	2022.0	1069.5	1023.5	81%	96%	1782.5	1632.0	1069.5	1023.5	92%	96%	710	5.1	2.9	0.0	0.0	8.0
MC	ICU	4991.0	5761.5	1069.5	1092.5	115%	102%	4991.0	5347.5	1069.5	1012.0	107%	95%	837	13.3	2.5	0.0	0.0	15.8
MC	Ward A7	1782.5	2444.0	1426.0	1597.3	137%	112%	1426.0	2144.5	1069.5	1304.0	150%	122%	905	5.1	3.2	0.0	0.0	8.3
IM&C	Ward C21	1483.5	1054.5	1633.0	1484.0	71%	91%	1127.0	770.5	1276.5	1144.0	68%	90%	762	2.4	3.4	0.0	0.0	6.0
IM&C	Ward B14	1069.6	1081.0	1782.5	1587.0	101%	89%	713.0	713.0	1069.5	1104.0	100%	103%	744	2.4	3.6	0.0	0.0	6.1
IM&C	Ward B12	1069.5	932.0	2495.5	2083.0	87%	83%	713.0	713.0	1828.5	1621.5	100%	89%	651	2.5	5.7	0.0	0.2	8.6
IM&C	Ward B19	1426.0	1085.5	1728.5	1497.0	76%	87%	1069.5	1069.5	1426.0	1275.0	100%	89%	837	2.6	3.3	0.0	0.0	5.9
IM&C	Ward A8	1782.5	1667.5	1782.5	1414.5	94%	79%	1426.0	1345.0	1426.0	1391.5	94%	98%	1054	2.9	2.7	0.0	0.1	5.7
IM&C	Ward A9	1782.5	1602.0	1782.5	1755.5	90%	98%	1069.5	1299.5	1426.0	1403.0			1005	2.9	3.1	0.0	0.0	6.0
Totals		38634.1	35688.0	28364.0	26539.0	90%	98%	29978.6	29633.8	21818.7	20497.6	99%	94%	14691	4.40	3.20	0.00	0.00	7.60
		= above 100%			= above 90%			= above 80%			= below 80%								

Appendix 4

November 2020 - Mitigating Actions

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

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

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

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
Ward A4	77%	99%	77%	99%	Vacancy - band 5 2.3wte band 2 0.57 wte Sickness rate - 9.79% december Action taken - all sickness as per hospital policy
Ward A5	79%	103%	79%	103%	Vacancy - band 6 0.72 wte band 5 2.48 wte band 2 2.51 wte Sickness rate - 7.82% december Action taken - all sickness as per hospital policy
Ward B18	118%	99%	118%	99%	Vacancy - Band 5 1.32 wte band 2 2.0 wte sickness band 2 2.0 wte long term all managerd as per policy Sickness rate - 6.60% Action taken - all managed as per policy
Ward A6	80%	90%	80%	90%	Vacancy - band 6 = 1.25 WTE trauma coordinator post, band 5 = 4 WTE , band 2 = fully established Sickness rate - 9.32% 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	89%	82%	89%	82%	Vacancy - band 5 = 7.7 WTE , band 2 = 2.3 Sickness rate - 5.53% Action taken - recruitment for vacant posts, sickness abscence policy followed for all staff, occupational health referrals completed and advice sought from HR for complex cases
Ward C20	78%	96%	78%	96%	Vacancy - 0 Sickness rate - Action taken - all absences managed with policy and HR
Ward C23	94%	98%	94%	98%	Vacancy - 0.0% Sickness rate - 12.08% Action taken - Managed in line with OHWB/HR
Delivery Suite	97%	94%	97%	94%	Vacancy - 0.0% Sickness rate - 9.35% Action taken - Managed in line with OHWB/HR
The Nest	89%	81%	89%	81%	Vacancy - 0.0% Sickness rate - no report available

Ward B11	96%	97%	96%	97%	__
NNU	73%	88%	73%	88%	Vacancy - Sickness rate - Action taken -
Ward A1	87%	106%	87%	106%	Vacancy - Band 6 fully established/ Band 5 2.72 vacancy / Band 4 3.82 vacancy/ band 2 hca 1.24 vacancy - ongoing recruitment Sickness rate - 8% managed in line with policy Action taken - Ongoing recruitment, use of agency and bank and WM filling shortfalls in staffing
Ward A2	83%	86%	83%	86%	Vacancy - Band 6 & 5 fully established / band 4 x 1.12 vacancy / band 2 x 0.60 recruitment ongoing Sickness rate - 5.31% managed inline with policy Action taken - Ongoing recruitment, use of agency and bank and WM filling shortfalls in staffing
ACCU	81%	96%	81%	96%	Vacancy - 0 Sickness rate - 1.80% + 1.0wte RN Interim band 8a, 1.0wte RN shielding, 1.80wte RN M/L, 2.84wte RN K25, 1.0wte HCA K25, 0.31 wte HCA LTS Action taken - All absenses managed as per trust attendance policy. Awaiting a start date of new band 5
ICU	115%	102%	115%	102%	Vacancy - 6.3 Sickness rate - 5.5% Action taken -
Ward A7	137%	112%	137%	112%	Vacancy - Band 5 8.61 wte Band 2 7.56 Sickness rate - Band 6 sickness 1.84, Band 6 non clinical 0.92, Band 2 medical sheilding 2.53, Band 2 mat leave 0.61 Action taken - Recruitment in progress difficult due to risk assessment, all shortfalls supported by NHSP, agency and respiratory team
Ward C21	71%	91%	71%	91%	Vacancy - Sickness rate - Action taken -
Ward B14	101%	89%	101%	89%	Vacancy - 3.0wte Band 2 awaiting start date Sickness rate - 2.0 wte LTS x1 preganancy related x1being progressed through with HR Action taken - CSWD in post to support vacancies ,use of NHS P and agency
Ward B12	87%	83%	87%	83%	Vacancy -x1 band 5 redeployed and X1 band 5 awaiting start date Band 2 x2 vacancies CSWD in post to support this Sickness rate - LTS X2 1.6 wte being managed with HR 2.0wte sheilding Action taken - recruitment ongoing for Band 2's
Ward B19	76%	87%	76%	87%	Vacancy - 1.6 RN wte , 5.4 wte HCA. plan to recruit from trust wide recruitment process for band 2 HCAs by the end of March 2021. advert for RNA band 4 Sickness rate - 4.0 wte RNs and 2.0 wte band 2 redeployed, 1 WTE RN shielding working from home Action taken - supported with redeployment from ward B1 staff, use of NHSP and agency to backfill, supported by CBU,
Ward A8	94%	79%	94%	79%	Vacancy - 4.8 RN wte , 5.4 wte HCA. Sickness rate -, 1.0 wte RNs LTS, 1

to make a di					WTE RN working from home, 5 WTE Band 2 HCAs long term sickness, 2.0 WTE RNs redeployed due to risk assessments and 2.0 wte band 2 redeployed, Action taken - use of NHSP and agency to backfill, supported by CBU, CSWD to commence post in Jan 2021, recruitment plans in place
Ward A9	90%	98%	90%	98%	Vacancy - 2.0wte band 5 starting March 2021 4.0 wte band 2's starting March 2021 Sickness rate - x2 Band 2 maternity leave 1.0 wte RN & 2.0wte Band 2 sheilding Action taken - CSWD supporting vacancies& use of NHS P & agency
Total Fill Rate (%)	90%	98%	90%	98%	

Appendix Five

Warrington and Halton Hospitals International Nurse Recruitment Summary – February 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, we will have all these nurses in the Trust by the end of March 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.

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

	Arrival (approx)	OSEC Training	OSEC Exam	Arrival to Trust	Booked in WHH accommodation until…	Notes
WWL Cohort 1	December 2020 - 9 nurses arrived in the UK	Commenced early Dec-20	03/02/2021	05/02/2021	04/03/2021	8 of the 9 successfully completed their OSEC Examination; one resit planned for 12/02/2021. All currently on Trust Induction - on the wards on 1st March 2021
WWL Cohort 2	January 2021 - 11 nurses arrived in the UK	Commenced early Jan-21	25/02/21 x 4 11/03/21 x 4 20/03/21 x 2	TBC – from 08/03/2021		OSEC Examination on different dates due to arrivals and availability
WWL Cohort 3	February 2021 -10 nurses arriving	Commencing in February/March	Provisionally booked for 27/03/2021	TBC		

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

	Arrival (approx)	OSEC Training	OSEC Exam	Arrival to Trust	Booked in WHH accommodation until…	Notes
CIRC Cohort 1	26th February 2021 - 15 nurses arrive in the UK	Commencing 08/03/2021	21/04/2021	TBC		
CIRC Cohort 2	26th March 2021 - 15 nurses arrive in the UK	05/04/2021	TBC	TBC		OSEC training dates not confirmed we are on the waiting list for dates for these nurses.
The arrival of Cohort 1 and 2 nurses meet the terms of the NHSI funding (30 nurses in the UK by April 2021) which will secure the 210k funding to support the recruitment of these nurses. Weekly programme Board in place to monitor progress and action any changes during the COVID-19 Pandemic and possible delays.						
CIRC Cohort 3	21st May 2021 -12 nurses arrive in the UK	01/06/2021	13-15/07/2021	TBC	21 May x 12	
CIRC Cohort 4	23rd July 2021 – 12 nurses arrive in the UK	02/08/2021	09/09/2021	TBC	23 July x 12	
CIRC Cohort 5	10TH September 2021 -12 nurses arrive in the UK	20/09/2021	01/11/2021	TBC		Moved training date by a week which in turn moved the arrival date
The arrival of the 36 nurses in cohort 3-5 will take place before the NSHI deadline of arrival (end of Nov 21) – all progress monitored at the weekly CIRC programme Board						

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 21/03/31 b i	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	31 March 2021

Date of Meeting	2 February 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/21/02/ 35	**Hot Topic – Diabetes Service Review**	The Committee received the following noting background and context, learning from the pilot and how this had been shared both in acute and primary/community settings. - Clinicians and support workers from a number of health care specialisms and Diabetes patients had taken part, subsequent report in October 2020 had been endorsed by Diabetes UK. - The findings mirrored the national picture relating to face to face and virtual clinics to review patient care and provide education to support patients in their own management of care. 95% of all reviews undertaken virtually, which had been positively received locally. - Some challenges relating to data security/Information Governance for those patients with no access to appropriate IT/technology to continue their education and treatment. Pathways changed to ensure safe and secure area to bring patients into the hospital for treatment and close working with primary care to bring patients into the GP practices for on-line clinics in an IT secure environment.	The Committee noted the updates and received good assurance. KSJ/LA/LM to discuss resolution to IG challenges	**n/a**

QAC/21/02/37	**Deep Dive – Digital Services**	The Committee received a Deep Dive Review on Cyber Security and particularly noted: - All incidents over previous 12 months had been reviewed for themes. - No Cyber event breaches, key themes included process, continued use of paper systems in some areas and opportunities to reduce use of paper, plans progressing to eradicate where possible. - Challenges moving from fax (referrals etc) to email, possibility of emails not been picked up in empty mail boxes and any subsequent delays to alert the appropriate department/service, not all faxes had been switched off. - Current position of review of faxes in the Trust to be reported to next QAC in IG High Level Briefing. - No actions taken by the Information Commissioner Office (ICO). - Patient & Staff data sharing key elements COVID Checklist (From Audit Committee) update to February Audit Committee and March QAC.	The Committee noted the updated and noted moderate assurance in relation to the use of Fax Machines	**Audit Committee 25.02.2021 QAC 02.03.2021**
QAC/21/02/38	**Board Assurance Framework (BAF) and Strategic Risk Register**	The Committee **supported and approved** the following amendments to the BAF and Strategic Risk Register: - Addition of two new COVID-related risks to the BAF following approval at Trust Board on 27 January 2021. - Amendment to the description of one risk (#134) on the BAF following approval at the Trust Board on 27 January 2021; - Narrative to be updated with additional comments relating to Oxygen Risk on the BAF as a result of the HSIB Interim Report. - Interim HSIB Report Trust Oxygen report to PSCESC in February and to March QAC as Hot Topic	The Committee supported and approved the amendments to the BAF and received good assurance.	**QAC 02.03.2021 and Trust Board 31.03.2021**
QAC/21/02/40	**Review of Waiting Lists and Clinical Harm Review**	The Committee particularly noted: - Clinical and non-clinical wait times. - Assurance provided of processes in WHH and Regional Cancer Alliance and Network to track and monitor patients aligned to national database to enable visibility of category of patients and stage of their cancer treatment. - Endoscopy – access to full Endoscopy Service at Spire Cheshire to commence for duration of February and March 2021, improving position reported first two weeks of January 2021. - Improvement in a number of standards, despite COVID challenges.	The Committee noted the updates and received good assurance.	**QAC 02.03.2021**

		- Ongoing review of CRR and BAF to ensure Risks appropriately rated. - Progress of Clinical Harm Review meetings reported, two Panels scheduled in February and one in March. - Format of future reports to be agreed, a Tri-Report or two separate reports, (1) transactional /constitutional standards/performance and (2) Clinical Harm Reviews (CHR) for accurate reporting to FSC and QAC for those elements for which they have strategic oversight.		
QAC/21/02/41	**Maternity Safety Champion Report**	The Committee particularly noted: <u>SI Report</u> QAC received first SI Maternity report as part of Ockenden Report Recommendations for reporting to QAC and Trust Board meetings. <u>Internal Maternity Benchmark Review</u> WHH Commissioned 'desk top' based review of Maternity Services in October 2020 to provide the Trust with independent assurance regarding the safety and effectiveness of Maternity Services. - 24 recommendations - High Priority (4), Medium Priority (16), Low Priority (4). High Priority areas Executive, Senior and Maternity Senior management oversight. - High Priority recommendations all progressing, (1) Safeguarding Training, robust approach to take forward with oversight across CBUs to monitor.(2) Continuity of Care – robust process progressing in CBUs and business case prepared to support further. (3) HSIB investigations – work progressing, plans in place to embed process. - Action plans monitored through appropriate governance committees, one recommendation had been completed at the time of the review, identification of Board/Executive and Management Maternity Safety Champions. - Positive nature of the report noted, thoroughness of discussions had been captured, noting the achievements and positive leadership comments.	The Committee noted the updates and received good assurance.	**QAC 02.03.2021 and Trust Board 31.03.2021**
QAC/21/02/42	**MIAA: WHH Serious Incidents Final Report**	The Committee received update following MIAA review of Serious Incidents (SIs) (including Duty of Candour) and assurance on progress made. - Random sample of 17 SIs reviewed. The review concluded that overall adequate systems and processes are in place for management of SIs and Duty of Candour,	The Committee noted the updates and received moderate assurance.	**n/a**

		concluding Moderate Assurance. - Trust fully compliant reporting SIs to StEIS within 2 working days of an incident being identified as severe level of harm. - Duty of Candour (DoC) reviewed, where appropriate DoC had been undertaken within 10 days of incident being reported to StEIS, the Trust deemed fully compliant. - 11 risks identified, 1 High, 4 Medium, 6 Low. - 18 point action place produced, 8 actions had been completed. - Assurance provided that the remaining 10 actions are on track for completion. Progress relating to training on SMART actions with CBUs to improve the standard and compliance of action plans had slowed due to current operational pressures.		
QAC/21/02/43	**Urology Assurance Report**	The Committee received an update on progress of the work of the six workstreams of the Urology Service Improvement Group: - Work had paused during Wave 1 and Wave 2 but continue during Wave 3 of the Pandemic. - Recruitment/staff wellbeing and Team building/communication – actions remain on amber, team building work on going and evolving. - Clinical pathways – to be completed end of March 2021, business case progressing to support this work. - Capacity/demand exercise – work completed previously to be reviewed due to reduced capacity due to the pandemic (P2, P3 and 4 cases), working with Governance colleagues to look at Clinical Harm Reviews. - Weekly meetings with Governance and bi-weekly Executives for monitoring and oversight.	The Committee noted and discussed the updates and received moderate assurance.	**n/a**
QAC/21/02 44	**Quality Dashboard**	There were no issues escalated and the Committee noted: - The Increase in number of incidents over 40 days and Red indicator. Acknowledgement this was due to current operational pressures on services to complete investigations.	The Committee noted the update and received good assurance	**QAC 02.03.2021**
QAC/21/02/45	**Fit Testing Compliance Report**	The Committee received an update on Fit Testing compliance and noted: - WHH 4th out of 36 trusts in the Northern region in terms of the number of fit tests performed with pass rates of 68%. - In the whole of England WHH is in the top 1/3 in terms of fit tests completed. - GVS: Out of ALL the Northern Trusts conducting fit tests, WHTH has performed	Good Assurance provided for reporting to Trust Board of continued testing for other masks in addition to 3M, Fit testing	**QAC 02.03.2021 and Trust Board 31.03.2021**

		the highest number of fit tests with GVS masks (144). This is greater than 50% more than other Northern region trusts and gives the GVS over a 68% pass rate. HX3 Alpha Solway: WHTH have conducted the highest number of Alpha Solway HX3 fit tests in the Northern Region (52) with a pass rate of 58%. Assurance provided that the primary masks of choice are in good supply, no foreseeable supply issues with these masks.	compliance and oversight of stock utilisation to maintain satisfactory levels of PPE	
QAC/21/02/47	**COVID-19 Management of Health and Safety**	The Committee received details of the measures that have been put in place to ensure compliance with the regularly updated Health & Safety legislation and guidance during the COVID-19 pandemic.	Comprehensive report and good assurance of robust monitoring that is in place.	**n/a**

In addition to the reports highlighted above, the Committee also received the following:

QAC/21/02/35 – Moving to Outstanding Update Report
QAC/21/02/46 – Complaints & Serious Incident Quarter 3 Report

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

QAC/21/02/48 - Health and Safety Sub Committee
QAC/21/02/49 - Infection Control Sub Committee
QAC/21/02/50 - Equality, Diversity & Inclusion Sub Committee - progress of various sub-group, noting the appointment to two key ED&I posts.
QAC/21/02/51 - Information Governance and Corporate Records Sub Committee

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 21/03/31 b ii	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	31 March 2021

Date of Meeting	3 March 2021
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

Further to the matters below that the Committee wishes to bring to the attention of the Board, the Committee would also like to highlight the high quality of the reports that have provided assurance. The Committee recognises the considerable operational pressures during the third wave of the pandemic and wishes to commend those that have contributed to the work of the Committee during this difficult time.

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/21/03/ 57	**Matters arising**	The Committee received the following update: QAC/21/02/37 – Cyber Security Deep Dive - 32 out of 39 faxes had been decommissioned on Warrington site (87%, 17% increase since December); 21 out of 27 faxes decommissioned on Halton site (77%). Logistical difficulties acknowledged where it was more difficult to decommission some faxes, i.e. Pathology, timescales to be confirmed. QAC/21/01/40 – Waiting List report Update received relating to new monitoring, governance and oversight of Waiting List Prioritisation and performance against constitutional standards. - Bi-weekly Clinical Recovery Oversight Committee (CROC), reporting to Board, to be established, membership to include KSJ/AC/DM/JC/TA/MB/CR with Council of Governor representative, support from Governance and Finance teams, chaired by T Atherton Non-Executive. ToR to be presented for approval to Board 31.03.202. - Outputs shared at QAC and FSC meetings for oversight of those elements.	The Committee noted the updates and received good assurance	**PSCESC 29.03.2021** **QAC 06.04.2021** **Trust Board 31.03.2021**

QAC/21/03/58	**Hot Topic – Oxygen issues during COVID-19 Pandemic**	The Committee received an update in relation to O2 supply during the pandemic and particularly noted: - A number of wards have beds that do not all have bed head units. In order to mitigate this the oxygen supply had been increased on A7 with a temporary supply in the area between A7 and A8 and increased oxygen supply on A8 and A9 during Wave 3 to ensure sufficient oxygen flow and pressure. - Prospective reviews were being undertaken with continued monitoring to ensure patient's needs are met, with reporting and monitoring at Tactical Group. - BOC will alert the Trust to oxygen use over 60% over a 7-day period. Remote monitoring unit to be provided by BOC by the end of March. - Governance of Management of Medical Gases – to be strengthened with the establishment of a formal Medical Gases Committee to replace the Medical Gases Group. First meeting planned March 2021 to transition to the new Committee, revised ToR to be agreed, reporting into the Health & Safety Sub Committee. - Structural survey commissioned to review site structure and provide options to change/improve oxygen supply and capacity, to be reported to Estates Group, Tactical Group and Executives to agree future actions. - Assurance that the Trust is compliant with all national regulations.	**The Committee noted the comprehensive report and good assurance of the management and oversight of oxygen delivery during the COVID-19 Pandemic.**	**n/a**
QAC/21/03/59	**Moving to Outstanding (M2O)**	The Committee received the following update:, - CQC Task and Finish Group focussing on changing methodology, actions to be identified for progress to becoming an Outstanding organisation. - Provider Engagement meeting held 9 February 2021, quarterly meetings to continue. - WHH recognised as good practice at Provider Collaborative Review for work with 'Core 24' - CQC surveys – four of the five surveys completed, planning work in place with comprehensive actions for improvement where required. - CQC Insight Report – CQC had retired the Trust Composite indicator, positive improvement reported relating to Well Led, number of areas stable. Work to	**The Committee reviewed and noted the report and received good assurance.**	**QAC 06.04.2021 Trust Board 31.03.2021**

		improve two areas identified as declining, data queried with CQC relating to Diagnostic 6 week waits, 56% in January, focussed work when data has been validated. - Sickness absence deterioration, reported and monitored at Strategic People Committee		
QAC/21/03/63	**Review of Waiting Lists and Clinical Harm Review**	The Committee particularly noted: - Clinical and non-clinical wait times. - Cancer (November 2020 104 day category, 21 equating to 19, (2) over trajectory; 62+ day category 66 equating to 40 (26) over trajectory) - 62 day position December 2020 71.3%. monitoring continues - Diagnostics – 55% January 2021 improvement from previously reported position of 37% . - RTT – 52 week waits – off trajectory, 1171 against trajectory of 315 due to Wave 2 and Wave 3, critical care challenges impacting use of Theatres. Critical Care activity beginning to revert to more normal position, continued daily monitoring. - 52 week waits improving position. Mitigations to improve over 40 week waits through Clinical Validation Programme (CVP) to ensure each patient reviewed and assigned a P Code to reduce harm. 492 patients had been assigned a P Code, the Trust is highest in the CVP regionally, list being validated and patients brought forward from P3 and those waiting in excess of 52 week where deemed appropriate following clinical review. - RTT 18 weeks, decrease in performance by 2.5% from December 2020 (4910 patients) to 72.95% (5532 patients, assurance provided WHH not an outlier in C&M. - Endoscopy – waiting list reducing, supported with use of additional capacity of 4 rooms. - Trust had commissioned extra support from an alternative organisation for a mobile scanner. Discussions continue with Spire for additional support, if no agreement, the Trust will need to commission mobile unit to provide this service. Clinical Harm Reviews (CHR) update position reported following the meeting on 26th January 2021 that identified that for 7/9 P2/P3 patients there was no harm no harm. The remaining two cases were reported as moderate harm and transferred to the	**The Committee noted the updates and received good assurance.**	**QAC 06.04.2021**

		incident process and identified for scheduling as soon as possible. - 10 moderate harm cases identified following review of RTT cancer and non-RTT breaches. Assurance provided that all patients had been scheduled for treatment, 8 in March, 1 patient not fit for surgery currently and 1 further clinical review required. Duty of Candour applied to all.		
QAC/21/03/64	**Maternity Safety Champion Report**	The Committee particularly noted: Ockenden Review – scope widened; further submission of evidence made on 15 February 2021. Staff identified as Maternity Safety Champions in the Trust Board level - Executive Maternity Safety Champion – K Salmon-Jamieson, Chief Nurse & Deputy CEO Board Level – Non-Executive Maternity Safety Champion - Margaret Bamforth, Non-Executive Director Trust Maternity Safety Champions - Dr Kate Alldred, Consultant Obstetrician and Debby Gould, Midwifery Advisor, Interim Head of Midwifery. Midwifery Workforce – Birth rate plus - Desk Top review undertaken of Midwifery staff, in addition to review Medical Staff contained within the report. - Maternity work-force gap analysis to be undertaken as part of the Ockenden Review recommendations. - T&F group established which will move to a M20 workstream. Clinical Negligence Scheme for Trusts (CNST) - ePR procurement to progress, currently in 10-day Purdah, on trajectory for procurement and implementation of the system. - Digital Midwife appointment anticipated in 6-8 weeks. - Weekly CNST Group established, evidence to be completed by July 2021. Assurance that whilst some elements require further work to achieve 100% compliance this will be achieved by July. - Re: Medical Staff review, it was confirmed that two daily Consultants rounds are in place.	**The Committee noted the comprehensive report and received good assurance**	**QAC 06.04.2021 and Trust Board 31.03.2021**

		SI Maternity Monthly Report - 3 SIs in progress for Women's Health, one reported to StEIS which will be discussed at weekly harm meeting prior to sharing with CCG.		
QAC/21/03/65	**Mortality Report Q3**	The Committee received the report in line with National Guidance and the required National Reporting Criteria; and details learning following reviews. Particularly of note was: - During Q3 2020/21 **372** deaths have occurred within the Trust. - 55 have met the criteria to be subject to a structured judgement review (SJR). - Of the 55 SJRs completed by members of the MRG, 21 were considered to have received adequate care, 32 good care and 2 excellent care. - 0 were to subject to investigation using root cause analysis (RCA) methodology. - HMSR is as expected at 105.22 and is not an outlier. - SHMI is expected at 106.54 and is not an outlier. - The Mortality Review Group has completed a focus review of Cardiac dysrhythmia deaths from August 2019 – March 2020. Information from the Health Evaluation Data (HED) system reported that the Trust is an outlier for Cardiac Dysrhythmias deaths. The patients included in this review were all identified by Health Evaluation Data (HED) system i.e. those admitted with a primary diagnosis in the group 'Cardiac Dysrhythmias' that later died whilst inpatients. Twelve patients have been reviewed and the learning noted. - The Trust was notified by NHS England that they will no longer be funding the Mortality Datix platform used nationally. The Trust has created the Structured Judgement Review (SJR) form locally and it is available on the Trusts Datix system. - The roll out of the Datix mortality module may cause a delay to completion of the SJR's as additional training and demos will be required. As a result of the delay in completion, the team will continue to manually review SJRS.	**The Committee noted the comprehensive report and received good assurance**	**QAC 06.04.2021**
QAC/21/03/	**Fit Testing Compliance Report**	The Committee received the report and noted the following: - There are 134 members of Trust staff who have been trained to fit test to the Health and Safety Executive (HSE) recommended standard	**The Committee noted the report and received good assurance.**	**QAC 04.05.2021**

		- Fit testing is available via a central hub 7 days a week during 9-5 hours, and locally through the CBU's over a 24 hour period - WHTH are currently 3rd out of 36 trusts in the Northern region in terms of the number of fit tests performed with pass rates of 72%. - In the whole of England WHTH is in the top 1/3 in terms of fit tests completed. - GVS: Out of ALL the Northern Trusts conducting fit tests, WHTH has performed the highest number of fit tests with GVS masks (241). This is greater than 50% more than other Northern region trusts and gives the GVS over a 76% pass rate. - HX3 Alpha Solway: WHTH have conducted the highest number of Alpha Solway HX3 fit tests in the Northern Region (68) with a pass rate of 66%.		
QAC/21/03/69	**Nurse Safe Staffing – bi-annual review**	The report was taken as read: - Deficit for WTE 80, improvement on the previous 6 month position (139.79 WTE), assurance provided of the correct number of nurses on the right wards in place, 3x daily meetings to meet the significant continued daily challenges to ensure safe staffing levels with robust escalation process in place. - Number of Nurses and Midwives increased, vacancies reduced, position improved with International Nurse recruitment, vacancies currently 82, 85 in February 2021. - HCA vacancies – improving position, 50 at the end of February 2021. - Staff turnover - improvement reported in last 12 months. - CHPPD retained position 7.9 with escalated beds of B3 and K25 unfunded wards supported by AHP and medical and nurse staffing. - Women and Children's - NICU unit Birth Rate Plus acuity tool to be used this year as part of Ockenden Review.	**The Committee noted the report and received good assurance.**	**QAC 06.04.2021**

In addition to the reports highlighted above, the Committee also received the following:

QAC/21/03/61 – Strategic Risk Register & BAF
QAC/21/03/62 – Refresh & Review of Trust KPIs
QAC/21/03/67 – Quality Dashboard
QAC/21/03/68 – Learning From Experience Quart 3 Report

QAC/21/03/71 – DIPC Quarter 3 Report
QAC/21/03/72 – Infection Prevention and Control BAF
QAC/21/03/73 – Clinical Audit Quarter 3 Report
QAC/21/03/74 – Quality Priorities Quarter 3 Report.

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

- Patient Safety and Clinical Effectiveness Sub Committee
- Safeguarding Sub Committee
- Infection Prevention and Control Sub Committee
- Risk Review Group
- Equality, Diversity & Inclusion Sub Committee - progress of various sub-group, noting the appointment to two key ED&I posts.
- Information Governance and Corporate Records Sub Committee

Warrington and Halton Teaching Hospitals NHS Foundation Trust

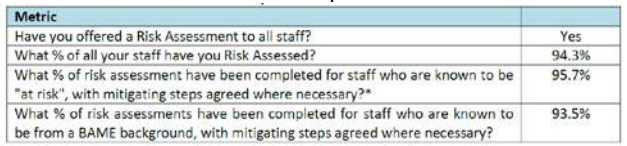
BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/21/03/31 c		TRUST BOARD OF DIRECTORS	DATE OF MEETING	31 March 2021

Date of Meeting	24 March 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/21/03/19	**Matters Arising:**	**On-Call Harmonisation, Chief People Officer** The Chief People Officer confirmed that all organisational change continues to be reviewed and paused or progressed appropriately in line with the North West SPF agreement. The Committee were updated that the on-call harmonisation process remains paused as per previous discussions in the SPC but that where there is an immediate requirement for a review	**Assurance** **On-Call Harmonisation** The Committee were updated that the on-call harmonisation process remains paused as per previous discussions in the SPC but that where there is an immediate requirement for a review of on-call arrangements this is actioned in line with the new on-call policy. **Local Induction for Temporary Medical Staff, Medical Director**	May 2021

		of on-call arrangements this is actioned in line with the new on-call policy. **Local Induction for Temporary Medical Staff, Medical Director** The Committee received an update report from the Medical Director on progress following discussions in the previous meeting: • The review of the e-platform is now complete and appropriate action taken. • Compliance at CBU level is shared on a monthly basis and monitored at Medical Cabinet. • Compliance has improved from 32% in August 2020 to 55.5% in March 2021.	The Committee will receive a further written update in May 2021.	
SPC/21/01/ 03/21	**Wellbeing Guardian Role**	**Wellbeing Guardian Role, Chief People Officer** The Committee received a paper on the emerging role of the Wellbeing Guardian and the organisational requirement to appoint to the role from an existing NED. The Committee supported the nomination of Cliff Richards, Non-Executive Director, for the role of Wellbeing Guardian.	**Decision** Trust Board are asked to approve the nomination of Cliff Richards, Non-Executive Director, for the role of Wellbeing Guardian.  HWB Guardian Role SPC March 2021.doc  Appendix 1 HWB Guardian Role.pdf	
SPC/21/01/ 03/24	**Workforce Recovery**	**Workforce Recovery, Chief People Officer** The Committee received a paper summarising the workforce recovery recommendations made by a variety of national bodies, and proposing the development of a Workforce Recovery steering group to oversee and monitor the implementation of the recommendations, to ensure that the organisational workforce risk around workforce recovery is mitigated.	**Assurance** The Committee approved the Workforce Recovery Steering Group terms of reference and will receive assurance reports in future Committee meetings.  Workforce Recovery Steering Group Term	
SPC/21/01/	**SPC/21/01/**	**Chief People Officer Report,**	**Assurance**	

		Chief People Officer The Chief People Officer updated the Committee on: • Vaccine uptake • COVID-19 Workforce Risk Assessments • NHS Pensions: the McCloud judgment • International Recruitment Code of Practice	Vaccine Uptake: The Committee noted the excellent progress on the vaccine programme, particularly in relation to the workforce uptake. COVID-19 Workforce Risk Assessments: The Committee noted the compliance as at 12 March 2021  NHS Pensions: the McCloud judgment: The Committee noted the update on the McCloud judgment and the impact on the NHS Pension Scheme. International Recruitment Code of Practice: The Committee noted the update on the International Recruitment Code of Practice and received assurance that processes within the Trust are in line with the scheme.	
SPC/21/03/27	**National Staff Opinion Survey**	**National Staff Opinion Survey** **Chief People Officer** The Committee received a paper outlining the organisational results of the 2020 National Staff Opinion Survey.	**Assurance** The Committee noted the results of the 2020 National Staff Opinion Survey. The Committee particularly noted the fact that the Trust scored above average in 8 of the 10 themes and the significant improvements in the Health and Wellbeing and Safety Culture themes. The Committee also noted the decline in the Line Manager theme and highlighted this as an area for focus in 2021/22. The Committee approved the proposed next steps relating to the survey results.	
SPC/21/03/28	**Attendance Management Deep Dive**	**Attendance Management Deep Dive,** **Deputy Chief People Officer**	**Assurance** The Committee received the final findings and conclusions of the deep dive, which are summarised below. The Committee were assured by the work undertaken.	March 2021

Metric	
Have you offered a Risk Assessment to all staff?	Yes
What % of all your staff have you Risk Assessed?	94.3%
What % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary?*	95.7%
What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary?	93.5%

		An interim report on findings to date from the Attendance Management deep dive was provided to Strategic People Committee in January 2021. The final findings, conclusions and recommendations of the deep dive were presented to the Committee in March 2021	• Sickness absence in January 2021 was 6.3%. This is above the 4.2% target. • When COVID-19 related sickness absence is removed, sickness absence rates have been lower than the same period in the previous year since October 2020. • Anxiety, Stress and Depression is the highest reason for sickness absence, followed by Chest and Respiratory problem. • Additional Clinical Services, Nursing and Midwifery and Estates and Ancillary are the most challenged staff groups. • The Trust scores above average on the Health and Wellbeing theme in the 2020 Staff Survey, across all COVID-19 classifications. • Sickness absence is higher amongst staff members who live in Halton, where there is significant local deprivation and, to a lesser extent, amongst staff who live in Warrington, where there are several areas of deprivation. • The North West region, and Cheshire and Merseyside in particular, experience consistently high levels of sickness absence. The Trust was not highlighted as an area of concern for sickness absence in the most recent North West SitRep report. • The Attendance Management Policy is in line with the legal requirements and with other local Trusts. • Policy is not always applied by line managers in a timely and consistent manner. • Line managers are confident in applying the policy but there is work to be done in terms of the line manager role around supporting wellbeing and promoting attendance. • The 'Supported Early Return' pilot was well received by managers.	

			• An audit has confirmed that the Occupational Health and Wellbeing Service proactively support staff to remain in and return to work. • There is a disconnect between the Occupational Health and Wellbeing Service and line managers. • There is a move amongst neighboring Trusts towards Attendance Management policies and approaches that are simple, easier for line managers to utilise and more person-centric, in line with Just Culture principles. This includes development for line managers to empower them to realise this significant change in management culture. The Committee supported the following recommendations: • Continue the current focus on employee Health and Wellbeing and the approach that has been in place since the appointment of the Head of Engagement and Wellbeing and the response to the COVID-19 pandemic. • Focus on interventions for staff living in Halton and Warrington, working with local and community partners. • Review 'Supported Early Return' pilot and roll out, prioritising specific the staff groups highlighted above. • Undertake a full and thorough review Attendance Management Policy, including liaison with organisations outside of the NHS. • Using the opportunity presented by the policy review to introduce a simpler process and embed Just Culture principles. • Continue the work on exploring opportunities relating to an absence management system. • Simplify management processes relating to Attendance Management, including but not limited to the Attendance Management Policy.	

			• Set expectations of line manager regarding people management practices. • Introduce a new training approach for line managers to meet those expectations. • Undertake a programme of engagement with line managers to promote education and understanding of the Occupational Health Service, strengthening links and joint working between line managers and the Service.	
SPC/21/03/30	**WHH People Strategy and EDI Strategy**	**WHH People Strategy and EDI Strategy** **Deputy Chief People Officer** The Committee received an update report on the 2020/21 priorities for the People Strategy and the EDI Strategy.	**Assurance** The Committee noted the work undertaken to deliver the 2020/21 strategic priorities: • Further develop interventions to tackle MSK related sickness absence • Implement an enhanced mental health offer to support our workforce during and following COVID-19 pandemic • Introduce team support programmes, for teams reforming and developing following the pandemic • Clarify and promote the WHH offer • Review and refresh of line managers development opportunities. Focus on new approaches to marketing WHH as the best place to work • Develop international recruitment • Introduce compassionate leadership development programmes and recruitment approaches • Introduce a framework for learning from formal HR processes • Develop a programme of work to increase diversity in decision making • Improve visibility and celebration of diversity across the Trust • Introduce Staff Networks for disabled staff and LGBTQ+ staff. • Introduce reverse mentoring • Launch targeted career management support	

			• Delivery the Model Employer action plan and goals	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/03/31 d i		TRUST BOARD OF DIRECTORS	DATE OF MEETING	31 March 2021

Date of Meeting	**17 February 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/21/02/23 & 24	Corporate Performance Report and Review of Waiting Lists and Clinical Harm Review Report	The Committee considered and reviewed the report noting:- • 75.3% January A&E performance which is a reduction from 75.5% in December. NHSI/E 81.1% trajectory. Reduction in attendances in month (6,687) compared to previous month (7,502) • The number of super stranded patients continues to be a challenge • Medical outliers' highest month year to date in January • RTT performance reduced due to COVID-19 Wave 3 resulting in a reduction in the delivery of elective performance • Recovery is impacted by Wave 2 and Wave 3 activity • Urgent cancer and elective activity (Priority 1 & 2) patients are being prioritised and a short-term delivery plan was included in the report • 40 & 52 week breaches being reviewed & prioritised weekly • Prioritisation of inpatient waiting lists	The Committee **noted** the updates and received moderate assurance.	FSC Mar 2021

		• PACU at Halton became operational in January and B4 was repurposed as a medical ward • Temporary reduction capacity at Spire in January which has impacted on endoscopy and cardiology • Management of clinical risk and governance was explained • Performance against cancer targets was impacted by the festive period and patient choice • There are current plans to establish a Recovery Board in the Trust		
FSC/21/02/25	Pay Assurance Report	The Committee considered and reviewed the report noting: - • The expansion of e-rostering was highlighted and there may be some potential impact on future Pay Assurance Reporting • Trend data reporting was requested for future reports • International nurse reporting to be included in future reports	The Committee **noted** the update	FSC Mar 2021
FSC/21/02/26	COVID-19	The Committee considered and reviewed the report noting:- • The position at the end of January was presented • The forecast has increased by £2.6m to £35.6m compared to £33.0m in December mainly due to extension of schemes and increase in self-isolation and sickness cover in January • The schemes with end dates in February are being reviewed and will either be extended or switched off • Recurrent costs to be reviewed as part of budget setting with clear review dates set	The Committee **noted** the update	FSC Mar 2021
FSC/21/02/27	Digital Services Board Report	The Committee considered and reviewed the report noting: - • The January Report had been circulated previously • Continued difficulties with Lorenzo performance highlighted	The Committee **noted** the update	FSC Mar 2021
FSC/21/02/28	Digital Services Deep Dive - ePR	The Committee received an update of ePR deep dive	The Committee **noted** the update	

FSC/21/02/29	International Nursing Business Case	The Committee supported the International Business Case Wave 3 to progress to Trust Board with enhanced reporting	The Committee **noted** the update The Committee **supported** the increase in cost and the Trust Board will be asked to **approve** The committee also **requested** enhanced reporting	Board Feb 2021
FSC/21/02/30	COVID-19 Extensions	The committee supported 4 COVID-19 extensions to go to Trust Board although concerns highlighted around continued expenditure and reimbursement	The Committee **noted** the update The Committee **supported** 4 extensions and the Trust Board will be asked to **approve**	Board Feb 2021
FSC/21/02/31	Midwifery Led Unit (MLU)	The Committee considered and reviewed the report noting: - • The reason for the £430k capital overspend was explained • £330k will be a pressure on next year as only able to mitigate £100k • MIAA to audit management of capital planning process • Additional monitoring of schemes has been put in place • The Chair requested early sight of the audit report • The committee approved the additional costs and the payment of the invoice	The Committee **noted** the update The Committee **approved** the additional capital costs and the payment of the invoice with delegated authority from the Trust Board Details of capital approvals provided in **Appendix 1**	FSC Mar 2021

FSC/21/02/32	18 Additional Beds	The Committee considered and reviewed the report noting: - • The additional capital request of £102k to cover the overspend • An additional £30k to relocate teams dislodged by this scheme • The risk that the £30k may not be delivered in the current year • This scheme will also be included in the MIAA audit highlighted above • The committee approved the additional costs	The Committee **noted** the update The Committee **approved** the additional capital costs Details of capital approvals provided in **Appendix 1**	FSC Mar 2021
FSC/21/02/33	Monthly Finance report incl: (a) Draft Capital Planning Group minutes (29.01.2021) (b) FRG minutes (meeting cancelled)	The Committee considered the report and capital proposals. Key points to note included: • On plan against the revised forecast of £16.6m deficit • Annual leave accrual increased by £2.7m to £5.3m and this is included in the £16.6m forecast deficit • £1.3m deficit against the £10.3m plan as reported to NHSE/I • Report included the exit run rate and COVID-19 impact • The annual review of IPR has been completed and no changes are required • Changes to capital programme were approved and are detailed in A**ppendix 1**	The Committee **noted** the updates and received good assurance The Committee **approved** the changes to the capital plan Details of capital approvals provided in **Appendix 1**	FSC Mar 2021
FSC/21/02/34	Risk Register including	In the absence of the Trust Secretary the Chair presented the Risk Register noting the following:- • No risks to escalate to Trust Board • No change to risk ratings • The wording of risk 134 has been changed to “There is a risk that future loans will be required which would raise the question if the Trust is • a going concern”	The Committee **noted** the updates	FSC Mar 2021
FSC/21/02/35	Local Clinical Excellence Awards	The Committee considered and reviewed the report noting: -	The Committee **noted** the update	Board Feb 2021

	(LCEA)	• The reason for the increase in cost of £63k and supported the passage to Trust Board	The Committee **supported** the increase in cost and the Trust Board will be asked to **approve**	

Appendix 1 – Capital items approved at the Finance and Sustainability Committee meeting 17th February 2021 with delegated authority from Trust Board

1) Approval of MLU overspend. Budget of £1.2m. Approval sought for £0.4m. £0.1m absorbed by removing another estates scheme not required. Acknowledged this places pressure on next years programme of £0.3m.

2) Approval of overspend to date and forecast overspend on 18 bed capital scheme. Overspend to date £0.1m over the budget of £0.3m. Requirement for additional £30k estimated to complete the scheme. This may not be completed until 2021/22.

3) Increases/(decreases) to the capital programme from £26.1m to £23.3m

Scheme	£m
Breast Screening	186
Workforce Deployment Systems	133
A&E Plaza	-3,300
Critical Care	145

4) Changes to the programme including additional schemes to mitigate under spend. Should all schemes complete per below the under spend is forecast to be £0.44m.

		£m
	Capital Programme	**23.26**
Movement of schemes	MLU	0.43
	Additional beds	0.10
	Covid	(0.20)
	MRI Turnkey	0.17
	Breast slippage (2)	(1.03)
	MRI Estates	(0.90)
	MRI turnkey (95% in 20/21) (4)	(0.02)
	AER Endoscopy (underspend)(5)	(0.03)
	Xray room 2	(0.28)
	Fixed installation (wiring)	(0.10)
	Contingency as at 31 Dec 2020	(0.40)
	Various	(0.29)
	Total Capital Spend	**20.71**
	Underspend	**(2.56)**
21/22 B/F schemes	Mandated / Business critical	(0.72)
	other	(0.07)
	Vesting (MRI and Xray)	(0.28)
	Boiler	(0.06)
	W&C	(0.27)
	Other	(0.29)
	Ultrasound machine	(0.21)
	Other	(0.06)
	Electric car	(0.05)
	Governance carpet	(0.05)
	Old Rotamap licenses to run to end	(0.04)
	Additional Air unit MRI	(0.02)
	Total Capital B/F	**(2.12)**
	Balance underspent	**0.44**

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/03/31 d ii		TRUST BOARD OF DIRECTORS	DATE OF MEETING	24 March 2021

Date of Meeting	**24 March 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/21/03/43 & 44	Corporate Performance Report and Review of Waiting Lists and Clinical Harm Review Report	The Committee considered and reviewed the report noting:- • 76.82% February A&E performance which is an improvement but below target. Reduced ED footprint in February due to works • One of highest Trusts for bed occupancy during February • Attendance levels high in March (3 consecutive weeks) • RTT performance reduced by 1% in month as expected in trajectory expect drop in 52 week waiters in July • Site reconfigurations being undertaken to support recovery • Use of independent sector continues and funding streams need to be identified • B3/B4 are extra beds and staffing these areas is becoming difficult. • Clinical services oversight group set up – looking at waiting lists and harm	The Committee **noted** the updates and received moderate assurance.	FSC April 2021

FSC/21/03/45	Pay Assurance Report	The Committee considered and reviewed the report noting: - • Increased trend analysis added to the report • Start to include more information on international recruitment • The link between medical staff FTE worked and the Medical report coming to April FSC • How we check VFM for agency staff • Compliance with the Trust rate card in February 2021 was 18% and has continued to decline since August 2020. •	The Committee **noted** the update	FSC April 2021
FSC/21/03/46	COVID-19	The Committee considered and reviewed the report noting:- • The position at the end of January was presented • The forecast has increased by £2.6m to £35.6m compared to £33.0m in December mainly due to extension of schemes and increase in self-isolation and sickness cover in January • The schemes with end dates in February are being reviewed and will either be extended or switched off • Recurrent costs to be reviewed as part of budget setting with clear review dates set	The Committee **noted** the update	FSC April 2021
FSC/21/03/47	Digital Services Board Report	The Committee considered and reviewed the report noting: - • SAN Storage Area Network – investment required included in 21/22 draft capital plan • Lorenzo contract to be escalated to Board	The Committee **noted** the update	FSC April 2021
FSC/21/03/48	Lorenzo	The Committee received an update of Lorenzo:- • Business case for a 5 year contract (3 years plus 2) completed but DXC have made some amendments to the contract regarding termination impacting on the whole year costs. The changes are not acceptable and they have been asked to reconsider their offer • The timeline regarding EPR procurement is being looked at to see if it can be reduced to complete within 3 years	The Committee **support** the update to be presented to Board on 31 March 2021	Board Mar 2021

FSC/21/03/49	SLR	The Committee considered and reviewed the report noting: - • Delay in national cost collection • SLR Q3 limited due to COVID changes in expenditure, activity and staff redeployment • Next steps include restarting the costing steering group and an Audit in April	The Committee **noted** the update	
FSC/21/03/51	Capital MIAA	The Committee noted the draft report had not yet had a full review, but has been shared for early assurance. The Committee proposed that the final report is brought back to April FSC. The Chair acknowledged the work Sarah has done in completing the audit.	The Committee **noted** the progress	FSC April 21
FSC/21/03/52	Performance Assurance Framework Review 2021/22	The Committee noted the PAF report and noted key changes:- • Digital is now covered in FSC • Trust Operation Board is currently paused • Oversight of CBU to be undertaken by Executive Team in the absence of TOB	The Committee **supported** the changed to be presented to Trust Board	Trust Board March 21
FSC/21/03/53	Revenue Budget 21/22	The Committee received a presentation key points included:- • The impact COVID has had on the Trust underlying position and sustainability • Movement of the opening plan to Exit run rate • Very high COVID costs, further work has been done but context is important. One of high COVID populations in the North West so starting the year in a different position to others • Further guidance expected on Friday 26 March • Interim budget could be between a range of figures depending on Income and planning guidance • CIP not yet in the position but expected for the second half of the year. Plans would need to be developed in Q1 and Q2 • Walked through Business Cases, COVID, Cost Pressures and Developments • Should Recovery be recurrent or non recurrent further discussion needed	The Committee **supported** the interim budget to be presented to Trust Board	Trust Board March 21

FSC/21/03/54	Capital Budget 21/22	The Committee received a presentation key points included:- • Mandated, business critical and non mandated schemes • Possibly delay start of some schemes and split over 2 years to support the Cheshire and Mersey Health Care Partnership • Two issues first being allowed a limit and second getting the PDC	The Committee **supported** the outline plan to be presented to Trust Board	Trust Board March 21
FSC/21/03/55	Monthly Finance report incl: (a) Draft Capital Planning Group minutes (29.01.2021) (b) FRG minutes (meeting cancelled)	The Committee considered the report and capital proposals. Key points to note included: • On plan against the revised forecast of £11.9m deficit, year to date deficit of £6.3m with the annual leave accrual to be included in month 12 • The forecast has changed from £16.6m to £11.9m due to the additional income for the shortfall in top ups • Changes to capital programme were approved • The vaccination hub service will continue to run from 1 April to 30 September at a cost of circa £1m, the costs will be fully reimbursed at no extra cost to the Trust.	The Committee **noted** the updates and received good assurance The Committee **approved** the changes to the capital plan The Board is asked to **approve** the vaccination hub costs and income	FSC April 21
FSC/21/03/56	SORD / SFI Amendment	The Committee considered the report which asked for an amendment to the Trust's Standing Financial Instructions to include a standard tender evaluation criterion based on 60% technical and service capability and 40% related to cost along with the process to be followed for any deviations from this standard.	The Committee **supported** the amendments to be presented to Trust Board	Trust Board March 21
FSC/21/03/57	Risk Register including	The Committee considered the Risk Register noting the following:- • No risks to escalate to Trust Board • No change to risk ratings	The Committee **noted** the updates	FSC April 2021
FSC/21/03/58	Draft FSC Cycle of Business 2021-22	The Committee considered the cycle of business for 2021-22	The Committee **approved** the cycle of business	Trust Board March 21
FSC/21/03/59	Clinical Recovery Oversight	The Committee supported the Terms of Reference to be presented at Board for approval	The Committee **supported** the TOR to	Trust Board March 21

	Committee (CROC) Terms of Reference		be presented to Trust Board	

Appendix 1 – Capital items approved at the Finance and Sustainability Committee meeting 17th February 2021 with delegated authority from Trust Board

	Capital Programme	**23.26**
Movement of schemes	MLU	0.43
	Additional beds	0.10
	Covid	(0.20)
	MRI Turnkey	0.17
	Breast slippage (2)	(1.03)
	MRI Estates	(0.90)
	MRI turnkey (95% in 20/21) (4)	(0.02)
	AER Endoscopy (underspend)(5)	(0.03)
	Xray room 2	(0.28)
	Fixed installation (wiring)	(0.10)
	Contingency as at 31 Dec 2020	(0.40)
	Various	(0.29)
	Total Capital Spend	**20.71**
	Underspend	**(2.56)**
21/22 B/F schemes	Mandated / Business critical	(0.72)
	other	(0.07)
	Vesting (MRI and Xray)	(0.28)
	Boiler	(0.06)
	W&C	(0.27)
	Other	(0.29)
	Ultrasound machine	(0.21)
	Other	(0.06)
	Electric car	(0.05)
	Governance carpet	(0.05)
	Old Rotamap licenses to run to end	(0.04)
	Additional Air unit MRI	(0.02)
	Total Capital B/F	**(2.12)**
	Balance underspent	**0.44**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21//03/31 e	COMMITTEE/ GROUP	TRUST BOARD OF DIRECTORS	DATE OF MEETING	31 March 2021

Date of Meeting	25 February 2021
Name of Meeting + Chair	Audit Committee, Chaired by Ian Jones, Non-Executive Director
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
AC/21/01/02	**Matters arising**	Electronic Patient Record Procurement Position/Lorenzo update received. Principal Senior CIO and Associate posts appointed to support the Executive Medical Director as central lead going forward. Current Ormis contract is to be extended to allow for final migration sign off by Theatre Management for June 2021. ICE optimisation on-going to be operational April/May.	**The Committee discussed the update and received good assurance and requested a further update to August Audit Committee**	**Audit Committee 12.08.21**
AC/21/02/04	**Changes or updates to the BAF**	The Committee received an update on changes to the BAF since the last meeting and particularly noted: - Five new risks had been added to the BAF. - Amendments to the descriptions of two of the risks on the BAF. - The ratings of two risks have been amended. - No risks de-escalated from the BAF since the last meeting.	**The Committee discussed the report and received good assurance**	**Audit Committee 29.4.2021 Trust Board 31.03.2021**
AC/21/02/06	**Progress report on Internal Audit Follow-**	The Committee received a report providing details of Internal Audit Reports with any outstanding management actions. The Committee	**The Committee discussed the report and received**	**Audit Committee 19.08.2021**

	Up actions at 31.12.2020	particularly noted: - One audit had one overdue management action. CBU overtime compliance with the Policy, deadline extended from 30.03.2020 and remains on hold due to Pandemic operational challenges. - Committee requested a further update to the August Audit Committee following follow-up review by MIAA in June. - 9 Audits with 17 management actions reviewed by MIAA in 2020-21 and have agreed extended deadlines by Management. - Overdue Critical and High recommendations – one high recommendation overdue relating to Overtime Review 2018-19.	**good assurance** **The Audit Committee reviewed and discussed the report and progress made to reach the current assurance.** **CBU overtime compliance follow-up in August Report**	
AC/21/02/07	**Internal Audit Progress report**	The Committee received a report providing a position statement on progress of implementations of recommendations. The Committee particularly noted the following: - 18 follow-up audits completed, 6 partially implemented, some partial compliance and extensions requested for others. The Audit Committee agreed proposals to extend a number of deadlines. - Serious Incidents Review - assurance provided that the amended Policy was in place and benchmarking against compliance of the Policy will be undertaken to provide a greater level of assurance. - It was agreed that if greater assurance and more granular detail is required, timeframes should be clearer in management responses. - Overtime Extension – The Committee requested for Overtime expenditure to be included in the Pay Assurance report to be received at the Finance & Sustainability Committee in March.	**The Committee noted and discussed the report and progress against actions will be reported at the next meeting. Moderate assurance was received**	**FSC 24.03.2021** **Audit Committee 29.04.2021**
AC/21/02/08	**Internal Audit Progress Report**	The Committee particularly noted: - 8 reports issued, 3x Substantial Assurance, 1x Moderate Assurance, 1x Limited Assurance o Combined Financial Systems **(Substantial Assurance)** o Data Quality A&E Indicators Review **(Substantial**	**Following discussion the Committee requested Extra Duties be followed up by the Finance & Sustainability Committee**	**Audit Committee 29.04.2021 and 19.08.2021**

		Assurance) ○ Estates Statutory Compliance **(Substantial Assurance)** ○ Review of Safety Standards for Invasive Procedures – **(Moderate Assurance).** QAC to receive MIAA review on completion of recommendations/actions for oversight of LocSSIP centralised monitoring system for training. ○ Extra Duties – **(Limited Assurance).** Chair of Finance and Sustainability Committee (FSC) requested Extra Duties Payment to be included in Pay Assurance Reports to FSC for additional oversight. <u>Assurance Framework (AF) Opinion – Phase 2</u> –Conclusions - AF contained all key elements relating to Structure, Engagement, Quality & Alignment and Deep Dive into Controls & Assurances, evidence of development of risk appetite.	**as part of the Trust's own internal follow up process. In addition this review will be included as part of the MIAA follow up report due to the August AC – Finance Dept & SB.** **The Committee reviewed and discussed all the reports and assurances in the report that there is adequate response and monitoring to actions identified.** **The Committee <u>approved</u> change to Audit Plan, to include Capital Programme Review.**	**QAC 06.08.2021**
AC/21/02/11	**Counter Fraud Progress Report**	The Committee received a report detailing the anti-fraud activity undertaken 1 November 2020-31 January 2021 and an update on progress made in addressing fraud referrals received by the Trust's Anti-Fraud Specialist. - New Government Functional Standard (GovS 013) introduced in February 2021, Trusts required to submit a return against these standards in May 2021, new standards and implications for the Trust being worked through. - Work programmes to adhere to standards to achieve compliance to be included in Annual Report to Audit Committee in April as per work programme. - 13 fraud alerts issued during the period	**The Committee discussed the report and received good assurance**	**Audit Committee 29.04.2021**

		- Investigations – two referrals, one carried forward and one closed. No IMO cases carried forward. One investigation closed in the reporting period.		
AC/21/02/13	**Tenders and Waivers 1 October 2020-31 December 2020**	The Committee particularly noted: - 27 waivers at a value of £1,475,948, which included 8 waivers specifically related to COVID-19 at a value of £833,246. - Breakdown of total waivers,68 in total, 32 deemed appropriate and 36 retrospective waivers. Of the 68, 27 were COVID-related. Process continues to be reinforced at Finance Resource Group. - 3 Quotation Waivers above £40,000, one above £80,000, Bioquell Pods and Nursing agency spend highlighted. - The Committee requested that further information be included in the waiver if alternative providers had been sourced and procurement process followed for Compassionate Leadership Programme (£51,000) and Bioquell Pods (£210,600), which had been discussed at Trust Board on 24 February as part of the Critical Care Capital Scheme. - Concerns noted relating to increased number of retrospective waivers and the process, monitoring and scrutiny of the process.	**The Audit Committee noted the report and assurance provided of processes in place to monitor the Tender and Waiver process and received moderate assurance.** **Future Tender/Waiver reports to include statement (1) if alternative provider sourced and (2) reasons if not.** **Detail relating to Bioquell and Abbott Medical to be shared with TA and IJ outside of the meeting.**	**Audit Committee 29.04.2021**
AC/21/02/14	**Annual Report and Accounts Timetable and Plans 2021-22**	The Committee noted key dates in the production of the Annual Report and Accounts Timetable 2021-22. - Submission of unaudited Statutory Accounts to NHSE/I and External Audit to NHSE/I by 27.04.2021, draft Annual Report and Accounts to Audit Committee 29.04.2021 prior to formal approval at Audit Committee prior to submission to NHSE/I by	**The Committee discussed the report and received good assurance**	**Trust Board 31.03.2021 and Audit Committee 29.02.2021**

		15.06.2021. • Trust Secretary to seek **delegated authority from the Trust Board for Audit Committee to approve the Final Accounts prior to Submission on 15 June 2021.**		

Other items included on the agenda were:

AC/21/02/03 - Update from Chairs of Quality Assurance (QAC), Strategic People (SPC), Finance + Sustainability (FSC)
AC/21/02/05 - Internal Audit Plan and Fees 2021-2022
AC/21/02/10 - External Audit Report
AC/21/02/12 - Review Losses and Special Payments Period 1 October 2020-31 December 2020
AC/21/02/15 - Draft Annual Report and Accounting Policies
AC/21/02/16 - Annual review of Audit Committee Cycle of Business 2021-22
AC/21/02/17 - Conflict of Interest Policy
AC/21/02/18 - North West Skills Development Network (NWSDN) Bi-Annual Report
AC/21/02/19 - Hosting of financial services for the ICON Programme (Babies Cry, You Can Cope) Bi-Annual Report

We are WHH & We are PROUD to make a difference

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/32**			
SUBJECT:	**The Trust's ongoing response to the Ockenden Report 2020 included in the Maternity Safety Champion Report**			
DATE OF MEETING:	31 March 2021			
AUTHOR(S):	Debby Gould (Consultancy), Professional Midwifery Advisor Interim			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x 		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1108 Failure to maintain staffing levels, caused by high sickness and absence, including those affected by Covid, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides assurance and update on: The Trust's ongoing response to the Ockenden Report 2020 (Appendix i) including the: - • Midwifery Workforce – Birth rate plus • Update on the Maternity Safety Champion Role and Responsibilities • Summary of progress on the Clinical Negligence Scheme for Trusts • High level summary of Serious Incidents (Sis)			
PURPOSE: *(please select as appropriate)*	Information x	Approval	To note x	Decision
RECOMMENDATION:	To receive and note the content of the report including the:- • Update on the Trust response to the Ockenden report ('Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust' on 11th December 2020). • Update on Maternity Safety Champion Roles and Responsibilities • Update on progress against the CNST Safety Actions High-level summary of Serious Incidents			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/03/64		

	Date of meeting	2 March 2021
	Summary of Outcome	For on-going monitoring as per work plan agreed.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

BOARD OF DIRECTORS

SUBJECT	The Trust's ongoing response to the Ockenden Report 2020 included in the Maternity Safety Champion Report	AGENDA REF:	BM/21/03/32

*Appendices available on request

1. BACKGROUND/CONTEXT

This monthly report focuses on the:

The Trust's ongoing response to the Ockenden Report 2020 (Appendix i) including the: -

- Midwifery Workforce – Birth rate plus
- Update on the Maternity Safety Champion Role and Responsibilities
- Summary of progress on Clinical Negligence Scheme for Trusts
- High level summary of Serious Incidents (Sis)

2 KEY ELEMENTS

2.1 Midwifery Workforce – Birthrate Pus

The Ockenden report asked all Trusts providing maternity services to use the report and the seven 'Immediate and Essential Actions' (IEA) to redouble efforts to bring forward lasting improvements in maternity services. The Trust was required to report on the implementation of 12 urgent clinical priorities from the IEAs, one of which was midwifery workforce planning.

As part of Warrington and Halton Teaching Hospitals Trust response to the Ockenden Report)[1] the Trust were required to undertake a maternity work-force gap analysis and to put a plan in place to meet the Birthrate Plus (BR+)[2] (or equivalent) standard.

Birthrate Plus ®: THE SYSTEM

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision making and has been in use in UK maternity units since 1988. It is a methodology endorsed by the National Institute for Health and Care Excellence (NICE) 2013. Whilst NICE does not recommend how frequently BR+ should be undertaken within an organisation, it does stipulate that staffing levels

[1] Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust (Ockenden Report 2020)

[2] How this midwifery workforce planning tool can give you assurance about quality and safety

[3] Safe midwifery staffing for maternity settings NICE guideline [NG4] Published date: 27 February 2015

should be reported to the Board 6 monthly. There is no other research-based methodology for workforce planning in maternity services and traditional methods are of little value in today's health service.

Birthrate Plus® is sensitive to local factors such as demographics of the population, socio-economic needs, rurality issues and the complexity of associated neo-natal services. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to safely provide intrapartum and postpartum care.

The last time a full and comprehensive BR+ report was commissioned by the Trust was in 2015, with the full BR +report published in 2016. The Trusts maternity management team undertook an internal desktop review to locally refresh the 2015 assessment in May 2018. In both instances funding was allocated by the Trust to remediate gaps identified.

In response to the Ockenden report there is a requirement to undertake a maternity work-force gap analysis and to have a plan in place to meet the Birthrate Plus (BR+)4 (or equivalent) standard. An internal table-top exercise has been undertaken in January / February 2021 by midwifery management, finance and CBU HR & OD to inform the gap analysis using the BR+ methodology to meet these requirements.

Cheshire and Merseyside LMS are planning to undertake a regional wide BR+ assessment. This will be funded by the LMS. The LMS will confirm funding in the timeframe the Trust is required to meet the Ockenden Report assurance requirements.

Following the National submissions to the Ockenden report on the 8th February by all Maternity providers, the Chief Midwife (North), on 19th February 2021 confirmed that there is an expectation that the BR+ is performed every 3 years in full (with an expectation that it is refreshed annually locally), and that there is a requirement for Trust Boards to agree local commissioning intentions for a full BR + assessment.

To support the BR+ review the Trust approved the funding of a midwife for 3 months to support the data collection at £10,328 at the Senior Executive Oversight Group on 22nd February 2020 (appendix ii).

2.3 Update on the Maternity Safety Champion Role and Responsibilities

[4] How this midwifery workforce planning tool can give you assurance about quality and safety

The purpose of Maternity Safety Champions as set out by NHS England5 is to work towards a safer maternity system by using their collective insights and skills at each level to deliver and embed improvements, through evidence-based improvement science. Enabling strong leaders at every level of the system across regional, organisational or service boundaries to promote the professional cultures required to deliver better care by adopting best practice (terms of reference for the maternity champions have been developed see appendix iii).

There is much variation in care provision and care outcomes nationally. Maternity Safety Champions are central in driving down the variation through their leadership and promotion of current best practice. The role of the maternity safety champions in the wider maternity and neonatal system is set out below.

The Immediate and Emergency Action 2b in The Ockenden Report 20206 recommended that each Trust Board must identify Maternity Safety Champions including: -

Board Level Maternity Safety Champions

- **An Executive Director** with specific responsibility for maternity services:

  The role of the Trust Board Safety Champion is to act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, LMS leads, the Regional Chief Midwife and Lead Obstetrician and the Trust board to understand, communicate and champion learning, challenges and successes.
- **A Non-Executive Director** who has oversight of maternity services:

  This role will support the Executive Director Maternity Safety Champion bringing a degree of independent, supportive challenge to the oversight of maternity and neonatal services and:
  - ensuring they are resourced to carry out their role
  - challenging the board to reflect on the quality and safety of its maternity services
  - ensuring that the voices of service users and staff are heard.

The Board level Safety Champions must work collaboratively together and with their Trust Maternity Obstetric and Midwifery Safety Champions to address and escalate locally identified issues.

Trust Maternity Safety Champions

At frontline level, every maternity provider is expected to nominate an obstetrician and a midwife who are jointly responsible for championing maternity safety locally, making appropriate links with

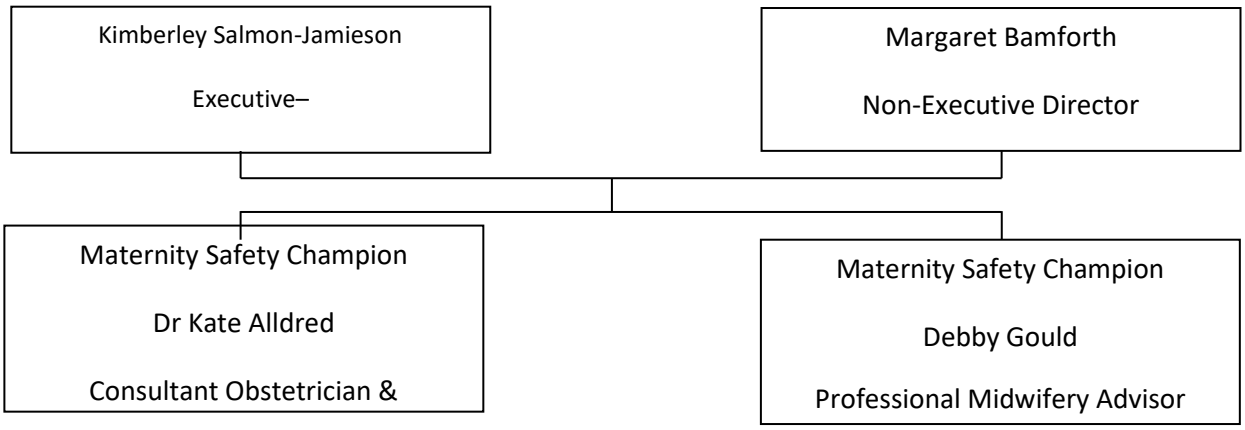
[5] A guide to support maternity safety champions February 2018 Maternity_safety_champions_13feb.pdf (england.nhs.uk)

[6] Emerging Findings and Recommendations from the Independent Review of MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST 11th December 2021 (Ockenden Report 2021)

the board, the local maternity clinical network and the maternal and neonatal health safety collaborative in their region.

- Named Obstetric Maternity Safety Champion
- Named Midwifery Maternity Safety Champion

The four maternity safety champions are described in the organogram below.



2.4 Clinical Negligence Schemes for Trusts (CNST) update

The Trust is on course to meet the CNST Safety Action requirements by 15th July 2021 submission. With regards to two of the Safety Actions there are additional plans in place to ensure compliance which are outlined below: -

- **Safety Action 2: Are you submitting data to the Maternity Service Data Set (MSDS) to the required standard? MSDS criterion 3 –**
- **Criteria: 2.1, 2.2 and 2.4 – 2.13**
- **Safety Action 2:** *Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?*

The Trust Informatics Teams, Data Analysts and Maternity Teams continue to monitor data quality to ensure that all the required MSDSv2 information is submitted on a monthly basis to NHS Digital. The Trust has successfully made monthly MSDSv2 data submissions for criteria 2.1, 2.2 and 2.4 – 2.13 from August 2020 onwards.

In December 2020 the Trust demonstrated compliance in achieving 11 out of 11, in the required tables in the NHSX monthly data quality scorecard, for the first time. As of 24th February 2021, the Trust has maintained compliance in 11 out of 11 tables for the last three months.

Compliance with element 2.3, MSDSv2 Information Standards Notice, DCB1513 Amd 10/2018 will be reported to NHS Resolution as part of the Board declaration process in July 2021. Before

the submission deadline the Trust Board will need to confirm that they have fully conformed with the MSDSv2 ISN, or that a locally funded plan is in place to do this and agreed with the maternity safety champion and the Local Maternity System (LMS). This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-C.

The current maternity Lorenzo EPR system does not support the gathering of data required to be compliant with the ISN before the CNST July 2021 deadline. A letter has been sent to NHSX outlining the supplier's limitations to conform to ISN DCB3006 Digital Maternity Records Standard and the impact this will have on the Trusts ability to comply with the ISN DCB1513 Amd 10/2018 requirement (appendix iv). A response from NHSX is still awaited.

The change to the alternative EPR provider with the incoming new computer system will continue to support full compliance with the CNST Safety Actions. The procurement process is underway however the system will not be live by the 15th July 2021 CNST submission deadline although a plan to achieve compliance is in place, as evidenced by the current compliance rates.

Where SBLCBv2 data cannot be fully submitted to MSDSv2 the Maternity Service will complete in-house audits using locally available data from health records to assess compliance with the SBLCBv2 metrics.

- **Safety Action 4:** *Can you demonstrate an effective system of clinical workforce planning to the required standard?*

A neonatal nursing workforce review has been completed and the staffing levels meet the service specification for a Local Neonatal Unit. Findings of the review have been included in the Trust Biannual Nursing and Midwifery Staffing Review which will be presented to the Workforce Committee for consideration.

In response to the 2019 General Medical Council National Training Survey (appendix v) question:

> *'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'*

62.5% of Trust Obstetrics and Gynaecology Trainees responded that they 'disagreed/strongly disagreed' with question:

An action plan has been developed to address lost educational opportunities which will be submitted to the Royal College of Obstetrics and Gynaecology following Trust Board approval at the Quality Assurance Committee.

Appendix 4: Findings from the Obstetrics and Gynaecology GMC National Trainees Survey 2019

On 2nd March 2021 the Anaesthetic Department will participate in the assessment Anaesthesia, Clinical Services Accreditation (ACSA) standards. The assessment will cover CNST Safety Action 4 requirements for maternity anaesthetic workforce planning.

An initial review of paediatric medical staffing has noted the current level of provision for tier 2 medical staff will not meet the British Association of Perinatal Medicine (BAPM) neonatal medical staffing requirements. A report of the current position and the development of an action plan to support staffing standards are under development.

2.5 Confirmation of compliance with Ockenden

The Trust submitted the second submission of the Ockenden Maternity Services Assessment and Assurance Tool Document in time for the 15th February 2022 deadline to the LMS as requested (Appendix v).
The Trust also submitted SI reports as requested in the Ockenden Report to the LMS prior to 15th February 2021. A further compliance document is being developed within the CBU and progress against full compliance is being monitored through the Maternity Quality Safety and Improvement Group.

2.6 High level summary of Serious Incidents as at 22nd February 2022

There are currently 3 serious incident investigations in progress for women's health.

- One relates to a vaginal pack left in situ. This investigation is on-going with 1 interview left to complete.
- One relates to the closure of the maternity unit. This is at the draft report stage.
- One relates to an antenatal stillbirth. At the Perinatal Mortality Review, the antenatal care was graded D which states that there were care issues identified that were likely to have made a difference to the outcome for the baby. The care issues identified related to lack of escalation to the Consultant on a plan of care in relation to abnormal blood results. This incident has been reported to StEIS and will be discussed at the Weekly Meeting of Harm before the report is shared with the CCG.

3. RECOMMENDATIONS

To receive and note the content of the report including the: -

- Update on the Trust response to the Ockenden report ('Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust' on 11th December 2020).
- Update on Maternity Safety Champion Roles and Responsibilities
- Update on progress against the CNST Safety Actions
- High-level summary of Serious Incidents

Appendices available on request

Appendix i

'Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust' on 11th December 2020 (Ockenden Report)

ockenden-report.pdf

Appendix ii

SEOG Birth rate plus paper.

SEOG Birthrate plus 19.02.2021.docx

Appendix iii

Maternity Safety Champions Terms of Reference

Maternity Safety Champion ToR V 1 Fir

Appendix iv

Trust Letter of Conformity to ISN DCB3006 Digital Maternity Records Standard

Letter to NHS Digital dated 11th February

Appendix v

Findings from the Obstetrics and Gynae

Appendix vi

Ockenden Quality and Assurance Tool Submission 9th February 2021

#MASTER Maternity Assessment Tool - v.5

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Capital Plan for 2021/22

Trust Board 31 March 2021

Andrea McGee, Chief Finance Officer/Deputy Chief Executive

Capital Update

- 2020/21 capital underspend forecast circa £1.9m
- Informed Health & Care Partnership capital required 2021/22
- Early indication from Cheshire & Mersey shows that capital plans exceed envelope by circa £70m
- Conversation with CMHCP 22/3/21 requesting voluntary reduction in capital - request response by 26/3/21
- Once the capital envelopes are agreed per Trust, applications for PDC to support the programme will be required

Draft capital plan 2021/22

	January	February	March
Summary	£m	£m	£m
Board approved schemes (prior year - Breast)	1.2	1.2	1.2
MRI completion		0.9	0.9
ICU completion			1.0
Other scheme slippage 20/21 - funded by cash (underspend)			1.9
Mandated schemes (Appendix 1)	2.7	2.7	2.7
Business Critical (Appendix 2)	2.4	2.7	2.7
Contingency	1.0	1.0	1.0
High risk schemes - Proportion of the £14.3m non mandated put forward (Appendix 3)	2.6	2.4	1.5
Total of Depreciation and carry forward contingency	**9.9**	**10.9**	**12.9**
Other schemes including ED Plaza (£3.7m increased to £5m), car park (£10m), 2 ward refurbishments (£2.5m), Urology and Paediatrics outpatients (£1.6m), New Town (£2.9m), Additional Breast (£0.5m) and step down beds (£3.5m)	24.1	25.8	26.0
Early indication of capital Programme 2021/22	**34.0**	**36.7**	**38.9**
2021/22 depreciation (estimate at 30 Oct 2020 then 28 Feb 2021)	9.4	9.4	11.0
Cash Surplus (20/21 underspend)	0.5	0.3	1.9
Council Funded (New Town)	1.0	1.0	1.0
PDC needed	23.1	26.0	25.0
Total Budget	**34.0**	**36.7**	**38.9**

- CMHCP requesting reduction. Further discussion taking place

We are WHH & We are PROUD to make a difference

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Next Steps / Recommendation

- Final plans are to be submitted to the HCP on 6th April 2021

- The Trust Board is asked to approve (subject to NHSE/I support) :-
  - the suggested capital schemes for 2021/22
  - the request for additional capital funding

Appendix 1 Mandated Schemes

Mandated schemes	£000
Call Alarms for all Anaesthetic & Recovery Rooms Halton Site	90
IT Staffing	316
Essential power installation - Halton Pharmacy	9
Substation B at Warrington Replace 2no. Air Circuit Breakers and 1no. HV Ring Main Unit	200
Fire - Relocate and replace medical gas AVSU's to clinical wards	20
Backlog - Croft Wing Electrical remedial works following fixed electrical testing of clinical areas	30
Backlog - Provide safe surface temperatures of radiators in patient clinical areas	10
Backlog - North Lodge Basement Electrical Installation Replacement	225
Backlog - Fire install of fire dampers 2nd phase	100
Backlog - Catering Department remove or replace roof lantern	30
Fire - Replacement of obsolete 5000 series fire alarm panels and end of line devices	600
Estates Capital Staffing for Design Team Works	177
Fire - Halton 30 minute Fire Compartmentation (Phase 2)	150
Appleton Wing Circulation Areas Fire Doors	200
Warrington and Halton Gas Meter Replacement	100
Backlog - All areas fixed installation wiring testing	100
6 Facet survey annual update	55
Backlog - Water Safety Compliance	50
Backlog - Annual Asbestos Management & Remedial	30
Estates Department Fire Doors	0
Backlog - HV (High Voltage) Maintenance annual	40
CMTC Replacement Emergency Lighting	150
SUB TOTAL	**2,682**

This is a scheme mandated by statute or legislation and is legally enforceable by the governing body (CQC, Fire & Rescue, NICE, NHSI/E, Data Protection Authority).

Appendix 2 Business Critical Schemes

	Capital
	£000
Business Critical	
New Maternity system integration to Lorenzo	132
New Maternity system	100
005 Cisco Refresh (Phase 1)	192
006 Comms Cabinets (Phase 2) x 2 (one each site)	90
007 IP Telephony	65
012 UPS - Main Server Room at Warrington	190
013 Data Warehouse Infrastructure Refresh	85
014 Device Replacement (Tech Refresh)	55
EPMA 1-4	24
Health & Wellbeing Workplace	13
Cardiac Catheterisation Suite	800
Radiology - DEXA Scanner	0
Radiology - Fluoroscopy Room	300
Induction of labour	22
Image Intensifier - Theatre	0
Lorenzo Theatres Licences	218
Chief Nurse Information Post	31
Electronic Patient Record Procurement	243
Phase 2 Structure - Digital Project Management and Benefits Management resource - 3 X Band 7	165
SUB TOTAL	2,725

193 of 298

This is a scheme deemed critical to service delivery and/or the health and safety of patients, staff or visitors and cannot be mitigated by any other option or action

We are WHH PROUD to make a difference

Appendix 3 High risk capital schemes

Non mandated	Jan	Feb	Mar	17 March
Schemes above 385	£k	£k	£k	
Expansion of Children's Outpatients	663	663	663	22/23
Sub A Statix Fire Protection	50	50	50	22/23
008 Network Switch Expansion	23	23	23	22/23
Backlog - Flooring Replacement Works	150	150	150	22/23
Breast Relocation Equipment – ultrasound, biopsy machine	216	216	216	
Urology	600	900	0	900
Shopping City (revised)	380	380	380	380
SAN - IT risk raised at Digital Board			240	240
Total	2,082	2,382	1,722	1,520

All items in this section have been highlighted as urgent CQC requirements or critical

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/37**	
SUBJECT:	**NW BAME Assembly**	
DATE OF MEETING:	31 March 2021	
AUTHOR(S):	Michelle Cloney, Chief People Officer	
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	#145 (a) Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper seeks to update Trust Board on: • The Vision, Mission and published priority areas for the NW BAME Assembly, and, • The submission of a Trust response detailing the work to eliminate race discrimination and a commitment from the Trust to becoming an Anti-Racist Organisation. <u>North West BAME (Black Asian and Minority Ethnic) Assembly</u> On ***18 November 2020***, Chairs and Chief Executives in NW NHS organisations received a letter from Bill McCarthy, Regional Director NHSE/I & Co Chair of the BAME Assembly and Evelyn Asante-Menah, Chair Pennine Care NHS Trust and Co-Chair of the BAME Assembly. The NW BAME Assembly provided information on their vision, mission and priority areas. The letter requested that each NHS organisation in the NW prepare and submit ***by 22 December 2020*** the following: • How you are planning to share the statement with your staff and engage them in conversations about racism and inequalities. • How you plan to link with the Assembly and its members, to support the development of your response to our statement • How you plan to build on the work already done in your own organisation – and by others – on promoting the health and wellbeing of your staff and the outcomes from the risk assessments carried out so far, particularly in relation to the roll out of the COVID vaccination programme. The Trust submitted a response as required and was informed that the intention following submission to NHSE/I was for all submissions to be collated and reported to the BAME Assembly in January 2021. Feedback would then be provided to each Trust on areas of good practice, areas for improvement and the support to be made	

	available from NHSE/I and the NW BAME Assembly. To date this feedback has not been provided. ***19 March 2021***, Chairs and Chief Executives in NW NHS organisations received a letter from Bill McCarthy, Regional Director NHSE/I & Co Chair of the BAME Assembly and Evelyn Asante-Menah, Chair Pennine Care NHS Trust and Co-Chair of the BAME Assembly relating to the Unite Nations International Day for Elimination of Racial Discrimination and providing an update on the expected review of the submitted information required from the letter of 18 November 2020.			
PURPOSE: ***(please select as appropriate)***	Information ✓	Approval	To note	Decision
RECOMMENDATION:	Trust Board are asked to: • Note the launched NW BAME Assembly mission, vision and strategic priorities, • Note the submitted information to NHSE/I and the NW BAME Assembly in December 2020, • Note the letter received on 19 March 2021 from the NW BAME Assembly indicating the need to share Trust plans to community leaders and staff, and • Approve the ambition for the Trust to be an Anti Racist organisation.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/21/01/07		
	Date of meeting	January 2021		
	Summary of Outcome	Received for Assurance		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	NW BAME Assembly	AGENDA REF:	

1. BACKGROUND/CONTEXT

The North West BAME (Black Asian and Minority Ethnic) Assembly was formed in July 2021 with senior leaders from across the North West. There are two chairs, Bill McCarthy, Regional Director NHSE/I and Evelyn Asante-Menah, Chair Pennine Care. The Trust does not have representation at the NW BAME Assembly as we do not have a BAME Trust Board member and therefore do not met the criteria set for membership.

The NW BAME Assembly report to the North West Regional People Board.

2. KEY ELEMENTS

2.1 North West BAME (Black Asian and Minority Ethnic) Assembly launch vision, mission and strategic priorities

On 18 November 2020, Chairs and Chief Executives in NW NHS organisations received a letter from Bill McCarthy, Regional Director NHSE/I & Co Chair of the BAME Assembly and Evelyn Asante-Menah, Chair Pennine Care NHS Trust and Co-Chair of the BAME Assembly (Appendix 1_Letter).

The NW BAME Assembly provided information on their vision, mission and priority areas (Appendix 2).

As part of their launch, they requested that each NHS organisation in the North West prepare and submit by 22 December the following:

- How you are planning to share the statement with your staff and engage them in conversations about racism and inequalities.
- How you plan to link with the Assembly and its members, to support the development of your response to our statement
- How you plan to build on the work already done in your own organisation – and by others – on promoting the health and wellbeing of your staff and the outcomes from the risk assessments carried out so far, particularly in relation to the roll out of the COVID vaccination programme.

2.2. The Trusts Response to the NW BAME Assembly

The Trust's response was submitted as required and is attached at Appendix 3 & 4. The Trust was informed that the intention following submission to NHSE/I was for all submissions to be collated and reported to the BAME Assembly in January 2021. Feedback would then be provided to each Trust on areas of good practice, areas for improvement and the support to be made available from NHSE/I and the NW BAME Assembly. To date this feedback has not been provided.

To progress this work within the Trust, the letter, mission, vision and priorities for the NW BAME Assembly were shared with the BAME Staff Network Chair (December 2020) and the Equality, Diversity and Inclusion Sub-Committee (15 January 2021). A webpage has been set up to share the information

provided from the NW BAME Assembly and a survey monkey – *Lets Talk About Racism* – was circulated to the Trusts BAME workforce in December 2021. Over 80 members of staff responded by 10 January 2021. The results will be collated and help to support any actions scheduled along with the feedback from NHSE/I on the submission.

Strategic People Committee were informed in January 2021 that a full briefing would be provided to Trust Board on 31 March 2021 on the NW BAME Assembly and the programme of work for the Trust to meet the requirement to become an Anti-Racist Organisation.

2.3 Elimination of Race Discrimination and Update on NW BAME Assembly ambition for NW Trusts to be Anti-Racist

On ***19 March 2021***, Chairs and Chief Executives in NW NHS organisations received a letter (Appendix 5 _Letter) from Bill McCarthy, Regional Director NHSE/I & Co Chair of the BAME Assembly and Evelyn Asante-Menah, Chair Pennine Care NHS Trust and Co-Chair of the BAME Assembly relating to the Unite Nations International Day for Elimination of Racial Discrimination and providing an update on the expected review of the submitted information required from the letter of 18 November 2020.

The letter focused on five key areas:

- **Feedback on plans to tackle racism and reduce inequalities**
  The letter acknowledged receipt of the Trusts submission in December 2020, and indicated that due to Covid-19 the work had not progressed to date. A report will be presented to the Strategic Advisory Group of the NW People Board in due course and shared with the Trust after that.

  Trust Board are asked to note the rescheduling of feedback to the Trust from the submitted information in December 2020.

- **Sharing Plans with your staff and your communities**
  The Trust is required to share plans with the workforce, stakeholders and community leaders and seek challenge to ensure that they are formed to make the greatest impact. Specifically the Trust is asked to write to MPs, council leaders, Healthwatch and community groups to summarise our work (to share a copy with NHSE/I)

  Trust Board are asked to note the requirement to share plans with staff and communities. The plans have been shared with the Staff Networks, and a webpage has been established. A formal letter will be drafted and sent in April 2021.

- **Sharing best practice and resources**
  Development of a NW BAME Assembly webpage is available to support Trusts with local actions.

  Trust Board are asked to note the availability of regional resources.

- **COVID Vaccine rollout and Ramadan**
  The NW BAME Assembly extended a thank you to Trusts for work undertaken to ensure the rollout of the vaccine to help minimise the disproportionate effect the virus has on some colleagues and communities. A range of guidance resources were circulated to support the continued rollout of the COVID Vaccine in the context of Ramadan (commencing in April 2021)

Trust Board are asked to note that the resources have been circulated to the COVID Vaccination team at the Trust to implement and to the Head of Employee Engagement and Wellbeing for dissemination to our BAME workforce as appropriate.

- **How we describe people and communities**
  The Government has published new guidance on stopping using the acronym BAME: Writing about ethnicity - GOV.UK (ethnicity-facts-figures.service.gov.uk) The NW BAME Assembly are reviewing the guidance with a view to developing a recommended approach for NHS organisations in the North West.

  Trust Board are asked to note the impending review of the use of the acronym BAME in favour of the term Minority Ethnics, and an intention to have a NW approach.

3. ASSURANCE COMMITTEE

Strategic People Committee / Equality Diversity and Inclusion Sub-Committee

4. RECOMMENDATIONS

Trust Board are asked to:

- Note the launched NW BAME Assembly mission, vision and strategic priorities,
- Note the submitted information to NHSE/I and the NW BAME Assembly in December 2020,
- Note the letter received on 19 March 2021 from the NW BAME Assembly indicating the need to share Trust plans to community leaders and staff, and
- Approve the ambition for the Trust to be an Anti Racist organisation.

Ref BMc EA KMcB 2020-11-18

Bill McCarthy
North West Region
5th Floor
3 Piccadilly Place
Manchester
M1 3BN

E: bill.mccarthy@nhs.net

TO ALL NHS CHAIRS, CHIEF EXECUTIVES AND ACCOUNTABLE OFFICERS FOR THE NORTH WEST

By email

18 November 2020

Dear Colleagues

During this second wave of Covid-19, it is important that we learn the lessons from earlier in the pandemic for our communities and the impact on the services we provide, in order to minimise the disproportionate effect the virus has on our BAME colleagues and communities. The North West continues to be one of the regions which is most affected by the high levels of community transmission of COVID. Fourteen out of the fifteen local authority areas with the highest COVID prevalence in over 60 years are in the region: and it is not therefore surprising that hospital admissions are high and growing and pressure remains intense in all parts of our systems, including primary, community, mental health and social care.

Black History Month provided us all with an opportunity to reflect on the progress that has been taken to confront racism within our organisations and wider society and to shine a light of the contribution of our BAME colleagues to the NHS. We are clear that racism has no place in our NHS and as leaders in our organisations and our systems, we must all make sure that equality is intrinsic in everything we do. We want our NHS in the North West to be clearly and unashamedly anti-racist, which means working to dismantle the structures that mean it is difficult for our BAME communities to access services and to enter the NHS workforce and progress.

Many colleagues are tired of and frustrated by the repeated pattern they see in how the NHS approaches the issue of BAME inequalities. Action rather than just talk is an imperative. Committing consistent attention and action over the long period of time is needed to tackle the deep-rooted issues behind inequalities is a must.

As an Assembly, we want to work with our North West organisations to develop action plans that leverage the collective power of the region acting together, to make a lasting change. Our members are a group of senior BAME leaders, with invaluable collective knowledge and experience, who can provide advice and guidance on the vital steps needed to tackle the deep-rooted issues behind inequalities.

The Assembly has now developed its vision, mission and identified its priorities. We ask that you:

1. Consider the attached statement from the Assembly and provide us with a response from your organisation, setting out your commitment to supporting our vision, mission and objectives. As part of your response, describe your aspirations in terms of tackling racism and inequalities and the actions you will take. The Assembly will consider these plans and identify areas where we can focus additional support (please complete the template provided).

2. Use the statement as a catalyst to have further discussions within your own staff about the issues of racism and inequality and to inform the development of your organisation's response. We know that many of our colleagues from all backgrounds across the region want to engage and stand up to racism but are sometimes fearful of saying the wrong thing and causing offense. It is only by encouraging safe space conversations that we can shine a light on the experiences of BAME staff.
3. Share information provided about the Assembly with your staff. To support this, we have provided the following:

    - A link to a short film, which can be shared with staff
    - Content for your staff intranet sites and bulletins
    - A set of slides to guide conversations with staff

We will have a discussion on this topic at the next meeting of the Chairs' forum at the end of November. It would be good if you could come prepared to give an overview of the following:

- How you are planning to share the statement with your staff and engage them in conversations about racism and inequalities
- How you plan to link with the Assembly and its members, to support the development of your response to our statement
- How you plan to build on the work already done in your own organisation – and by others – on promoting the health and wellbeing of your staff and the outcomes from the risk assessments carried out so far, particularly in relation to the roll out of the COVID vaccination programme

We would ask that you return your responses to our statement with us by close of play on Tuesday 22 December. We will be pulling responses from all NHS organisations together in a report for the Assembly to consider at its next meeting in January.

In the meantime, if you want to discuss anything further about our agenda, please either of us as co-chairs of the Assembly, Anthony Hassall or Raj Jain, who are also supporting the Assembly.

May we also take this opportunity to thank you for the leadership and ongoing commitment you and your teams have demonstrated to tackling inequalities. It is only through working collaboratively together as a region that we will be able to confront racism to become anti-racist and reduce health inequalities.

Yours sincerely,

Evelyn Asante-Mensah
Co-Chair, North West Black, Asian and Minority Ethnic Strategic Assembly and Chair Pennine Care NHS Foundation Trust

Bill McCarthy
Co-Chair, North West Black, Asian and Minority Ethnic Strategic Assembly and Executive Regional Director (North West)

North West Black, Asian and Minority Ethnic Strategic Advisory Committee

Vision

A significant and sustained change within the NHS, based on what really matters to our Black, Asian and Minority Ethnic colleagues and communities, tackling inequalities and taking positive action on racism.

Mission

Our ambition is for the NHS in the North West to be Anti-Racist and at the forefront of challenging and tackling racism and the health inequalities faced and experienced by people in our communities, brought into stark relief by the coronavirus pandemic.

We want our NHS in the North West to be clearly and unashamedly Anti-Racist, which means working to dismantle the structures that mean it is difficult for our Black, Asian and Minority Ethnic communities to access services and to enter the NHS workforce and progress.

We believe that we can bring about real improvements, by working with our NHS colleagues as our allies, to improve knowledge of the issues that our Black, Asian and Minority Ethnic colleagues face not just in the NHS but society in general.

We must unapologetically and purposefully identify, discuss and challenge issues of race and colour and the impact they have on our organisations, our systems, and our people and communities.

We must actively seek racism out and remove it from our great NHS. Our ambition is equality for all.

Strategic Objectives

In response to the disproportionate impact of COVID 19 and Black Lives Matter movement, a strategic advisory committee (our Assembly) has been established to lead on our drive for positive action on racism.

Our Assembly will work with its members to support our NHS system to be anti-racist, with the expectation that this will lead to real and sustained change, which will be noticed at all levels of the NHS from board level to the frontline. There will not be any place for bigotry and racism on any level.

Our Assembly brings together the collective will of our system, to make a significant and sustained change to what really matters to our Black, Asian and Minority Ethnic colleagues and communities, tackling inequalities and taking positive action on racism.

There are examples where organisations are making progress, however many colleagues are frustrated by what they see as the repeated pattern in some places in relation to how the NHS approaches the issue of racism and inequalities. Committing consistent attention and action to tackle the deep-rooted issues behind inequalities is an imperative.

We aim to achieve this by:

- Supporting our many colleagues of all backgrounds that want to engage and stand up to racism
- Addressing structural processes and issues that embed racism in the NHS
- Ending the “data secrecy” and being open and willing to share data that reveals inequities.

We will seek to influence decisions made at the highest level in the NHS for our region. We will develop action and strategies that dismantle racism within all aspects of the North West NHS region.

We have identified three main themes and a supportive work programme:

1. Minimise the risks posed by Covid-19 to our Black, Asian and Minority Ethnic colleagues
    - Act on information/intelligence derived from staff risk assessments
    - Support development of staff networks at an organisational level

2. Address underlying racism within our structures, which prevents our Black, Asian and Minority Ethnic colleagues from fulfilling their potential
    - Set improvement trajectories for representation at each grade in every organisation
    - Nurture the understanding of all colleagues of the depth of equality and inclusion issues

3. Tackle the inequalities of access, which mean that our Black, Asian and Minority ethnic communities have poorer health and health outcomes
    - Increase the confidence of our communities to access services and self-support
    - Utilise data points to identify inequality of service provision
    - Understanding population communities and ensuring services are meeting needs
    - Target pre employment and job opportunities at most disadvantaged
    - Challenge Reset programmes to evidence that are working on EDI agenda

Evelyn Asante-Mensah
Co-Chair, North West Black, Asian and Minority Ethnic Strategic Advisory Group
Chair, Pennine Acute NHS Foundation Trust

Bill McCarthy
Co-Chair, North West Black, Asian and Minority Ethnic Strategic Advisory Group
North West Regional Director, NHS England and Improvement

We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Private and Confidential
Evelyn Asante-Mensah
Co-Chair, North West Black, Asian and Minority Ethnic Strategic Assembly
Chair Pennine Care NHS Foundation Trust

Bill McCarthy
Co-Chair, North West Black, Asian and Minority Ethnic Strategic Assembly
Executive Regional Director (North West)

Warrington Hospital
Headquarters Kendrick Wing,
Lovely Lane,
Warrington
WA5 1QG

Tel: 01925 662299
Simon.Constable@nhs.net
www.whh.nhs.uk

23 December 2020

Dear Evelyn and Bill

Re: NORTH WEST BLACK, ASIAN AND MINORITY ETHNIC STRATEGIC ASSEMBLY

Thank you for your letter of 18 November 2020, providing details of the Assembly's vision and mission statement and associated communication materials.

The documents provided by the Assembly set out an inspiring vision for provider Trusts and we are fundamentally committed to the ambition to have all NW NHS organisations are Anti-Racist.

I am delighted to write enclosing the Trust's response in support of the Assembly's vision and mission, setting out the work we have progressed and providing details of plans for 2021/2.

I look forward to the review of North West responses as you continue to drive the sharing of best practice across organisations. If you have any queries on the content of our response please do not hesitate to contact me.

Yours sincerely

Simon Constable
Chief Executive

North West Black, Asian and Minority Ethnic Strategic Advisory Committee

Response to the Assembly Statement

Please use the questions below, to help frame your response to the Assembly's statement.

1. **The Assembly has set out its vision, mission and objectives, to support the NHS in the North West to be anti-racist; please describe your own organisation's commitment to achieving this**

Warrington and Halton Teaching Hospitals (WHH) NHS Foundation Trust is highly committed to Equality, Diversity and Inclusion (EDI) for its workforce and for those populations of Warrington and Halton who use our services. The Trust has an EDI Strategy which covers both the workforce and patient/ service users, aligned to the Public Sector Equality Duties.

The Trust Board recognises that the protection from discrimination is a human right, enshrined in law. It also knows that racism within public sector institutions exist across the UK and the NHS is not immune to this, either on the surface or behind the scenes. Inequality of opportunity for our staff with protected characteristics and for our populations using our services was highlighted in 2020 as a direct consequence of the pandemic, COVID-19. The Trust is working to address systemic racism but is absolutely committed to ensuring that the manner and approach undertaken is not tokenistic and is more than words and gestures. Key to supporting action is a genuine culture of engagement with our workforce and our patients.

WHH fundamentally support the NW BAME Assembly vision, mission and objectives to be anti-racist.

In 2019, the Trust established a BAME (**B**uilding **A** **M**ulticultural **E**nvironment) Staff Network. A Chair and Vice Chair were formally appointed by the Network in early 2020.The Trust developed a 'Recognition Agreement' for staff networks – BAME, LGBTQA+, Disability and Veterans – which provides protected time for chairs / vice chairs to undertake their role. The Chairs of networks met with the Chief People Officer weekly during Wave 1 and continue to meet fortnightly during Wave 2. This meeting is to identify priorities for action and agree next steps. On a quarterly basis the Chairs meets with the Chief Executive.

The BAME Staff Network Chair attends a range of national, regional and local network meetings which ensures that as a Trust we are responding to emerging information on racial injustice and health inequalities for BAME populations and BAME workforces and that we are driving forward and adapting our EDI agenda. On 24 June 2020 the Chairman, Chief Executive and Chief People Officer were invited to attend a virtual BAME Staff Network meeting to engage with members, actively seeking member's views and respond to questions about COVID-19 Risk Assessments.

In July 2020 the Trust commissioned an independent, external review of EDI governance arrangements and the role of Trust Board to seek and receive assurance. A desk top review of performance in line with equality legalisation, NHS standards and best practice was undertaken and one to one interviews with Trust Board members were conducted. The review was presented to Trust Board in September 2020, and provided significant assurance especially around the Trusts ambition to move from CQC Good to Outstanding for Well Led.

During 2021/22 the Trust has commissioned:

- A review of Equality Impact Assessment processes and the development and delivery of Training for Managers;
- A series of Trust Board development sessions throughout 2021, to include:
  - Cultural Competence
  - Equality Impact Assessment Training
  - Anti-Racism and Belonging
  - Diversity Icebreaker Questionnaire and Training :
    - ✓ Team development
    - ✓ Self-awareness
    - ✓ Social interaction
    - ✓ Appreciating differences
    - ✓ Constructive group dynamics
    - ✓ Building trust
    - ✓ Common understanding of concepts
    - ✓ Appreciating diversity
    - ✓ Collective reflection
- Bespoke support for the EDI Sub Committee members to fully understand their role in setting the EDI agenda aligned to Public Sector Equality Duties, NHS People Plan, NW People Board priorities, NW BAME Assembly objectives and organisational culture of inclusive and kind.
- Bespoke support for the Staff Network Chairs, Vice Chairs to support them to create thriving networks, to upskill them in influencing skills, especially assurance committees and Trust Board and focus on how they work with management and the workforce on identifying and responding to EDI priorities.
- A review of the performance information for Quality Assurance Committee (Patient EDI Priorities / Phase 3 response) and Strategic People Committee (Workforce) with the Chairs of Committees and the Executive leads for Patient / Workforce EDI

In November 2020 the Trust Board approved the outcome of a review of the organisational values and added in two new values (Inclusion and Kind). These will be launched in January 2021.

Our WHH Values:

- **Working Together**: We will work together to ensure patients come first and our staff feel valued
- **Excellence**: We will provide excellent care.
- **Embracing Change**: We are always learning and improving for our patients, the public and each other.
- **Inclusion**: ***We will be inclusive in all that we do so that our patients and staff can be their whole and authentic selves***
- **Kind: *We will act with compassion, empathy and respect to relieve each person's pain, distress, anxiety or need***

Here at Warrington and Halton Teaching Hospitals NHS Foundation Trust we know that neither our Board nor senior leadership team is as diverse as we would like (Model Employer Report 2019). The Trust is exploring the creation of Associate Non-Executive roles to create opportunities for positive action and a pipeline for under-represented communities who are looking for their first step into a Board position.

In 2020, the HRD Network nominated a lead role in each of the sub regions. Our Chief People Officer is one of these leads and therefore we expect that as an organisation we will be at the forefront of EDI developments and proactively responding to these.

HRD Lead(s):	David Wilkinson, University Hospitals Morecombe Bay (L&SC) Jacqui Grice, Wirral University Hospitals (C&M) **Michelle Cloney, Warrington & Halton Teaching Hospitals (C&M)** Nicky Clarke, Northern Care Alliance (GM)
Deputy Lead(s):	**Debs Smith, Deputy CPO, Warrington & Halton Teaching Hospitals (C&M)** Ruth Francis, Head of OD, Greater Manchester Mental Health (GM)

A Project Initiation Document was developed and submitted for approval, and included:

1	**All organisations and Integrated Care Systems within North West NHS region to become an Anti-Racist organisation in order to advance racial justice.**
	• NW HRD EDI Leads Scoping Project Milestones - ***December 2020 - March 2021*** • NW HRD EDI Leads Drafting Commitment Statement - ***December 2020 - January 2021*** • NW HRD Network Approval to Commitment Statement – ***January - February 2021*** • NW Organisational and ICS Commitment – ***March 2021*** • NW HRD EDI Leads develop an anti-racist work programme / routemap for implementation by each organisation – ***January – March 2021*** • Implementation of Anti-Racist Toolkit – ***April 2021 - March 2022***

The Chief People Officer is one of the HRD Leads for EDI in Cheshire and Merseyside. This has enabled improved links with NHSE/I EDI Specialists. The HRD Lead for EDI is required to meet with NW EDI HRD Leads across the North West and with NHSE/I EDI Specialists on a monthly basis during 2021, and will be responsible for driving forward the implementation of the Anti-Racist Toolkit across the North West (when launched in February 2021).

Standford - Ideal Engage Anti-Racism Framework

WHH will use the *Stanford – Ideal Engage Anti-Racist* framework to:

- Improve individual staff members understanding of EDI and racism
- Provide development sessions during 2021 on how to get comfortable with being uncomfortable and how to talk about racism
- Take action to confront and reject racism in all its forms
- Focus on building Allyship within the Trust,
- Create the conditions for BAME staff to Speak Up,
- Promote understanding of intersectionality across staff networks and in how we provide services to our patients, and,
- Report on the work via the BAME Staff Network and the EDI Sub Committee through to the Assurance Committees for Quality and People.

WHH will lead from the top, by driving the promotion and roll out of a '***Be Kind'*** programme in 2021 aimed at individuals, teams and managers covering the principles of Zero Tolerance and creating inclusive cultures of civility, kindness and respect which promote a sense of 'belonging'. It will be aligned to the findings of our Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) Action Plan and will draw on the National Staff Survey (2020) results in 2021.

During 2021 WHH will produce an EDI Calendar of significant events, to raise awareness and enhance cultural competence, including Black History Month, South Asian Heritage Month, observing religious holy days and festivals.

WHH will continually evaluate the impact of its actions and re-prioritise as appropriate to maintain the momentum of change required to make a difference to our workforce and our patients.

2. Please share the key points from feedback you have had from staff within your organisation, which has helped you to shape this commitment

Engagement with our workforce has been vital during COVID-19 and a range of mechanisms have been used to seek our staff views, including De-Briefing Sessions with staff in wards and departments following Wave 1; attendance at staff forums such as Grand Round, Medical Cabinet, Nurse Leadership Forum, and virtual Team Brief ; survey monkey questionnaires; Staff Welfare Champions linked to clinical areas; emails from staff to Executive Team members; attendance at Staff Networks; participation in calendar of activities such as South Asian Heritage Month events.

During COVID-19 staff have raised issues with leaders/managers in the Trust, including the Trust Board, and these have been addressed immediately. The BAME Staff Network has been instrumental in getting key messages out to our workforce, including recently providing communications around COVID-9 Vaccine Misinformation.

WHH will continue this active dialogue during 2021/22. It should be noted that currently a survey 'Let's Talk About Racism' is 'live' awaiting responses on the key questions of:

- How do you feel we as an organisation have responded to the increased awareness of the issues of racial discrimination?
- Are you aware of any experiences of racial discrimination in our organisation, either your own experiences or those of others?
- Do you feel we do enough as an organisation to ensure equal opportunities for everyone?
- Do you feel we do enough as an organisation to build a culture where everyone can come to work and be themselves?
- What would you like to see us do more of to further inclusion in our organisation?
- What would you like to see us do more of to further inclusion in our organisation?
- What else would you like us to be aware of?
- What's needed for you to feel comfortable and confident to talk openly about racism

To date our workforce has told us that they would like us to:

- Implement inclusive recruitment approaches, through training in unconscious bias and cultural competence for Recruitment Panels;
- Review EDI Training relevant for all staff and implement recommendations;
- Increase education and awareness of race equality, micro-aggressions, intersectionality, allyship;

- Support career progression and talent management for BAME staff;
- Address the lack of awareness of WRES reports;
- Address the lack of understanding of the EDI elements of the National Staff Survey results;
- Encourage BAME staff to actively connect with Executive Directors to provide feedback in their lived experience at the Trust, which included addressing their perception that they are treated less favourably that their white colleagues;
- Consistently and fairly address the pre-COVID-19 BAME staff feedback that managers were reluctant to give annual leave over the 'normal' allocation of 2 weeks for overseas visits, despite this often being for weddings, special events, or funerals;
- Celebrate Inclusion and Diversity – promote the *Inclusion Ally* Award at WHH Thank You Awards (2021);
- Improve the lack of career promotion or opportunities for secondments for BAME staff;
- Improve conditions for the workforce and ensure these are replicated in improvements for our patients and service users; and
- Increase Public Participation and Involvement with local communities and hard to reach population groups.

With the above feedback and the bespoke independent support for Staff Network Chairs / Vice Chairs, the intention is to create a Network action plan.

During September – November 2020 a review of all Employee Relations case work was undertaken using the principles set out by Dido Harding on *Improving People Practices*. The findings of this review provided assurance to the Strategic People Committee that the Trust was adopting a *Just and Learning Culture*, and that BAME staff were not treated less favourably or in a discriminatory manner when considering, commencing or conducting (Informal / Formal) disciplinary procedures.

3. Please give an overview of what you are going to do differently as a senior leadership team, in order to put this commitment in to action

The Trust Board will continue to enhance their knowledge and understanding of racism and anti-racism, through the 2020/1 commissioned development programme.

Reports on EDI Sub Committee and Network Chairs/Vice Chair development programme to be presented to Strategic People Committee (2021/2).

The NW BAME Assembly Anti-Racist Toolkit, due in February 2021, will be presented to the EDI Sub Committee, Strategic People Committee and Trust Board, along with an action plan to implement all aspects and build on areas of good practice.

The Chief People Officer will roll out 'Intentional About Inclusion' training within WHH during 2021/2.

The immediate next steps in Quarter 1 and 2 (2021/2) to be taken include:

- CEO personal commitment to the organisation becoming anti-racist (January 2021)
- EDI Objective on Inclusion for Executive Directors in 2021/2 appraisal cycle;
- Implementation of Reverse Mentoring with Executive Directors and Senior Leaders
- Launch of new values – Inclusion and Kind
- Roll out of 'Be Kind' programme
- Development of Allyship Programme – to support workforce to step up and challenge any discriminatory behaviour

- Deliver Phase 3 – Addressing Inequalities for Patients / Service Users
- Review of Model Employer targets for Board and senior leadership representation
- Commitment to promote visibility of BAME staff in communications and imagery
- Promotion of BAME Staff Network and Network Lead contact details

4. **Given where we are with the second wave of the pandemic, please give an overview of how you are going to focus on some immediate challenges facing our BAME colleagues and communities i.e.:**

- The health and wellbeing of staff, in particular building on risk assessments for BAME staff

WHH has provided significant Health and Wellbeing resources since the start of the Pandemic, building on existing provision. A Health and Wellbeing resource information booklet was provided to all staff in Wave 1 and is currently being revised to update it with new local, regional and national offers.

Risk Assessments continue to be monitored and revised as services re-open or organisational change occurs. Managers are supported with complex Risk Assessments via Occupational Health & Wellbeing Services. The HR Department has established a Redeployment Hub to support BAME staff who are Clinically Extremely Vulnerable or Clinical Vulnerable to either work from home or be safely redeployed.

A daily update on Risk Assessments – Self Assessments by individuals and those who require a Manager Risk Assessment is provided to managers in the Trust. Daily updates on completion information is provided to the Executive Team to provide oversight which has led to personal letters and emails being sent to staff who need to complete the Self Assessment and to Managers to undertake the Manager Risk Assessment in a timely manner. Regular updates are reported to the Trust's Tactical Meeting (attended by the Chief Operating Officer, Chief Nurse, Executive Medical Director and Chief People Officer) which is circa. held 4 days a week.

BAME Staff will be included in the staff prioritisation list for access to the COVID-19 Vaccine, in line with PHE guidelines.

WHH has rolled out Lateral Flow Testing to patient facing staff in the first instance and has now rolled this out further to any non-patient facing staff working in a Clinical Business Unit.

- Support for your BAME staff networks and effective communications with them in general

The BAME Staff Network has a very proactive Chair and Vice Chair. In addition to their work, the Trust's EDI Workforce Specialist and EDI Administrator work with them to ensure that information is available on the Trusts intranet site. The Head of Engagement and Wellbeing oversees the Trust EDI portfolio and provides support and oversight to the Chairs of Staff Networks.

The Communications Team have designed and produced a BAME Staff Network Logo and the Charitable Committee has provided the network with a small budget to enable them to promote their network within the Trust.

Staff Side Chair and Deputy Staff Side Chair attend the EDI Sub Committee and have been active members of the BAME Staff Network meetings.

A dedicated BAME Staff Network email address has been set up for the Chair of the network to access and promote their network activities.

- The take up of the flu and the Covid vaccines by staff in particular BAME staff

During December 2020, the Staff Network Chair was asked to support the SRO for COVID-19 Vaccination programme at WHH to address misinformation about the vaccine and to encourage BAME Staff to access reputable sites in order to inform themselves about the vaccine. Frequently Asked Questions and communications on the COVID-19 vaccination are promoted internally.

As previously indicated the COVID-19 Vaccine will be offered to BAME Staff as a priority staff group, along with staff over 70 years of age and those with Clinically Extremely Vulnerable conditions.

As at 23 December 2021, over 80% of patient facing staff have received the Flu Vaccination. The Occupational Health & Wellbeing Service have actively contacted all patient facing staff to ensure they are aware of clinic times, names of peer vaccinators in clinical areas and to provide any additional information in order to encourage them to have the inoculation.

- Ensuring BAME communities are not disproportionately impacted by any temporary changes to services; and that as services are brought back on line, health inequalities are not made worse

WHH has an approved Clinical Strategy and Patient and Public Participation and Involvement (PPPI) Strategy, which specifically reference the needs of the local populations in Warrington and Halton and hard to reach communities. Health inequalities is addressed within these strategies, and has been further enhanced through the recently revised EDI Patient Priorities Action Plan which covers the Phase 3 Letter sent by NHSE/I COO Amanda Pritchard.

For any service change, a Change Form is completed and submitted to the Governance Lead of the Trust for review and retention. Engagement with system partners ensures that any service change impacting on service delivery are flagged and any mitigations, where possible, are taken to ensure that BAME staff or BAME service users are not disproportionately impacted by service changes.

WHH has reviewed the Head of Patient Experience role and expanded this to include Inclusion, with responsibility for delivering the EDI Patient Priorities. In addition the Trust has invested in a new role of Patient Experience Manager to ensure that EDI Patient Priorities are actioned during 2021/2.

5. What are you proud of; what initiatives or programmes in place to tackle health inequalities and take positive action against racism

Since the beginning of the Pandemic in the UK, our Chief Executive at Warrington and Halton Teaching Hospitals NHS Foundation Trust has produced a ‘Good Morning WHH’ daily email message to all staff. On the 10 June 2020, the Good Morning Message was entitled: ***‘Us at WHH – who we are and who we are not***.’ In this message he wrote:

“So I believe I speak for all of us when I say that we were all shocked, horrified and saddened by the killing of George Floyd in the United States. We also recognise that racial

injustice is not isolated to the US but is a genuine lived experience for thousands across the globe. Racial injustice is still prevalent within the UK. We want to add our voice to the many voices around the world who are rightly calling out racial injustice, prejudice and discrimination.

Within our Trust, there is still work to do, we must and we will continue to invest in support for equality, diversity and inclusion, consistent with our kindness, and looking after each other. It is unacceptable that instances of bullying, harassment and discrimination continue with more prevalence for Black, Asian and Minority Ethnic (BAME) people anywhere, let alone within the NHS, and let alone WHH more specifically. And more must be done to promote BAME staff into senior positions. We are committed to working hard to improve this in our Trust.

COVID-19 has brought the issue of racial inequality to the fore, through reasons not fully understood. This week, Public Health England published its report 'Disparities in the risk and outcomes of COVID-19' which identifies a disproportionate impact of COVID-19 on our Black, Asian and Minority Ethnic population, and although there is still much work required to fully understand what this means across the country and within the NHS, we already know that we must put in place safeguards to protect those most vulnerable."

Some of the initiatives we have undertaken in 2020 include:

- Letter to all BAME staff from Chief Executive in Wave 1 to ensure they were aware of the Health and wellbeing offer available to them and to promote Risk Assessment completion
- Response to roll out and completion of BAME Risk Assessments
- Continued support to all Staff Networks during a Pandemic, including support provided to the BAME Staff Network Chair who was unable to return to the UK following the cessation of flights from India during Wave 1;
- Fortnightly meetings for Staff Network Chairs with Chief People Officer;
- Quarterly meetings for Staff Network Chairs with Chief Executive;
- Held a number of engagement events on WRES in order to develop the Trust's action plan for 2020/21
- Attendance by 10 key WHH staff at the Cheshire Fire and Rescue Pride II event on Intersectionality – to share best practice across public sector organisations
- Support for Staff Network Chairs to develop and share knowledge and resources across networks
- Promotion of Black History Month and active participation within this by BAME Staff Network
- Recognition of our Sikh community leaders who provide staff during Wave 1 and 2 with hot meals
- Active membership of regional and national chair network activities by BAME Staff Network Chair
- Commissioned a Review of EDI Governance in 2020 with a focus on the assurance the Trust Board received on EDI activities
- Commissioned a services of activities on EDI from an independent expert for 2021

Ref BM HH 2021-03-19

Bill McCarthy
North West Region
4th Floor
3 Piccadilly Place
Manchester
M1 3BN

E: bill.mccarthy@nhs.net

19 March 2021

NHS Trust Chief Executives
CCG Accountable Officers
ICS Leads
North West Region

By email

Dear Colleagues

We are writing to you ahead of the United Nations International Day for Elimination of Racial Discrimination, which takes place annually on Sunday 21 March.

We are planning to issue a media release linked to the UN initiative to mark the continued commitment of NHS organisations across the North West to tackle racism and address inequalities.

We would also welcome your support by sharing your organisation's own commitment on your social media channels, and briefing information is being sent to your communications team.

We also want to update you on other work which we are undertaking to drive forward our actions to tackle racism and reduce inequalities.

Feedback on your plans to tackle racism and reduce inequalities

We would firstly like to thank all of you for submitting details of your plans to make the NHS in the North West clearly and unashamedly anti-racist.

We had hoped to review these and compile a report for the Strategic Advisory Group to discuss in January. However, this timescale has been amended to take account of the impact of the recent COVID wave. We are now able to pick up this work and look forward to discussing your plans and sharing the report with you very soon.

Sharing your plans with your staff and your communities

We know from feedback that many of you are already shaping your plans on tackling racism and reducing inequalities by engaging with your staff, patients and community leaders.

If your organisation has not already done this then can we please ask that you do so, engaging through your existing channels, and any new ones which you have formed in

responding to the COVID-19 pandemic. We will succeed in tackling racism only if we fully engage with our staff and the communities which we serve.

We need to recognise that this will be an iterative process and we hope that you will seek constructive challenge to your plans, to ensure that they are formed to make the greatest impact.

To support that approach, could we ask you to also write to your local stakeholders including MPs, council leaders, Healthwatch and appropriate community groups to summarise your work. Please copy us into this correspondence – nhsi.nwregional_director@nhs.net

Sharing best practice and resources

We will be developing the North West Assembly webpage at https://www.england.nhs.uk/north-west/north-west-black-asian-and-minority-ethnic-strategic-advisory-group/ as a place where useful information and best practice can be shared, and the report mentioned above will be published on it too. We want to see this webpage become a practical resource to support you in your own actions.

COVID vaccine rollout and Ramadan

We would like to thank you all for the efforts made to ensure that the rollout of the COVID-19 vaccine is helping minimise the disproportionate effect the virus has on some of our colleagues and communities. Reviewing successes for Black and Minority Ethnic uptake so that lessons learned can be shared widely, and analysing reasons for gaps in uptake, are priority actions for the Assembly.

Ramadan begins in April, and the attached information, produced by the Northern Care Alliance - Inclusion Centre of Excellence and the British Islamic Medical Association, will assist your organisation in discussing appropriate support and consideration for staff and patients, particularly within the context of the COVID vaccine rollout.

How we describe people and communities

We are all aware of the importance of language when discussing ethnicity and racism.

The Government has published new guidance on this for the gov.uk website, which includes stopping use of the acronym BAME. The guidance is available here - Writing about ethnicity - GOV.UK (ethnicity-facts-figures.service.gov.uk)

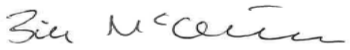
The Assembly will be reviewing this guidance with a view to developing a recommended approach for NHS organisations in the North West.

Next steps

In addition to the plans set out above, we would welcome any suggestions which you have as to how the Assembly can support your work to ensure that the NHS across the North West is anti-racist and successfully reduces health inequalities. If you have any suggestions then please contact either ourselves, or Raj Jain, Group Chief Executive of the Northern Care Alliance, who is supporting the Assembly in its work.

Thank you for your continued efforts to ensure that we work collaboratively together as a region.

Best wishes



Evelyn Asante-Mensah

Co-Chair

North West Black, Asian and Minority

Ethnic Strategic Advisory Group

Bill McCarthy

Co-Chair

North West Black, Asian and Minority

Ethnic Strategic Advisory Group

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/38**			
SUBJECT:	**National Staff Opinion Survey**			
DATE OF MEETING:	31st March 2021			
AUTHOR(S):	Deborah Smith, Deputy Chief People Officer			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People Officer			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. 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)***	#145 (a) Failure to deliver our strategic vision.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The 2020 staff survey took place between September and November 2020 during the second wave of the COVID-19 pandemic. In the 2020 staff survey, the organisation's response rate was 36%. Despite the context in which the survey was undertaken, the results show areas of improvement and also results above the national average. The organisation is better than the average score in 8 areas and in line with the average score in 2 areas. The results show two areas of statistically significant improvement when compared with the previous year: • Health and Wellbeing • Safe Environment – Violence The results also show two areas of statistically significant decline: • Immediate Managers • Team Work This paper also provides a breakdown of the survey results relating to Workforce Race Equality Standard and Workfare Disability Equality Standard.			
PURPOSE: *(please select as appropriate)*	Information X	Approval	To note	Decision
RECOMMENDATION:	Trust Board are asked to note the 2020 Staff Opinion Survey Results and the next steps.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/21/03/27		
	Date of meeting	24 March 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	National Staff Opinion Survey	AGENDA REF:	BM/21/03/38

1. BACKGROUND/CONTEXT

The NHS Staff survey is a nationally mandated survey across all organisations to inform local improvement in staff experience and wellbeing. It is a national measure against the pledges set out in the NHS Constitution and provides useful intelligence to the Care Quality Commission and local commissioners.

The 2020 staff survey took place between September and November 2020 during the second wave of the COVID-19 pandemic. The survey was administered via Quality Health, who are an approved NHS staff survey provider. The organisation undertook a mixed mode approach to the survey providing paper copies as well as an online option for all members of staff.

The staff survey is made up of a number of questions, which equate to the following themes:

- Equality, Diversity and Inclusion
- Health and Wellbeing
- Immediate Managers
- Morale
- Quality of Care
- Safe Environment – Bullying and Harassment
- Safe Environment – Violence
- Safety Culture
- Staff Engagement
- Team Working

The 2020 staff survey also included additional questions relating to staff experience during the COVID-19 pandemic, with free text comments which will be shared with organisations in April 2021. In addition to the free text comments, staff were asked four classification questions relating to their place of work during the COVID-19 pandemic as illustrated below:

- Have you worked on a COVI10 specific ward or area at any time? (Yes / No)
- Have you been redeployed due to the COVID-19 pandemic at any time? (Yes / No)
- Have you been required to work remotely / from home due to the COVID-19 pandemic? (Yes / No)
- Have you been shielding?
    - Yes, for myself
    - Yes, for a member of my household
    - No

The results from the survey provide the organisation with the opportunity to understand staff experience in terms of what is going well and the areas that may require further improvement. The full report is attached at appendix 1.

In addition to the publication of results, organisations are required to develop local priority work streams to address the results from both an organisation and directorate (Clinical Business Unit) perspective to demonstrate to staff how the organisation is listening and responding to staff feedback.

2. KEY ELEMENTS

2.1. Response Rate

In the 2020 staff survey, the organisation's response rate was 36% which is a decrease of 17% from the 2019 staff survey figures; however it is important to note that the survey was undertaken during wave 2 of the pandemic. In total, 1,492 members of staff completed their survey. The organisation's response rate was 7% below the national score when compared with other acute trusts nationally.

The upward trend in response rate from 2017 onwards demonstrates the impact of specific and coordinated programmes to increase response rate each year. These have been based around 2 key principles:

1. The important role of line managers and senior managers in distributing surveys, encouraging uptake and sharing key messages.
2. Direct engagement (as opposed to electronic communications) from the Engagement and Wellbeing Team and the HR Team in partnership with Staff Side with the workforce, particularly front line staff.

During the roll out of the 2020 staff survey, the COVID-19 response meant that these principles could not be implemented and this has impacted on the survey response rate.

Diagram One: Trust Response Rate

	2016	2017	2018	2019	2020
Best	76.3%	72.6%	71.6%	76.0%	79.8%
Your org	38.3%	45.6%	50.6%	53.0%	36.0%
Median	42.3%	43.9%	43.6%	46.9%	45.4%
Worst	28.8%	27.3%	24.6%	27.2%	28.1%

2.2. Overview of Results

Despite the context in which the survey was undertaken, the results show areas of improvement and also results above the national average.

Diagram two highlights the thematic results from the 2020 staff survey including best and average scores. The results illustrate that the organisation is better than the average score in 8 areas and in line with the average score in 2 areas.

Diagram Two: Staff Survey Thematic Results 2020

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.4	6.5	6.9	6.3	7.6	8.4	9.5	6.9	7.1	6.5
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	1,486	1,481	1,489	1,480	1,156	1,480	1,481	1,481	1,488	1,469

Significance Testing: 2019 vs. 2020 Theme Results

Statistical significance is tested by the survey provider, using a two-tailed t-test with a 95% level of confidence. The results show two areas of statistically significant improvement:

- Health and Wellbeing
- Safe Environment – Violence

The results also show two areas of statistically significant decline:

- Immediate Managers
- Team Work

Table One: Organisation Thematic Results Comparison

Theme	Year on Year*			Against Average		
	2019	2020		Av.	WHH	
Equality, Diversity and Inclusion	9.4	9.4	↔	9.1	9.4	↑
Health and Wellbeing	6.3	6.5	↑	6.1	6.5	↑
Immediate Managers	7.1	6.9	↓	6.8	6.9	↑
Morale	6.4	6.3	↔	6.2	6.3	↑
Quality of Care	7.7	7.6	↔	7.5	7.6	↑
Safe Environment – Bullying and Harassment	8.4	8.4	↔	8.1	8.4	↑
Safe Environment – Violence	9.4	9.5	↑	9.5	9.5	↔
Safety Culture	6.9	6.9	↔	6.8	6.9	↑
Staff Engagement	7.1	7.1	↔	7.0	7.1	↑
Team Working	6.8	6.5	↓	6.5	6.5	↔

**based on statistical significance, see page 180 of the Staff Survey Benchmark Report at appendix 1.*

2.3. Themed Results – Key Highlights

2.3.1 Equality Diversity and Inclusion

In relation to the theme of Equality, Diversity and Inclusion, staff members feel that that organisation has made adequate adjustment(s) to enable staff to carry out their work with an increase of 8.1% in comparison with the 2019 staff survey results. In addition to adequate adjustments, individuals experiencing discrimination at work from patients / service users, their relatives or other members of the public has decreased by 0.4% compared with 2019 results. There are, however, areas which the organisation needs to improve upon in relation to the perception of the organisation acting fairly in relation to career progression or promotion irrespective of protected characteristic as well as individuals experiencing discrimination from their manager, team leader or work colleagues. The organisation performs above average when compared with Acute Trusts nationally in relation to the equality, diversity and inclusion theme.

2.3.2 Health and Wellbeing

The questions relating to the theme of Health and Wellbeing demonstrate that staff feel that the organisation takes positive action on health and wellbeing with an increase of 6.8% in comparison with the 2019 staff survey results and better than the Acute Trust national average. This is likely to be testament to all of the increased activity and focus on health and wellbeing during the pandemic with the development of the mental wellbeing hub and the increased presence of interventions in this area. The percentage of individuals experiencing musculoskeletal (MSK) problems as a result of work has decreased by 1.4% and individuals coming into work in the last three months despite not feeling well enough to perform their duties has also decreased by a substantial amount of 11.2%, which is very positive and better than the Acute Trust national average. There are some areas to improve within the organisation, namely work-related stress which has seen an increase of 5.1% of staff feeling unwell due to work related stress in the last 12 months. This also reflects the national picture as the last 12 months has seen the start of the COVID-19 pandemic as well as the preceding winter pressures with pressures both within work life and home life for some of our staff. The Occupational Health and Wellbeing team and the newly established Mental Wellbeing Hub have a range of actions and interventions that are already being implemented, based on

evidence and best practice from the British Psychological Society and this activity will continue to evolve and increase, responding to the needs of our workforce.

2.3.3 Immediate Managers

In relation to Immediate Managers, the thematic results demonstrate an overall reduction, which could be attributable to a range of factors such as staff not working in their substantive roles currently, a change in line management due to the response to the COVID-19 pandemic or having to shield at home due to an on-going medical concern. The national average results for this theme have also declined. The Trusts results do show an increase of 0.9% in comparison to 2019 in staff feeling that their immediate manager asks for their opinion before making decisions that affect their work. There is work to be done in relation to staff feeling that clear feedback is given on their work which has decreased by 4% and is slightly less than the national Acute Trust average. The number of staff who feel that line managers take a positive interest in their health and wellbeing has also decreased, against a national average increase in relation to this question and also against a significant increase for the Trust overall in relation to the Health and Wellbeing theme.

2.3.4 Staff morale

The staff morale theme focuses on how staff voice is listened to within the workplace, relationships between colleagues and also an individual's intention to leave the organisation. There has been a 5.8% improvement on individuals feeling that they have unrealistic time pressures which is also a best score in comparison with Acute Trusts nationally. Other positive improvements have been made in relation to staff feeling that they are involved in deciding changes that affect their work area / team / department which has improved by 0.5% in comparison with the 2019 staff survey results. Areas for improvement include the respect that staff receive from colleagues, which has decreased by 3.4% in comparison with 2019 and also the immediate managers encouraging individuals at work which has decreased by 2.4%. The pandemic has had an impact on all facets of the organisation including line manager relationships and the HR and OD Directorate have developed a range of guidance and development for line managers which focus on the importance of checking in on their teams and how to lead during a pandemic. In addition to line managers, this theme also identifies that there has been deterioration in the percentage of individuals often thinking about leaving the organisation which has deteriorated by 0.3% in comparison with 2019.

2.3.5 Quality of Care

The results relating to quality of care demonstrate that staff feel satisfied with the quality of care they give, with an increase of 0.5% from the 2019 results. However, there has been deterioration in staff feeling that they are able to deliver the care they aspire to which has decreased by 0.4%. There is also a disconnect between the percentage of staff feeling satisfied with the level of care that they provide and that their role makes a difference to patients or service users which has decreased by 0.5% and is less than the national average for Acute Trusts.

2.3.6 Safe Environment – Bullying and Harassment

In relation to bullying and harassment, in the last 12 months the workforce has experienced a decrease in harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public, however there has been an increase in staff

reporting harassment, bullying or abuse from managers (2.5%) and other colleagues (1.1%). It is important to note that despite the deterioration, the organisation performs above the Acute Trust national average, which provides a good foundation to focus on this important priority in the coming 12 months.

2.3.7 Safe Environment – Violence

There have been improvements across the board in relation to staff experiencing violence from patients / service users, their relative or other members of the public, managers and other colleagues.

2.3.8 Safety Culture

The safety culture theme focuses on whether the workforce feel that concerns can be raised and that feedback is listened to. This theme and subsequent questions relating to safety culture all score higher than the national Acute Trust average. There have been improvements across all questions, with the exception of a deterioration of 0.7% in staff feeling that they are given feedback about changes made in response to reported errors, near misses and incidents.

2.3.9 Staff Engagement

The theme of staff engagement focuses on staff motivation, ability to contribute to improvements and recommendation of the organisation as a place to work or receive treatment. From a motivation perspective there has been deterioration in staff feeling enthusiastic about their job (3.1%) and looking forward to going to work (0.7%). Improvements have been made in comparison with the 2019 staff survey results of staff feeling able to make improvements happen in their area of work (1.9%) and staff feeling able to make suggestions to improve the work of their team or department (0.3%) which does buck the national trend. There has also been a 4% improvement of staff recommending the organisation as a place to work and an improvement of 6% of staff recommending the organisation as a place for care or treatment. Overall, the Trust results show that the workforce is more engaged that average and this has remain the same from 2019.

2.3.10 Team Working

The final theme of team working focuses on how staff members feel as part of a team. The 2020 staff results in comparison with 2019 demonstrate that although there has been improvement in staff feeling that the team they work in has a set of shared objectives, there has been a 6.1% deterioration in staff feeling that their team often meets to discuss the teams effectiveness.

2.3.11 Workforce Race Equality Standard and Workforce Disability Equality Standard

In addition to the thematic results, tables two and three illustrate some of the results that are used for the national Workforce Race Equality Standard (WRES) and the national Workforce Disability Equality Standard (WDES).

Table Two: Workforce Race Equality Standard

Question	BAME Staff Results 2020	White Staff Results 2020	BAME Staff 2019 vs. 2020	BAME Staff Experience vs. White Staff Experience
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	16.5%	17.7%	↓	Positive
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	20.8%	19.3%	↓	Negative
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.	79%	91.4%	↓	Negative
Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months.	11.2%	4.2%	↑	Negative

Table Three: Workforce Disability Equality Standard

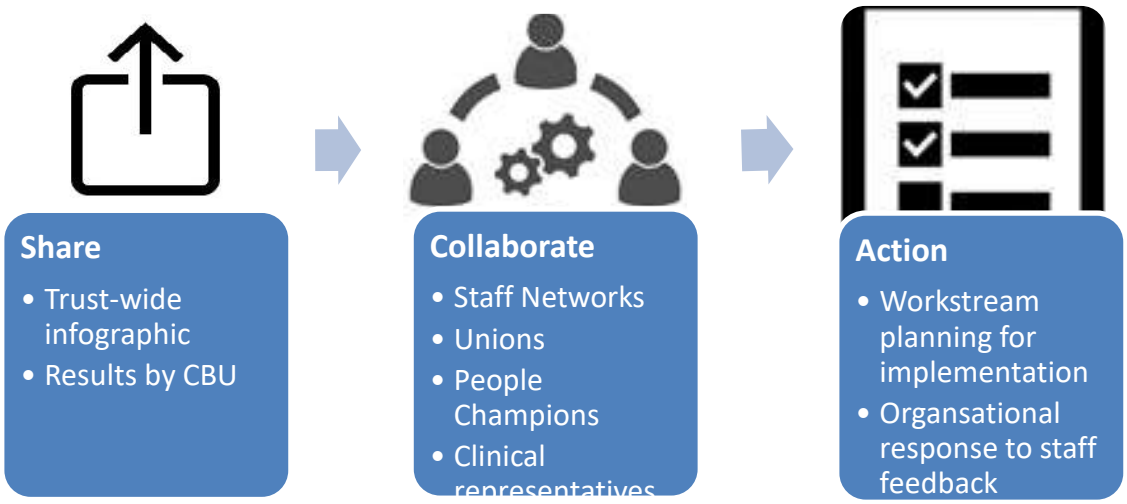
Question	Staff with a LTC or illness 2020	Staff without a LTC or illness 2020	Staff with a LTC or illness 2019 vs. 2020	Comparison of Staff Experience
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	22.4%	16.5%	↑	Negative
Percentage of staff experiencing harassment, bullying or abuse from colleagues in last 12 months.	21.2%	12.8%	↔	Negative
Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months.	17.5%	8.6%	↑	Negative
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	49.2%	50.2%	↑	Negative
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.	89.1%	90.6%	↑	↔
Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	32.9%	19.3%	↑	Negative
Percentage of staff satisfied with the extent to which their organisation values their work	43%	53.8%	↑	Negative
Staff Engagement Score	6.8	7.3	↑	Negative

3. NEXT STEPS

The staff survey results provide the organisation with the opportunity to directly respond to staff feedback through robust assurance and priority setting.

The staff survey results will be shared in a variety of methods that are accessible and capture all staff by utilising some of our existing engagement approaches and communication channels. Diagram Three identifies some of the steps that will be undertaken to enable the organisation to feed back to the workforce, develop a response and implement actions on the basis of staff feedback.

Diagram Three: 2020 Staff Survey Results Next Steps



The staff survey results will be shared via a Trust -wide info-graphic to provide a visual representation of our progress and CBU specific results will be distributed to each CBU area via the HR and OD Directorate, please see appendix 2. Results will also be shared with our various networks for staff, such as the LGBTQA+, BAME, Disability and Armed Forces Network, Committee meetings such as the EDI Sub-Committee, Operational People Committee, Nursing and Midwifery Forum, Medical Cabinet and the HCA Forum and with our People Champion Network and our Staff Side Chairs. This will allow for action to be taken in relation to specific groups of staff, in addition to the Trust-wide plan.

In order to develop a plan for implementation based on staff feedback, the Staff Engagement and Wellbeing team will collaborate with the Staff Networks, Trade Unions, People Champions and Clinical personnel to develop key actions that can be implemented across the organisation to demonstrate to staff how the organisation are responding to their feedback. It is important that this is undertaken via a collaborative approach in order to secure buy-in whilst also empowering individuals and ensuring that their contribution is valued by the organisation, which will have an impact on future staff engagement scores. As part of this collaborative approach, representatives will be reminded of what is already in place within the organisation in order to address the staff survey results and what may already be underway.

This collaborative approach demonstrates the organisation values the contribution and feedback that the workforce has made and enables the staff engagement and wellbeing team

to facilitate collaborative interventions that directly resonate with and are owned by our workforce.

4. RECOMMENDATIONS

Trust Board are asked to note the 2020 Staff Opinion Survey Results and the proposed next steps.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/39**			
SUBJECT:	**Board Assurance Framework**			
DATE OF MEETING:	31st March 2021			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	✓		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Since the last meeting: • No new risks have been added to the BAF; • The rating of one risk has been amended. • There have been no amendments to the descriptions of any risks on the BAF; • 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 21/03/61		
	Date of meeting	2nd March 2021		
	Summary of Outcome	The Committee reviewed, discussed and approved the amendments		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework and Strategic Risk Register report	AGENDA REF:	BM/21/03/39

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.

There are currently 21 risks on the Strategic Risk Register, 12 of which relate specifically to the COVID-19 Pandemic. Moreover, the 7 highest rated risks refer directly to COVID-19.

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

2. KEY ELEMENTS

2.1 New Risks

Since the last meeting no new risks have been added to the BAF.

2.2 Amendment to Risk Ratings

Since the last meeting, and following approval at the quality Assurance Committee on 2nd March 2021, the rating of one risk on the BAF has been reduced

Risk 1126

Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.

COVID-19 demand has significantly reduced from c243 patients to c130 patients. Monitoring over a number of weeks indicates an average 30-35% usage. As the number of COVID-19 patients reduce, the expected use of O2 should also reduce.

2.3 Amendments to descriptions

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

2.4 De-escalation of Risks

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
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	• Clean/green pathways have been developed for those priority 2 patients (cancer & urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward 5 on the Warrington site. • Continued use of the independent sector (Spire Cheshire) under national contract until 31st March 2021. Under new contracting arrangements, activity will be maintained; however, commissioned specialties will differ from those prior to 1st January 2021. • During February 2021, the Respiratory Service went live with a new virtual ward service in line with national guidance to support safe monitoring and supervision of patients who would have otherwise required a ward bed.	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.	• Clear curtains are in place all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. • Expected deployment of Bioquell Pods in ED & ICU in March/April 2021	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.	• Daily system pressures meeting that reviews hospital and wider system bed capacity to support safe and timely discharge of patients from hospital to support flows • 'Where's best next' event initiated in January 2021 with system partners to support safe discharge of patients with long lengths of stay to create capacity • Scheme issued by the Government to support indemnity concerns of care homes in relation to caring for COVID-19 patients. • 'Discharge to Assess' process has gone live to reduce the length of stay for a cohort of patients who would otherwise be assessed in hospital can be assessed in a transitional care bed.	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• Progressing the procurement of a new software programme which will be able to accurately track and share system delays with partners. By improving information, it will enable quicker and more effective decisions on discharges. Procurement set to take place before the end of FY 2020/21 with deployment in 6-8 weeks.	
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	• Clear curtains are in place all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. • Process for assurance of 3 and 5 day swabs to be completed in clinical areas to be agreed and introduced	No impact on risk rating
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	• The re-start of the Warrington site green pathway commenced w/c 8th February in the newly established ward A5 elective footprint. At present this support cancer and non-cancer priority 3 surgical activity.	No impact on risk rating
115	Failure to provide adequate staffing levels in some specialities and wards, caused by inability to fill vacancies, sickness, resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	Care Hours Per Patient Day (CHPPD) currently 7.5 (Year to date position 7.8) HCA There are currently 29 Health Care Assistant vacancies within the Trust. All vacancies to be recruited to by April 21. Interviews weekly; • 94 have been recruited • 62 going through pre employment checks • 15 commenced induction in March All recorded on spreadsheet tracker – currently -3 • Media campaign with Warrington Guardian - April • Weekly meeting and reporting to ensure we achieve target • Reserve list	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• Working up a process with NHSP and HR to ensure all HCA's are automatically recruited by NHSP. RN Recruitment • There are currently 101 registered nurse vacancies within the Trust. • 46 nurses going through pre employment checks (31 students due to qualify in Sept) • 9 International Nurses joined us in March after their OSCE. Progress tracker to detail on plan for 30 nurses arriving before April 21 with Mid-Cheshire. • International nurses have started to join WHH in March 21. 9 have commenced on the wards with a further 8 starting their induction in the Trust on the 15th March 21. <u>Assurances Gaps</u> Recruitment Gaps • 101 RN Vacancies Retention Gaps • 10.25% nursing turnover	
134	Risk: Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	<u>Assurance updates</u> • Submitted revised forecast of £13.9m deficit which includes the impact of wave 2 COVID-19. This has increase to £16.6m following a request by NHSE/I to review the annual leave accrual. The annual leave accrual will not be counted against the overall expenditure position. • Participating in exercise to understand run rate for 2020/21 to support funding envelopes for 2021/22 • Notified that non-NHS income will be provided to the Trust and will improve forecast outturn position – value to be confirmed by NHSE/I. • Budget Setting process underway for 2021/22 • Capital and Revenue budgets to be submitted to the Trust Board form approval on 31.03.2021	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• c£34m cash support secured in the form of PDC in March 2021 • Achieved 95% BPPC May, June & July 2020, 98% BPPC August, 98% September, 96% October, November 96%, December 92%, January 87%, February 96% • Executive review of COVID-19 costs which need to remain in place for 21/22 underway • Clinical Review Oversight Committee (CROC) to be established to provide oversight and assurance on recovery performance. **Gaps** • Capital schemes funded by PDC are at risk if not completed by 31st March 2021. Funding for the ED Plaza has been withdrawn as the scheme could not be completed in 2020/21. There is currently no ability to fund this scheme. The Critical Care scheme is at risk as it has not yet commenced due to the critical care pressures as a result of the COVID-19 pandemic. • A number of capital schemes are now forecasting an underspend. • Need to determine the future run rate which is currently uncertain in order to mitigate risks. • Current system gap of £99m. Working across the footprint to seek a resolution. • Awaiting confirmation of cash funding for March 2021 (c£38m required). National cash team instructed the Trust not to restrict creditor payments	
1134	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	• Engagement plan in place to continue to increase uptake for Lateral Flow Testing. • Moving over to LAMP testing, which we anticipate will increase uptake as it is less invasive for staff. Currently awaiting confirmation of external funding and then can agree a go live date. • Occupational Health opening times have been extended since 4 January 2021. • COVID vaccine programme in place. Good uptake from across the workforce, with monitoring arrangements in place.	

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• COVID-19 Workforce Recovery Steering Group to be implemented. • Overall absence rate (Sickness and isolating/sheiling) is 7.54% (04/03/21) and is therefore reducing • Business cases have now been approved to recruit a total of 96 International Nurses which 36 are already in the country • Supported by funding from NHSI there has been a big push to fill our HCA vacancies, we currently are predicting to be at 0 FTE by 31/03/2021. • Our HCA Vacancies have been supplemented by the recruitment of Nursing Students (25 FTE), in post until Apr-21, by this time it is forecasted the equivalent number of HCAs will have been recruited ensuring our HCA vacancies remain at 0 FTE • A number of Medical Students have also been recruited to support across the Trust • The redeployment hub continues to support those shielding and are working with line managers to ensure, where possible we have identified suitable work for them	
1079	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services Resulting in the inability to capture all required	• Following completion of supplier decision making process, implementation due to complete in September 2021	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.		
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.	• Outstanding assessments have been escalated to Tactical Meeting and Chair has requested detailed information for individuals in the CBUs with the highest number outstanding. • Routine contacting of managers with outstanding assessments from HR Team • Escalation process in place to escalate to senior HR Team member if no response after 2 contacts Position @ 4th March 2021 • 94% staff risk assessed • % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary – 95.19% • Of the 100 staff know to be at risk who are yet to have a management risk assessment 46 have had the COVID Vaccine. • HR continue to support managers to complete the risk assessments. • % of risk assessment have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary – 93.13% • 86% of our staff have received the COVID Vaccine	No impact on risk rating
125	Failure to provide a safe, secure, fit for purpose hospitals and	• £4.3m Business Case for ED Plaza Scheme approved: Phase 1 Paediatric ED reconfiguration commencing in November	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	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.	2020 to be completed by 26th January 2021. This will increase the Paediatric ED Urgent Care footprint allowing for a better segregated flow of paediatric patients to support Covid-19. Phase 2 due to commence March 2021 and complete in June 2021. Commencement of Phase 2 (although approved) reliant on support from NHSE/I. • Gaps • Yet to receive support from NHSE/I to commence Phase 2 of the ED Plaza. • Limitations to Oxygen flow as described in Risk #1126 • Threat to the delivery of capital schemes due to the pandemic e.g. manufacturing delays, additional costs of construction relating to IPC guidelines and the unavailability of an appropriately skilled workforce. • Confirmation from NHSE/I that the original PDC funding stream will not be carried over to 2021/22 meaning that phase 2 must revert to the Trust's own capital programme.	
1108	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by Covid, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team	• Interim Birth suite Manager appointed and in post 15th Feb 2021 (NHSP) • Additional 3 Band 7 Birth suite Co-ordinators appointed 1st Feb 2021 2021 • Birthrate plus full review funded by Local Maternity System to be carried out by 31st Dec 2021.	No impact on risk rating
1124	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff	• Supply issues continue with 3m with regard to FFP3 with Trusts encouraged to move to more sustainable FFP3 models. In line with this the Trust has recently changed its preferences from 100% 3m to include a further two FFP3 masks where there has been a fit test % achieved. • Board oversight of Fit Testing compliance	No impact on risk rating
145	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration,	• Strategic Outline Case (SOC) for both new hospital developments approved by the Trust Board. Both CCGs normally supported by wider partners through the Scrutiny Health & Wellbeing Boards • Additional phase of HIP funding announced with the opportunity for	

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	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.	investments in 8 additional new hospital developments. The Trust stated its intention to bid via a competitive process which is likely to take place in spring 2021. • Town Deal plan for Warrington submitted. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £24m funding approved for the Town investment plan, including £3.75m for the Health & Wellbeing Hub and £1m foe the Health & Social Care academy. • Town Deal plan for Runcorn due for submission in January 2021, including £3m for Health & Wellbeing Education Hub in Runcorn.	
1126	Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.	• COVID-19 demand has significantly reduced. Monitoring over a number of weeks indicates an average 30-35% usage. As the number of COVID-19 patients reduce, the expected use of O2 should also reduce. • Escalation process in place to Trust Tactical Board Meeting in heightened demand • HSIB report received and recommendations reviewed and actioned with assurance to PSCEC and QAC	
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 Procurement Department has undertaken a review of all suppliers as part of the national self-assessment exercise which was completed as C&M HCP system. Whilst this piece of work has been completed with no apparent adverse impact the Procurement Department continues to monitor fulfilment of orders to adopt a process of early investigation where supply appears to be disrupted. In addition, the Procurement Department is implementing processes to monitor prices to determine if there has been any financial impact upon exit from the EU.	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.	• The Digital department has reviewed all the Trust key IT systems and data flows. To date no issues have been identified which will impact upon data flows. A time limited 'bridging mechanism' has been agreed which will allow personal data to continue to flow as it does now from the EEA whilst EU adequacy decisions for the UK are discussed.	

3 RECOMMENDATIONS

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

Board Assurance Framework

Board Assurance Framework

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

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
1215	Daniel Moore	Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm	1	25 (5x5)	6 (3x2)	TBC	Quality Assurance Committee
1272	Kimberley Salmon-Jamieson	Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 meters apart, resulting in reduced capacity to admit patients and a potential subsequent major incident.	1	25 (5x5)	5 (5x1)	TBC	Quality Assurance Committee
1273	Daniel Moore	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.	1	25 (5x5)	5 (5x1)	TBC	Quality Assurance Committee
1275	Kimberley Salmon-Jamieson	Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks	1	25 (5x5)	5 (5x1)	TBC	Quality Assurance Committee
1289	Daniel Moore	Failure to deliver planned elective procedures caused by the Trust's decision to pause some elective procedures in order to ensure safe staffing and critical care capacity during the COVID-19 pandemic, resulting in potential delays to treatment and possible subsequent risk of clinical harm	1	25 (5x5)	5 (5x1)	TBC	Quality Assurance Committee
1331	Daniel Moore	Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the increase in critically unwell COVID-19 positive patients resulting in potential harm.	1	25 (5x5)	5 (5x1)	TBC	Quality Assurance Committee
1332	Daniel Moore	Failure to provide a suitable patient environment caused by the rapid creation and opening of additional capacity/wards resulting in potential harm	1	25 (5x5)	5 (5x1)	TBC	Quality Assurance Committee
115	Kimberley Salmon-Jamieson	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	1	20 (5x4)	12 (4x3)	TBC	Trust Operations Board

Board Assurance Framework

134	Andrea McGee	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee
1134	Michelle Cloney	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee
1114	Phill James	FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	1	20 (5x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1079	Kimberley Salmon-Jamieson	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.	1	20(4x5)	2 (1x2)	TBC	Quality Assurance Committee
1207	Michelle Cloney	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and	2	16 (4x4)	8 (2x4)	TBC	Strategic People Committee

Board Assurance Framework

		welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.					
125	Daniel Moore	Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	1	16 (4x4)	4 (4x1)	TBC	Trust Operations Board
1108	Kimberley Salmon-Jamieson	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by Covid, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team	1	16 (4x4)	4 (4x1)	TBC	Quality Assurance Committee
1124	Kimberley Salmon-Jamieson	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff	2	15 (3x5)	8 (4x2)	TBC	Quality Assurance Committee
145	Simon Constable	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	3	15 (3x5)	8 (4x2)	TBC	Trust Operations Board
1126	Daniel Moore	Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.	1	15 (3x5)	5 (5x1)	TBC	Quality Assurance Committee
1274	Kimberley Salmon-Jamieson	Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.	1	15 (3x5)	5 (5x1)	TBC	Quality Assurance Committee
1290	Andrea McGee	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.	3	12 (3x4)	4 (1x4)	TBC	Finance & Sustainability Committee

Board Assurance Framework

1205	Phill James	FAILURE TO send accurate continuity of care information medication and / or allergies information from the Lorenzo EPR to external stakeholder. E.g. GPs CAUSED BY errors within the Lorenzo EPR electronic discharge summary code and/or configuration, i.e. the DXC PAN summarises the issue as: *"Discharge medications documented in Lorenzo do not match those showing on the discharge summary – this results in some medications being duplicated, missing completely or being incorrectly cited into appropriate sections." The medications section of the Discharge summary is split into the four heading of "Continued", "Stopped", "Changed" and "UnChanged" but the Trust response has deduced that medications are also appearing in the allergies section of the discharge summary.* RESULTING IN patient harm due to errors and/or omissions within the medications and allergies information that is transmitted from the WHH FT Lorenzo EPR to its external stakeholders for approximately 4% of all patient discharges for the affected period. *** There is currently no evidence of patient harm but there is evidence of potential for harm to result *****	1	10 (2x5)	5 (1x5)	TBC	Quality Assurance Committee

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

Board Assurance Framework

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

Assurance Details:

Phase 3 planning guidance received on 31st July 2020 expediting the return of near normal health services between August – December 2020

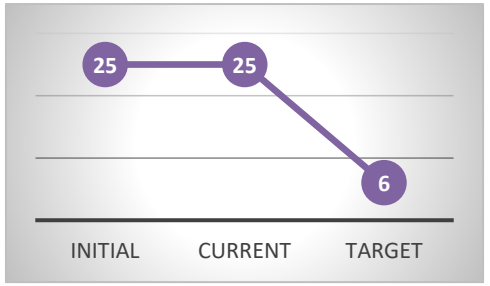
- Phase 3 second submission -10th September 2020
- Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery
- Pause of non-time critical elective services to support safe staffing across the organisation.
- Some elements of the Phase 3 plan continue to be monitored by Gold Command on a daily basis. This relates to elective surgical activity.

Radiology

- Capacity is reduced across Radiology by 30-40%.
- New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance.
- Department has been supported by the Trust through £380K recurrent funding to recruit additional staff. Advert out 11th June 2020. Recruiting 4 Radiographers, 2 Sonographers, 2 Healthcare Assistants.
- Additional staff will support additional capacity through extended working days across all scanners – currently unable to achieve this due to Covid-19 demands.
- Additional CT capacity (15 exams per week) will be provided mid-July 2020 via use of mobile CT scanner supported by the National Imaging Team Covid-19 Response initiative. This is sited at Whiston Hospital – WHH patient will have to travel to this site.
- All outstanding requests are clinically reviewed by Senior Consultant Radiologists as per local SOP. Exams are deferred in line with clinical priority. Cancer and Urgent patients are being imaged as per pre-Covid-19 as per national guidance.
- Those deferred patients are sent a letter informing of delay, and to contact their Doctor if any concern. The referrer of delayed patients are also sent a letter informing of delay, but this referrer letter includes a direct telephone number to the Senior Radiology Consultants, and also an email address should there be a concern with delaying. Any exams that are highlighted from referrers as not suitable for delay are appointed on the next available appointment.
- This delay process has been discussed via Medical Cabinet and agreed as most appropriate process.
- This clinical review and delay process is ongoing daily.
- Current building works to increase the footprint of the CT department will bring increased patient areas. This will allow addition Outpatients to be imaged at Warrington where currently due to lack of waiting areas, the service is almost 100% Inpatient based. This completion if works will increase capacity and flexibility for CT. Completion date due end of September 2020
- Improvement against all modalities for numbers waiting more than 6 weeks noted in July performance.
- CT Business case approved to increase CT capacity and support expediting recovery.

Unplanned care

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



Board Assurance Framework

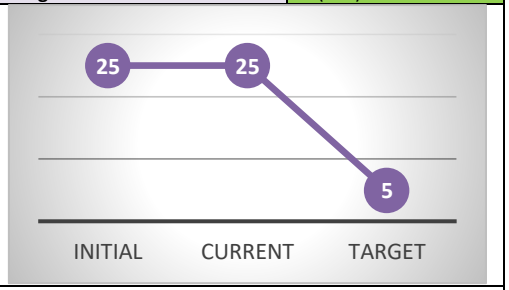
	• In patient capacity is reviewed with the patient flow and CBU teams daily to ensure that there is adequate capacity for all patient groups to be admitted. • ITU business continuity plans have been agreed to escalate critical care as and when required. • Clinic templates have been revised to ensure social distancing measures are in place and patients are not brought to a face to face appointment unless clinically indicated. Virtual appointments are in place (telephone and video) for use where this is clinically appropriate. • Suspected cancer, cancer and clinically urgent patients are allocated out patients and diagnostic appointments as a priority. • Waiting lists are reviewed through the performance review group weekly – outpatients and diagnostics. • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • NHS 111 First pilot went live on 8th September 2020 to reduce attendances to the emergency department and to support the planning of activity in a more streamlined way to reduce overcrowding and risk of nosocomial infection. • £4.3m Business Case for ED Plaza Scheme approved. • Reconfiguration of Paediatric ED as per phase 1 of the ED Plaza business case commend in December 2020 and is due to be completed in January 2021 which will support an increase in paediatric capacity and further support compliance against RCEM guidance e.g. segregated flows. • Phase 2 ED Plaza due to commence in March 2021 for completion in Q2 2021 • Expected deployment of Bioquell Pods in ED & ICU in January 2021 to support flow and IPC compliance. This will help reduce instances of have to escalate capacity to the Main Theatre at the Warrington site. • During February 2021, the Respiratory Service went live with a new virtual ward service in line with national guidance to support safe monitoring and supervision of patients who would have otherwise required a ward bed. Planned Care • All elective patients have been clinically reviewed and categorised in line with national guidance. • Suspected cancer, cancer and clinically urgent patients are treated as a priority. • Theatre capacity has been reviewed and additional capacity is now available with the de-escalation of the theatre PODs • The Halton site is being developed as a covid secure site and will be run as an Elective Centre. • Two theatre PODs have been retained in the event they are required and plans are in place to utilise if required. • Elective Surgery Standard Operating Procedure (SOP) in place • Capacity identified and being utilised at spire Healthcare • An elective meeting takes place three times a week to plan the recovery of individual services • Clean/green pathways have been developed for those priority 2 patients (cancer & urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward 5 on the Warrington site. This pathway is set to commence w/c 8th February and replaces the B18 pathway. • A separate pathway has been developed for Emergency surgery and future plans and bed base has been agreed as part of the ward reconfiguration process. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Workforce plans are continually reviewed to ensure that all wards and teams are staffed safely. • Waiting lists are reviewed through the performance review group weekly • Theatre expansion programme in place to support delivery of Phase 3 guidance • Weekly theatre scheduling to ensure listing of patients in line with national guidance. • Post Anaesthetic Care Unit (PACU) Business Case approved by the Board on 10th September 2020 for implementation in January 2021	

Board Assurance Framework

	• Continued use of the independent sector (Spire Cheshire) under national contract until 31st March 2021. Under new contracting arrangements, activity will be maintained; however, commissioned specialties will differ from those prior to 1st January 2021. • Contracting guidance produced w/c 7th December. Negotiation underway to support contracted arrangements in Quarter 4. This may mean less ISP activity in January 2021 but more in February and March 2021. • A review of other ISP providers to support waiting lists activity is underway in line with the new national framework arrangements. • Participation in national clinical validation exercise commenced in November 2020 to support and inform patient waiting time status and support safe management of waiting lists.	
Assurance Gaps:	Radiology 1. Harm may be caused due to the incompleteness of clinical information on a referral. This may also be compounded by the referrer incorrectly entering the wrong priority code on the referral. • It is thought that the letter to the referrer will highlight the exam has been delayed and that the provision of a direct link to the Radiology Consultant team by phone/email will allow these cases to be expedited where appropriate. 2. Harm may be caused by the delay of a routine examination where there is an unlikley serious pathological finding present. • This risk is present in all routine exmas as the waiting time for routine diagnostic imaging is up to 6 weeks as per national targets. This risk is hightened due to Covid-19 and the reduced capacity at present. It is thought the letter to the patient advising to contact their Doctor with any concern will reduce this risk. Unplanned care 1. Estates work is required to complete the segregation of paediatric patients in the emergency department. • This is being progressed with the support of the estates and capital planning team. 2. Expansion of the emergency department is required to ensure any increase in demand can be accomodated in line with RCEM guidance 3. Referrals do not include adequate information to triage and prioritise patietns appropriately • Regular meetings and communication with the CCG and GP's to inform them with recovery progress within the organisation and to highlight/address any identified problems 4. Reduction in face to face primary care appointments having a negative impact on increased attendances. 5. Capacity challenge with social workers to keep on top of demand and necessary patient assessments. 6. Estates work required to increase general ICU Capacity & ICU cubicle capacity e.g. Installation of Bioquell cubicles 7. Risk to funding of Phase 2 ED Plaza following national review of Urgent Care schemes by NHSE/E – awaiting outcome. Weekly progress and financial returns submitted to NHSE/I Planned Care 1. Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility. • This is being progressed with the support of the estates and capital planning team. 2. Waiting list do not include adequate information to triage and prioritise patients appropriately • Regular meetings and communication with the waiting list and scheduling teams and inform them of recovery plans and to highlight/address any identified problems 3. New framework for ISP will not include all specialties currently being undertaken. This will increase waiting list pressure for those specialties on this site.	

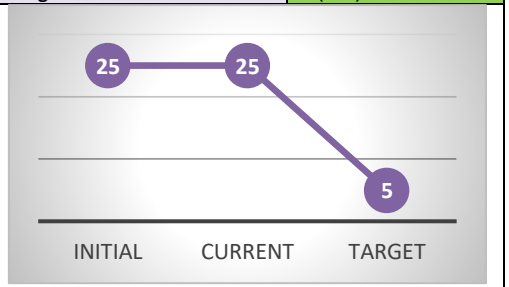
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
ED Plaza building works	Completion of ED Plaza building works	Complete Building work	Sharon Kilkenny	31/03/2020	Phase 1 completed
Install of Bioquell Cubicles	Install of Bioquell Cubicles	Complete Installation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

Board Assurance Framework

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

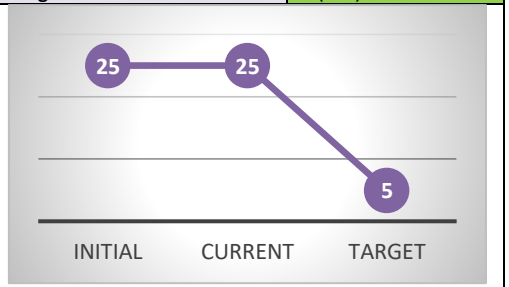
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
To develop a Trust Wide Environmental Plan to identify appropriate mitigations to minimise the risk of transmission.	Development of a Trust Wide Environmental Plan.	Develop Plan	Layla Alani	30.10.2020	30.10.2020
All individual clinical areas to complete a risk assessment to include bed space.	Completion of a Ward base risk assessment.	Completion of a Ward base risk assessment.	Layla Alani	30.10.2020	06.11.2020

Board Assurance Framework

Risk ID:	1273	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.			**Initial:**	25 (5x5)
				Current:	25 (5x5)
				Target:	5 (5x1)
Assurance Details:	Integrated Discharge Team comprising of hospital and Local Authority colleagues from Warrington and Halton to develop systems and process of discharge acknowledging difficulties of Covid-19. Daily system pressures meeting that reviews hospital and wider system bed capacity to support safe and timely discharge of patients from hospital to support flows Trust participates in Mid-Mersey Operational Group which supports Out of Hospital Cell discussions in relation to system discharge planning. Trust participates in daily Gold Command System call which supports regional decisions on discharge capacity e.g. access to Nightingale and other such supportive facilities The number of discharge delays in relation to Super Stranded patients is reported daily in the Executive Summary and reviewed so that Executive Directors can support and escalate pathway delays. 'Where's best next' event initiated in January 2021 with system partners to support safe discharge of patients with long lengths of stay to create capacity through December and January expected winter pressures and support wave 3. Scheme issued by the Government to support indemnity concerns of care homes in relation to caring for COVID-19 patients. It will support the system in the creation of COVID-19 designated setting capacity. New 'Discharge to Assess' process has gone live to reduce the length of stay for a cohort of patients who would otherwise be assessed in hospital can be assessed in a transitional care bed. Progressing the procurement of a new software programme which will be able to accurately track and share system delays with partners. By improving information, it will enable quicker and more effective decisions on discharges. Procurement set to take place before the end of FY 2020/21 with deployment in 6-8 weeks.				
Assurance Gaps:	Delays in discharge caused by adherence to Covid-19 infection control pathways and the patient's C0vid-19 status. Intermediate Care and other community capacity impacted and restricted by Covid-19 e.g. Care Home and other facility closures due to outbreaks. Access to community capacity impacted by Covid-19 as a result of staff sickness Internal staff shortages to help support discharge planning. Restricted as a result of Covid-19 sickness and self-isolation Internal and external system required to undertake other services e.g. those relating to time critical pathways means that staff in these services paused in wave 1 are unable to support in wave 2. High number of patients in Warrington awaiting social work assessment, causing a delay in discharges from the acute site in to care homes and intermediate care capacity				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

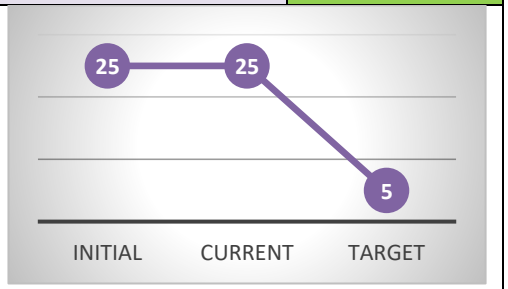
Risk ID:	1275	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to prevent Nosocomial Infection caused by asymptomatic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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Health and Safety inspections to include the monitoring of social distancing and ensure hand sanitiser and masks are located at each entrance.	Health and Safety inspections to be carried out.	Health and Safety inspections to be carried out.	Ali Kennah	30/12/2020	30/11/2020

Board Assurance Framework

1289	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Failure to deliver planned elective procedures caused by the Trust's decision to pause some elective procedures in order to ensure safe staffing and critical care capacity during the COVID-19 pandemic, resulting in potential delays to treatment and possible subsequent risk of clinical harm			**Initial:**	25 (5x5)
			Current:	25 (5x5)
			Target:	5 (5x1)

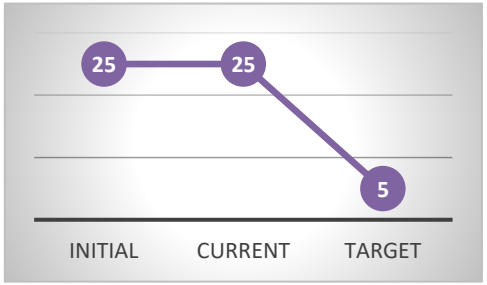
Confirmed continued use of the private sector (Spire Cheshire) until 31st March 2021. Under new contracting arrangements activity will be maintained; however, commissioned specialties will differ in these prior to January 2021.
Waiting lists monitored and measured weekly
Continue to develop and plan for opening of the Post Anaesthetic Care Unit (PACU) in January 2021
Continue to undertake harm review process
Continue to specifically focus on and monitor patients waiting greater than 52 weeks
Continue to ensure urgent cancers are prioritised.
A review of other ISP providers to support waiting lists activity is underway in line with the new national framework arrangements.
Expected deployment of Bioquell Pods in ED & ICU in March/April 2021 to support flow and IPC compliance. This will help reduce instances of have to escalate capacity to the Main Theatre at the Warrington site.
Plan being worked up to develop the ward B18 footprint adjacent to Critical Care to support alternative Critical Care escalation capacity and avoid the use of the main Warrington Theatre. This will better protect elective flow on Warrington & Halton sites.
Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee.
Trust responded to the Cheshire & Merseyside hospital cell instruction to not undertake priority 3 & 4 elective inpatient operating for w/c 11th & 18th January 2021. This is kept under review in line with the impact of wave 3.
Safe staffing levels reviewed daily. If necessary this may mean a review of clinical services to support the release of staff on a temporary basis.
The re-start of the Warrington site green pathway commenced w/c 8th February in the newly established ward A5 elective footprint. At present this support cancer and non-cancer priority 3 surgical activity.



Confirmation awaited for continued use of the private sector after 31st December 2020
New framework for ISP will not include all specialties currently being undertaken. This will increase waiting list pressure for those specialties on this site.
Consequence of Wave 3 & expected COVID-19 occupancy may mean that critical care development of B18 may not progress.

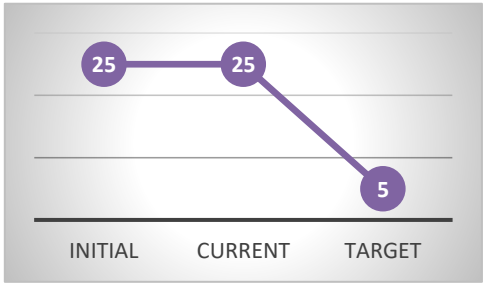
Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop plan for Ward 18 Footprint to support alternative critical care escalation.	Develop plan for Ward 18 Footprint	Kilkenny, Sharon	28/02/2021	

Board Assurance Framework

Risk ID:	1331	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the increase in critically unwell COVID-19 positive patients resulting in potential harm.			**Initial:**	25 (5 x 5)
				Current:	25 (5 x 5)
				Target:	5 (1 x 5)
Assurance Details:	• Creation of additional appropriate clinical areas with appropriate clinical staff; • Non-urgent elective procedures stepped down to help support sufficient staffing levels and provide additional clinical areas. • Daily submission of Critcon score to SEOG, Gold Command and the wiser network to optimise the deployment of mutual aid as required. • National 'Call to Arms' to encourage experienced ICU Nurses & Doctors to return to work; - 2 staff joined ICU from external providers • Internal 'Call to Arms' for staff who have previous experience of the ICU setting and communications with Managers to support release - 15 staff identified – worked in Wave 1 and 2 on a part and full time basis depending on availability and release from current role. 86 staff identified in the re deployment process under Category A (category A are staff in the trust with Critical care experience or transferable skill suitable for critical care) • AHP, Proning & Transfer Teams created to support ICU staff • Transfer out of ICU via the Critical Care Network to support decompression; • Mutual aid in place to ensure adequate provision of essential equipment e.g. Non-Invasive Ventilation (NIV) • Incentive scheme in place to help support sufficient staffing levels; • Off framework agency usage to help support sufficient staffing levels; • Nurse buddy system in place;				
Assurance Gaps:	• Limited estate • Limited O2 flow capacity • Limited staffing				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	12 (4x3)

Assurance Details:

- Monthly workforce information produced via workforce dashboard. Information is reviewed and monitored at the Workforce Group Chaired by the Chief Nurse
- Robust staffing escalation process across WHH to manage staffing daily – This has become the forum for responsive staff management during the COVID 19 pandemic
- Lead Nurse identified daily to co-ordinate staffing supported by a senior nurse rota 7 days a week 8am – 8pm which commenced in April 2020
- 4 hourly update shared as part of Gold Command template
- Wards & Departments use E-Roster and Safecare data to support staffing ratios
- New models of care currently being implemented in Maternity in line with BR+. Business case being developed as there will be a requirement for a staffing uplift
- Recruitment / media plan produced and recruitment campaign ongoing
- Rolling advert for RN's continue with 12 nurses accepted an offer of employment at WHH in July 2020. Students who were redeployed to the Trust during the COVID 19 pandemic have been offered substantive posts
- International Nurse Business Case has been approved for 30 Registered Nurses – we have set up a task and finish group to implement this. We have recruited 73 HCAs since February 2020 with rolling HCA recruitment programme in place
- National staffing guidance has been utilised to inform new staffing models
- Care Hours Per Patient Day (CHPPD) currently 7.6 (Year to date position 7.8)

<u>Recruitment Assurances</u>

- Rolling advert for B5 Nurses
- 12 month recruitment plan in place taking into consideration social distancing restrictions
- Developing WHH recruitment campaign
- Career advice events in local schools and colleges
- Production of monthly and bi-annual staffing reports received by the Trust Board
- Trust has intensified the HCA recruitment plan to achieve 0 vacancies by April 21. NHSI funding support received to achieve this aim. Weekly monitoring on progress and reporting to NHSI in place
- International Nurses Business cases – 30 Nurses recruited in partnership with Wigan, Wrightington & Leigh. 10 arrived in November 2020. Further nurses to arrive in January 2021. Due to join the Trust in March 2021.
- The Trust has joined the Mid Cheshire Collaborative after an additional successful business case – 36 Nurses to be recruited after April 2021.
- The Trust has been approached by NHSI to expand the Mid Cheshire International Nurse recruitment numbers to access further funding. Business Case currently being drafted to increase numbers by another 3 – Jan 2021

HCA

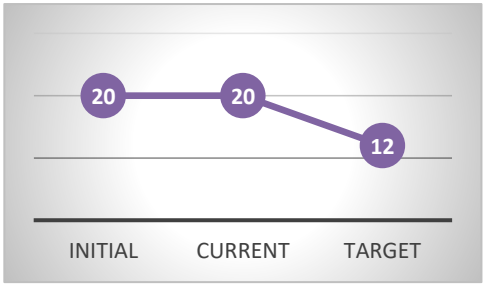
There are currently 29 Health Care Assistant vacancies within the Trust. All vacancies to be recruited to by April 21.

Interviews weekly;

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

All recorded on spreadsheet tracker – currently -3

- Media campaign with Warrington Guardian - April



Board Assurance Framework

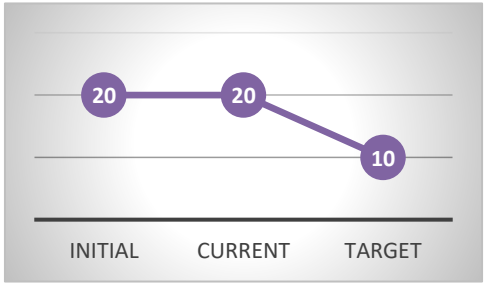
	• Weekly meeting and reporting to ensure we achieve target • Reserve list Working up a process with NHSP and HR to ensure all HCA's are automatically recruited by NHSP. RN Recruitment There are currently 101 registered nurse vacancies within the Trust. 46 nurses going through pre employment checks (31 students due to qualify in Sept) 9 International Nurses joined us in March after their OSCE. Progress tracker to detail on plan for 30 nurses arriving before April 21 with Mid-Cheshire. <u>Retention Assurances</u> • Workforce Dashboard reporting monthly in relation to leavers • WHH Nursing retention plan to be refreshed for 2020 • Burdett Nursing Trust award winners • Highly commended for nursing retention data provision • 'Transfer Window' implemented allowing staff to move to other specialties without having to apply for role • Registered Nurse Turnover 10.25% • International nurses have started to join WHH in March 21. 9 have commenced on the wards with a further 8 starting their induction in the Trust on the 15th March 21. <u>COVID-19 Assurances</u> • Implemented a graduated and planned nurse staffing response to the COVID-19 Pandemic. • Revised staffing models for the expansion of critical care capacity, acute and supportive respiratory wards • Strengthened daily staffing meetings chaired by the Associate Chief Nurse for senior oversight • Workforce expansion initiative in place, including the development of a redeployment Hub, local and national call to arms and student deployment • Increased use of temporary staffing through NHSP and off framework agencies – close monitoring arrangements in place • Implementation of NHSP incentive scheme for staff to improve fill rates – update monitored weekly • Nursing Times Workforce Award winners in November 2021 – Best Recruitment Experience During COVID-19 Pandemic Response • As the number of COVID patients in March 21 reduce the staffing plans are being revised and the number of agency staff is starting to reduce.	
Assurance Gaps:	Increase staffing pressure due to ongoing use of temporary winter ward for which there is no funded establishment <u>Recruitment Gaps</u> • 101 RN Vacancies <u>Retention Gaps</u> • 10.25% nursing turnover

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

Board Assurance Framework

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

Board Assurance Framework

Risk ID:	134	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that future loans will be required which would raise the question if the Trust is a going concern.			**Initial:** **Current:** **Target:**	20 (5x4) 20 (5x4) 10 (5x2)
Assurance Details:	•Core financial policies controls in place across the Trust •Revised governance structure within the Trust to enable strengthened accountability •Finance and Sustainability Committee (FSC) established overseeing financial planning •Regular financial monitoring with NHSI •Regular review at Executive team meeting and development sessions •Annual plan development process • Achieved 2019/20 Control Total. •Positive Value for Money conclusion & unqualified audit opinion •Head of Internal Audit Opinion of Significant Assurance •Corporate Trustee Charities Commission Checklist, reporting bi-annually through Board •Monitoring of charitable funds income, assessment of return on investment and controls on overhead ratios via quarterly financial reports •Regular updates to Executive Team, FSC and Trust Board •Financial Resources Group (FRG)that reports to FSC – currently paused due to pandemic • Workshop undertaken with - Exec, CBU, Corporate to review of 2020/21 cost pressures • 2021 cost pressures supported by Trust Board. Business cases being developed to secure required levels of funding. •Trust Board approval of Capital Plan including the requirement for PDC as part of the final programme • Receipt of £51.8m PDC funding to repay revenue and capital loans in full in September 2020. •Completed MIAA Governance Checklist received by Audit Committee •Critical Infrastructure Capital Funding (£2.41m) to support schemes with critical and high levels of backlog maintenance approved •Cancer Alliance funding of £0.5m for endoscopy enabling work at Halton to improve the environment •Submitted revised forecast of £13.9m deficit which includes the impact of wave 2 COVID-19. This has increase to £16.6m following a request by NHSE/I to review the annual leave accrual. The annual leave accrual will not be counted against the overall expenditure position. Notified that non-NHS income will be provided to the Trust and will improve forecast outturn position – value to be confirmed by NHSE/I. •Budget Setting process underway for 2021/22 •Capital and Revenue budgets to be submitted to the Trust Board form approval on 31.03.2021 •c£34m cash support secured in the form of PDC in March 2021 <u>COVID-19</u> • Governance process in place to ensure all additional costs are being approved and monitored – re-introduced for Wave 2 & Wave 3 • Reporting to NHSE/I • Regular attendance to regional and national conference calls • Attend Recovery Board to monitor financial impact of the changes relating to Covid19 Recovery plans – identifying revenue and capital expenditure				

Board Assurance Framework

	• Review of latest guidance NHSE/I established block payments for the first 6 months of 2020/21 to ensure no impact of loss of elective activity • Accessed additional cash to pay outstanding creditors £16m paid in April 2020 • Achieved 95% BPPC May, June & July 2020, 98% BPPC August, 98% September, 96% October, November 96%, December 92%, January 87%, February 96% • Circulate latest guidance from MIAA Counter Fraud team • Ensure governance and processes in place including checks in place for all expenditure in particular procurement, contracts, payroll and HR. • Highlighted the different methods of fraud/ scam in operation to all staff and share it as widely through Trust • Weekly update to Strategic Executive Oversight Group in relation to the cost impact of COVID-19 – Monthly from June 2020 • Receiving Charitable donations that will support sustainability of Trust Charity • Submitted COVID-19 capital bids to NHSE/I & Hospital Cell to support Business as Usual & Recovery plans • Monthly Report to F&SC on COVID Pay Costs • Deloitte due to commence audit of all capital and revenue COVID-19 Expenditure w/c 21 January 2021 • Participating in exercise to understand run rate for 2020/21 to support funding envelopes for 2021/22 • Executive review of COVID-19 costs which need to remain in place for 21/22 underway • Clinical Review Oversight Committee (CROC) to be established to provide oversight and assurance on recovery performance.	
Assurance Gaps:	• Inability to develop a strategic plan to deliver a break even position over the next 5 to 10 years • Non-recurrent CIP presents a risk to in-year and future year financial position. • Failure to fully comply with emerging national employment litigation resulting in additional pay costs or the trust receiving potential claims. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Risk that capital needs exceed capital funding resources available. • Hospital Infrastructure Programme (HIP) announcement. WHH not included in with phase 1 or phase 2 funding allocation.. • Submitted 5 Year Plan on 2nd March, jointly with Warrington & Halton CCGs & Bridgewater Community Healthcare NHS FT with system gap of £26.5m • Capital schemes funded by PDC are at risk if not completed by 31st March 2021. Funding for the ED Plaza has been withdrawn as the scheme could not be completed in 2020/21. There is currently no ability to fund this scheme. • A number of capital schemes are now forecasting an underspend. • Trust funded capital incurred in full. There will be no carry forward to next year. Currently breast is forecast to underspend by £1m. Schemes that could be brought forward are being examined. • Need to determine the future run rate which is currently uncertain in order to mitigate risks. • Increased threat of fraud during COVID-19 global pandemic • Unclear on financial envelope to support COVID-19 capital & revenue needs.	

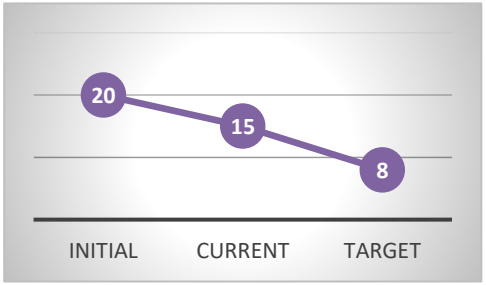
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Submit requested Workforce & CIP information to NW Intensive Support Director	Cheshire and Merseyside Health & Care Partnership in receipt of Tier 1 Intensive Support – Information requested by NHSE/I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

Board Assurance Framework

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

Assurance Details:

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



Board Assurance Framework

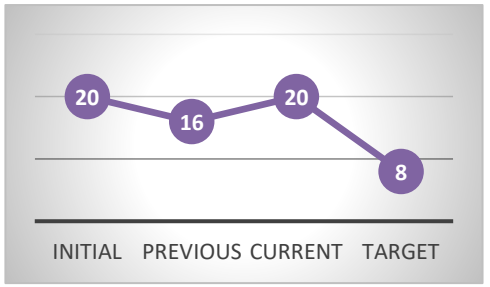
	• All additional hours and bank shifts worked by medical staff between 7th April 2020 and 31st May 2020, will be paid at the enhanced rates. This arrangement was extended until 9 June 2020 to review the scheme and consider whether this should continue – decision taken by Strategic Oversight Group to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

Board Assurance Framework

	• Business cases have now been approved to recruit a total of 96 International Nurses which 36 are already in the country • Supported by funding from NHSI there has been a big push to fill our HCA vacancies, we currently are predicting to be at 0 FTE by 31/03/2021. • Our HCA Vacancies have been supplemented by the recruitment of Nursing Students (25 FTE), in post until Apr-21, by this time it is forecasted the equivalent number of HCAs will have been recruited ensuring our HCA vacancies remain at 0 FTE • A number of Medical Students have also been recruited to support across the Trust • The redeployment hub continues to support those shielding and are working with line managers to ensure, where possible we have identified suitable work for them	
Assurance Gaps:	• Unable to control staff selecting to use national track and trace system for swabbing rather than local service. Therefore staff will receive results and instructions from national Trace and Trace service and any contacts in the workplace could be instructed to self-isolate. Escalated to National & Regional Teams • Awaiting National Update from NHSE/I to concern raised about local management of staff self-isolating following symptoms & swabbing versus National Trace and Trace advice. No National or Regional solution to date. • National Policy on sickness absence monitoring and payments are being negotiated nationally - unable to influence outcome. May increase gaps in provision due to additional sickness absence allowances and associated pay arrangements. Negotiations ongoing. National Guidance expected in coming weeks.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Deliver the NHS People Plan 2020-2021	Deliver on the local implementation of the NHS People Plan 2020-2021, prioritising those elements that relate to supporting the workforce recovery.	• Produce integrated strategic workforce delivery plan, amalgamating WHH People Strategy priorities, WHH EDI Strategy workforce priorities, NHS People Plan. - *COMPLETE* • Monitor delivery of plan via Operational People Committee - *ONGOING*	Deborah Smith, Deputy Director of HR and OD	31 March 2020	

Board Assurance Framework

Risk ID:	1114	**Executive Lead:**	James, Phill	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	FAILURE TO provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, CAUSED BY increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber attack, RESULTING IN poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statatory obligations (e.g. Civil Contigency measures) and subsequent reputational damage.			**Initial:** **Current:** **Target:**	20 (5x4) 20 (5x4) 8 (2x4)
Assurance Details:	**Assurance:** • **Digital Governance Structure** including weekly structured Senior Leadership Team meetings, Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Data Standards Group reporting to the Information Governance and Corporate Records Sub-Committee with escalations to the Quality Assurance Committee and onwards to the Digital Board, which itself submits highlights to the QAC and resource go to FSC. The **Quality Assurance Committee report provides** assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Cyber Essentials Plus/Audit Actions/IG training figures). • **Digital annual IT audit** plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with progress monitored at the Trust Audit Committee. • **Trust benchmarking** activities including Use of Resources reviews (Model Hospital). • ITHealth Assurance Dashboard is live, monthly external penetration testing is now in place using NHS Digital's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. **Controls:** • **Digital Operations Governance** including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard. • Active membership of the **Sustainability Transformation Partnership Cyber Group.** • **Digital Change Management** regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions. • **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training. • **Cyber Training** for the Trust Exec Board • Secured annual capital investment to increase Digital skills and capacity. • Digital Board support for profiling of a 7 Year Capital investment based upon asset replacement cycle and strategic roadmap (to deliver the approved Digital Strategy (January 2020)) • Oct & Nov security patching back on desktop-based machines as workaround is in place for the emergency peg board incompatibilities.				
Assurance Gaps:	**Gaps In Assurance:** • No parent committee for reporting • Achievement of mandated compliance with DSPT, GDPR and Cyber Essentials Plus and the EU NIS directive. • Deployment of NHS Digital Secure Boundary for the Internet connection				

Board Assurance Framework

	Gaps In Controls: • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Outcome of the Phishing exercise by NHS Digital, too many people clicked on the link. Next steps for staff awareness to be agreed. • Current performance of Lorenzo and whether migration to the cloud will provide any benefit. • Implementation of an effective workforce plan via an approved structure investment business case that delivers fit for purpose levels of skills, resilience and capacity. • Development of staff behaviours to protect data evidenced via reduced IG incident report levels. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Office 2010 being used while end of life for up to 5 months due to the N365 deployment plan • Not all Windows Server 2003 server will be migrated to Windows Server 2016 before the N365 agreement starts. (1 out of 77 servers are at risk of not being migrated in time. The system at risk is Medicorr.) • 5 servers 2008 R2 unable to install security patches: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system & Winscribe dictation system. • No local-based firewalls in use while on site, dependant on the site boundary firewalls

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Standardised policies and procedures across the C&M STP using the core documentation from standard of ISO 27001 and the DSPT	Standardise policies and procedures across the C&M STP	• MIAA to map the basic standards to form the minimum and gold standard of documentation for Cyber. MIAA and WHHT to create the documentation templates from the mapping: • ISO 27001 (ISMS) • Data Security & Protection Toolkit (DSPT) • Information Security Standard (ISF) • Center for Internet Security (CIS) • Information Systems Audit and Control Association (ISACA) • National Institute of Standards and Technology (NIST) • Cyber Security Body Of Knowledge (CyBOK) [MIAA to make a proposal to secure funding for a resource to draft up the policy templates and iMersey exploring the platform to be used to hold and share the policy templates.]	Deacon, Stephen	31/03/2021	
Move medical devices into VLAN bubble. This will involve participation of multiple 3rd parties and internal WHH staff. [Delivers: Best Practice]	Add medical devices to the Medical VLAN bubble	• A better solution to isolate the medical devices have been devised. It's the same as the "VLAN bubble" in that it's a firewalled VLAN, its more secure as devices within a VLAN are not limited in communicating with each other, keeping all PACs	Deacon, Stephen	31/03/2021	

Board Assurance Framework

		devices separate is better than isolating them all together with other medical devices. [Relooking at the way we move medical devices in terms of what is their renewal date and importance with Medical Engineering. This reduce disruption to the service and potential 3rd party costs. Head of Digital Compliance has contacted the Medical Engineering Manager for a copy of their asset register.]			
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system). [Delivers: Best Practice]	Migrate all 2003 and 2008 servers to 2016.	• Migrate the servers to Windows Server 2016 • Extend Support for Windows Server 2008 until Feb 2022 [Status September 20] Total Completed % Complete 2003 Servers 21 14 66.7% 2008 Servers 56 38 67.9% [Status October 20] Total Completed % Complete 2003 Servers 21 14 66.7% 2008 Servers 56 38 67.9% [Status November 20] Total Completed % Complete 2003 Servers 21 16 76.2% 2008 Servers 56 39 69.6% [All simple migrations have been completed by IT Services. A report was presented at the October's Digital Board, providing progress made in the decommissioning of Windows 2003/2008 servers, the timetable for decommissioning the remaining servers and the mitigations identified for those servers which are unlikely to be decommissioned before 31st December 2020. The only server at risk is the Medicorr Server]	Deacon, Stephen	30/06/2021	

Board Assurance Framework

To upgrade all windows 7 to Windows 10 before end of March 2020 [Delivers: Best Practice]	To upgrade all windows 7 to Windows 10 before end of March 2020	• Deployment and Desktop Team to go out and reimage the devices around the Trust. [99% migrated – November 2020] 10 outstanding devices to be migrated: Department: Outstanding Pathology 2 (Issues with the software – a mitigation plan will be needed by IT Seniors) Catering 1 (Waiting on MenuMark system upgrade) Ophthalmology 4 (Waiting on 3rd party post Covid-19) Theatres 2 (Covid-19 hotspot, unable to access) ED 1 (Covid-19 hotspot, unable to access) The 5 devices in Audiology have now been migrated to windows 10. IT Services have completed the migration as far as they can until the issues above can be resolved. CIO/SIRO has been made aware and is happy with the current risk. IT to look at the rest during the IT Seniors meeting to give an evaluation on dates. IT are looking into Whitelisting these devices so that only the designed software can be run on these devices, mitigating the risk. The Virtual Desktops (VDI) Windows 7 and Blue Prism image migration to the Windows 10 image is set to be complete by the beginning of January 21..	Deacon, Stephen	31/03/2021	
As part of Cyber Essentials+ all unsupported software should be updated or isolated from internet based networks. Office 2010 will need upgrading to the latest version of Office for all endpoint devices on the WHHT network. [Delivers: Best Practice]	Migrate from Office 2010	• Secure funding and take advantage of the NHS Digital's N365 discount licensing offer (May 20 – COMPLETE) • Submit the Trust's licensing requirement (June 20 - COMPLETE) • NHS Digital approval (August 20 - COMPLETE) • Migrate to N365 using remote installing software SCCM (Sept 20)	Deacon, Stephen	26/02/2021	

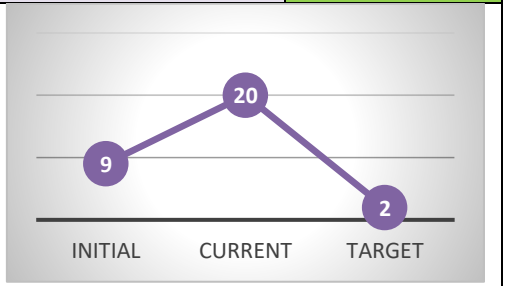
Board Assurance Framework

		• Phase 1 – IT Technical Team Migration (OCT 20) • Phase 2 – Rest of Digital Services and key system leads (DEC 20) • Phase 3 – Execs (DEC 20) • Phase 4 – Rest of the Trust (DEC 20) [The timescales for the above corporate Covid pandemic restrictions. Digital Services will do its upmost to complete the migration ahead of schedule.]			
Deliver fit for purpose Lorenzo EPR Performance and agility of changes to deliver the paperless strategy. [Delivers: Optimisation / Timeliness]	Work with supplier to assure EPR performance whilst enhancing Digital capability (people and finance).	• Work with EPR supplier to safely migrate Lorenzo to the modern cloud solution. • Implement staffing structure enhancements within financial opportunities (i.e. capitalisation of roles).	Gardner, Matthew	31/03/2021	
From the review of the first phishing exercise, provide a comms strategy and send it out to the users. Once finished rerun the phishing exercise next year.	Lessons learnt from previous phishing exercise and rerun phishing exercise	Lessons learnt from previous phishing exercise rerun phishing exercise • Produce a comms plan and send out comms to all staff • Arrange a rerun the phishing exercise • Examine the results and publish at the IGRSC	Deacon, Stephen	31/03/2021	
DXC to create a RED Health Team	DXC to create a RED Health Team	Red Team liaises with local Digital Services and investigates performance-related issues and both DXC and Local Trust act on any recommendations • DXC to provide technical support to investigate performance-related issues (COMPLETE) • DXC to produce a findings report (COMPLETE) • Digital Services to review the report (IN PROGRESS) • Feedback local review back to DXC • Act on any recommendations • Retest for improvements *[DXC have provided a report and has been passed to key members of the Digital Services SLT and senior IT Services staff for review]*	Deacon, Stephen	31/03/2021	
2020/2021 rollout of new devices	2020/2021 rollout of new devices	• Obtain capital funding	Deacon, Stephen	30/03/21	

Board Assurance Framework

		• Purchase the required devices • Build and deploy the new devices [1.18 million Capital funding agreed. Still to complete the backlog of 19/20. A plan has been devised to catch up on the backlog including a fixed term contract for extra help.]			
Implementation of the revised staff structure	Implementation of the revised staff structure	Draft costs have been obtained and the business case has been written with to exec approval and waiting on HR to give the go ahead to go to staff consultation. [Consultation complete. Process to now to get the staff in place.]	Deacon, Stephen	31/03/2021	
Mitigate 5 2008 servers not patching	Mitigate 5 2008 servers not patching	System Action Plan Symphony document server Decommissioned server (COMPLETE) Data warehouse app server MS was able to repair the Windows updates system manually, so it is up to date. Data Warehouse Team to progress migrating the apps off. (COMPLETE) Trust Print Server The OS is repaired and updating now. (COMPLETE) Dawn Anticoagulant system The OS cannot be repaired. A project has been paid for and started with 4S to migrate DAWN to a new server. In progress arranging a date with 4S and dept. Winscribe dictation system The OS is repaired and updating now. (COMPLETE)	Deacon, Stephen	31/03/2021	
DXC to move the cloud with the latest version of SQL (backend database) and using a single instance for Trust data	DXC to move Lorenzo to the cloud	• Migrate the data onto the cloud using the latest version of SQL [Migration will occur by May 2021 but the current target is February 2021.]	Caisley, Sue	18/06/2021	

Board Assurance Framework

Risk ID:	1079	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.			**Initial:**	9 (3x3)
				Current:	20 (4x5)
				Target:	2 (2x1)
Assurance Details:	CBU Triumvirate attended Executive financial update board to highlight continuing issues with Lorenzo system Chief Nurse, medical director and head of safety and risk aware of system issue Digital IT paper to QAC and PSCE in collaboration with IT director to highlight system failures and inoperability paper based backup systems introduced Additional administration in significantly affected areas. Site visit to MBFT for lessons learnt in improving system Miro meeting with IT manager to look for interim solutions Scoping new systems with procurement Capital funding meeting attended to seek funds to support alternative maternity specific system New mobile phones for community to support hot spotting in areas with no connectivity IT visited community clinics with Lorenzo connectivity issues Support from lead midwife for IT. To ensure data quality, data is cross-checked to ensure that accurate data is submitted to for screening and Payment By Results Quick reference guides have been created for users to improve data quality related to erroneous input Off line version of Lorenzo to assist Community midwives to input real time data and reduce errors Support currently in place is cleansing historical data staff required to cleanse data going forward In order to ensure health visitors are notified, the current system is a paper based crosschecking system which is dependent on individuals pulling data of current pregnancies at 28 weeks gestation and cross checking the Lorenzo system to confirm ongoing pregnancy. Presentation provided by prospective suppliers on 18th December 2020 Decision on supplier expected by 31st January 2021 EPR Strategic Outline Case supported by the Trust Board in December 2020 Temporary fix for CTG archiving agreed and fitted in December 2020 with review in January & February 2021 Following completion of supplier decision making process, implementation due to complete in September 2021				
Assurance Gaps:	Lack of connectivity to ensure that system can operate Lack of data to provide internet hotspot Poor quality lap tops The current digital solution is contributing to poor data quality and its detrimental care quality and activity income effects, poor staff moral and concerns by regulators. Work related stress due to additional hours required to achieve correct level of data inputting leading to sickness absence Lack of assurance that all women are captured for both operational clinical and financial ends. This leads to uncaptured activity and risk to safety if women are not entered onto the system appropriate due to the above Loss of income due to poor data quality. The cross checking is dependent on time being available for the team to complete this time consuming task.				

Board Assurance Framework

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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Identification of appropriate system for maternity comply with new national maternity standard records	Identification of an appropriate IT system (Materntiy EPR)	Scoping exercise in alignment with Trust IT strategy and CNST Agreement to purchase. The following actions are required: Digital Maternity Group to agree statement of requirements, due 11.9.20. This will inform subsequent procurement. Business process mapping forecast for w/c 7.9.20 – key deliverable to support maternity EPR system selection, but also change initiative required beyond tech to transform maternity. Business case presented to Maternity Improvement Committee, due 16.9.20. At this stage it will explore options to procure. Commence procurement of maternity EPR - due 1.10.20. Likely to conclude JANUARY 2021 with formal business case / recommendation to FSC and Trust Board.	Gardner, Matthew	29/01/2021	

Board Assurance Framework

CTG archiving required to ensure data kept for claims, complaints. The current CTG archive expires on 19th Nov 2020 requiring a new CTG archiving solution that will be procured as part of the Maternity EPR.	Purchase new CTG archiving system	Purchase new archiving system to archive CTG traces. This will require: Engage K2 to resolve existing CTG + Archive solution challenges – 21.8.20. K2 remotely investigating, onsite visit completed 26.8.20 K2 GUARDIAN contract expires 19.11.20; likely to require interim extension. K2 will determine viability of support to Q1 FY21/22. Site visit will determine what is viable to capture CTGs using current solution in the interim. Resolution due 1.10.20	Gardner, Matthew	28/02/2021	
The current system does not support appropriate referral to outside agencies. Required is a review of the current Data System with solutions put into place to overcome the lack of intra-operability.	Amendment to the Lorenzo Data System	Meeting held with the IT operations manager for WHHFT to highlight the concerns relating to Lorenzo as a Maternity Data system. Further meetings to be held to try to find a solution for this problem.	Loughman, Claire	26/02/2021	
Develop outline business case for Maternity EPR for Trust consideration and commence procurement for system in Oct 2020 in order to mitigate risk with current platform use for maternity pathway (Lorenzo_	Develop outline business case for Maternity EPR and commence procurement for system	Pre-Market engagement with incumbent suppliers (K2 and BadgerNet) – 21.8.20 COMPLETE Establish Digital Maternity Group with draft ToR for MIC approval – 21.8.20 COMPLETE Submit indicative capital costs to Capital Planning Group to ascertain prospect of funding implementation costs within Q4 FY20/21 – 21.8.20 - FSC and Board to then be sighted. COMPLETE MLCSU engagement to aid production of business case, statement of requirements and process mapping – due 29.9.20	Gardner, Matthew	28/02/2021	

Board Assurance Framework

Lorenzo will remain the platform supporting compliance with regulatory obligations and CNST incentives until new maternity EPR is deployed. The dates for new reporting obligations under the Maternity Record Standard (ISN) will require implementation prior to the date at which a new Maternity EPR can be deployed.	Optimise the existing Lorenzo platform to support new reporting obligations for CNST incentives (incl MSDSv2 and SBL)	Lorenzo will remain the platform supporting compliance with regulatory obligations and CNST incentives until new maternity EPR is deployed: MSDSv2 functionality planned Nov 2020, with compliance due Feb 2021. Detailed plan required with W&C CBU to map how this will be facilitated. Due Nov 2020. Saving Babies' Lives (SBL) data capture to follow MSDSv2 release. Due Nov 2020. Disconnected Maternity for community midwifery due to be piloted in Sept 2020. Though not related to reporting obligations nationally, it will improve data quality capture within the community which is a current challenge.	Gardner, Matthew	28/02/2021	

Board Assurance Framework

Risk ID:	1207	**Executive Lead:**	Michelle Cloney, Chief People Officer	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)

Assurance Details:

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

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

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

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

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

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

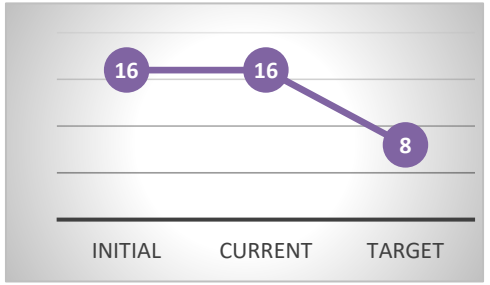
Training for line managers is in place and on-going Audit process is in place and live Staff communications have included:

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

Regular reporting to Recovery Board (twice weekly) and Executive Team (daily) is in place
Daily meetings are held with Deputy Director of HR and OD and Deputy Chief Operating Officer to review all outstanding risk assessments with CBU/Corporate Managers.

Position @ 4th March 2021

- 94% staff risk assessed
- % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary – 95.19%

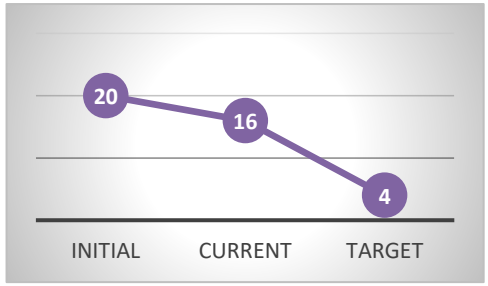


Board Assurance Framework

	○ Of the 100 staff know to be at risk who are yet to have a management risk assessment 46 have had the COVID Vaccine. ▪ HR continue to support managers to complete the risk assessments. • % of risk assessment have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary – 93.13% • 86% of our staff have received the COVID Vaccine • Outstanding assessments have been escalated to Tactical Meeting and Chair has requested detailed information for individuals in the CBUs with the highest number outstanding. • Routine contacting of managers with outstanding assessments from HR Team • Escalation process in place to escalate to senior HR Team member if no response after 2 contacts	
Assurance Gaps:	The required quick turnaround requires enagement at all levels of the organisation. The Trust requires all staff to recognise the importance of the Workplace Risk Assessment and therefore make accessing the training and support available a priotiy. To ensure the Workforce Risk Assessments are completed in a timely manner and to a high standard. Due to the nature of COVID-19 our knowledge of it is changing constantly; therefore it is a challenge to keep up-to-date with the guidance and then react appropriately through changes in our processes Circa 406 staff members yet to complete self-assessment	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Close scrutiny and monitoring of compliance is required to ensure local implementation.	Ensure senior level oversight and awareness of the progress of compliance ant staff group and CBU / Department level.	• Daily reporting to Chief People Officer and follow up with accountable managers where required - *Complete* • Inclusion in daily SITREP • Weekly reporting to Recovery Board *(temporarily stood down and now reporting to SEOG)* • Monthly reporting to Operational People Committee *(temporarily stood down and now reporting to SEOG)*	Deborah Smith, Deputy Director of HR and OD	31/10/2020	

Board Assurance Framework

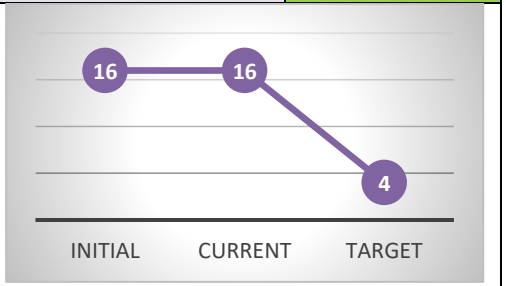
Risk ID:	125	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide a safe, secure, fit for purpose hospitals and environment caused by the age and condition of the WHH estate and limited availble resource resulting in a risk to meeting compliance targets, staff and patient safety, increased backlog costs, increased critical infrastructure risk and increased revenue and capital spend.			**Initial:**	20 (5x4)
				Current:	16 (4x4)
				Target:	4 (4x1)
Assurance Details:	Controls: 2018 C&M H&CP Estates strategy – updated annually Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out Capital Planning Group and associated capital funding allocation process Planned Maintenance Program Reactive maintenance regime Annual asbestos survey - asbestos management survey makes an assessment of the condition of any materials present and determine the likelihood of any fibres being released. Annual PLACE assessments Assurance: External estates compliance audit carried out in November 2019 which has in formed a number of remedial actions to improve compliance across the estate Monthly Estates compliance audit Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers Fire Safety Group – monitors fire safety issues across the trust and provides assurance to Cheshire fire and rescue service on Fire Safety Management PLACE assessment action plan and monitoring - Capital Planning Group – determine how the trust capital is spent Use of resources group – monitors how cost effective and value for money estates and facilities are in relation to a number of national and regional benchmarks New hospitals for Warrington and Halton groups – providing a platform to address the critical infrastructure and backlog risk 20-21 capital programme approved which includes £2.27m to address backlog maintenance £4.3m Business Case for ED Plaza Scheme approved: Phase 1 Paediatric ED reconfiguration commencing in November 2020 to be completed by 26th January 2021. This will increase the Paediatric ED Urgent Care footprint allowing for a better segregated flow of paediatric patients to support Covid-19. Phase 2 due to commence March 2021 and complete in June 2021. Commencement of Phase 2 (although approved) reliant on support from NHSE/I. Critical Infrastructure Capital Funding (£2.41m) to support schemes with critical and high levels of backlog maintenance approved Cancer Alliance funding of £0.5m for endoscopy enabling work at Halton to improve the environment Phase 1 of CT Buildings work complete Paediatric ED reconfiguration commencing in November 2020 to be completed by 31 December 2020. This will increase the Paediatric ED Urgent Care footprint allowing for a better segregated flow of paediatric patients to support Covid-19 Additional staff rest areas deployed to support social distancing and reduce staff nosocomial infection during rest and break times during the Covid-19 pandemic.				
Assurance Gaps:	Estates staffing - reduced staffing numbers since 2011 has impacted on ability to carry out elements of essential maintenance – review to be undertaken in 2021 Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome Cost pressures – unfunded elements of maintenance in I&E budget Use of Resources - benchmarking against backlog maintenance and critical infrastructure risk are below national medium				

Board Assurance Framework

	Confirmation from NHSE/I that the original PDC funding stream will not be carried over to 2021/22 meaning that phase 2 must revert to the Trust's own capital programme. Limitations to Oxygen flow as described in Risk #1126 Threat to the delivery of capital schemes due to the pandemic e.g. manufacturing delays, additional costs of construction relating to IPC guidelines and the unavailability of an appropriately skilled workforce.

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

Board Assurance Framework

Risk ID:	1108	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.			
Risk Description:	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by Covid, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team			**Initial:** 16 (4x4) **Current:** 16 (4x4) **Target:** 4 (4x1)
Assurance Details:	Provided listening events and 1:1 meetings for all staff. This has resulted in accumulated feedback to identify key themes to be addressed. Review of all processes. Interim Head of Midwifery in post New CBU manager appointed and in post. Appointment of 9.2 WTE midwives. Daily staff meetings taking place to intensively monitor staffing. NHSP and agency staff are being used to back fill shifts where possible. Nursing staff utilised for C23 when it is not possible for a midwife to fill the post. When short staffed on C23, an extra maternity support worker is asked to work. Midwifery management team strengthened – Four Matron in post until 31st March 2021 All additional 9.2 WTE Midwives in post. Midwives redeployed across the unit as appropriate 1:1 care rate currently @ 92% Interim Birth suite Manager appointed and in post 15th Feb 2021 (NHSP) Additional 3 Band 7 Birth suite Co-ordinators appointed 1st Feb 2021 2021 Birthrate plus full review funded by Local Maternity System to be carried out by 31st Dec 2021			
Assurance Gaps:	Potential for uncertainty across the services as a result of COVID-19 pandemic 3 x Interim Matrons contract until 31st March 2021			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Uplift of 7.5 WTE midwives to enable continuity of carer	Uplift of midwives for continuity of carer	Paper going to the board. To closely monitor vacancy rates so that the vacancies can be appointed to in timely manner	Gould, Debby	30/06/2021	

Board Assurance Framework

Risk ID:	1124	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff			**Initial:**	25 (5x5)
				Current:	15 (3x5)
				Target:	8 (4x2)

Assurance Details:

PPE - General

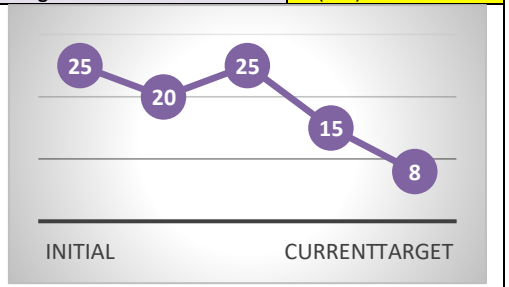
- A number of DHSC managed centralised PPE stores in place across the country with PPE issued in accordance with Trust demand profiles, Procument oversse and manages this in and out of hours process in place, daily monitoring process and escalation to the NSDR, extended opening hours in procurement and 7 day service, issuing PPE material management services i.e topping up areas, etc
- Centralised Cheshire & Merseyside (extending across the North West as necessary) mutual aid plan in place led by the Trust's Chief Finance Officer & Deputy CEO
- Regional mutual aid arrangements in place
- Where services are re-started, recovery forms and PPE burn rate to be documented on appropriate proformas with monitoring via the Elective Planning Meeting, with escalation to the Recovery and Strategic Groups.
- No staff member to work without appropriate PPE.
- National managed PPE inventory process is in place; The Managed Inventory (now known as Auto Replenishment) is based on the Trusts actual demand averaged out over the previous 7 days. Stock is pushed out based on 14 days stock holding. Gowns and FFP3 are remain tightly controlled. Inventory will include details of FFP3 masks required
- National PPE Strategy in place to support the management and monitoring of stock levels.
- PPE stock levels reported daily with early escalation via the Tactical Board
- Entrance Safety Team in place across the three formal open entrances at Warrington site in accordance with the lockdown plan to help supply PPE to patients, public and staff.
- The Health and Safety Team visit ward and departmental areas, which in addition to reviewing the environment, checks the stock and availability of PPE and addresses shortfalls at the time.
- We have 58 PPE champions to support the clinical teams and ensure correct PPE is available
- The Trust has a back-up storage provision in the form of the Arena Conference and Convention Centre (ACC) in Liverpool
- Nationally work is being undertaken for 80% off PPE to be manufactured in the UK
- The Trust has a clearly defined escalation processes in place
- The Trust has a clearly defined internal stock control systems in place

PPE – Quality

- Participation in Quality Improvement Programme with NHE/I on Fit Testing with focus on high risk areas
- National team are taking additional steps with quality control. Associated Director of Procurement will escalate any issues to the national team

PPE – FFP3s

- Fit Testing support is in place via the DHSC and has been utilised by the Trust bringing increases fit test pass rates. General consensus that Trusts need a ring fenced number of staff to provide a Fit Testing service. On-site NHSE/I support for Fit Testing until March 2021. Live database to demonstrate compliance with the number of staff Fit Tested
- Training and education of staff, Fit Testing programme in place for FFP3/FFP2 respirators, risk assessment and contingency plan in place if recommended PPE stock is not available
- Supply issues continue with 3m with regard to FFP3 with Trusts encouraged to move to more sustainable FFP3 models. In line with this the Trust has recently changed its preferences from 100% 3m to include a further two FFP3 masks where there has been a fit test % achieved.



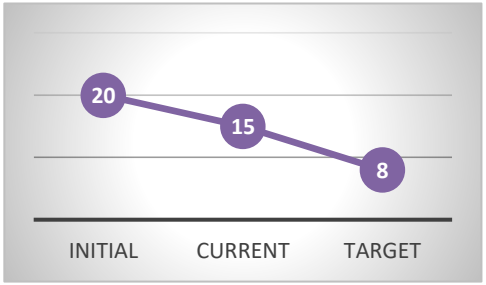
Assurance Gaps:	Current shortage of specific PPE equipment e.g. small Solway FFP3 respirators and expected shortage of 8833 respirators, Repeated Fit Testing will be required as different makes/models of FFP3 respirators are supplied – with potential to disrupt service provision.

Board Assurance Framework

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

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

Board Assurance Framework

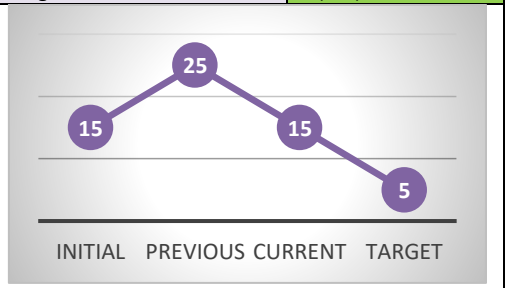
Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.			**Initial:**	20 (5x4)
				Current:	15 (5x3)
				Target:	8 (4x2)
Assurance Details:	The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the C&M Health and Care Partnership plans. The Trust has developed effective clinical networking and integrated partnership arrangements. Some examples include: - The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. - Collaboration with Bridgewater – currently paused due to the COVID -19 pandemic - Council and CCG in both Warrington & Halton supportive of development of new hospitals. Agreement with key stakeholders to progress single programme and proceed with OBC development. - Agreement of sustainability contract with Warrington CCG and subsequently Warringotn & HaltonSystem Financial Recovery Plan - Collaboration with STHK– currently paused due to the COVID -19 pandemic - Regular GP engagement events held - Regular Strategy updates are provided to the Council of Governors - Clinical strategy wide engagement - Clinical Strategy approved by Trust Board - CBU specialty level strategies complete and incorporated in business plans. - Successful in One Public Estate revenue funding bid for Halton - Initial talks held with Elective Care C&M Lead in relation to the suitability of Halton as a potential Elective Care Hub. Opportunity to accelerate elective hub as part of Covid recovery - Trust has met with Cheshire & Merseyside leads for Women's and Children's review to demonstrate strength of local Women's and Children's services and help inform outcomes of regional review. - NHSE and local Commissioners supportive of draft strategy for breast screening. Breast Centre of Excellence being implemented as a priority to support COVID-19 recovery. - Initial meeting for Cheshire & Merseyside respiratory review held. Trust presentation well received. - DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. The Trust has written to NHSP to seek support in raising the profile of our needs – NHSP has used the Trust as a case study in their national campaign - Strategic Outline Case (SOC) for both new hospital developments approved by the Trust Board. Both CCGs normally supported by wider partners through the Scrutiny Health & Wellbeing Boards - Letter written to Government from senior stakeholders requesting funding as part of HIP - Additional phase of HIP funding announced with the opportunity for investments in 8 additional new hospital developments. The Trust stated its intention to bid via a competitive process which is likely to take place in spring 2021. - Positive meeting the Medical Director and Director of Strategy at Alderhey confirming their intention to work with the Trust to repatriate WHH patients. – currently paused due to the COVID -19 pandemic				

Board Assurance Framework

	- Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside. Currently options for further development do not include any option where WHH is a hub. All options proposed include an Essential Services Lab (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESL. Pathology OBC supported by the Trust Board - Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. - Director of Strategy invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington - Town Deal plan for Warrington submitted. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £24m funding approved for the Town investment plan, including £3.75m for the Health & Wellbeing Hub and £1m foe the Health & Social Care academy. - Strategy refresh completed and approved at Trust Board to confirm 2020/21 priorities. Town Deal plan for Runcorn due for submission in January 2021, including £3m for Health & Wellbeing Education Hub in Runcorn.	
Assurance Gaps:	Organisational sovereignty and the need for individual Trusts, CCGs and others to meet performance targets at an organisational level have the potential to slow or block progress. Risk to Women's and Children's future provision due to Cheshire & Merseyside led review. Risk to securing capital funding to progress new hospitals Progress in collaboration with Alderhey to repatirate activity hindered due to COVID-19. Focus on addressing waits with organisation prioritised	

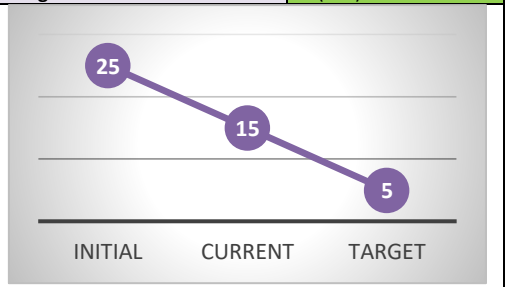
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Progress plans for new hospitals to be best placed to secure funding when available	Develop SOCs and OBCs	Develop SOCs and OBCs	Lucy Gardner	SOCs – April 2020 OBCs – Q4 2021/22 Warrington Q3 2021/22 Halton	SOCs – March 2020
Retain contact and relationship with Alderhey	Retain contact and relationship with Alderhey	Regular meetings with Alderhey Director of Strategy	Lucy Gardner	31/03/2021	
Rapidly implement general surgery partnership as soon as reasonably possible given COVID-19 recovery	Rapidly implement general surgery partnership as soon as reasonably possible given COVID-19 recovery	Rapidly implement general surgery partnership as soon as reasonably possible given COVID-19 recovery	Dan Moore	31/03/2021	

Board Assurance Framework

Risk ID:	1126	**Executive Lead:**	Moore, Daniel	**Rating**
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.			
Risk Description:	Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.			**Initial:** 25 (5x5) **Current:** 15 (3x5) **Target:** 5 (1x5)
Assurance Details:	Estates to manage evaporators and VIE supplies. Estates to regularly monitor site consumption and pressure. It has been agreed by Command that clinical staff will complete a return with the amount of oxygen in use on each Ward. ICU and Theatres will complete a separate return. This will be sent out by the Incident Management Team. Estates will monitor oxygen usage via the BOC website and provide daily updates at the Tactical Meeting. Maximum capacity of 3,000l/min but maximum2,400 l/m safe flow to be maintained to allow for unexpected surge in demand to provide a wider safety margin to deploy oxygen concentrators if necessary Re-commissioned CPAP devices available Receipt of Oxygen Concentrators Oxygen Concentrators to be deployed when the oxygen capacity for the site pipeline system reaches 2400 litres per minute so that the maximum flow rate is not exceeded and patients can be supported with the concentrators to keep them off the main system and maintain the supplies to the ventilated patients. Oxygen concentrators on-site and SOP in place. Oxygen usage monitored via ward staff and estates Daily SitRep reports oxygen usage on Warrington Site and monitored hourly 1.9.2020 - daily sitreps up to August 2020 revealed throughout the Covid management period the Trust's medical piped gassed capacity was not compromised. However, the risk is worthy of recognition up until April 2021 at the earliest. Reviewed and updated the Oxygen monitoring SOP in line with regional and national guidance. This now includes the process for the use of replacements O2 cylinders for wards that do not have piped oxygen. This policy also supports the oxygen requirements as a result of CPAP beds established on Ward A7. COVID-19 demand has significantly reduced from c243 patients to c130 patients. Monitoring over a number of weeks indicates an average 30-35% usage. As the number of COVID-19 patients reduce, the expected use of O2 should also reduce. Escalation process in place to Trust Tactical Board Meeting in heightened demand HSIB report received and recommendations reviewed and actioned with assurance to PSCEC and QAC			
Assurance Gaps:	Maximum flow rate of 3,000l/min			

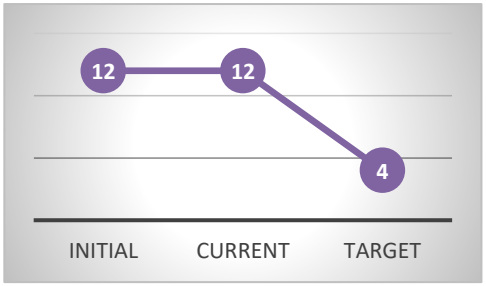
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

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

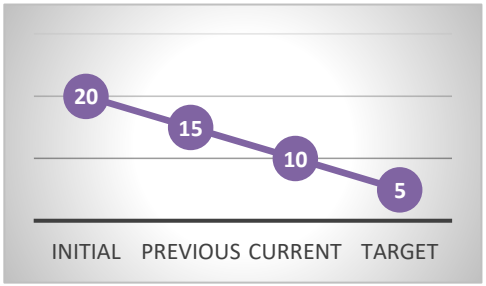
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Risk ID:	1290	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices, technology products and services, clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.			**Initial:**	12(3x4)
				Current:	12 (3x4)
				Target:	4 (1x4)
Assurance Details:	• The Brexit Sub Group has been stepped up with key leads for the associated work streams (Procurement, Pharmacy, EPRR, Finance, Communications, HR and Information). • The Procurement Department has undertaken a review of all suppliers as part of the national self-assessment exercise which was completed as C&M HCP system. Whilst this piece of work has been completed with no apparent adverse impact the Procurement Department continues to monitor fulfilment of orders to adopt a process of early investigation where supply appears to be disrupted. In addition, the Procurement Department is implementing processes to monitor prices to determine if there has been any financial impact upon exit from the EU. Monitoring of prices continues, and fluctuations will be measured on a monthly basis. The Procurement department are aware of some price increases looming and are looking at mitigation as prices increase. • The Pharmacy department has contacted the Regional Procurement Pharmacist who has advised that there will be monitoring of medicines purchases and usage centrally to manage medicines continuity. Issues / concerns / actions required will be communicated via regular updates to the Chief Pharmacist network. • Service level business continuity plans continue to be refreshed. • The majority of Pathology consumable suppliers are being checked by DHSC for supply assurances. Suppliers not on this list have been identified to procurement and are being address through the procurement department. • The Digital department has reviewed all the Trust key IT systems and data flows. To date no issues have been identified which will impact upon data flows. A time limited 'bridging mechanism' has been agreed which will allow personal data to continue to flow as it does now from the EEA whilst EU adequacy decisions for the UK are discussed. The Information Governance team continue to monitor the ICO website for news of the data adequacy decision. • Nationally, lessons in supplies and medicines have been captured from the COVID-19 period and there has been assurances made around national supplies of PPE and consumables. • Assurance letters and communication regarding the EU settlement scheme were sent out in February 2021 • Re-instigated the Brexit Sub-Group on 9th September 2020 and the group continues to meet at least monthly. • In December 2020 NHSE/I completed an assurance exercise with NHS Trusts to ensure EU Exit SRO and EU Exit Team in place. • NHSE/I to communicate further details of national changes and updates to guidance. • Daily SitRep reporting continues to monitor the impacts of the EU Exit. • Single point of contact in place for operational response, aligned with Winter Planning and COVID-19 response. • An EU Exit deal was established on 24th December 2020. The impacts of the terms of this deal and the implications on the supply of medicines and consumables are under review nationally and locally. The Brexit Subgroup continues to meet to monitor the implications of the established deal.				
Assurance Gaps:	Continued national uncertainty on the terms of the EU exit. Trusts being requested not to stockpile supplies. Potential price increases to supplies. Winter pressures, COVID-19 pressures and increase demand on Workforce and UEC.				

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

Board Assurance Framework

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

Board Assurance Framework

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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Recover As this is a third similar event in the past 12 months the Trust should now de-risk the lack of assurance demonstrated by DXC and implement more robust and comprehensive site testing.	Ensure a range of test patients records are exercised in all Lorenzo acceptance tests to incorporate a range of patient complexities and history permutations.	Document and implement strengthened Trust discharge summary acceptance test process for all Lorenzo EPR releases (Emma O'Brien) There is a meeting in Governance regarding the approval of the PAN process on the 13/10/20. Chased the Matron for Clinical Informatics to see if the PAN process is up-and-running.	O'Brien, Emma	28/02/2021	
Recover Ensure PAN notices are processed robustly and without delay and dovetail into clinical risk processes.	Document and implement more robust PAN receipt, confirmation, triage and management process.	• Review existing PAN management process (10/07/20 - Sue Caisley) • Consider automation of Datix for all PANs (10/07/20 - David Kelly) • Ensure Email is not a weakness (10/07/20 - Sue Caisley) • Ensue DXC seek formal response of receipt and action (10/07/20 - Sue Caisley) • Review PAN format for aiding Trust triage and prioritisation in response to potential threat to patient care, i.e. understand why the DXC assessment of this risk was "Medium" (17/07/20 - Sue Caisley) [The meeting in Governance went ahead, they are happy to assist the PAN process, however, due to workload created by Covid, the team are currently stretched supporting risk assessments, audits etc. so aren't able to pick this up at the moment. – IT Manager to chase.]	Caisley, Sue	28/02/2021	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/40**			
SUBJECT:	**Clinical Recovery Oversight Committee (CROC) Terms of Reference 2021-2022**			
DATE OF MEETING:	24 March 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.	X 		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The COVID-19 pandemic has significantly impacted NHS services in Warrington and Halton, putting pressure on all health and social care services. It is proposed that the Clinical Recovery Oversight Committee (CROC) is established to be accountable to the Trust Board for providing oversight, assurance and triangulation in relation to: • Referral to Treatment (RTT) • Patient Cancer Pathways • Diagnostics including Endoscopy and Outpatients • Progress of clinical harm reviews (CHR)			
PURPOSE: ***(please select as appropriate)***	Information	**Approve √**	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the CROC Terms of Reference.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee		
	Agenda Ref	FSC/21/03/59		
	Date of meeting	24.03.2021		
	Summary of Outcome	Supported		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

TERMS OF REFERENCE

CLINICAL RECOVERY OVERSIGHT COMMITTEE

1. PURPOSE

The COVID-19 pandemic of 2020/21 has significantly impacted NHS services in Warrington and Halton, putting pressure on all health and social care services.

The intended recovery of clinical services and a planned reduction of the treatment backlog has been complicated in Warrington and Halton by a second COVID-19 wave (October/ November 2020) and third COVID-19 wave commencing in December 2020. It is anticipated that these system wide pressures will remain throughout Q4 and beyond, with a requirement to support other regions in the North West (if necessary) in a response to the demands on acute and critical care services.

Due to this increased pressure on staffing, critical care and General and Acute beds, there is a significant risk that the ability to continue with the same elective surgical programme within Warrington and Halton Teaching Hospitals NHS Foundation Trust which has continued to date will be significantly reduced and the system in Warrington and Halton will have to enact a process of prioritisation for outpatients, diagnostics and surgery..

The purpose of the Clinical Recovery Oversight Committee is to be accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of quality and performance in relation to:

- Referral to Treatment (RTT)
- Patient Cancer Pathways
- Diagnostics including Endoscopy and Outpatients
- Progress of clinical harm reviews (CHR)

The Committee is a temporary Committee established during the COVID-19 pandemic and is accountable to the Board to ensure triangulation of matters detailed above under the purview of the Quality Assurance Committee and the Finance & Sustainability Committee; and ensuring that the organisational risks are managed appropriately in line with professional and regulatory standards.

2. FREQUENCY OF MEETINGS

Meetings shall be held fortnightly

3. QUORUM

Quorum shall be four members, of which at least two should be Non-Executive Director(s).

4. MEMBERSHIP

The Committee shall be composed of three Non-Executive Directors, one of whom shall be appointed by the Board to be Chair of the Committee

Core Members

- Non-Executive Chair of Finance & Sustainability Committee

- Non-Executive Chair of Quality Assurance Committee
- Non-Executive member of Quality Assurance Committee
- Chief Nurse & Deputy CEO
- Executive Medical Director
- Chief Operating Officer
- Deputy Director Governance
- Deputy Chief Finance Officer

Attendees

- Other Directors including the Chief Executive or staff members may also be invited/expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting

Observers

- **Public Governor**

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval.

5. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.
The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of people external to the Trust, with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it or require executive action.
- The Chair of the Committee will provide a written Committee Assurance report to the Board bi-monthly following each meeting providing assurance of the quality governance arrangements in place within the Trust and provide an annual report to be presented to the Board meeting on its work and performance in the preceding year.

The following groups will report into the Committee:

- COVID-19 Tactical Group (designated sessions on Waiting List Oversight and Clinical Harm Reviews)

7. DUTIES & RESPONSIBILITIES

The Committee will provide oversight and assurance on all aspects of quality and performance in relation to:

- Referral to Treatment (RTT)
- Patient Cancer Pathways
- Diagnostics including Endoscopy and Outpatients
- Progress of clinical harm reviews (CHR)

8. ATTENDANCE

A record of attendance will be kept; attendance of 75% per year is expected
Members unable to attend must send a deputy who is able to make decisions on their behalf.
Other Executive Directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Officers who are unable to attend a meeting of the Group may appoint a deputy who will attend. It is the responsibility of the core member to inform the Chair of the Group if they are unable to attend and who will attend as their deputy.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reached with the Chair of the Group the Agenda and Papers will be sent out 3 working days before the date of the meeting. No Papers will be tabled at the meeting without prior approval of the Chair. The Group will be supported by TBC

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business will be established

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Divisional leads/service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed
5. Presentations must be sent to the Administrator ahead of the meeting
6. No tabled papers will be accepted unless in an emergency and with permission of the Committee Chair.

10. REVIEW / EFFECTIVENESS

The Group will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Group.
The Cycle of Business will be reviewed by the Group every 12 months.

Recommendations

TERMS OF REFERENCE REVISION TRACKER

Name of Group:	Clinical Services Recovery Oversight Committee
Version:	1
Implementation Date:	TBC
Review Date:	12 months from approval
Approved by:	Finance & Sustainability Committee 24.03.2021 Trust Board xx.xx.2021
Approval Date:	

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
TERMS OF REFERENCE OBSOLETE			
Date	**Reason**		**Approved by:**

DRAFT

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/41**			
SUBJECT:	**Joint strategic agreement between University of Chester and Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH)**			
DATE OF MEETING:	31st March 2021			
AUTHOR(S):	Lucy Gardner, Director of Strategy Viv Groom, Strategy Programme Support Manager			
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Director of Strategy			
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			 X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	#145 a. Failure to deliver our strategic vision.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Joint Strategic Agreement sets out the proposed strengthened collaboration between WHH and University of Chester to develop and strengthen education, training and recruitment into healthcare roles and further develop research across Cheshire and Merseyside.			
PURPOSE: *(please select as appropriate)*	Information	Approval x	To note	Decision
RECOMMENDATION:	It is recommended that the Board supports the collaboration and approves the Joint Strategic Agreement. Section 7 of the agreement proposes the appointment of a Non-Executive Director from the University of Chester to WHH's Trust Board. This has been approved by an amendment to the constitution at Council of Governors on 8th January 2021 and Trust Board on 27th January 2021. A reciprocal arrangement, with WHH representation on the University's Governing Body is included in the Partnership Agreement.			
PREVIOUSLY CONSIDERED BY:	**Committee**	SEOG		
	Agenda Ref.			
	Date of meeting	19th March 2021 26th March 2021		
	Summary of Outcome	The Partnership agreement was supported by SEOG.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Joint strategic agreement between University of Chester and Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH)**	**AGENDA REF:**	**BM/21/03/41**

1. BACKGROUND/CONTEXT

An opportunity has been identified for WHH and University of Chester to form a joint strategic committment and work closer together at a strategic level to develop and strengthen education, training and recruitment into healthcare roles and further develop research across Cheshire and Merseyside.

2. KEY ELEMENTS

The draft relationship agreement formalises and sets out the strategic aims, objectives, roles and responsibilities of WHH and University of Chester to achieve the vision.

The collaboration is underpinned and led by the Joint Vision:
The Warrington and Halton Teaching Hospitals NHS Foundation Trust and University of Chester will work collaboratively, to provide nationally and internationally recognised excellence in health care, planned and delivered by a well-trained and supported workforce, underpinned by robust evidence, within an innovative and research-led culture.

In brief, the collaboration agreement covers and includes the detail on:

- The joint vision;
- Shared values;
- Collaborative mission;
- Aligned strategic aims;
- Framework for joint working, covering:
    - Recruitment
    - Excellence in education and training
    - Supporting development of broader clinical workforce
    - Training next generation of scientists
    - Attraction and retention of internationally recognised scientists
    - Identify and develop research projects providing direct benefits to patients
    - Share expertise and resources to develop a plan to grow staff in to leaders
    - Make best use of buildings, estates and resources

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

It is recommended that:

- The Trust Board approves the Partnership Agreement.

Section 7 of the agreement proposes the appointment of a Non-Executive Director from the University of Chester to WHH's Trust Board. This has been approved by an amendment to the constitution at Council of Governors on 8th January 2021 and Trust Board on 27th January 2021. A reciprocal arrangement, with WHH representation on the University's Governing Body is included in the Partnership Agreement.

4. TRAJECTORIES/OBJECTIVES AGREED

The strategic aims of the collaboration are:

1. We wish to encourage and recruit people, whatever their background, into healthcare professions.
2. We will work together to provide excellent education and training opportunities throughout the professional lives of University and NHS staff; spanning foundation, undergraduate and postgraduate levels, including continuing professional development.
3. We will support the development of a broader clinical workforce, breaking down traditional barriers, encouraging inter-professional education and emerging roles such as Advanced Clinical Practitioners, Physician Associates, Allied Health Professionals and supporting and further developing apprenticeships as a recruitment pathway.
4. We aim to train and enthuse the next generation of scientists, providing broad and detailed education in the basic medical sciences within a clinical context and equipping them with the communication skills required to maximise their contribution to healthcare demonstrating and embodying kindness.
5. We will attract, support and retain internationally recognized scientists and clinicians to work on focussed basic science research projects. We will give NHS staff the opportunity to actively contribute to these research groups.
6. We will work together to identify priorities and develop clinical research projects of direct benefit to patients, carers, and the wider community in Warrington and further afield.
7. We will share our expertise and resources to develop a comprehensive plan to grow our staff into leaders, focused on efficient use of resources and quality improvement, with a robust, accessible and well mapped CPD framework to help the Trust to further develop and retain high quality staff.
8. We will make the best use of our buildings, estates and resources, sharing and giving access as appropriate, in the furtherance of our joint vision.

9. We will work together with other partners to offer the very best opportunities for education and skills development. For example we will be key partners to Warrington and vale Royal College in the development of a Health and Social Care Academy in Warrington, as part of the Warrington Town Deal programme.

5. MONITORING/REPORTING ROUTES

Following approval of this Joint Strategic Agreement the monitoring and governance arrangements will be finalised and agreed, with reporting through both University of Chester and WHH Boards.

6. ASSURANCE COMMITTEE

The collaboration will be overseen by the Quality Assurance Committee and Strategic People Committee.

7. RECOMMENDATIONS

It is recommended that:

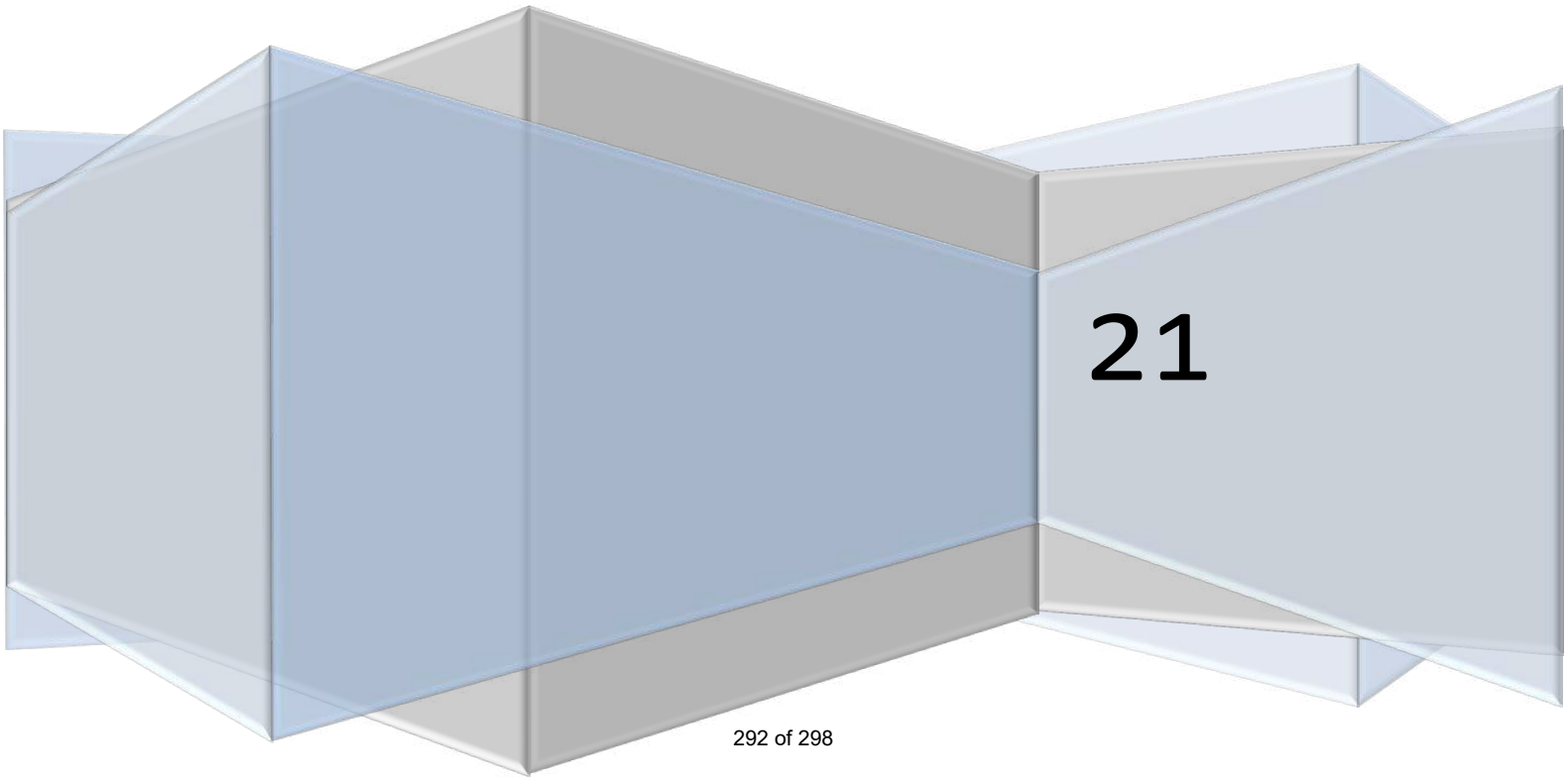
- The Trust Board approves the Partnership Agreement.

Section 7 of the agreement proposes the appointment of a Non-Executive Director from the University of Chester to WHH's Trust Board. This has been approved by an amendment to the constitution at Council of Governors on 8th January 2021 and Trust Board on 27th January 2021. A reciprocal arrangement, with WHH representation on the University's Governing Body is included in the Partnership Agreement.

Warrington and Halton Teaching Hospitals NHS Foundation Trust and University of Chester

Joint Strategic Agreement

A collaborative agreement: To provide outstanding care, education research and innovation for our patients and communities.



The Warrington and Halton Teaching Hospitals NHS Foundation Trust and

The University of Chester

JOINT STRATEGIC COMMITMENT

Our Joint Vision: The Warrington and Halton Teaching Hospitals NHS Foundation Trust and University of Chester will work collaboratively, to provide nationally and internationally recognised excellence in health care, planned and delivered by a well-trained and supported workforce, underpinned by robust evidence, within an innovative and research-led culture.

Our Shared Values:

We share the values of working together, being inclusive and being kind, recognising the worth of every individual. We embrace change and excellence, recognising the role of education in the service of society.

We will hold ourselves accountable to these values work in partnership to provide the best possible experience and achieve the best possible results.

Our Collaborative Mission: "To be outstanding for our patients, our communities and each other. To provide exceptional care, education, research and innovation together"

Our Aligned Strategic Aims:

1. We wish to encourage and recruit people, whatever their background, into healthcare professions.
2. We will work together to provide excellent education and training opportunities throughout the professional lives of University and NHS staff; spanning foundation, undergraduate and postgraduate levels, including continuing professional development.
3. We will support the development of a broader clinical workforce, breaking down traditional barriers, encouraging inter-professional education and emerging roles such as Advanced Clinical Practitioners, Physician Associates, Allied Health Professionals and supporting and further developing apprenticeships as a recruitment pathway.
4. We aim to train and enthuse the next generation of scientists, providing broad and detailed education in the basic medical sciences within a clinical context and equipping them with the communication skills required to maximise their contribution to healthcare demonstrating and embodying kindness.
5. We will attract, support and retain internationally recognized scientists and clinicians to work on focussed basic science research projects. We will give NHS staff the opportunity to actively contribute to these research groups.
6. We will work together to identify priorities and develop clinical research projects of direct benefit to patients, carers, and the wider community in Warrington and further afield.
7. We will share our expertise and resources to develop a comprehensive plan to grow our staff into leaders, focused on efficient use of resources and quality improvement, with a robust, accessible and well mapped CPD framework to help the Trust to further develop and retain high quality staff.

8. We will make the best use of our buildings, estates and resources, sharing and giving access as appropriate, in the furtherance of our joint vision.
9. We will work together with other partners to offer the very best opportunities for education and skills development. For example we will be key partners to Warrington and vale Royal College in the development of a Health and Social Care Academy in Warrington, as part of the Warrington Town Deal programme.

FRAMEWORK FOR JOINT WORKING

DRAFT

1. We wish to encourage and recruit people, whatever their background, into healthcare professions.

We will work together to develop;

- Outreach activities to local schools and Further Education institutes, specifically targeting currently under-represented socio-economic and demographic groups.
- Inform the public of the wide-range of NHS careers that are available and the academic and practical routes to that are available through the University and the Trust.
- Promote and support the Foundation Year programme, based in Warrington, as a mechanism by which students that meet our widening participation criteria may enter undergraduate training across multiple disciplines.
- Promote and support our Graduate Entry Medicine programme, based in University of Chester, as a route to study medicine for a wide range of students, including those with a non-science “A” level background and those seeking a change of career
- Promote and support University of Chester nursing and midwifery programmes, Trainee Nurse Associates and Trainee Assistant Practitioners programmes for individuals with a nursing vocation.
- The planning and delivery of Open Days, Summer Schools and work experience opportunities
- Support for the development of innovative University of Chester programmes, for example, Physician Associates, and the expansion of current courses, including those open to International students
- Attracting a diverse range of people into healthcare roles
- An apprenticeship programme covering a breadth of roles in Healthcare leadership and management as well as clinical and medical roles.

2. We will work together to provide excellent education and training opportunities throughout the professional lives of University and NHS staff; spanning foundation, undergraduate and postgraduate levels, including continuing professional development.

We will work together by;

- Providing high quality clinical placement opportunities to students on programmes of study in Medicine, Nursing, Midwifery, dietetics and Physician Associate Studies.
- The Trust will work with the University to identify clinical placements in the required specialties and to expand the number of opportunities to assure the volume of placements required to support their future workforce projections.
- The Trust will consider the University the "preferred partner" when assessing its capacity to provide clinical placements
- The University will work with the Trust to quality assure clinical placements in line with regulatory requirements and feedback from student evaluations and HEE surveys.
- Both organisations will explore innovative ways of expanding clinical placement capacity, for example, by placing students in emerging specialties and investing clinical placement tariff to support new initiatives
- Both organisations will work together, being mindful of the guidance provided by Regulators, to ensure curricula and clinical placements produce graduates that are fit for purpose and are matched to the needs of the NHS and wider Integrated Care System.
- The Trust will have due regard to the needs of University students in relation to travel, accommodation, study spaces and subsistence, in accordance with agreed standards, in order to ensure the Trust becomes a preferred site for students to undertake their clinical placements
- We will explore opportunities by which we can work together to expand Postgraduate Taught Courses based in University of Chester and Warrington and Halton Teaching Hospitals, including Diplomas, Masters, and stand-alone "short courses" for Continuing Professional Development.
- An integrated education pathway, integrating new roles across Health and Social Care in to development pathways, allowing the training to develop alongside developments in Health and Social Care roles.

DRAFT

3. We will support the development of a broader clinical workforce, breaking down traditional barriers, encouraging inter-professional education and emerging roles such as Advanced Clinical Practitioners and Physician Associates

We will work together by;

- Continuing to develop the Masters in Physician Associate Studies programme.
- Supporting the Advanced Clinical Practitioner programme
- Identifying opportunities for Inter-Professional Education, for example by shared use of high-fidelity clinical simulation teaching opportunities and appointments jointly facilitated by the University and Trust.

4. We aim to train and enthuse the next generation of scientists, providing broad and detailed education in the basic medical sciences within a clinical context and equipping them with the communication skills required to maximise their contribution to healthcare

We will work together by;

- Confirming our commitment and support to the continued delivery of the BSc in Medical Physiology & Therapeutics programme based in the Medical School in Chester.

- Identifying opportunities by which undergraduate students on this programme may gain "added value" by being taught adjacent to a large University hospital, e.g. by visits to the laboratories, wards and clinic areas to annotate their studies
- Identifying opportunities for these students to work with the Trust on topics of relevance for their final-year research projects
- Promoting NHS laboratory science careers to students

5. ***We will attract, support and retain internationally recognized scientists and clinicians to work on focussed basic science projects housed in research laboratories in University of Chester and Warrington and Halton Teaching Hospitals. We will give NHS staff the opportunity to actively contribute to these research groups, and the non-clinical scientists the opportunities to engage with clinical staff***

We will work together by;

- Confirming our commitment and support for the presence of non-clinical, research-active, University of Chester academic staff based in laboratories within the School of Medicine.
- Providing opportunities for non-clinical academic staff to liaise with the Trust regarding their research projects, e.g. to explore sources of clinical material for their projects, with due respect to regulatory requirements
- Promote communication between non-clinical academic staff and NHS staff to help inform and develop basic-science projects and joint grant applications that may lead to direct patient benefit
- Continue to develop posts, such as Clinical Fellows, which allow NHS staff to combine a clinical service role with the opportunity to work on a research project, leading to the award of a higher degree such as a PhD, MD or MPhil.
- Develop arrangements by which the University of Chester and the Trust contribute to the consumable costs of basic science research projects undertaken with, or in collaboration with, NHS staff.

6. ***We will work together to identify priorities and develop clinical translational research projects of tangible direct benefit to patients, carers and the wider community in Chester, Warrington and further afield.***

We will work together by;

- Supporting the appointment of University of Chester clinical academic staff (medical and non-medical) with job plans that contain time for academic activities
- Develop a funding model for clinical academic posts that is fair, transparent and responsive to the needs of the Trust and University.
- Identify opportunities for substantive NHS clinicians to have funded academic sessions within their job plans
- Planning and appointing strategically to support our aligned service and academic priorities. For example, by investing in clinical academic time to recruit and retain in specific disciplines or areas of expertise
- Managing clinical academic staff in accordance with Follett Principles. Joint appraisals will be informed by a clear understanding of the expectations of both the Trust and the University
- We will identify priorities for clinical research based on local needs, national NHS priorities, the emerging Integrated Care System and those of the University, always aiming to attract funding from NIHR, the Research Councils and charities

- The Trust R&D Department will work closely with the University and all research-active staff to support research. We will develop clear guidelines regarding which projects should be sponsored by the Trust or University and streamline the processes involved.

7. We will share our expertise and resources to develop a comprehensive plan to grow our staff into leaders, focused on efficient use of resources and quality improvement

We will work together by;

- Developing a "Unique Selling Point" of the Warrington and Halton Teaching Hospitals experience that relates to the close working relationship with the University of Chester and the advantages gained from being in an environment where all we do is underpinned by robust evidence in a research-led environment
- We will share our organisational and personal development expertise to ensure all our staff are empowered to make a real difference to patient care, beyond the merely expected to the outstanding. Examples include collaborating on quality improvement work and developing the next generation of clinical academics
- We will work together to further develop Quality Improvement and Leadership learning opportunities on undergraduate and postgraduate programmes. For example, we will explore how to identify QI as a longitudinal strand in our Graduate Entry Medicine problem-based-learning cases
- The University will award honorary academic titles to NHS staff, to the level of Professor (or University fellow for those outside the traditional academic pathways), in recognition of contributions to academic life.
- The University will be represented by a Non-Executive Director on the Trust Board. This will be a reciprocal arrangement with the Trust being represented at University by a Council and Board member.

8. We will make the best use of our buildings, estates and resources, sharing and giving access as appropriate, in the furtherance of our joint vision.

We will work together by;

- Sharing a strong commitment that the University of Chester will have a significant presence at the Warrington and Halton site.
- Acknowledging that on occasions, both organisations may require short-term access to additional space, e.g. seminar rooms or lecture theatres. We will work together to provide such access if possible
- The Trust will consider the needs of the University when planning developments on its sites, for example to car parking, travel, accommodation, childcare, and catering provision
- Where opportunities exist for longer-term arrangements, e.g. the leasing of buildings, the Trust and University will take into account the close working partnership and the added value to be gained by entering into such agreements

DRAFT

Trust Board

DATES 2019-2021

All meetings to be held in the Trust Conference Room

Date of Meeting	Agenda Settings	Deadline For Receipt of Papers	Papers Due Out
2019			
Wednesday 27 November	Thursday 7 Nov (EXECS)	Monday 18 November	**Wednesday 20 November**
2020			
Wednesday 29 January	Thursday 9 January (EXECS)	Monday 20 January	**Wednesday 22 January**
Wednesday 25 March	Thursday 5 March (EXECS)	Monday 16 March	**Wednesday 18 March**
Wednesday 27 May	Thursday 7 May (EXECS)	Monday 18 May	**Wednesday 20 May**
Wednesday 29 July	Thursday 9 July (EXECS)	Monday 20 July	**Wednesday 22 July**
Wednesday 30 September	Thursday 10 September (EXECS)	Monday 21 September	**Wednesday 23 September**
Wednesday 25 November	Thursday 5 November (EXECS)	Monday 16 November	**Wednesday 18 November**
2021			
Wednesday 27 January	Thursday 7 January (EXECS)	Monday 18 January	**Wednesday 20 January**
Wednesday 31 March	Thursday 10 March (EXECS)	Monday 22 March	**Wednesday 24 March**