WHH Board of Directors Meeting Part 1

Wednesday 29 SEPTEMBER 2021
10.00am-12.30pm
vias 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 29 September 2021 time 10.00am -12.30pm

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

REF BM/21/09	ITEM	PRESENTER	PURPOSE	TIME	
BM/21/09/ 119 PAGE 7	**ENGAGEMENT STORY** - A story of managing complex challenging behaviours in an acute paediatric setting	Deborah Carter, Project Director Women and Children's Services	Presentation	10.00	
BM/21/09/ 120	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	10.15	Verb
BM/21/09/ 121 PAGE 13	Minutes of the previous meeting held on 28 July 2021	Steve McGuirk, Chairman	Decision	10:17	Encl
BM/21/09/ 122 PAGE 26	Actions & Matters Arising	Steve McGuirk, Chairman	Assurance	10:20	Encl
BM/21/09/ 123 PAGE 28	Chief Executive's Report	Simon Constable, Chief Executive	Assurance	10:25	Encl
BM/21/09/ 124	Chairman's Report	Steve McGuirk, Chairman	Information	10:35	Verb

Quality People Sustainability

BM/21/09/ 125 (a) PAGE 158	Integrated Performance Dashboard and Assurance Committee Reports PAGE 58	All Executive Directors Daniel Moore Chief Operating Officer	To note for assurance	10:40	Enc
(a i)	- Quality Dashboard including o Monthly Nurse Staffing Report PAGE 37	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO			Enc
(b) PAGE 122	- Quality and Assurance Committee – Committee Assurance Report (02.08.2021 & 07.09.2021)	Margaret Bamforth Committee Chair			Enc
	People Dashboard	Michelle Cloney Chief People Officer			Enc
(c) PAGE 131	- Strategic People Committee – Committee Assurance Report (22.09.2021)	Anita Wainwright Committee Chair			
	- Sustainability Dashboard	Andrea McGee Chief Finance Officer & Deputy CEO			
(d) PAGE 137	- Finance and Sustainability Committee – Committee Assurance Report (25.08.2021 & 22.09.2021)	Terry Atherton Committee Chair			
(e) PAGE 149	- Audit Committee – Committee Assurance Report (19.08.2021)	Ian Jones Committee Chair			
(f) PAGE 154	- Clinical Recovery Oversight Committee (CROC) – Committee Assurance Report 23.07.2021, 18.08.2021, 14.09.2021)	Terry Atherton Committee Chair			

Quality

BM/21/09/126 PAGE 173	Moving to Outstanding (M2O) Update	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	To note for assurance	11:30	Enc

Sustainability

People

BM/21/09/129 PAGE 180	Strategic Priorities	Lucy Gardner Director of Strategy & Partnerships	To note for assurance	11:50	Enc
BM/21/09/130 PAGE 182	Flu Campaign & COVID Vaccine Booster plan	Michelle Cloney Chief People Officer	Approval	11:55	Enc

GOVERNANCE

BM/21/09/131 PAGE 192	Strategic Risk Register + BAF	John Culshaw Trust Secretary	To note	12:05	Enc

MATTERS FOR APPROVAL

	ITEM	Lead (s)				
BM/21/09/133 PAGE 50	Audit Committee Chairs Annual Report	John Culshaw Trust Secretary	Committee Agenda Ref. Date of meeting Summary of Outcome	Audit Committee AC/21/08/68 19.08.2021 Supported	12;15	Enc
BM/21/09/134 PAGE 56	Changes to the Constitution	John Culshaw Trust Secretary	Committee Agenda Ref. Date of meeting Summary of Outcome	Council of Governors COG/21/08/ 12.08.2021 Approved		Enc
BM/21/09/135 PAGE 61	Charitable Funds Committee Governing Document and Cycle of Business	Pat McLaren Director of Communications & Engagement	Committee Agenda Ref. Date of meeting Summary of Outcome	Charitable Funds Committee CFC/21/09/80 09.09.2021 Approved		Enc
BM/21/09/136 PAGE 68	GMC Revalidation Annual Report (Medical Appraisal)/NHSE Statement of Compliance & NHSE Annual Organisation Audit (AOA)	Alex Crowe Executive Medical Director	Committee Agenda Ref. Date of meeting Summary of Outcome	Strategic People Committee SPC/21/09/72 22.09.2021 Approved		
BM/21/09/137 PAGE 77	EPRR Assurance Compliance letter	Daniel Moore Chief Operating Officer	Committee Agenda Ref. Date of meeting Summary of Outcome	Finance + Sustainability Committee FSC/21/09/155 22.09.2021 Approved		
BM/21/09/138 PAGE 97	Digital Systems Tender Evaluation Criterion	Alex Crowe Executive Medical Director	Committee Agenda Ref. Date of meeting Summary of Outcome	Finance + Sustainability Committee FSC/21/09/160 22.09.2021 Approved		

MATTERS FOR NOTING FOR ASSURANCE

	ITEM	Lead (s)				
BM/21/09 139 PAGE 104	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/21/09/218		
			Date of meeting	07.09.2021		
			Summary of Outcome	Noted		
BM/21/09/ 140 PAGE 161	Infection Prevention and Control Q1 Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/21/08/184		
			Date of meeting	03.08.2021		
			Summary of Outcome	Noted		
BM/21/09/ 141 PAGE 179	Learning From Experience Q1 Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/21/09/219		
			Date of meeting	07.09.2021		
			Summary of Outcome	Noted		
BM/21/09/ 142 PAGE 216	Mortality Review Q1 Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/212/09/189		
			Date of meeting	03.08.2021		
			Summary of Outcome	Noted		
BM/21/09/ 143 PAGE 247	Freedom to Speak Up Bi-Annual Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	Committee	Strategic People Committee		Enc
			Agenda Ref.	SPC/21/09/79		
			Date of meeting	22.09.2021		
			Summary of Outcome	Noted		
BM/21/09/ 144 PAGE 283	Guardian of Safe Working Q1 Report	Alex Crowe Executive Medical Director	Committee	Strategic People Committee		Enc
			Agenda Ref.	SPC/21/09/81		
			Date of meeting	22.09.2021		
			Summary of Outcome	Noted		
BM/21/09/ 145 PAGE 291	Bribery Act 2010 & Trust Anti-Bribery Strategy	Andrea McGee Chief Finance Officer & Deputy CEO	Committee	Audit Committee		Enc
			Agenda Ref.	AC/21/08/59a		
			Date of meeting	19.08.2021		
			Summary of Outcome	Noted		
BM/21/09/ 146 PAGE 293	Digital Board Report	Alex Crowe Executive Medical Director	Committee	Finance + Sustainability Committee		Enc
			Agenda Ref.	FSC/21/09/150		
			Date of meeting	22.09.2021		
			Summary of Outcome	Noted		

BM/21/09 / 147	Any Other Business	Steve McGuirk, Chairman	N/A	16:55	Ver
	Date of next meeting: Wednesday 24 November 2021, Trust Conference Room				

Conflicts of Interest

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

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

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

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

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

Interests fall into the following categories:

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

GLOSSARY OF TERMS

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

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Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Managing a young person with Complex Behaviours Which Challenge in an Acute Paediatric Setting.

Deborah Carter, Project Director Women and Children's Services

MF 13 year old boy presenting to ED with mental health concerns

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Situation:

- Attended ED with Mum due to concern over MF mental health deterioration & escalating violent behaviour.
- Requiring urgent assessment by Child and Young People's Mental Health Services (CYPMHS).
- Assessment by mental health worker that admission required, Section 2 Mental Health Act (MHA), due to risk of harm to self and others.
- Became aggressive towards staff when he was unable to leave. Sedation given.
- MF absconded from ED brought back by the police.
- Admitted to paediatric ward in a cubicle detained under Section 2 MHA
- Behaviour escalating presenting risk to MF and staff police called, anaesthetic team sedated MF.

Background

- MF has learning difficulties and is diagnosed with Autism spectrum disorder (ASD) and Attention deficit hyperactivity disorder (ADHD).
- He lives with Mum with minimal support. Was not currently open to CYPMHS or social services.
- MF behaviours had escalated during adolescence , becoming more destructive in the home and physically assaulting Mum.
- Police were called following increasing risk of harm to self and others. Discussions with social services/agencies who advised ED due to risks.

Multi Disciplinary Working

Warrington and Halton Teaching Hospitals NHS Foundation Trust

To ensure the best care for MF the WHH paediatric/CBU management team supported by the executive team escalated and reached out for support and expertise internally, regionally and nationally, including linking with: -

Safeguarding	Warrington CCG	Security	Estates	Governance team	Legal Team
Anaesthetics	CAMHS	Pharmacy	Cheshire & Merseyside Paediatric Network	Psychologist	Social services
Brooks & Brooks (education, health and social care agency)	Support from national leaders in NHS England				

Risk Assessment and Planning

- Dynamic , responsive and multidisciplinary.
- Safety of MF, Mum and staff. Joint risk assessments and plans which included: Safeguarding, security, agency, staff and CAMHS.
- Ensuring the safety and care of all other children on the paediatric ward.
- MF moved into bay. Joint Risk Assessment with health & safety advisor and nursing staff around environment.
- Ward flexed to accommodate needs of other children, planned surgery cancelled
- Ensuring the voice of the child-MF and Mum in risk assessment and planning
- Communication and documentation.
- Clear plan for facilitating MF transfer and discharge to more appropriate facility.

Emotional Care for staff

- Visible, supportive presence from clinical, CBU management team and executive colleagues.
- Responsive recognition of staff well being.
- 1:1 support for staff.
- Increased staffing.
- Health and Wellbeing team visiting the ward.
- Communication around available support within the Trust.
- Timely return to usual clinical environment.
- Enhanced debrief in progress.

Outcomes and Learning

- Regular updates MF now being safely supported at home with Mum and appropriate team in place.
- The requirement to have a rapid tranquilisation policy for children.
- Early escalation.
- Effective team work within the Trust and external agencies.
- Joint up working with CAMHS and agency.
- To review distraction/activities for young people.
- Additional training for nursing staff.
- COVID status.
- Rapid need to repair the estate to ensure other children were not disadvantaged
- Through debrief process reviewing MF clinical pathway and the needs of staff.

"Amazing work the team and ward have done on behalf of MF. You all have been outstanding in ensuring he has had the best possible care in awful circumstances. It has reinforced how lucky the children in Warrington are to have such an amazing trust and such dedicated staff to care for them when they need it."
Pauline Owens - Designated Nurse safeguarding children and Children in care Warrington CCG.

DRAFT

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 28 July 2021 via MS Teams	
Present	
Steve McGuirk (SMcG)	Chairman
Simon Constable (SC)	Chief Executive
Terry Atherton (TA)	Deputy Chair, Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
Alex Crowe (AC)	Executive Medical Director & Chief Clinical Information Officer
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Daniel Moore (DM)	Chief Operating Officer
Cliff Richards (CR)	Non-Executive Director
K Salmon-Jamieson,	Chief Nurse & Deputy CEO and Director of Infection Prevention & Control (DIPC)
Anita Wainwright (AW)	Non-Executive Director
In Attendance	
Michelle Cloney (MC)	Chief People Officer
Lucy Gardner (LG)	Director of Strategy & Partnerships
Pat McLaren (PMcL)	McLaren, Director of Communications & Engagement
John Culshaw (JC)	Trust Secretary
Jane Hurst (JH)	Deputy Chief Finance Officer
Julie Burke	Secretary to The Trust Board
Adam Harrison (AH)	Chair of LGBTQ Staff Network (*Item BM/21/07/85 only)*
Suresh Krisshna (SK)	Chair of BAME Staff Network (*Item BM/21/07/85 only)*
Rebecca Patel (RP)	Associate Chief People Officer (I*tem BM/21/07/97 only)*
Apologies	A McGee, Chief Finance Officer & Deputy Chief Executive
Observing N Holding, Lead Governor Members of the public 2	S Fitzpatrick, S Hoolachan, C McKenzie, A Robinson Public Governors, L Mills Staff Governor, N Newton Partner Governor 3 Staff members (*Item BM/21/07/85 only),* 1 staff member shadowing Chief Nurse & Deputy CEO

BM/21/07/85	**Overview of Staff Networks Q&A** The Chair and CEO welcomed Adam and Suresh who provided a high-level overview of the work, development and progress of the LGBTQA+ and BAME Staff Networks. SC referred to the recent inclusion of Kindness and Inclusivity into the Trust Values and Behaviours, the progress of the Networks which continue to thrive and develop across the Trust and the wider community. MC explained the Strategic People Committee had received this overview with update in January on how the networks engage and embed their priorities. Adam provided a high-level overview of the work, development and progress of LGBTQA+ Staff Network over the last 6 months in his role of Chair and an Ambassador of LGBTQA+: - Nominated Chair and 2 Vice Chairs appointed with protected time, communication through various of routes including monthly meetings and social events. - 800+ staff with Rainbow Badge demonstrating to patients and staff, the Trust advocates and celebrates a non-judgemental, open, transparent and inclusive environment.

	- The Network had supported 4 key themes identified in the LGBT Foundation Hidden Figures Report, including Isolation, Mental Health Support, Safety and Allyship. - Adam represents the Trust at regional and network forums, working together to share best practice. - Virtual meetings had continued to support staff and raise awareness on key issues of the LGBTQ+ community. Suresh provided a high-level overview of the work, development and progress of the BAME Staff Network and his involvement. - WHH one of the few Trusts to provide protected time for the Chair and Vice-Chair of the Network. Full access and support of the CEO and CPO to discuss BAME related matters. - Focus on celebration of different cultures, sharing of stories through various communication routes. - Support the Trust internally and regionally and nationally, including support to International Nurses working in new environment, increasing visibility of the Network across the Trust supported by funding from the Trust Charity, supporting anxious BAME staff to take up their COVID vaccination and complete risk assessment. - Strive to resolve challenges on a sustainable footprint for longevity, for staff to come together, stay strong and continue the successful work of the BAME Network. - Positive culture shift evident across the Trust since networks established. MC echoed Suresh's involvement in the COVID Hesitancy Campaign in C&M and wider engagement being provided through Adam both in WHH and externally. SMcG thanked both for their support and efforts developing the networks and their positivity, passion and determination to develop these further, providing healthy challenge to the Board on support in this area, acknowledging cultural change will take time both in WHH and the wider community.
BM/21/07/86	**Welcome, Apologies & Declarations of Interest** The Chairman welcomed all to the meeting. No declarations made in relation to the agenda.
BM/21/07/87	**Minutes of the meeting held 26 May 2021** Attendance - Members of the public to read 2, typographical amendment page 2. With these amendments the minutes of 26 May 2021 were agreed as an accurate record.
BM/21/07/88	**Actions and Matters Arising. Action log and updates noted and recorded.**
BM/21/07/89	**Chief Executive's report** The report was taken as read. Correction in section 2.7 NHS Big Tea £90k of CSTM monies available to apply for. The CEO emphasised the current unprecedented activity and increased demand being experienced in Urgent and Emergency Care (U&EC) against a backdrop of COVID-19, the restoration and recovery of elective services, including diagnostics and cancer, and high levels of paediatric attendances, in what would normally be anticipated as being less busy during summer months. This increased activity is similar across C&M, the North West and nationally. Levels of attends overall had returned to pre-COVID-19 activity; however there has been in a shift through U&EC with increase in Type 1 with relative reduction in Type 3 activity

	such as walk-in centres and UTC attends; average daily attends circa 280-300. This type of activity normally seen in January not June/July. Current ED Department designated for 180 attends per day which presents a challenge with patient flow, especially with COVID-19. The Trust had performed *relatively* well in the key performance indicator of the 4h standard despite these pressures, with the most recent benchmarking showing the Trust as being 64th out of total of 116 Trusts nationally and 18th out of 39 Trusts in the North. MB enquired of support for ED staff dealing with the relentless pressure and impact on their health and wellbeing. SC explained as well as targeted H&WB, the Trust it is offering a range of support for this group of staff, encouraging taking of annual leave and, importantly, practical steps to decompress the ED. AW enquired of any impact on WHH Vaccination Programme due to the recent 'pop-up' vaccination centres offered at a variety of venues. LG explained the Trust had provided the largest drop-in service for vaccines locally, working closely with CCG, Council GPs and NHSE/I. NHSE/I and the Council supported with targeted door knocking to promote the provision of a drop-in service at the hospital. WHH vaccination service has not impacted by other drop-in services, which had been limited in Warrington specifically. A reduction was seen in demand initially. Focus on second doses to complete the initial vaccine programme on 11 September, prior to commencing boosters for staff and other health and care staff, alongside flu vaccines. Summary of vaccination rates for Warrington and Halton: 82% of population had first dose, 69% of population had both doses. CR enquired if increase in A&E attends is due to latent/unmet demand after COVID or patients using health services differently with A&E preferred place of treatment which could be a more permanent way to seek treatment in the future. SC commented little can be done to change patient behaviour to effect demand in the immediate term, 25-35% patients had sought treatment in other settings, were not satisfied with response and accessed A&E which provides face to face consultation/triage. Multi-faceted reasons driving latent demand, including people more reflective and seeking advice of their own health since COVID-19. The Trust response to cope with this demand will be key **The Board noted the report.**
BM/21/07/90	**Chairman's Report** The Chair reported meetings continue, internal and external meetings including CEO/NED briefings, Board, Council of Governors, Governor Briefing meetings and 1:1 meetings with the Lead Governor. External meetings included Local Authority CEOs, NW Chairs, local partners and stakeholders. Attended first meeting of newly established Acute Alliance Partnership. The Chair had recently visited ED, acknowledging and commending the resourcefulness of staff to address challenges and the positive staff attitude across the whole department. Interviews for Non-Executive Director to take place 28 July. National appointment process to commence for Chairs of Integrated Care Systems (ICS). **The Board noted the update**
BM/21/07/92	**IPR Dashboard and IPR Key Issues**

	The CEO introduced the report, requesting an update on response to the increased ED demand and mitigating actions for Quality and Performance portfolios. **Quality –** KSJ particularly highlighted the following mitigations: - Emergency Department (ED) Response Group established, Chaired by ED Consultant, members include U&EC Triumvirate, ED Commercial Development and Information Teams to support the workstream. - Urgent priorities to review activity trends. Attends currently predominantly late afternoon, evening and night-time. Review response particularly during the evening time and at night-time, large number of patients and staff plans required at these times. - Implementing 'Push Doctor' providing services to primary and secondary care providers, supporting patients back to primary care with an on-line GP appointment, working closely with Halton and Warrington GPs. Currently three organisations in England have implemented this. Potential to see 10-20 patients per day. - 3 'hot' clinics set up to ensure correct patients seen and triaged out of ED with appropriate follow-up, further GP clinic working with 'hot' clinics. - CAU currently bedded to support through evening time to ensure safe environment for patients, slow each evening, looking at prevention measures. - Small ED footprint, looking to expand to utilise majors and minors. Bespoke package of H&WB offers for ED staff, staff asked what extra support they need working under current significant pressure to ensure everything possible is being done to support individuals and teams. Clinical Governance and Safety oversight mitigations - Process in place to ensure responsiveness to all ED incidents, reviewed by KSJ and Governance to review any variance and/or recurrent themes. Reporting and monitoring at weekly Harm Meetings, Patient Safety Clinical Effectiveness Sub Committee (PSCESC) and Quality Assurance Committee (QAC). - ED Nurse business case to be considered in Part 2, bespoke ED recruitment campaign if ED business case supported. Weekly and daily planning of staff requirements including weekend to support proactive forward-looking management of medical and nursing staff. **Access and Performance** DM outlined mitigations to unlock pressures, managing volatility in demand. Increase in C&M Command and Control across teams to enable response to change and demand in ED. Further guidance awaited from NHSE/I of 10-point plan outlining national support. Response Group set up to support action plans. AC added ED Response Group will support response to backlog of medical conditions (as a result of COVID-19 pandemic)/increase in ED patient attendees by sign-posting patients with minor illness/injury to primary care; work stream being developed with primary care colleagues (including option of 'Push Doctor'). Cognisant of H&WB support needed for medical work force. There has been a reduction in FY3 doctors available to support clinical services, also impact of Deanery gaps on work force. Workforce establishment work stream referenced and regular review of medical staff status reported to Medical Cabinet and Tactical Group meetings.
BM/21/07/92	

(a) ***BM/21/07/ (b)***	**Monthly Safe Staffing Reports, April 2021 and May 2021** The reports were taken as read providing detail of ward staffing data which continues to be systematically reviewed to ensure the wards and departments were safe. Quality Assurance Committee (QAC) Assurance Report 01.06.2021 MB - no matters of escalation. July QAC cancelled due to operational pressures. A number of reports reviewed and approved via Chair's action. Sepsis deep dive deferred to August QAC. MB referred to ED response provided by KSJ which appears to be WHH specific, what system response is with emerging PLACE and new partnerships. DM explained number of workstreams inward looking but other workstreams progressing to unlock opportunities at WHH, ie LoS. Twice weekly meetings continue with CCGs, LA, Mid-Mersey ED Delivery Board to be re-established for system action/response. Other challenges as COVID-19 restrictions lifted, challenges in domiciliary care staffing medium and long term. Short term spot purchase of care home beds to support current pressures. Reciprocal support from/with primary care, some contractual ties, ie E-Consult. Referring to Sepsis, KSJ explained red indicators, KSJ explained red indicators, deep dive near completion. Interim deep dive supported by ED Medical Consultant, supporting training of safety nurses in ED and taking forward robust Sepsis training plan, utilising some of the funding available from ED Nurse business case. Further work to understand timeframes of all delays and actions taken to address, to be shared in next IPR report. Focus on training of timeframes for Doctors and Nurses on wards and in ED. Business case for Pharmacy support in ED to be escalated to support IV antibiotics. CR asked when does clock start, deep dive to QAC highlighted possible catheter care management and use of catheter. KSJ explained clock start is 4 hours or more. Gram Negative Bloodstream Group runs parallel with Sepsis work identifying number of patients referred. **People** - MC referred to sickness absence indicator against backdrop post COVID. - Similar absence compared to same period last year, current position reported 7.57% including COVID-19 related absence. - Staff continue to be encouraged to take annual leave, increase in notification of staff self-isolating. - Work continues to bring staff back to work with appropriate risk assessments and mitigations working with Infection Control and Microbiology Team, aligned with national safety guidance. - Staff not at work due to self-isolation continue to be monitored by OH ensure appropriate support in place, circa 20 staff per day. - Deterioration in Return to Work (RTW) indicator in part due to lag of data reporting, anticipate increase next month. Bespoke RTW training support continues for Line Managers, W&C, Digestive Diseases and Clinical Support Services completed to be followed by Surgical Specialities, ICM and Medical Care. Monthly RTW 64% and year to date RTW 73% - Bank and Agency spend – monitoring market force, peer oganisations offering incentives which is impacting on WHH as this cohort of staff may choose other

	organisations for place of work. Paper to C&M CEO 30 July 2021 of what these are.
BM/21/07/91 c	CR referred to apprenticeship levy funding. MC explained WHH is over the 3% required of take-up of apprenticeships, however it is monitored in two different ways, dependent on level of training qualification before funds can be drawn down down. There are more lower level qualifications available to access which cost less and therefore drawing down funds from the LEVY is less. Higher qualifications continue to be developed and as appropriate to the workforce development needs these will be accessed when available. In the meantime, to maximise utilisation of apprenticeship levy a link to ECF process is in place so that all vacancies as considered for an apprentice opportunities. Strategic People Committee (SPC) Assurance Report 21.07.202 - no issues escalated. H&WB Guardian role on Board agenda. **Sustainability** – JH highlighted June position: - £0.6m deficit against planned £0.4m deficit; expectation to achieve break-even position for H1 (September 2021), £0.9m to be identified. - Capital Programme underspend of £1.2m, committed orders of £0.7m - £1m extra COVID-19 requests than planned. - CIP risk to position, annual target £4.8m, £1.5m delivered. - Elective Recovery Fund - activity targets increased, system-wide achievement required for WHH to receive their share of ERF, could impact break-even position. - SMcG enquired of confirmation of self-funding of 3% uplift. JH explained before announcement tone was could not confirm what CIP would be for H2 as dependent on pay uplift expected September 2021 and that CIP may increase. - Capital Programme –5 emergency schemes had been approved by the CFO & Deputy CEO; Laboratory Air Conditioning – Halton £8k; Nurse call system – Ante Natal Day Unit £25k; Emergency generator repair – Nightingale £24k; Damper power supply – Burtonwood £9k; Modular building road surfacing/street lighting £30k - FSC had supported additional capital requests of £96k for new Hospital SOC; Additional Estates Project Manager £28k (August to March 2022); Clinical Skills programme £30k; Reallocation in the capital programme to replace circuit breaker funding with electrical infrastructure £200k **The Board:** • **Noted, reviewed and discussed the IPR and approved the amendments to the Quality Indicators (FOI, Ward Moves).** • **Noted and supported approved emergency capital by the Chief Finance Officer & Deputy Chief Executive as above and additional capital requests supported by FSC on 21 July 2021 as above.**
BM/21/07/91 (d)	• **Noted the NHSE/I Provider Finance Return for month 3 matches the report.** Finance & Sustainability Committee (FSC) (3.06.2021 & 21.07.2021. TA escalated concerns relating to the delay to move forward ED Plaza capital scheme.
BM/21/07/91 (e)	Clinical Recovery Oversight Committee (CROC) 25.05.2021, 08.06.2021 & 06.06.2021, 08.07.2021. TA reported CROC had met 7 times. Whilst operational pressures remain, oversight of recovery programmes continues a Clinical Services Oversight Group (CSOG),

BM/21/07/91 (f)	TA explained CROC had supported changing frequency of CROC to monthly. CROC ToR had been provided in supplementary papers for approval. The Board approved the CROC ToR with the amendment to change frequency of meetings to monthly. Audit Committee (24.06.2021) - Final audit process to be completed including approval of and submission of Annual Report to Parliament. Financial Accounts had been signed off and submitted to NHSE/I. PMcL requested additional FOIs indicators be paused to reflect the outcomes of a deep dive exercise since the report had been produced and will revert at next Board meeting on improved indicators. No further matters escalated or questions raised.
BM/21/07/92	**Moving to Outstanding Update Report** The report was taken as read, providing an update on CQC compliance and the new methods of assessment being undertaken. KSJ highlighted: - Zero CQC enquiries received. - Working with Executive's on action plans to address the 16 WHH 'Red' flags linked to CQC Insight Report, reporting and monitoring at M2O. - Action plan following internal maternity mock inspection in place to be reviewed when new Head of Midwifery commences 2 August. - Internal ED mock inspection to be rescheduled due to current operational pressures. - Plan in place for remaining core services. Anaesthetic Clinical Services Accreditation (ACSA). Initial assessment March 2021, initial Royal College report received May 2021, assurance provided that all actions on track for completion, ACSA will form part of the overall CQC accreditation. CQC new ways of working will review all accreditation of other services as well as CQC accreditation. New CQC Strategy – as part of Transitional Monitoring Assessments (TMA) maternity and ED completed and previously reported. Urgent Care completed and positive feedback received by KSJ/DM/AC and ED Team. Celebration outstanding practice – shortlisted for Patient Safety Awards September 2021 for Maternity Continuity of Carer and ITU/CC. • **The Board reviewed, noted and discussed the report and assurance provided of monitoring in place.**
BM/21/07/94	**National COVID-19 Inquiry and Trust Look Back** KSJ explained background and context to the report to ensure the timely delivery of safe care, approach taken by the Trust to manage the Pandemic, robust governance processes implemented to ensure that decisions had been made collectively, with appropriate oversight from Ward to Board. KSJ highlighted references to the approach to the management of the pandemic with each wave (1-3) noted alongside phases referenced as 'gateways'. These included Risk Assessments; Pathways; Policies and Standard Operating Procedures (SOPs). All underpinned by a robust governance framework ensuring that decisions had been made collectively across a range of senior disciplines. - Physical changes described ie, ED segregated flows, essential management of PPE/FIT

	testing. - Response of Executives and Board, external reporting and SITREPs. - Outbreaks, recovery and plans for next stage of recovery. - H&S and Risk Management section – high volume of SOPs developed, implemented and actioned during this period. Questions invited CR enquired during first wave and local/national processes followed to move patients from hospital to care homes and reference to testing within 72 hours of discharge. KSJ explained WHH had followed national guidance, referring to paper presented to QAC in June 2020 providing detail of WHH response and response from Coroner if WHH could have done anything differently, that WHH had done everything they could. KSJ to share QAC report with Board members and include elements in final report/presentation. SMcG thanked KSJ and LA for the comprehensive report, colleagues proposed the following additions: - Inclusion of COVNED meetings to document governance put in place to enable urgent Board decisions to be taken in the event of national guidance, Command and Control reporting - Vaccination Programme and related SOPs. • **The Board noted the comprehensive report for a future reference in the event of any public inquiry.** • **June QAC Report to be circulated.**
BM/21/07/95	**NHS System Oversight Framework (SOF) 2021-22 and metrics** JH a high-level overview of the NHSE/I SOF which had been reviewed in detail at a previous Board meeting. No significant changes, the following additional information highlighted: - Greater emphasis on the system and role of the ICS, collaborative working. ICS to agree MoU, further work to understand any implications of governance conditions. - Replacement of Intensive Support with the Recovery Support Programme led by Service Improvement Director (Segment 4). NHSE/I to confirm decision, other additional interventions that may be included highlighted including appointment to Board vacancies and enhanced reporting. WHH in Segment 2 initially. - 6 Themes, 5 National with 1 Local Theme - NHSE/I to continue to work with ICSs, Commissioners and Providers in 2021/22 to further develop approach and oversight. Updated framework for 2022/23 to outline ICSs role in more detail once formal legislation has been enacted. - NHSE/I statutory responsibilities will remain the same in 2021/22 and the accountabilities of individual organisations also remain unchanged. - New metrics to be reviewed and changes reflected in Trust IPR. • **The Board noted and reviewed the update.**
BM/21/07/96	**Use of Resources Assessment (UoRA) Q1 Report** The report was taken as read, providing a current status of the UoRA Dashboard, noting that many of the indicators had not been updated on the Model Hospital. Key highlights: - Final report expected in Q3 following national benchmark exercise. Each KLOE lead had completed a self-assessment. - SMcG queried consistently higher back-office functions, finance and HR costs

	compared with other organisations. JH explained data compared with similar organisations, optimum being £300m organisation, costs appearing more expensive if below this. This data will be reviewed when final report received and reported to Finance and Sustainability Committee. - SC observed reference cost metric not included. WHH favourable at less than 1. • **The Board noted the report and assurance provided relating to progress in relation to Use of Resources Dashboard.**
BM/21/07/97	**Health and Wellbeing (H&WB) Stocktake and Wellbeing Guardian update** CR introduced the item, providing background and context of this new role, requiring different mindsets on what H&WB is, defining direction of travel for the Trust for evidence based, effective interventions and how these can positively affect people's H&WB. R Patel provided an overview of baseline completed, gaps identified, how the Trust will embed and measure itself against standards in the Trust's ambition to be 'outstanding', and to provide assurance to H&WB Guardian and Trust Board. Stocktake looked at health inequalities, PPP&I, WHH Charity and investment to secure funding for interventions, and link to social value within the local community. Areas of improvement and next steps for the three priorities (1) Infrastructure (2) Interventions (3) Relationships. Next steps to include: Infrastructure - staff facilities and rest areas, kitchen and shower facilities. Standing item on JNCC agenda. Annual review / stocktake of WHH offer aligned to population health needs. Interventions – to support mental and H&WB of staff, promotion of suicide awareness alongside national strategy, develop and embed suicide information available to staff, implement Physical activity offer, include H&WB in People Champion roles. Relationships – raise WHH profile through collaborative working, via Wellbeing Guardian as a member of the NW WG Network, mental health wellbeing support for staff via Warrington's Peace Centre, develop internal bespoke support programmes, ie ITU/ED respond to national HWB framework review and to national review of Occupational Health. Evidence of improved H&WB support via staff survey feedback. CR thanked RP for the overview which highlighted links to quality, ED&I, LGBTQ+ community. As anchor organisation important WHH shows Ward to Board support to begin next step discussions. As well as workforce metrics, opportunities to consider wellbeing of patients, visitors and community and where the Trust sees itself in social values and health inequalities as an anchor organisation. SMcG recognised progress of offers available for staff in short space of time, the importance of sustaining these to support staff, ie Wingman Lounge, alongside day-day needs. AW asked if RP had considered schemes such as Car Share. RP advised car share is not currently being encouraged due to IPC requirements, should that change then this would be something to reconsider at the appropriate time. Monthly meetings with H&WB Guardian, formal reporting monitoring via Operational

	People Committee, Strategic People Committee and Trust Board. • **The Board noted the stocktake and endorsed the actions identified as prioritised for improvement.**
BM/21/07/98	**Engagement Dashboard Q4 and Q1 2021-22** The report was taken as read, PMcL highlighted the following: - Increase in social media engagement. - Instagram added as new metric to the dashboard as this platform is extensively used by the younger generation. - Website visitors reached 70k in January, now settled to 50k, double of what was via the previous platform. - Partnership with Alder Hey to develop 'Chat box' digital assistant to support and direct visitors quickly and easily to information they are looking for. Anticipated this will relieve pressure on general enquiries to switchboard and Communications Team. - Introduced Google Reviews, excellent feedback, particularly CMTC (4*) and CSTM (4.9*) - SMcG had received positive feedback from several people at the NHS Big Tea Party that they had visited the website regularly for updates on COVID-19 and ED access. • **The Board noted data, improved and increased access to various digital platforms.**
BM/21/07/99	**Strategic Risk Register and Board Assurance Framework (BAF)** The report was taken as read. JC highlighted the following for the Board to review and consider proposals for the BAF since the last meeting and the rationale. The proposals had been approved at the appropriate Sub Committees and by the Quality Assurance Committee via Chairs actions on 6 July 2021. Since the last meeting: Three new risks had been added to the BAF all at a risk score of 16. - Risk #224 relating to emergency access standard; Risk #1233 relating to review surgical patients; Risk #1372 relating to future Electronic Patient Record solution. Ratings of four risks had been amended: - Risks #1331 and #1332, reduced from risk score of 15 to 10 as the number of COVID-19 positive patients in the Community and the Trust had reduced. - Risk #1124 risk score reduced from 15 to 10 for same reasons as above. - Further to the escalation of Risk #224, the Trust Board considered and approved the proposal to increase the current rating of 16 to 25 to reflect the significant pressure currently experienced. The descriptions of two risks on the BAF had been amended to best describe the current situation, Risk #1108 (staffing levels) and Risk #1289 (planned elective procedures). It was proposed to amend the description of one further Risk #224 (staff wellbeing) Four risks had been de-escalated from the BAF since the last meeting, Risks #1331, #1332 and #1124 and de-escalated to the Corporate Risk Register for continued monitoring. Due to current pressures and impact on bed capacity, the Board **supported** the re-escalation of Risk #1331 to the BAF at a score of 25. Following the completion of all the actions of risk #1205 this risk had been closed. The Board also reviewed notable updates to existing risks #1273,1272, 1275, 115; 134;

	1114; 1207; 125; 1108; 1274; 1290 • **The Board reviewed and noted the BAF and Strategic Risk Register providing assurance of processes for oversight, scrutiny, management and escalation of strategic and corporate risks.** **The Board approved:** • **The amendments outlined above and the updates to existing risks.**
BM/21/07/100	**Annual Senior Information Risk Owner Report (SIRO) Report** AC highlighted key points in the report for the Board to note which provided detail of the self-assessed performance against the standards in the Data Security and Protection Toolkit. The Trust continues to perform well against the standards, continuously working to reduce risk and improve processes. The following were highlighted: **IG Framework** - All meetings of the IGRSC took place during COVID - IGRSC cycle of business for 21/22 approved - **Information Risk Analysis** - Digital Services meets once a month to go through all risks. Once the details are approved the approved changes are entered on Datix ready for the Trust Risk Review Group to review. The 1st risk (Cyber Security (risk of 12) is our biggest risk score in Cyber/IG) with migrating from unsupported operating system our biggest action - **Data Security and Protection Toolkit Performance** - 149 standards in the DSPT - 110 mandatory standards in the DSPT - Action plan submitted to NHSD containing 11 mandatory standards which the Trust cannot currently comply with. This was submitted in June 2021 - MIAA DSPT readiness assessment audit (page 9) shows 4 'traffic lights. These are now all green/complete. - MIAA Progress report final report into DSPT submission for 2021) concluded **Substantial Assurance** for the veracity of our assessment with overall assurance levels across all 10 DSPT domains at **Moderate Assurance** - **Cyber Security Arrangements** - Digital Services ensures that all NHS Digital Security bulletins (CareCERTS) are prioritised for action. High critical CareCERT's are highlighted to the CIO / Deputy CIO and Medical Director. NHS Digital are also kept informed of progress via their CareCERT Portal. Digital Services uses the ITHealth Assurance Dashboard to track all CareCERT progress. - IT Services are currently migrating all Server 2003 (77% complete) & Server 2008 (70% complete) operating systems to the latest version to ensure we receive the important security patches. - Digital Services uses a system Bitsight, which benchmarks our Trust cyber security to others in the health sector. The Trust's external security score continues to be in the top 10% of the Healthcare / Wellness sector, with an advanced score of 780. - 3rd party company performs network penetration tests on a monthly basis. Such tests enable the Trust to identify the security vulnerabilities and flaws that are currently present on our network which enables the Trust to understand the level of security risk and priorities mitigations plans to resolve the security vulnerabilities and flaws. - The NHS Secure Boundary provides additional firewall security which effectively allows WHH to control what passes in and out of our digital estate. This augments

	the security already deployed by the Trust. Use of the NHS Secure Boundary enables NHS Digital to scan for potential threats in real time, detecting and neutralising them to help the Trust increase their security protection against cyber-related attacks - **Externally Reported Data Security Incidents** - 10 data security/protection incidents reported to NHSD in the 2020/21 financial year - ICO has taken no action against the Trust in relation to any of the incidents **Role of SIRO and Caldicott Guardian** - SIRO and CG routinely informed on all elements of Information Governance performance via IGRSC with reports provided to Quality Assurance Committee - SIRO and Board level training to be refreshed in 2021 • **The Board noted the report and assurance provide that SIRO responsibilities are being fulfilled effectively.**
	Any Other Business On behalf of the Board, the Chairman congratulated A Crowe on his new appointment, thanking him for all his support to WHH, wishing him every success. JC advised newly developed framework for Board walkarounds to be re-introduced when restrictions when permit.
MATTERS FOR APPROVAL/RATIFICATION	
BM/21/07/101	**Quality Assurance Committee - Committee Chair's Annual Report 2020-21** The Board **ratified** the Annual Report, approved via Quality Assurance Committee Chairs action on 6 July 2021.
BM/21/07/102	**Nursing and Midwifery Strategy 2021-2024** The Board **ratified** the Strategy, approved via Quality Assurance Committee Chairs action on 6 July 2021.
BM/21/07/103	**Safeguarding Annual Report** The Board **ratified** the Annual Report noted via Quality Assurance Committee Chairs action on 6 July 2021.
BM/21/07/104	**Terms of Reference (ToR) Strategic People Committee (SPC) and Clinical Recovery Oversight Committee (CROC)** The Board **ratified** the ToR which had been approved respectively by the SPC on 21 July 2021 and the CROC on 25 May 2021.
BM/21/07/105	**Finance and Sustainability Committee (FSC) - Committee Chair's Annual Report 2020-21** The Board **ratified** the report, approved by the FSC on 21 June 2021.
BM/21/07/106	**CNST Maternity Incentive Scheme evidence of compliance 2021** The Board **ratified** the evidence, approved by QAC 14 May 2021, final declaration, uploaded to the NHSR portal 19th July, signed by the CEO on behalf of the Trust Board.

MATTERS FOR NOTING FOR ASSURANCE	
BM/21/07/107	**DIPC Annual Report** This report had been reviewed and noted via Quality Assurance Committee Chairs action on 6 July 2021. **The Board noted the report.**
BM/21/07/108	**Infection Prevention and Control Board Assurance Framework** This report had been reviewed and noted via Quality Assurance Committee Chairs action on 6 July 2021. **The Board noted the report.**
BM/21/07/109	**Medicines Management and Controlled Drugs Annual Report** This report had been reviewed and discussed at the Quality Assurance Committee on 1 June 2021. **The Board noted the report**
BM/21/07/110	**Risk Management Strategy Annual Update Report**

DRAFT

	This report had been reviewed and discussed at the Quality Assurance Committee on 4 May 2021. **The Board noted the report**
BM/21/07/111	**Emergency Preparedness Annual Report** This report had been reviewed and approved at the Event Planning Group on 28 June 2021 and Brexit Sub-Group on 28 June 2021. As NED with oversight for Emergency Preparedness, TA requested this report is presented to the FSC for review. **The Board noted the report**
BM/21/07/112	**Guardian of Safeworking Q4 Report** This report had been reviewed and discussed at the Strategic People Committee on 21 July 2021. **The Board noted the report**
BM/21/07/113	**Digital Board Report** This report had been reviewed and discussed at the Finance and Sustainability Committee on 21 July 2021. **The Board noted the report**
BM/21/07/114	**Charities Commission Checklist** This Report had been reviewed and supported at the Charitable Funds Committee on 10 June 2021. **The Board noted the report**
BM/21/07/115	**Confirmation of Breast Unit development decision.** PMcL reported C Marsh, Chief Commissioner Warrington and Halton CCG had formally written to NHSE/I to provide CCGs assurance on the public consultation and confirming their support for the new model. **The Board noted the report**
BM/21/07/116	**Confirmation of Shopping City development decision.** Formal letter of support had been received from NHSE/I to progress to next steps for both programmes. **The Board noted the report**
BM/21/07/117	**Quality Strategy 2021-2024** This report had been reviewed and discussed at the Quality Assurance Committee on 1 June 2021. **The Board noted the report**
BM/21/07/118	**Annual Health and Safety Annual Report** This report had been reviewed and noted via Quality Assurance Committee Chairs action on 6 July 2021 **The Board noted the report**
	Next meeting to be held: Wednesday 29 September 2021

Signed …… Date ……
Chairman ……..

BOARD OF DIRECTORS ACTION LOG

Warrington and Halton Teaching Hospitals NHS Foundation Trust

AGENDA REFERENCE	BM/21/09/122	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	29 September 2021

1. ACTIONS ON AGENDA

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

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
	26.05.2021	Any other business	Dedicated Board session to discuss how the Trust can contribute to local boroughs 'Green' agenda	**Chairman / Director of Strategy & Partnerships/ Chief Operating Officer**	**October Board session 27.10.2021**			
BM/21/05/67	26.05.2021	COVID Situation Report	Reflective report of COVID and summary of summer activity to future meeting at an appropriate time point.	**CEO**	**Date TBC**			
BM/21/05/	26.05.2021		Facilitated Board session – to discuss wider health inequalities contribution from WHH.	**Chairman/ Director of Strategy & Partnerships**	**24.11.2021**		Initial session taken place. Update report to September Board. Deferred to November	
BM/21/07/94	28.07.2021	COVID-19 Overview Report	Presentation of key points to future Board.	**Chief Nurse & Deputy CEO**	**24.11.2021**			

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/21/07/111	28.07.2021	Emergency Preparedness Annual Report	To be presented to FSC as Board Assurance Committee	**Chief Operating Officer**	**FSC 25.08.2021**	**25.08.2021**	Report presented and reviewed by FSC.	

RAG Key

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/123**			
SUBJECT:	**Chief Executive's Briefing**			
DATE OF MEETING:	29th September 2021			
AUTHOR(S):	Simon Constable, Chief Executive			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO BAF RISK:	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

SUBJECT	Chief Executive's Briefing	AGENDA REF:	BM/21/09/123

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 28th July 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, 27th September 2021, we have a total of 27 COVID-19 positive inpatients (14 days or less since their first positive sample); 4 of those patients are in critical care. In total, 37 of our inpatients have tested positive at any time during their admission (7 of these in critical care). We have discharged a total of 2310 patients with COVID-19 to continue their recovery at home. Sadly, a total of 529 patients with COVID-19 have died in our care.

In terms of community numbers, new daily COVID-19 cases remain high but are relatively static. In the latest 7 days fully published (14th September – 20th September) in Warrington there were 267 cases per 100,000 people (the average area in England had 287); 560 new cases were reported in that week, down 140 compared with the previous week. In Halton, there were 353 cases per 100,000 people; 458 new cases in that week, down 17 compared with the previous week.

Vaccination of our boroughs has achieved 83% for the first dose and 78% for the second dose in Warrington; for Halton, the figures are 81% and 75% respectively. We have commenced this year's 'flu vaccination and COVID-19 booster programme. As at 8am on 24th September 2021, 1,040 of us have been vaccinated for 'flu already this year – this is very impressive given the programme started less than two weeks ago.

The COVID-19 Booster programme starts on Monday 27th September 2021. In terms of the COVID-19 Vaccination programme so far, as of 21st September WHH had administered 59,000 doses. We have vaccinated 93.74% of WHH staff and 90.84% of WHH staff have now had their second doses.

2.2 Cheshire & Merseyside System Development

As the C&M Integrated Care System moves towards a statutory footing from 1st April 2022, we have continued to be involved at all levels of development, including the development of partnerships at a place level for both our boroughs as well as leadership of the C&M-wide system. We also pay an active role in the newly formed Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative.

2.3 Senior Leadership Changes

I can confirm the appointment of Dr Paul Fitzsimmons as Executive Medical Director at Warrington and Halton Teaching Hospitals. He will take up his post later this year. Paul will

replace our current Executive Medical Director, Dr Alex Crowe, who is set to leave us to take up a national role with NHS Resolution.

Paul is currently Deputy Executive Medical Director at Liverpool University Hospitals NHS Foundation Trust and works as a consultant in geriatric and stroke medicine in Liverpool. Paul has a particular interest in quality improvement and organisational culture having been a Health Foundation national leadership fellow.

Since my last Board report, we have also welcomed Zoë Harris as Director of Operations and Performance (and Deputy Chief Operating Officer). Zoë has over 20 years managerial and clinical experience within the NHS.

2.4 New Hospitals Programme

On 7th September 2021 we submitted our bid to the Department of Health and Social Care (DHSC) for new hospital developments in Warrington and Halton as part of the Government's £3.8bn New Hospitals Programme.

We have been developing the proposals for new high quality health and care facilities for our local communities for many years and the bid will now compete to be one of eight new hospitals built through the New Hospitals Programme, as part of the Government's commitment to fund and build 40 new hospitals by 2030.

The bid, developed in collaboration with a range of partners, proposes that the existing Halton site is comprehensively redeveloped as a hospital and wellbeing campus and a new Warrington Hospital is built either on the site of the existing hospital or in another central location in the town.

Our vision for Warrington Hospital is as a centre for acute healthcare. We will create a new hospital as a focal point of a wider health and wellbeing campus, replacing aging and outdated facilities with a modern, sustainable, compliant estate which reflects the town's population growth (4th biggest population increase in the North West since 2001). This would enable us to redesign our facilities to provide our residents with exceptional care, as well as education and employment opportunities.

Our vision for Halton is as an outstanding place to go for elective care, taking advantage of its location and accessibility to host services on behalf of wider Cheshire and Merseyside, improving outcomes for patients and addressing inequalities, including a 12 year difference in life expectancy within the borough. To achieve this, we will create a campus environment upon the Halton General Hospital site. This involves replacing the dated Nightingale (General Hospital) building with a new wing adjacent to our Captain Sir Tom Moore Building. Released land will enable creation of a wellbeing campus, supporting the regeneration of Halton Lea, in the top 10% most deprived wards in England.

We will work in partnership with the Local Councils, CCGs, Housing Associations and more to utilise any released land to provide complementary facilities such as leisure, rehabilitation and housing.

Our bid will be one of many submitted to become one of only eight new hospitals to be built under the New Hospital Programme and competition will be fierce.

We do have an extremely compelling case. Entirely complementary, not mutually exclusive, proposals for two very different campuses separating patient flows, that start to reimagine healthcare in the 21st century. We have thought creatively about how NHS estate can be used to enhance patient outcomes and address health inequalities including the wider determinants of health, through the integration of health, wellbeing, education, leisure, and housing. This is a journey we have already started with our greater utilisation of Halton as an elective/green site and the work we have been doing with the Warrington and Runcorn Town Deals and Shopping City offers. They play to our strength as an anchor institution working in partnership with others to achieve social and economic wellbeing in our communities. All of this needs to be done alongside health and social care education and training for a sustainable workforce in the future.

Uniquely, we have also built up a broad and supportive coalition of local stakeholders who have helped us shape what we are proposing. A New Hospitals Strategic Oversight Group has been established to lead programme development. This group is chaired by Dr Andrew Davies, Chief Clinical Officer of NHS Warrington CCG and NHS Halton CCG. Membership includes all local MPs, both Council leaders and CEOs, and senior leaders from within the Trust, Warrington Borough Council, Halton Borough Council and the University of Chester.

A final decision on the eight successful bids is expected in Spring 2022.

2.5 Warrington and Runcorn Town Deals

Within WHH we work with others to continually seek and deliver innovative opportunities to improve health and care outcomes in Warrington and Halton, including working with partners to increase the resources available to us collectively to deliver the best possible care and services. As a team and a Trust we also have a responsibility, which is even starker given the impact of COVID-19, to support our communities to live healthy and happy lives in the widest possible sense. This may include supporting economic regeneration to provide employment opportunities and ensuring that we protect the environment by reducing waste for example.

The national Town Deal programme is a great example of how we can work with partners to improve outcomes for our communities.

Earlier this year we were able to confirm that Warrington had been awarded £22.1m funding, following submission of our Town Investment Plan. Our plan included 7 projects and as a Trust we are leading one project - the development of a health and wellbeing hub in Warrington town centre. We will submit our full business case for the health and wellbeing hub to Government in October and hope to open the new hub in Autumn 2022. The hub will provide a range of services for older people, children and families from health, council and charitable sector partners, aimed at addressing the 11 year gap in life expectancy in Warrington and supporting town centre regeneration through increased footfall.

We are also now able to confirm that Runcorn too has been successful in securing Town Deal funds. Runcorn has been awarded £23.6m. Similarly to Warrington, we are leading on one

of the 7 projects in Runcorn, a health and education hub. We hope to receive a approximately £3m of the £23.6m to develop the health and education hub. In our initial submission we focussed the proposed provision within the hub on diagnostics and women's and children's services, integrated with an education offer from our partners at Riverside College. Our proposals have targeted known health inequalities within Runcorn, for example, a baby in Halton is 50% more likely to be born to a mother smoking in pregnancy or at birth. We now have 12 months to describe in detail the proposed provision and complete a full business case to Government.

2.6 Creamfields Weekend

As the roadmap for recovery from COVID-19 progresses an increasing number of large-scale public events have been taking place. Creamfields 2021 was one of the world's biggest dance music festivals and took place from 26th to 29th August in Daresbury.

This type of event can place additional pressures on local health services regardless of existing system pressures. An extensive amount of planning for this event occurred and all local site mitigations were in place with all of our partners, including NWAS and the medical provider on site, with whom we had been closely involved. A full review will be undertaken but we successfully navigated the Creamfields bank holiday weekend without significant incident. 413 welfare cases were managed by the onsite welfare team – mainly drug induced issues. The welfare services on site provided by the event organiser have been invaluable in reducing pressures on the health system, particularly in relation to cases involving drug ingestion and mental health. This is an example of good practice which will be captured in the debrief and continued at future events.

2.7 Urgent & Emergency Care

Urgent and emergency care has continued to be under significant pressure across Cheshire and Merseyside, and WHH has been no different. Emergency Department attendances and admissions have been relatively high. Our super-stranded position of patients with a length of stay greater than 21 days have been consistently over 100 and were 114 on 26th September 2021. This remains a significant challenge for us to manage patient flow effectively.

2.8 Retirement of Dr Mohammad Al-Jafari

Friday 24th September 2021 was the last working day upon the retirement of Dr Mohammad Al-Jafari, Consultant Histopathologist. He is our longest serving consultant. Dr Al-Jafari has worked as a consultant histopathologist at WHH for 37 years after completing basic medical qualification in Iraq, followed by specialist training in Nottingham and Mersey.

In his time at WHH he has acted as Clinical Director for Pathology, Divisional Medical Director, and more recently as Associate Medical Director for Appraisal and Revalidation, responsible for high standards in medical appraisal. He has also played an important role in the Royal College of Pathologists.

Dr Al-Jafari will be missed as clinician within the histopathology team, as well as the broader trust.

2.9 NHS Staff Survey 2021

This year's survey has been 'refreshed' to take account of questions related specifically to COVID-19 and it has been aligned to the NHS People Plan (20/21) and the NHS People Promise.

In 2020 the survey was completed at the height of Wave 2 COVID-19. So unsurprisingly we had less surveys completed than we had in 2019. We would like this year's return to be more in line with what we achieved in 2019.

Examples of some of the things we did as a direct result of the response to last year's results are:

- We focused on team working by introducing the Affina Team development programme.
- We supported staff who were redeployed into different teams to come back to their original team.
- We established and supported four staff networks – LGBTQA+; Building a Multi-ethnic Environment (BAME); Disability Awareness Network and Veterans.
- We invested in the wellbeing sanctuary and enhanced our mental health and psychological wellbeing offer.
- We worked with community partners such as the Peace Centre around bespoke enhanced mental health care.
- We looked after staff by providing the Project Wingman lounge and distributing food and drink and gifts to teams unable to easily leave their place of work during breaks, and
- We developed the 'check in conversation' approach to support wellbeing and development conversations supplementing the PDR and appraisal conversation.

2.10 The SIREN Study

We were delighted when WHH was accepted as a site for the SIREN (SARS-CoV2 Immunity and Reinfection Evaluation) study back in September 2020. The study was launched by Public Health England (PHE) in the summer of 2020 with the main aim being to find out whether the presence of antibody to SARS-CoV-2 (anti-SARS-CoV-2) is associated with a reduction in the subsequent risk of re-infection over short term periods (reviewed monthly), the next year and in the longer-term. There were some secondary aims including: i) understanding the prevalence of SARS-CoV-2 infection in healthcare staff using baseline antibody testing, ii) to determine how the antibody response changes over time, iii) to determine whether there is a relationship between antibody response and the presence of protective antibodies as well as, iv) to monitor the immune response to vaccination over time. The initial study period was 12 months. Our threshold of having 250 participants was met quite early in the study. Knowing their PCR swab status and their antibody status has helped reassure the participants. The dropout rate was quite consistent with national rate.

As most of the healthcare workers have had 2 doses of COVID-19 vaccine, an important aim of the SIREN study is to assess the vaccine effectiveness over time. For that reason, study follow-up is being extended for up to an optional, additional 12 months (up to a total 24 months) for study participants. WHH has taken the offer to continue being a site for this extension period. The extension period to this study starts from 18th August 2021. By

extending the follow-up to up to 24 months, we will better be able to understand vaccine effectiveness, as well as immune responses, over the longer-term and as new variants emerge and this will help address key questions of the durability of vaccine-induced immunity and inform the national response to COVID-19.

2.11 Special Days/Weeks for professional groups

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

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

National Cycle to Work Day: 3rd August 2021
World Suicide Prevention Day: 10th September 2021
Disability Awaress Day: 12th September 2021
Acute Medicine Awareness Week: 20th – 24th September 2021
Organ Donation Week: 20th – 26th September 2021
Falls Awareness Week: 20th – 26th September 2021

2.12 Local political leadership communication

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

2.13 Employee Recognition

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

Chief Executive Award (September 2021): Medical Education Team

This award has recognised the efforts of our Medical Education Team in supporting all of our students and trainees over the last 18 months. They have had significant positive feedback from individuals and other key stakeholders.

Chief Executive Award (September 2021): Denis Ward

Denis Ward, Theatre Practitioner, has retired after 50 years service with the Trust!

Chief Executive Award (September 2021): Dr Mohammad Al-Jafari

Dr Mohammad Al-Jafari, Consultant Histopathologist, is our longest serving consultant and has retired after 37 years service with the Trust.

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

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

- Matthew Rogers, Vaccination Service Manager - Vaccination Service
- Linda Doherty & Team, Ward Manager, C20 - Women's & Children's Health
- Lynn Shaw & Team, Ward Manager, C21 - Integrated Medicine & Community
- Ms Gemma Gossedge, Consultant Surgeon - Digestive Diseases
- Warrington Endoscopy Team, Digestive Diseases
- Natalie Crosby, Associate Chief Nurse - Planned Care
- Kim Bird, Sister - Paeds ED, Urgent & Emergency Care
- Mr Curtis Robb, Consultant Orthopaedic Surgeon - Surgical Specialities
- Denise Ellis, Ward Manager, A9 - Medical Care
- Sue Robinson, Healthcare Assistant - Medical Care
- Maureen Leadbetter, Staff Nurse - Medical Care
- Denis Ward, Theatre Practitioner - Digestive Diseases
- Julie Will, Team Leader, A1 - Urgent & Emergency Care
- Mr Rajiv Sanger, Consultant Orthopaedic Surgeon - Surgical Specialities
- Karen Hyde, Staff Nurse - Integrated Medicine & Community
- Carol Jones, Ward Manager - Surgical Specialities
- Margaret Headicarr, Healthcare Assistant - Integrated Medicine & Community
- Diane Duane, Nurse Practitioner - Cardiac Rehabilitation Service
- David Croughton, Porter - Estates and Facilities
- Dr Mohammad Al'Jafari, Consultant Histopathologist - Clinical Support Services
- Janet Tasker, Staff Nurse - Medical Care

2.14 Signed under Seal

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

- Lease for Hospital Food Court
- ED Plaza Construction Contract

3 MEETINGS ATTENDED/ATTENDING

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

- NHSE/I COVID-19 System Leadership (Biweekly)
- C&M Provider Collaboration CEO Group Calls (Bi-weekly)
- C&M Acute And Specialist Trust (CMAST) Provider Collaboration CEO Group Calls Monthly)
- C&M Medical Directors Clinical Prioritisation & Mutual Aid meeting (Weekly)
- C&M and NW Critical Care Network Gold Command Calls (Twice Weekly)
- Steve Broomhead, Chief Executive, Warrington Borough Council
- Dr Andy Davies, Clinical Chief Officer, NHS Warrington and Halton CCG

- C&M Hospital Cell (Weekly)
- Warrington Health & Wellbeing Board Workshop
- North West Regional Leadership Group
- C&M Strategic Estates Group
- North West Wellbeing Workshop

4) RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/125 a (i)**			
SUBJECT:	**Safe Staffing Assurance Report – June & July 2021**			
DATE OF MEETING:	29th September 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 June and July 2021. Ward staffing data continues to be systematically reviewed to ensure the wards and departments are safe. Mitigation was provided and associated actions put in place when a ward was below 90% of planned staffing levels. Registered nurse & midwife sickness absence in the month of June was recorded at 6.22% showing a slight increase from the April/May report which was recorded at 6.14%. Sickness data in July details a decrease to 5.95%. In the month of June, it was noted that 12 of the 21 wards were above the 90% target during the day, in July 8 of the 21 wards were above the 90% target. In order to ensure safe staffing levels, mitigation and responsive plans were implemented daily to ensure that the safe delivery of patient care. CHPPD in June was 7.9 and 7.6 in July, with a year to date rate 7.8. This report provides assurance that the Trust is safely staffed and staffing is monitored as appropriate . The report does not cover the analysis of spend and staffing cost.			
PURPOSE: *(please select as appropriate)*	Information *	Approval	To note *	Decision
RECOMMENDATION:	Trust Board asked to receive the contents of this report as discussed and received at the Strategic People Committee.			
PREVIOUSLY CONSIDERED BY:	**Committee**	**Strategic People Committee**		
	Agenda Ref.	SPC/212/07/55		

	Date of meeting	22nd September 2021
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Safe Staffing Assurance Report – June & July 2021	AGENDA REF:	BM/21/09/125 a (i)

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report – June & July 2021.

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

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

2. KEY ELEMENTS

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

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

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

Care Hours Per Patient Day

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

Table 1 illustrates the monthly CHPPD data. In the month of June CHPPD was recorded at 7.9 and July recorded at 7.6 with a 2021/22 YTD figure of 7.8.

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

Table 1 – CHPPDD Data 2020/21

	Trust wide			
Month	**Cumulative count over the month of patients at 23:59 each day**	**Registered midwives/nurses**	**Care Staff**	**Overall**
Apr-21	13769	4.4	3.3	7.7
May-21	13645	4.6	3.5	8.1
Jun-21	13134	4.5	3.4	7.9
Jul-21	13964	4.4	3.3	7.6
YTD	54512	4.5	3.4	7.8

Key Messages

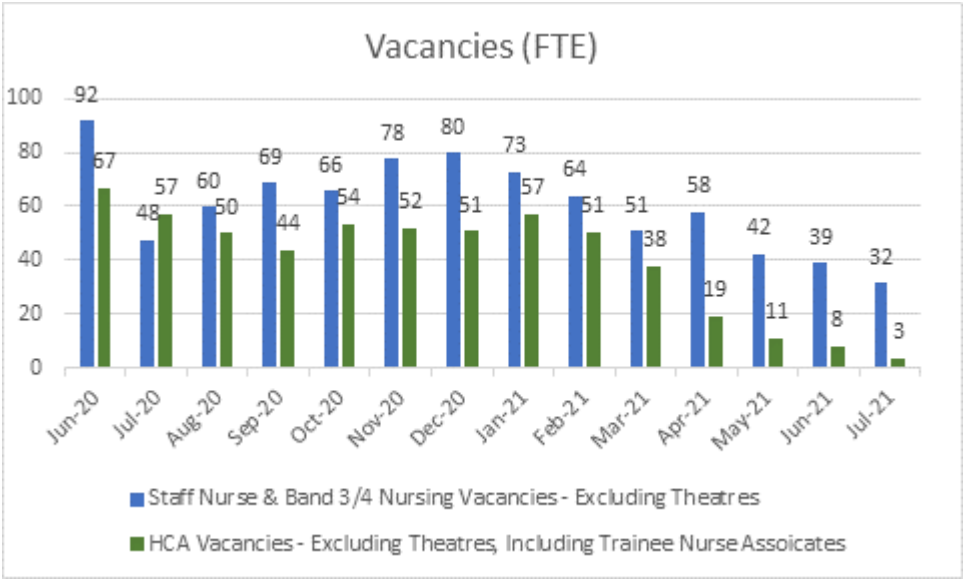
In the month of June, it was noted that 12 of the 21 wards were above the 90% target during the day, in July 8 of the 21 wards were above the 90% target. In order to ensure safe staffing levels, mitigation and responsive plans were implemented daily to ensure that the safe delivery of patient care. Staffing is reviewed twice daily by the senior nursing team and staff are moved based on acuity and activity to ensure safe patient care at all times.

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

Maternity (ward C23) was 84% in June which was lower than previous months. In July though C23 reported 99% planned versus actual. Ward C23 use their responsive staffing plans in the unit to move staff to support if acuity requires additional staffing.

Vacancy Summary

In June 2021 the Trust had 39 registered nurse and 8 health care assistant vacancies at WHH, which required reliance on temporary staffing to ensure safe staffing levels on the wards. In July vacancy levels were 32 registered nurse and 3 health care assistant vacancies.



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

Recruiting to HCA vacancies has previously been a challenge. However, the Trust received funding from NHSI to enhance HCA recruitment and pastoral support in the clinical areas. In June 2021 we had 8 HCA vacancies. There are 3 vacancies in July, recruitment to these posts is in progress.

Escalation Beds and Costs

In the months of June & July 2021 ward B3 has been open for medically fit patients, the ward is managed by the Unplanned Care Group. Staff are moved from other wards and augmented by temporary staff. The unfunded revenue costs associated with B3 are detailed below in table 2 and 3.

Table 2 – Cost associated with additional beds in June 2021

Jun-21			
No. Bed Days	**Additional Costs £**	**Notional Bed Day Cost £**	**Total Cost £**
687	155,297	0	155,297
687	**155,297**	**0**	**155,297**

Table 3 – Costs associated with additional beds in July 2021

Jul-21			
No. Bed Days	**Additional Costs £**	**Notional Bed Day Cost £**	**Total Cost £**
710	160,497	0	160,497
710	**160,497**	**0**	**160,497**

Off Framework Agency Usage

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

Sickness Absence – June & July 2021

Registered nurse and midwife sickness absence in the month of June was recorded at 6.22% showing a slight increase from the April/May report which was recorded at 6.14%. Sickness data in July details a decrease to 5.95%. The cost of bank/agency cover of qualified nursing sickness (at usual bank/agency fill rates) is £247,669 in June and £236,793 for July as detailed in the tables 4 and 5 below;

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

	Jun-21
Contracted Nursing WTE (Band 5 to 7)	936.24
% Sickness	6.22%
WTE Equivalent of Sickness	58.23
NHSP Fill Rate	79%
WTE Covered by Temporary Staffing	46.00
Cost at Average NHSP Rates	***247,669***

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

	Jul-21
Contracted Nursing WTE (Band 5 to 7)	947.74
% Sickness	5.95%
WTE Equivalent of Sickness	56.39
NHSP Fill Rate	78%
WTE Covered by Temporary Staffing	43.98
Cost at Average NHSP Rates	***236,793***

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

Clinically Extremely Vulnerable (CEV) Staff

The number of Clinically Extremely Vulnerable (CEV) staff are a driver behind additional spend on temporary staff in the clinical areas. A significant proportion of CEV staff members continue to work non-clinically or in 'green' pathways. 35 clinical CEV staff have been identified, who are unable to work their substantive role. It is estimated this will cause an annual additional temporary staffing spend of £1.8 million, however this somewhat offset by £650kdue to the areas the CEV have been redeployed into.

Midwifery Staffing Incidents

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

In July there were 23 Red Flags raised for staffing related issues in Maternity, this provides assurance that issues are raised and dealt with in a timely manner. Previously the issues would have been recorded on Datix and investigated retrospectively.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Paediatrics - Respiratory Syncytial Virus (RSV) 2021 Preparedness

BW772 Respiratory syncytial virus 2021 ı

In August the Trust received this (embedded document) guidance from NHS England on preparing for an earlier and a greater than usual increase in respiratory syncytial virus (RSV) as well as other respiratory illnesses in children. It is anticipated that this will increase pressure on paediatric critical and inpatient care.

The Matron and Lead Nurse in Paediatrics are reviewing the guidance and will plan accordingly. The plan will be shared in the next safe staffing assurance report.

The principles are:-

1. A flexible, pragmatic and staged approach with an emphasis on team working should be followed.

2. Through appropriate workforce planning, aim to maintain nationally recommended nurse-to-patient ratios using mutual clinical aid options including system working.

3. Should such mutual aid arrangements no longer be viable, strategies to increase the clinical workforce to meet staffing requirements at times of exceptional demand need to be planned in advance being cognisant of the impact deployment decisions have on other services.

4. Nursing staff identified as able to support the requirement for an increased paediatric critical care workforce in response to exceptional demand are categorised into four groups: paediatric critical care trained nurses and category A, B and C staff.

5. Identification of staff to support the paediatric workforce should consider the actual and potential requirements of other services.

6. Redeployment of staff into paediatric critical care areas or children's and young people's wards from another service should be on a voluntary basis.

7. Following conversations with the identified staff, individualised training needs analysis should be completed. Staff must receive appropriate training, induction and familiarisation with the new work environment and processes. Health Education England e-Learning for Healthcare (HEE e-LfH) has created an e-learning programme to support the cross-skilling of the NHS workforce available.

8. Organisations should ensure that staffing plans are reviewed and signed off by the Chief Nurse, with staffing decisions including redeployment and daily deployment of staff led by the senior clinical leadership teams. Discussions about staffing at meetings to agree mutual aid and how to address system challenges – at hospital cell/situation report (SitRep) meetings, local system resilience meetings and regional Emergency Preparedness, Resilience and Response (EPRR) calls – should be documented.

9. The Trust Board should review its risk appetite in relation to quality and workforce risks associated with potential future spikes in demand for children's services as a result of RSV and other respiratory illnesses and be clear about the tolerances it is willing to accept. The trust board should be assured that appropriate measures are in place to mitigate any identified risks.

Although this guidance focuses on the clinical nursing workforce, the response to increased demand must be agile and multiprofessional, based on holistic person-centred need. Trusts will need to employ the skills of the full multiprofessional team appropriately to ensure the clinical environment is as safe as it can be for patients, staff and their respective families.

Action – Prepare an action plan for the next assurance report
Responsible officer – Jill Tomlinson, Matron for Child Health

4. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Monthly Safe Staffing Data – June 2021																			
		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1725.0	1443.3	1380.0	1426.0	84%	103%	1380.0	1299.5	1380.0	1357.0	94%	98%	957	2.9	2.9	0.1	0.0	5.9
DD	Ward A5 G	1035.0	888.5	1035.0	1035.0	86%	100%	690.0	690.0	1035.0	966.0	100%	93%	588	2.7	3.4	0.3	0.0	6.3
DD	Ward A5 E	1000.5	816.5	667.0	707.0	82%	106%	690.0	685.5	690.0	287.5	99%	42%	246	6.1	4.0	0.0	0.0	10.1
MSK	Ward A6	1725.0	1656.0	1725.0	1690.5	96%	98%	1035.0	1069.5	1725.0	1506.5	103%	87%	1010	2.7	3.2	0.0	0.0	5.9
MSK	CMTC	1035.0	1368.5	690.0	908.5	132%	132%	690.0	678.5	690.0	460.0	98%	67%	262	7.8	5.2	0.0	0.0	13.0
W&C	C20	1041.2	863.2	790.5	645.0	83%	82%	690.0	690.0	0.0	11.5	100%	N/A	201	7.1	3.3	0.0	0.0	10.3
W&C	Ward C23	1380.0	1156.5	690.0	529.0	84%	77%	690.0	575.0	690.0	667.0	83%	97%	340	5.1	3.5	0.0	0.0	8.6
W&C	Birth Suite	2070.0	1794.0	345.0	333.5	87%	97%	2070.0	1852.0	345.0	322.5	89%	93%	251	14.5	2.6	0.0	0.0	17.1
W&C	The Nest	690.0	540.5	345.0	276.0	78%	80%	690.0	552.0	345.0	253.0	80%	73%	33	33.1	16.0	0.0	0.0	49.1
W&C	Ward B11	2576.0	2432.0	880.2	875.0	94%	99%	1499.4	1530.8	312.0	301.6	102%	97%	347	11.4	3.4	1.0	0.3	16.2
W&C	NNU	1725.0	1104.0	345.0	310.5	64%	90%	1725.0	1092.5	345.0	310.5	63%	90%	154	14.3	4.0	0.0	0.0	18.3
UEC	Ward A1	1868.0	2060.3	2121.8	2015.8	110%	95%	1592.6	1456.0	960.6	909.6	91%	95%	711	4.9	4.1	0.0	0.0	9.1
UEC	Ward A2	1385.5	1266.0	1417.7	1350.7	91%	95%	983.7	842.8	954.0	963.4	86%	101%	860	2.5	2.7	0.0	0.0	5.1
UEC	ED	6308.5	6441.2	1929.9	1936.1	102%	100%	4371.8	4909.9	1511.5	1751.3	112%	116%						
MC	ACCU	2415.0	2005.5	1035.0	1035.0	83%	100%	1725.0	1610.0	1035.0	1058.0	93%	102%	797	4.5	2.6	0.0	0.0	7.2
MC	ICU	4830.0	4324.0	1035.0	874.0	90%	84%	4830.0	4312.5	1035.0	805.0	89%	78%	480	18.0	3.5	0.0	0.0	21.5
MC	Ward A7	1725.0	1761.0	1380.0	1636.5	102%	119%	1380.0	1611.0	1035.0	1035.0	117%	100%	982	3.4	2.7	0.0	0.0	6.2
IM&C	Ward C21	1035.0	1023.0	1380.0	1430.0	99%	104%	690.0	690.0	1035.0	1268.5	100%	123%	742	2.3	3.6	0.0	0.0	6.1
IM&C	Ward B14	1035.0	1070.5	1725.0	1646.0	103%	95%	690.0	690.0	1035.0	1196.0	100%	116%	720	2.4	3.9	0.0	0.0	6.4
IM&C	Ward B12	1069.5	1035.0	2495.5	2200.0	97%	88%	713.0	713.0	1782.5	1794.0	100%	101%	651	2.7	6.1	0.0	0.0	9.0
IM&C	Ward B19	1035.0	1023.5	1725.0	1486.5	99%	86%	690.0	793.5	1380.0	1253.5	115%	91%	720	2.5	3.8	0.0	0.0	6.3
IM&C	Ward A8	1667.5	1529.5	1380.0	1383.0	92%	100%	1380.0	1230.5	1035.0	1153.0	89%	111%	1041	2.7	2.4	0.0	0.0	5.2
IM&C	Ward A9	1725.0	1668.0	1725.0	1846.0	97%	107%	1035.0	1284.5	1725.0	1478.0	124%	86%	1041	2.8	3.2	0.0	0.0	6.0
	Total	42101.67	39270.32	28242.62	27575.58	93%	98%	31930.55	30858.98	22080.58	21108.41	97%	96%	13134	4.5	3.4	0.0	0.0	8.0
		= above 100%			= above 90%			= above 80%			= below 80%								

Appendix 2

June 2021 - Mitigating Actions

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

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

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
Ward A4	84%	104%	94%	98%	Vacancy - band 5 2.0wte recruiting international nurses uplift staffing budget agreed international nurses recruited cswd utilised Sickness rate - 12.5% (long term 5.05%%) Action taken - All sickness managed as per policy
Ward A5 Gastro	94%	96%	100%	93%	Vacancy - nil Sickness rate - 5.43% (long term 2.51%) all sickness manages as per policy Action taken -
Ward A5 Elective	121%	94%	99%	42%	Vacancy - band2 2.33 wte band 5 0.38 wte band 5 0.48 wte Sickness rate -8.7 % (longterm 4.35) Action taken - All sickness managed as per policy
Ward A6	88%	95%	103%	87%	Vacancy - band 7 x1 WTE, band 2 x1 WTE Sickness rate - 4.48% STS, 5.35% LTS all return to works completed all staff referred and reviewed by OH Action taken - all vacancies out to recruit
CMTC	113%	124%	98%	67%	Vacancy - x1 band 3 Housekeeper Sickness rate - 3.52 STS, 1.75 LTS Action taken - all staff reviewed by OH sickness abscence meetings taking place with HR
C20	97%	96%	81%		Vacancy - Sickness rate - Action taken -
Ward C23	88%	95%	83%	97%	Vacancy - 0% Sickness rate - 10.68% Action taken - Managed in line with OHWB/HR support.
Birth Suite	90%	87%	89%	93%	Vacancy - 0.38WTE Sickness rate - 5.26% Action taken - All absence monitored through HR
The Nest	68%	84%	80%	73%	Vacancy - 0WTE Sickness rate - 0WTE Action taken -
Ward B11	89%	98%	102%	97%	Vacancy- fully established however waiting for pre-employmentchecks for 3 WTE. Sickness- 3.3 WTE long term. Maternity Leave 3 WTE. HDU 13 beds. Actions taken-sickness fallen in

					line with Trust attendance management policy.
NNU	72%	100%	63%	90%	Vacancy - 5 WTE Sickness rate - 5.5% Action taken - Sickness absence managed as per policy
Ward A1	86%	85%	91%	95%	Vacancy - Band 5 x 3.72 (full in sept when new starters start) Band 4 x 5.42 (not actively recruiting) Band 2- fully established Sickness rate - 6.24% managed inline with policy Action taken - Use of agency/bank to fill shortfalls in staffing. WM filling shortfalls also.
Ward A2	99%	85%	86%	101%	Vacancy - Fully Established Sickness rate - 13.28% managed in line with policy Action taken - Use of NHSP and agancy staff where needed, ward manager filling any shortfalls in staffin also
ED	85%	101%	112%	116%	Vacancy - Band 7 x 1 - out to advert / Band 6 x 1.43 out to advert / Band 5 x 1.85 overestablished / Band 2 x 22.5hrs out to advert Sickness rate - 12.23% Managed in line with policy Action taken - use of agency and nhsp staff. Matrons and ward manager working clinically to support shortfalls also
ACCU	91%	81%	93%	102%	Vacancy - 0.76wte Band 2 & 0.92wte RN seconded to nurse training, 1.0wte RN on mat leave, 1.0wte RN LTS, 0.76wte RN seconded to K25, 0.31wte HCA LTS. Sickness rate - 4.5% Action taken - All sickness managed in line with Trust policy
ICU	108%	112%	89%	78%	vacancy- 3.7%- fully recruited- awaiting start dates .sickness 5.3- health and wellbeing support.
Ward A7	97%	101%	117%	100%	Vacancy - Band 6 0.4, Band 2 2.44 Sickness rate - 9.28% Action taken - all appropriate actions completed via recruitment and HR
Ward C21	100%	95%	100%	123%	Vacancy - fully established Sickness rate - 7.18% sickness being manged in line with policy Action taken - HR &OH supporting with sickness
Ward B14	95%	87%	100%	116%	Vacancy - no vacancy at band 5 band 2 vacancy 1.44wte Sickness rate - 2.86% manages in line with policy Action taken - CSWD in place to support vacancy
Ward B12	86%	82%	100%	101%	Vacancy - no vacancy at band 5 Band 2 3.78 wte Sickness rate - 8.84% sickness being manged in line with policy Action taken - CSWD in post to support vacancy while recuriting to band 2
Ward B19	84%	106%	115%	91%	Vacancy - fully established for 24 beds Sickness rate - 5.15% sickness being managed as per policy Action taken - HR & OH supporting with sickness as requred

Ward A8	87%	95%	89%	111%	Vacancy - band 5 awaiting confirmation as budget to be adjusted Band 2 no vacancy Sickness rate - 0.94% being managed as per policy Action taken - new starter awaiting start date
Ward A9	91%	95%	124%	86%	Vacancy -fully established Sickness rate - 13.38% sickness being managed as per policy Action taken - CSWD in post to support HR&OH supporting with sickness
Total Fill Rate (%)	91%	95%	96%	96%	

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 3

Monthly Safe Staffing Data – July 2021																			
		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	%RN fill rate	%HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1782.5	1483.5	1426	1483.5	83%	104%	1426	1334	1426	1380	94%	97%	1023	2.8	2.8	0.1	0.0	5.6
DD	Ward A5 G	943	885.5	1069.5	1023.5	94%	96%	713	713	1069.5	920	100%	86%	319	5.0	6.1	0.4	0.1	11.6
DD	Ward A5 E	690	835.5	690	649.5	121%	94%	713	713	690	333.5	100%	48%	222	7.0	4.4	0.0	0.0	11.4
MSK	Ward A6	1782.5	1577.5	1782.5	1702	88%	95%	1069.5	1081	1782.5	1483.5	101%	83%	1007	2.6	3.2	0.0	0.0	5.8
MSK	CMTC	1069.5	1207.5	713	885.5	113%	124%	713	713	713	584.5	100%	82%	210	9.1	7.0	0.0	0.0	16.1
W&C	C20	1069.5	1035.5	713	686.5	97%	96%	713	713	0	220.5	100%	N/A	460	3.8	2.0	0.0	0.0	5.9
W&C	Ward C23	1426	1253.5	713	678.5	88%	95%	713	575	713	644	81%	90%	639	2.9	2.1	0.0	0.0	4.9
W&C	Birth Suite	2139	1925	356.5	310.5	90%	87%	2139	1853	356.5	253	87%	71%	316	12.0	1.8	0.0	0.0	13.7
W&C	The Nest	713	483	356.5	299	68%	84%	713	632.5	356.5	345	89%	97%	25	44.6	25.8	0.0	0.0	70.4
W&C	Ward B11	2822	2518.5	828.5	811	89%	98%	1573.4	1712.8	322.4	322.4	109%	100%	389	10.9	2.9	1.1	0.0	14.9
W&C	NNU	1782.5	1278	356.5	356.5	72%	100%	1782.5	1207.5	356.5	345	68%	97%	227	10.9	3.1	0.0	0.0	14.0
UEC	Ward A1	2293.75	1977.75	2176	1859	86%	85%	1635.12	1469.95	992.32	872.43	90%	88%	925	3.7	3.0	0.0	0.0	6.7
UEC	Ward A2	1446.5	1436.5	1637.3	1385.33	99%	85%	1045.03	949.68	1033.47	1014.15	91%	98%	877	2.7	2.7	0.0	0.0	5.5
UEC	ED	6498.25	6606.42	1865.08	1987.75	102%	107%	4527.6	5098.8	1556.0	1646.0	113%	106%						
MC	ACCU	2495.5	2125	1069.5	1081	85%	101%	1782.5	1609.5	1069.5	1046.5	90%	98%	825	4.5	2.6	0.0	0.0	7.1
MC	ICU	4991	4519.5	1069.5	868.3	91%	81%	4991	4577	1069.5	885.5	92%	83%	470	19.4	3.7	0.0	0.0	23.1
MC	Ward A7	1782.5	1920.5	1426	1603.5	108%	112%	1426	1858	1069.5	1318	130%	123%	1026	3.7	2.8	0.0	0.0	6.5
IM&C	Ward C21	1069.5	1042.5	1426	1445	97%	101%	713	724.5	1069.5	1125.5	102%	105%	775	2.3	3.3	0.0	0.0	5.7
IM&C	Ward B14	1069.5	1074.5	1782.5	1692.5	100%	95%	713	713	1242	1322.5	100%	106%	744	2.4	4.1	0.0	0.0	6.5
IM&C	Ward B12	1069.5	1012.5	2495.5	2173.5	95%	87%	713	713	1782.5	1748	100%	98%	651	2.7	6.0	0.0	0.2	9.0
IM&C	Ward B19	1276.5	1103	1782.5	1466	86%	82%	920	839.5	1426	1322.5	91%	93%	744	2.6	3.7	0.0	0.0	6.4
IM&C	Ward A8	1702	1437.5	1426	1506.5	84%	106%	1426	1311	1069.5	1104	92%	103%	1041	2.6	2.5	0.1	0.0	5.3
IM&C	Ward A9	1782.5	1558	1782.5	1686.5	87%	95%	1426	1228.5	1782.5	1541	86%	86%	1049	2.7	3.1	0.0	0.0	5.8
	Total	43696.5	40296.67	28943.38	27640.88	92%	95%	33586.65	32340.18	22948.16	21777.48	96%	95%	13964	4.4	3.3	0.0	0.0	7.7
		= above 100%			= above 90%			= above 80%			= below 80%								

Appendix 4

July 2021 - Mitigating Actions

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

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

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
Ward A4	88%	95%	81%	90%	Vacancy - band 5 2.0wte recruiting international nurses uplift staffing budget agreed international nurses recruited cswd utilised Sickness rate - 9.43%% (long term 7.14%%) Action taken - All sickness managed as per policy
Ward A5 G	90%	87%	87%	71%	Vacancy - nil Sickness rate - 4.88% (long term 0%) Action taken - all sickness managed as per policy
Ward A5 E	68%	84%	89%	97%	Vacancy - band2 2.33 wte band 5 0.38 wte band 5 0.48 wte Sickness rate -3.78 % (longterm 0%) Action taken - All sickness managed as per policy
Ward A6	89%	98%	109%	100%	Vacancy - band 7 = 1 pending retirement out to advert, band 5 = 1 WTE, band 2 = 1 WTE vacancies awaiting new starters Sickness rate - 3.08% ST and 6.21 % Lt Action taken - recruitment for vacant posts, sickness abscence policy followed for all staff, occupational health referrals completed and advice sought from HR for complex cases
CMTC	72%	100%	68%	97%	Vacancy - band 5 = 0 WTE NQN commencing September 2021 , band 2 = 0 vacancies Sickness rate - 0% ST and 2.11 % Lt Action taken - recruitment for vacant posts, sickness abscence policy followed for all staff, occupational health referrals completed and advice sought from HR for complex cases
C20	86%	85%	90%	0%	Vacancy - 0 Sickness rate - 3.43% Action taken - Absenses managed with HR policy and guidance
Ward C23	99%	85%	91%	98%	Vacancy - 0% Sickness rate - 8.79% Action taken - appropriate action inline with HR/OHWB
Birth Suite	102%	107%	113%	106%	Vacancy - 0.13% Sickness rate - 9.06% Action taken - Managed alongside HR/OHWB
The Nest	85%	101%	90%	98%	Vacancy - 0% Sickness rate - 5.47%

					Action taken - managed along with HR/OHWB
Ward B11	91%	81%	92%	83%	Vacancy - 3.33 WTE Band 5 Maternity Leave 4 WTE HDU 46 days Sickness rate - Long-term 4.5 WTE Action taken - Vacancies out to NHS Jobs advert closes 2nd August interviews 9th August. Maternity Leave 2 WTE return to work August. Sickness managed as trust attendance policy 1.9 WTE resumed end July.
NNU	108%	112%	130%	123%	Vacancy - 5 WTE Sickness rate - 5.5% Action taken - Sickness absence managed as per policy
Ward A1	97%	101%	102%	105%	Vacancy - 18.87% (includes non-nursing vacancies) Band 6 x 1.29 (not recruiting as overestablished at Band 5) Band 5- overestablished by Sept 21 / Band 2 - fully established Sickness rate - 14.23% Managed in line with policy. Short term and long term sickness. Action taken - use of agency and NHSP . WM filling shortfalls in gaps also. Regular meetings with NHSP.
Ward A2	100%	95%	100%	106%	Vacancy - Fully Established. No Vacancies Sickness rate - 4.96% Managed in line with policy. Action taken - Use of agency and NHSP to fill gaps . WM filling shortfalls in gaps also. Regular meetings with NHSP.
ED	86%	82%	91%	93%	Vacancy - 8.97% Ongoing recruitment. Band 7 fully established / Band 6 x4 / Band 5 x1.45/ Band 2 x 2.43 Sickness rate - 9.33% Managed in line with sickness Action taken -Use of agency and NHSP . WM and Matrons filling shortfalls in gaps also. Regular meetings with NHSP.
ACCU	84%	106%	92%	103%	Vacancy - band 6 - 0.87wte Sickness rate - 4.17% - all managed as per policy Action taken - Band 6 currently out to advert
ICU	87%	95%	86%	86%	Vacancy -1.15% ROLLING RECRUITMENT Sickness rate - 5.5 % OH/wellbeing assessments/support in place Action taken -
Ward A7	97%	101%	102%	105%	Vacancy - band 7 1.0, band 6 0.4, band 2 1.44 plus 2.45 redeployed hca due to risk assessment Sickness rate - 3.82% short term, 6.3% long term Action taken - All vacancies reviewed and plan in place, all sickness managed in line with policy
Ward C21	100%	95%	100%	106%	Vacancy - 0 Vacancy Sickness rate - 4.52% Action taken - in line with policy
Ward B14	95%	87%	100%	98%	Vacancy - awaiting start date for band 5 Band 2 1.0 wte Sickness rate - 7.32% Action taken - sickness being managed in line with policy
Ward B12	86%	82%	91%	93%	Vacancy - awaiting start date for Band 5 HCA X2 starting September Sickness rate - 6.79%

					Action taken - sickness being managed in line with policy LTS x1HCA
Ward B19	84%	106%	92%	103%	Vacancy - 0 Sickness rate - 6.55% Action taken - in line policy
Ward A8	87%	95%	86%	86%	Vacancy - band 5 0 0.92wte Band 2 Sickness rate - 11.84% Action taken - LTS x2 being managed in line with management policy
Ward A9	91%	94%	95%	98%	Vacancy - Band 5 new starter awaiting start date band 2 no vacancy Sickness rate - 3.42% x2 HCA on maternity leave Action taken - x1 LTS being managed with HR support
Total Fill Rate (%)	91%	94%	95%	98%	

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix Five

Warrington and Halton Hospitals International Nurse Recruitment Summary – June 2021

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/125a**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	29th September 2021	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Andrea McGee - Chief Finance Officer and Deputy Chief Executive Dan Moore - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1215 Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic. #1272 Failure to provide enough beds caused by the requirement to adhere to social distancing guidelines. #1273 Failure to provide timely patient discharge caused by system-wide COVID-19 pressures. #1275 Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission. #1289 Failure to deliver planned elective procedures caused by the Trust's decision to pause some elective procedures in order to ensure safe staffing and critical care capacity during the COVID-19 pandemic. #115 Failure to provide adequate staffing levels in some specialities and wards caused by the inability to fill vacancies and staff sickness. #134 Financial Sustainability a) Failure to sustain financial viability caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has 75 IPR indicators which have been RAG rated in August as follows: Red: 29 (from 30 in July) Amber: 9 (from 9 in July) Green: 32 (from 31 in July) Not RAG Rated: 5 (from 5 July)	

	As a result of the COVID-19 pandemic, the Trust has not met the RTT 18 week, RTT 52 week, Diagnostics 6-week, Cancer 2 week or Cancer 62-day urgent standards. The Trust has achieved all other cancer standards. A&E and Ambulance Handover performance remains challenging with increased attendances. There was 1 patient waiting over 12 hours in A&E in August. Sepsis screening and anti-biotics administration within the one hour timeframe remains a key focus. A focussed improvement plan is in place with oversight from the Deputy Chief Nurse for Patient Safety and Clinical Education. The Trust has been set a control total for H1 of breakeven and has submitted a plan to the Cheshire and Merseyside Health and Care Partnership (CMHCP) to deliver this. For the period ending 31 August 2021 performance is £0.2m surplus against a planned £0.1m deficit, a £0.3m favourable variance. There are a number of risks that have emerged that have been offset by under spends. If these are not managed, they pose a risk to the delivery of a break even position for the year. The Elective Recovery Fund (ERF) trajectories have been updated for August to September. The latest forecast position is £3.1m for H1. This is subject to the delivery of the revised performance trajectories and delivery of the gateway requirements across the Cheshire and Merseyside system. The position of breakeven for H1 is therefore reliant on achievement of ERF of £3.1m. To date £2.3m has been confirmed with £0.8m expected for June. The cash position at the end of month 5 is £36.7m against a plan of £11.2m.

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

RECOMMENDATION:	The Trust Board is asked to: 1. Approve the Capital schemes to be funded from the contingency. 2. Note the schemes that are no longer required in 2021/22 to be moved back into the contingency. 3. Note that the NHSE/I Provider Finance Return for month 5 matches this report. 4. Approve the proposed amendment to the Workforce section of the IPR. 5. Note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee (KPI Amendment)
	Agenda Ref.	SPC 21/09/71
	Date of meeting	22nd September 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/21/09/125a

1. BACKGROUND/CONTEXT

The RAG ratings for all 75 IPR indicators from September 2020 to August 2021 are set out in **Appendix 1.** The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the Trust Board with assurance in relation to the delivery of all Key Performance Indicators (KPIs) across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

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

Table 1: RAG Rating Movement

	July	August
Red	30	29
Amber	9	9
Green	31	32
Not RAG Rated	5	5
Total:	75	75

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

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

Quality

Quality KPIs

There are 6 Quality indicators rated Red in August, an increase from 4 in July.

The 4 indicators rated Red in July, which have remained rated Red in August are as follows:

- Sepsis % Screening for Emergency Patients within 1 hour – the Trust achieved 67.00% in August, an improvement from 54.00% in July, against a target of 90.00%.
- Sepsis % Screening for Inpatients within 1 hour – the Trust achieved 57.00% in August, a deterioration from 73.00% in July, against a target of 90.00%.

- Sepsis % Emergency Patients Administered Antibiotics Within 1 Hour – the Trust achieved 44.00% in August, an improvement from 26.00% in July, against a target of 90.00%.
- Friends and Family Test (ED) – the Trust achieved 70.00% in August, a deterioration from 73.00% in July, against a target of 87.00%.

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

- Incidents – there were 4 incidents over 40 days old in August, an increase from 0 in July, against a target of 0.
- Sepsis % Inpatients Administered Antibiotics Within 1 Hour – the Trust achieved 70.00% in August, a deterioration from 100.00% in July, against a target of 90.00%. A focussed improvement plan is in place with oversight from the Deputy Chief Nurse for Patient Safety and Clinical Education.

Access and Performance

Access and Performance KPIs

There are 14 Access and Performance indicators rated Red in August, the same number of indicators as in July. Performance against Access & Performance indicators has been significantly impacted by the COVID-19 pandemic and recovery plans are in place to address this performance.

The 13 indicators which were rated Red in July and remain rated Red in August are as follows:

- Diagnostic 6 Week Target – the Trust achieved 75.96% in August, a deterioration from 77.91% in July, against a target of 99.00%.
- Referral to Treatment Open Pathways – the Trust achieved 77.08% in August, an improvement from 76.22% in July, against a target of 92.00%.
- Referral to Treatment 52+ Week Waiting – there were 967 patients waiting over 52 weeks in August, an improvement from 981 patients in July, against a target of 0. RTT and Diagnostic performance is as a result of the reduction in the elective programme, suspension of services and the associated backlog during the initial phases of the pandemic. The Trust has robust recovery plans in place with clinical prioritisation.
- A&E Waiting Times 4-hour National Target – the Trust achieved 72.84% (excluding Widnes Walk ins) in August, an improvement from July's position of 72.64%, against a target of 95.00%.
- A&E Waiting Trajectory – the Trust did not achieve the trajectory in month.
- Cancer 2 Week Wait - the Trust achieved 90.98% in July, a deterioration from 91.21% in June, against a target of 93.00%.
- Cancer 62 Days Urgent - the Trust achieved 74.77% in July, an improvement from 63.77% in June, against a target of 85.00%.
- Ambulance Handovers 30 – 60 minutes – there were 101 patients who experienced a delayed handover in August, an improvement from 126 patients in July against a target of 0.
- Ambulance Handovers 60 minutes plus - there were 47 patients who experienced a delayed handover in August, an improvement from 67 patients in July against a target of 0.

- Discharge Summaries % sent within 24 hours – the Trust achieved 84.75% in August, an improvement from 83.75% in July, against a target of 95.00%.
- Discharge Summaries NOT sent within 7 days (to achieve the 95.00% standard) – there were 293 discharge summaries not sent within 7 days to achieve the 95.00% standard in August, a deterioration from 267 discharge summaries not sent in July.
- Super Stranded Patients – there were 113 super stranded patients at the end of August, a deterioration from 106 patients at the end of July, against a trajectory of 95 patients.
- COVID-19 Recovery – the average performance across all diagnostic modalities was 55.61% in August 2021/22 in comparison with activity in the same period in 2019/20, against a target of 95.00%.

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

- Cancer 2 Week Breast Symptomatic - the Trust achieved 96.43% in July, an improvement from 87.34% in June, against a target of 93.00%.

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

- A&E Wait Over 12 hours – there was 1 patient waiting over 12 hours in A&E in August, a deterioration from 0 patients in July, against a target of 0.

PEOPLE

Workforce KPIs

There are 5 Workforce indicators rated Red in August, an improvement from 7 in July.

The 5 indicators which were rated Red in July and remain rated Red August are as follows:

- Sickness Absence – the Trust's sickness absence was 6.05% in August, an improvement from 6.18% in July, against a target of less than 4.20%.
- Return to Work Compliance – interview compliance was 60.98% in August, a deterioration from 63.94% in July, against a target of 85.00%.
- Bank/Agency Reliance – the Trust's reliance was 13.15% in August, an improvement from 15.84% in July, against a target of less than 9.00%.
- Agency Shifts Compliant with the Cap – 25.40% of agency shifts were compliant with the cap in August, a deterioration from 27.81% in July, against a target of 49.00%.
- Agency Rate Card Compliance – 35.24% of agency shifts were compliant with the rate card in August, a deterioration from 39.13% in July, against a target of 60.00%.

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

- Turnover – staff turnover was 14.61% in August, an improvement from 15.12% in July, against a target of less than 13.00%. However, when excluding temporary staff, the position is 12.32% in August 2021.

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

- Monthly Pay Spend – monthly Trust pay spend was £0.25m below budget in August, an improvement from £0.8m above budget in July.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 4 Finance & Sustainability indicators rated Red in August, a reduction from 5 in July.

The 4 indicators which were rated Red in July and remain rated Red in August are as follows:

- Capital Programme – the actual spend year to date is £3.2m which is £3.0m below the planned spend of £6.2m. However, the Trust has committed orders of £1.9m.
- Agency Spending – the year to date spend of £5.1m is £1.1m above the plan of £4.0m.
- Cost savings schemes in-year compared to plan, the current forecast is £2.1m against a plan of £4.8m.
- Cost savings schemes recurrent compared to plan, the current forecast is £2.1m against a plan of £4.8m.
  At 31 August, £2.7m of CIP has yet to be identified to achieve the target of £4.8m. Further work to increase identification of CIP schemes is underway across the Trust.

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

- Trust Financial Position – the Trust is in a surplus position of £0.2m, against a deficit plan of £0.1m at the end of August 2021.

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

COVID-19 expenditure at 31 August 2021 is £4.0m, this is £2.0m higher than the planned spend of £2.0m. April, May & June were on average £0.3m above plan, July was £0.7m above plan and August was £0.4m above plan. This is mainly due to £2.0m for COVID-19 sickness and isolation which was not switched off at 31 March 2021 as planned.

The Trusts ERF allocation for April and May 2021 has been confirmed at £2.3m.
The revised ERF forecast (as of August 2021) for H1 has been reduced to £3.1m, which is a decrease of £0.5m (in comparison to the July 2021 forecast).
The reason for the reduction relates to an overestimate (based on original guidance) of £0.1m in the June 2021 ERF. An updated estimate has now been provided by the system (based on updated guidance). There has also been a revision of the forecast for August and September ERF as the Trust is not delivering above 95.00%. The forecast is reliant on confirmation that the system as a whole has delivered for June 2021.

Should the Trust be awarded £3.1m for ERF in H1, this will provide a mitigation of £0.5m to support the control total as the plan for ERF was initially £2.6m.

The movement in ERF forecast at August can be seen in **Table 2**.

Table 2: ERF forecast movement at August 2021

	Apr - Jul	Aug	Sep	Total
	£ 000	£ 000	£ 000	£ 000
At July 21	3,233	169	195	3,597
At August 21	3,101	-	-	3,101
Movement	(132)	(169)	(195)	(496)

Please note: Only April and May ERF of £2.3m has been confirmed.

It has been confirmed that there will be ERF monies in H2, however the targets to achieve this have not yet been released.

Cash

The cash position at the end of August 2021 is £36.7m against a plan of £11.2m. This is due to several reasons including:

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

A new cash flow forecast has been developed, however this will need to be reviewed when funding has been agreed for H2.

Capital Programme

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

Table 3: Capital Expenditure as at 31 August 2021

Capital	Annual Plan	Original Plan to Date	Revised Plan to Date
	£000	£000	£000
Trust Funded	18,770	5,947	3,210
PDC Funded:			
Cardiac Catheterisation Suite	800	240	0
Total Approved Capital Programme	**19,570**	**6,187**	**3,210**
Total Planned Capital Investment	**19,570**	**6,187**	**3,210**

A revised capital spending profile has been supported by the Finance & Sustainability Committee, the key changes are:

a) Breast Unit Relocation, the work was due to be completed in August and is now due to be completed in October (£0.5m).
b) Fire schemes have been re-phased due to work commencing later than anticipated, the scheme was due to commence in June and actually commenced in August (£0.4m).
c) Contingency has moved from profiling in twelfths to September to March (£0.9m).
d) MRI work was due to be completed in July and is now due to be completed in October (£0.2m).
e) Cardiac Catherisation Suite delivery was due commenced in June and will now commence in October (£0.8m).
f) Shopping City has been reprofiled from June-March to October-January (£0.2m).
g) Reprofile of smaller capital schemes (£0.8m).

Table 4 provides the detail of revised YTD and future capital spending plan.

Table 4: Revised YTD and future capital spending plan

Capital	Annual Plan	Revised Plan to Date	Revised Plan							
			Mth 6	Mth 7	Mth 8	Mth 9	Mth 10	Mth 11	Mth 12	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Estates	13,744	2,648	1,052	1,936	1,740	1,643	1,805	1,422	1,522	13,767
IM&T	2,185	402	79	226	306	193	294	286	399	2,185
Medical Equipment	1,456	160	0	806	0	90			377	1,433
Contingency*	2,185	0	16	488	316	392	360	310	303	2,185
Total Planned Capital Investment	**19,570**	**3,210**	**1,147**	**3,456**	**2,362**	**2,318**	**2,459**	**2,018**	**2,601**	**19,570**

*The remaining contingency will be distributed throughout the remainder of 2021/22, in line with the expected expenditure requested.

A peer review group was held on 16 August 2021 to allocate additional schemes against the 2021/22 contingency. Schemes put forward by members of the Capital Planning Group (CPG) and unfunded schemes from the original capital proposals were reviewed and prioritised.

Table 5 outlines detail of agreed changes to the capital plan, requests for additional capital schemes to be funded from the contingency (including schemes considered by the peer review) and detail of capital schemes which are no longer required and are to be moved into contingency. The Finance & Sustainability Committee has been asked to support the new Capital schemes.

Table 5: Capital Plan Changes & Requests

	£000s	Month of Expenditure
Total Contingency available as at 28th July 2021	**2,185**	
Capital Schemes Approved Since the last Trust Board Report (28th July 2021)		
ED Plaza Increase (approved at Trust Board 25th August 2021)	(1,303)	7-12
Shopping City Increase (approved at Trust Board 21st August 2021)	(215)	7-10
Total Value of Schemes Approved Since 28th July 2021	**(1,518)**	
Capital Schemes Requesting Trust Board Approval		
Ophthalmology Equipment - Heidelberg Anterion	(60)	7
Schemes Supported as part of the Peer Review		
Ophthalmic Microscope (Peer Review)	(126)	6
Image Intensifier (Peer Review)	(80)	7
Maxillofacial 3rd Surgery (Peer Review)	(60)	7
Ultrasound (Peer Review)	(105)	8
CT Room Halton Upgrade (Peer Review)	(90)	8
Dexa Scanner turnkey/enabling works (Peer Review)	(125)	10
Backlog - Replace Obsolete Nurse Call Systems Ph 1 (Peer Review)	(50)	10
Operating Tables (Peer Review)	(61)	11
Total Value of Capital Schemes Seeking Trust Board Approval	**(757)**	
Schemes to be Added Back into Contingency		
Health & Wellbeing Software Upgrade – no longer required in 2021/22	13	N/A
Osmosis/Dialysis – no longer required in 2021/22	58	N/A
Capital Underspends	395	N/A
Total to be added back into contingency	**466**	
Contingency Closing Balance as at 29th September 2021	**376**	

The contingency of circa £0.4m will be held for capital emergencies.

The Trust Board is asked to:

- Approve the Capital schemes to be funded from the contingency.
- Note the schemes that are no longer required in 2021/22 to be moved back into the contingency.

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

3. RECOMMENDED UPDATES/AMENDMENTS TO THE IPR

Table 6 & Table 7 outlines a proposed temporary amendment to the IPR which was supported by the Strategic People Committee on 22nd September 2021. The proposal will separate safeguarding training from the current mandatory/core skills training indicator to provide increased monitoring and assurance of compliance. This will be a temporary amendment until 31st March 2023.

Table 6: Proposed Updated KPI

KPI	Change	Rationale
Core Skill/Mandatory Training	The safeguarding training (Adults and Children's) element of this indicator will be separated into a new indicator.	This will allow improved assurance on safeguarding training following the introduction of the *Adult Safeguarding: Roles and Competencies for Health Care Staff*, also referred to as the Intercollegiate Document for safeguarding.

Table 7: Proposed New KPI

KPI	Proposed RAG Rating	Rationale
Safeguarding Training	The RAG rating will follow the same format as the current Core Skills/Mandatory Training and Role Specific Training indicator as follows: **RAG Criteria:** Green = meeting or better than trajectory. Red = worse than trajectory. **Trajectory:**	This will allow improved assurance on safeguarding training following the introduction of the intercollegiate document for safeguarding. Following the introduction of the intercollegiate document, Trusts had three years to implement the changes (31/03/2023), this new KPI will enable improved assurance that the Trust is on target to achieve compliance.

MONTH	SAFEGUARDING TRAJECTORY
OCT-21	60%
NOV-21	62%
DEC-21	65%
JAN-22	68%
FEB-22	71%
MAR-22	74%
APR-22	77%
MAY-22	80%
JUN-22	83%
JUL-22	86%
AUG-22	89%
SEP-22	90%
OCT-22	90%
NOV-22	90%
DEC-22	90%
JAN-23	90%
FEB-23	90%
MAR-23	90%

The Trust Board is asked to approve the proposed amendment to the Workforce Section of the IPR.

This amendment will increase the overall number of indicators on the IPR from 75 to 76. If approved by the Trust Board, the changes will take place from November's IPR Board Report (October's Data).

4. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

5. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

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

6. RECOMMENDATIONS

The Trust Board is asked to:

1. Approve the Capital schemes to be funded from the contingency.
2. Note the schemes that are no longer required in 2021/22 to be moved back into the contingency.
3. Note that the NHSE/I Provider Finance Return for month 5 matches this report.
4. Approve the proposed amendment to the Workforce section of the IPR.
5. Note the contents of this report.

Key

Improvement in Performance	↕
Deterioration in Performance	↕
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating September 2020 – August 2021

KPI	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21
QUALITY												
Incidents (over 40 days old)	↓	↓	↑	↓	↔	↑	↑	↔	↔	↔	↔	↓
Duty of Candour	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Healthcare Acquired Infections - MSRA	↓	↑	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Healthcare Acquired Infections – Cdiff	↑	↓	↑	↔	↓	↕	↓	↔	↓	↑	↓	↑
Healthcare Acquired Infections – Gram Neg	↑	↓	↑	↑	↑	↕	↓	↓	↑	↓	↑	↓
Healthcare Acquired Infections – COVID-19 Hospital Onset & Outbreaks												
VTE Assessment	↓	↓	↑	↓	↓	↓	↑	↑	↑	↑		
Total Inpatient Falls & Harm Levels	↓	↓	↓	↑	↓	↑	↓	↑	↓	↑	↓	↑
Pressure Ulcers	↓	↑	↓	↑	↓	↑	↓	↑	↔	↓	↓	↑
Medication Safety (24 Hours)	↓	↑	↑	↑	↑	↓	↑	↓	↑	↑	↓	↓
Staffing – Average Fill Rate	↑	↑	↑	↓	↑	↑	↓	↑	↑	↑	↓	↓
Staffing – Care Hours Per Patient Day	↓	↑	↑	↓	↑	↑	↑	↓	↑	↓	↓	↑
Mortality ratio - HSMR												
Mortality ratio - SHMI												
NICE Compliance	↑	↑	↓	↑	↑	↑	↓	↑	↑	↑	↑	↓
Complaints					↔	↔	↔	↔	↔	↔	↔	↔
Friends & Family – Inpatients & Day cases	-	-	-		↔	↓	↔	↑	↔	↓	↔	↔
Friends & Family – ED and UCC	-	-	-		↑	↓	↓	↓	↓	↔	↓	↓
Mixed Sex Accommodation Breaches (Non ITU Breaches Only)									↔	↔	↔	↔
Continuity of Carer	↓	↓	↑	↑	↓	↑	↑	↓	↑	↓	↑	↓
Sepsis - % screening for all emergency within 1 hour.									↑	↓	↑	↑
Sepsis - % screening for all inpatients within 1 hour.									↑	↓	↓	↓
Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis.									↓	↓	↑	↑
Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis.									↓	↓	↑	↓
Ward Moves between 10:00pm and 06:00am												

Key

Improvement in Performance	↑
Deterioration in Performance	↓
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating September 2020 – August 2021

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

Key

Improvement in Performance	
Deterioration in Performance	
Static Performance	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating September 2020 – August 2021

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

Key

Improvement in Performance	
Deterioration in Performance	
Static Performance	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating September 2020 – August 2021

KPI	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21
FINANCE												
Trust Financial Position												
System Financial Position	-	-	-	-	-	-	-	-	-	-	-	-
Cash Balance												
Capital Programme												
Better Payment Practice Code												
Use of Resources Rating	-	-	-	-	-	-	-	-	-	-	-	-
Agency Spending (Monthly)												
Cost Improvement Programme – Performance to date	-	-						-	-	-		
Cost Improvement Programme – Plans in Progress (In Year)	-	-	-	-	-	-	-	-	-	-		
Cost Improvement Programme – Plans in Progress (Recurrent)	-	-	-	-	-	-	-	-	-	-		

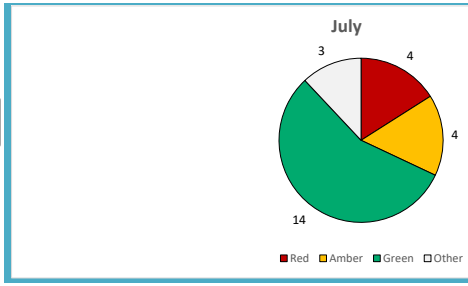
*RAG rating is based on previous month's validated position for these indicators.

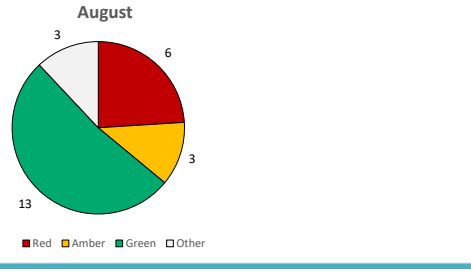
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Integrated Dashboard - August 2021

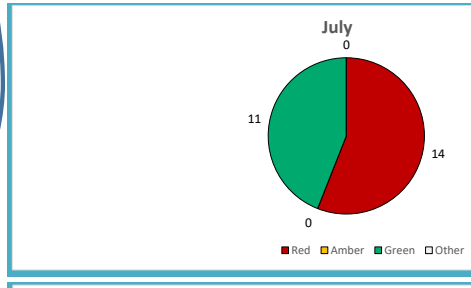
Appendix 2

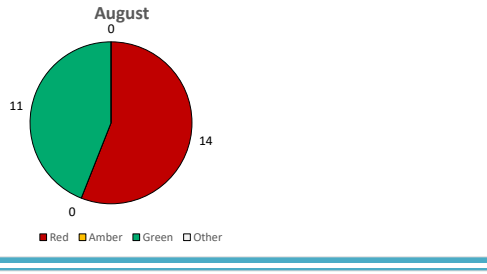
Quality Improvement



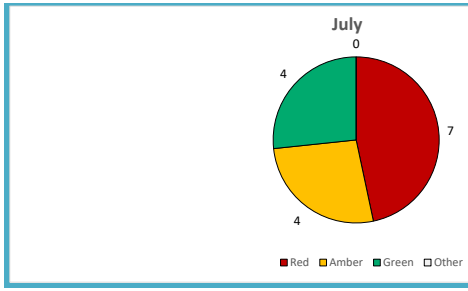


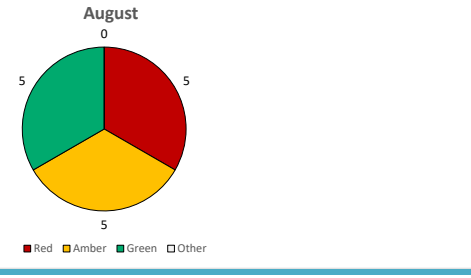
Access & Performance



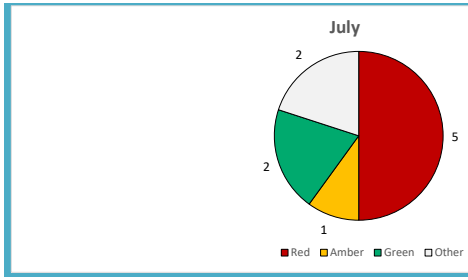


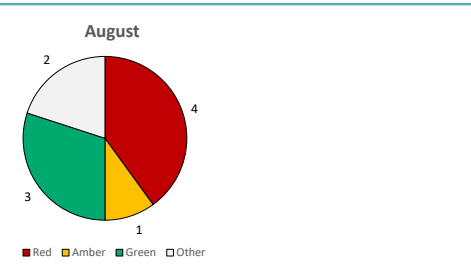
Workforce





Finance





Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

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

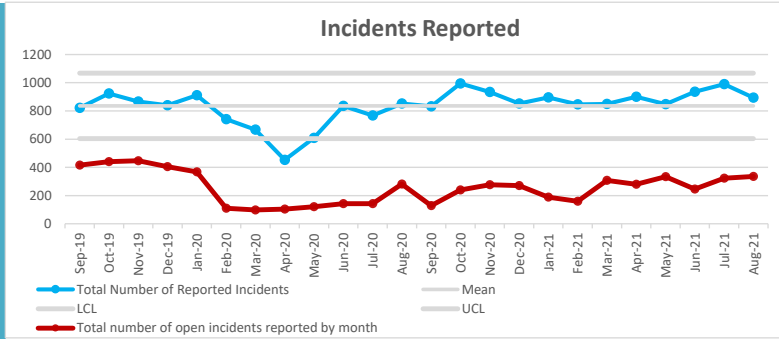
Patient Safety

SOF CQC

Incidents

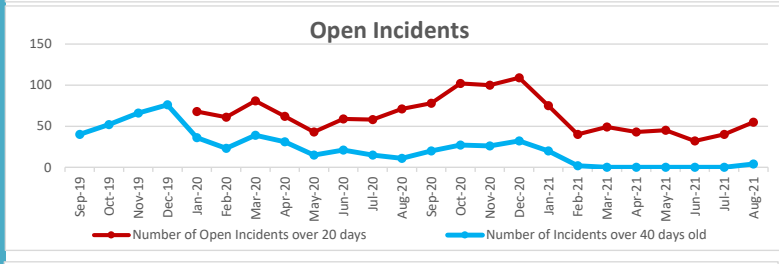
Red: Open incidents outside 40 day timeframe
Amber: Open incidents between 20 - 40 days old.
Green: Open incident within timeframe of 20 days.

There were 4 incidents open over 40 days in August 2021 across the 6 CBUs and Clinical Support Services.



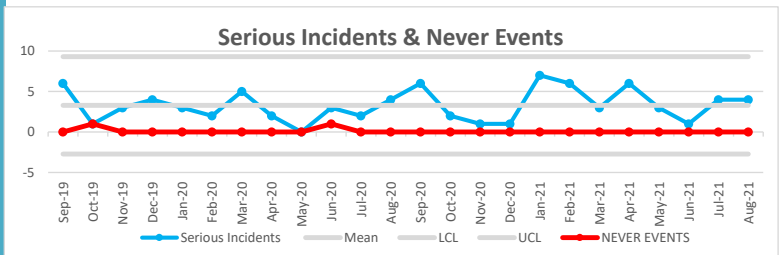
Incident reporting remains within range with minimum variance across the Trust.

The Report to Improve Campaign continues with close weekly monitoring of incident reporting at Trust, CBU and specialty level. The Governance Managers monitor the reporting of incidents daily including the levels of harm identified with escalation to the Associate Director of Governance.



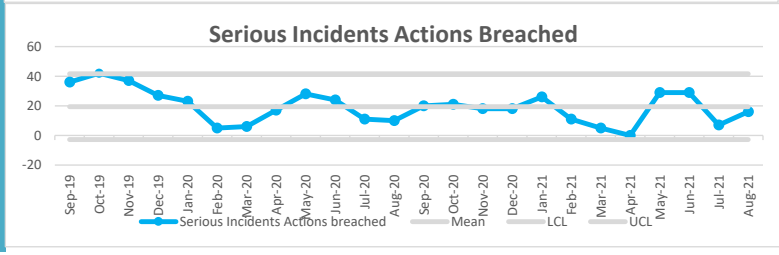
There are 4 incidents open over 40 days awaiting further evidence to close. These relates to Estates and Facilities.

Plans are in place to work toward a position of incidents to be closed under 20 days. Weekly meetings are in place with all CBUs with timely escalation to the Associate Director of Governance as required.



There is no variance in the number of Serious Incidents for August when compared to July 2021, with no themes identified.

To ensure lessons are learnt across the organisation, findings are shared via the Trust Safety Brief, speciality and CBU Governance Meetings. Learning is also shared in the format of newsletters. This is also triangulated with learning following inquests. Themes are monitored weekly by the Governance Team.



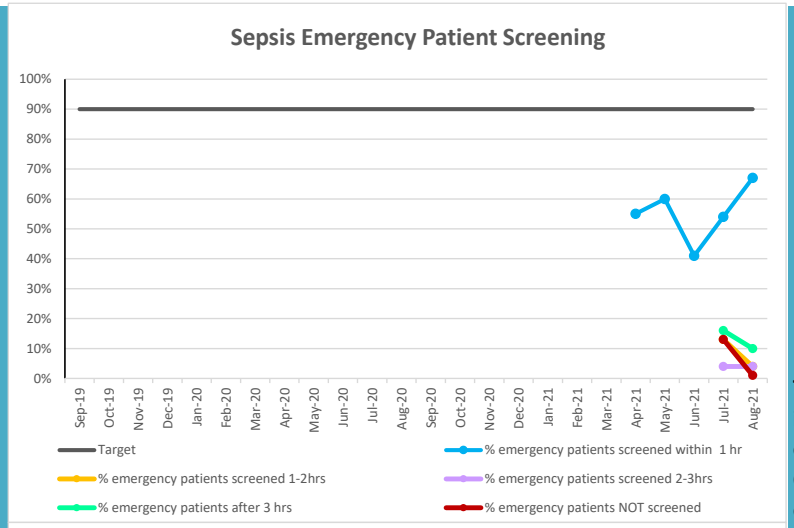
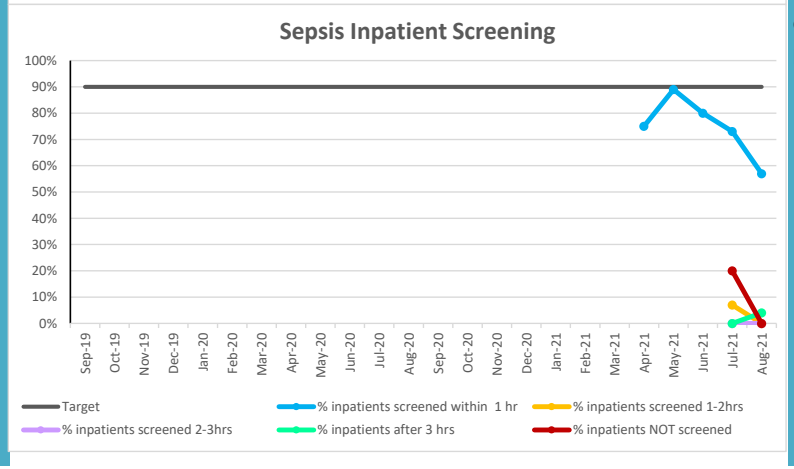
There were 16 breached serious incident actions in August 2021, compared with 7 in July 2021. This has reduced to 4 in September 2021. Variance is due to further evidence needed to close actions.

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

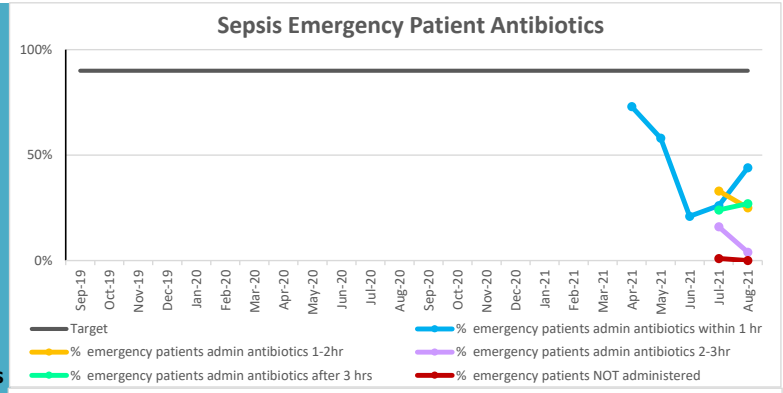
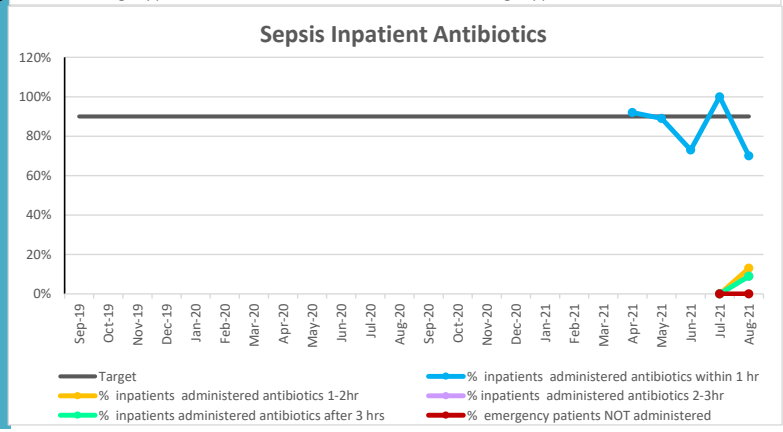
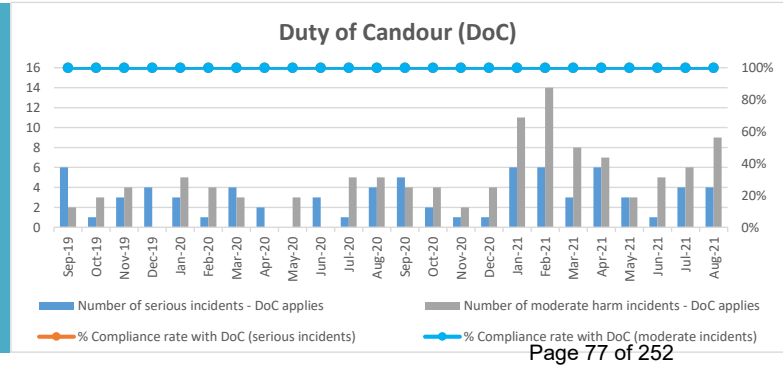
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Sepsis - % screening for all emergency patients. Red: Below 90% Green: 90% or Above	The Trust achieved: • 67.00% (78/117) for Sepsis screening for all emergency patients with suspected Sepsis within 1 hour. • 57.00% (13/23) for Sepsis screening for all inpatients with suspected Sepsis within 1 hour.		The reason for the variance in screening is due to the delay in obtaining blood cultures within the 1 hour timeframe. Obtaining blood cultures is one of two elements required for sepsis screening compliance. Attendance and acuity of patients presenting at in the Emergency Department (ED) continues to be high.	Weekly Task and Finish Group meetings continue to monitor progress against the Trust Wide Sepsis Action Plan. The clinical teams are now obtaining blood cultures at the time of cannulation which has improved compliance. The Patient Safety Nursing Team are present in ED weekly to support with sepsis education and recognition and across the Trust to support the use of the new electronic screening tool. 'Sepsis & Safety Week' will commence 13th-17th September to ensure sepsis awareness remains a priority. Work to improve the assessment of inpatients with sepsis is underway with the Acute Care Team, junior doctors, Infection Prevention and Control Team and senior ward staff.
Sepsis - % screening for all inpatients Red: Below 90% Green: 90% or Above				

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

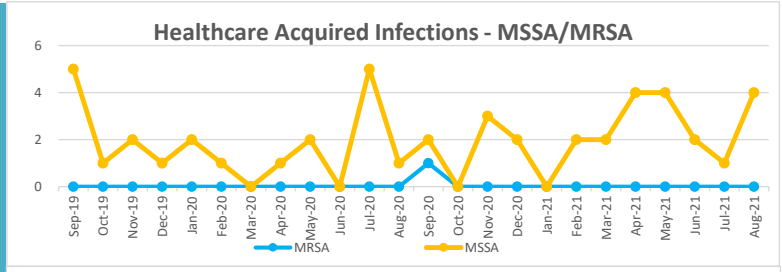
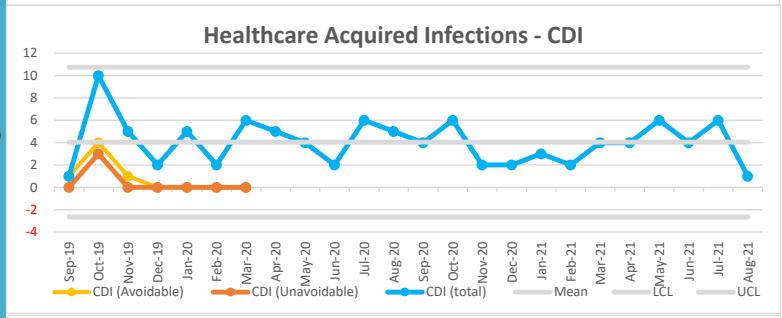
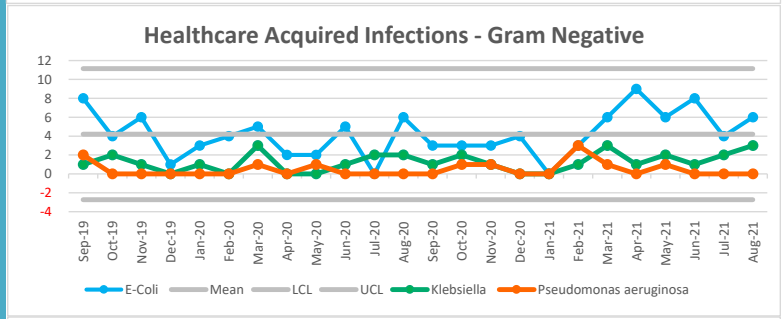
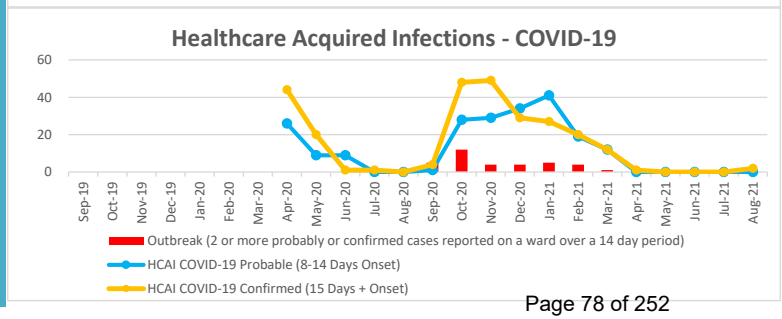
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag sepsis **Red: Below 90%** **Green: 90% or Above**	**The Trust achieved:** **• 44.00% (51/117) of emergency patients had antibiotics administered within 1 hour of a diagnosis of Sepsis being made.** **• 70.00% (16/23) of inpatients had antibiotics administered within 1 hour of a diagnosis of Sepsis being made.**	 	**The reason for the variance with administration of antibiotics is due to a combination of a delay in prescription and delay in administration of antibiotics once prescribed.**	**Weekly performance figures for antibiotic administration are shared with the Emergency Department and monitored at the Task and Finish Group. This remains a real focus for improvement across the clinical teams. A business case is in progress for pre-made antibiotics to be available in the Emergency Department to minimise any delay caused by reconstitution. There are identified staff within the Emergency Department to support sepsis management with a deteriorating patient. A focus on improvement for in patient antibiotic administration includes, reinforcing the use of the new electronic sepsis tool, teaching to medical and nursing staff and engaging the clinical education team to support the wards.**
Duty of Candour **Red: <100%** **Green: 100%**	CQC **The Trust achieved 100% for Duty of Candour in month.**		**There is no variance, the Trust remains 100% compliant.**	**Weekly scrutiny and monitoring is in place by the Patient Safety Manager and a Duty of Candour Policy has been ratified.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework (SOF) | Risk Register (RR1275) | Care Quality Commission (CQC) | Trust Strategy (S)

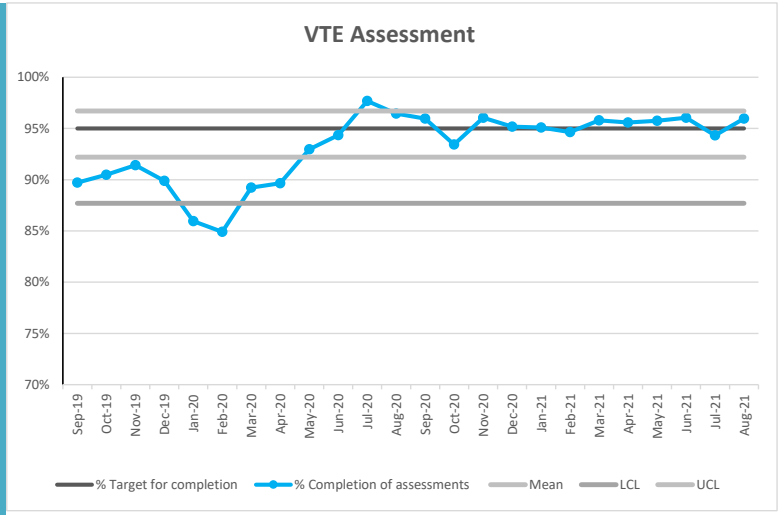
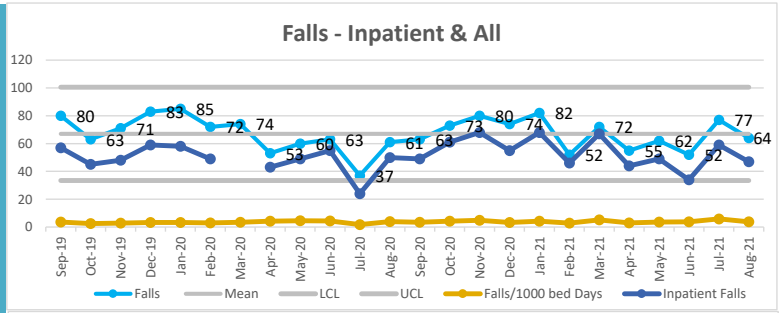
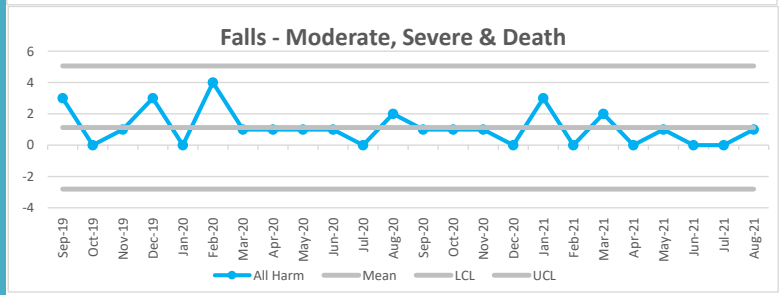
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Healthcare Acquired Infections MRSA Red: 1 or more Green: 0	In August 2021, the following cases were reported across the Trust: CDI – 1 cases - 21 Cases YTD E-Coli – 6 cases - 33 cases YTD Klebsiella – 3 cases - 9 cases YTD MRSA - nil cases MSSA – 4 cases - 15 YTD Pseudomonas aeruginosa - nil cases - 1 case YTD Covid-19 15+ days - 3 cases. Only 1 case was reported externally as the other patients were reported asymptomatic. There were 2 hospital onset probable healthcare associated cases in August 2021.		The change in the apportionment standard has increased the number of GNBSI (Gram Negative Bloodstream Infection) cases apportioned to the Trust.	Action plans are in place for the prevention of all HCAIs (Healthcare Acquired Infections). The GNBSI Reduction Group is established with 7 wards engaged in phase 1. Focus areas include hydration, continence management, care of urethral catheters, hand hygiene and UTI detection and management. A series of events are in progress to launch the National Catheter Passport.
Healthcare Acquired Infections C-Difficile Red: 44+ per annum Green: Less than 44 per annum				
Healthcare Acquired Infections - Gram Negative E-Coli Red: 81+ per annum Green: Less than 81 per annum Pseudomonas aeruginosa & Klebsillea - No Threshold Set				
Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks			Continuing global COVID-19 pandemic with high local prevalence per 100,000/ 7-day rate.	Learning from COVID-19 RCA (Root Cause Analysis) investigations has been shared at CBU level with drill down to individual wards. Action plans are in place to address findings including missed screening, length of stay, multiple ward moves, environmental hygiene, IPC (Infection Prevention & Control) training compliance and PPE (Personal Protective Equipment) compliance. Robust processes are in place for COVID-19 admission, day 3 and day 5 testing with IPC guidance on isolation and PPE.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework (SOF) | Risk Register (RR118)
Care Quality Commission (CQC) | Trust Strategy (S)

Quality Improvement - Trust Position

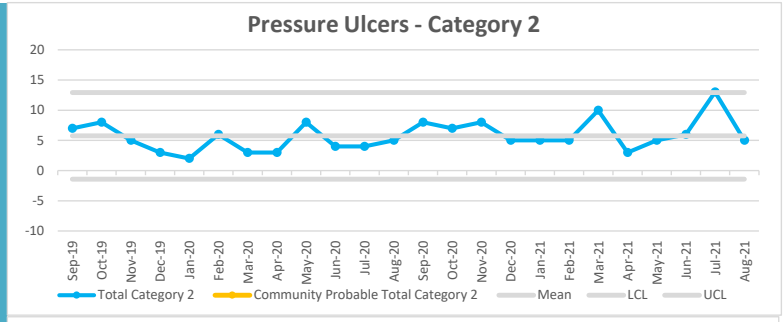
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
VTE Assessment Red: <95% Green: 95% or above based on previous months' figures due to timescales for validation of data	The Trust achieved 95.30% for VTE assessments on average in Q1 2021/22.		The Trust achieved 95.96% for VTE assessments in August 2021. The quality standard has been achieved this month; however this indicator is reported as a quarterly position.	Ongoing work is in place with the clinical teams to improve VTE compliance. Missing VTE assessments in each ward area is communicated via the Trust Wide Safety Brief. Work is underway to develop an earlier alert system to improve better compliance with 14 hours target as per NICE (National Institute for Health and Care Excellence) guidance. Consistent use of a Ward Round Clinical Data Capture (CDC) forms within the Lorenzo Electronic Patient Record will further improve the future VTE compliance data following the planned migration onto the Lorenzo Cloud.
Total number of Inpatient Falls & harm levels Red: <10% decrease from 19/20 Amber: 10-19% decrease from 19/20 Green 20% or more decrease from 19/20	There were 64 total falls reported, 47 of those were inpatient falls. 1 fall which resulted in harm was reported.	 	Falls prevention remains a constant focus across the Trust. The number of falls remains within normal variation.	Weekly falls meetings reinforce preventative measures to address immediate issues. The Trust Wide Safety Brief highlights falls awareness and learning. The Falls Collaborative Quality Improvement Programme continues with 10 wards focussing on tests of change which has seen an overall reduction in falls on the innovation wards.

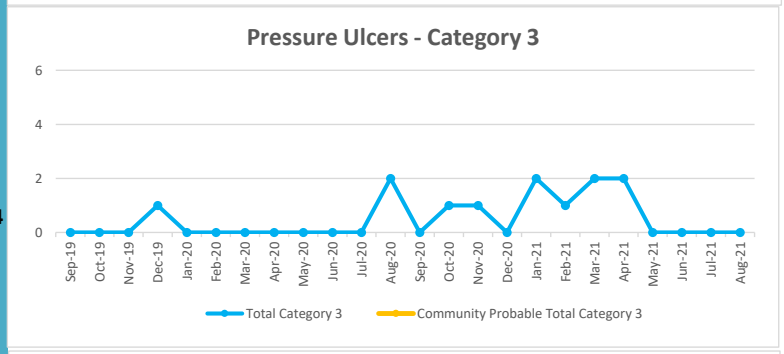
Warrington and Halton Teaching Hospitals NHS Foundation Trust

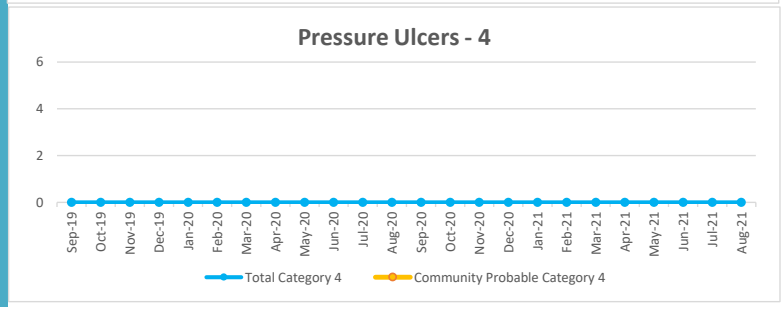
Key:
Single Oversight Framework (SOF) | Risk Register
Care Quality Commission (CQC) | Trust Strategy

Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Pressure Ulcers Based on 65 in 2019/20 Red: 4% reduction or below Amber: 5%-9% reduction Green: 10% reduction or above.	CQC There were 5 hospital acquired category 2 pressure ulcers in August. This is a 61.53% reduction from the previous month. There were no category 3, 4 or unstageable pressure ulcers in August.	The delay in obtaining pressure relieving equipment has been noted as a contributory factor for the number of pressure ulcers, as has the use of devices. Prolonged length of time on ED trolleys has also been identified as a factor.	Close monitoring of action plans continues in areas of higher prevalence. Specific pressure relieving equipment has been ordered for trolleys in the Emergency Department to reduce skin damage. The Quality Improvement Programme continues with ward manager/matron support. Learning from incidents is shared across the Cheshire and Mersey Tissue Viability Steering Group, with attendance from WHH. An Orthotic/Orthopaedic Observation Chart has now been introduced Trust wide following a successful evaluation on Ward A6.



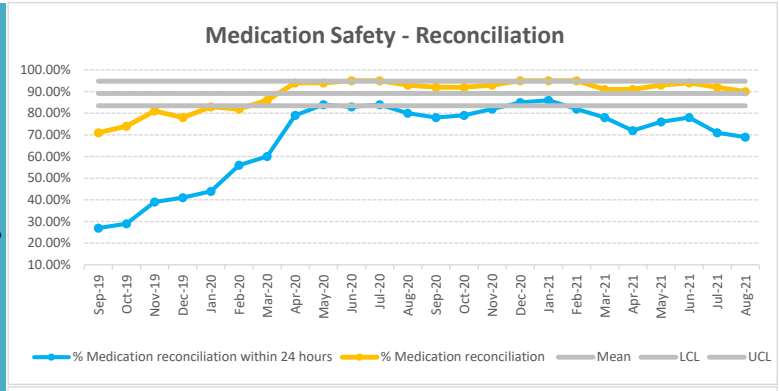
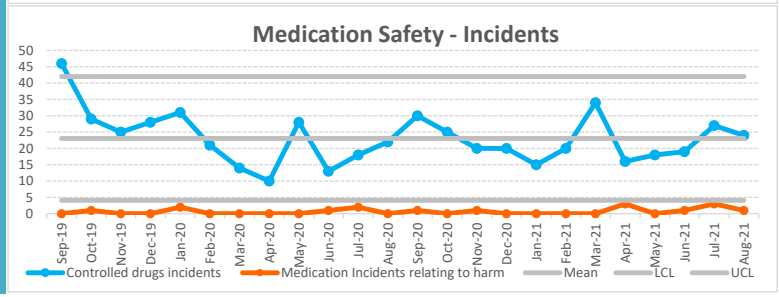
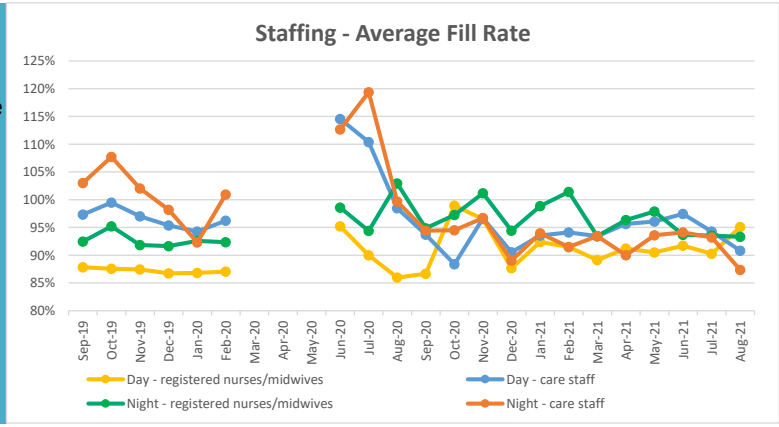




Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

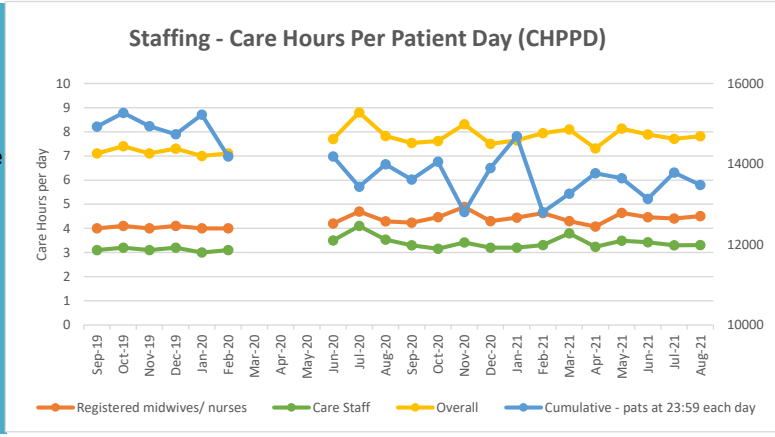
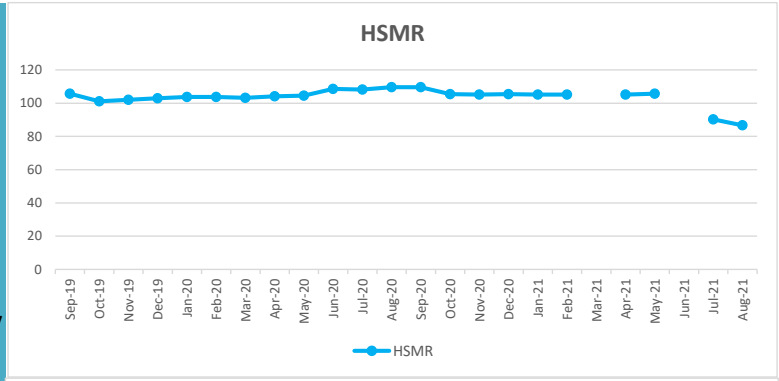
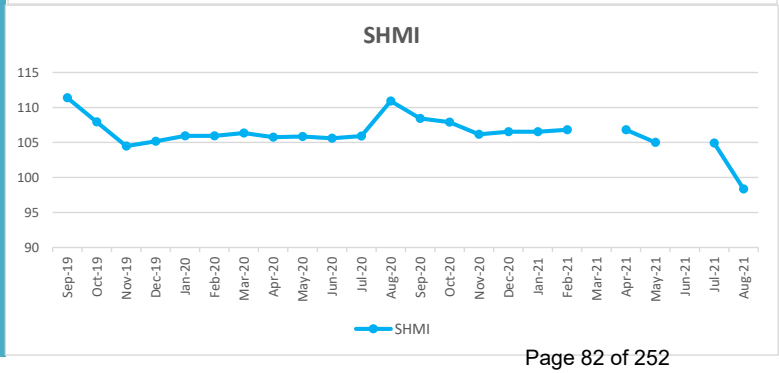
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Medication Safety Reconciliation within 24 hours Red: below 60% Amber: 60% - 79% Green: 80% or above	S The Trust achieved 69.00% for medicines reconciliation within 24 hours and 90.00% for overall medicines reconciliation. There was 1 incident reporting harm. There were 24 controlled drug incidents, this is within usual variance.	 	Quarterly CD (Controlled Drug) audits were completed in August/September. Discrepancies identified by Pharmacy staff are escalated via completion of a DATIX.	Pharmacy recruitment is complete, and staff are in post, undergoing training and competency assessment. A business case for a pharmacy service to ED is under development which will significantly impact positively on medicines reconciliation levels. All incidents are reviewed to assess whether harm has occurred, derive learning and improvement and need for safety communications. Ward based medicines safety champions have attended training (August 2021) on safe and secure medicine storage and CD standards presented by the Deputy Chief Pharmacist (Clinical Services and Medicine Safety).
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	RR115 RR1108 In August 2021, the average staffing fill rates were: Day (Nurses/Midwife) 95.1% Day (Care Staff) 90.81% Night (Nurses/Midwife) 93.33% Night (Care Staff) 87.35%		16 of the 21 wards reported staffing levels over 90.00% in August 2021. Additional beds in use across the Trust and increased staff absence due to COVID-19 related reasons remains a driver for variation.	Staffing is reviewed twice daily by the senior nursing team and acuity and activity are monitored to ensure safe patient care at all times. All wards have senior nurse oversight by a matron and lead nurse. The recruitment of 96 international nurses along with full recruitment to health care assistant vacancies ensures consistent fill rates.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Staffing - Care Hours Per Patient Day (CHPPD) Red: Below 6.0 Amber: 6.0 - 7.8 Green: 7.9 or More	RR115 RR1108 In August 2021, the average CHPPD were: Nurse/Midwife: 4.5 hours Care Staff: 3.3 hours Overall: 7.8 hours		A small increase is noted in CHPPD for August as sickness absence has improved in month.	Ward staffing levels continue to be systematically reviewed, which includes planned versus actual staffing levels and the overall staffing plans are on track. A Trust wide SOP (Standard Operating Procedure) is in place to support the return of COVID-19 exposed staff following risk assessment.
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	CQC SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 86.97. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 98.36	 	No variation. HSMR and SHMI remain within expected range.	Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning. The Trust's Mortality Lead post has now been recruited to in order to support with the learning from deaths agenda.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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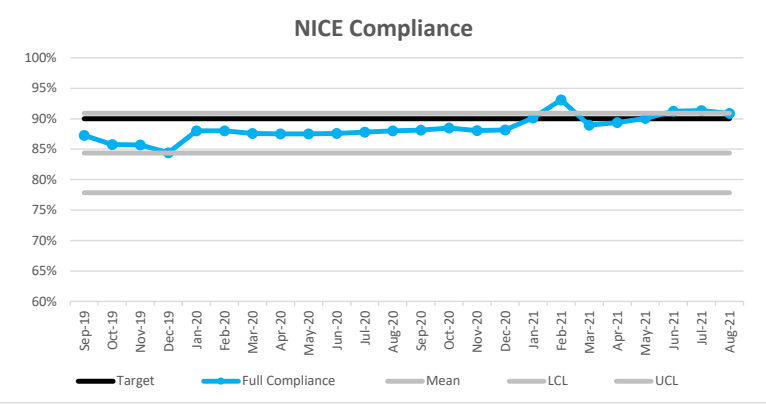
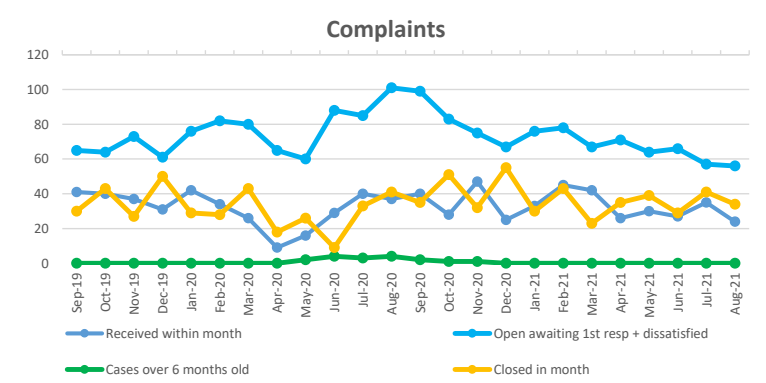
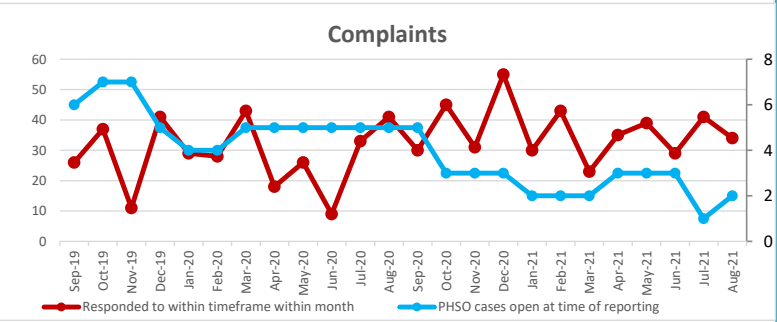
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
NICE Compliance Red: Below 75% Amber: 75% to 89% Green: 90% or Above	SOF The Trust achieved 90.86% in month.		The Trust has maintained compliance against the trust's target of over 90.00%.	The position is monitored and reviewed at CBU governance meetings. Clear escalation processes are in place.

Patient Experience

Complaints Red: Complaints over 6 months old/69% or less responded to within the timeframe Amber: No complaints over 6 months old, 70% - 89% responded to within the timeframe Green: No backlog, 90% responded to within the timeframe.	In August 2021, 24 new complaints were received to the Trust which was an increase of 8 from the previous month. There was 1 dissatisfied response received, which was the same when compared to the previous month. This has however decreased since April 2021 (4 noted in April). S	 	The Trust increased its performance in the timeliness of responding to complaints. There are no complaints over 6 months old.	A named complaint lead for each CBU has supported with strengthening complaints response timeliness and response quality. A key drive has been on local resolution meetings with families/patients to enhance the patient experience.

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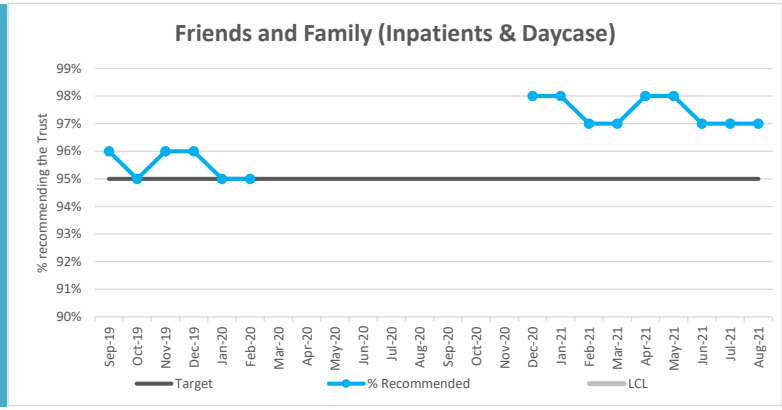
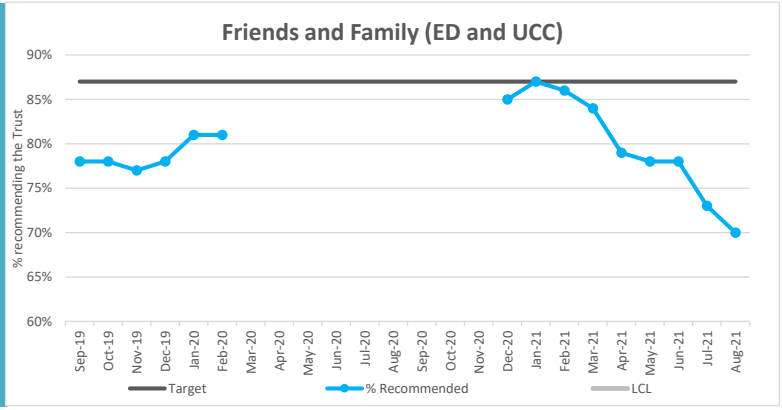
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	SOF CQC S The Trust achieved 97.00% in month.		The Trust achieved 97.00% positivity rate in August 2021.	The Trust continues to receive positive responses through the FFT (Friends & Family Test). Any variation is addressed locally and monitored through the Patient Experience Sub-Committee.
Friends and Family (ED and UCC) Red: Less than 87% Green: 87% or more	SOF CQC S The Trust achieved 70.00% in month.		The Trust achieved 70.00% positive feedback in friends and family test results. The reason for the variance against the target is largely related to patients experiencing longer waits in the Emergency Department.	An Emergency Department Response Group has been developed to improve flow and patient experience within the Emergency Department and subsequent in-patient stay across the organisation. Emergency Department staff ensure clear communication with patients to explain any delays. It is pertinent to highlight the dip in positive recommendations is in line with other hospitals within Cheshire and Merseyside with the lowest score at 58% and highest at 83%.

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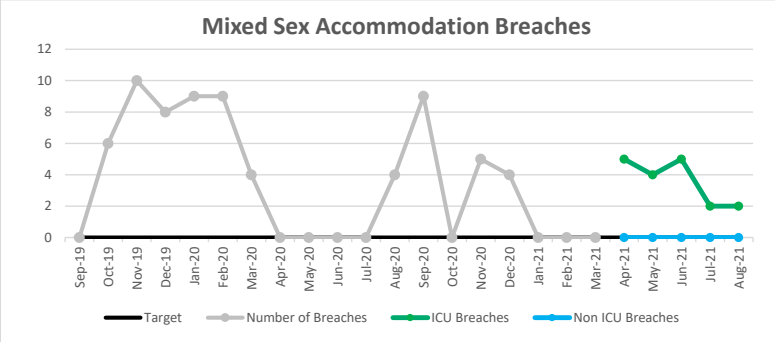
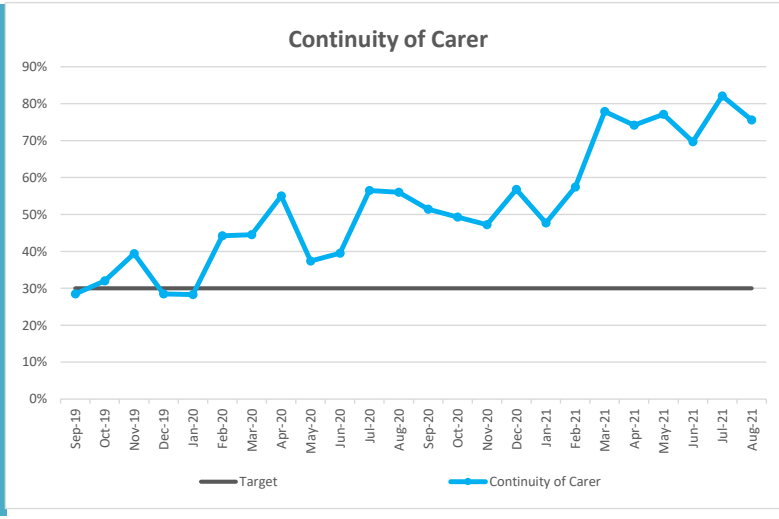
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Mixed Sex Accommodation Breaches (Non ITU Only) Red: 1 or more Green: Zero	SOF There were 2 mixed sex accommodation incidents during August 2021. All breaches occurred in Intensive Care Unit.		There were 2 mixed sex accommodation breaches reported in August 2021 in the Intensive Care Unit, due to the increased activity across the Trust resulting in less bed availability. There were zero breaches within any other ward area.	Patients are cohorted within the Intensive Care Unit to minimise breaches. Patients who are due to step down from the Intensive Care Unit are tracked and prioritised in the regular patient flow meetings. Any delays are escalated via 'silver command'.
Continuity of Carer Green: 51% or Above Amber: 35% - 50% Red: below 35%	In August 2021, 100% of Warrington women are booked onto a Continuity of Carer pathway (CoC), if 'out of area' bookings are included the position is 75.60% as we cannot provide the postnatal aspect of the pathway.		The Trust achieved 75.60% onto a CoC pathway (including intrapartum care) in August 2021. This is a decrease in total women on a CoC pathway due to an increased proportion of out of area women being booked for care at WHH as WHH cannot provide the full CoC for out of area women.	New care new models have been developed by the CBU to enable delivery of 100% against the continuity of carer standard for in-area women. To meet the criteria of Better Births (which includes limits on team size and considerably lower caseload numbers than the traditional model of community midwifery), the requirement for additional staffing was identified and a business case was approved. Staff are now in post and completing their supernumerary and orientation period.

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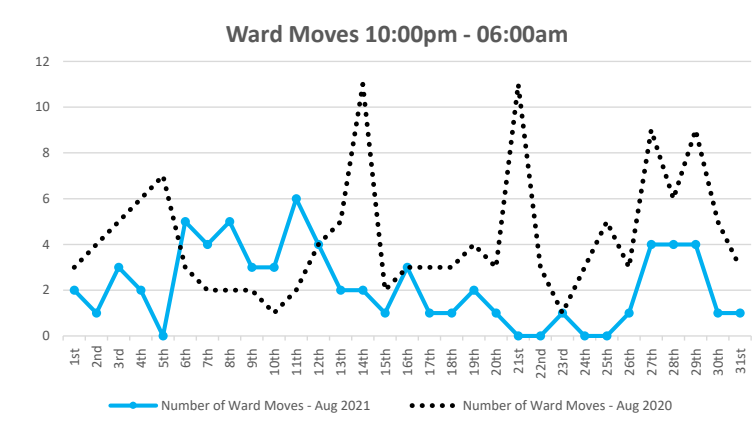
Quality Improvement - Trust Position

	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)?
Ward Moves between 10:00pm and 06:00am	There were a total of 67 ward moves between 10pm-6am in August 2021 compared to 133 in August 2020.		The reason for the reduction on ward moves after 10pm for this reporting period compared to last year is as a result of the out of hours patient flow and senior manager on call minimising non-essential clinical patient moves.	Increased focus on the reduction of non-essential clinical patient moves at night is part of the improvement workstreams in relation to patient flow.

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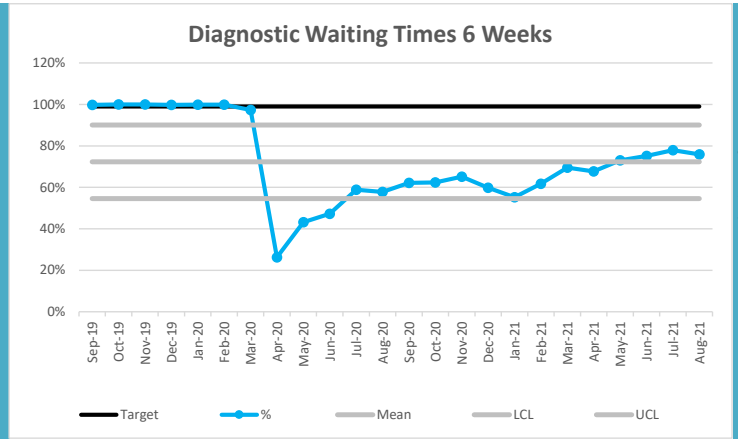
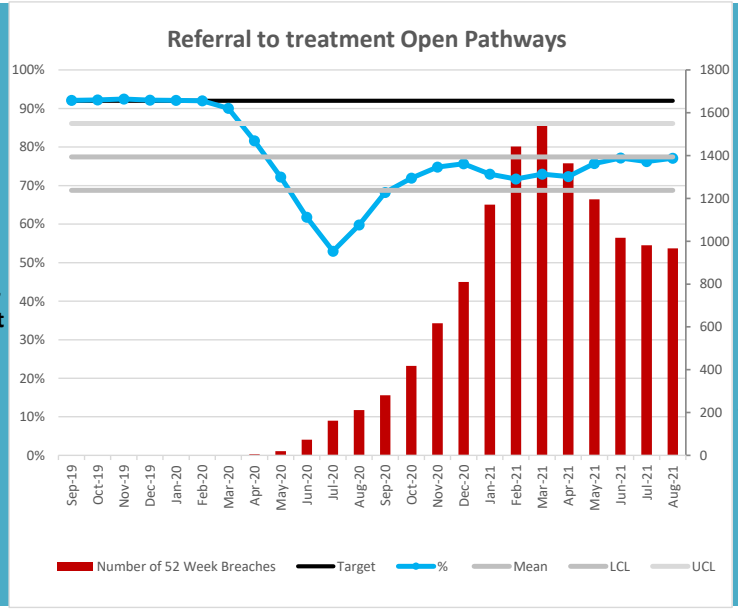
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Diagnostic Waiting Times 6 Weeks **Red: Less than 99%** **Green: 99% or above**		**The diagnostic standard was not achieved in August 2021, this was due to the impact of the COVID-19 pandemic. The position continues to be manged in line with the recovery trajectory.**	**A recovery plan has now been agreed and patients are being clinically prioritised accordingly in line with national guidance. The recovery plan is demonstrating that the actions agreed are delivering recovery with fewer breaches recorded as services are brought back on-line. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although there has been good progress in radiological modalities, challenges remain in Endoscopy, Cardiorespiratory, Cystoscopy and CT.**
The Trust achieved 75.96% in month.			
Referral to treatment Open Pathways **Red: Less than 92%** **Green: 92% or above**		**RTT performance in August achieved 77.08% this is an increase of 0.86% from July. Elective activity for all priority group patients has been maintained on site and with support from the independent sector. The number of patients waiting 52 weeks + at the end of August was at 967 which is better than trajectory.**	**Recovery of the elective programme is taking place with:** **• Urgent cancer and elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of vulnerable patients.** **• Elective capacity has been restored at the Halton Elective Centre and Captain Sir Tom Moore Centre.** **• The Trust continues to utilise Independent Sector Capacity.** **• Restoration and recovery plans for 2021/22 have been drawn up in line with Operational Planning Guidance.**
RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red			
The Trust achieved 77.08% in month. There were 967, 52 week breaches in August 2021.			

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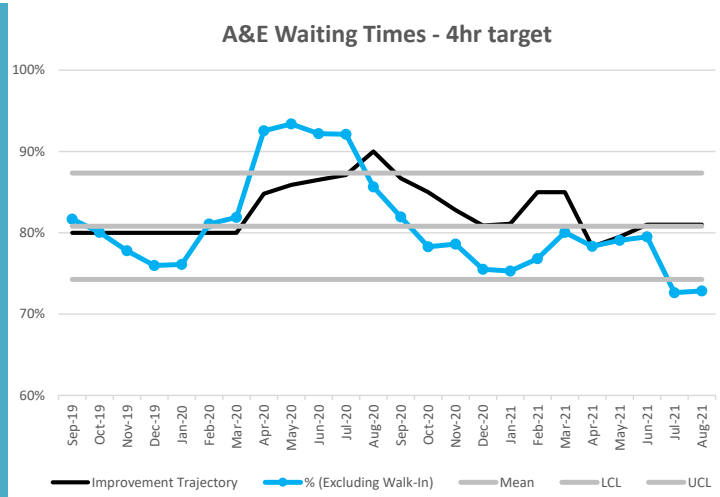
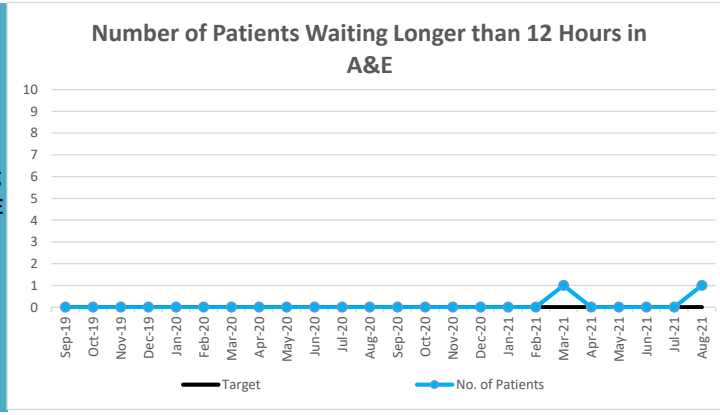
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Four Hour Standard - National Target Red: Less than 95% Green: 95% or Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory	SOF CQC The Trust achieved 72.84% excluding walk ins in month. RR224 RR1125		There was a slight increase in performance in Type 1 activity achieving 72.84% in August (excluding Widnes Walk-in activity). This is attributable to the ongoing impact of the pandemic and a significant growth in Urgent Care attendances in the Emergency Department. This trend is being seen across Cheshire and Merseyside.	• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity to support flow. • An ED recovery group has been established to support demand management and deflection from site. • Additional beds remain open on the Halton site to support bed capacity and flow.
The 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 was 1 patient waiting longer than 12 hours in A&E in month.		There was 1 patient who waited longer than 12 hours in the Emergency department, this patient was undergoing specialised monitoring and was subsequently transferred to another Trust for on-going treatment.	The Trust will continue to monitor and manage compliance around the 12 hour standard.

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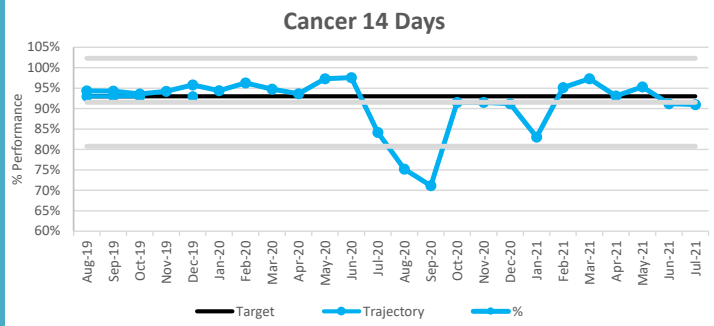
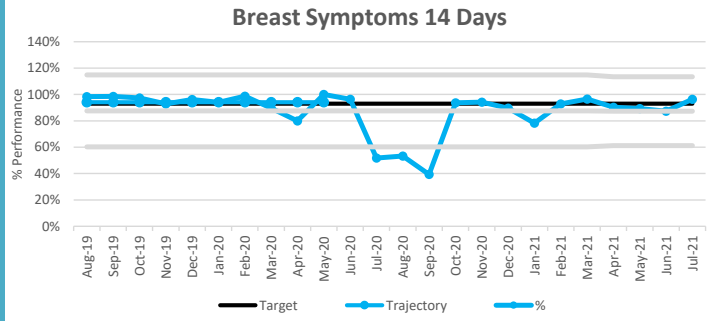
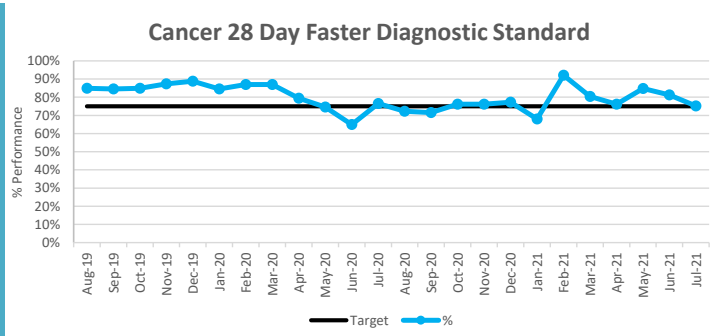
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 14 Days Red: Less than 93% Green: 93% or above SOF CQC RR1125 **The Trust achieved 90.98% in July 2021.**		**The Trust did not achieve the 2 Week Wait standard in July 2021. The position continues to be challenged by the availability of capacity due to COVID-19.**	**The Trust will continue to review capacity with clinical service restoration plans to support ongoing compliance against this standard.** **Performance against this standard is monitored via the Performance Review Group (PRG), the KPI sub-committee and the Clinical Services Recovery Oversight Group (CSOG).**
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above SOF CQC RR1125 **The Trust achieved 96.43% in July 2021.**			
28 Day Faster Cancer Diagnosis Standard Red: Less than 75% Green: 75% or above **The Trust achieved 75.25% in July 2021.**		**The Trust continues to participate as the test site for the 28 day Faster Diagnosis standard as part of the clinical review of all cancer access standards. The Trust achieved the standard in July 2021 with 75.25% against a target of 75.00%.**	**The Trust will continue to maintain improvement against the FDS clinical review of standards pilot.**

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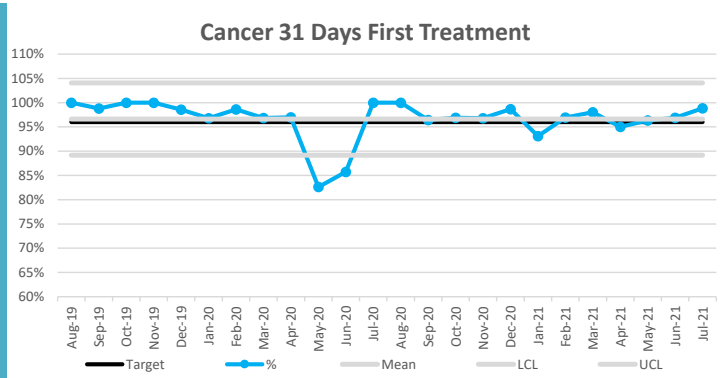
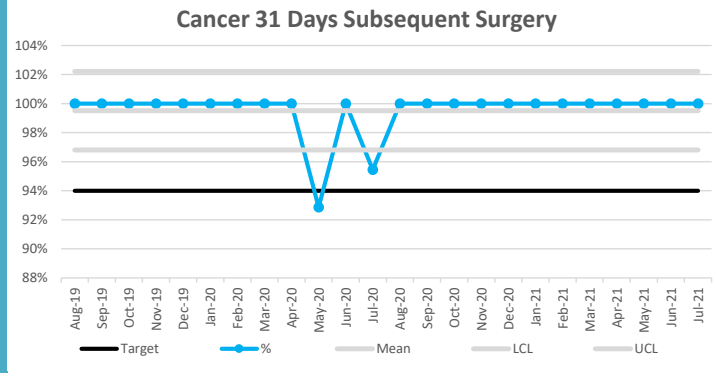
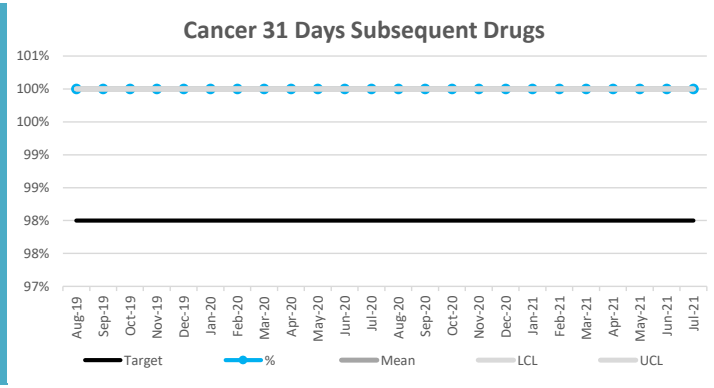
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	SOF CQC The Trust achieved 98.86% in July 2021. RR1125		The 31 day cancer target was achieved in July 2021 at 98.86% (First Treatment) and 100% (Surgery).	There remains a risk for performance due to the impact of the pandemic. Capacity is being reviewed in line with clinical service restoration plans.
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	SOF CQC The Trust achieved 100% in July 2021. RR1125			
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	SOF CQC The Trust achieved 100% in July 2021. RR1125		The Trust achieved 100% in July 2021.	Maintain compliance against the 31 day subsequent treatment (drug) standard.

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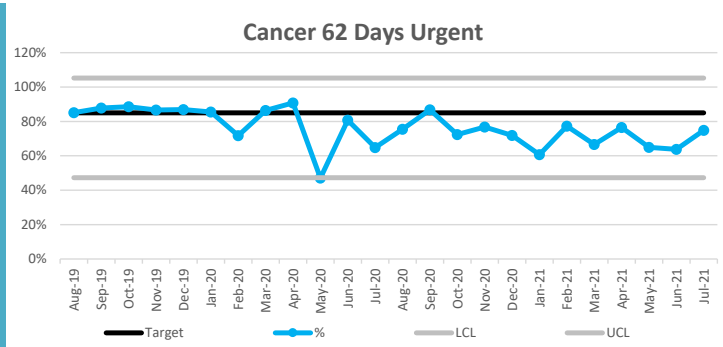
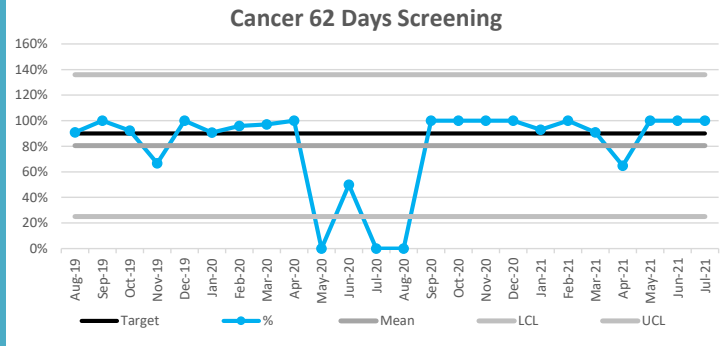
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 62 Days Urgent **Red: Less than 85%** **Green: 85% or above**	**The Trust achieved 74.77% in July 2021.**		**The 62 day urgent target was not achieved in July 2021 at 74.77%. The Trust is meeting the agreed Trajectories for improvement as agreed by the Cheshire and Merseyside Cancer Alliance. The Trust did achieve the 62 day screening standard at 100%.**	**There remains a risk for performance due to the impact of the pandemic.**
Cancer 62 Days Screening **Red: Less than 90%** **Green: 90% or above**	**The Trust achieved 100% in July 2021.**			

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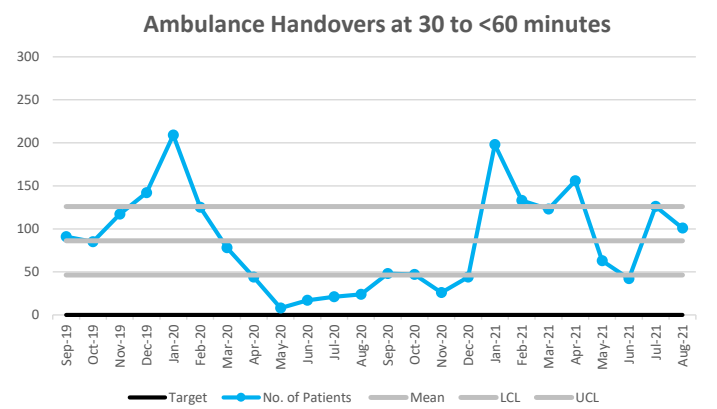
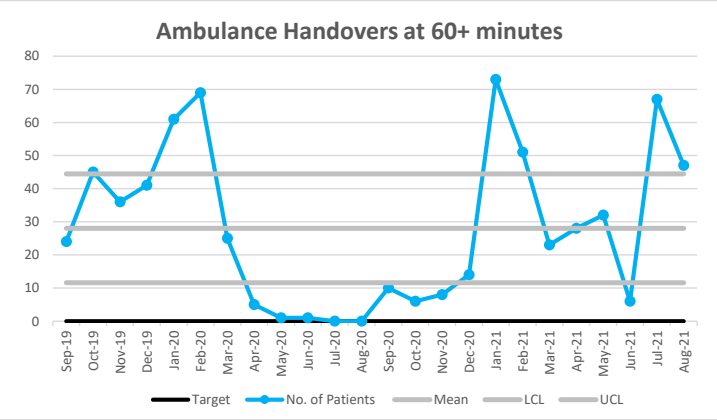
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Ambulance Handovers 30 to <60 minutes **Red: More than 0** **Green: 0** **There were 101 patients who experienced a delay in Ambulance Handovers between 30 to 60 minutes in month.**		**Handover performance has improved following the improvement collaborative with the North West Ambulance Service (NWAS).**	**In May 2021, the Trust began a service improvement collaborative with NWAS to improve ambulance handover waiting times. The Trust will continue to work in partnership with the NWAS to identify and implement improvements.**
Ambulance Handovers at 60 minutes or more **Red: More than 0** **Green: 0** **There were 47 patients who experienced a delay in Ambulance Handovers over 60 minutes in month.**			

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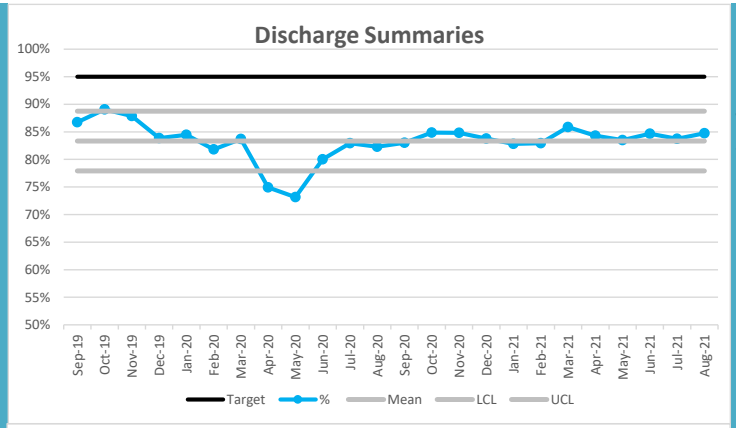
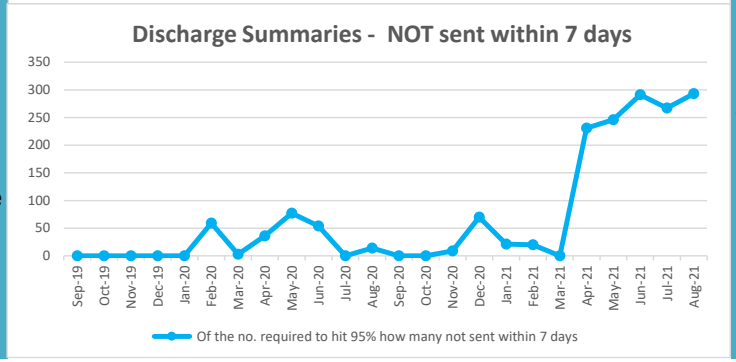
Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Discharge Summaries - % sent within 24hrs **Red: Less than 95%** **Green: 95% or above**	**The Trust achieved 84.75% in month.**		**There has been a sustained improvement in the number of discharge summaries sent within 24 hours. Performance is returning to pre COVID-19 levels. However the standard remains a focus of the CBUs. There is weekly scrutiny at the PRG and monthly at the KPI meeting.**	**The Performance Review Group (PRG) continues to monitor this standard to support improvements.**
Discharge Summaries - Number NOT sent within 7 days **Red: Above 0** **Green: 0**	**There were 293 discharge summaries not sent within 7 days required to meet the 95.00% threshold.**		**The step change in compliance from April 2021 was as a result of a review and update of the specialties included in the report. Care Groups are reviewing compliance with a request for recovery plans to be put in place.**	

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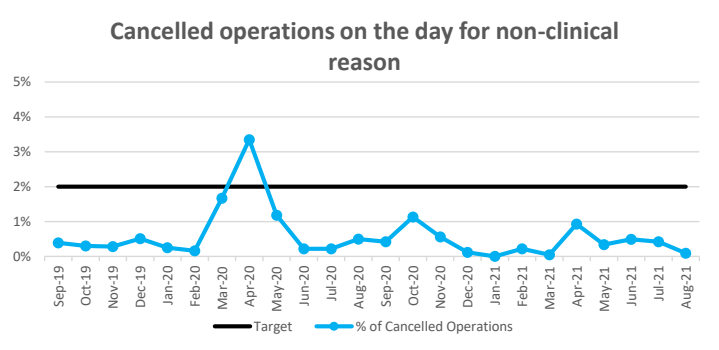
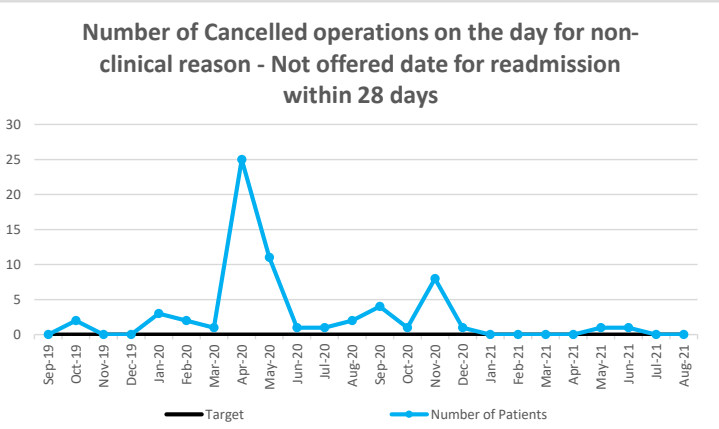
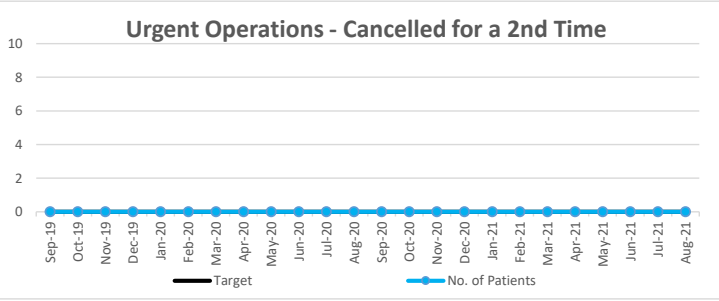
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancelled Operations on the day for a non-clinical reason Red: > 2% Green: < 2%	CQC 0.09% of operations were cancelled on the day for non clinical reasons in month.		Compliance against this standard remains below the monitored threshold of 2.00% (positive).	Recovery of elective activity continues to be monitored via the Clinical Services Recovery Oversight Group (CSOG).
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	There was 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.

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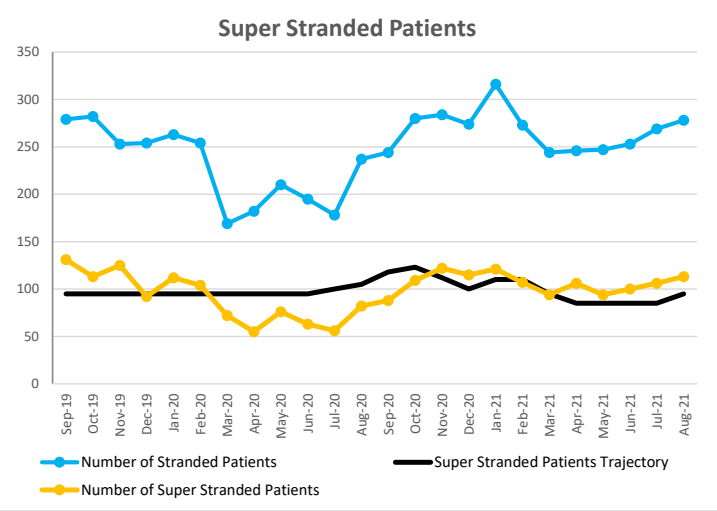
Single Oversight Framework
Care Quality Commission

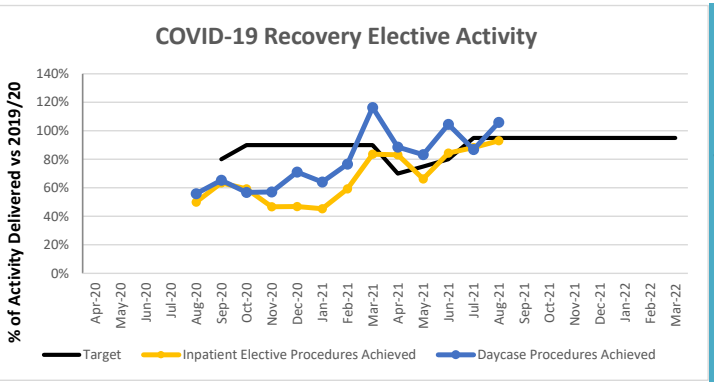
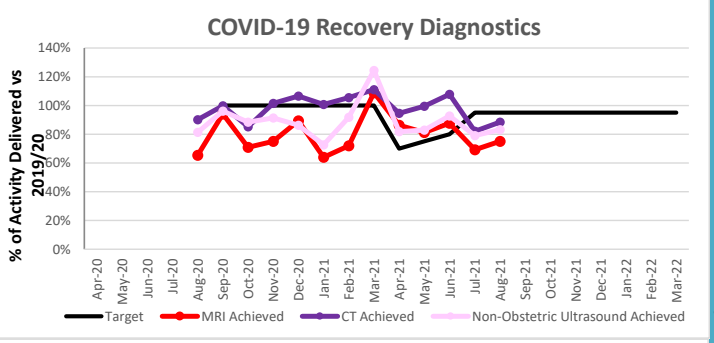
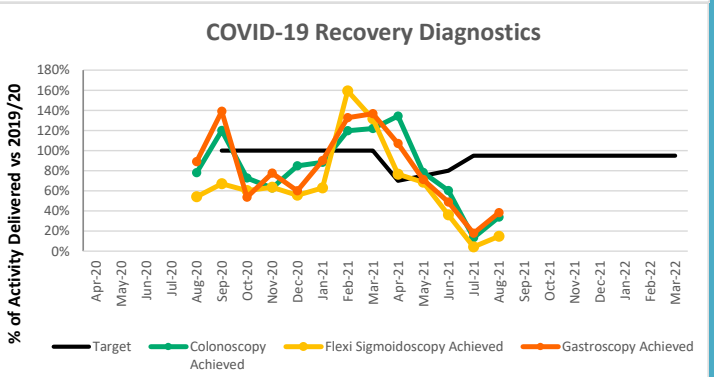
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Super Stranded Patients Green: Meeting Trajectory Red: Missing Trajectory	There were 278 stranded and 113 super stranded patients at the end of August 2021.		The number of Stranded and Super Stranded patients in the organisation is increasing. This is in part a reflection of delays and shortages in domiciliary care and intermediate care at home offers.	The Trust is working in collaboration with partners from Local Authorities and community providers to ensure community capacity is available throughout the pandemic. The Trust has introduced "Where's best next" Length of Stay meetings on a daily basis to support timely discharge.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

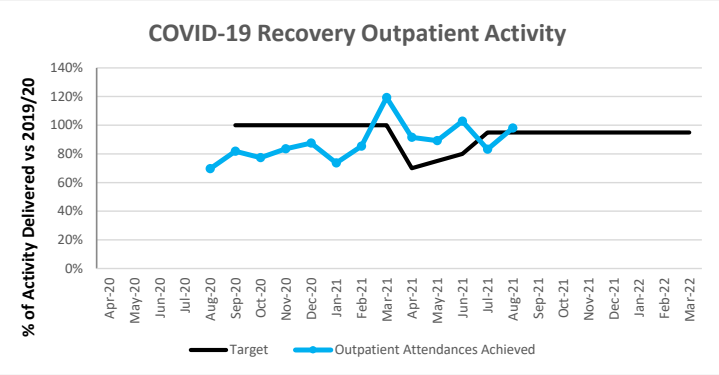
Key:
Risk Register
Single Oversight Framework
Care Quality Commission

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
COVID-19 Recovery Elective Activity RED = Below Elective Recovery Target Green = Elective Recovery Target % activity is against activity in the same month in 2019/20	In August 2021, the Trust achieved the following % of activity against August 2019 (plan adjusted). This included 106.00% of Daycase Procedures and 93.00% of Inpatient Elective Procedures.		The Trust met the aggregated elective activity recovery trajectories for August 2021.	The Trust monitors the impact weekly and will progress measures to switch services back on at the earliest opportunity based on the impact of COVID-19. The Trust actively engages and explores opportunities for mutual aid in the form of staffing, ICU and surgical capacity.
COVID-19 Recovery Diagnostic Activity RED = Below Elective Recovery Target Green = Elective Recovery Target % activity is against activity in the same month in 2019/20	In August 2021, the Trust achieved the following % of activity against August 2019 (plan adjusted). This included: 75.07% of MRI 88.40% of CT 83.19% of Non Obstetric Ultrasound	 	The Trust did not meet the diagnostic activity recovery trajectories for August 2021. Colonoscopy, Flexi Sig and Gastroscopy have started to show an improvement.	The Trust continues to restore clinical services in line with the national operating guidance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance

Trend

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

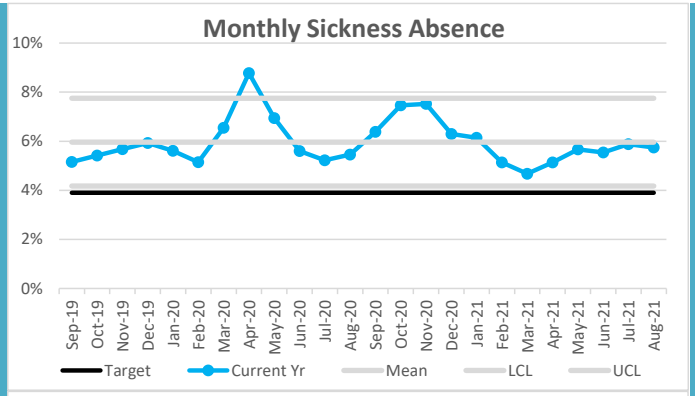
How are we going to improve the position (Short & Long Term)?

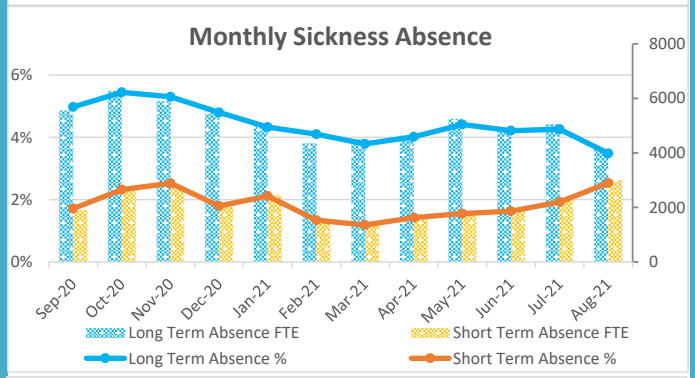
Sickness Absence

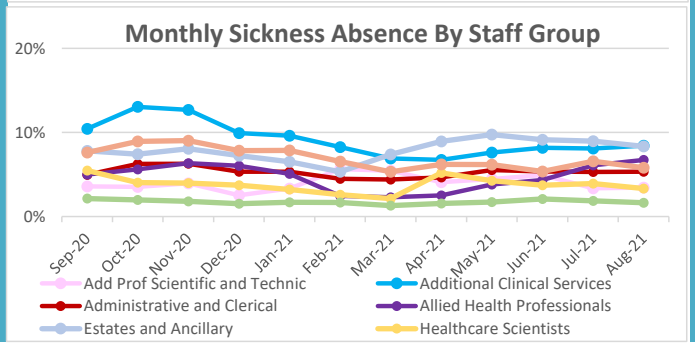
Red: Above 4.5%
Amber: 4.2% to 4.5%
Green: Below 4.2%

UoR SOF S RR200 RR1134 RR1108

The Trust's sickness absence rate was 6.05% in month.
SPC - There is evidence of special cause variation for sickness absence.







The majority of absence (3.50%) relates to long term absence.

Sickness absence in August 2020 was 6.30%.

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

Estates & Ancillary (8.30%) and Additional Clinical Services (8.44%) Staff Groups have the highest sickness absence rates.

The Trust is working in partnership with NHSE/I to explore and implement the findings of the North West Deep Dive into Sickness Absence.

Recommendations from NHSE/I will be further explored as part of the Sickness Absence Workstream, which will be enabled through a task and finish group to be set up in September 2021.

The Trust is currently working on a bid to secure additional funding from NHSE/I to further support a reduction in sickness absence in line with one or more of the recommendations referenced above.

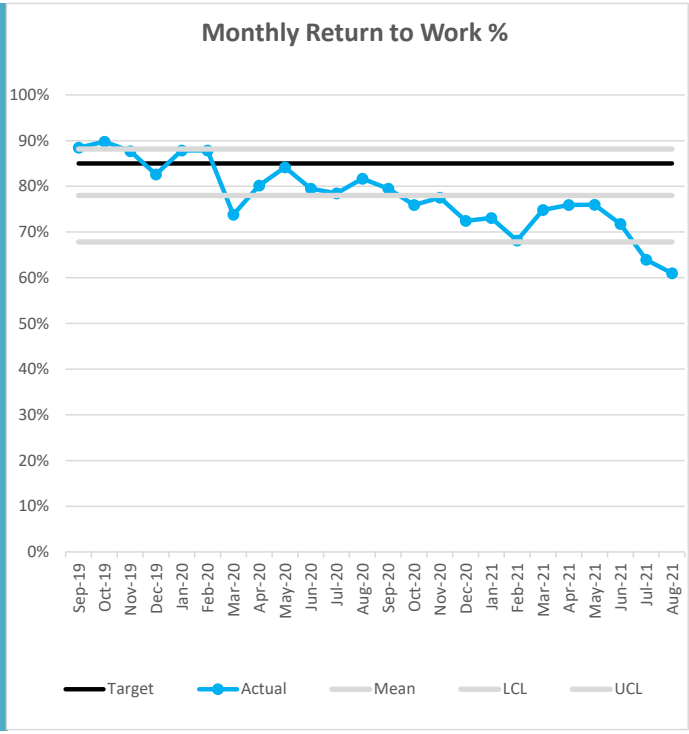
The HR Business Partner Team is providing ongoing support to operational managers in managing sickness absence.

KPI's continue to be monitored through Operational People Committee (OPC), where operational colleagues are required to provide assurance on key metrics (incl. Sickness Absence), provide plans for improving KPI's as required and sharing best practice.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

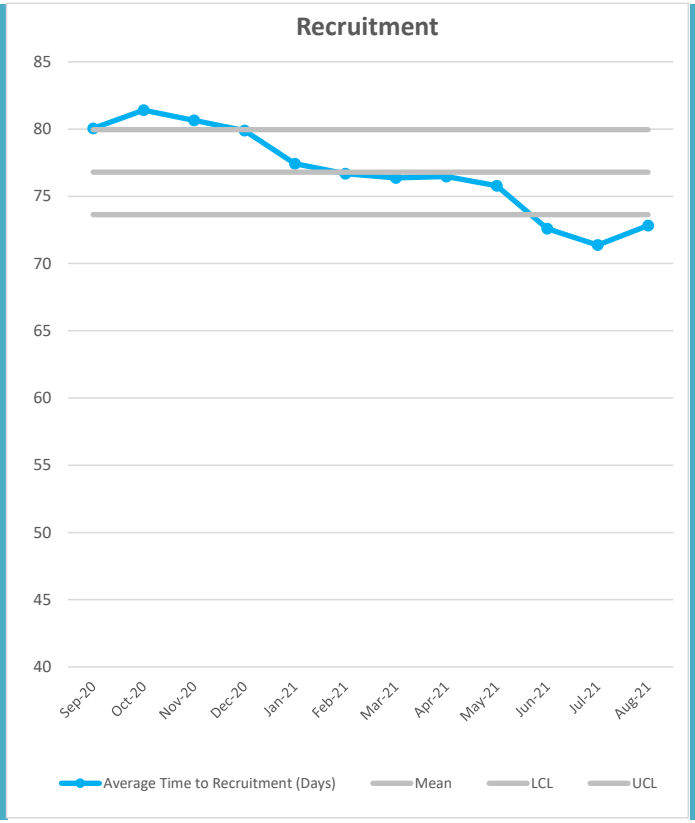
Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%		Return to work interview compliance has reduced significantly to 60.98%.	Return to work interviews remain a vital part of the support in place for our workforce. The Operational People Committee has requested plans/trajectories to demonstrate improving compliance for each CBU. Managers within Women's and Children's (as a mini pilot) have been offered a 1-2-1 RTWI briefing sessions with a member of the HR team. In these sessions the RTWI process and the recording have been discussed. There has been a high take up of these sessions within the CBU. Plans to review options to roll this out further are currently being explored. In addition, the Workforce Systems teams are arranging monthly drop-in sessions (an expansion to what is currently delivered). Part of this offer will include RTW data input demonstrations in both ESR and E-Rostering.
The Trust's return to work compliance was 60.98% in month. SPC - There is evidence of special cause variation for Return to Work compliance.			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

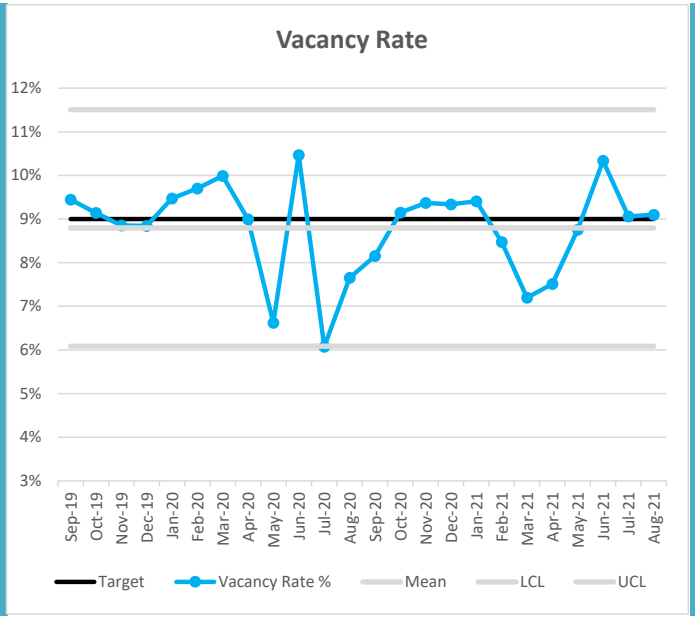
Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or below		Recruitment time to hire has continued to improve from October 2020 onwards, but slightly increased to 73 days in August 2021. This indicator includes notices periods.	A review of the time to hire took place and identified the following areas where recruitment time can be reduced: • Advert close to Interview • Pre-Employment Checks Since the review, the Recruitment team has refined their communications to recruiting managers, to both manage expectations and also support them to proactively consider their recruitment timeline. This has supported the reduction in time to hire. E-forms are still in development for the candidates to complete, which will allow them to upload copies of their ID documents. This will utilise SharePoint Online. The Trust is planning to launch this in late 2021/early 2022. Finally, the Trust has launched an Inclusive Recruitment action plan following a review, this will have an indirect impact on time to hire through raising awareness and training.
The average number of working days to recruit is 73 days, based on the last 12 months average. SPC - Recruitment time is within common cause (expected) variation.			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR **The Trust vacancy rate was 9.10% in month. SPC - there is evidence of special cause variation for Vacancy Rates.**		**The vacancy rate is just above the 9.00% target, at 9.10% in August 2021.**	**Part of this increase in workforce includes 96 international nurses since November 2020 and the Healthcare Assistants (HCA) recruitment drive.** **The Trust headcount is currently 4508, with the exception of March 2021, when the headcount included all the COVID-19 support staff (Medical and Nursing Students), this is the highest on record.**

Vacancy Rates

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

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

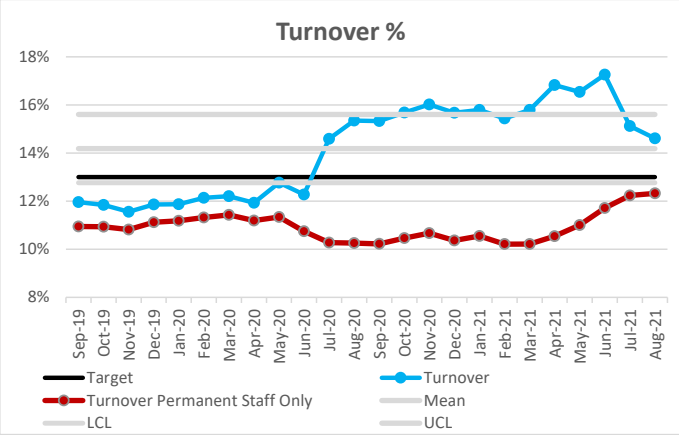
Turnover

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

CQC UoR

The Trust Turnover was 14.61% in month.
SPC - There is evidence of special cause variation for Turnover.

S SOF



Trust Turnover in August 2021 is above target at 14.61%. Turnover of Permanent staff is 12.32%.
Retention in August 2021 and is above target at 84.06% (positive). Retention of Permanent staff is 88.89%

For permanent staff only, the Trust is performing well for both Turnover and Retention.

However, because of the response to COVID-19 the Trust engaged 270 fixed term temporary staff that have both joined and left the Trust since January 2020. Therefore our overall Turnover and Retention isn't performing well against the Trust target.

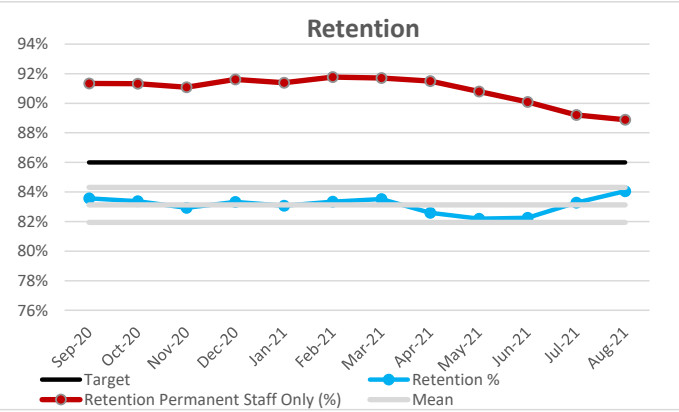
A range of work has been delivered and is on-going as part of the WHH People Strategy and the NHS People Plan to support the retention of staff, including:
- **Compassionate Leadership Development Programmes**
- **Staff networks and celebrations of diversity**
- **Promotion of flexible working**
- **Review 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 84.06% in month.
SPC - There is evidence of special cause variation for Retention.



Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance

Trend

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

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

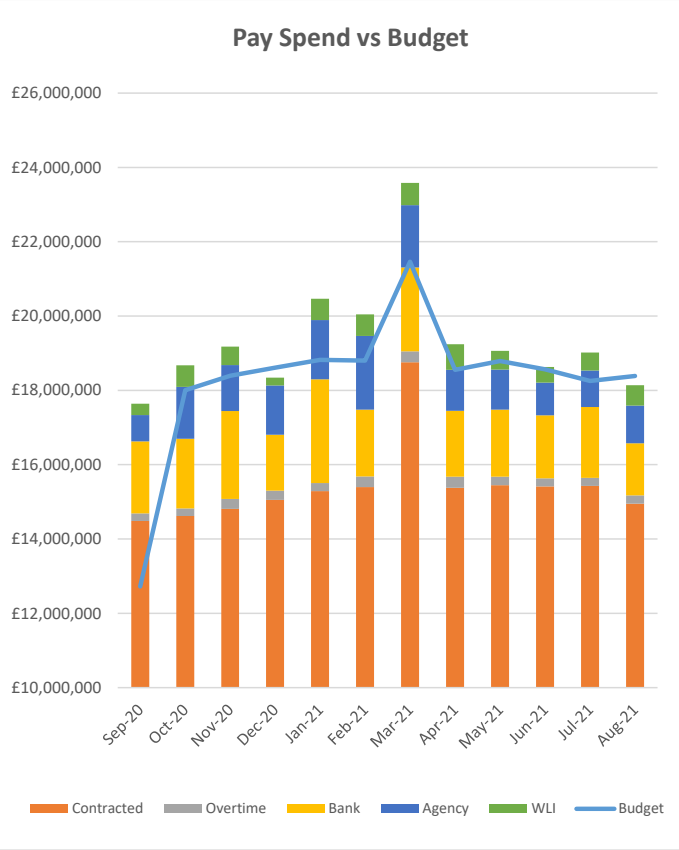
Pay

Red: Greater than Budget

Green: Less than Budget

UoR SOF RR199

Total pay spend in August 2021 was £18.39m against a budget of £18.14m.



Total pay spend in August 2021 was £18.39m against a budget of £18.14m.

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

- **£14.95m Contracted Pay (i.e. substantive staff)**
- **£1.4m Bank Pay**
- **£1.0m Agency Pay**
- **£0.55m Waiting List Initiative (WLI) Pay**
- **£0.23m Overtime Pay.**

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

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

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

The current focus is the introduction of an equivalent ECF process for Medical Bank and Agency spend.

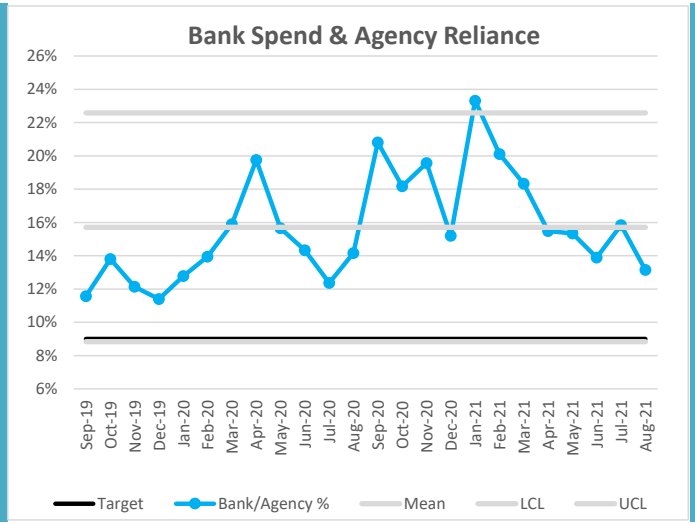
Mersey Internal Audit (MIAA) is currently conducting a WLI Audit which is due to conclude in November 2021.

The Finance & Sustainability Committee is due to sign off on a new Medical Bank Rate card to provide rate consistency across the Trust.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Bank and Agency Reliance Red: 11% or Above Amber: 11% to 9% Green: 9% or Below	UoR RR199 **Bank and Agency Reliance was 13.15% in month. SPC - Bank/Agency reliance is within common cause (expected) variation.**		**Bank and Agency reliance peaked at 23.31% in January 2021 and there has been a continued reduction since. In August 2021, reliance is 13.15% which represents the lowest percentage reliance in 13 months.**	**Processes are in place to ensure appropriate usage of temporary staffing through the ECF process and/or NHSP booking platform with the links to the roster system.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

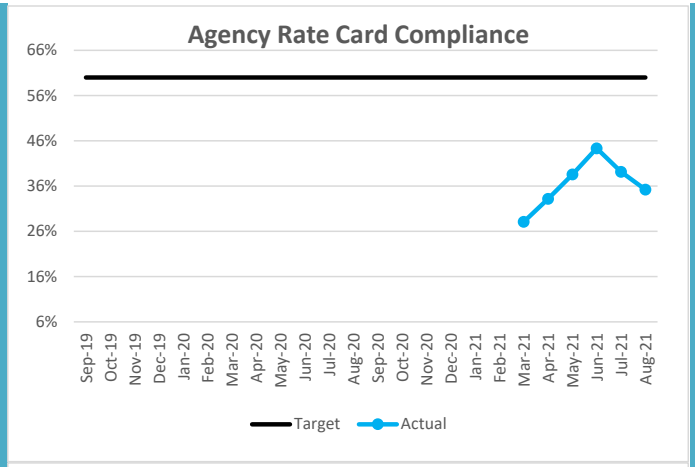
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Agency Rate Card Compliance

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

UoR

Agency Rate Card Compliance was 35.24% in month.



Compliance with the NHSE/I Pay Cap was 25.40%. In August 2021, non-compliance was highest amongst the following staff groups:

- **Medical and Dental: 98.00% above price cap**
- **Nursing and Midwifery: 85.00% above price cap**
- **AHPs: 57.00% above price cap**

Compliance with the Cheshire and Merseyside rate card was 35.24% in August 2021.

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

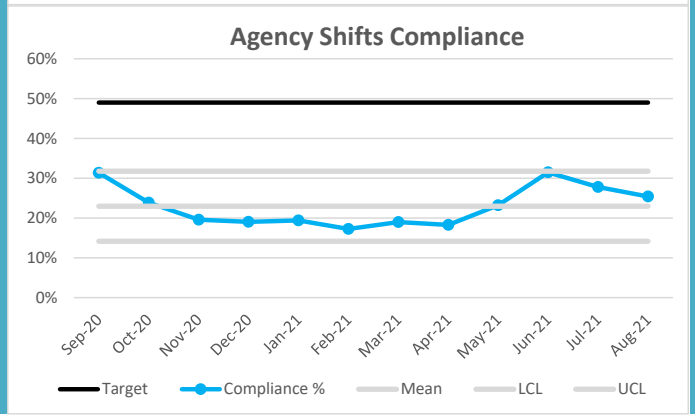
The Cheshire & Merseyside rate card has recently been amended to consider inflation.

Agency Shifts Compliant with the Cap

Red: below 49%
Green: above 49%

UoR

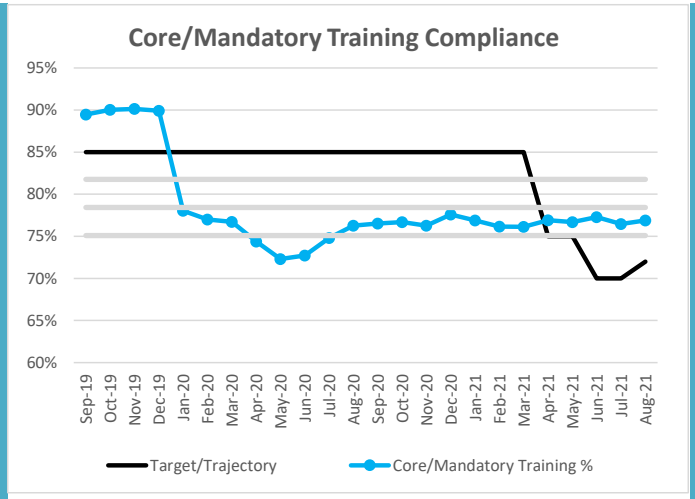
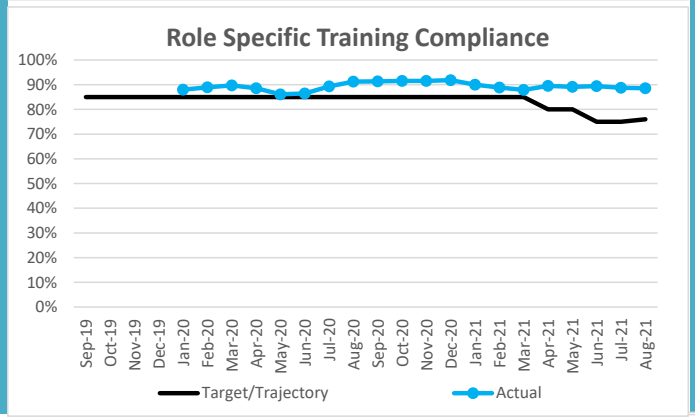
25.40% of shifts were compliant with the NHSI Price Cap.
SPC - There is evidence of special cause variation within Agency Shift Compliance.



Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

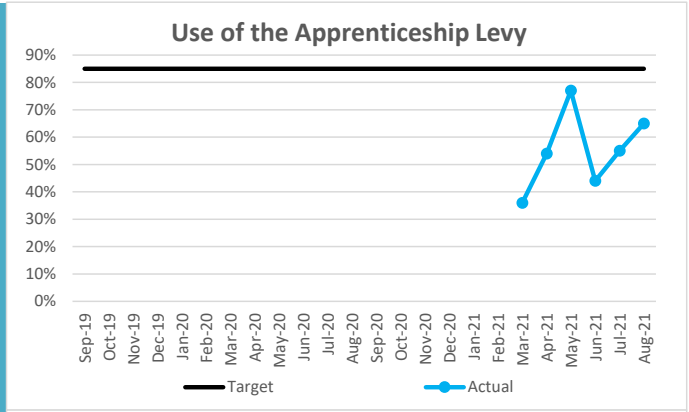
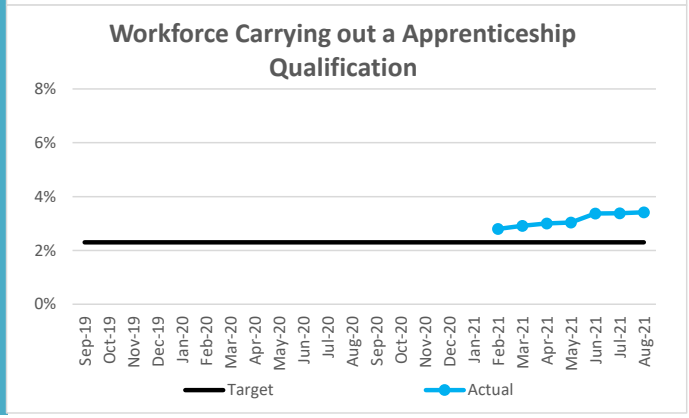
Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Core/Mandatory Training Red: Below Trajectory Green: Trajectory		In August 2021, Mandatory Training compliance was 76.88% and Role Specific Training compliance was 88.61%. Currently Mandatory Training and Role Specific Training are above the agreed trajectories.	The Mandatory Training compliance is currently under review to separate out Safeguarding training from overall Mandatory training compliance. The CBUs and Subject Matter Experts are being supported to develop trajectories to improve compliance, these are to be monitored through the Operational People Committee.
CQC Core/Mandatory training compliance was 76.88% in month. SPC - there is evidence of special cause variation. RR153			
Role Specific Training Red: Below Trajectory Green: Trajectory			
Role Specific Training compliance was 88.61% in month.			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

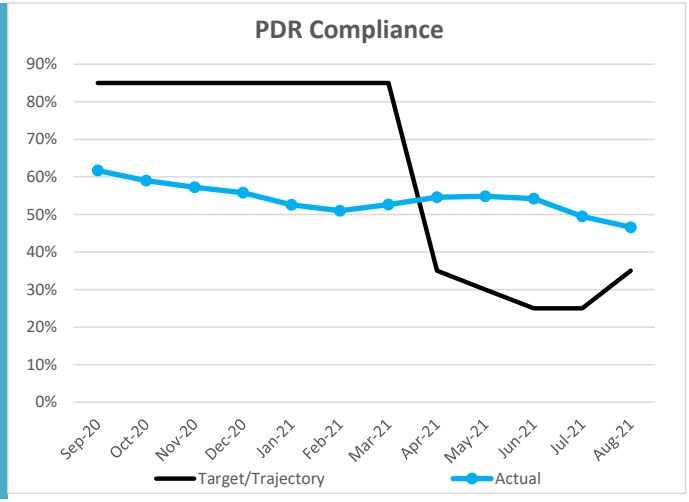
Key:
Single Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR200)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Use of Apprenticeship Levy Red: below 50% Amber: 50-84% Green: 85% or above	**Use of the Apprenticeship Levy was 65.00% in month.**		**Utilisation of the apprenticeship levy is below target in month, although 3.42% of staff are carrying out a qualification, which is above target (positive).**	**Use of the levy continues to be challenged for new recruitment episodes and the uptake of formal training, using the apprentice levy, which is regularly promoted.**
Workforce carrying out an Apprenticeship Qualification Red: below 1.5% Amber: 1.5% - 2.2% Green: 2.3% or above	**Percentage of the workforce carrying out a qualification was 3.42% in month.**			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
PDR Red: Below Trajectory Green: Trajectory **PDR compliance was 46.59% in month.**		**In August 2021 PDR compliance was 46.59%.** **Currently PDR rates are above the agreed trajectories.**	**An improvement trajectory to return to above target compliance has been approved and from July 2021.** **The CBUs and Subject Matter Experts are being supported to develop trajectories to improve compliance, these are to be monitored through Operational People Committee.** **The Executive team agreed an extension to the "Check In" conversation to March 2022. A communication plan is currently being rolled out to promote the use of the check in conversation where appropriate.**

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)?

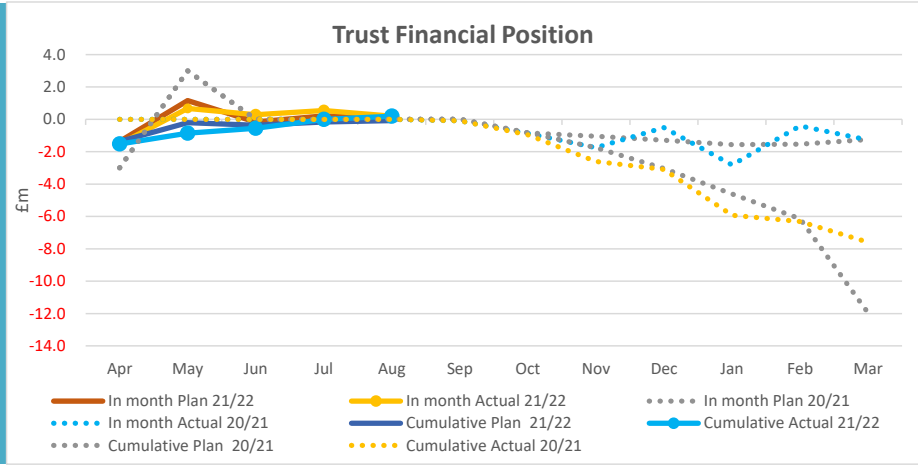
Trust Financial Position

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 surplus position of £0.2m as at 31 August.

RR134



For the period ending 31 August 2021, the Trust has recorded a surplus position of £0.2m against a deficit plan of £0.1m. The position includes an overspend on COVID-19 partly offset with underspends in other areas of the organisation.

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

System Financial Position

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

Warrington & Halton System reporting is currently on hold.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

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

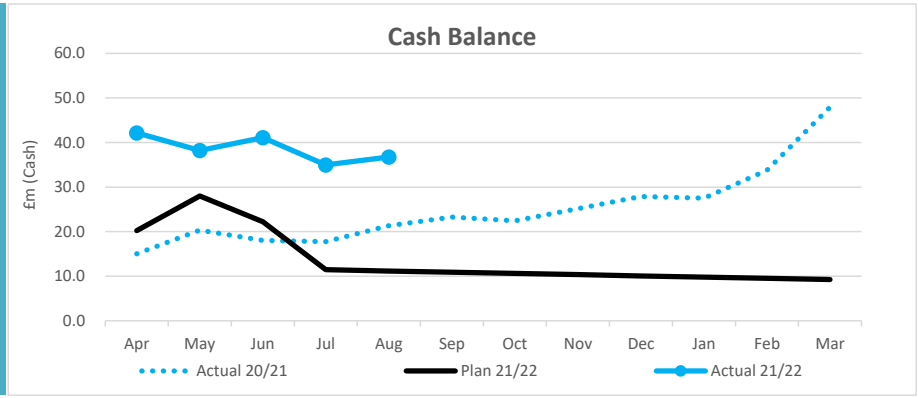
Cash Balance

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 £36.7m.

RR134



The current cash balance is £36.7m which is £25.5m better than the initial cash plan due to:
- **A delay in both creditor and capital creditor payments due to orders of goods and services being made later than originally anticipated.**
- **Cash has been received for the annual leave accrual which has not yet been incurred.**
- **An improvement in the year end deficit position due to central income and cash awards made in March 2021.**

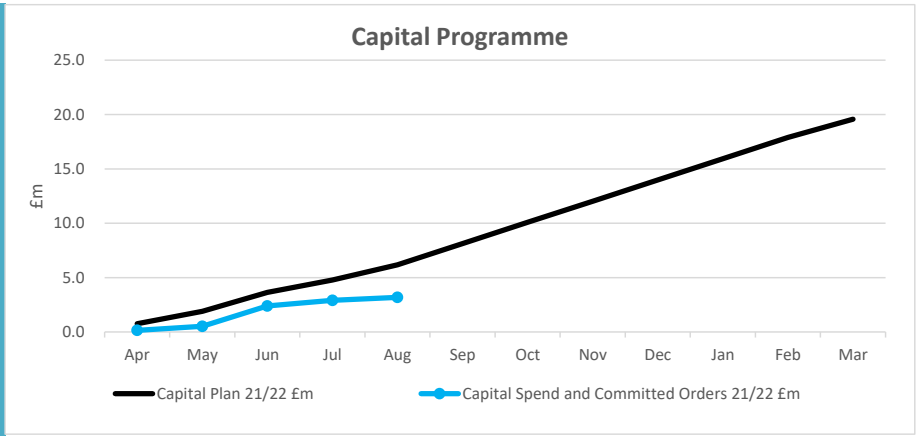
Capital Programme

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

UoR SOF

The actual capital spend in month 5 was £3.2m. In addition there are £1.9m of committed orders on the system.

RR1176



The Trust Board approved capital plan is £19.6m. The actual spend year to date is £3.2m which is £3.0m below the planned spend of £6.2m. However, the Trust has committed orders of £1.9m.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

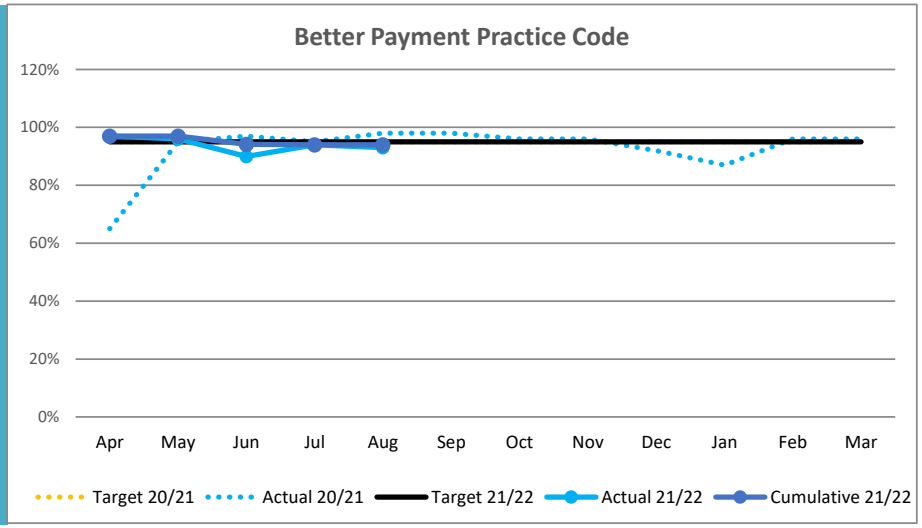
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

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 93.00% of suppliers within 30 days.



Performance of 93.00% is below the national standard of 95.00%.

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

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.

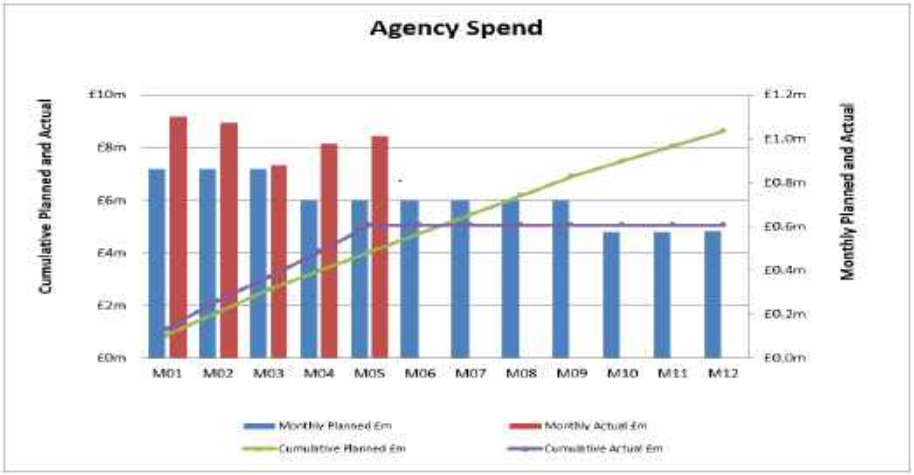
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

Agency Spending

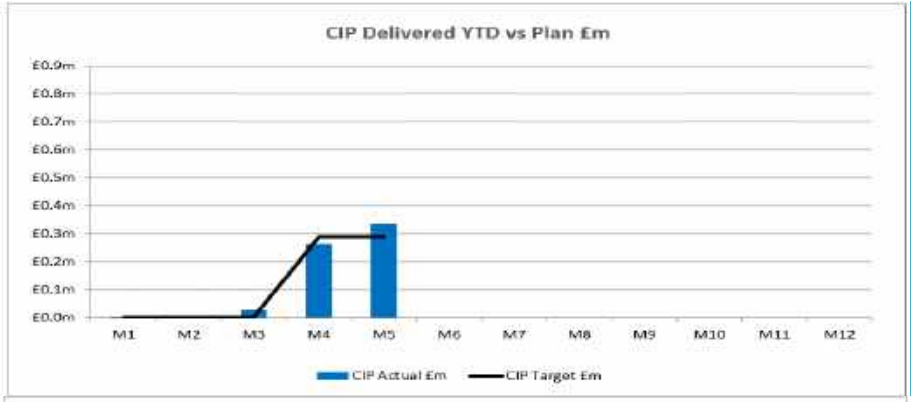
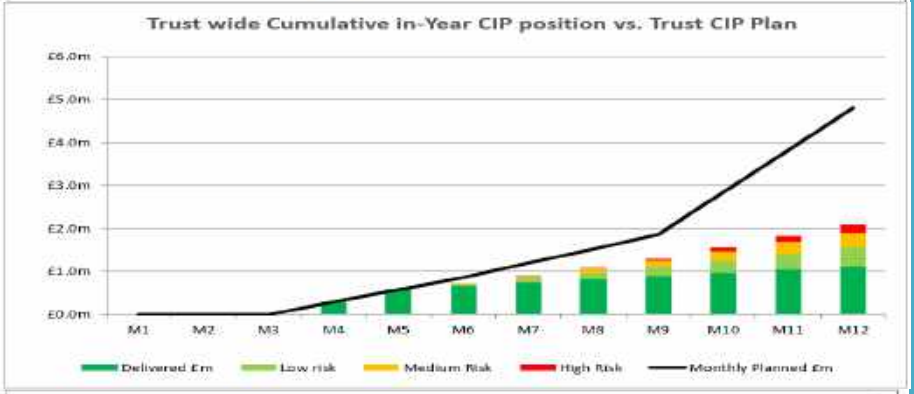
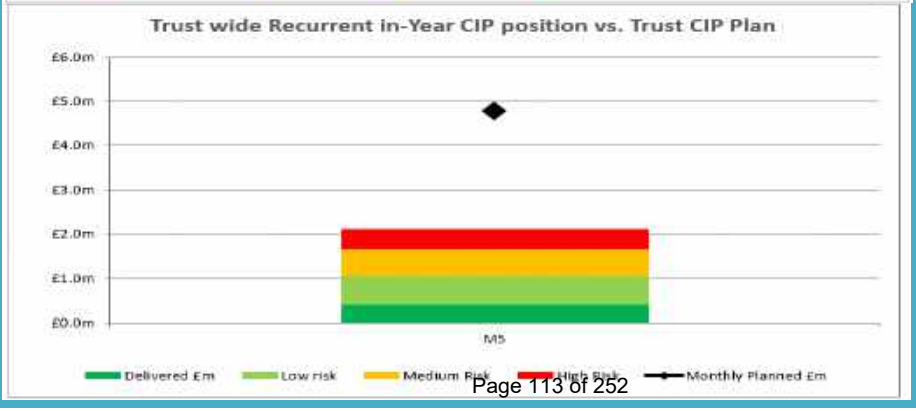
Red: More than 105% of ceiling
Amber: Over 100% but below 105% of ceiling
Green: Equal to or less than agency ceiling.

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR SOF **The actual agency spend in month is £1.0m.** RR199		**The year to date spend of £5.1m is £1.1m above the plan of £4.0m.**	**The Trust continues to monitor and report the use and spend on agency as well as the use of efficiency models to reduce costs. The Trust is part of a Cheshire & Merseyside collaborative that has established a standard rate card across all staff groups and specialties to reduce rates and is enhancing processes and controls to ensure appropriate and best use of agency staff.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cost Improvement Programme - In year performance to date Red: 0-70% Plan delivered YTD Amber: 70-90% Plan delivered YTD Green: >90% Plan delivered YTD	UoR **The monthly savings are £0.34m, against a target of £0.29m**		**The year to date savings are £0.60m which is better than the plan of £0.58m.**	**CIP progress is reviewed on a weekly and monthly basis. Where possible, the Trust seeks to accelerate schemes and is reviewing additional areas to support further cost reductions.**
Cost Improvement Programme - Plans in Progress - In Year Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	UoR **The current forecast based on schemes identified is £2.1m, against a plan of £4.8m.**		**There was no CIP target in Q1 2021/22. The Trust has a target of £4.8m for the year and schemes are being developed with CBU and Corporate Services to deliver the CIP.**	**To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT is being used. Further work to increase identification of CIP schemes continues across the Trust.**
Cost Improvement Programme - Plans in Progress - Recurrent Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	UoR			

Appendix 3 – Trust IPR Indicator Overview

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

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

A&E Waiting Times Over 12 Hours (Decision to Admit to Admission)	The number of patients who has experienced a wait in A&E longer than 12 hours from the decision to admit the patient to the patient being admitted as an inpatient to hospital.
Cancer 14 Days	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%.
Breast Symptoms – 14 Days	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%.
Cancer – 28 Day Faster Diagnostic Standard	All patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis. The national target is 75%.
Cancer 31 Days - First Treatment	All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%.
Cancer 31 Days - Subsequent Surgery	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%.
Cancer 31 Days - Subsequent Drug	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%.
Cancer 62 Days - Urgent	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory.
Cancer 62 Days – Screening	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%.
Ambulance Handovers 30 – 60 minutes	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system).
Ambulance Handovers – more than 60 minutes	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system).
Discharge Summaries – Sent within 24 hours	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patient's discharge. This metric relates to Inpatient Discharges only.
Discharge Summaries – Not sent within 7 days	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patient's discharge.
Cancelled operations on the day for non-clinical reasons	% of operations cancelled on the day or after admission for non-clinical reasons.
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
Urgent Operations – Cancelled for a 2nd Time	Number of urgent operations which have been cancelled for a 2nd time.
Super Stranded Patients	Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.
COVID-19 Recovery Elective Activity	% of Elective Activity (Inpatients & Day Cases) against the same period in 2019/20, monitored as part of 2021/22 Operational Planning Guidance.
COVID-19 Recovery Diagnostics	% of Diagnostic Activity against the same period in 2019/20, monitored as part of 2021/22 Operational Planning Guidance.

COVID-19 Recovery Outpatients	% of Outpatient Activity against the same period in 2019/20 monitored as part of 2021/22 Operational Planning Guidance.
Workforce	
Sickness Absence	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and peer average.
Return to Work	A review of the completed monthly return to work interviews.
Recruitment	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks.
Vacancy Rates	% of Trust vacancies against whole time equivalent.
Retention	Staff retention rate % over the last 12 months.
Turnover	A review of the turnover percentage over the last 12 months.
Bank & Agency Reliance	The Trust reliance on bank/agency staff against the peer average.
Agency Shifts Compliant with the Price Cap	% of agency shifts compliant with the Trust cap against peer average.
Agency Rate Card Compliance	% of agency shifts which comply with the Cheshire & Mersey rate card.
Pay Spend – Contracted and Non-Contracted	A review of Contracted and Non-Contacted pay against budget.
Core/Mandatory Training	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation 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?

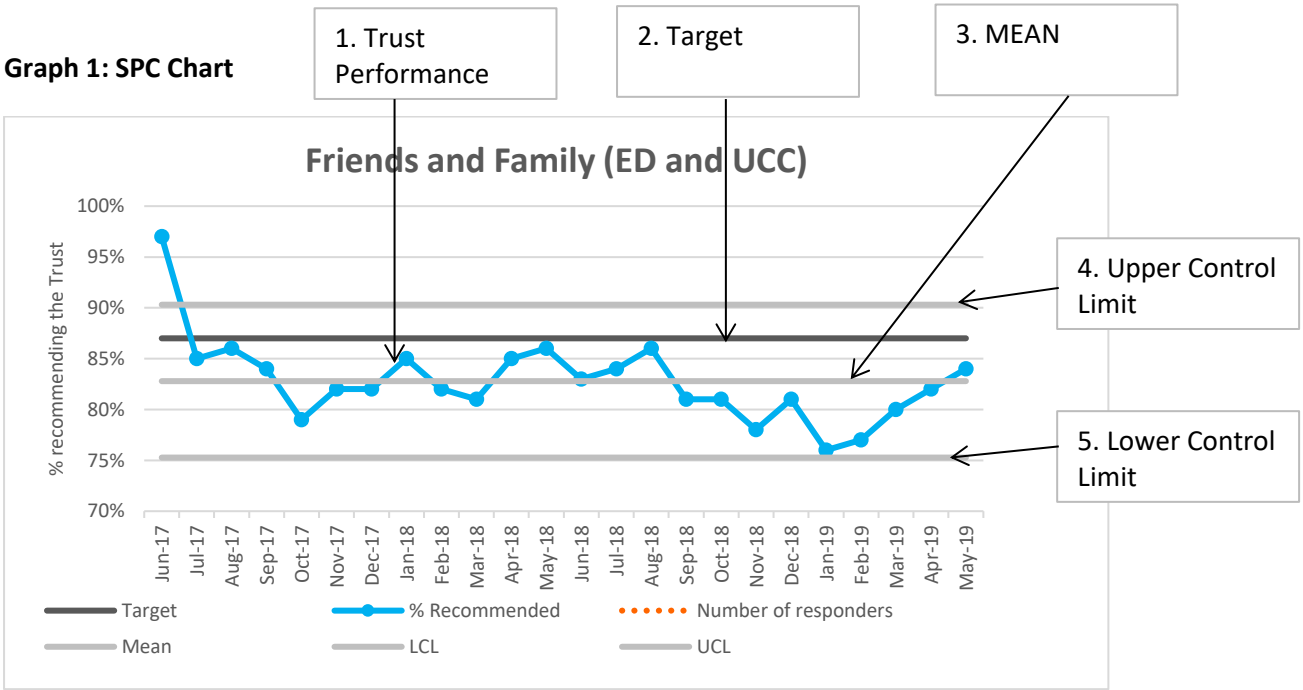
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

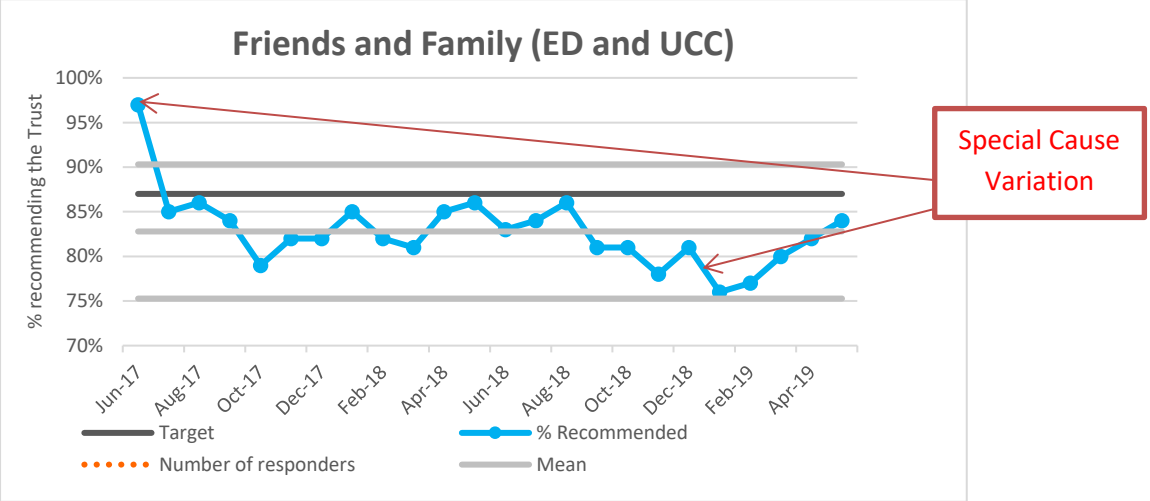
Graph 1: SPC Chart



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 31st August 2021

Income Statement	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income						
NHS Clinical Income						
Elective Spells	1,221	-10,252	-11,473	11,271	-1,322	-12,593
Elective Excess Bed Days	-29	-60	-31	21	-42	-63
Non Elective Spells	5,374	-24,253	-29,627	29,317	-712	-30,029
Non Elective Bed Days	85	-746	-831	800	-94	-894
Non Elective Excess Bed Days	-316	-678	-362	282	-468	-750
Outpatient Attendances	3,445	-12,460	-15,905	15,883	298	-15,585
Accident & Emergency Attendances	2,214	-5,621	-7,835	7,860	783	-7,077
Other Activity	7,329	-21,893	-29,222	29,983	1,855	-28,128
COVID Top up Income (Liverpool CCG)	5,916	-20,170	-26,087	25,534	1,011	-24,523
Sub total	**25,238**	**-96,135**	**-121,373**	**120,951**	**1,310**	**-119,640**
Non NHS Clinical Income						
Private Patients	0	14	14	0	143	143
Non NHS Overseas Patients	3	0	-3	15	8	-7
Other non protected	81	52	-28	404	205	-199
Sub total	**84**	**67**	**-17**	**419**	**357**	**-62**
Other Operating Income						
Training & Education	683	683	0	3,413	3,413	0
Donations and Grants	0	0	0	0	0	0
Miscellaneous Income	1,122	1,317	195	5,650	6,122	473
Sub total	**1,804**	**2,000**	**195**	**9,062**	**9,535**	**473**
Total Operating Income	**27,126**	**-94,068**	**-121,194**	**130,432**	**11,202**	**-119,230**
Operating Expenses						
Employee Benefit Expenses	-18,387	-17,919	468	-92,546	-92,920	-374
Drugs	-1,232	-1,529	-297	-6,189	-7,580	-1,391
Clinical Supplies and Services	-1,840	-2,034	-194	-9,309	-9,127	183
Non Clinical Supplies	-2,931	-3,022	-91	-14,431	-14,799	-368
Depreciation and Amortisation	-914	-451	463	-4,571	-4,107	463
Net Impairments (DEL)	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0
Total Operating Expenses	**-25,305**	**-24,956**	**349**	**-127,046**	**-128,533**	**-1,486**
Operating Surplus / (Deficit)	**1,821**	**-119,024**	**-120,846**	**3,386**	**-117,331**	**-120,717**
Non Operating Income and Expenses						
Profit / (Loss) on disposal of assets	0	14	14	0	25	25
Interest Income	0	0	0	0	0	0
Interest Expenses	0	0	0	0	0	0
PDC Dividends	-447	-447	0	-2,235	-2,235	0
Total Non Operating Income and Expenses	**-447**	**-433**	**14**	**-2,235**	**-2,209**	**25**
Surplus / (Deficit) - as per Accounts	**1,374**	**-119,457**	**-120,831**	**1,151**	**-119,540**	**-120,691**
Adjustments to Financial Performance						
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0	0	0
Less Donations & Grants Income	0	0	0	0	0	0
Add Depreciation on Donated & Granted Assets	16	19	3	80	93	13
Total Adjustments to Financial Performance	**16**	**19**	**3**	**80**	**93**	**13**
Adjusted Surplus / (Deficit) as per NHSI Return	**1,390**	**-119,438**	**-120,828**	**1,231**	**-119,448**	**-120,679**

Activity Summary	Planned	Actual	Variance	Planned	Actual	Variance
Elective Spells	2,279	2,269	-10	10,719	11,412	693
Elective Excess Bed Days	47	0	-47	233	56	-177
Non Elective Spells	2,660	2,482	-178	14,637	12,831	-1,806
Non Elective Bed Days	498	474	-24	2,490	2,416	-74
Non Elective Excess Bed Days	562	0	-562	2,773	1,037	-1,736
Outpatient Attendances (PBR Only)	28,418	35,518	7,100	136,062	182,241	46,179
Accident & Emergency Attendances	9,994	9,515	-479	49,324	52,154	2,830

Appendix 6 - Capital Plan Analysis as at 31 August 2021

Scheme	£000's	Approval Required	Approval Status
Warrington & Halton Breast Unit Relocation	1,200	Board paper	Completed
MRI Estates	908	Board paper	Completed
Underspends from 20/21:			
Estates - Various all under £500k	953	CPG paperwork	
IT	342	CPG paperwork	
Medical Equipment - Various all under £500k	952	CPG paperwork	
2021/22			
Contingency - for urgent and emergency schemes through out the year:	972	Urgent Capital requests	
Modular Build - Carparking, Lighting and Pathways	288		Completed
Damper Power Supply Units - Burtonwood Wing	9		Completed
Generator Repair - Halton Nightingale	24		Completed
Halton Air Conditioning - Pathology	8		Completed
W&C Nurse Call	25		Completed
Room 2 Detector	38		Completed
Pharmacy Fridge	6		Completed
Non Mandated:			
Shopping City	630	CPG paperwork	Completed
New Town	100	CPG paperwork	Completed
Sub A Statix Fire Protection	50	CPG paperwork	Completed
008 Network Switch Expansion	23	CPG paperwork	Outstanding
Backlog - Flooring Replacement Works	150	CPG paperwork	Completed
Breast Relocation Equipment - this is included in the £2.1m (Scheme 68872 above)	0	CPG paperwork	Completed
Other	0	CPG paperwork	
SAN	240	CPG paperwork	Completed
Urology Investigation Unit	900	Board Paper	Completed
SUB TOTAL	**2,093**		
Mandated schemes			
Call Alarms for all Anaesthetic & Recovery Rooms Halton Site	113	CPG paperwork	Submitted/Incomplete
IT Staffing	316	CPG paperwork	Completed
Essential power installation - Halton Pharmacy	9	CPG paperwork	Completed
Substation B at Warrington Replace 2no. Air Circuit Breakers and 1no. HV Ring Main Unit	0	CPG paperwork	Replaced by 65502 (next scheme)
Electrical Infrastructure	200	CPG paperwork	Completed
Fire - Relocate and replace medical gas AVSU's to clinical wards	20	CPG paperwork	Completed
Backlog - Croft Wing Electrical remedial works following fixed electrical testing of clinical areas	30	CPG paperwork	Completed
Backlog - Provide safe surface temperatures of radiators in patient clinical areas	10	CPG paperwork	Completed
Backlog - North Lodge Basement Electrical Installation Replacement	225	CPG paperwork	Completed
Backlog - Fire install of fire dampers 2nd phase	0	CPG paperwork	Deferred to 2022/23
Backlog - Catering Department remove or replace roof lantern	30	CPG paperwork	Completed
Fire - Replacement of obsolete 5000 series fire alarm panels and end of line devices	500	Board Paper	Completed
Estates Capital Staffing for Design Team Works	205	CPG paperwork	Completed
Fire - Halton 30 minute Fire Compartmentation (Phase 2)	728	CPG paperwork	Completed
Appleton Wing Circulation Areas Fire Doors	0	CPG paperwork	Deferred to 2022/23
Warrington and Halton Gas Meter Replacement	141	CPG paperwork	Completed
Backlog - All areas fixed installation wiring testing	0	CPG paperwork	Deferred to 2022/23
6 Facet survey annual update	55	CPG paperwork	Completed
Backlog - Water Safety Compliance	1	CPG paperwork	Completed
Backlog - Annual Asbestos Management & Remedial	30	CPG paperwork	Completed
Backlog - HV (High Voltage) Maintenance annual	40	CPG paperwork	Completed
CMTC Replacement Emergency Lighting	72	CPG paperwork	Completed
SUB TOTAL	**2,725**		
Business Critical			
New Maternity system integration to Lorenzo	132	CPG paperwork	Submitted/Incomplete
New Maternity system	100	CPG paperwork	Completed
EPR Tactical Lorenzo 5 Year Extended Service	0	CPG paperwork	Not Going Ahead
Phase 2 Structure - Digital Project Management and Benefits Management resource	165	CPG paperwork	Completed
005 Cisco Refresh (Phase 1)	192	CPG paperwork	Completed
006 Comms Cabinets (Phase 2) x 2 (one each site) (Network Cabinets)	90	CPG paperwork	Completed
007 IP Telephony	65	CPG paperwork	Completed
012 UPS - Main Server Room at Warrington	190	CPG paperwork	Completed
013 Data Warehouse Infrastructure Refresh	85	CPG paperwork	Completed
014 Device Replacement (Tech Refresh)	55	CPG paperwork	Completed
EPMA 1-4	24	CPG paperwork	Completed
Health & Wellbeing Workplace	13	CPG paperwork	Not Going Ahead
Cardiac Catheterisation Suite	800	Board Paper	Completed
Flouroscopy	300	CPG paperwork	Submitted/Incomplete
Lorenzo Theatres Licences	218	CPG paperwork	Outstanding
Chief Nurse Information Post (Digital Nurse)	31	CPG paperwork	Completed
Electronic Patient Record Procurement	243	CPG paperwork	Completed
Induction Bay	22	CPG paperwork	Outstanding
SUB TOTAL	**2,725**		
PDC Funded			
Paeds (Children's Outpatients)	700	Board Paper	Completed
ICU (B18)	1,000	Board Paper	Completed
Speciment Cabinet (Part of Breast Screening)	0	CPG paperwork	Completed
ED Plaza	5,000	Board Paper	Completed
SUB TOTAL	**6,700**		
TOTAL	**19,570**		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 21/09/125 b i	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	29 September 2021

Date of Meeting	3 August 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/21/08/ 176	**Hot Topic - Delirium**	The Committee received presentation providing an overview of the processes put in place to support the Trust to identify patients presenting with Delirium to ensure the patients are treated on the correct care pathway. It was particularly noted - WHH consistently achieve CQUIN target of 90% in monthly Dementia return to NHSE/Digital. - All ED patients screened as part of ED triage screening and Sepsis tool to consider Delirium with appropriate referrals either to Cognitive Team, LLAMS service or community post-discharge. - Further work to fully embed "think Delirium" alongside 4AT Test as part of clinical assessment. - Referrals to Cognitive Team through ICE, proactive work with wards to identify any potential patients requiring 4AT Test. - Cognitive Team continue to deliver training	**The Committee discussed the overview and received good assurance**	**n/a**
QAC/21/08/ 178	**Deep Dive (June 2020-May 2021) - Management of Sepsis at WHH**	The Committee received a presentation on the Management of Sepsis following a request for a deep dive from the Committee. I was noted that: - The data was benchmarked through AQuA and supplemented with an internal review of in-patient and patients attending ED where Sepsis is suspected.	**The Committee discussed the update and actions in place, received moderate assurance and noted the**	**QAC 07.09.2021**

		- Improvement reported during March 2021 as part of Sepsis Awareness week and dedicated staff to support the screening process and delivery of antibiotics in a timely manner. Slight deterioration since March with increased ED attendances contributing factor. Further improvement work to be taken forward. - Improvement in in-patient measures reported through MET calls. - A review of Death Certificates between June 2020 and May 2021 had taken place where Sepsis had been recorded on part 1a,1b,1c or part 2 of the death certificate. 84 patients were identified. - 15 cases met the criteria for Mortality Review Group (MRG), no lapses in care found and no concerns from Trust Medical Examiner, no avoidable deaths recorded. - No harm caused to patients identified where Sepsis had been recorded on death certificates. - Training continues to be reinforced through various avenues. - A Sepsis Trust wide action plan was being monitored at Patient Safety & Clinical Effectiveness Sub-Committee (PSCESC) and reported to QAC; clinical Sepsis leads were working in ED; Patient Safety Nurse presence in ED; Sepsis Quality Improvement Programme in place and a team is to visit Wigan ED to share best practice on management of Sepsis in ED. - Additional resources into ED to support Sepsis management and training. - Pharmacy support in ED to be progressed as part of Phase 2 business case, additional pressure on staff due to length of time to make up IV antibiotics. - Supported the inclusion of addition to IPR of identification of Sepsis within 1 hour, 2-3 hour and over 3 hours.	**further improvement work on-going,** **Update report to September QAC to include clear narrative if patient outside of the 1 hour, and progress against actions** **Outcomes of review of 15 cases to be presented outcomes to QAC in October.**	**QAC 05.101.2021**
QAC/21/08/ 180	**Maternity Safety Champion Report**	The Committee received the Maternity Report and Ockenden Review update report No issues were escalated, and the following matters were noted: - Maternity Safety Champion meetings continue. Director of Midwifery commenced 3 August 2021. - Daily Trust staffing meetings continue, Gold command set up, daily sitreps across C&M LMS. - Healthcare Safety Investigation Branch (HSIB) - suitability of equipment and	**The Committee noted the updates and received good assurance.**	**QAC 07.09.2021**

		technology used for continuous foetal heart rate monitoring (CTG machines). Gap Analysis of CTG machine to future QAC meeting. - Maternity Voices Partnership (MVP) Neonatal Safety Champions and Maternity Voices Partnership Chair invited to attend Maternity Safety Champions meeting. - Continuity of Carer (CoC) on track to achieve 100% of in-area women to be booked on a continuity pathway by March 2022, 69.7% of women booked in June 2021 on a CoC pathway. - 5 CoC teams in place, 6th team to roll out September 2021. - WHH shortlisted for CoC for HSJ Patient Safety Awards, results September 2021. (a) **Maternity Monthly SI Report** - High level summary of Maternity Serious Incidents (SIs) noted. - Next report to include Post-Partum Haemorrhage information as appendix to report**.**		
QAC/21/08/ 181	**MIAA LocSSIPS review/ recommendations**	The Committee received a high-level overview of key findings and noted: - Moderate assurance provided following the review. - 11 recommendations with associated risk ratings, 1 high, 4 medium, 6 low. - 1 'High Risk' recommendation achieved with reporting to the PSCE subcommittee. - 9 of the 11 recommendations completed or on track within the agreed time frame. - 2 recommendations behind trajectory (1) Training compliance, centralised recording and recording by CBUS (Medium risk). Assurance provided that e-learning package developed, functionality confirmed, to go live shortly on ESR. - (2) Documentation from CBU's. (Medium risk), assurance provided, CBUs reviewed all LocSSIPs, checklist updated. Documentation and compliance with LocSSIPs training to be recorded on ESR. - Training Education newsletter, reinforced at N&M and other forums.	**The Committee discussed the update and received moderate assurance. A further update to be provided to the Audit Committee in August.**	**Audit Committee 19.08.2021**

QAC/21/08/182	**Quality Dashboard**	The Committee received the latest Quality Dashboard. The matters were highlighted: - A change to the FFT test for A&E recommendation rate. Will now only include narrative of feedback, not numbers. - Patient Experience Team supporting ED, hierarchy within system reviewed to ensure correct people are receiving SMS message. "Sit and See" in ED and waiting times under review. - Benchmarking exercise identified that WHH send SMS messages to circa 3 times more people, some neighbouring organisations sending far fewer and may be duplicating people being asked. - As part of IPSOS MORI/CQC survey (18 organisations), WHH achieved 98% positive feedback	**The Committee noted the update and received good assurance.**	**QAC 07.09.2021**
QAC/21/08/183	**Information Governance & Corporate Records**	The Committee discussed the high-level briefing received in relation to Information Governance & Corporate Records. - Security Toolkit submission – action in place to address areas of non-compliance against 11 mandatory Data Security Protection Toolkits (DSPT) standards, rigorously reviewed by NHS Digital. MIAA completed readiness audit, Moderate Assurance provided against the standards. - National Data Opt-Out – compliance data extended to 30 September 2021, potential for further extension of this date. SOP to be presented to IG & Corporate Records Sub Committee for approval in August 2021 <u>Data Security and Protection Deep Dive</u> - undertaken at the request of the Chair of the QAC and Executive IG Lead relating to Trust's Data Security and Protection arrangements. <u>Cyber Security</u>: - fully compliant (100%) in response to all NHSD CareCERT alerts - 77.3% of 2003 servers upgraded; 70.0% of 2008 servers upgraded - BitSight, external security rating, within top 10% of health care sector of 780 organisations. - Additional firewall for NHS Security boundary to detect cyber activity. - Patches and upgrades continue to ensure systems protected.	Assurance provided that all data standards adhered to, including toolkits and actions against cyber security	**QAC 07.09.2021**

		- ICO report – 10 incidents reported, none requiring action by the ICO.		

The Committee received and noted the following
- Moving to Outstanding Bi-Monthly
- DIPS Infection Control Q1 Report
- SI and Complaints Q1 Report
- Quality Priorities Q1 Report
- Quality Improvement Progress Q1 Report
- Mortality Review Q1 Report
- Fit Testing Compliance Quarterly Report
- Health & Safety Executive Bench Marking Exercise against HSE COVID-19 Spot Check Inspection Programme Findings
- Annual Review of Patient Experience Strategy 2020-2023

The Committee received the High Level Briefing Reports from the following Sub Committees:
- Patient Safety and Clinical Effectiveness Sub Committee
- Safeguarding Sub Committee
- Patient Experience Sub Committee

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

The Committee received the High Level Briefing Reports from the following Sub Committees deferred from July QAC
- Patient Safety and Clinical Effectiveness Sub Committee
- Risk Review Group
- Infection Control Sub Committee
- Quality Academy Board
- Equality, Diversity & Inclusion Sub Committee

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 21/09/125 b ii	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	29 September 2021

Date of Meeting	7th September 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/21/09/ 211	**Patient Story - A story of managing complex challenging behaviours in an acute paediatric setting**	The Committee heard about a recent experience, learning and outcomes of a patient journey. The patient was a young person with complex behaviours in an Acute Paediatric setting. An overview was provided of the very complex incident, learnings and multi-disciplinary work across many different areas which came together and provided support for the patient and emotional support for the staff involved in the case.	**The Committee discussed the presentation and received good assurance concerning the how the Trust worked across many areas and the ultimate outcome**	**n/a**
QAC/21/09/ 212	**Hot Topic – Bronchiolitis and RSV Surge – WHH Response**	The Committee received a presentation on the recent surge in Bronchiolitis and RSV. The Committee noted the Trust's and C&M Network's response including: - Gold & Sliver Command structure (C&M)- bring organisations together to work in partnership through extreme pressure. - Daily capacity SITREPS - Weekly meetings - Mutual aid - North West Surge planning The Committee commended the team and its response to the surge.	**The Committee discussed the presentation and received good assurance.**	**n/a**

QAC/21/09/213	**Deep dive review/Service review – Learning Disabilities – Learning from Inquests**	The Committee received a presentation looking at the lessons learned following the death of a patient living with a learning disability. An overview of the patients experience and treatment was provided and details of the lessons explained including: - A strategy for patients with an LD diagnosis has been launched that reflects the lessons learnt from the patient's care and subsequent death - There is an associated work plan that is monitored via the LD Steering Group, providing assurance about progress to Safeguarding Committee (SC) and to Quality Assurance Committee (QAC) - Learning Disability is a Trust wide Quality Priority for 2021-2022, progress of all LD work streams are monitored via the LD Steering Group	**The Committee discussed the update and received good assurance. Additional assurance was also requested about lessons learned which are to be presented to QAC in October 2021**	**QAC 05.10.2021**
QAC/21/09/216	**Maternity Safety Champion Report**	The Committee received the Maternity Report and Ockenden Review update report No issues were escalated, and the following matters were noted: - Continuity of Carer (CoC) – WHH have achieved 100% CoC for in area women since March 2021. - Continue to be a positive outlier regionally and nationally and have been shortlisted for Health Service Journal Patient Safety Awards 2021. - Update on transfer of Bridgwater midwives – Paper to be presented to Finance & Sustainability Committee and the Trust Board - Vacancy rates minimal and have received Ockenden Funding uplift of 5.3 WTE Band 6 Midwives. - Saving Babies Lives - Compliant with all five elements - Post-Partum Haemorrhage (PPH) - The WHH PPH average percentage over a 12 month period was 3.2%. The national PHH rate is 3-5% of all births and WHH is within this range. (b) Maternity SI Report - High level summary of Maternity Serious Incidents (SIs) noted.	**The Committee noted the updates and received good assurance.**	**QAC 05.10.2021**

QAC/21/09/217	**Sepsis Improvement Update Report**	The Committee received an update on the current compliance rates and the measures in place the improve practice following the deep dive into the management of patients with sepsis. It was noted that: - A Trust wide Sepsis Action Plan has been developed with weekly monitoring at the multidisciplinary Task and Finish Group - Designated clinical presence in the Emergency Department - Ongoing education and training within ED - Sepsis Champions identified across the Trust in all areas - A "Think Sepsis" campaign planned for September aligned to National Sepsis Week - Focussed work on increasing training compliance is underway across CBU's - Mortality review underway - Patient Group Directives (PGDs) will be developed to facilitate the administration of antibiotics and essential fluids without the requirement for the clinician to prescribe. Work is currently underway with the pharmacy department to complete this action. - Pre-made antibiotics will be stored within the Emergency Department to support timely administration A further update to be provided at the Quality Assurance Committee in October	**The Committee noted the update and received moderate assurance. A further update was requested in the next meeting**	**QAC 05.10.2021**

The Committee also received and discussed:
- Updates to the Strategic Risk Register & BAF
- Key discussion points from the Clinical Recovery Oversight Committee (CROC)

The Committee received and noted the following
- Infection Prevention & Control BAF Bi-Monthly report
- Learning From Experience (LFE) Q1 report
- Clinical Audit Q1 Report
- External Review Letter to Board Safety Champion
- Committee Effectiveness Bi-Annual Survey Outcomes

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

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

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/21/09/125 c		TRUST BOARD OF DIRECTORS	DATE OF MEETING	29th September 2021

Date of Meeting	22 September 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/21/09/ 72	**GMC Revalidation Annual Report**	**GMC Revalidation Annual Report, Executive Medical Director** Monitoring completion of annual appraisals to support GMC revalidation for the medical workforce	**Assurance** The report provides assurances to the Board that the system for medical appraisal and the processes for monitoring the completion of annual appraisals to support GMC revalidation for the medical workforce are robust. • Total number of doctors with a prescribed connection as at 31 March 2021: 279 • Total number of appraisals undertaken between 1 April 2020 and 31 March 2021: 186	

			• Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021: 61 • Total number of agreed exceptions: 56	
SPC/21/09/ 76	**GMC National Trainee survey action progress report**	**GMC National Trainee survey action progress report, Executive Medical Director** Summary Report on the National Trainee Survey (NTS)	**Assurance** The 2021 survey was undertaken in May 2021 and results published in July 2021. The results of the 2021 GMC NTS show promising improvements in some areas, however, there is still improvement work to be undertaken. Areas of concern are being monitored and actioned in line with the usual escalation processes with tighter oversight from Medical Education Quality Committee.	
SPC/21/09/ 77	**Medical Establishment Workforce Element**	**Medical Establishment Workforce Element, Executive Medical Director** Presentation on the workforce impact of the Medical Staffing Review	**Assurance** The £4.8m cost pressure was explained by highlighting the rota gaps due to skills shortages or increased activity. The development of a clinical workforce plan will be incorporated into the WHH People Strategy review which will support long term recruitment plans. CBUs will build the clinical workforce plans into their annual workforce plans, aligned to the business plans.	
SPC/21/09/ 70	**BAF & Risk Register – Workforce**	**BAF & Risk Register – Workforce** **Trust Secretary** Update of the Trust BAF & Corporate Risk Register for those relating to the workforce	**Assurance** **BAF & Risk Register** *No changes to the Risk scores on the BAF or Corporate Risk Register* • **1207**, Workplace Risk Assessments • **1134**, Provide adequate staffing caused by absence relating to COVID-19	

			Action SPC noted the updates and requested a review of the wording used to describe Risk 1207 The current sickness absence level was discussed, and it was highlighted that the results of a review of the Trust's OH services would be presented to the Committee in January 2022	SPC January 2022
SPC/21/09/ 71	**Proposed Amendments for IPR**	**Proposed Amendments for IPR** **Chief Finance Officer, Deputy Chief People Officer** Reporting of Mandatory and Safeguarding Training Components Separately	**Decision** SPC supported the temporary amendment to the Trust IPR. Safeguarding training will now be reported separately from the current mandatory/core skills training indicator. This will provide increased monitoring of compliance and assurance. This will be a temporary amendment until 31st March 2023.	
SPC/21/09/73 & 74	**Workforce Race Equality Standards (WRES) & Workforce Disability Equality Standards (WDES)**	**WRES and WDES** **Deputy Chief People Officer** WRES and WDES action plans were presented for approval.	**Decision** **WRES and WDES** Following the Trust's WDES/WRES data being submitted to the national central government portal by 31st August 2021, two action plans have been developed with staff networks. The Trust's WDES and WRES action plans were approved by SPC, compliance against them will be monitored through the Workforce ED&I committee.	Sept-21
SPC/21/07/75	**Chief People Officer Report**	**Chief People Officer Report,** **Deputy Chief People Officer**	**Assurance**	Sept-21

		The Deputy Chief People Officer updated the Committee on: • COVID-19 Workforce Risk Assessments • Self-Isolation SOP • LAMP testing • Pulse Staff Survey Update • Annual Staff Survey • Pay Award & Flowers • The Brathay Trust • Support for Veterans • New HR&OD Appointments	**COVID-19 Workforce Risk Assessments** – maintain high compliance levels, and for assurance reports are provided daily to managers and are escalated weekly to tactical. The HR team also proactively chase. **Assurance** **Self-Isolation SOP –** Since the last SPC national guidance has been released to support organisations to identify fully vaccinated staff who are identified as a contact of a positive COVID-19 case, to return to work, subject to the safeguards put in place. The Trusts e-form and SOP support managers through this process. **Assurance** **Lamp Testing** – On average within any one week, 10% of the workforce complete a LAMP test. To improve uptake: • Continued communication on LAMP importance • Introduced a LAMP uptake dashboard • Developed a text reminder service **Assurance** **Pulse Staff Survey Update** – SPC received an overview of the results which demonstrated that WHH scores higher than the Average NHS Trust in 19 out of the 24 questions. **Assurance** **Annual Staff Survey** - The 2021 Annual NHS staff survey approaches, it will open to staff from Monday 4 October 2021 at the latest, with a closing date of Friday 26 November 2021. **Assurance** **Pay Award** – the 3% pay award and back pay to April 2021 to be paid in September 2021.	Sept-21

			Flowers – Overtime payments owed due to the Flowers Case will paid within the September 2021. **Assurance** **The Brathay Trust** is a staff offer from a psychological and wellbeing perspective, SPC were updated about the offer and target audience. **Support for Veterans** – Recognising the situation in Afghanistan, a package of support was developed for anyone to access.	
SPC/21/09/77 (a)	**Joint Vaccination Paper**	**Joint Vaccination Paper,** **Deputy Chief People Officer** Update on the delivery of both the Flu vaccination and COVID Booster	**Assurance** The Trusts approach to the annual Flu Vaccination is to utilise the COVID Vaccination Service infrastructure. The Joint Vaccination Task and Finish Group has been working up plans to deliver both the Flu and COVID Booster, either separately or at the same time. Flu Vaccination programme commenced on 13th Sept 2021 and remain on track to achieve the target of 85% of patient facing staff.	
SPC/21/09/78	**Policies and Procedures Report**	**Policies and Procedures Report,** **Deputy Chief People Officer** Update on progress relating to the development of workforce policies and procedures.	**Decision** The following policy has been to the Trust's JLNC for review, OPC for approval and SPC gave their final ratification: • Remediation Policy	
SPC/21/09/79	**Freedom to Speak-up Bi-Annual Report**	**Freedom to Speak-up Bi-Annual Report,** **Chief Nurse & Deputy CEO** Update on FTSU Disclosures	**Assurance** From the 1st April 2021 to 31 August 2021 the FTSU team has managed 11 disclosures. The majority of which relate to culture, allegations of bullying and relationship issues within teams. The FTSU team continues to work closely	

			with HR and OD to support individuals and teams to resolve the issues that are highlighted. The wellbeing services across the Trust offer a good resource for FTSU to sign post staff to access further support.	
SPC/21/09/81	**Trust Board Monthly Staffing Report**	**Trust Board Monthly Staffing Report, Chief Nurse & Deputy CEO** This paper details ward staffing data for the months of June and July 2021	**Assurance** In order to ensure safe staffing levels, mitigation and responsive plans are implemented daily to ensure that the safe delivery of patient care. CHPPD in June was 7.9 and 7.6 in July, with a year to date rate 7.8. Staffing gaps are caused by sickness absence, vacancies and our Clinically Extremely Vulnerable (CEV) staff where they are unable to work within their substantive roles. Vacancies for HCAs and Nursing are reducing and new guidance for CEV staff have recently been received.	
SPC/21/09/81	**Committee Effectiveness Annual Survey**	The Committee received the results of the Annual Effectiveness Survey and noted the positive feedback	The Committee received good assurance and the Chair will discuss possible further enhancements with the Chief People Officer and Trust Secretary based on the feedback received.	SPC November 2021
SPC/21/09/83	**Bi-Annual Health & Wellbeing Guardian Report**	**Bi-Annual Health & Wellbeing Guardian Report, Deputy Chief People Officer** Update on Health and Wellbeing Guardian Principles	**Assurance** The paper outlined the 9 Wellbeing Guardian Principles, which the Trust Wellbeing Guardian, Dr Cliff Richards, receives monthly assurance on and progress updates to ensure the Trust is compliant.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/20/09/125 di		TRUST BOARD OF DIRECTORS	DATE OF MEETING	29 September 2021

Date of Meeting	**25 August 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/21/08/124	Corporate Performance Report	The Committee considered and reviewed the report noting:- • 72.64% July A&E performance which is a deteriorating position. Increased attendance continues across Acute Trusts nationally (WHH middle of the pack 68/116), along with an additional ward worth of COVID-19 patient and LOS increases due to lack on Domestic care • Ambulance handover has increased in 0-15 minutes however the Trust continues to perform well compared to peers • Achieved 52 week in July • Narrowly missed 2 week wait and hit 31 day • The 62 day cancer target was not achieved in July 2021 • DNA is increasing and a concern • Outpatient deep dive via CROC is taking place	The Committee **noted** the updates and received moderate assurance.	FSC September 2021

FSC/21/08/125	Pay Assurance Report	The Committee considered and reviewed the report noting: - • Cost of shielding 26 WTE have come back and deployed at CEV in different roles so redeployment is required • Team is reviewing if environmental checks need to be updated. • Medical rate card issue not complete finalised paper to Executive Meeting next month excluding the WLI issue which has slowed the process down • Cheshire and Mersey average rates and reflecting the cost of living has been taken to Collaboration at Scale Board and they confirm it is not being used anywhere else in Cheshire and Mersey. Decision to continue to monitor with revised cost of living and push with CAS Board to reconsider oversight.	The Committee **noted** the update	FSC September 2021
FSC/21/08/126	Monthly CIP	The Committee considered and reviewed the monthly CIP noting:- • Target increased from £2.6m to £4.8m anticipating H2 guidance • On plan at the end of month 4 £290k delivered • Gap in H1 of Circa £400k • Gap for the whole year of £2.9m significant concern • Continue to focus in operational meetings	The Committee **noted** the CIP report and limited assurance	FSC September 2021
FSC/21/08/127	COVID-19	The Committee noted the COVID-19 update, noting:- • The position for year to date • Year to date expenditure is £3.4m which is £1.6m more than budget due mostly to the impact of CEV staff	The Committee **noted** the update	FSC September 2021
FSC/21/08/128	Reference cost update	The Committee noted the reference cost update, noting:- • Current provisional score of 98 • Update on 2020/21 collection • Medical establishment and LOS needs considering wider when we look at productivity	The Committee **noted** the update	

FSC/21/08/129	Capital planning group cycle of business	The Committee noted the CPG Cycle of Business	The Committee **noted** the update	FSC June 2022
FSC/21/08/131	Additional Oversight of Capital	The Committee considered and reviewed the presentation noting: - • Current underspends against budget • Concerns for timelines for ED Plaza raised • Take stock in September bring forward next year schemes where appropriate • MIAA Estates Capital recommendations complete and anticipate MIAA to review the information provided in September	The Committee **noted** the update	FSC September 2021
FSC/21/08/132	Digital Services Board Report	The Committee considered and reviewed the report noting: - • Comprehensive report from meeting on 8 August including assurance ratings • Dedalus (formerly DXC) Vendor management. Ongoing performance issues, with the move to the Cloud the next major step, with a revised date of 11th September 2021 being proposed. • IT services update. Moderate assurance. Issues with a backlog of device deployments are being resolved with a 50% reduction during June and July. Server patching is on track, but issues with desktop patching are noted and being investigated. • Strategic Electronic Patient Record (including tactical solution). Moderate assurance. The Outline Business Case for the strategic solution was approved at Trust Board in July 2021 with procurement planning starting in August. Risks were noted on the contract for Lorenzo and for Ormis (theatres) due to the delays in Cloud migration. Additional national funding will potentially support, VAT treatment is being reviewed and a revised business case to September FSC and Board	The Committee **noted** the update and the **escalation** of cloud migration delay to Board	FSC September 2021

FSC/21/08/133	EPR	The Committee considered the update noting next steps:- • A review of the five year capital plan for the Trust is required • Seek external support from the ICS for any additional capital over internally generated funds • Further detail regarding existing benefits needs to be provided • More benefits to be identified to support in year deficits in 2023/24 and 2024/25 and potential additional capital charges • SEOG received this update, now inform Trust Board of the NHSE/I OBC feedback • Updated business case to be presented to SEOG, FSC and Trust Board November 2021	The Committee **noted** the update	FSC September 21
FSC/21/08/134	Monthly Finance report incl: a) June 2021 b) Draft Capital Planning Group minutes (25.06.2021) c) CPG Terms of Reference d) FRG minutes (19.05.2021)	The Committee considered the report and capital proposals. Key points to note included: • Capital behind plan • BPPC 94% top 10 performers in region • ERF not achieved in July resulting in lost income – link to outpatient review • Position carries risk on anticipated ERF for May, June and August and September • Submitted best, worse and likely forecast, currently forecasting breakeven with some risks on CIP, non pay pressures, COVID costs and ERF • Capital noted and supported 2 items in **Table 11** endoscopy and call alarm system • Items raised for escalation by the Financial Resources Group (FRG) are: • assurance from internal audit regarding additional waiting list sessions and the adherence to relevant governance procedures • Outpatient recovery performance • Items raised for escalation by the Capital Planning Group (CPG) include: that capital is currently underspending from plan and a forecast is being prepared which will be provided to FSC in September 2021	The Committee **noted** the updates and received good assurance The Committee **supported** the changes to the capital plan.	FSC September 21 Board August 2021

FSC/21/08/135	Emergency Preparedness	The Committee considered the Emergency Preparedness Annual report noting the following:- • Noted due to COVID-19 it has been a different year than usual • Highlighted areas of partial compliance and actions taken • This workstream is monitored through monthly Event Planning Group meetings and items escalated to Tactical Board •	The Committee **noted** the annual report	FSC September 2021
FSC/21/08/136	Capital costs estates endoscopy Halton	The Committee considered the additional costs noting the following:- • Original budget £592k, increase required due to additional building controls and ducting work (the cost increased by £48k, approval not sought in advance) • At handover in July an additional cost of £23k was identified and work paused to obtain approval for additional 2 x electric pendants with additional power & gases to each endoscopy room including design fees • Overall increase of £71k additional funds required for the scheme	The Committee **supported** the request for additional capital to be submitted to Board for approval	Board August 2021
FSC/21/08/137	Risk Register including	The Committee considered the Risk Register noting the following:- • No new risks or amendments to BAF • No new risks or amendments to Corporate register • Considered to monitor risks	The Committee **noted** the updates	FSC September 2021
FSC/21/08/138	Runcorn shopping city	The Committee considered the Runcorn shopping city capital addendum:- • Requesting additional £215k mainly due to increased construction costs even with professional original quotes • Reduced specification has been reviewed and found £12k reduction	The Committee **supported** the addendum to go to Board for approval	Board August 2021
FSC/21/08/139	New hospitals expression of interest	The Committee considered the new hospitals expression of interest:- • Next 8 Health Infrastructure Plan • Formal competitive process – 2 stage process	The Committee **supported** the expression of interest	Board August 2021

		• First stage limited word submission • Bid includes both Warrington and Halton with costs split in bid • The Committee noted will require further information on benefits and costs as we progress • Health inequalities should be referenced more clearly	to go to Board for consideration	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/09/125 (d)		TRUST BOARD OF DIRECTORS	DATE OF MEETING	29 September 2021

Date of Meeting	**22 September 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/21/09/145	Corporate Performance Report	The Committee considered and reviewed the report noting:- • August A&E performance for type 1 - 72.84%. WHH rated 42/116 nationally, 14/38 regionally • Ambulance handover has increased in 0-15 minutes however the Trust continues to perform well compared to peers, >60 minutes 2.85% • Achieved 52 week in August • The 62 day cancer target was not achieved in July 2021 • General and acute bed occupancy at 93% • Super stranded patients totalled 113 at the end of August • RRT 18 week target not met - 77.08% • Diagnostic target was not achieved in August – 24.04% The following issues to be escalated to CROC: • Overdue follow ups at 17+ weeks with no date has increased in August	The Committee **noted** the updates and **escalated** issues to CROC.	FSC October 2021 CROC October 2021

		• Paediatric DNA rate has increased in August • Incomplete pathway trajectory has worsened in August		
FSC/21/09/146	Pay Assurance Report	The Committee considered and reviewed the report noting: - • There were 370 FTE vacancies across the Trust compared to 373 FTE temporary work/additional hours undertaken – leaving a variance of 3 FTE, a significant decrease • The key drivers for additional temporary staffing remain COVID-19, CEV staff requirement and sickness • ECF approval is now required for all bank shifts • All international nurses have been recruited and are in the UK • MIAA proposals regarding extra duties payments have been completed and sent to MIAA for agreement	The Committee **noted** the update.	FSC October 2021
FSC/21/09/147	Monthly CIP	The Committee considered and reviewed the monthly CIP noting:- • On plan at the end of month 5 with £0.6m delivered • Gap in H1 of Circa £170k • Risk for the whole year of £2.7m leaving a significant challenge if the Trust is to achieve a break-even position • Limited CIP identified in Planned (£0.9m gap) and Unplanned Care (£1.6m gap) • Transformation teams absorbed into services impeding identification and deliver of CIP	The Committee **noted** the CIP report and **escalated** the risks to Board.	FSC October 2021
FSC/21/09/148	COVID-19	The Committee noted the COVID-19 update, noting:- • Year to date expenditure is £4.0m which is £2.0m more than budget due mostly to the impact of sickness and isolation	The Committee **noted** the update	FSC October 2021
FSC/21/09/149	Capital Plan – stocktake/deep dive outcomes	The Committee considered and reviewed the capital update, noting:- • Stock take and deep dive undertaken • Changes to the capital profile and allocation of contingency noted and supported	The Committee **noted** the update.	FSC October 2021

		• The 5-year draft capital plan • Schemes over £0.5m were reviewed, specifically the breast relocation and ED plaza schemes • Internal review of estates capital has been completed with the external review by MIAA to take place in October	The Committee **supported** the changes to the capital profile and allocation of contingency.	Board October 2021
FSC/21/09/150	Digital Services Board Report	The Committee considered and reviewed the report noting: - • Comprehensive report from meeting on 13 September including assurance ratings • Moderate assurance - Dedalus (formerly DXC) Vendor management. Patching has been carried out following the migration of Lorenzo to the cloud in mid-September. • IT services update. Moderate assurance. Password reset function to be reinstated for 4,000 staff, plan to address surge in helpdesk activity to be in place by October to complete. To ensure full cyber-attack protection, patching is required on all network switch equipment. • Strategic Electronic Patient Record (including tactical solution). Moderate assurance. The Outline Business Case for the strategic solution was approved at Trust Board in July 2021 with procurement planning starting in August. Comments made by NHSD are being reviewed and NHSE/I have proposed further work on benefits. This will be carried out and a revised version of the OBC will be submitted to Board in November.	The Committee **noted** the update.	FSC October 2021 FSC November 2021 Board in November 2021
FSC/21/09/151	Strategy & Sustainability monthly report	The Committee noted the strategy update, noting:- • First report of this type submitted to the Committee	The Committee **noted** the update.	FSC October 21
FSC/21/09/152	Monthly Finance report incl: a) August 2021 b) Draft Capital Planning Group	The Committee considered the report and capital proposals. Key points to note included: • £0.3m better than plan YTD • ERF not achieved in August resulting in lost income	The Committee **noted** the update.	FSC October 21

	minutes (25.06.2021) c) CPG Terms of Reference d) FRG minutes (19.05.2021)	• Position carries risk on anticipated ERF for June • £3.1m ERF income expected in H1 (down £0.5m compared to July) • Expenditure plan for H2 has been submitted, showing a £5.6m increase compared to H1 • H1 forecast position is breakeven however significant number of risks have been identified including unplanned COVID schemes and drug expenditure • Capital noted and supported items in **Table 13:** two items to be added back to contingency and the request for ophthalmology equipment. • Items raised for escalation by the Financial Resources Group (FRG) include: Urology and ENT at risk of further cost pressure due to additional sessions required to maintain target. To be monitored through H2 planning and monitored at CROC. • Items raised for escalation by the Capital Planning Group (CPG) include: 5-year capital plan and contingency fund plan to be presented to FSC.	The Committee **supported** the changes to the capital plan.	Board September 2021
FSC/21/09/153	Bridgewater Maternity Service Transfer	The Committee considered the presentation noting the following:- • The negative impact to the finance position and request made for block contract arrangements in the short term • Supported in principle the transfer (from a financial perspective) of Halton Midwifery Services, subject to the agreement of finance and contracting arrangements	The Committee **noted** the impact to the financial position and **supported (in principle)**, the transfer of service.	Board September 2021
FSC/21/09/154	Business case for Tactical EPR Procurement	The Committee considered the business case noting the following:- • National funding of OneED to be finalised and could lead to savings of circa £275k.	The Committee **supported** the revised business case to go to board for approval.	Board September 2021

		• Supported the changes in proposal resulting in reduced cost		
FSC/21/09/155	Annual EPRR assurance letter	The Committee considered the annual EPRR assurance letter noting:- • The EPRR self-assessment rating of 'substantial assurance'.	The Committee **supported** the self-assessment rating of 'substantial assurance'	FSC October 2021
FSC/21/09/156	Warrington Town Deal full Business Case	The Committee considered the proposed business case noting the following:- • Risk and benefits share to be agreed • There is recurrent revenue risk of £350k subject to legal support	The Committee **supported** the business case to go to Board for approval	Board September 2021
FSC/21/09/157	Committee Terms of Reference Annual Review	The Committee considered the terms of reference, noting:- • Following confirmation from the Executive Medical Director, the terms of reference will be updated to include the reporting of the Medical Cost Pressures Review Group.	The Committee **noted** the update	FSC October 2021
FSC/21/09/158	Risk Register	The Committee noted the update	The Committee **noted** the update	FSC October 2021
FSC/21/09/159	WHH Medical Bank Rate Card	The Committee considered the medical bank rate card proposal, noting:- • Approved the use of both the medical rate card • Approved the agenda for change rate card adjustment to reflect changes received in the pay award • Approved the change to the Medical Bank Escalation Rate SOP	The Committee **approved** the proposals	
FSC/21/09/160	Digital Systems Tender Evaluation	The Committee considered the request to amend Trust SFI's, noting:- • Proposed change to 70/30 ratio for digital evaluation criterion from 60/40	The Committee **supported** the change to SFI's	Board October 2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 21/09/125 e i	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	29 September 2021

Date of Meeting	19 August 2021
Name of Meeting & Chair	Audit Committee, Chaired by Ian Jones
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
AC/21/08/52	**Changes/update to BAF**	The Committee particularly noted the following since the last meeting: Three new risks had been added to the BAF; - Risks #224; #1233 and #1373 The ratings of 7 risks had been amended due to mitigating actions: - Risks #1272, #1275 and #1289 from 25 to 20; Risks #1331, #1332 and #1124 from 15 to 10. Descriptions of three risks had been amended to best describe the current situation; - Description of risks #1108: #1289 and - Description of risk #224 to reflect the potential impact on staff wellbeing: Three risks had been de-escalated to the Corporate Risk Register for continued monitoring: - risks #1331, #1332 and #1124. - Risk #1205 closed following completion of all the actions.	**The Committee discussed the report and received good assurance**	**Quality Assurance Committee 07.09.2021** **Trust Board 29.09.2021** **Audit Committee 18.11.2021**

		The Committee also reviewed and noted the updates to existing risks #1272, 1273, #1124, #1215, #1272, #1273, #1275 #115 #134, #1134, #1114, #1207 #125, #1108, #1274. #1290		
AC/21/08/53	**Progress Report on Internal Audit Follow-Up actions**	The Committee received a report providing details of Internal Audit Reports with any outstanding management actions. The Committee particularly noted and supported the following extension to deadlines: - 7 audits with 16 overdue management actions reported. The following requests for extensions agreed: - Conflict of Interest 2020-21 - first-time extension to the original deadline for the audit on Conflict of Interest 2020/21 **request to extend to 30.09.2021.** - Data Quality Review 2018-19 - third extension to the original deadline for the audit on Data Quality Review 2018/19 **request to extend to 30.11.2021** granted but disappointment expressed by the Committee Requests for further extensions agreed to complete the following audits of partially completion actions: - Information Standards Discharge Summaries Assignment Report 2018/19 **request to extend t0 31.08.2021** - Estates Statutory Compliance Review 2020/21 **request to extend to 30.11.2021** <u>Overdue Critical and High recommendations</u> - The Overtime (OT) Review Assignment Report 2018/19 - concerns still to be concluded. Matter to be escalated to Deputy COO. - It was agreed that 2018-19 review recommendations be resolved as soon as possible. Actions to achieve to be documented where national/other factors are restricting WHH to fully close down these recommendations.	**The Committee discussed and approved the report and received moderate assurance**	**Audit Committee 18.11.2021**
AC/21/08/55	**Internal Audit Progress Report**	The Committee received a report providing an update in respect of the assurances, key issues and progress against the internal Audit Plan for 2020/21. 3 reports issued:	**The Committee reviewed and discussed the report and assurances provided. Moderate assurance was**	**Audit Committee 18.11.2021**

		- Conflicts of Interest (20/21 Review) - Data Security and Protection Toolkit (DSPT) (June 2020 submission) (Assessment against Self-Assessment - Substantial Assurance; Assessment against National Guardian Standards - Moderate Assurance). - Patient Levels Costing System (Substantial assurance), 3x Medium, 4x Low Four reviews in progress - Data Quality Review (Draft report with Executives for review) and fieldwork in progress for three - CPR Decision Making; Waiting List Management; Discharge Planning Waiting List Payments review added to Internal Audit Plan. Masterclass events during Autumn 2021 highlighted including Health & Care Bill and update on ICS developments, 15 September 2021.	**received.**	
AC/21/08/56	**Draft Auditor's Annual Report 2020-21 (formerly Annual Audit Letter**	The Committee reviewed the report and particularly noted: - New focus on Value For Money, conclusions summarised relating to Financial Sustainability, Governance and Improving Economy, Efficiency and Effectiveness. - Financial Sustainability - no weaknesses identified following final review. Improvement in overall arrangements reflected in the report. One area for improvement identified - moving from current COVID-19 arrangements to 'business as usual' and relationships within ICS. - Report to be issued for inclusion and publication in the Annual Report and issue of Audit Certificate.	**The Committee noted the report and good assurance, and supported closing of the Audit and issue of the final Auditors Report.**	**n/a**
AC/21/08/57	**Counter Fraud Progress Report**	The Committee received a report detailing progress on counter fraud activity and particularly noted the following: - Work undertaken in Q1, included Counter Fraud Annual Report, submission of returns to Counter Fraud Commission, FOIs; nomination of Marie Garnett as new Trust Fraud Champion. - Fraud Cases and Awareness Training to strengthen evidence of compliance against standards. - Continued sharing of Protect and Deter alerts; national proactive exercise	**The Committee reviewed the report and assurances provided of monitoring processes in place to manage Fraud within the Trust. Good assurance was noted.**	**Audit Committee 18.11.2021**

		deadline week commencing 23 August; reviewed Anti-Fraud, Bribery and Corruption Policy. - Fraud referrals on-going, one joint case with local Trust. - New financial fraud standards, work progressing to turn Amber ratings to Green by March 2022. - 122 additional national fraud risk standards, circa 40-45 applicable for Trusts to be shared by September. - Investigation summary and recovery of losses highlighted. No matters of escalation.		
AC/21/08/59 (b)	**Anti-Fraud, Bribery & Corruption Policy**	The Committee received an updated Anti-Fraud, Bribery & Corruption policy for approval. Minor changes included updating of new Trust Fraud Champion, new fraud standards and Bribery Act 2010 & Trust Anti-Bribery Strategy. Policy will be disseminated via a Trust-wide Communications Strategy and awareness raised across the Trust for it to be 'real'. Anti-Fraud, Bribery & Corruption training will form part of the Trust Mandatory Training requirements on a 3-year cycle.	**The Committee approved the updated policy and received good assurance.**	**Audit Committee, August 2023**
AC/21/08/61	**Review of Quotation & Tender Waivers 01.04.2021-30.06.2021**	The Committee received the report and noted: - There had been 25 waivers at a value of £930,655 - This represents a decrease of two (7%) compared to the number for the same period last year with the value decreasing by £54,782 (5.5%). - Retrospective waivers (excluding those relating to COVID-19) represent 20% of the total number of waivers submitted, the number of retrospective waivers has increased by 25% compared to the same period last year. The value of the waivers was noted and the Chair raised some concerns relating to the increase in retrospective waivers and nature of requests, particularly for maintenance contracts as highlighted and importance of staff awareness of when these are due for renewal	**The Committee noted and discussed the report and received moderate assurance**	**Audit Committee 18.11.2021**

AC/21/08/67	**Risk Management Annual Update Report**	The Committee received a report providing assurance of the planned and systematic approach to the management, identification, evaluation and control of risks within the Trust during 2020-21. The following was noted: - Good risk appetite through COVID-19 Pandemic. - Risk Review Group had continued to meet monthly. Risks discussed in real-time with introduction of appropriate governance structure during COVID-19, i.e. Tactical Group reporting direct to Strategic Executives Oversight Group (SEOG) to allow escalation and de-escalation of risks as appropriate. - Additional COVID-19 Risk Register introduced aligned to CBU, Corporate Risk Register and BAF.	**The Committee noted and discussed the report and received good assurance**	**Audit Committee August 2021**

Other items included on the agenda were:

AC/21/08/60 - Review Losses and Special Payments 1 April 2021-30 June 2021
AC/21/08/62 - Deloitte COVID-19 Cost Reimbursement Review Phase 3
AC/21/08/63 - Annual On-Call Report
AC/21/08/64 - Overtime Annual Update Report
AC/21/08/65 - North West Skills Development Network (NWSDN) Bi-Annual Report
AC/21/08/66 - ICON (Babies Cry, You Can Cope) Programme Bi-Annual Report
AC/21/08/69 - Audit Committee Chairs Annual Report

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/09/125 f		TRUST BOARD OF DIRECTORS	DATE OF MEETING	29 September 2021

Date of Meeting	**23rd July 2021**
Name of Meeting + Chair	**Clinical Recovery Oversight Committee (CROC) Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
CROC/21/06 /76	Harm Profile update	• Overall, there has been a further reduction of 11 reviews completed, therefore an overall reduction of 1390 reviews completed since 7th April 2021 (Figures 2&3). • Urology harm review – 1 patient seen last week due to a/l in the team but schedules have been reviewed and will improve on this going forward. Urology will continue to be tracked, and this one will be removed from figures. • KSJ noted T&O trajectories currently rated red on page 33 of agenda pack, Spire Cheshire & private consultations being undertaken. Team is meeting next week to discuss and seek improvements.	The Committee **noted** the update	CROC August 2021
CROC/21/07 /77	Waiting List update	DM talked through the waiting list times and trajectories currently being seen in the Trust, with particular focus on the areas below the 92% standard, the specialties of focus were:	The Committee **noted** the report.	CROC August 2021

		• General surgery 53.7 • Urology 67.9 • T&O 54.8 • Gynaecology 66.6 MB asked more assurance detail about what is being done in the services to improve. **Priority codes:** July has seen an improvement against waiting list times against P2 trajectory and backlog. Live position as of 22/7/21 is 400 pts in backlog and is continuing to reduce. Forecast is 183 against the trajectory of 421. **Cancer: G**ood assurances and are tracking comfortably against the trajectory. Wait list over 62 days is coming down each month and is currently 16 for June against 25, with a live figure for July at 13 patients **MRI recovery -** additional capacity needed to achieve the targets? DM commented will be ramping up more activity – currently, construction on site is delaying progression, this should be completed end of August. Trend is downwards though and will be improving		
CROC/21/07/79	July 2021 BAF & Risk Register Update	**BAF update** • Since the last meeting one new risk has escalated to the Board Assurance Framework. • There have been no amendments to the ratings of any risk on the BAF however, a proposal will be made to the Trust Board on 28th July 2021 to increase the rating of risk #224 (detail in agenda pack) from 16 to 25 to reflect current operational pressures.	The Committee **noted** the update	CROC August 2021

		• There has been one amendment to the title of a risk on the BAF (#224) and a proposal will be made to the Trust Board on 28th July 2021 to amend the description of another risk (#1289). • Since the last meeting two risks have been de-escalated to the Corporate Risk Register. **Corporate Risk Register** • No new risks have been added to the CRR and there have been no amendments to the ratings of any risks on the CRR for which this committee is the monitoring Committee. • Currently, two risks have been de-escalated (#1331 & 1332, rating from 15 down to 10) as agreed by the Risk Review group and the Quality Assurance Committee.		
CROC/21/07/81	Data Specialty Overview	• JH gave an update on the target having moved from 85% to 95%, and the tariff coming down to 100% from 120%. • Virtual clinics target is 25% (we are currently 3%), and there is a target of 10% for advice and guidance (we are at 3%).	The Committee **noted** the update	CROC August 2021
CROC/21/07/82	C&M data comparisons	**Outpatients -** TA discussed the data table and would like comments re being an outlier on this area. Current figure is 87% (FU) and 85% (1st) against 107% and 111% for the north west. CSOG are to set the improvement trajectory and include in the pack going forward. MB commented is there any recognition that we are heading towards a fourth wave of covid increases, so we might not be able to achieve all targets? DM commented that we are planning for expected July-sept covid increases	The Committee **noted** the update	CROC August 2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/09/125 f		TRUST BOARD OF DIRECTORS	DATE OF MEETING	29 September 2021

Date of Meeting	**18th August 2021**
Name of Meeting + Chair	**Clinical Recovery Oversight Committee (CROC) Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
CROC/21/08/89	Harm Profile update	• There has been a further reduction of 18 reviews completed in week, therefore an overall reduction of 1500 reviews completed since 7th April 2021 (Figures 2&3) • No new harms identified and one had been downgraded, so now a total of 12 • DM advised that Urology and MaxFax will be completed in August • MB asked if the outstanding T&Os were on track to be completed in August? DM replied that there was some new reporting and there are some to do regarding looking back and re-assessing earlier reviews. He acknowledged that there was a large number of patients coming back for review which is causing delays in the system.	The Committee **noted** the update	CROC September 2021

CROC/21/08/91	Waiting List update	RTT update: Key Issues; Priority Code & Waiting Times – Key Issues DM talked through the waiting list times and trajectories currently being seen in the Trust, with particular focus on the areas below the 92% standard, the main specialties of focus of support are General surgery and Urology which need more theatre time. This is to be addressed as part of H2 planning. Total RTT Waiting List size 21191 (this does not include ASI, RAS patients) higher than the submitted estimate of 20506 including ASI, RAS, total is 22625 Endoscopy – Key Issues • Strong improvements in overall waiting reduction to date • Room 3 on the Warrington site remains closed due to ongoing staffing challenges • With the current capacity and increase in referrals, the waiting list for Diagnostic and Surveillance is expected to grow • Plans being evaluated to open Room 3 on the Warrington site • Increasing Endoscopy capacity is necessary to improve Cancer performance recovery. Theatres 3 and 4 at Halton are still closed due to Endoscopy services being run until Endoscopy roof is completed which is due to happen in the next couple of months. Cancer (62,104) – Key Issues	The Committee **noted** the report.	CROC September 2021

		• Trajectories for >62 and >104 day being achieved in line with the Cancer Alliance trajectories • Continued good compliance against 31 day and 28-day Faster diagnosis standard • Trajectory and plan being drawn up to achieve Q3 compliance for 62 day • Colorectal and Prostate noted as the most challenged pathways, trajectory and plan to be received at CSOG on 19th August 2021 <u>Radiology – Key Issues</u> • Reporting performance increasingly reliant on reporting outsourcing due to increased activity levels to maintain the recovery trajectory. • Delay in the opening of the static MR scanner to be offset with the Mobile MR van staying until October. This will provide important elective and inpatient capacity. • Pressures in Ultrasound due to staffing an issue at present due to leavers (x3) and Mat leave (x2) • Continued growth in Obstetric ultrasound compared to 2020 <u>Outpatients – Key Issues</u> • Continuation of Outpatient Recovery Improvement Group (ORIG), focusing on 5 Workstreams: • Operational, Workforce, Risk Stratification of Outpatients, Access Policy, Performance/KPIs • Trajectory for the attainment of 95% in development • Clinic template updates in progress to ensure accurate recording of Virtual Clinics		

		• Clinic utilisation and productivity reports being revamped to give greater accuracy and timeliness to support booking • Continue to report the following Activity into PRG: • Outpatient performance by priority and risk, DNA, Cancellations, E-Outcome position Outpatient Deep Dive requested for Septembers meeting.		
CROC/21/08/92	Access to Recovery Fund update	JH reported that the April 2021 value was confirmed as £1.1m. For May/June 2021 target achieved but confirmation of payment depends on whole ICS achievement of targets. July 2021 target will not be achieved due to Outpatients. August and September 2021 are estimates and non-achievement will have an impact on the overall financial position.	The Committee **noted** the update	CROC September 2021
CROC/21/08/93	Other key issues	Total Waiting List by Trust and Wait Bands across Cheshire and Merseyside to be included at the next board meeting	The Committee **noted** the update and information to be shared at August Board.	No further review.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/21/09/125 f		TRUST BOARD OF DIRECTORS	DATE OF MEETING	29 September 2021

Date of Meeting	**14th September 2021**
Name of Meeting + Chair	**Clinical Recovery Oversight Committee (CROC) Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
CROC/21/09 /102	Harm Profile update	• There has been a further reduction of 34 reviews completed in week, therefore an overall reduction of 1536 reviews completed since 7th April 2021 (Figures 2&3). • 1 moderate harm has been identified in Urology on Tuesday 31/08/21. Patients renal function has declined whilst waiting for surgery. TCI date is being prioritised by CBU. • LA advised a further moderative harm has now been identified in ENT and is being looked into.	The Committee **noted** the update	CROC October 2021
CROC/21/09 /104	Waiting List update	<u>RTT update: Key Issues</u> • Total RTT Waiting list size 21383(this does not include ASI, RAS patients) higher than the submitted estimate 20512) Including ASI, RAS Total WL size 23825 • Additional activity requirements are being reviewed as part of H2 planning	The Committee **noted** the report.	CROC October 2021

		<u>Priority code & waiting times</u> Position continues to be tracked against Cheshire & Merseyside benchmark. • The 52 week wait trajectory remains on track. Progress is expected to slow during the month of August owing to a high uptake of annual leave. • Once the P2 backlog hits the end trajectory in October 21, an additional 60-70 theatres slots will be redirected to support reductions in P4. • July and August trajectories achieved re: restoration, currently 961 against September trajectory of 913. • The Trust achieved the P2 backlog target for August and is forecast to achieve in September. Priority code update: Key Issues - • A review of the P3 waiting list is underway and is being monitored in CSOG – a trajectory for P3 will be available for the October CROC meeting • There is a national steer to ensure there are no patients waiting >104 weeks by the end of March 2022. Although analysis is ongoing, early indications are that the Trust will be compliant with this. • Consideration is being given to elective recovery during winter and will form part of the Trust and wider Cheshire and Mersey/ICS winter plan. <u>Cancer (62 and 104 days)</u> • The Trust remains on trajectory with final figure for August, 10 patients against a target of 23.		

		Cancer: Key Issues –
		• Trajectories for >62 and >104 day being achieved in line with the Cancer Alliance trajectories
		• Continued good compliance against 31 day and 28-day Faster diagnosis standard
		• Trajectory and plan has been drawn up to achieve Q3 compliance for 62 day by December 2021
		  • Colorectal and Prostate noted as the most challenged pathways
		• Continued increase in 2ww referrals over and above pre pandemic levels. 2ww has struggled in the last 2 months but September is more likely to achieve
		• Diagnostic waiting times contributing to the under-performance – particularly Endoscopy.
		  • CT Colon referral pathway work underway to manage the demand for referrals underway and due to complete in August 2021
		  • Work ongoing with endoscopy to understand required demand and capacity requirements
		  • Implementation of transperineal biopsies for prostate patients is starting to show pathway improvement.
		
		<u>Diagnostics</u>
		
		• Radiology remains on track to achieve the 99% standard in October 2021. The biggest risk to achievement is the Ultrasound waiting list.
		
		Radiology: Key Issues –		

		• Reporting performance increasingly reliant on reporting outsourcing due to increased activity levels to maintain the recovery trajectory.
		• Delay in the opening of the static MR scanner to be offset with the Mobile MR van staying until October. This will provide important elective and inpatient capacity.
		• Pressures in Ultrasound due to staffing an issue at present due to leavers (x3) and Mat leave (x2)
		  • Successfully recruited 3 F/T Sonographers 8th Sept 2021, this will support the recovery against the DMO1 standard.
		  • Insourcing options being reviewed.
		• Continued growth in Obstetric ultrasound compared to 2020
		
		Endoscopy
		Waiting List:
		• Internal trajectory to achieve 6-week diagnostic target by October.
		• 81 patients behind trajectory for August
		• Currently trying to set up additional weekend working to recover the position for September.
		Surveillance Waiting List:
		• Significant amount of work undertaken in August with validating surveillance waiting list.
		• In line with C&M Endoscopy Network guidance, all patients who been given a low risk FIT score have been deferred by 6 months.		

		<u>Endoscopy</u> TA advised that he had spoken with Andrea McGee, Chief Finance Officer & Deputy Chief Executive regarding what the H2 position would look like to give consideration to some financial investment in Endoscopy. Endoscopy: Key Issues – • The Endoscopy team are currently preparing for the 5 yearly JAG visit due in January 2022. All data to be submitted by the end of October 2021. This involves a huge amount of work from clinical, nursing and management teams. The Team are on track with it. • In line with national guidance, all overdue surveillance patients will need to be added to an active waiting list. This will result in approx. 800 patients being added onto the waiting list. DM will be taking paper to Executive Team re: does the Trust comply with this guidance. TA queried if options may need to be looked at regarding a potential impact over time? • Difficulties in staffing additional capacity due to WHH staff working at other NHS and Private Endo units for increased pay out of hours. <u>Cardio-Respiratory: Key Issues</u> - • Main concern is echoes and stress echoes. Capacity and Demand modelling shows deficit of 12 sessions per week. Increase in 2 WTE required to meet current demand.		

		• Imaging consultant that left for sabbatical was not replaced by imaging locum- impacted upon stress echo capacity • 3 shielding clinical members of staff who can only work in green area- impacted upon staffing for other tests <u>Outpatients</u> New and Follow Up – • August Position is expected to achieve. Based on values (£) the OP estimate is expected to be >95%. Work is ongoing increase the closing position before the cut- off date. • September forecast is on target to achieve. Improvements to estimated activity position are under development • October set to be the most challenging month of the financial year 2021/2022 Outpatients: Advice and Guidance (A&G) - • Second highest Trust in C&M region for Advice and Guidance utilisation • Plans in place to collect non-eRS Advice and Guidance from October 2021 • 11 Services Live – Ophthalmology to be introduced October 2021 Outpatients: Virtual Clinics – • Performance is tracking at 26.46% for August. Face to Face activity is expected to increase slightly for September for High Risk patients. Plans are in place to maintain > 25%		

		Outpatients: Key Issues – • Continuation of Outpatient Recovery Improvement Group (ORIG), focusing on 5 Workstreams		
CROC/21/09 /105	Outpatients Deep Dive	ZH presented a deep dive paper taken as read. The Trust achieved the Outpatient ERF trajectory April – June 2021, however, failed to reach the target of 95% in July and are currently at risk of not achieving in August due to an underperformance in new appointments. Key issues contained within the report were noted. TA noted that a few areas had volume issues. ZH replied that this was due to a number of reasons including: handover from COVID-19 and some changes around workforce. ZH reported that Ophthalmology have done a lot of work and are forecast to hit trajectory for September 2021. CR acknowledged that the report gave an overall understanding of what capacity the Trust has and coupled with H2 funding, the final figure to be confirmed, he felt that the Trust was gaining control. DM added that there was some legacy issues re: ENT. This links to the Medical Staffing piece of work that Dr Alex Crowe is undertaking. Also, that although Ophthalmology is now switching back re: activity, the same needs to be done with other specialties.	The Committee **noted** the update	CROC March 2022

		The Clinical Recovery Oversight Committee noted the content of the report and the capacity risks identified in some key services that will impact compliance with the ERF target.		
CROC/21/09/106	Risk update	**BAF** • Since the last meeting one new risk, for which this Committee is monitoring Committee, has escalated to the Board Assurance Framework (BAF). It is also proposed that one further risk is escalated from the Corporate Risk Register. • Since the last meeting the rating of one risk on the BAF for which this Committee is a monitoring Committee; has been increased. • Since the last meeting, there have been amendments to the titles of two risks on the BAF for which this Committee is a monitoring Committee. • Since the last meeting no have been de-escalated to the Corporate Risk Register. **Corporate Risk Register** • Since the last meeting, no news risks have been added to the Corporate Risk Register for which this committee is the monitoring Committee. • Since the last meeting, there have been no amendments to the ratings of any risks on the CRR for which this committee is a monitoring Committee. • Since the last meeting, there have been no amendments to the titles of any risks on the CRR for which this committee is a monitoring Committee.	The Committee **noted** the update	CROC October 2022
CROC/21/09/107	Access to Recovery Fund update	JH reported that guidance has not yet been received for HS2, however, she did advise that there would be ERF funding within it.		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/126**	
SUBJECT:	**Moving to Outstanding Bi-Monthly Report**	
DATE OF MEETING:	29/09/2021	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**#224** Failure to meet the emergency access standard, caused by system demands and pressures. Resulting in potential risks to the quality of care and patient safety, staff health and wellbeing, Trust reputation, financial impact and below expected Patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in	

	potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident. **#1331** Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.

EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Moving to Outstanding Steering Group continues to focus on:
	• The 'Red Flags' report, linked to CQC's Insight Report
	• Oversight of CQC enquiries (13 received July 21 to date)
	• Oversight of the mock inspection programme
	• A Regulatory update
	• Progress updates on:
	  ○ CQC registration of 'Shopping City'
	  ○ RCEM action plan
	  ○ Progress towards ACSA accreditation
	  ○ Progress towards JAG accreditation renewal
	  ○ Use of Resources
	  ○ Moving to Outstanding Task and Finish Group

	○ Communications This paper provides high-level updates across each of these areas.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors are asked to receive and note the content of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 41 – confidentiality			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Moving to Outstanding Bi-Monthly Report	AGENDA REF:	BM/21/09/126

1. BACKGROUND

The Moving to Outstanding Steering Group continues to focus on:

- The 'Red Flags' report, linked to CQC's Insight Report
- Oversight of CQC enquiries (13 received July 21 to date)
- Oversight of the mock inspection programme
- A Regulatory update
- Progress updates on:
    - CQC registration of 'Shopping City'
    - RCEM action plan
    - Progress towards ACSA accreditation
    - Progress towards JAG accreditation renewal
    - Use of Resources
    - Moving to Outstanding Task and Finish Group
    - Communications

2. KEY ELEMENTS

2.1 Red flags report

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

- 25 indicators in total outstanding, for which plans are in place.
- Overall, 9 indicators are improving, 1 has remained static and 15 have showed some decline namely relating to sickness absence of clinical and non-clinical staff and elements of operational performance. Operational performance is being supported by the patient flow programme with oversight provided at the Clinical Services Oversight Group and Performance Review Group. An ED steering group has also been established. Work is underway to improve sickness absence. The HR and the OD team have established a programme of work which will focus upon improving attendance with consideration for employee Health and Wellbeing with strengthened links between line managers and the Occupational Health Department. The HR and OD team are also participating in a NHSE/I regional absence management deep dive that will form part of this workstream.

There are plans in place to monitor and progress all outstanding indicators with oversight at relevant committees.

2.2 CQC Enquiries

From 1 July 2021 the Trust has received 10 new enquiries from CQC. The increase in enquiries has largely been as a result of CQC returning to their routine monitoring of NRLS, which results in requests for copies of rapid incident reviews or root cause analysis reports, as previous. Enquiries are being responded to with no concerns to escalate to this committee.

2.3 Oversight of the mock inspection programme

The mock inspection of maternity has been completed. An initial compliance action plan is in place, which is monitored at the Moving to Outstanding Steering Group. A more comprehensive action plan focusing on supporting the service moving to outstanding has been developed and this will be monitored through the CBU governance process and the Moving to Outstanding Steering Group.

An unannounced inspection for Urgent and Emergency Care is scheduled (September 2021), which will be followed by an inspections of outpatients and a wider implementation plan.

2.4 Shopping City CQC application

An initial meeting has been held with the CQC to register the activity of shopping city which is a legal requirement. Following approval at Quality Assurance Committee this will be submitted. This is an agenda item.

2.5 Oversight of the RCEM action plan

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

- IPC 06 – Nursing for Escalation areas – A business case is progressing to the Finance and Sustainability Committee.
- IPC09 – ED Plaza – A contractor has been identified.
- IPC 16 – Single Medical Clerking.

2.6 Oversight of progress towards ACSA accreditation

- ACSA have scheduled their next virtual assessment visit for 21 October 2021 with all actions on track.
- Weekly meetings are in place to ensure the team are fully prepared for the next visit. The action plan for the visit is overseen by the CBU governance meeting and Moving to Outstanding Steering Group.

2.7 Oversight of progress towards JAG accreditation renewal

- JAG accreditation is expected in January 2022 with data submissions due in October 2021. This is being supported by the Associate Director for compliance.
- Weekly meetings are in place to help prepare the team for the visit. The action plan will be overseen by the Moving to Outstanding Steering Group from October 2021.

2.8 Updates on Use of Resources

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

2.9 Regulatory Update

2.9.1 Proposed changes to regulatory model and assessment framework

CQC are reviewing their current methodology. Once formalised an update will be provided to this committee.

2.9.2 Mandated support and Recovery Support Programme

CQC has shared more detail about the link between them and the mandated support and recovery programme. This has now replaced special measures for NHS Trusts.

CQC ratings are one of the possible criteria for Trusts entering mandated support and mandated intensive support as described below:

2.9.3 Mandated support

This is provided by the NHS England and NHS Improvement regional teams. If a Trust receives a 'requires improvement' rating, a Trust will be considered for this level of support by NHSE/I.

2.9.4 Mandated intensive support

This is provided by the national intensive support team through the national Recovery Support Programme. If CQC give a rating of inadequate for well-led and for at least one other key question, the CQC will make a recommendation that the Trust enters mandated intensive support.

2.9.5 Assessments of quality and updates to ratings

CQC have published an update (How we will assess quality and update ratings from August 2021 | Care Quality Commission (cqc.org.uk)) on how they plan to assess quality and update ratings.

Key points include:

There is not a maximum interval based on previous ratings, between inspections, thus inspections will be undertaken as required.

The CQC will use a wider range of regulatory approaches to assess quality and rate trusts accordingly. This approach will include:

- Making more use of technology to support how evidence is gathered across all services.
- Updating a rating without a site visit.
- Where they have gathered evidence of a deterioration in quality or taken enforcement action
- Where they ask a provider to show that they have addressed the concerns that affected their rating in a previous inspection
- Assessments will still include whether services are safe, effective, caring, responsive and well-led using our assessment frameworks
- For this year the CQC will carry out some well-led plus core service inspections. They will continue to use information from monitoring, to decide which core services to include in the inspection.

3.0 Engagement

The CQC have increased their engagement activity to include risk-based assessments Transitional Monitoring Assessments (TMA). These assessments involve submission of a comprehensive response. To date these have been undertaken for Maternity and Urgent and Emergency Care. A Trust-Wide assessment has also been undertaken. The Trust has received positive feedback for each Transitional Monitoring Assessment completed. At this stage the Trust has not received notification of any further assessments. The Trust has recently had a new Inspector and Inspection Manager allocated and we are awaiting their proposals for future engagement meetings, which are likely to be face to face.

4.0 Our Outstanding Teams

At Moving to Outstanding this new agenda item has been introduced to enable services to share their outstanding practice. In August 2021 this included recognition of maternity services following shortlisting for a HSJ award.

5.0 RECOMMENDATIONS

The Board of Directors are asked to receive and notes the content of this report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/129**			
SUBJECT:	**Trust Strategic Objectives**			
DATE OF MEETING:	29th September 2021			
AUTHOR(S):	Pat McLaren, Director of Communications & Engagement Stephen Bennett, Head of Strategy & Partnerships			
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Director of Strategy & Partnerships			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#145** Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	Enclosed is a poster which summarises the refreshed Trust Strategic Priorities and Objectives, which were approved by Trust Board in July 2021. The poster is intended to inform the public of our updated priorities. A more detailed public document is also being produced to include progress against delivery of our 5 year strategy 2018-2023.			
PURPOSE: *(please select as appropriate)*	Information x	Approval	To note	Decision
RECOMMENDATION:	Trust Board is provided with the attached poster for information.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Our Strategic Priorities

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

	QPS Domain	Objectives	Required Outcomes
Quality	**Quality -** We will… always put our patients first delivering safe and effective care andan excellent patient experience.	**Patient Safety -** We are committed to developing and enhancing our patients' safety and learning culture where quality and safety is everyone's top priority.	• We will have safe systems of work in place. • We will ensure that we minimise harm for patients.
		Clinical Effectiveness is about ensuring practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients.	• We will ensure that we providing care that is evidence based. • We will ensure that we are focused on outcomes for patients and that are benchmarking/peer reviewing ourselves against the 'best in class'. • We will ensure that we foster a culture of Quality Improvement. • Every patient should have the opportunity to give feedback about their experience and we promise to use this to improve care and services.
		Patient Experience - By focusing on patient experience we want to place the quality of patient experience at the heart of all we do where "seeing the person in the patient" is the norm.	• We will communicate in line with our values. • We will ensure partnership working and needs based care. • We will simplify patient focused processes.
People	**People -** We will…be the best place to work with a diverse and engaged workforce that is fit for now and the future.	We will create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience.	• WHH will be a great and inclusive place to work • Staff will be supported to develop new skills and ways of working
		We will attract and retain a diverse workforce aligned to our culture and values, to ensure that we have the staff with the skills to deliver excellent patient care.	• Staff will be supported to be healthy and supported if they are unwell. • Staff will feel proud, enthusiastic and happy in work
		We will develop a collaborative, compassionate and inclusive culture of collective leadership and organisational learning.	• Staff at all levels in the Trust are able to develop as leaders • Staff feel empowered to identify improvements and put them in place
		We will build and maintain a diverse and representative workforce that is empowered, engaged and supported to demonstrate inclusive behaviours.	• WHH is a diverse and representative workforce • Staff are empowered, engaged and supported to demonstrate inclusive behaviours
		We will work to ensure that the Trust has inclusive and diverse leadership across all levels of the workforce.	• Leadership is developed and displayed across all levels of the workforce • Our leaders are inclusive and diverse
Sustainability	**Sustainability -** We will…work in partnership with others to achieve social and economic wellbeing in our communities	Enhance our role as an anchor institution by building on the provision of integrated place-based care and addressing health inequalities within our populations, being guided by the principles of social value.	• Provider of integrated services. • Improved pathways for local residents to ensure that everyone receives the right support, care and treatment at the right time. • Strong relationships and collaborative working with all partners, including councils, CCGs, mental health and community services providers and the voluntary sector. • Develop the Trust as an anchor institution within the locality.
		Work with other acute care providers to ensure that those services which need to be provided by an acute environment are the best they can be and are clinically and financially sustainable.	• Ensure services meet the demand of our populations. • Provide services on behalf of others where our services are clinically and financially superior. • Disinvest in or transform services which are not financially sustainable and do not currently provide high quality outcomes. • Share best practice and collaborate to ensure the best outcomes for our populations. • Maintain and then improve financial position.
		Provide our services in an estate that is fit for purpose, supported by the realisation of digital opportunities, and aligned to the needs of our patients, staff, and populations.	• New hospital and wellbeing campus in Halton. • New hospital in Warrington. • Recognised digital exemplar.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/130**			
SUBJECT:	WHH Annual Season Influenza Vaccine (including Influenza flu vaccination best practice management checklist) and COVID-19 Booster Vaccine Final Plan			
DATE OF MEETING:	September 2021			
AUTHOR(S):	Diane Matthew, Chief Pharmacist Caroline Eardley, Head of Occupational Health and Wellbeing Jonathan Brown Vaccination Service Manager			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People Officer Lucy Garnder, Director of Strategy and Partnerships			
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 briefing paper provides information about the planning, implementation and delivery of a joint vaccination programme, for COVID-19 Booster Vaccination and Influenza Vaccination. The programme is aimed at vaccinating: Frontline NHS staff and Health and Social Care Workers, external to the Trust (COVID-19 booster vaccine only), and, • WHH Trust staff: o Influenza vaccine– intention of offering to all staff o COVID-19 booster vaccine – frontline / patient facing staff, in accordance with JCVI Guidance. In addition, this briefing paper seeks approval from Trust Board specifically related to the 'Healthcare Workers Flu Vaccination Best Practice Management Checklist'			
PURPOSE: *(please select as appropriate)*	Information	Approval √	To note	Decision
RECOMMENDATION:	For Trust Board to note and approve the content of this paper, specifically related to the 'Healthcare Workers Flu Vaccination Best Practice Management Checklist'			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/21/09/77 (a)		
	Date of meeting	22 September 2021		
	Summary of Outcome	Approved paper for onward approval by Trust Board		

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

REPORT TO BOARD OF DIRECTORS

SUBJECT	WHH Annual Season Influenza Vaccine (including Influenza flu vaccination best practice management checklist) and COVID-19 Booster Vaccine Final Plan	**AGENDA REF:**	**BM/21/09/130**

1. BACKGROUND/CONTEXT

The Trust's COVID-19 Vaccination Service commenced in December 2020, to vaccinate eligible individuals in the priority groups set out at that time by the Joint Committee on Vaccination and Immunisation (JCVI). Following the delivery of 1st and 2nd dose COVID-19 Vaccinations, planning is underway to support the delivery of a COVID-19 Booster Vaccination programme for eligible Health and Social Care Staff in line with national guidance and directives.

The Occupational Health and Wellbeing service leads on the delivery of the annual seasonal influenza vaccination. In 2020-21 the CQUIN target was achieved by offering the influenza vaccine to 100% of staff and gaining 84.3% uptake in patient facing staff. This was implemented by registered nurses across the Trust delivering peer vaccinations to their colleagues in conjunction with the Occupational Health nursing team. The vaccination programme gave priority to frontline patient facing staff and then offered to all staff working at WHH.

The influenza uptake was reported monthly to Public Health England by the Occupational Health manager, and monthly data was provided to the Executive Team via reports from ESR.

In the COVID-19 Vaccination Autumn/Winter (Phase 3) planning letter, the JCVI advised that 'early evidence on the concomitant administration of COVID-19 and flu vaccines used in the UK supports the delivery of both vaccines where appropriate. Once the final results of the relevant clinical studies are published (expected later this summer) and where supply, regulation, and alignment of cohorts allows, co-administering flu and COVID-19 vaccines in the same appointment will allow more efficient use of resources and a better service for patients, as well as potentially helping to improve uptake of both vaccines. However, the delivery of either vaccine should not be unduly delayed facilitating co-administration[1].

Recognising that adopting the planning letter approach would alter significantly the delivery model used for Influenza vaccinations last year, it became necessary to establish a working party namely the WHH Vaccination Task and Finish Group.

2. KEY ELEMENTS

2.1 Establishment of a Joint Vaccination Task and Finish Group The purpose of this group was to provide joint oversight of the planning and implementation for both the Influenza and COVID-19 Booster vaccine programmes, with the aim of complying with National planning paper [1] in order to offer Influenza and COVID-19 Booster vaccines to eligible WHH staff to maximise uptake.

Membership of this group includes:

- Associate Chief People Officer (Chair)

- Director of Strategy and Partnerships,
- Chief Pharmacist,
- Deputy Chief People Officer,
- Head of Occupational Health,
- COVID-19 Vaccination Service Manager,
- Deputy Chief Nurse,
- Associate Director of Clinical Support Services,
- Head of Clinical Education,
- Communications Officer.

2.2 The vaccination programmes eligibility will follow National Guidance

2.2.1 Influenza Vaccination for WHH staff, will initially prioritise frontline patient facing staff (this has been extended to non-clinical staff who have regular patient contact) with the intention of offering the vaccine to 100% of staff in due course, with the ambition of achieving 85% uptake in the frontline patient facing staff cohort. Staff will be prioritised and targeted for vaccination as per previous years. As the National Protocol and Public Health England Patient Group Direction documents do not cover vaccination of Acute Trust staff at present, local Patient Group Direction (PGD) has been developed and will be reviewed by Medicines Governance Committee on Thursday 9th September 2021.

2.2.2 The COVID-19 Booster vaccination programme is awaiting JVCI approval and the update of chapter 14a of the Green Book. This together with the COVID-19 vaccine National Protocol will guide the prioritisation of staff. At present this guidance is as follows, “frontline healthcare staff involved in direct patient care, staff vaccinators, nonclinical ancillary staff who may have social contact with patients but are not directly involved in patient care. Laboratory and pathology staff, Hospital-based laboratory and mortuary staff who frequently handle SARS-CoV-2 or collect or handle potentially infected specimens [1.2].”

2.3 Vaccination process for staff Eligible WHH Trust and wider Health and Social Care staff (as per national guidance/directives) will be invited by email to book a vaccination slot. Only WHH staff will be offered the opportunity to attend an Influenza vaccination.

2.4 Current timescales for implementation The timescales indicated below are subject to receipt of the vaccines on the scheduled delivery dates.

- 13th September 2021: the commencement of administration of Influenza vaccinations for WHH Trust Staff only (priority groups - high risk areas with patient facing staff, then clinical areas with patient facing staff.)
- 20th September 2021: the administration of the COVID-19 Booster to eligible patient facing WHH and Health and Social Care.
- The joint vaccination programme will be active between the 13th September and the 11th December 2021. Although the Influenza vaccine programme may continue up to February 2022 if required to do so using a more traditional delivery approach and using peer vaccinators/ Occupational Health nurses. The time period is subject to change if the vaccine delivery or National guidance changes.

2.5 Clinic Location(s) Due to the vaccine stability constraints of the COVID-19 vaccine, clinics will be based on the Warrington site and as such Halton staff will need to travel to Warrington to receive their COVID-19 vaccine. As per the traditional approach of previous Influenza campaigns, a limited number of vaccines will be offered to staff on the Halton site. The

majority of the COVID-19 Booster and Influenza Vaccination programme will be delivered from a small clinic area within Main Outpatients at Warrington Hospital Monday to Saturday. This approach will minimise disruption to other outpatient clinics and support the outpatient recovery programme. This model provides a maximum capacity of 150 vaccines per day Monday to Saturday initial, and with experience this may increase. Early slots from 7am will be offered on several days for night staff to access.

2.6 Identification of Vaccinators (including Training) Vaccinators have already been identified. As the service will be operating using National protocol (COVID-19 Booster vaccine) and Patient Group Direction (Influenza Vaccine) the vaccinators will be registered staff who are legally entitled to operate under National Protocol/ Patient Group Direction, will have undertaken the required training and have been authorised to vaccinate staff. Practitioners must be aware of any changes to best practice recommendations, changes to the recommendations for the preparation listed, including recommendations from the Department of Health (DH) and adverse drug reaction (ADR) bulletins.

2.7 National Reporting Requirements As an annual requirement, we are required to complete and submit a 'Healthcare Workers Flu Vaccination Best Practice Management Checklist' to board, providing assurance to the board that we are following national best practice and publishing this assurance on our externally facing website. This checklist has been completed for 21/22 and can be reviewed in Appendix 1. Support for this checklist is sought from this committee prior to submission to Board in September 21. Nationally reporting for COVID-19 Booster and Influenzas vaccine is on NIMS and IMMFORM. Local reporting will be sourced from NIMS and uploaded on ESR at agreed intervals throughout the campaign.

2.8 National targets It is expected that 100% of eligible staff are offered the COVID-19 Booster vaccine. For the Influenza vaccine we aim to offer 100% staff access, with the aim of achieving a target of 85% for patient facing staff is recommended.

2.9 Communications The launch and implementation of the joint vaccination programme will be supported by a full Communications plan developed in partnership with the Communications Team. This will include a weekly update across the trust of success stories, venues availability, priority groups, release of appointments and uptake.

2.10 Local reporting Tactical Meeting and Executive Meetings will be updated throughout the programme timeframe on uptake for both vaccinations. Campaigns will be targeted and adjusted based on compliance with the programme and any areas of poor uptake will be reported to enable line managers to take appropriate supportive action to enable staff to access the clinic and promote uptake.

3. RISKS

- National guidance may exclude some WHH staff from receiving the COVID-19 Booster with the risk of an increase in the sickness absence rate for this cohort of staff.
- The local reporting source will be from NIMS and not ESR, therefore manual reporting of excluded staff will be required with the risk of a reduction in accuracy. Work is ongoing to mitigate this risk.
- Delayed delivery of vaccine from the supplier, risk of extending the end date of the joint vaccination programme

4. ASSURANCE COMMITTEE

5. RECOMMENDATIONS

Note the inclusion criteria specified by JCVI may result in staff who are not patient facing not being considered eligible for the COVID-19 Booster vaccine in the early stages of the Booster programme. This may require sensitive communication.

- Approve the contents of this paper giving particular consideration to Appendix one – 'Healthcare Workers Flu Vaccination Best Practice Management Checklist'

Appendix One: Healthcare workers flu vaccination best practice management checklist.

Legend:

Trust fully meets best practice guidance	
Trust partially meets best practice guidance	
Trust does not meet best practice guidance	

For public assurance via trust boards by December 2021			
A	**Committed leadership**	**Evidence**	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	The WWH Board support the influenza campaign year on year, receiving and acknowledging the Public Support Document and encouraging all frontline patient facing staff to be vaccinated as part of the communications plans as required. As representatives of the Board the Executive team receive regular assurance reports on vaccine update through the influenza programme and advocate uptake as required.	
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	The Trust has ordered: 3400 QIVe quadrivalent influenza vaccines for adults up to the age of 64 100 QIVc quadrivalent influenza vaccines for adults over the age of 65 This quantity is sufficient to achieve 100% patient facing vaccination.	
A3	Board receive an evaluation of the flu programme 2020 to 2021, including data, successes, challenges and lessons learnt	**Data:** • 2020-21 achieved 84.3.% administration of influenza vaccination for frontline healthcare workers across both sites. **Successes** • Achieved 'herd immunity' (70%) providing the best protection for our staff, patients (and wider community). • Frontline healthcare professionals engaged in the influenza vaccination programme. • Achieved the CQUIN criteria in offering 100% of staff the influenza vaccination.	

		Challenges • Due to PHE guidance on social distancing taking the campaign to staff within clinical areas as in previous years was complex due to COVID-19 restrictions. • Recruiting and training of Peer vaccinators has been challenging due to the training time to meet the National Minimum Standard of vaccination training and staff sickness. • Peer vaccinators found it difficult to support the vaccination programme due to other clinical commitments. • Drop-in clinics (previously successful) was difficult to implement due to social distancing restrictions. **Lessons learnt** • The early implementation of a centrally accessible clinic could have been implemented earlier in the campaign by the occupational health nurses, but due to social distancing guidance from PHE this was discouraged. • Peer vaccinators need to be supported by senior management at a local level to allocate time to vaccinate colleagues. Although the clinical commitment was difficult due to COVID-19 • Weekly reporting to key stakeholders was often delayed due to lack of administration support in inputting the data onto ESR. • Celebrate success frequently to the Trust staff. This will encourage teamwork and a positive culture of the organisation.	
A4	Agree on a board champion for flu campaign	Michelle Cloney, Chief People Officer	
A5	All board members receive flu vaccination and publicise this	As previous years the receipt of the influenza vaccination will be staggered from the supplier. Therefore, the board will be offered the influenza vaccine following the administration of the influenza vaccine to all patient facing staff. This is anticipated to be mid-end October 21. When the vaccination is administered publicist photographs will be taken (by communications team) with the consent of the board individual.	
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	A task and finish group has been developed to plan, implement and deliver the influenza vaccine alongside the COVID-19 booster vaccine. Trade union representatives are engaged in the flu campaign and are kept updated via regular partnership meetings.	

A7	Flu team to meet regularly from September 2021	The Occupational Health team will lead on the influenza vaccination programme and work in conjunction with the COVID-19 booster vaccination team to deliver both vaccinations. The task and finish group will continue during the campaign. The Vaccinators will meet regularly in vaccination HUB and are able to access support from an Occupational Health Specialist Nurse when required.	
B	**Communications plan**		
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	The task and finish group will discuss and agree communications and updates required in line with clinical guidance. The Trust will receive regular updates in relation to vaccine administration in the same format as the COVID-19 vaccination programme, with regular communications including rationale for the vaccination programme along with key facts to be disseminated across the trust at regular intervals and sponsored by influential stakeholders as required.	
B2	Drop-in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	The influenza administration will predominately take place on the Warrington site in the Vaccination HUB, although vaccine opportunities will also take place on the Halton site to offer patient facing staff the influenza vaccination. This is due to the COVID-19 booster vaccination this year and the potential of co-administration of both vaccines to maximise resources, provide ease of access to both vaccines for staff (if available) and increase uptake. Opportunities to be vaccinated will be published and promoted via mix media as per the robust communications plan.	
B3	Board and senior managers having their vaccinations to be publicised	With consent photographs capturing the board and senior management will be publicised within the Trust by the Communications Team.	
B4	Flu vaccination programme and access to vaccination on induction programmes	Later in the Influenza vaccination campaign induction vaccination will be offered. This is due to the targeted approach for patient facing staff and the prioritisation of staff.	
B5	Programme to be publicised on screensavers, posters and social media	As per the Communications Plan, the Trust screensaver will be utilised during the campaign to promote vaccination information and opportunites to be vaccinated. Social media will also be used by the communication team. Posters have been ordered and are awaiting delivery.	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Weekly figures will be provided from the data submitted on NIMS. Headlines of this information will be provided to communications for publicising across the Trust.	
C	**Flexible accessibility**		

C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Peer vaccinators have been trained and are ready to support. As this year's delivery model is different due to the COVID-19 booster, peer vaccinators will be promoting and supporting colleagues in receiving the vaccination and administering the vaccination in the Vaccination HUB. Peer Vaccination in clinical areas will be considered as part of the ongoing programme delivery as required.	
C2	Schedule for easy access drop-in clinics agreed	The influenza vaccination will be delivered in conjunction with the COVID-19 booster based in Warrington outpatients.	
C3	Schedule for 24-hour mobile vaccinations to be agreed	Early morning clinics will be held to enable night staff easy access to the vaccination.	
D	**Incentives**		
D1	Board to agree on incentives and how to publicise this	Current incentives include, stickers, pens and a fruit voucher for staff.	
D2	Success to be celebrated weekly	Success to be celebrated weekly as per the trust influenza vaccine communication plan. Key messages will be updated and promoted weekly via social media channels and internal communication infrastructure.	
Guidance Appendix H: healthcare workers flu vaccination best practice management checklist. Updated 28 July 2021			

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/131**			
SUBJECT:	**Board Assurance Framework**			
DATE OF MEETING:	29th September 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: • One new risk has been added to the BAF and there is a proposal to add a further risk; • There have been no amendments to the ratings of any risks. • The description of one risks on the BAF have been amended. • No risks have been de-escalated from the BAF since the last meeting. Notable updates to existing risks are also included in the paper.			
PURPOSE: ***(please select as appropriate)***	Information	Approval ✓	To note	Decision
RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC 21/09/214		
	Date of meeting	07.09.2021		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework and Strategic Risk Register report	AGENDA REF:	BM/21/09/131

1. BACKGROUND/CONTEXT

This is an update of strategic risks on the Trust Strategic Risk Register. It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately.

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

2. KEY ELEMENTS

2.1 New Risks

Since the last meeting **one** new risk has been added to the BAF.

Following discussion at the Trust Board on 28th July 2021; and subsequent approval at the Quality Assurance Committee on 7th September 2021, it was agreed to re-escalate risk **#1331** from the Corporate Risk Register at an increased rating of **15** to reflect the current pressures.

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

Furthermore, and following support from the Clinical Recovery Oversight Committee (CROC), it is proposed to escalate risk **#1125** (detailed below) from the Corporate Risk Register to reflect the current situation.

ID	Risk description	Rating (current)	Rating (Proposed)	Risk Register	Executive Lead	Monitoring Committee
1125	Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in non-compliance for RTT, Diagnostics, Cancer and ED Performance	20	20	BAF	Dan Moore	Quality Assurance Committee

2.2 Amendment to Risk Ratings

Since the last meeting there have been no amendments to the ratings of any risks.

2.3 Amendments to descriptions

Since the last meetings, the description of **one** risk has been updated.

Further to the escalation of risk #1331 as described in section 2.1, it was also agreed that the description of the risk was amended as follows:

Previous: *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.*

Current: *Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.*

2.4 De-escalation of Risks

Since the last meeting no risks have been de-escalated.

2.5 Existing Risks - Updates

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

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
224	Failure to meet the emergency access standard, caused by system demands and pressures. Resulting in potential risks to the quality of care and patient safety, staff health and wellbeing, Trust reputation, financial impact and below expected Patient experience.	• ED Response Group established in August 2021, clinically led by Dr Vondy to review internal ED processes. • Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place 3 times per week.	No impact on risk rating
1215	Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm	• MR business case supported to provide a mobile MR van until October 2021 until the new static MR capacity commences. • Reconfiguration of Paediatric ED completed and operational • Deployment of Bioquell Pods in ICU live and operational • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery.	No impact on risk rating
1273	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in	• Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place 3 times per week.	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	potential reduced capacity to admit patients safely.	• Significantly reduced capacity in the domiciliary care market due to the high number of vacancies. This is causing package of care delays.	
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	• Environmental Safety Action plan in place reported by exception to Silver Infection Control	No impact on risk rating
1289	Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm	• Bioquell Pods in ED live and operational • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery. • Theatres 3 and 4 currently used for Endoscopy rather than as Theatres until the Endoscopy rooms are completed in October 2021 • Limited bed base within A5 elective footprint • Increase in COVID-19 ICU patients as a result of wave 4 (July 2021) impacted on scheduling for patients requiring ICU post op	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.	• The Trust will be placing 96 International Nurses by Dec 21. • In July 21 we have 32 wte band 5 vacancies – all will be filled by December 2021. • Business case approved for increased staffing in ED. Recruitment drive planned with an open day in mid September supported by PR campaign in print and social media • There are currently 3 Health Care Assistant vacancies within the Trust. All vacancies are subject to further recruitment. • WHH Nursing retention plan to be refreshed for 2022 • Registered Nurse Turnover 11.59% • International nurses have started to join WHH in March 21. 67 have commenced on the wards.	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
134	Risk: Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	• 2021 cost pressures supported by Trust Board. Business cases being developed to secure required levels of funding. There are 11 are in progress, 3 are complete, 2 have been closed as the funding is in budget. These are expected to be completed in September 2021 • H2 Expenditure Budgets to be submitted to the Trust Board in October 2021 • Increased assurance gained re: Capital Expenditure for all schemes over £0.5m and reported to FSC • •Increased scrutiny of CIP through weekly updates to the Executive Team Meetings and monthly to FSC • Phase 3 of the Health Infrastructure Programme (HIP) announced. WHH drafting an Expression of Interest (EOI) for submission in September 2021 • Submitted plan of breakeven for H1. ERF funding of £2.5m assumed to achieve target. This was updated to £3.1m	No impact on risk rating
1134	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	• Overall absence rate is 6.13% for July 2021 and is therefore reducing. July 2020's absence rate was 5.53%. • Supported by funding from NHSI there has been a big push to fill our HCA vacancies, we currently reporting 13 FTE vacancies (31/07/2021) • Extension of existing temporary changes to terms and conditions to support the covid response; special leave – 31st Dec 2021, Retire and Return – 31st Dec 2021 and Band 8a overtime reintroduced until 31st Oct 2021 • In July 2021 overall vacancy rate is 9.06% compared to a peak in Jun 2020 of 10.5%. • 87 of our 96 international Nurses are now in the country. • Therefore, as vacancies and sickness absence reduced it is expected our bank and agency reliance reduce and within July	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		2021 reliance on bank and agency staff increased slightly to 15.84% compared to a peak of 23.3% in Jan 2021.	
1114	FAILURE TO provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, CAUSED BY increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber attack, RESULTING IN poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	• No agreed patching schedule for network equipment with the Trust.	No impact on risk rating
1207	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	Trust compliance as at 6th September 2021 • Have you offered a Risk Assessment to all staff? - Yes • What % of all your staff have you Risk Assessed? – 93.54% • What % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary? – 96.12% • What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary? – 91.63% At 6th September 2021:	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		•226 staff members yet to complete self-assessment •5 Management Risk Assessments (required when an individual identifies as having a COVID Vulnerability) have been outstanding since at least March 2021 • 77 Management Risk Assessments have been outstanding since April 2021	
125	Failure to provide a safe, secure, fit for purpose hospitals and environment caused by the age and condition of the WHH estate and limited availble resource resulting in a risk to meeting compliance targets, staff and patient safety, increased backlog costs, increased critical infrastructure risk and increased revenue and capital spend.	• Approved and recruiting for additional Estates Compliance Manager role to support routine compliance and routine small estates works. • Ward B18 refurbishment expected to be completed by 3rd September 2021 • New MRI build set to be completed in October 2021 • New Endoscopy roofing infrastructure at Halton set to be completed in September 2021 • Capital schemes to improve paediatric outpatients due for completion in December 2021 • Capital schemes to develop a Urology Investigation Unit set to be completed by March 2022 • Mortuary refurbishment set to be completed by October 2021	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, 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	• Phase 3 of the Health Infrastructure Programme (HIP) announced. WHH drafting an Expression of Interest (EOI) for submission in September 2021 • Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. • £90k funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington • WHH commenced a focussed programme of work on addressing health inequalities, the green agenda and our role as an anchor institution. Initial work recognised	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	as the exemplary within Cheshire & Merseyside.	
1274	Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.	• New self-isolation guidelines received, and SOP developed. SOP circulated and effective from 23.08.2021	No impact on risk rating
1290	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices, technology products and services, clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.	• The Pharmacy department has contacted the Regional Procurement Pharmacist who has advised that there will be monitoring of medicines purchases and usage centrally to manage medicines continuity. Issues / concerns / actions required will be communicated via regular updates to the Chief Pharmacist network. To date there have been no medicines supply issues linked to the end of the EU transition period, however some recent logistical changes have impacted on the way some items are delivered. This has not caused much of an impact on the service and will be monitored through Brexit Subgroup or escalated if there is an impact on business continuity. • Processes developed by UEC and Finance to ensure chargeable patients are managed appropriately. From the Chargeable Patients point of view, there are no risks to financial procedures, patients or staff. Additional processes and a	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		dashboard have been shared for assurance purposes. Additional communications plans continue with clinical teams to ensure the Chargeable Patients SOP is embedded.	

3 RECOMMENDATIONS

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

Board Assurance Framework

Board Assurance Framework

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

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	Daniel Moore	Failure to meet the emergency access standard, Caused by system demands and pressures. Resulting in potential risks to the quality of care and patient safety, staff health and wellbeing, Trust reputation, financial impact and below expected Patient experience.	1	25 (5x5)	8 (2x4)	TBC	Clinical Recovery Oversight Committee
1215	Daniel Moore	Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm	1	25 (5x5)	6 (3x2)	TBC	Quality Assurance Committee
1273	Daniel Moore	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.	1	25 (5x5)	5 (5x1)	TBC	Quality Assurance Committee
1272	Kimberley Salmon-Jamieson	Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident.	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
1275	Kimberley Salmon-Jamieson	Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
1289	Daniel Moore	Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
115	Kimberley Salmon-Jamieson	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	1	20 (5x4)	12 (4x3)	TBC	Quality Assurance Committee
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	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee

Board Assurance Framework

		future loans cannot be repaid and this puts into question if the Trust is a going concern.					
1134	Michelle Cloney	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee
1114	Alex Crowe	FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	1	20 (5x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1079	Kimberley Salmon-Jamieson	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.	1	20(4x5)	2 (1x2)	TBC	Quality Assurance Committee
1207	Michelle Cloney	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	2	16 (4x4)	8 (2x4)	TBC	Strategic People Committee
1372	Alex Crowe	FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements	3	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee

Board Assurance Framework

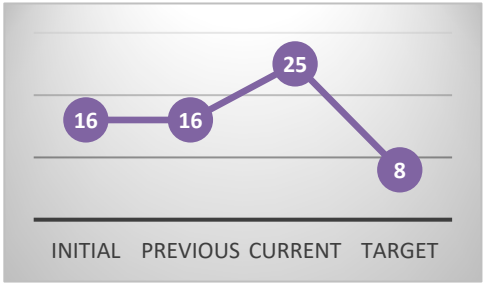
		CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which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

Board Assurance Framework

1331	Daniel Moore	Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.	1	15 (5x3)	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

Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.
Strategic Objective 2: We will… Be the best place to work with a diverse and engaged workforce that is fit for now and the future
Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.

Board Assurance Framework

Risk ID:	224	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to meet the emergency access standard, Caused by system demands and pressures. Resulting in potential risks to the quality of care and patient safety, staff health and wellbeing, Trust reputation, financial impact and below expected Patient experience.			**Initial:**	16(4x4)
				Current:	25(5x5)
				Target:	8 (2 x 4)
Assurance Details:	•Regular Trust Wide Capacity meetings led by the Senior Site Manager for the day •Systemwide relationships including social care, community, mental health and CCGs •Discharge Lounge/Patient Flow Team/Silver Command •Red to Green - Discharge Planning •ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing •Controller •Private Ambulance Transport to complement patient providers out of hours •FAU/Hub operational from June 2018 - Now operating 5 days per week. •Discharge Lounge opened 26th November 2018 •Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance. •System actions agreed supporting the Winter Plan •Further development of Rapid Response to avoid admission •Increase IMC provided by the system such as the opening of the Lilycross site •Increase IMC at home •Regular monitored at the Mid Mersey A&E Board •Trust is working with ECIST on a number of Long Length of Stay & Flow improvement projects •ECIST is supporting effective deployment of the national discharge policy •Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. •The Trust participates at the system & regional UEC improvement meeting on each Wednesday •Redeveloped ED 'at a glance' dashboard •Trust implemented NHS 111 first successfully in August 2020 allowing for directly bookable ED appointments •Board approval of capital plan to build new £5m purpose built acute Medical Ambulatory Care area aka ED Plaza •Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings •Integrated discharge Team now in place •Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients •ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised. •Respiratory Ambulatory Care Facility agreed by CCG •Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved •Collaborative working with Orthopaedics in management ok MSK Minor injuries via Minor's Stream •Reinstated CAU 24/7 •Upgrade to Minor's resulting in Oxygen points in all cubicles •Non-Elective flow activity now above 2019/20 activity levels for type 1 & 3 •Operation Re-set undertaken at the end of May 2021 to support flow and discharge •ED Response Group established in August 2021, clinically led by Dr Vondy to review internal ED processes.					

Board Assurance Framework

	•Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place 3 times per week.	
Assurance Gaps:	•Staffing pressure created as a direct result of COVID-19 Global pandemic. •Confirmed exponential growth in types 1 & 3 as a result of population nedd and lack of access to Primary Care	

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

Board Assurance Framework

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

Assurance Details:

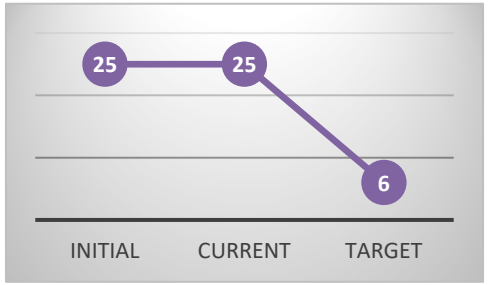
- Operational Planning Guidance submission – 23rd April 2021
- Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery
- Operational planning to be monitored by Gold Command on a daily basis, by Cheshire & Merseyside elective restoration meeting weekly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

Radiology

- New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance.
- Department has been supported by the Trust through £380K recurrent funding to recruit additional staff. Advert out 11th June 2020. Recruiting 4 Radiographers, 2 Sonographers, 2 Healthcare Assistants.
- Additional staff will support additional capacity through extended working days across all scanners – currently unable to achieve this due to Covid-19 demands.
- Additional CT capacity (15 exams per week) will be provided mid-July 2020 via use of mobile CT scanner supported by the National Imaging Team Covid-19 Response initiative. (this has been extended to mid-September 2021)
- MR business case supported to provide a mobile MR van until October 2021 until the new static MR capacity commences.
- All outstanding requests are clinically reviewed by Senior Consultant Radiologists as per local SOP. Exams are deferred in line with clinical priority. Cancer and Urgent patients are being imaged as per pre-Covid-19 as per national guidance.
- Those deferred patients are sent a letter informing of delay, and to contact their Doctor if any concern. The referrer of delayed patients are also sent a letter informing of delay, but this referrer letter includes a direct telephone number to the Senior Radiology Consultants, and also an email address should there be a concern with delaying. Any exams that are highlighted from referrers as not suitable for delay are appointed on the next available appointment.
- This delay process has been discussed via Medical Cabinet and agreed as most appropriate process.
- This clinical review and delay process is ongoing daily.
- Improvement against all modalities for numbers waiting more than 6 weeks noted in April performance.
- CT Business case approved to increase CT capacity and support expediting recovery.

Unplanned care

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



Board Assurance Framework

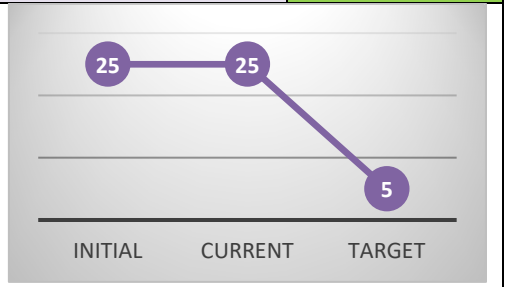
	• Clinic templates have been revised to ensure social distancing measures are in place and patients are not brought to a face to face appointment unless clinically indicated. Virtual appointments are in place (telephone and video) for use where this is clinically appropriate. • Suspected cancer, cancer and clinically urgent patients are allocated out patients and diagnostic appointments as a priority. • Waiting lists are reviewed through the performance review group weekly – outpatients and diagnostics. • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • NHS 111 First pilot went live on 8th September 2020 to reduce attendances to the emergency department and to support the planning of activity in a more streamlined way to reduce overcrowding and risk of nosocomial infection. • Business Case for ED Plaza Scheme approved in 2021/22 Capital Plan • Reconfiguration of Paediatric ED completed and operational • Phase 2 ED Plaza commenced in February 2021. • Deployment of Bioquell Pods in ICU live and operational Planned Care • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery. • All elective patients have been clinically reviewed and categorised in line with national guidance. • Suspected cancer, cancer and clinically urgent patients are treated as a priority. • Theatre capacity has been reviewed and additional capacity is now available with the de-escalation of the theatre PODs • The Halton site is being developed as a covid secure site and will be run as an Elective Centre. • Elective Surgery Standard Operating Procedure (SOP) in place • Capacity identified and being utilised at spire Healthcare • Clinical Services Oversight Group (CSOG) established • Clinical Recovery Oversight Committee (CROC) established • Clean/green pathways have been developed for those priority 2 patients (cancer & urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward 5 on the Warrington site. This pathway is set to commence w/c 8th February and replaces the B18 pathway. • A separate pathway has been developed for Emergency surgery and future plans and bed base has been agreed as part of the ward reconfiguration process. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Workforce plans are continually reviewed to ensure that all wards and teams are staffed safely. • Waiting lists are reviewed through the performance review group weekly • Weekly theatre scheduling to ensure listing of patients in line with national guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021 • Continued use of the independent sector (Spire Cheshire) under new contract in 2021/22 with support from the CCG. • Participation in national clinical validation exercise commenced in November 2020 to support and inform patient waiting time status and support safe management of waiting lists.	
Assurance Gaps:	Radiology 1. Harm may be caused due to the incompleteness of clinical information on a referral. This may also be compounded by the referrer incorrectly entering the wrong priority code on the referral. • 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.	

Board Assurance Framework

	• This risk is present in all routine exmas as the waiting time for routine diagnostic imaging is up to 6 weeks as per national targets. This risk is hightened due to Covid-19 and the reduced capacity at present. It is thought the letter to the patient advising to contact their Doctor with any concern will reduce this risk. Unplanned care 1. Estates work is required to complete the segregation of paediatric patients in the emergency department. • This is being progressed with the support of the estates and capital planning team. 2. Expansion of the emergency department is required to ensure any increase in demand can be accomodated in line with RCEM guidance 3. Referrals do not include adequate information to triage and prioritise patietns appropriately • Regular meetings and communication with the CCG and GP's to inform them with recovery progress within the organisation and to highlight/address any identified problems 4. Reduction in face to face primary care appointments having a negative impact on increased attendances. 5. Capacity challenge with social workers to keep on top of demand and necessary patient assessments. 6. Estates work required to increase general ICU Capacity & ICU cubicle capacity e.g. Installation of Bioquell cubicles Planned Care 1. Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility. • This is being progressed with the support of the estates and capital planning team. 2. Waiting list do not include adequate information to triage and prioritise patients appropriately • Regular meetings and communication with the waiting list and scheduling teams and inform them of recovery plans and to highlight/address any identified problems 3. New framework for ISP will not include all specialties currently being undertaken. This will increase waiting list pressure for those specialties on this site.

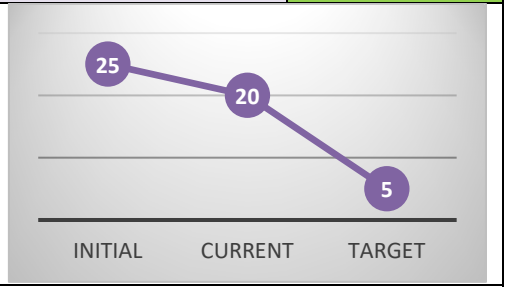
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Install of Bioquell Cubicles	Install of Bioquell Cubicles	Complete Installation	Sharon Kilkenny	28/02/2021	Installation in ICU Complete Jan 2021
Build ED Plaza	Completion of ED Plaza building works	Complete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

Board Assurance Framework

Risk ID:	1273	**Executive Lead:**	Moore, Daniel	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.			**Initial:** 25 (5x5) **Current:** 25 (5x5) **Target:** 5 (5x1)
Assurance Details:	Integrated Discharge Team comprising of hospital and Local Authority colleagues from Warrington and Halton to develop systems and process of discharge acknowledging difficulties of Covid-19. Daily system pressures meeting that reviews hospital and wider system bed capacity to support safe and timely discharge of patients from hospital to support flows Trust participates in Mid-Mersey Operational Group which supports Out of Hospital Cell discussions in relation to system discharge planning. The number of discharge delays in relation to Super Stranded patients is reported daily in the Executive Summary and reviewed so that Executive Directors can support and escalate pathway delays. 'Where's best next' event initiated in January 2021 with system partners to support safe discharge of patients with long lengths of stay to create capacity through December and January expected winter pressures and support wave 3. Scheme issued by the Government to support indemnity concerns of care homes in relation to caring for COVID-19 patients. It will support the system in the creation of COVID-19 designated setting capacity. New 'Discharge to Assess' process has gone live to reduce the length of stay for a cohort of patients who would otherwise be assessed in hospital can be assessed in a transitional care bed. Progressing the procurement of a new software programme which will be able to accurately track and share system delays with partners. By improving information, it will enable quicker and more effective decisions on discharges. Established Patient Flows Oversight Group (PSOG) to develop and support pathways relating to discharge efficiency. Trust working with ECIST on improving flow and implementation of national discharge policy Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place 3 times per week.			
Assurance Gaps:	Delays in discharge caused by adherence to Covid-19 infection control pathways and the patient's Covid-19 status. Intermediate Care and other community capacity impacted and restricted by Covid-19 e.g. Care Home and other facility closures due to outbreaks. Access to community capacity impacted by Covid-19 as a result of staff sickness Internal staff shortages to help support discharge planning. Restricted as a result of Covid-19 sickness and self-isolation High number of patients in Warrington awaiting social work assessment, causing a delay in discharges from the acute site in to care homes and intermediate care capacity Significantly reduced capacity in the domiciliary care market due to the high number of vacancies. This is causing package of care delays.			

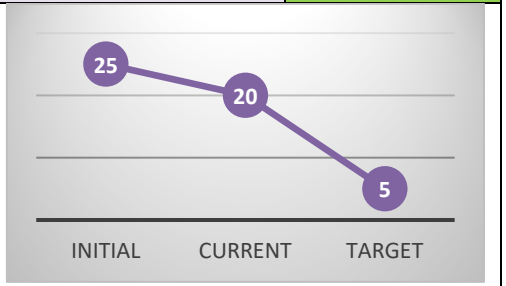
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
An environmental inspection plan to be set up to ensure there is monitoring of social distancing.	Clear curtains are in place on all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. Bioquell Pods are now in place in ICU. As the number of COVID positive patients has reduced and the nosocomial outbreaks has also reduced, it was agreed at QAC on the 4th May 2021 to reduced the risk from 25 to 20. The situation needs to be continually monitored and therefore the action will remain open and reviewed each month.	Health and Safety to develop and implement an environmental inspection programme in all clinical areas.	Kennah, Ali	31.12.2021	
All wards and departments to have up to date risk assessments in place.	All wards and departments to have up to date risk assessments in place.	Review risk assessments	Wynn, Helen	30.09.2021	

Board Assurance Framework

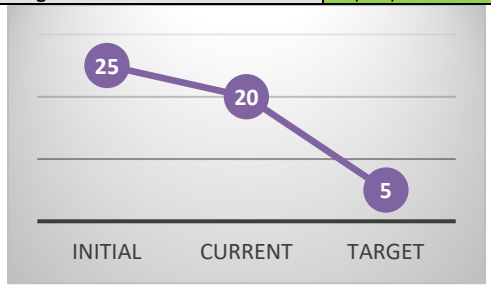
Risk ID:	1275	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to prevent Nosocomial Infection caused by asymptomatic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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Health and Safety inspections to include the monitoring of social distancing and ensure hand sanitiser and masks are located at each entrance.	Findings from inspections. Findings will be fed back to the Deputy Chief Nurse and reported to Silver Command each Monday. Health and Safety inspections continue on an 8 week programme.	Health and Safety inspections to be carried out.	Kennah, Ali	30.09.2021	

Board Assurance Framework

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

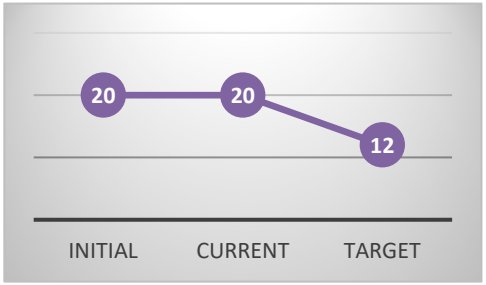
Confirmed continued use of the private sector (Spire Cheshire) in 2021/22. Under new contracting arrangements.
Waiting lists monitored and measured weekly
Post Anaesthetic Care Unit (PACU) remains open and operational
Continue to undertake harm review process and triangulate with waiting list process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



Theatres 3 and 4 currently used for Endoscopy rather than as Theatres until the Endoscopy rooms are completed in October 2021
Limited bed base within A5 elective footprint
Increase in COVID-19 ICU patients as a result of wave 4 (July 2021) impacted on scheduling for patients requiring ICU post op

Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop plan for Ward 18 Footprint to support alternative critical care escalation.	Develop plan for Ward 18 Footprint	Kilkenny, Sharon	28/02/2021	28/02/2021
Complete the B18 development	Complete the B18 development	Kilkenny, Sharon	30/09/2021	

Board Assurance Framework

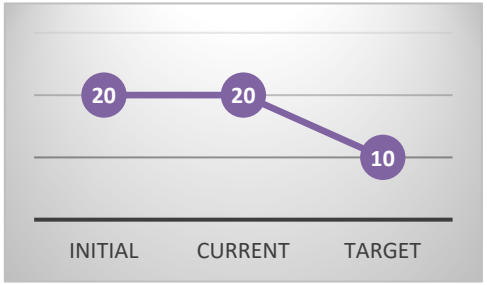
Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.			**Initial:** 20 (5x4) **Current:** 20 (5x4) **Target:** 12 (4x3)
Assurance Details:	• Monthly workforce information produced via workforce dashboard. Information is reviewed and monitored at the Workforce Group Chaired by the Chief Nurse • Robust staffing escalation process across WHH to manage staffing daily – This has become the forum for responsive staff management during the COVID 19 pandemic • Lead Nurse identified daily to co-ordinate staffing supported by a senior nurse rota 7 days a week 8am – 8pm which commenced in April 2020 • 4 hourly update shared as part of Gold Command template • Wards & Departments use E-Roster and Safecare data to support staffing ratios • New models of care currently being implemented in Maternity in line with BR+. Business case being developed as there will be a requirement for a staffing uplift • Recruitment / media plan produced and recruitment campaign ongoing • Rolling advert for RN's continue. Students who were redeployed to the Trust during the COVID 19 pandemic have been offered substantive posts • International Nurse Business Case has been approved for 96 Registered Nurses – all nurses have been recruited and will be in post by December 2021 • 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 paused for 3 months whilst international nurses are placed • Developing WHH recruitment campaign • Career advice events in local schools and colleges • Production of monthly and bi-annual staffing reports received by the Trust Board • Trust has intensified the HCA recruitment and achieved 0 vacancies by April 21. NHSI funding support received to achieve this aim. Weekly monitoring on progress and reporting to NHSI in place • The Trust will be placing 96 International Nurses by Dec 21. • In July 21 we have 32 wte band 5 vacancies – all will be filled by December 2021. • Business case approved for increased staffing in ED. Recruitment drive planned with an open day in mid September supported by PR campaign in print and social media HCA • There are currently 3 Health Care Assistant vacancies within the Trust. All vacancies are subject to further recruitment. <u>Retention Assurances</u> • Workforce Dashboard reporting monthly in relation to leavers • WHH Nursing retention plan to be refreshed for 2022 • Burdett Nursing Trust award winners			

Board Assurance Framework

	• 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 11.59% • International nurses have started to join WHH in March 21. 67 have commenced on the wards. • COVID-19 Assurances • Implemented a graduated and planned nurse staffing response to the COVID-19 Pandemic. • Revised staffing models for the expansion of critical care capacity, acute and supportive respiratory wards • Strengthened daily staffing meetings chaired by the Associate Chief Nurse for senior oversight • Increased use of temporary staffing through NHSP and off framework agencies – close monitoring arrangements in place • Implementation of NHSP incentive scheme for staff to improve fill rates – update monitored weekly • Nursing Times Workforce Award winners in November 2021 – Best Recruitment Experience During COVID-19 Pandemic Response • As the number of COVID patients in March 21 reduce the staffing plans are being revised and the number of agency staff is starting to reduce.	
Assurance Gaps:	Increase staffing pressure due to ongoing use of temporary winter ward for which there is no funded establishment Recruitment Gaps • 32 RN Vacancies in July 21 Retention Gaps • 11.59% nursing turnover	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
WHH to review international nurse recruitment to support registered nurse vacancy fill.	Targeted recruitment campaign	International nurse recruitment programme in place. Develop a business case. Agreement to join GTECH in partnership with WWL. Business case agreed for 30 nurses. Task and finish group established to support the recruitment campaign and welcome nurses to WHH Application for bid to access financial support for the programme.	Browning, Rachel	30/07/2021	30/07/2021

Board Assurance Framework

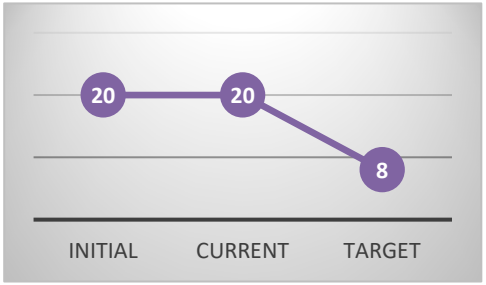
Risk ID:	134	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that future loans will be required which would raise the question if the Trust is a going concern.			**Initial:** **Current:** **Target:**	20 (5x4) 20 (5x4) 10 (5x2)
Assurance Details:	•Core financial policies controls in place across the Trust •Revised governance structure within the Trust to enable strengthened accountability •Finance and Sustainability Committee (FSC) established overseeing financial planning •Regular financial monitoring with NHSI •Regular review at Executive team meeting and development sessions •Annual plan development process • Achieved 2020/21 Control Total. • Unqualified audit opinion (2020/21) •Corporate Trustee Charities Commission Checklist, reporting annually through Board •Monitoring of charitable funds income, assessment of return on investment and controls on overhead ratios via quarterly financial reports •Regular updates to Executive Team, FSC and Trust Board •Financial Resources Group (FRG) and Capital Resources Group that report to FSC • Workshop undertaken with - Exec, CBU, Corporate to review 2021/22 cost pressures • 2021 cost pressures supported by Trust Board. Business cases being developed to secure required levels of funding. There are 11 are in progress, 3 are complete, 2 have been closed as the funding is in budget. These are expected to be completed in September 2021 •Completed MIAA Governance Checklist received by Audit Committee •H1 Expenditure Budgets approved by the Trust Board on 31st March 2021 •H2 Expenditure Budgets to be submitted to the Trust Board in October 2021 •Capital Plan approved by Trust Board on 31st March 2021 (£19.75m) •c£34m cash support secured in the form of PDC in March 2021 •Increased assurance gained re: Capital Expenditure for all schemes over £0.5m and reported to FSC •Increased scrutiny of CIP through weekly updates to the Executive Team Meetings and monthly to FSC •Phase 3 of the Health Infrastructure Programme (HIP) announced. WHH drafting an Expression of Interest (EOI) for submission in September 2021 <u>COVID-19</u> • Governance process in place to ensure all additional costs are being approved and monitored – re-introduced for Wave 2 & Wave 3 • Reporting to NHSE/I • Regular attendance to regional and national conference calls • Circulate latest guidance from MIAA Counter Fraud team • Ensure governance and processes in place including checks in place for all expenditure in particular procurement, contracts, payroll and HR. • Highlighted the different methods of fraud/ scam in operation to all staff and share it as widely through Trust • Receiving Charitable donations that will support sustainability of Trust Charity				

Board Assurance Framework

	• Monthly Report to Exec & F&SC on COVID Pay Costs • Deloitte Audit completed. Positive report received with one overclaim reported (£112k). Final report received by the Finance & Sustainability Committee in July 2021 and to be presented to the Audit Committee in August 2021 • Participating in exercise to understand run rate for 2020/21 to support funding envelopes for 2021/22 • Executive review of COVID-19 costs completed and supported as part of budget setting. • Clinical Review Oversight Committee (CROC) established to provide oversight and assurance on recovery performance. • Submitted plan of breakeven for H1. ERF funding of £2.5m assumed to achieve target. This was updated to £3.1m	
Assurance Gaps:	• Inability to develop a strategic plan to deliver a break-even position over the next 5 to 10 years • Non-recurrent and unidentified CIP presents a risk to in-year and future year financial position. • Failure to fully comply with emerging national employment litigation resulting in additional pay costs or the trust receiving potential claims. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Risk that capital needs exceed capital funding resources available. • Hospital Infrastructure Programme (HIP) announcement. WHH not included in with phase 1 or phase 2 funding allocation. However, an expression of interest EOI will be submitted after seeking support from the Trust Board on 25th August 2021 • Need to determine the future run rate which is currently uncertain in order to mitigate risks. • Increased threat of fraud during COVID-19 global pandemic • Uncertainty of the Trust allocation from the Cheshire & Merseyside Health & Care Partnership • Cheshire & Merseyside system is required to break-even • ERF Funding is not guaranteed and is non-recurrent & subject to system performance and achievement of five gateways. • PDC Capital still to be confirmed	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Submit requested Workforce & CIP information to NW Intensive Support Director	Cheshire and Merseyside Health & Care Partnership in receipt of Tier 1 Intensive Support – Information requested by NHSE/I on workforce & CIP	Submit requested Workforce & CIP information to NW Intensive Support Director	Andrea McGee	30/03/2020	Paused
Monitor all COVID-19 requests	COVID-19 Revenue	All covid expenditure to be reported to Execs and only extended following approval (Currently undertaken monthly)	McGee, Andrea	31/03/2022	
H2 Budget Approval	Approve H2 Budget	Present H2 to the Trust Board in October 2021	McGee, Andrea	31/10/2021	

Board Assurance Framework

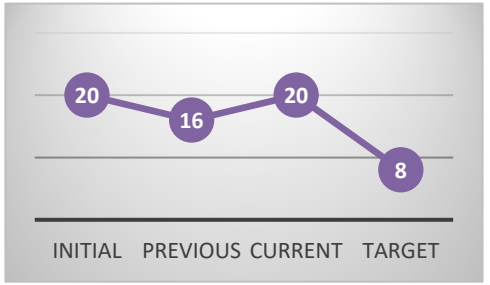
Risk ID:	1134	**Executive Lead:**	Cloney, Michelle	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to provide adequate staffing caused by absence relating to COVID-19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

Board Assurance Framework

	• Electronic system continues to be available to support the COVID-19 Workforce Risk Assessment Tool in line with Risk Reduction Framework • Regular reporting on compliance with risk assessment requirements is in place and reported at Tactical on a weekly basis. • Regular training on COVID-19 Workforce Risk Assessment is in place. • Trust continues to be challenged by high sickness absence rates nationally the North West has higher sickness absence rates. Trust has conducted a deep dive into their data and also participated in a NHSE/I deep dive to understand the challenged faced. Improving attendance programme to commence in August 2021 incorporating the data findings and recommendations of both deep dives. • Overall absence rate is 6.13% for July 2021 and is therefore reducing. July 2020's absence rate was 5.53%. • Extensive communications via Trust Safety Huddle and global emails to promote use of PPE, social distancing and compliance with environmental risk assessments restricting numbers within confined staff areas. • Participation in LAMP testing. Due to low update a comprehensive communication and engagement plan has been deployed in order to increase compliance. • Occupational Health opening times have been extended since 4 January 2021. • COVID vaccine programme continues with good uptake from across the workforce, with monitoring arrangements in place. • COVID-19 Workforce Recovery Steering Group commenced. • Supported by funding from NHSI there has been a big push to fill our HCA vacancies, we currently reporting 13 FTE vacancies (31/07/2021) • Extension of existing temporary changes to terms and conditions to support the covid response; special leave – 31st Dec 2021, Retire and Return – 31st Dec 2021 and Band 8a overtime reintroduced until 31st Oct 2021 • In July 2021 overall vacancy rate is 9.06% compared to a peak in Jun 2020 of 10.5%. • 87 of our 96 international Nurses are now in the country. • Therefore, as vacancies and sickness absence reduced it is expected our bank and agency reliance reduce and within July 2021 reliance on bank and agency staff increased slightly to 15.84% compared to a peak of 23.3% in Jan 2021.	
Assurance Gaps:	• Unable to control staff selecting to use national track and trace system for swabbing rather than local service. Therefore, staff will receive results and instructions from national Trace and Trace service and any contacts in the workplace could be instructed to self-isolate. Escalated to National & Regional Teams • Awaiting National Update from NHSE/I to concern raised about local management of staff self-isolating following symptoms & swabbing versus National Trace and Trace advice. No National or Regional solution to date. • National Policy on sickness absence monitoring and payments are being negotiated nationally - unable to influence outcome. May increase gaps in provision due to additional sickness absence allowances and associated pay arrangements. Negotiations ongoing. National Guidance expected in July 2021. • Continued lack of national/regional clarity of the management of long covid in the context of the National agreement.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Following an overall reduction in absences, review the trends of each category of COVID-related absence and re-assess risk score.	Review Recent Absence Trends	Data analysis and recommendation relating to risk score	Roberts, Carl	30/09/2021	

Board Assurance Framework

Risk ID:	1114	**Executive Lead:**	Crowe, Alex	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	FAILURE TO provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, CAUSED BY increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber attack, RESULTING IN poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statatory obligations (e.g. Civil Contigency measures) and subsequent reputational damage.			**Initial:** **Current:** **Target:**	20 (5x4) 20 (5x4) 8 (2x4)
Assurance Details:	**Assurance:** • **Digital Governance Structure** including weekly structured Senior Leadership Team meetings, Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Data Standards Group reporting to the Information Governance and Corporate Records Sub-Committee with escalations to the Quality Assurance Committee and onwards to the Digital Board, which itself submits highlights to the QAC and resource go to FSC. The **Quality Assurance Committee report provides** assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Cyber Essentials Plus/Audit Actions/IG training figures). • **Digital annual IT audit** plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with progress monitored at the Trust Audit Committee. • **Trust benchmarking** activities including Use of Resources reviews (Model Hospital). • ITHealth Assurance Dashboard is live, monthly external penetration testing is now in place using NHS Digital's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. (March 2021) **Controls:** • **Digital Operations Governance** including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard. • Active membership of the **Sustainability Transformation Partnership Cyber Group.** • **Digital Change Management** regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions. • **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training. • **Cyber Training** for the Trust Exec Board • Secured annual capital investment to increase Digital skills and capacity. • Digital Board support for profiling of a 7 Year Capital investment based upon asset replacement cycle and strategic roadmap (to deliver the approved Digital Strategy (January 2020)) • The use of automatic patching software to rollout security updates to devices. • Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links.				

Board Assurance Framework

	• 5 servers 2008 R2 unable to install security patches: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system & Winscribe dictation system (all issues resolved). • Office 2010 being used while end of life due to the N365 deployment plan (100% migrated) • Secondary secure backup at Halton Data Centre	
Assurance Gaps:	**Gaps In Assurance:** • Mostly achieving of mandated compliance with DSPT, incorporating CE+ (to be confirmed post MIAA audit results) **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Outcome of the Phishing exercise by NHS Digital, lack of awareness of staff. Communications have been sent out to staff members regarding phishing. Arranging second test with NHS Digital. • Current performance of Lorenzo and whether migration to the cloud will provide any benefit. • Not been able to fully recruit to the Digital Service restructure in terms of cyber. Majority of post filled by end of Sept 21. Not being able to recruit to post that are planned in Traunch 2 of the paperless care programme • Development of staff behaviours to protect data evidenced via reduced IG incident report levels, impacted training due to Covid-19 pandemic. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Not all Windows Server 2003 server will be migrated to Windows Server 2016 before the N365 agreement starts. (1 out of 77 servers are at risk of not being migrated in time. The system at risk is Medicorr.) • No local device (PC & laptop) based firewalls in use while on site, dependant on the site boundary firewalls • Using generic logins staff usernames and passwords are stored in browser when selecting “remember me” • No dedicated logging tool to pull all key logs together and provide useable alerts. MIAA to review processes and tools (July 21) •Using no longer supported Exchange 2010 email system for mail archive • Using SharePoint 2010 for the Hub •Remote devices bypassing the proxy • Lack of process to check antivirus alerts in console. MIAA to review processes and tools (July 21) • Administrator accounts still have access to the Internet & email, although only used when required (SIRO to approve process). • No controls in place for Bluetooth connectivity. • Active Directory password set not to expire. • No agreed patching schedule for network equipment with the Trust.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Standardised policies and procedures across the C&M STP using the core documentation from standard of ISO 27001 and the DSPT	Standardise policies and procedures across the C&M STP	• MIAA to map the basic standards to form the minimum and gold standard of documentation for Cyber. MIAA and WHHT to create the documentation templates from the mapping: • ISO 27001 (ISMS) • Data Security & Protection Toolkit (DSPT) • Information Security Standard (ISF) • Centre for Internet Security (CIS) • Information Systems Audit and Control Association (ISACA) • National Institute of Standards and Technology (NIST)	Deacon, Stephen	28/02/2022	

Board Assurance Framework

		• Cyber Security Body Of Knowledge (CyBOK) [Progress has been slow as core members were trying to provide an automated "bot" style document suite. This was too ambitious, and the group decided to scale it down to templates only. MIAA have writing the templates. The workstream are currently reviewing these documents for the 5th review and providing feedback and will be approved by the May C&M STP Cyber Group. Once approved Digital Compliance would rewrite the local documentation and seek approval from the Information Governance and Records Sub Committee.]			
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system). [Delivers: Best Practice]	Migrate all 2003 and 2008 servers to 2016.	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to Windows Server 2016 • Extend Support for Windows Server 2008 until Feb 2022 [Status June 21] Total Completed % Complete 2003 Servers 22 17 77.3% 2008 Servers 80 57 71.3% [Status July 21] Total Completed % Complete 2003 Servers 22 18 81.8% 2008 Servers 80 54 67.5% [Status Aug 21] Total Completed % Complete 2003 Servers 22 17 95.4% 2008 Servers 80 56 70.0% NB: Windows Server 2003 is out of support; however, Windows Server 2008 is still in support until March 22.	Deacon, Stephen	31/03/2022	

Board Assurance Framework

		[All simple migrations have been completed by IT Services. A report was presented at the October's Digital Board, providing progress made in the decommissioning of Windows 2003/2008 servers, the timetable for decommissioning the remaining servers and the mitigations identified for those servers which are unlikely to be decommissioned before 31st December 2020. The only server at risk is the Medicorr Server. As part of the DSPT requirements we have asked for an update action plan.]			
Deliver fit for purpose Lorenzo EPR Performance and agility of changes to deliver the paperless strategy. [Delivers: Optimisation / Timeliness]	Work with supplier to assure EPR performance	• Work with EPR supplier to safely migrate Lorenzo to the modern cloud solution. The date is subject to national contract changes that our out of our control. [Waiting on the cloud migration]	O'Brien, Emma	12/09/2021	
Implementation of the revised staff structure	Implementation of the revised staff structure	Phase 1 Consultation complete. Process to now to get the staff in place. Contractors are covering the gaps [Review with the DSPT action plan to resources available.]	Deacon, Stephen	30/09/2021	
From the review of the first phishing exercise, provide a comms strategy and send it out to the users. Once finished rerun the phishing exercise next year.	Lessons learnt from previous phishing exercise and rerun phishing exercise	Lessons learnt from previous phishing exercise rerun phishing exercise • Produce a comms plan and send out comms to all staff • Arrange a rerun the phishing exercise • Examine the results and publish at the April IGRSC [Engaged with Templar (NHS Digital) and agreed September for the next phase of the phishing exercise]	Deacon, Stephen	30/09/2021	
Migrate the last 9 endpoints devices to Windows 10	Migrate the last 9 endpoints devices to Windows 10	4 devices migrated with 5 devices left The below endpoint devices can be replaced: 1 x Laptop in Medical Engineering – Unsure why this is still in use.	Waterfield, Tracie	30/09/2021	

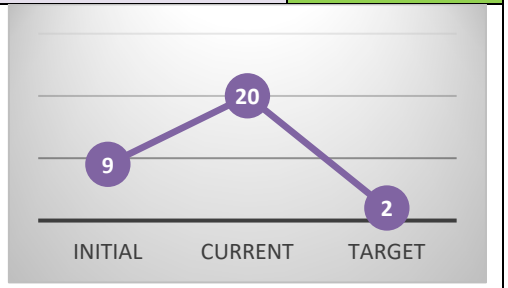
Board Assurance Framework

		(Deployment contacting ME regarding whether still in use) Endpoint devices more complicated to migrate: 1 x Dexa Scanner computer – This cannot be replaced at the moment, however, a new dexa scanner has been procured, just waiting on delivery and installation (waiting on date). 1 x Ophthalmology Fundus imaging computer – This cannot be upgraded/replaced as the Fundus camera is not Windows 10 compatible. Conversations on going with the department around replacement camera or removing use of the system altogether. 1 x Pathology Cognos client – This is some sort of information reporting system used in Pathology. They have supposedly purchased a replacement, just not implemented it yet (waiting on date) 1 x Cardiology (can be replaced but need to contact the 3rd party)			
Obtain funding for configuring web protection for remote devices	Obtain funding for configuring web protection for remote devices	Obtain quotes (COMPLETE) Obtain funding (COMPLETE) Configuration [Funding agreed, require date for the configuration]	Deacon, Stephen	29/10/2021	
Ongoing recruitment in the ePR Team	Ongoing recruitment in the ePR Team	Ongoing recruitment in the ePR Team	O'Brien, Emma	30/09/2021	
Enable 90-day password reset for Active Directory	Enable 90-day Password Reset	- Approval from the IGRSC & Medical Director (COMPLETE) - Enable 90-day password reset through CAB - Provide enough staffing for the Service Desk - Enable 90-day password reset	Waterfield, Tracie	30/09/2021	
Turn on device firewalls, to help limit a spread of an infected device infected other devices on the internal network	Turn on local device firewalls	Prioritise workload to look at turning on personal firewalls Create a test group Phase turn on / turn on	Deacon, Stephen	30/09/2021	

Board Assurance Framework

		[Meeting set up for 03/09/21]			

Board Assurance Framework

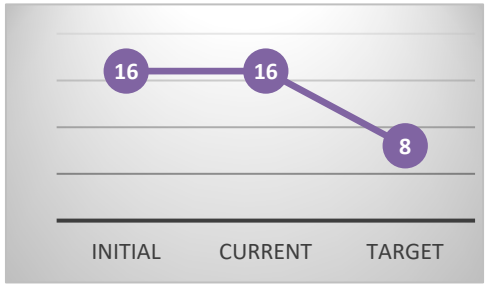
Risk ID:	1079	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.			**Initial:** **Current:** **Target:**	9 (3x3) 20 (4x5) 2 (2x1)
Assurance Details:	CBU Triumvirate attended Executive financial update board to highlight continuing issues with Lorenzo system Chief Nurse, medical director and head of safety and risk aware of system issue Digital IT paper to QAC and PSCE in collaboration with IT director to highlight system failures and inoperability paper based backup systems introduced Additional administration in significantly affected areas. Site visit to MBFT for lessons learnt in improving system Miro meeting with IT manager to look for interim solutions Scoping new systems with procurement Capital funding meeting attended to seek funds to support alternative maternity specific system New mobile phones for community to support hot spotting in areas with no connectivity IT visited community clinics with Lorenzo connectivity issues Support from lead midwife for IT. To ensure data quality, data is cross-checked to ensure that accurate data is submitted to for screening and Payment By Results Quick reference guides have been created for users to improve data quality related to erroneous input Off line version of Lorenzo to assist Community midwives to input real time data and reduce errors Support currently in place is cleansing historical data staff required to cleanse data going forward In order to ensure health visitors are notified, the current system is a paper based crosschecking system which is dependent on individuals pulling data of current pregnancies at 28 weeks gestation and cross checking the Lorenzo system to confirm ongoing pregnancy. Presentation provided by prospective suppliers on 18th December 2020 Decision on supplier expected by 31st January 2021 EPR Strategic Outline Case supported by the Trust Board in December 2020 Temporary fix for CTG archiving agreed and fitted in December 2020 with review in January & February 2021 Following completion of supplier decision making process, implementation due to complete in September 2021				
Assurance Gaps:	Lack of connectivity to ensure that system can operate Lack of data to provide internet hotspot Poor quality lap tops The current digital solution is contributing to poor data quality and its detrimental care quality and activity income effects, poor staff moral and concerns by regulators. Work related stress due to additional hours required to achieve correct level of data inputting leading to sickness absence Lack of assurance that all women are captured for both operational clinical and financial ends. This leads to uncaptured activity and risk to safety if women are not entered onto the system appropriate due to the above Loss of income due to poor data quality. The cross checking is dependent on time being available for the team to complete this time consuming task.				

Board Assurance Framework

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

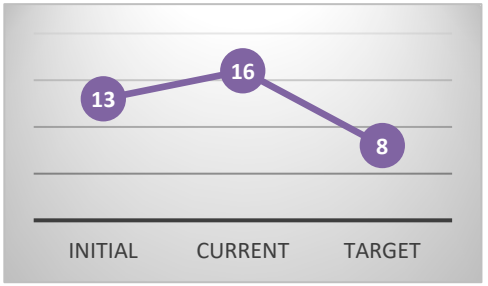
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Implementation of new EPR system	New EPR is fully in use and all training completed	Implementation plan Training of staff on new EPR.	Arya, Dr Rita	30/11/2021	

Board Assurance Framework

Risk ID:	1207	**Executive Lead:**	Michelle Cloney, Chief People Officer	**Rating**	
Strategic Objective:	Strategic Objective 2: We will… Be the best place to work with a diverse and engaged workforce that is fit for now and the future				
Risk Description:	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. 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 Trust COVID-19 Workforce Risk Assessment Tool was developed by the HR and OD Team and launched in July 2020. The electronic tool enables all members of staff to undertake a self-assessment and followed by a risk assessment with their line manager where required. The implementation of the tool was supported by guidance, virtual training and regular reporting. Trust compliance as at 6th September 2021 Have you offered a Risk Assessment to all staff? - **Yes** What % of all your staff have you Risk Assessed? – **93.54%** What % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary? – **96.12%** What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary? – **91.63%** Reports of any outstanding self-assessment and risk-assessments are provided to managers on a daily basis and numbers of outstanding assessments by CBU / Department are escalated to Tactical Meeting. In addition, the HR Team proactively make contact with any managers where there are outstanding assessments. HR continue to support managers to complete the risk assessments.				
Assurance Gaps:	At 6th September 2021: •226 staff members yet to complete self-assessment •5 Management Risk Assessments (required when an individual identifies as having a COVID Vulnerability) have been outstanding since at least March 2021 •77 Management Risk Assessments have been outstanding since April 2021				

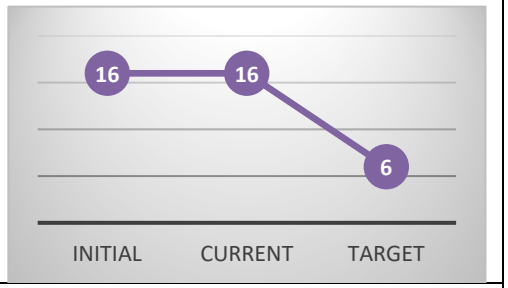
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Managers must complete all outstanding risk assessments and any new risk assessments that are triggered.	Completion of risk assessments.	• Completion of risk assessments.	Deborah Smith, Deputy Director of HR and OD	30/09/2021	
To encourage the completion of the Self-Risk Assessments	Completion of Self-Risk assessments.	• Further communication to staff re the importance of completing Self-Risk Assessments • Completion of Self-Risk assessments.	To encourage the completion of the Self-Risk Assessments	31/10/2021	

Board Assurance Framework

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

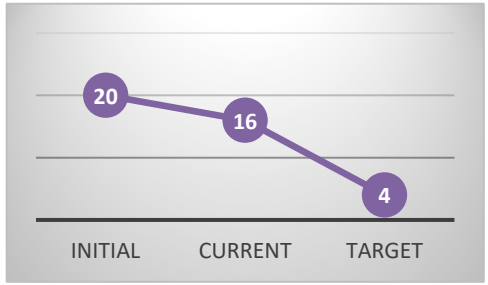
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Sign off PID for the maternity project	Sign off PID for the maternity project	Sign off PID for the maternity project	Deacon, Stephen	30/08/2021	
External review of OBC	External review of OBC	External review of OBC	Deacon, Stephen	31/08/2021	
Signing of tactical agreement	Signing of tactical agreement	Signing of tactical agreement	Deacon, Stephen	30/09/2021	
Maternity go live	Maternity go live	Maternity go live	Deacon, Stephen	31/04/2022	

Board Assurance Framework

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

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

Board Assurance Framework

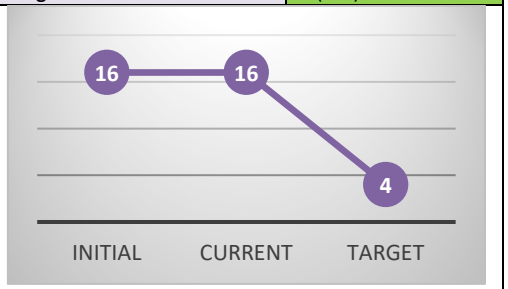
Risk ID:	125	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to provide safe, secure, fit for purpose hospitals and environment caused by the age and condition of the WHH estate and limited available resource resulting in a risk to meeting compliance targets, staff and patient safety, increased backlog costs, increased critical infrastructure risk and increased revenue and capital spend.			**Initial:**	20 (5x4)
				Current:	16 (4x4)
				Target:	4 (4x1)
Assurance Details:	Controls: 2018 C&M H&CP Estates strategy – updated annually Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out Capital Planning Group and associated capital funding allocation process Planned Maintenance Program Reactive maintenance regime Annual asbestos survey - asbestos management survey makes an assessment of the condition of any materials present and determine the likelihood of any fibres being released. Annual PLACE assessments Assurance: External estates compliance audit carried out in November 2019 which has in formed a number of remedial actions to improve compliance across the estate Monthly Estates compliance audit Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers Fire Safety Group – monitors fire safety issues across the trust and provides assurance to Cheshire fire and rescue service on Fire Safety Management PLACE assessment action plan and monitoring - Capital Planning Group – determine how the trust capital is spent Use of resources group – monitors how cost effective and value for money estates and facilities are in relation to a number of national and regional benchmarks New hospitals for Warrington and Halton groups – providing a platform to address the critical infrastructure and backlog risk 20-21 capital programme approved which includes £2.27m to address backlog maintenance Business Case for ED Plaza Scheme approved and due for completion in March in February 2022 Commencement of Phase 2 (although approved) reliant on capital funding in 2021/22 which is now confirmed. Progress will now be made against the scheme with indicative construction completion date of January 2022. Critical Infrastructure Capital Funding to support schemes with critical and high levels of backlog maintenance approved Cancer Alliance funding of £0.5m for endoscopy enabling work at Halton to improve the environment Phase 1 of CT Buildings work complete Additional staff rest areas deployed to support social distancing and reduce staff nosocomial infection during rest and break times during the Covid-19 pandemic. Approved and recruiting for additional Estates Compliance Manager role to support routine compliance and routine small estates works. Ward B18 refurbishment expected to be completed by 3rd September 2021 New MRI build set to be completed in October 2021 New Endoscopy roofing infrastructure at Halton set to be completed in September 2021 Capital schemes to improve paediatric outpatients due for completion in December 2021 Capital schemes to develop a Urology Investigation Unit set to be completed by March 2022				

Board Assurance Framework

	Mortuary refurbishment set to be completed by October 2021	
Assurance Gaps:	Estates staffing - reduced staffing numbers since 2011 has impacted on ability to carry out elements of essential maintenance – review to be undertaken in 2021 Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome Cost pressures – unfunded elements of maintenance in I&E budget Use of Resources - benchmarking against backlog maintenance and critical infrastructure risk are below national medium Threat to the delivery of capital schemes due to the pandemic e.g. manufacturing delays, additional costs of construction relating to IPC guidelines and the unavailability of an appropriately skilled workforce.	

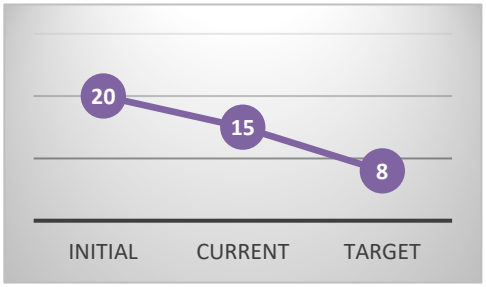
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Complete Premises Assurance Model by April 2021	Set up working group with Estates and Finance team to complete the documentation and file the evidence required to complete the PAM)	By completing, analysing and actioning any gaps in compliance	Lamb, Robert	25/06/2021	25/06/2021

Board Assurance Framework

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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Uplift of 7.5 WTE midwives to enable continuity of carer	Uplift of midwives for continuity of carer	Paper going to the board. To closely monitor vacancy rates so that the vacancies can be appointed to in timely manner	Gould, Debby	30/09/2021	
Band 6 and 7 midwife posts out to recruitment. To continue to closely monitor vacancy rates so that the vacancies can be appointed to in timely manner	Designated matron leading on recruitment.	Interviews for band 7 uplift posts planned for end June 2021. Advert for Band 6 posts awaiting closing date prior to interviews being arranged.	Gould, Debby	30/09/2021	

Board Assurance Framework

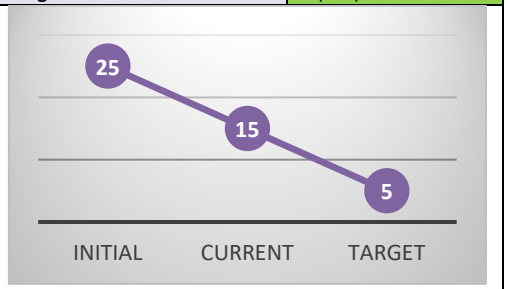
Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.			**Initial:**	20 (5x4)
				Current:	15 (5x3)
				Target:	8 (4x2)
Assurance Details:	The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the C&M Health and Care Partnership plans. The Trust has developed effective clinical networking and integrated partnership arrangements. Some examples include: - The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. - Council and CCG in both Warrington & Halton supportive of development of new hospitals. Agreement with key stakeholders to progress single programme and proceed with OBC development. - Agreement of sustainability contract with Warrington CCG and subsequently Warrington & HaltonSystem Financial Recovery Plan - Regular Strategy updates are provided to the Council of Governors - Clinical strategy wide engagement - Clinical Strategy approved by Trust Board - CBU specialty level strategies complete and incorporated in business plans. - Initial talks held with Elective Care C&M Lead in relation to the suitability of Halton as a potential Elective Care Hub. Opportunity to accelerate elective hub as part of Covid recovery - Trust has met with Cheshire & Merseyside leads for Women's and Children's review to demonstrate strength of local Women's and Children's services and help inform outcomes of regional review. - NHSE and local Commissioners supportive of draft strategy for breast screening. Breast Centre of Excellence being implemented as a priority to support COVID-19 recovery. - DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. Phase 3 of the HIP announced. WHH drafting an Expression of Interest (EOI) for submission in September 2021 - Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. - Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside. Currently options for further development do not include any option where WHH is a hub. All options proposed include Essential Services Labs (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESLs. Pathology OBC supported by the Trust Board - Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services to commence from January 2022.				

Board Assurance Framework

	- Director of Strategy invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington - Town Deal plan for Warrington submitted. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £22.1m funding approved for the Town investment plan, including £3.1m for the Health & Wellbeing Hub and £1m for the Health & Social Care Academy. - The Trust is leading the development of the detailed plan for the Health & Wellbeing Hub. - Strategy refresh completed and approved at Trust Board to confirm 2020/21 priorities. Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. - In February 2021 the Government White Paper, "Integration and Innovation: working together to improve health and social care for all - The Department of Health and Social Care's legislative proposals for a Health and Care Bill" was published. - The Trust Board agreed in March 2021 that a transaction between BCH and WHH is no longer required, given that the White Paper enables an acceleration of place-based integration including all commissioners and providers. - The Trust has been awarded Social Value Award status recognising the contribution to the outcomes of local populations. It is one of only two organisations in Cheshire & Merseyside to receive the award. - £90k funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington - WHH commenced a focussed programme of work on addressing health inequalities, the green agenda and our role as an anchor instiution. Initial work recognised as the exemplary within Cheshire & Merseyside.	
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 securing capital funding to progress new hospitals Progress in collaboration with Alderhey to repatirate activity hindered due to COVID-19. Focus on addressing waits within organisation prioritised	

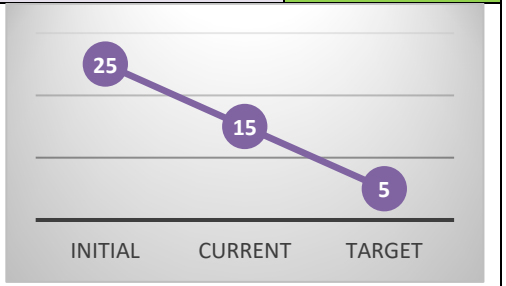
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Progress plans for new hospitals to be best placed to secure funding when available	Develop SOCs and participate in competitive process for HIP funding	Develop SOCs and participate in competitive process for HIP funding	Lucy Gardner	SOCs – April 2020 Expression of Interest due September 2021	SOCs – March 2020
Actively participate in and contribute to the development of integrated care partnerships at PLACE & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Simon Constable	31/03/2022	

Board Assurance Framework

Risk ID:	1274	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.			**Initial:** 25 (5x5) **Current:** 15 (3x5) **Target:** 5 (5x1)
Assurance Details:	Plan in place to carry out Asymptomatic testing of staff. There is a high-level rationale for testing due to the level of community transmission in the North West as well as nosocomial infection rates. Staff are being tested over a ten-day period. All staff to wear face masks in both non-clinical and clinical areas. Use of effective messaging and communication. Risk stratification in place so there is no service level disruption to provision. Staff groups have been split to ensure only 5 members of staff from each service are tested at any one time. Lateral flow self-testing twice weekly in place – 1.8% positivity rate Loop-mediated Isothermal Amplification (LAMP) testing introduced. LAMP testing commenced in ED/ICU LAMP testing to commence in Wards A7/A8 by the end of March 2021 Internal review of Clinically Extremely Vulnerable (CEV) completed to expedite return to work and ensure staff safety. New self-isolation guidelines received, and SOP developed. SOP circulated and effective from 23.08.2021			
Assurance Gaps:	Potential for unsafe staffing levels. Requirement to improve uptake of LAMP testing across the organisation			

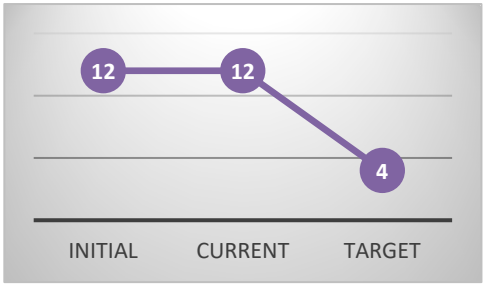
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Improve compliance with uptake of LAMP testing across the Trust	Campaign to increase awareness	Campaign to increase awareness	Rylett, Louise	31/08/2021	

Board Assurance Framework

Risk ID:	1331	**Executive Lead:**	Moore, Daniel	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.			**Initial:** 25 (5x5) **Current:** 15 (5x3) **Target:** 5 (5x1)
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
Creation of additional appropriate clinical areas with appropriate clinical staff.	Addtional Clinical Areas	Creation of additional appropriate clinical areas.	Martlow, Sharon	30/06/2021	30/04/2021

Board Assurance Framework

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

Board Assurance Framework

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board

DATES 2021-2022

All meetings to be held in the Trust Conference Room

Date of Meeting	Agenda Settings	Deadline For Receipt of Papers	Papers Due Out
2021			
Wednesday 27 January	Thursday 7 January	Monday 18 January	**Wednesday 20 January**
Wednesday 31 March	Thursday 10 March	Monday 22 March	**Wednesday 24 March**
Wednesday 26 May	Thursday 6 May	Monday 17 May	**Wednesday 19 May**
Wednesday 28 July	Thursday 8 July	Monday 19 July	**Wednesday 21 July**
Wednesday 29 September	Thursday 9 September	Monday 20 September	**Wednesday 22 September**
Wednesday 24 November	Thursday 4 November	Monday 15 November	**Wednesday 17 November**
2022			
Wednesday 26 January	Thursday 6 January (EXECS)	Monday 17 January	**Wednesday 19 January**
Wednesday 30 March	Thursday 10 March (EXECS)	Monday 21 March	**Wednesday 23 March**