NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

WHH Trust Board Meeting Part 1

Wednesday 25 May 2022
10.00am-12.30pm
Via MS Teams

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		

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.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 25 May 2022, 10.00am – 12.30pm
Via MS Teams

AGENDA ITEM	TIME	AGENDA ITEM	OBJECTIVE/DESIRED OUTCOME	PROCESS	PRESENTER
BM/22/05/48 **PAGE 8**	**10:00**	Engagement Story - JAG Accreditation	***To Note***	**Presentation**	Kimberley Salmon-Davidson, Chief Nurse & Deputy CEO
BM/22/05/49	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***		Steve McGuirk Chairman
BM/22/05/50 **PAGE 15**	**10:17**	Minutes and Action Log of the previous meeting held on 30 March 2022	***For decision***	***Minutes***	Steve McGuirk, Chairman
BM/22/05/51	**10:20**	Matters Arising	***For assurance***	***Verbal***	Steve McGuirk, Chairman
BM/22/05/52 **PAGE 28**	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Simon Constable, Chief Executive
BM/22/05/53	**10:30**	Chairman's Report	***For info/update***	***Verbal***	Steve McGuirk, Chairman

Quality People Sustainability

BM/22/05/54	**10:35**	Covid-19 Situation Report *(to follow)*	***To Note for Assurance***	***Report***	Simon Constable, Chief Executive
BM/22/05/55 **PAGE 39**	**10:40**	Integrated Performance Dashboard M3 and Assurance Committee Reports	***For assurance***	***Report***	All Executive Directors
(a) PAGE 104		**Quality Dashboard** Monthly Nurse Staffing Report	***For assurance***	***Report***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
(b) PAGE 114		Assurance Report – Quality and Assurance Committee (05.04.22 & 03.05.22)	***To note for assurance***	***Report***	Cliff Richards, Committee Chair
(c) PAGE 121		**People Dashboard** Assurance Report SPC (18.05.22)	***For assurance***		Michelle Cloney, Chief People Officer
		Sustainability Dashboard	***For assurance***		Andrea McGee, Chief Finance Officer & Deputy CEO
(d) PAGE 125		Assurance Report – Finance and Sustainability Committee (20.04.22 & 19.05.22)	***To note for assurance***	***Report***	Terry Atherton, Committee Chair
(e) PAGE 134		Assurance Report – Audit Committee (28.04.22)	***To note for assurance***	***Report***	Mike O'Connor, Committee Chair
(f) PAGE 137		Assurance Report – Clinical Oversight Recovery Committee (26.04.22 & 17.05.22)	***To note for assurance***	***Report***	Terry Atherton, Committee Chair

Quality					
		Maternity Update Report	***To note for assurance***	***Report***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
		SIRO Annual Report	***To note for assurance***	***Report***	Paul Fitzsimmons Executive Medical Director

People					
BM/22/05/59 PAGE 178		Engagement Year End Report	***To note for assurance***	***Report***	Pat McLaren, Director of Communications & Engagement
BM/22/05/60 PAGE 187		NHS Staff Opinion Survey	***To note for assurance***	***Report***	Michelle Cloney, Chief People Officer

Sustainability					
BM/22/05/61 PAGE 215		Use of Resources Q4	***To note for assurance***	***Report***	Andrea McGee, Chief Finance Officer & Deputy CEO
BM/22/05/62 PAGE 237		Bi-Monthly Strategy Update	***To note for assurance***	***Report***	Lucy Gardner Director of Strategy & Partnerships

GOVERNANCE					
BM/22/05/63 PAGE 261		Board Assurance Framework	***To note for assurance***	***Report***	John Culshaw Trust Secretary

SUPPLEMENTARY PAPERS (See Supplementary Agenda for Page Numbers)

FOR APPROVAL						
BM/22/05/64		Code of Governance Compliance & Compliance with Licence Annual Return – Completion of Cos7	***For approval***	n/a	***Report***	John Culshaw, Trust Secretary
BM/22/05/65		Terms of Reference Strategic People Committee Clinical Recovery Oversight Committee & Finance &	***For approval***	Committee: Finance & Sustainability Committee/Strategic People Committee/Clinical Recovery Oversight Committee Date of Meeting: 19.05.22/ 18.05.22 & 17.05.22 Agenda Ref: FSC/22/05/75/SPC/22/05/50 & CROC/22/05/52	***Report***	John Culshaw Trust Secretary

		Sustainability Committee		Outcome: Supported for approval		
BM/22/05/66		Cycle of Business Clinical Recovery Oversight Committee	***For approval***	Committee: Clinical Recovery Oversight Committee Date of Meeting:17/05/22 Agenda Ref: CROC/22/05/52 Outcome: Supported	***Paper***	John Culshaw Trust Secretary
BM/22/05/67		Policies: • Social Media & Media Policy • Accessible Information Policy	***For approval***	Committee: Quality Assurance Committee Date of Meeting:3 May 2022 Agenda Ref: QAC/22/05/XX Outcome: Noted	***Paper***	Pat McClaren, Director of Comms & Engagement
BM/22/05/68		Quality Account	***For approval***	Committee: Quality Assurance Committee Date of Meeting:3 May 2022 Agenda Ref: QAC/22/05/116 Outcome: Approved	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/05/69		Finance & Sustainability Committee Annual Report	***To note for assurance***	Committee: Finance & Sustainability Committee Date of Meeting: 19 May 2022 Agenda Ref: FSC/22/05/93 Outcome: To note for assurance	***Report***	Terry Atherton, Committee Chair

TO NOTE FOR ASSURANCE						
BM/22/05/70		Infection Prevention and Control (DIPC) Q4	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting:3 May 2022 Agenda Ref: QAC/22/05/126 Outcome: Noted for assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/05/71		Infection Prevention and Control - Board Assurance Framework	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting:3 May 2022 Agenda Ref: QAC/22/05/127 Outcome: Noted for assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/05/72		Learning from Experience Report Q4	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 3 May 2022 Agenda Ref: QAC/22/05/124 Outcome: Noted for assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/05/73		Digital Board Report	***To note for assurance***	Committee: Finance & Sustainability Committee Date of Meeting: 20.04.22/19.05.22 Agenda Ref: FSC/22/04/65 & FSC/22/05/84 Outcome: Noted for assurance	***Paper***	Paul Fitzsimmons Executive Medical Director
BM/22/05/74		Learning from Deaths Review Q4 Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 3 May 2022 Agenda Ref: QAC/22/05/131 Outcome: Noted for Assurance	***Paper***	Paul Fitzsimmons Executive Medical Director
BM/22/05/75		Working with People and Communities Strategy	***For approval***	Committee: Council of Governors Date of Meeting: 12 May 2022 Agenda Ref: COG/22/05/34	***Paper***	Pat McLaren, Director of Communications & Engagement
BM/22/05/76		Patient Experience Strategy	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 5 April 2022 Agenda Ref: QAC/22/04/91 Outcome: Noted for Assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/05/77		Quality Strategy Annual Update	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 1 March 2022 Agenda Ref: QAC/22/03/67 Outcome: Noted for Assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO

BM/22/05/78		IPC Strategy	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 3 May 2022 Agenda Ref: QAC/22/05/118 Outcome: Approval	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/05/79		Guardian of Safe Working Q4 Report, Safe Working Hours Jnr Doctors in Training	***To note for assurance***	Committee: Strategic People Committee Date of Meeting: 18 May 2022 Agenda Ref: SPC/22/05/58 Outcome: Noted for Assurance		Paul Fitzsimmons, Executive Medical Director
CLOSING						
BM/22/05/80		Any other business		Steve McGuirk, Chair		
Date of next meeting – Wednesday 27 July 2022						

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Our JAG Assessment Story

Dr Sundaramoorthy Bharathi, Endoscopy Lead
Emma Blackwell, Endoscopy Business Manager
Karen Smith, Endoscopy Unit Manager

8 of 306

Background

- The JAG accreditation programme works with endoscopy services across the UK to improve the quality of patient care.
- Accreditation is awarded to services which have demonstrated they meet the best practice quality standards covering all aspects of an endoscopy service including

Quality and Safety | **Patient Experience** | **Workforce** | **Training**

Accreditation process

- Annual Review undertaken
- 5 yearly annual assessment involves uploading evidence onto the JAG website to show compliance against the 133 standards
- In total over 200 pieces of evidence submitted
- Site visit over 2 days with JAG assessors visiting the units and speaking to 5 patients and over 20 staff

Patient Journey

JAG Accreditation Report feedback

Warrington and Halton Teaching Hospitals NHS Foundation Trust

"This is a highly effective patient-centred service that is exceptionally led by a dynamic team. Both sites operate to an equally exceptional standard and easily some of the highest standards we have seen in the UK"

- ✓ Excellent leadership demonstrated by a supportive and encouraging culture for staff learning, training and progression
- ✓ Service developments even with the challenges of the pandemic
- ✓ Excellent patient feedback
- ✓ The strength of the service is its workforce who are clearly passionate about the care that they provide
- ✓ The quality of endoscopists performance against key performance indicators is excellent
- ✓ Governance and safety structures are well structured and well organised
- ✓ Several outstanding examples of individualised patients care and innovation
- ✓ Exceptional administration team and their processes
- ✓ Excellent recovery plan and making good progress in clearing the current backlog

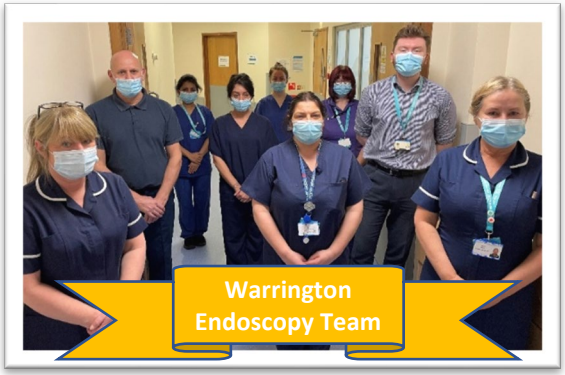
Assessment Summary

The service epitomises what a quality, safe endoscopy service with embedded standards is all about, it was a pleasure to assess this service. Congratulation on a job well done!'

JAG Accredited

Our Outstanding Endoscopy Team!!!

Warrington and Halton Teaching Hospitals NHS Foundation Trust



Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 30 March 2022, Via MS Teams	
Present	
Terry Atherton (TA)	Non-Executive Director & Deputy Chair
John Alcolado (JA)	Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
Michelle Cloney (MC)	Chief People Officer
Paul Fitzsimmons (PF)	Executive Medical Director
Julie Jarman (JJ)	Non-Executive Director
Andrea McGee (AMcG)	Chief Finance Officer & Deputy Chief Executive
Steve McGuirk (SMcG)	Chairman
Dan Moore (DM)	Chief Operating Officer
Michael O'Connor (MOC)	Non-Executive Director
Cliff Richards (CR)	Non-Executive Director
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse & Deputy Chief Executive
In Attendance	
Adrian Carradice-Davids	Associate Non-Executive Director
John Culshaw (JC)	Trust Secretary
Jayne Downey (JD)	Associate Non-Executive Director
Lucy Gardner (LG)	Director of Strategy & Partnerships
Jen McCartney (JMcC)	Head of Patient Experience & Inclusion
Pat McLaren (PMc)	Director of Communications & Engagement
Dave Thompson (DT)	Associate Non-Executive Director
Liz Walker (LW)	Secretary to the Trust Board (minute taking)
Observing Governors	
Julie Astbury	Public Governor
Dan Birtwistle	Staff Governor
Paul Bradshaw	Public Governor
Nathan Fitzpatrick	Public Governor
Akash Ganguly	Public Governor
Janice Howe	Public Governor
Kerry Maloney	Public Governor
Norman Holding	Lead (Public) Governor
Anne Robinson	Public Governor
Louise Spence	Staff Governor
Public Observers	
Robby Ryan	Member of the Public
Apologies	
Simon Constable	Chief Executive Officer

Agenda Ref	Agenda Item
BM/22/03/22	**PATIENT STORY – INCLUSIVE COMMUNICATION TO IMPROVE OUTCOMES** JMcC provided the background of the patient story which highlighted upon admission to hospital, it became evident there were issues regarding language. The story talked about a patient who had previously had the ability to communicate in English, but due to the patient living with dementia, resulted in reduced communication in English. It was important to note that patients wishes are at the forefront of what we do in the Trust, and all patient stories have next steps and shared with relevant teams to validate the process and understand how this would have a positive impact on the patient. SMcG asked about whether there was a "where next" meeting when there was a complex discharge process and would it bring together all MDT to ensure appropriate support was in place. DT asked about feedback from the family as often in these situations there can be anxiety. JMcC responded feedback from family had been positive and it was a proven example of how all teams had worked together to expedite the discharge of the patient. ACD asked if there was any promotion for feedback before patients enter hospital. JMcC added that this had started to happen, however there was always room to make improvements and it was important for those patients to know this before coming through the front door. ACD also asked about food and if there was a cultural option to which JMcC added there was a cultural section on the menu and work was taking place in the background by way of patient surveys and conversations, there was always room for improvement. SMcG asked if there was a Braille writer in the organisation, and although PMcC advised there was no dedicated service in the Trust, if one was required then this was available, however the request had never been raised before. DT noted at the last survey 22 people in Warrington could read braille and there had been good turnaround from RNIB. CR added he felt there was benefit of staff being offered the approach as explained, and felt the process was easier, having a complete joined up approach which was effective. SMcG stated that JMcC and the team were making a difference to patients and thanked the team for the work they did. **The Committee noted the Patient Story.**
BM/22/03/23	**WELCOME, APOLOGIES AND DECLARATIONS OF INTEREST** Apologies for absence were received from Simon Constable.

	It was noted there was a member of the public in attendance, Robert Ryan. SMcG informed the Committee it was Margaret Bamforth's last meeting and wanted to record the thanks of the Trust and everyone on the Board for her work and contribution during the last six years. MB thanks everyone and added she had enjoyed her time with the Trust and enjoyed being part of its journey during the last six years. **The Trust Board noted the apologies and attendance.**
BM/22/03/24	**MINUTES AND ACTION LOG FROM THE PREVIOUS MEETING HELD ON 26 JANUARY 2022** The minutes were agreed as an accurate record and approved subject to minor amendments. The Action Log was reviewed, and all actions closed. **The Trust Board approved the minutes of the meeting held on 26 January 2022.**
BM/22/03/25	**MATTERS ARISING** SMcG noted that virtual approval had been made in relation to Charitable Fund Committee Annual Report and Accounts. **The Trust Board noted the approval.**
BM/22/03/26	**CHIEF EXECUTIVES REPORT** Simon Constable, Chief Executive was absent from the meeting, however if there any questions these could be picked up outside of the meeting. SMcG noted several items to highlight and these included staff sickness levels at 10%, the appointment of two new Place Directors, Anthony Leo and Carl Marsh representing Runcorn and Warrington, respectively. The Prime Minister had made a visit to the hospital, albeit a very brief one, to open the new MRI scanner. It was noted staff car parking charges would be reintroduced from 1 May 2022 and that everyone who wanted to renew should do so as soon as possible. Joint Advisory Group, GI Endoscopy (JAG) Accreditation visit was made on both Endoscopy units at Warrington and Halton sites and accreditation awarded which provided independent partial recognition that a service demonstrates high levels of quality. ***Questions:*** JD asked about the 52-week breaches, and which were the specialty areas. DM responded these included General Surgery, Trauma, Orthopaedic. It was also noted the number of Covid patients reported stated 75 however the current numbers were 96, along with the increased number of super stranded patients at 144 which was extremely high.

	DT referenced the long covid service as had met with Minister for Disabled people, where it was widely recognised that people are affected by long covid and asked if the Trust had a learning specialist nurse. KSJ responded the Safeguarding team does have a learning disability specialist nurse. **The Trust Board noted the Chief Executive's Report.**
BM/22/03/27	**CHAIRMAN'S UPDATE** SMcG noted that the Q&A sessions with the governors would continue. It was also advised there had been several proposals in relation to the non-Executive roles (NED), these included Jayne Downey becoming a Non-Executive Director, Cliff Richards to extend his role for a second term as a NED. and would become the Chair of the Quality Assurance Committee. He would also become the Senior Independent Director. The recruitment had now been completed for these positions and formally approved. **The Trust Board noted the update and formally approved the recruitment as highlighted.**
BM/22/03/28	**COVID -19 PERFORMANCE SUMMARY AND SITUATION REPORT** DM highlighted the increase in numbers of Covid patients and it continues to grow and reflected on the lowest number being c55 and peaked at 99. Rising admissions would continue to rise with numbers in the Cheshire and Mersey footprint around two thirds of the way towards the figures in Wave 5. This was a real challenge as there was uncertainty as to whether the numbers would continue to rise. One of the challenges for the Trust was staff sickness, as well as community staff with a third of care homes shut in Halton, with expected closures of some in Warrington, however there had been no impact on the flow of patients out of the hospital. The same picture had been seen across all providers and community providers in Cheshire and Mersey, along with an Increase in critical care admissions also. MC noted the absence level currently stood at 11.65% which equated to around 527 staff. DT noted a story in the press whereby two large employers had been blasted for insisting staff go into work if they had Covid. This was particularly disturbing as one was a garden centre where there would be many the older vulnerable population visiting, and there was a need for Public Health England to raise awareness that Covid had not gone away and there were still vulnerable people out there, along with a rise in numbers. SMcG responded that on the last regional call he attended similar observations were made and the message needed to be ramped up and was on the radar of Public Health. TA highlighted 527 staff absence today with a high proportion due to the consequences of Covid. SMcG responded the public were not receptive to the

	message being sent out even though the consequences were significant. DM added there were complications on the ground with the massive relaxation of rules around what needs to be done around isolation, however for healthcare settings the advice remains unchanged. MC noted as an employer the Trust has a separate process for those staff who had been off sick with Covid with no detriment to pay, therefore was very different to private organisations where the Public Health messages had been different, along with differing pay structures in private organisations where staff might not get paid. **The Trust Board noted the report**
BM/22/03/29	**INTEGRATED PERFORMANCE DASHBOARD & COMMITTEE ASSURANCE REPORT** ***Quality Dashboard*** SMcG asked about the 52-week RTT for which there were 1038 patients, a slight improvement of c.100, what does this mean next. DM responded the RTT position had seen a slight improvement based on referral rate and backlog, this would probably flat line. However, with the plans in place for 2022/23 would start to slowly see marginal improvement over the next 12 months and did not expect the position to worsen significantly. With a quantum of unmet demand there might be a surge of referrals coming forward in 2022/23. Going forward the focus would be on the elimination of patients waiting 104 weeks over 18 months by March 2024 and would see 104- and 78-week waiters reducing in line with the plan, however the final plans for 2022/23 had not yet been finalised. MB asked about Fracture Clinic 72-hour standard on IPR and where the action plan was up to as several indicators had moved to either Red or Amber with a comment on workforce pressure and the link between quality and workforce. ACD asked about sickness levels and the key question of the softer issues other than finance and bank staff, but more about impact on patient outcomes due to sickness levels and what risks and mitigations were in place. JD asked about impact on patients where targets were not being met and what was being done, regarding the fracture clinic and long term affect on patients if not treated early on. PF responded the delays in the Fracture Clinic had an impact and this had been resolved by increasing capacity to see patients in virtual fracture clinics which had been adopted this month. There was the option if necessary to still see someone face to or if urgent intervention was needed, and this should result in a reduction in the figures. JD asked about dedicated times for specific issues for patients to attended face to face appointments and PF responded the majority took place on site, however additional scheduling software was being introduced which would help to improve the process.

KSJ noted there had been a Fracture Clinic Deep Dive on incidents for patients wating beyond 72 hours and if required could be shared separately if it would be helpful.

Sepsis

The data had been improving; however, March data had declined due to staffing issues and ED attendance. This had been reviewed at the Task and Finish Group and audits were undertaken for patients waiting more than an hour for medication for Sepsis treatment.

A&E

The number of patients had been as many as 150, however the staffing compliment was to enable support for 80 to 90 patients maximum, and this would inevitably result in delays. Staff were moved to ED where possible to support the A&E corridor.

Infection Control

This was more into the red but was less worried as 1 case of MRSA had moved the indicator into the Red and the case had been reviewed in depth. For CDiff, there had been 44 cases which was the maximum allowed in a year, however looking at national variance the Trust was in a better position that most other hospitals, nevertheless was still in the Red.

Pressure Ulcers were also Red, due to staffing levels, but reassurance had been provided as there had been a decrease in level 3 Pressure Ulcer. Reviews took place weekly, which could react to changes, however with staffing issues it was wards were at minimum staffing levels. The schemes implement in December for Nursing and Midwifery were being revisited to extend this, as this may help to fill some of the necessary gaps.

With 50 escalated beds open, high sickness levels and 2 hourly monitoring of staff to keep the Trust safe, staff are moved and flexed accordingly . A Deep Dive was being undertaken to try to understand the correlation, but mitigation was taking place weekly and review with specialist teams on each of the indicators.

Assurance Report – Clinical Recovery Oversight Committee (CROC)

TA highlighted Cancer performance as one of the key issues from CROC and indicated moderate assurance in respect of the recovery agenda along with Covid related issues. Other areas for noting included harm reviews for the priorities on the waiting list which has resulted in 14 cases of moderate harm but no serious cases. Breast 2-week wait was proving to be particularly challenging but was on track to achieve by the end of March.

MOC asked about ambulance handovers and with the continued concern over performance, what work was being undertaken to ensure it did not get worse. KSJ responded the data in March had declined and it was a priority, however due to operational working sometimes it was impossible to offload patients due to numbers already waiting to be seen.

	CR asked about MRSA and the choice of invasive devices need to be improved along with Sepsis training. In relation to the IPR it was about understanding the impact of Covid on this. KSJ noted not sure of the impact of Covid on MRSA. In terms of device related issues, there was a need to refresh training however, in the main good in overall infection training. Often the learning was around device and blood stream infections along with human error. DM noted in relation to advice and guidance, an increased number of services offered this, and trajectories were set out in the planning guidance. All additional beds had been reopened for use in Wave 5, and therefore had to escalate capacity in response to pressures. JD asked while on the recovery pathway and patients were meeting trajectory, were those patients being reviewed who had been missed. ***Staffing and Assurance Report*** DT asked about Return to Work (RTW) and MC noted there had been a lot of work undertaken to review expectations around a RTW interview, with rebranding and educational processes put in place. Documentation had been streamlined with the emphasis on ensuring there was awareness around the issues of why staff were off sick and that if required support was available. There had been a pilot launch with the Rugby League called Rugby League Cares which provided an additional lever and support mechanism to reach staff either seldom heard or hard to reach as part of the Supporting Attendance management approach. A question was asked about the uptake in those staff retiring or near retirement, and it would be useful to see the data and if the Trust were working on succession planning in relation to this. MC added in relation to Retire and Return the rules had been changed up until October 2022, and 21 members of staff had retired and returned under these revised rules. Further work would be needed prior to presenting an update on this and would agree when to present an update to the Trust Board. ***Assurance Report - Quality Assurance Committee (QAC)*** MB highlighted several areas from the Assurance Report for QAC which included. • 12-hour breaches had been reviewed, and the Committee had noted appropriate assurance. • The implementation of the Medical Examiner programme had been successful. MB thanked everyone for their contribution during the last 6 months, it had been a difficult time with considerable operational pressures but have received appropriate assurance in the reports received. MB noted, in her capacity as Maternity Safety Champion, the Ockenden report would be published and felt it would be useful to feedback on a recent visit to Maternity with KSJ. There had been considerable change over the last two years with staff wanting meet and talk rather than having to round them up, this

included the leadership team, with Chris Bentham and Catherine Owens, along with the Neonatal team, so a joined-up approach was being seen. The staff were wanting to say how proud they were of the service and the investment that had been made towards the improvements.

KSJ noted the actions from the first Ockenden Report were halfway complete and would continue into next year. Not all actions related to the Trust as a single provider, but also the LMS. Ockenden 2 report was due to be published today and support was in place if there were any issues that came out of the report. An update would be provided to the Trust Board on the plan for Ockenden 2 and noted the Trust was constantly making improvements, making it better for family and staff.

Assurance Report – Strategic People Committee

The report was taken as read. JJ Noted the two excellent presentations from the staff networks including disability which highlighted hidden disabilities and its relation to the work undertaken regarding blue badge holder parking. The Trust had been the first to undertake such a project, and the network highlighted several projects in the pipeline.

It was noted the working group on agile working had been reintroduced, it had been paused due to Covid and the risk reduced and taken off BAF, along with the risk relating to VCOD.

There was a further discussion around agile working and assumptions about working from home and the expectations of the younger generation. It does make it more difficult to recruit, especially if shifts are required over the weekend or night shifts, so this needed to be addressed. KSJ added it was predominantly HCS and support staff who are requested to work extra shifts and therefore impact on a work life balance, and resulting in staff leaving, so more work was needed to be done in relation to this.

DT added the work undertaken by the networking teams was excellent.

MC noted as part of the National Flex Programme which would look a flexible and agile working, the Trust was part of 10 national organisations to work toward Disability Confident Scheme Level 3.

Sustainability Dashboard

AMcG noted the annual review indicators and NHSE system oversight framework had been presented to a number of committees with regards to amendments. There were 79 indicators for 2022/23 rather than 78 and the Board were asked to approve.

Regarding sustainability there was a £0.5m deficit at the end of February and was on track to achieve breakeven for the financial year. In relation to Capital, there was a significant amount to be spent in March. There was £10.5m to be spent, which would be very challenging but on track to spend with mitigations and work undertaken to achieve this. The Board was asked to note movement in contingency and the highlighted changes.

	For Look Ahead, the deficit plan of £19.2m 2022/23 was in draft, with significant risk with 3% CIP just under £10m. Sickness levels had not been budgeted for, and any continuation of sickness will put pressure on the plan for next year. ***Assurance Report – Finance and Sustainability Committee*** TA highlighted escalation relating to EPCMS and Lorenzo, the digital report in supplementary pack identified items escalated by Digital Board relating to national directive in relation to EPCMS which should be compatible. Procurement of new system was underway but would mean tight timescales with existing Lorenzo system. This would create further significant pressures with the replacement of the Lorenzo system prior to a new system being procured. MOC asked about increasing efficiency percentages on the NHS CIP. AMcG responded the minimum expectation was set out in planning guidance with no mandate for a higher CIP. In the settlement the Trust has a 50% reduction for Covid. In setting the CIP target it was expected to support and achieve breakeven. The report was taken as read. ***Assurance Report – Audit Committee*** MOC noted there had been several requests for extension of actions and on a general note, there were some issues with auditors and would need to bear this in mind. **The Trust Board discussed and noted the reports.**
BM/22/03/30	**MOVING TO OUTSTANDING** KSJ noted three regulatory breaches had been put in place following an ED inspection in 2019, however the CQC had not come back to assess, therefore the three breaches still in place. A focussed internal mock inspection would be undertaken in ED which would advise Execs and the Board on the wider position of ED from a regulatory perspective. A Well Led review had been commissioned and with the Good Governance Institute. There was an open line of communication with the CQC. Thanks were expressed to those Board Members involved in the mock inspection undertaken in surgery. DT asked about inspections for services and KSJ said inspections for all services were in place and governors were involved. SMcG added Healthwatch had also be invited to be involved in this work. **The Trust Board discussed and noted the update**
BM/22/03/31	**ANNUAL PERFORMANCE ASSURANCE FRAMEWORK (PAF) 2022/23** AMcG noted the report highlighted the key updates which included removal of Trust Operational Board, inclusion of the Care Group Triumvirates, purpose of the Integrated Performance Report, proposed inclusion of Leadership Observational rounds and other minor updates to reflect the changes to the organisation, including team names and job titles. It was proposed to change the appearance of

	the dashboard in line with adoption of NHSE/I "making data count" and assurance and variation icons. However, it was proposed to retain the current method to include RAG ratings and overlay with the new format. SMcG added this would be a quicker way of pulling together the groups and leadership observations, in a more structured approach than previously presented. Steve asked about assurance around the data and further information to support deaths as part of the Ockenden Review. PF provided assurance that independent review on deaths were undertaken in the Trust and therefore would be able to provide assurance in the event of questions raised. JD added that sometimes there were culture issues in some organisations and KJS responded there was first line assurance with teams and reporting, along with the types of complaints, including staff. Metrics on deaths were reported outwardly, therefore needs to be triangulated and ensuring effective governance was in place. Decision making was based on good quality data, and it was important to ensure everyone understood that what they were reading was meaningful. MB added governance was a clinical tool in supporting safer practice and providing good care to patients. **1. The Trust Board approved the amendments to the PAF as part of the annual refresh.** **2. The Trust Board approved the presentational amendments to the IPR in relation to NHSE/I "Making Data Count" icons.**
BM/22/03/32	**GREEN PLAN** LG provided an overview and explained the report had been sighted at the Finance and Sustainability Committee and previously to the Trust Board in draft form. The paper summarised the set target to achieve net zero by 2040 and to have a Green Plan in place. This was a priority for the Trust and the paper set out the key elements in reducing carbon emission and waste. The Trust Board was being asked to approve the plan and recognise the long-term plan, with elements which might require investment in the future. SMcG asked about the branding of the plan and that it did not seem to highlight the environmental impact the Trust adds to it. When looking at the aims and goals it felt very long term and wanted to ensure that it was not just a tick box exercise. LG responded from a branding perspective, the Trust owned the plan and can remove any of the branding not felt appropriate. The Plan was far reaching and some of the elements were not fully appreciated. It was important this was communicated to staff and was accessible and would be discussed at COVNED in terms of it being an anchor and an opportunity to capture individual's passion within the organisation. LG noted there was already a communication plan in place around the Green Agenda. AMcG commented it was a good plan, with the devil in the detail, it would help to make important decisions, particularly around how it would be resourced. It could

	mean there was a conflict between cost and reduction in carbon so there would be big decisions to be made as a Board. SMcG added there were some clinical risks around analysis of estimated carbon footprint, an example being some inhalers produced twice the carbon footprint of others. **The Trust Board discussed and noted the report.**
BM/22/03/33	**ENGAGEMENT DASHBOARD Q3** PMcC noted the dashboard now linked elements to KLOE 7 of the CQC framework and at the Shadow Board meeting the paper was discussed and provided feedback which would be brought back for further development to the next meeting. The Shadow Board discussed what does good look like and to continue with the work. It was added the Trust was a forerunner in producing this kind of dashboard, with less than 10 trusts in the country producing an engagement dashboard. 1. **The Trust Board noted the comments.** 2. **An update on the discussion and feedback from Shadow Board to be presented to the next meeting.**
BM/22/03/34	**DELEGATION OF AUTHORITY TO APPROVE ANNUAL ACCOUNTS/ANNUAL REPORT** JC asked Board to delegate authority of the Audit Committee to approve Annual Accounts/Annual Report. **The Trust Board approved the request for the Audit Committee to approve the Annual Accounts/Annual Report.**
BM/22/03/35	**STRATEGIC RISK REGISTER & BOARD ASSURANCE FRAMEWORK (BAF)** JC proposed amendments to Risk #1207 - workplace risk assessments and to reduce the score from 8 to 6; Risk #1590 relating to VCOD had now been now removed from legislation and therefore it was proposed to remove. This had been supported by SPC and OPC; Risk #1207 deescalate to Corporate Risk Register for continued monitoring. **The Trust Board supported the proposed amendments.**
BM/22/03/36	**TRUST BOARD ANNUAL CYCLE OF BUSINESS** **The Board approved the Cycle of Business.**
SUPPLEMENTARY PAPERS	
BM/22/03/37	**BOARD COMMITTTEE CYCLES OF BUSINESS** The Audit Committee and the Finance and Sustainability Committee Cycles of Business were presented for approval after updating. **The Board approved the updated Cycles of Business for Audit and Finance and Sustainability Committees.**
BM/22/03/38	**CHARITABLE FUNDS COMMITTEE – GOVERNING DOCUMENT & CYCLE OF BUSINESS**

	The Board supported the Governing document and Cycle of Business for the Charitable Funds Committee.
BM/22/03/39	**FREEDOM TO SPEAK UP BI-ANNUAL REPORT**
BM/22/03/40	**INFECTION PREVENTION AND CONTROL (DIPC) Q3 UPDATE**
BM/22/03/41	**LEARNING FROM DEATH EXPERIENCE REPORT Q3**
BM/22/03/42	**OCKENDEN PROGRESS REPORT**
BM/22/03/43	**ATAIN REVIEW**
BM/22/03/44	**HOSPITAL VOLUNTEER ANNUAL REPORT**
BM/22/03/45	**LEARNING FROM DEATHS & MORTALITY REVIEW REPORT Q3**
BM/22/03/46	**DIGITAL BOARD REPORT**
	The Trust Board noted Agenda items BM/22/03/39, 40, 41, 42, 43, 44, 45, and 46.
The Date and Time of the next Trust Board Meeting is Wednesday 25 May 2022	

Approved …… Dated ……

CHAIRMAN S McGUIRK

BOARD OF DIRECTORS ACTION LOG

Warrington and Halton Teaching Hospitals NHS Foundation Trust

AGENDA REFERENCE	BM/22/03/24 i	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	25 May 2022

1. ACTIONS ON AGENDA

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

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

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

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

RAG Key

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/52**	
SUBJECT:	**Chief Executive's Briefing**	
DATE OF MEETING:	25th May 2022	
AUTHOR(S):	Simon Constable, Chief Executive	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO BAF RISK:	All	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.	

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

RECOMMENDATION:	The Board is asked to note the content of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

SUBJECT	Chief Executive's Briefing	AGENDA REF:	BM/22/05/52

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 30th March 2022, some of which are not covered elsewhere on the agenda for this meeting.

2) KEY ISSUES

2.1 Current COVID-19 Situation Report

As at the time of writing (20th May 2022), we have a total of 20 COVID-19 positive inpatients (14 days or less since their first positive sample); none of those patients are in critical care. In total, 70 of our inpatients have tested positive at any time during their admission (3 of these are in critical care). There has been a steady but slow decline in the number of our COVID-19 inpatients over the last few weeks. We have discharged a total of 3965 patients with COVID-19 to continue their recovery at home. Sadly, a total of 680 patients with COVID-19 have died in our care.

Estimated infections fell in across the United Kingdom in the week ending 7th May, according to the infection survey by the Office for National Statistics. Total infections were down by a quarter on the previous week, with an estimated one in every 45 people infected. This is about 2% of the population. The survey is thought to give the best picture of infections across the UK because people are selected to take part at random. Survey participants across the country are tested weekly and there is a lag of several days before the figures are published.

Total staff absence is just over 6.6% (a headcount of 301), one of the lowest rates it has been for a long time, once again reflecting the decreasing community rates.

2.2 Overview of Trust Performance

Once again, with this report, I have included a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete datasets. In this case, this is month 1, April 2022. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside Committee Assurance Reports.

We have continued to see urgent and emergency care under real pressure across the North West, including Cheshire and Merseyside and WHH. The Omicron burden from January onwards has significantly impacted patient flow, as well as staff sickness absence both inside and outside of hospital, also affecting our partners, especially with care home closures. This has improved more recently as case rates have come down.

Our total number of super stranded patients with a length of stay greater than 21 days remains far too high at 129, although it is much better than it has been, peaking at over 170 earlier this year. Looking at it through a slightly different lens, the number of our patients who don't meet the criteria to reside (in an acute hospital) is 125.

The Trust continues to undertake a recovery elective programme with urgent, cancer and elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of vulnerable patients. There is prioritisation of priority 2 patients, those awaiting 104 weeks or more as well 52-week breaches for scheduling into capacity in line with national guidance for the reduction of waiting lists.

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

2.3 NHS COVID-19 Incident Response

On 13th December 2021, a Level 4 (National) Incident was declared to help prepare the NHS for the predicted surge in Omicron cases and to deliver the COVID-19 vaccine booster national mission. Since that point, the NHS has surpassed 730,000 patients with COVID-19 treated in hospitals and 123 million vaccine doses delivered, as well as delivering over 140,000 treatments through our new COVID medicine delivery units.

With community cases and hospital inpatient numbers now seeing a sustained decline across the country, and following advice from the National Incident Director, it was reported to the NHS England and NHS Improvement Board on 19th May 2022 that a decision has been made to reclassify the incident from a Level 4 (National) to a Level 3 (Regional) Incident. This decision has been with immediate effect, and we will be working through with regional colleagues as to the impact that this will have on matters such as reporting requirements.

2.4 Cheshire & Merseyside System Development

The C&M Integrated Care System moves towards a statutory footing on 1st July 2022. NHS Cheshire and Merseyside Integrated Care Board (ICB) will be legally and operationally established on this date.

The Health and Care Bill received Royal Assent on 28th April 2022, marking a milestone in the recovery and reform of how health and care services work together. It will ensure the NHS can rebuild from the pandemic and tackle the COVID-19 backlog, harness the best ways of working and ensure people are benefitting from more joined-up care. The Health and Care Act builds on the proposals for legislative change set out by NHS England in its Long Term Plan, while also incorporating valuable lessons learnt from the pandemic to benefit both staff and patients.

On 27th April Designate Chair Raj Jain led his first C&M System Oversight Board meeting.

We have continued to be involved at all levels of development of the ICS and the associated provider collaboratives, including the development of partnerships at a place level for both our boroughs as well as leadership of the C&M-wide system. We play an active role in the Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative. Other

executive colleagues take similar roles outside of the organisation beyond their traditional portfolios, in support of the Cheshire and Merseyside system.

CMAST has a number of programmes of work including those for Elective Restoration and Recovery, Diagnostics, Workforce and Finance. Closely aligned to that for elective restoration, a formal Clinical Pathways Programme has been launched and will bring a structured and methodical process to review specialties and develop improvement plans at a whole pathway level. I am the programme Senior Responsible Owner (SRO), on behalf of Cheshire and Merseyside, to maintain the oversight and manage interdependencies with the other programmes.

A dedicated team will work with the clinical networks to build on existing work, and identify, prioritise, and implement opportunities for improvement for some of our key specialties to support longer term transformation. Three specialties have been prioritised for first wave of reviews due to their size and complexity, and the scale of opportunity highlighted in previous work and national metrics: Orthopaedics, ENT and Urology.

Immediate project objectives include i) provision of a current state assessment, ii) identification of opportunities for improvement and critical success factors, iii) development of a matrix of opportunities, iv) engage and bring together partners to prioritise opportunities using co-designed criteria, and v) development of an implementation roadmap.

2.5 WHH Nursing and Midwifery Strategy

Kimberley Salmon-Jamieson, Chief Nurse and Deputy Chief Executive, launched our WHH Nursing and Midwifery Strategy this month. There 5 objectives that form our strategy:

- Brilliant Basics, getting the basics right every time. Lead: Emma Painter, Associate Chief of Nursing, Unplanned Care
- Year on year improvements in patient care. Lead: Natalie Crosby, Associate Chief Nurse, Planned Care
- Empowering all nurses and midwives to drive service improvement and quality. Lead; Layla Alani, Director of Governance and Quality
- Valuing and developing our workforce. Lead: Ali Kennah, Deputy Chief Nurse
- Developing our leaders. Lead: John Goodenough, Deputy Chief Nurse

2.6 WHH Dementia Strategy

This month has also seen the launch of the WHH Dementia Strategy (2022-2025). An increasingly common condition, our strategy will enable us to deliver outstanding dementia care for our patients and support to their carers that is meaningful and makes dementia care at WHH ‘everyone’s business.’

This strategy has been developed with involvement from patients living with dementia and their carers who told us what was important to them. Engagement events took place to capture the views of staff across all disciplines to ask what we can do to support patients who may have an undiagnosed dementia or be living with dementia and how we can support their carers.

The Dementia strategy has six main objectives:

- Comprehensive assessment for delirium and pain
- Information and communication
- Dementia training
- Nutrition
- Hospital admissions, re-admissions, transfers, and discharges
- Improving the experience of people with dementia and their carers while in hospital

2.7 WHH Internal Professional Standards

In the first week of April, Dr Paul Fitzsimmons, Executive Medical Director, launched our Internal Professional Standards (IPS). These set out behaviours and professional responsibilities expected at WHH, in line with our Trust values, to ensure patients get the care they need without delays or duplication. Done well this will help us deliver the very highest standards of care for our patients and the compassionate effective working environment for our colleagues to which we aspire.

In short, they are what we have agreed is 'The Way We Do Things Around Here' and as our culture is demonstrated in the way we do things, the standards outline the culture that our patients and colleagues can expect from services within the Trust. The standards are underpinned by the Trust Behavioural Framework and rely on effective communication and team behaviours between colleagues, teams and services to deliver effective patient care.

Medical professionals from across the Trust have co-developed the WHH Internal Professional Standards. The standards consider five domains of the patient care pathway: acute admission, inter-specialty referrals, ward care, theatres/procedures, and outpatients.

The principles within these standards that promote civility, respect, kindness and effective delivery of medical care, are not aspirational, and are standards that we will hold ourselves to from the outset. It is these standards that will ultimately deliver the Trust Quality Objective: '*We will always put our patients first, delivering safe and effective care and an excellent patient experience*.'

2.8 Clinical Research at WHH

The core clinical research team consists of a clinical research fellow, research nurses (adult, paediatric and midwifery), phlebotomist, clinical research practitioners and administrators.

WHH currently has 30 studies open to recruitment including those for services such as critical care, gastroenterology, maternity, paediatric & neonatal and rheumatology. We couldn't do these studies without doctors and other healthcare professionals to act as principal investigators (PIs) to oversee a study, with the RD&I team available to provide expert support for PIs.

We have the SIREN study looking at COVID-19 infection patterns in healthcare workers, which has recruited 261 of our own workforce. We have several studies in rheumatology, such as Sequencing Based Analysis of SLE (Systemic Lupus Erythematosus), a study looking at how genetics play their part in SLE. Maternity services are about to start with GBS3 which will be offering rapid testing for Group B Streptococcus to expecting parents.

We have a significant proportion of the team who work at the Halton Clinical Research Unit, one of the only dedicated research units opened in a district general hospital in England. Since its opening in March 2021, this fantastic space has hosted three COVID-19 vaccine studies, and we intend to open more studies covering a wider range of conditions and investigative products.

We work in partnership with Liverpool University Hospitals NHS Foundation Trust (LUHFT) and the Clinical Research Network North West Coast (CRN NWC) on the unit, a really productive collaboration that has allowed us to conduct more complex studies and offer more people the opportunity to take part in research. Recently, the team have been working tirelessly to recruit to the Moderna Omicron Booster vaccine study, looking at a formulation that could be used as a booster against the Omicron variant of COVID-19.

Preliminary end-of-year figures show that teams and services across the Trust have recruited 697 participants, further evidence of everyone's hard work.

2.9 Special Days/Weeks for professional groups

Since our last Board meeting in March 2022, a number of topics, professional or interest groups or disciplines have had special days or weeks marked locally, nationally or internationally. WHH has recognised, embraced and celebrated all of these:

World Autism Acceptance Week: 28th March – 3rd April 2022
Dying Matters Awareness Week: 2nd - 6th May 2022
International Day of the Midwife: 5th May 2022
International Nurses' Day: 12th May 2022
Operating Department Practitioners' Day: 14th May 2022

2.10 Local political leadership engagement

Since the last Board meeting both the Chairman and I have continued regular communication and updates with our local political leadership, through the chief executives of both Warrington Borough Council and Halton Borough Council and the respective council leaders. I have also continued to be in regular communication with all four of our local Westminster MPs – Derek Twigg MP (Halton), Mike Amesbury MP (Weaver Vale), Charlotte Nichols MP (Warrington North) and Andy Carter MP (Warrington South). I have been updating them on the WHH situation, both in terms of COVID-19 as well as other significant issues; similarly they have asked questions on behalf of their constituents. All of our senior stakeholders are active participants and members of our New Hospitals Strategic Oversight Group.

2.11 Employee Recognition

Our *You Made a Difference Awards* are now fully up and running. Nominations are reviewed and awards made by a mutli-professional panel.

You Made a Difference Award (December 2021) – Ward B19

The nomination spoke of the compassion, care and kindness showed towards a lady who was an inpatient on B19 for six months. As a team, this individual was treated with the upmost kindness, dignity and respect. During her time on the ward, B19 went above and beyond to support her, hosting a birthday party with a birthday tea and decorations, finding out which

activities she enjoyed and assisting her to take part, and even fulfilling her craving for fish and chips by bringing them in for her (and the other patients on the ward to enjoy). Working together, they prepared her to be discharged to a nursing home, and created a journal filled with photographs and memories of her time spent on B19, which her family were thrilled to receive. We know this was not a 'one off' act of kindness.

You Made a Difference Award (February 2022) – Integrated Hospital Discharge Team
This award was made for the hard work and commitment from the team in ensuring the safest and best possible discharge route for our patients, in a fast paced and complex environment along with the team's dedication to their role in delivering excellent patient care. This was clearly reflected in the nomination for this award, made at the most difficult of times from a patient flow perspective.

You Made a Difference Award (March 2022) - Dr Zoe Apple – Consultant Anaesthetist
The award was made for the excellent work done by Dr Apple as governance lead for the Anaesthetic Department, from investigating incidents, learning and presenting these cases to the department. Dr Apple does an amazing job of speaking to families and staff about incidents and their learning as well as presenting these cases to the department. She always seems to get the right balance between thoroughly exploring an incident and learning for the department without anyone feeling 'targeted' or 'blamed', which is very important for the Trust and the way we work. This can be extremely difficult at times and there is a skilful balance to always get it right. I have received a number of compliments with recognition of Dr Apple's good work.

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

Chief Executive Award (March 2022): Dave Gallagher, Ward Manager – K25
Dave has been an exemplar of great discharge practice in a really challenging environment over the last few months, setting some new standards of how we aspire to do things well.

Chief Executive Award (March 2022): Bereavement Team
The last couple of years have placed a very different kind of demand on the Bereavement Team, supporting families at the most difficult of times. The feedback from teams and families has been amazing.

Chief Executive Award (March 2022): Occupational Health and Wellbeing
The pandemic has brought to the fore a number of different teams and departments and Occupational Health and Wellbeing is one of those such teams. They have needed to respond to so much so quickly, from changing risk assessments to supporting staff through difficult times.

Chief Executive Award (March 2022): Task Team
This team have had to be really flexible and responsive to our infection prevention and control needs, and providing the cleanest of clinical environments. They have been some of the unsung heroes of the last two years.

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

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

- Dave Cain, Haematology Operations Manager - Clinical Support Services
- Patricia Miller, Domestic Supervisor - Estates and Facilities
- Kathryn Garvey, Secretary, Speech & Language Therapy - Clinical Support Services
- Susan Cunningham, Administration Assistant, Ward A6 Integrated Medicine & Community
- Lesley James, Ward Clerk, Ward A4 - Integrated Medicine & Community
- Dr Caroline Hicks, Chief Registrar - Women's & Children's Health
- Mr Barry Taylor, Consultant Surgeon - Digestive Diseases
- Jessica Jones, Staff Nurse - Ward B10/B11, Women's & Children's Health
- Dr Margaret Bamforth, Non-Executive Director - Trust Board
- Dr Ioannis Moukas, Consultant Cardiologist - Medical Care
- Lyn Malpas, Midwife - Women's & Children's Health
- Susan Ratcliffe, Cardiology Advanced Clinical Practitioner - Medical Care
- Barbara Jewkes, Staff Nurse, Ward B19 - Integrated Medicine & Community
- Dr Isabel Forster, Foundation Year 2 Doctor - Surgical Specialities
- Sarah Hardagon & Team, Matron - Medical Care
- Natalie Slater, Deputy Ward Manager - CSTM
- Maria Hewitt, Student Nurse - Surgical Specialities
- Catherine Owens, Director of Midwifery - Women's & Children's Health
- Barry Chesterton, Senior Biomedical Scientist - Clinical Support Services
- Janet Brown, Sister - Digestive Diseases
- Adam Harrison, Patient Experience & Inclusion Manager - Corporate Nursing
- Sofia Higgins, Equality, Diversity & Inclusion Manager - HR/OD

2.12 Signed under Seal

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

Grant Funding Agreement with Warrington Borough Council

3) MEETINGS ATTENDED/ATTENDING

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

- NHSE/I National Leadership Event, London, April 28th 2022
- NHSE/I COVID-19 System Leadership (Monthly)
- NHSE/I COVID-19 NW Hospital Cell Gold (Weekly)
- C&M Integrated Care System Transitional Oversight Board (Monthly)
- C&M Provider Collaboration CEO Group (Bi-weekly)

- C&M Acute And Specialist Trust (CMAST) Provider Collaboration CEO Group (Monthly)
- C&M Medical Directors Clinical Prioritisation & Mutual Aid meeting (Weekly)
- Steve Broomhead, Chief Executive, Warrington Borough Council
- Dr Andy Davies, Clinical Chief Officer, NHS Warrington and Halton CCG
- C&M Hospital Cell (Weekly)
- Warrington Wider System Sustainability Group (Fortnightly)
- Warrington and Halton System Pressures Meeting (Daily)
- Clinical Research Network North West Coast Health Research Alignment (Monthly)

4) RECOMMENDATIONS

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

Appendix 1 - CEO Dashboard Month 1 – April 2022

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target	Actual
Diagnostic 6 Weeks	99.00%	80.83%
RTT 18 Weeks	92.00%	66.49%
RTT 104 Weeks +	0	22
A&E % patients seen within 4 hours	95.00%	69.72%
A&E % of patients seen within 12 hours	98.00%	83.68%
Cancer 14 Days	93.00%	90.60%
Breast Symptomatic 14 days	93.00%	92.31%
Cancer 28 Day Faster Diagnostic Standard	75.00%	70.27%
Cancer 31 Days First Treatment	96.00%	98.65%
Cancer 31 Day Surgery	94.00%	100%
Cancer 31 Day Drug	98.00%	100%
Cancer 62 Days Urgent	85.00%	77.32%
Cancer 62 Days Screening	90.00%	100%
Ambulance Handovers within 15 mins	65.00%	41.62%
Ambulance Handovers within 30 mins	95.00%	65.46%
Ambulance Handovers within 60 mins	100%	76.55%
Discharge Summaries 24 hours	95.00%	88.35%
Discharge Summaries not sent within 7 days	0	1
Cancelled Operations – non clinical reasons	Less than 2.00%	-
Cancelled Operations – non clinical not rebooked within 28 days	0	-
Urgent Operations Cancelled for a 2nd time	0	0
Fracture Clinic – 72 Hours	95.00%	11.36%
% Outpatient Appointments Delivered Remotely	25.00%	11.67%
Super Stranded Patients	Trajectory	-

37 of 306

Quality of Care

Indicator	Target	Actual
Incidents open over 40 days	0	0
Sepsis	90.00%	87% 53% 76% 87%
Duty of Candour	100%	100%
Inpatient Falls (cumulative)	20.00% reduction based on 590 falls in 2021/22	64
VTE	95.00%	Reported Quarterly
Pressure Ulcers (cumulative)	10.00% reduction based on 91 in 2021/22	0 Category 4 10 Category 2 2 Category 3
Medication Reconciliation (24 hrs)	80.00%	64.00%
Staffing Average Fill Rates	90.00%	Average 87.00%
Care Hours Per Patient Day (CHPPD)	7.9	7.5
NICE Compliance	90.00%	91.42%
Friends & Family Test (IP/Day Case)	95.00%	98.00%
Friends & Family Test (ED & UTC)	87.00%	68.00%
Complaints over 6 months	0	0
Continuity of Carer	51.00%	79.70%
Healthcare Infections - MRSA	0	0
Healthcare Infections – CDI (cumulative)	Less than 37	4
Healthcare Infections - E. coli (cumulative)	Less than 57	6
Healthcare Infections – Klebsiella (cumulative)	Less than 19	1
Healthcare Infections - P. aeruginosa (cumulative)	Less than 6	0
COVID-19 nosocomial (in month) – 8-14 Days 15 Days +	N/A	 22 27
Mixed Sex Accommodation Breaches (Non ICU Only)	0	0

Appendix 1 - CEO Dashboard Month 1 – April 2022

Warrington and Halton Teaching Hospitals NHS Foundation Trust

People

Workforce

Indicator	Target	Actual
Supporting Attendance	Less than 4.20%	7.44%
Welcome Back Conversations	85.00%	58.51%
Recruitment Time to Hire	65 days or less	76 Days
Vacancy Rates	9.00% or less	10.10%
Turnover	Less than 13.00%	15.99%
Retention	85.00%	83.21%
Core/Mandatory Training	85.00%	84.61%
Role Based Training	85.00%	91.26%
Safeguarding Training	Trajectory	70.00%
Workforce Carrying Out a Qualification	2.30%	2.23%
Payspend (month)	Budget (£20.0m)	£20.9m
Bank/Agency Reliance	9.00% or less	16.15%
PDR Compliance	85.00%	59.39%

Sustainability

Finance

Indicator	Plan	Actual
Income & Expenditure	-£2.02m	-£2.07m
Capital Spend	£1.54m	£0.71m
Cash	£33.73m	£40.55m
Better Practice Payment Code	95.00%	93.00%
CIP In Year Delivered	£0.68m	£0.59m
CIP Forecast (Recurrent)	£14.00m	£1.90m

Strategy

Strategy

- **Clinical Strategies Workshops** - Workshops are underway to review strategies for all clinical specialities in light of national, regional and local drivers of change. This will identify priorities and what organisational support may be needed to deliver them. Discussions are recommencing with St Helens and Knowsley Teaching Hospitals NHS Trust to look at how a collaborative approach might help both organisations to tackle care backlogs, reduce unwarranted variation, address health inequalities and deliver more efficient, sustainable services.
- **New Hospitals –** Work is progressing on the financial and economic models underpinning the strategic outline cases. Sessions have been held with benefit leads to localise the previous high level benefits. Work is due to complete at the end of May 2022, at which point the options appraisal of the shortlisted sites will be undertaken. Outcome of the first stage of the EOI process is still awaited.
- **Green Plan –** The Trust Board approved the Green Plan in March 2022. The plan is due for imminent launch to Trust colleagues with a forum being established to empower staff to take forward initiatives to support the Green Plan.
- **Shopping City –** Building work has commenced for Shopping City and the project remains on track to open in Summer 2022.
- **Breast –** The public consultation on the proposal to consolidate Warrington Breast Screening Services at Bath Street Health and Wellbeing Centre is underway. The consultation will close on Monday 20th June and findings will be used to inform final plans.
- **Warrington Public Sector Estate Review** – The review of public sector estate across Warrington was extended to maximise partner input. The review is now due to conclude in May 2022 and will culminate in a digital map which, for the first time, plots all public sector estates across Warrington, along with its utilisation. Additionally, an estates maximisation report will be produced based on identified opportunities from the review.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 22/05/55**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	25th May 2022	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Andrea McGee - Chief Finance Officer and Deputy Chief Executive Dan Moore - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will.. Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are assessed as only able to work on a non-respiratory pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	

<table>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="4">The Trust has 79* IPR indicators which have been RAG rated in April as follows:

Red: 33 (from 38 in March)
Amber: 11 (from 9 in March)
Green: 22 (from 27 in March)
Not RAG Rated: 13 (from 4 in March)
*Please note that the number of indicators on the IPR has increased from 78 to 79 as a result of annual review and refresh approved by the Trust Board in March 2022. In addition, there have been a number of changes to the indicators which means the overall RAG rating comparators are not comparable between March and April.

As a result of the COVID-19 pandemic, the Trust has not met the RTT 18 week, RTT 104 week, Diagnostics 6-week, Cancer 2 Week, Breast Symptomatic 2 week, Cancer 28 day faster diagnostic or Cancer 62-day urgent standards. A&E and Ambulance Handover performance remains challenging with increased attendances and system pressures.

The Trust has submitted a £16.8m deficit plan for 2022/23. This includes achieving £7.8m ERF (Elective Recovery Fund) and £14.0m CIP. The month 1 position is £2.07m deficit which is £0.05m worse than plan.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval
X</td><td>To note
X</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to:
1. Note the Capital request of £19k approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.
2. Note the contents of this report.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3"></td></tr>
<tr><td>Agenda Ref.</td><td colspan="3"></td></tr>
<tr><td>Date of meeting</td><td colspan="3"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="3"></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="4">Choose an item.</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM 22/05/55

1. BACKGROUND/CONTEXT

The RAG ratings for all 79 IPR indicators from May 2021 to April 2022 are set out in **Appendix 1.**

Appendix 2 details "Making Data Count" icons and data in relation to Statistical Process Control (SPC).

The Integrated Performance Dashboard (**Appendix 3**) 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

	March	April
Red	38	33
Amber	9	11
Green	27	22
Not RAG Rated	4	13~
Total:	78	79*

*Please note that the number of indicators on the IPR has increased from 78 to 79 as a result of annual review and refresh approved by the Trust Board in March 2022. In addition, there have been a number of changes to the indicators which means the overall RAG rating comparators are not comparable between March and April.

~The increase in indicators which have not been RAG rated include: 4 new indicators which are provided for information as part of the System Oversight Framework and are not planned to be RAG rated, 2 indicators where data has not been validated in month, 1 indicator which is under development and 2 indicators where improvement trajectories have not yet been agreed with commissioners for 2022/23.

Descriptions of each KPI are available in **Appendix 4**. Further detail around interpretation of Statistical Process Control (SPC) charts and "Making Data Count" icons can be found in **Appendix 5**.

Quality

Quality KPIs

There are 2 Quality indicators rated Red in April, a decrease from 7 in March. However, it should be noted that 3 indicators have been reset for 2022/23 and a new Amber RAG rating criteria has been included on the Sepsis indicators.

The 2 indicators rated Red in March, which have remained rated Red in April are as follows:

- Sepsis % Screening for Inpatients within 1 hour – the Trust achieved 53.00% in April, a deterioration from 83.00% in March, against a target of 90.00%.
- Friends and Family Test (ED) – the Trust achieved 68.00% in April, an improvement from 66.00% in March, against a target of 87.00%.

The following indicators are measured against an annual target/threshold and have been reset for 2022/23 and therefore the indicators have moved Red to Green:

- Healthcare Acquired Infections (CDI)
- Healthcare Acquired Infections (Gram Negative)
- Pressure Ulcers

There are 2 indicators which have moved from Red to Amber in month. A new Amber criteria on the RAG rating has been included for the Sepsis indicators from April 2022.

- Sepsis % Screening for Emergency Patients within 1 hour – the Trust achieved 87.00% in April, an improvement from 77.00% in March, against a target of 90.00%.
- Sepsis % Emergency Patients Administered Antibiotics Within 1 Hour – the Trust achieved 76.00% in April, a deterioration from 78.00% in March, against a target of 90.00%.

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

- Incidents – the RAG rating criteria has changed for 2022/23 as agreed by the Trust Board as part of the 2022/23 IPR refresh. The Trust continues to have 0 incidents open over 40 days.
- Inpatient Falls – this indicator is reported against an annual target which has been reset for 2022/23.

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

- Sepsis % Inpatients Administered Antibiotics Within 1 Hour – the Trust achieved 87.00% in April, a deterioration from 96.00% in March, against a target of 90.00%.

Access and Performance

Access and Performance KPIs

There are 19 Access and Performance indicators rated Red in April, an increase from 18 in March. However there have been a number of changes to the Access & Performance indicators as approved by the Trust Board in March 2022.

The 10 indicators which were rated Red in March and remain rated April in are as follows:

- Diagnostic 6 Week Target – the Trust achieved 80.83% in April, a deterioration from 81.39% in March, against a target of 99.00%.
- Referral to Treatment Open Pathways – the Trust achieved 66.49% in April, a deterioration from 66.60% in March, against a target of 92.00%.
- A&E Waiting Times 4-hour National Target – the Trust achieved 69.72% (excluding Widnes Walk ins) in April, an improvement from March's position of 68.72%, against a target of 95.00%.
- Cancer 14 Days - the Trust achieved 90.60% in March, an improvement from 84.69% in February, against a target of 93.00%.
- Breast Symptoms – the Trust achieved 92.31% in March, an improvement from 71.83% in February, against a target of 93.00%.
- Cancer 28 Day Faster Diagnostic Standard – the Trust achieved 70.27% in March, an improvement from 68.72% in February, against a target of 75.00%.
- Cancer 62 Days Urgent - the Trust achieved 77.32% in March, an improvement from 71.28% in February, against a target of 85.00%.
- Discharge Summaries sent within 24 hours – the Trust achieved 88.35% in April, a deterioration from 89.88% in March, against a target of 95.00%.
- Outpatient Appointments Deliver Remotely - the Trust achieved 11.67% in April, a deterioration from 11.91% in March, against a target of 25.00%.
- Fracture Clinic 72 Hours - the Trust achieved 11.36% in April, a deterioration from 15.56% in March, against a target of 95.00%.

There are 4 indicators which has moved from Green to Red in month as follows:

- Discharge Summaries NOT sent within 7 days (to achieve the 95.00% standard) – there was 1 discharge summary not sent within 7 days to achieve the 95.00% standard in April, a deterioration from 0 discharge summaries not sent in March.
- COVID-19 Recovery (Inpatient & Daycase) – the Trust achieved 94.82% of inpatient procedures and 101.35% of daycase procedures in April 2022/23 in comparison with activity in the same period in 2019/20, against a target of 104.00%.
- COVID-19 Recovery (Diagnostics) – the average performance across all diagnostic modalities was 61.84% in April 2022/23 in comparison with activity in the same period in 2019/20, against a target of 104.00%.
- COVID-19 Recovery (Outpatients) – the Trust achieved 86.44% of Outpatient Activity in April 2022/23 in comparison with activity in the same period in 2019/20, against a target of 104.00%.
  Please note: The target has been changed for 2022/23 for COVID-19 recovery from 95.00% to 104.00%.

The following indicator is new on the IPR for 2022/23 and is rated Red in month:

- Ambulance Handover % of patients handed over within 15 minutes – 41.62% of patients were handed over within 15 minutes in April, against a target of 65.00%.

The following indicators have been changed as part of the 2022/23 IPR refresh, all 4 indicators in their previous iterations were Red in March and remain Red in April:

- RTT 104 weeks + (this replaced RTT 52 weeks) – there were 22 patients waiting over 104 weeks in April, against a target of 0.
- Ambulance Handover % of patients handed over within 30 minutes (previously the number of patients waiting between 30 and 60 minutes) – 65.46% of patients were handed over within 30 minutes in April, against a target of 95.00%.
- Ambulance Handover % of patients handed over within 60 minutes (previously the number of patients waiting over 60 minutes) – 76.55% of patients were handed over within 60 minutes in April, against a target of 100.00%.
- A&E % of patients seen within 12 hours (previously number of patients waiting over 12 hours in A&E) – 84.00% of patients were seen within 12 hours in A&E against a target of 98.00%.

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

- Cancer 62 Days Screening - the Trust achieved 100% in March, an improvement from 66.67% in February, against a target of 90.00%.

There were 3 indicators which were Red in March and cannot be RAG rated in month as follows:

- Cancelled Operations (not rebooked within 28 days) – the data is still under validation for April 2022.
- A&E Improvement Trajectory – an A&E improvement trajectory has not been agreed for 2022/23. The trajectory for March was 85.00%, performance in April was 69.72%.
- Super Stranded Patients – a Super Stranded patient trajectory has not yet been agreed for 2022/23. The trajectory for March was 59 patients, there were 142 super stranded patients at the end of April.

PEOPLE

Workforce KPIs

There are 9 Workforce indicators rated Red in April, an decrease from 10 in March.

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

- Supporting Attendance – the Trust's sickness absence was 7.44% in April, a deterioration from 7.18% in March, against a target of less than 4.20%.
- Welcome Back Conversations – interview compliance was 58.51% in April, a deterioration from 61.96% in March, against a target of 85.00%.
- Recruitment Time to Hire – Trust time to hire average was 76 days in April, the same as March, against a target of less than 65 days.

- Turnover – the Trust's turnover was 15.99% in April, an improvement from 16.34% in March, against a target of less than 13.00%.
- Bank/Agency Reliance – the Trust's reliance was 16.15% in April, an improvement from 19.00% in March, against a target of less than 9.00%.
- Monthly Pay Spend – monthly pay spend was £20.9m against a budget of £20.0m
- Safeguarding Training – training compliance was 70.00% in April, a deterioration from March's position of 73.00%, against a trajectory of 77.00%.
- PDR Compliance – PDR compliance was 59.39% in April, a deterioration from 61.94% in March, against a target of 85.00%.

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

- Mandatory Training – training compliance was 84.61% in April, a deterioration from March's position of 85.47% against a target of 85.00%.

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

- Workforce Carrying out a Qualification – 2.23% of the workforce was carrying out a qualification in April, a deterioration from 3.54% in March, against a target of 2.30%.

There were 2 IPR workforce indicators which were removed from the IPR Dashboard as part of the 2022/23 refresh which were rated Red in March.

SUSTAINABILITY

Finance and Sustainability KPIs

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

- The Trust's Financial position is £2.07m deficit which is £0.05m worse than the planned deficit of £2.02m.
- Capital Programme – the actual spend year to date is £0.71m which is £0.26m below the planned spend of £0.97m.
- The Trust is in the process of identifying and developing cost saving schemes (CIP) for 2022/23. Therefore, the CIP Forecast indicator has not been RAG rated in month. The recurrent CIP savings plan is £6.5m (of the total £14.0m CIP for 2022/23).

The Income and Activity Statement for month 1 is attached in **Appendix 6**.

The 2022/23 operational plan has been submitted with a £16.8m deficit. It is expected a further submission of the plan will be requested in June 2022 as both the Trust and the C&M ICS has submitted a deficit plan.

Table 2 details the Trust performance for April 2022 against the draft baseline.

Table 2: Trust performance for April 2022 versus draft baseline

Point of delivery	DRAFT BASELINE £000	APRIL 2022 ACTUALS £000	VARIANCE £000	75% ERF Reduction £000
Daycase	1,328	1,247	-81	-61
Elective	918	657	-261	-196
Outpatient First Attendance	1,225	832	-393	-295
Outpatient Procedures	822	603	-219	-164
Totals	**4,293**	**3,339**	**-954**	**-716**

The Trust's performance outlined in Table 2 is not a finalised position, however the activity levels were below plan for all points of delivery. The assessment of activity in Table 2 is the best current estimate.

Due to cancelled day cases and elective procedures as a result of site pressures, availability of beds and COVID-19 sickness as well as cancelled outpatient clinics to support staffing levels, it is anticipated that ERF of £0.5m will not be achieved. This value has been removed from the position in April 2022. There is potential that this position will improve as cases are clinically coded.

Cash

At the end of month 1 there is a cash balance of £40.6m. Capital creditors relating to 2021/22 are still to be paid as invoices have not been received for costs accrued at year end.

Capital Programme

The Trust Board approved a Capital Programme of £12.8m. To date CDEL (Capital Department Expenditure Limit) of £10.5m has been allocated to the Trust. The Trust is awaiting the outcome of further capital bids submitted to the C&M ICS.

In the Operational Plan, the Trust was required to submit a capital plan based on CDEL allocated to date. In addition, the Trust was asked to include strategic capital bids to support elective recovery and diagnostic services and any capital to be funded from grants. **Table 3** provides a breakdown of the capital plan.

Table 3: Capital Plan Summary by Category

	NHSI Plan FY	NHSI Plan YTD	Trust Plan FY	Trust Plan YTD	Actual YTD	Variance against NHSI Plan YTD	Variance against Trust Plan YTD
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Estates	6,929	819	8,023	900	535	284	365
IM&T	2,175	66	2,113	66	50	16	16
Medical Equipment	1,387	0	1,845	2	128	-128	-126
Contingency	0	0	783				
Subtotal	10,491	885	12,764	968	713	172	255
External Funded	10,187	* 566	10,187	0	0	566	0
Total	20,678	1,451	22,951	968	713	738	255

*This related to grant funding schemes not yet planned to commence. The NHSI plan will be amended to reflect this.

One emergency request for £19k has been approved by the Chief Finance Officer & Deputy Chief Executive in April 2022. **Table 4** outlines the changes to the contingency.

Table 4: Balance of contingency fund as at 30 April 2022

DETAIL	£'000
Contingency balance start of month 1	**802**
Proposed changes in month	
Emergency request	
Sense Spine Coil	-19
Contingency as at end of month 1	**783**

Appendix 7 contains the updated Capital Programme.

The Trust Board is asked to:

- **Note the Capital request of £19k approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.**

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

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

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the Capital request of £19k approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.
2. Note the contents of this report.

Key

Improvement in Performance	↑
Deterioration in Performance	↓
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating May 2021 – April 2022

	KPI	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22
	QUALITY												
1	Incidents (over 40 days old)	↔	↔	↔	↓	↑	↔	↔	↔	↔	↔	↔	↔
2	Duty of Candour	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
3	Healthcare Acquired Infections - MSRA	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
4	Healthcare Acquired Infections – Cdiff	↑	↓	↑	↓	↓	↑	↓	↓	↓	↓	↑	↓
5	Healthcare Acquired Infections – Gram Negative	↓	↑	↕	↑	↑	↓	↓	↓	↓	↑	↑	↓
6	Healthcare Acquired Infections – COVID-19 Hospital Onset & Outbreaks												
7	VTE Assessment (Quarterly)	↑	↑	↑	↑	↑	↑	↓	↓	↑	↑	↓	
8	Total Inpatient Falls & Harm Levels	↓	↑	↓	↑	↑	↑	↓	↓	↓	↑	↓	↓
9	Pressure Ulcers	↔	↓	↓	↑	↓	↑	↑	↓	↑	↓	↑	↓
10	Medication Safety (24 Hours)	↑	↑	↓	↓	↓	↓	↑	↓	↑	↓	↓	↕
11	Staffing – Average Fill Rate	↑	↑	↓	↓	↑	↓	↓	↓	↓	↓	↑	↕
12	Staffing – Care Hours Per Patient Day	↑	↓	↓	↑	↑	↓	↓	↑	↑	↓	↑	↔
13	Mortality ratio - HSMR												
14	Mortality ratio - SHMI												
15	NICE Compliance	↑	↑	↑	↓	↑	↓	↓	↓	↓	↑	↓	↑
16	Complaints	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
17	Friends & Family – Inpatients & Day cases	↔	↓	↔	↔	↔	↓	↑	↓	↑	↔	↔	↔
18	Friends & Family – ED and UCC	↓	↔	↓	↓	↑	↓	↑	↑	↔	↓	↓	↑
19	Mixed Sex Accommodation Breaches (Non ITU Breaches Only)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
20	Continuity of Carer	↑	↓	↑	↓	↓	↑	↓	↑	↓	↓	↑	↓
21	Sepsis - % screening for all emergency within 1 hour.	↑	↓	↑	↑	↓	↑	↑	↓	↓	↑	↓	↑
22	Sepsis - % screening for all inpatients within 1 hour.	↑	↓	↓	↓	↑	↑	↓	↑	↔	↑	↑	↓
23	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis.		↓	↑	↑	↑	↕	↑	↓	↓	↑	↑	↓
24	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis.	↓	↓	↑	↓	↑	↓	↑	↓	↑	↓	↑	↓
25	Number of CAS Alerts Actions Breached												
26	Number of Hospital Acquired Acute Kidney Injuries												

Key

Improvement in Performance	↑
Deterioration in Performance	↓
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating May 2021 – April 2022

27	**Ward Moves between 10:00pm and 06:00am**												

	KPI	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22
	ACCESS & PERFORMANCE												
28	Diagnostic Waiting Times 6 Weeks	↑	↑	↑	↓	↑	↓	↑	↓	↓	↑	↑	↓
29	RTT - Open Pathways	↑	↑	↓	↑	↓	↓	↑	↓	↓	↑	↓	↓
30	RTT – Number of Patients Waiting 104+ Weeks												
31	A&E Waiting Times – % of patients see within 4 hours	↑	↑	↓	↑	↑	↓	↓	↓	↑	↓	↑	↑
32	A&E Waiting Times – ICS Trajectory	↑	↓	↓	↑	↑	↓	↓	↓	↑	↓	↑	
33	A&E Waiting Times – % of patients seen within 12 hours												
34	Cancer 14 Days*	↓	↑	↓	↓	↓	↑	↓	↓	↓	↑	↑	↑
35	Breast Symptoms 14 Days*	↓	↓	↓	↑	↑	↓	↓	↓	↓	↑	↑	↑
36	Cancer 28 Day Faster Diagnostic*	↓	↑	↓	↓	↑	↑	↑	↓	↓	↓	↑	↑
37	Cancer 31 Days First Treatment*	↓	↑	↑	↑	↓	↓	↑	↑	↓	↑	↑	↓
38	Cancer 31 Days Subsequent Surgery*	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
39	Cancer 31 Days Subsequent Drug*	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
40	Cancer 62 Days Urgent*	↑	↓	↓	↑	↓	↓	↓	↑	↓	↑	↓	↑
41	Cancer 62 Days Screening*	↓	↑	↔	↔	↔	↓	↑	↓	↑	↓	↓	↑
42	Ambulance Handovers % within 15 minutes												
43	Ambulance Handovers % within 30 minutes												
44	Ambulance Handovers % within 60 minutes												
45	Discharge Summaries - % sent within 24hrs	↓	↑	↓	↑	↓	↓	↓	↓	↓	↓	↓	↓
46	Discharge Summaries – Number NOT sent within 7 days	↓	↑	↑	↓	↑	↓	↓	↓	↓	↑	↔	↓
47	Cancelled Operations on the day for a non-clinical reasons	↑	↓	↑	↑	↑	↓	↑	↓	↓	↑	↑	
48	Cancelled Operations– Not offered a date for readmission within 28 days	↓	↔	↑	↔	↓	↔	↔	↓	↓	↑	↔	
49	Urgent Operations – Cancelled for a 2nd time	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
50	Super Stranded Patients	↑	↓	↓	↓	↓	↓	↑	↑	↓	↑	↓	
51	COVID-19 Recovery Elective Activity												
52	COVID-19 Recovery Diagnostic Activity												
53	COVID-19 Recovery Outpatient Activity												

Key

Improvement in Performance	
Deterioration in Performance	
Static Performance	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating May 2021 – April 2022

54	**% Outpatient Appointments delivered remotely**												
55	**% of patients seen in the fracture clinic within 72 hours**												
56	**Advice & Guidance (A&G) Activity Levels**												
57	**Patient Initiated Follow Up (PIFU) Activity Levels**												
58	**% of zero-day length of stay admissions SDEC (as a proportion of total)**												
59	**Average time in department ED**												

Key

Improvement in Performance	↕
Deterioration in Performance	↕
Static Performance	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating May 2021 – April 2022

	KPI	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22
	WORKFORCE												
60	Supporting Attendance	↓	↑	↓	↑	↓	↑	↓	↓	↓	↑	↓	↓
61	Welcome Back Conversations	↓	↑	↓	↑	↑	↑	↑	↓	↑	↑	↓	↓
62	Recruitment Timeframe	↔	↑	↑	↓	↓	↑	↔	↓	↑	↓	↓	↓
63	Vacancy Rates	↓	↓	↑	↓	↑	↑	↑	↓	↓	↓	↓	↑
64	Retention	↓	↑	↑	↑	↓	↓	↓	↓	↑	↑	↑	↓
65	Turnover	↑	↓	↑	↑	↓	↓	↓	↓	↑	↑	↑	↑
66	Bank & Agency Reliance	↑	↑	↓	↑	↓	↑	↑	↓	↑	↑	↓	↑
67	Monthly Pay Spend (Contracted & Non-Contracted)	↑	↑	↓	↑	↓	↑	↑	↓	↓	↑	↓	↑
68	Core/Mandatory Training	↓	↑	↓	↑	↑	↑	↑	↑	↑	↓	↑	↓
69	Role Specific Training	↓	↑	↓	↓	↑	↑	↓	↑	↑	↑	↑	↓
70	Safeguarding Training							↑	↑	↔	↓	↑	↓
71	% Workforce carrying out an Apprenticeship Qualification	↑	↑	↑	↑	↓	↑	↓	↑	↑	↓	↑	↓
72	PDR	↓	↓	↓	↓	↑	↑	↑	↑	↑	↓	↓	↓

	KPI	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22
	FINANCE												
73	Trust Financial Position	↓	↑	↑	↑	↔	↓	↑	↓	↑	↑	↑	↓
74	Cash Balance	↓	↑	↑	↑	↑	↑	↑	↓	↑	↑	↑	↑
75	Capital Programme	↓	↑	↑	↑	↑	↑	↑	↓	↑	↑	↑	↑
76	Better Payment Practice Code	↔	↓	↔	↔	↔	↔	↔	↔	↔	↓	↔	↔
77	Use of Resources (Suspended)	-	-	-	-	-	-	-	-	-	-	-	-
78	Cost Improvement Programme – Performance (In Year)												
79	Cost Improvement Programme – Performance (Recurrent)												

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 2

Statistical Process Control - Assurance & Variation

		Latest				Previous		Assurance
	QUALITY	Plan/Target	Actual	Period	Variation	Actual	Period	
1	Incidents (over 40 days old)	0	0	Apr-22	L	0	Mar-22	P
2	Duty of Candour (serious incidents)	100.00%	100.00%	Apr-22		100%	Mar-22	P
3	Healthcare Acquired Infections - MSRA	0	0	Apr-22		0	Mar-22	P
4	Healthcare Acquired Infections – CDI	Less than 37 for 2022/23	4	Apr-22		2	Mar-22	No SPC
5	Healthcare Acquired Infections – Gram Negative (E.coli)	Less than 57 for 2022/23	6	Apr-22		3	Mar-22	No SPC
6	Healthcare Acquired Infections - COVID-19 Outbreaks	N/A	2	Apr-22	No SPC	6	Mar-22	No SPC
7	VTE Assessment	95.00%	94.77%	Apr-22		95.61%	Mar-22	No SPC
8	Total Inpatient Falls & Harm Levels	20.00% annual reduction based on 590 in 2021/22	64	Apr-22		59	Mar-22	No SPC
9	Pressure Ulcers (Total)	10.00% reduction based on 91 in 2021/22	12	Apr-22		9	Mar-22	No SPC
10	Medication Safety (24 Hours)	80.00%	64.00%	Apr-22	L	63.00%	Mar-22	F

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 2

Statistical Process Control - Assurance & Variation

11	Staffing – Average Fill Rate (Combined)	90.00%	86.8%	Apr-22	No SPC	89.65%	Mar-22	No SPC
12	Staffing – Care Hours Per Patient Day	7.9	7.5	Apr-22		7.5	Mar-22	?
13	Mortality ratio - HSMR	N/A	84.64	Apr-22	No SPC	84.64	Mar-22	No SPC
14	Mortality ratio - SHMI	N/A	99.74	Apr-22	No SPC	99.74	Mar-22	No SPC
15	NICE Compliance	90.00%	91.42%	Apr-22		91.22%	Mar-22	?
16	Complaints (open over 6 months)	0	0	Apr-22		0	Mar-22	P
17	Friends & Family – Inpatients & Day cases	95.00%	98.00%	Apr-22	No SPC	98.00%	Mar-22	No SPC
18	Friends & Family – ED and UCC	87.00%	68.00%	Apr-22	No SPC	66.00%	Mar-22	No SPC
19	Mixed Sex Accommodation Breaches (Non ITU Breaches Only)	0	0	Apr-22	No SPC	0	Mar-22	No SPC
20	Continuity of Carer	51.00%	79.70%	Apr-22	H	80.00%	Mar-22	P
21	Sepsis - % screening for all emergency within 1 hour.	90.00%	87.00%	Apr-22	No SPC	77.00%	Mar-22	No SPC
22	Sepsis - % screening for all inpatients within 1 hour.	90.00%	53.00%	Apr-22	No SPC	83.00%	Mar-22	No SPC

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 2

Statistical Process Control - Assurance & Variation

23	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis.	90.00%	76.00%	Apr-22	No SPC	78.00%	Mar-22	No SPC
24	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis.	90.00%	87.00%	Apr-22	No SPC	96.00%	Mar-22	No SPC
25	Number of CAS Alerts Actions Breached	0	0	Apr-22	No SPC	0	Mar-22	No SPC
26	Number of Hospital Acquired Acute Kidney Injuries	Please note: This indicator is under development.						
27	Ward Moves between 10:00pm and 06:00am	N/A	126.00	Apr-22	No SPC	N/A	N/A	No SPC

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 2

Statistical Process Control - Assurance & Variation

		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
28	Diagnostic Waiting Times 6 Weeks	99.00%	80.83%	Apr-22	H	81.39%	Mar-22	F
29	RTT - Open Pathways (18 Weeks)	92.00%	66.49%	Apr-22		66.60%	Mar-22	F
30	RTT – Number of Patients Waiting 104+ Weeks	0	22	Apr-22		28	Mar-22	F
31	A&E Waiting Times – % patients seen within 4 hours	95.00%	69.72%	Apr-22	L	68.72%	Mar-22	F
32	A&E Waiting Times – ICS Trajectory	Trajectory TBC for 2022/23						
33	A&E Waiting Times – % patients seen within 12 hours	98.00%	83.68%	Apr-22	No SPC	-	Mar-22	No SPC
34	Cancer 14 Days*	93.00%	90.60%	Mar-22	L	84.69%	Feb-22	?
35	Breast Symptoms 14 Days*	93.00%	92.31%	Mar-22	L	71.83%	Feb-22	F
36	Cancer 28 Day Faster Diagnostic*	75.00%	70.27%	Mar-22		68.72%	Feb-22	?
37	Cancer 31 Days First Treatment*	96.00%	98.65%	Mar-22	H	100.00%	Feb-22	P

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 2

Statistical Process Control - Assurance & Variation

38	Cancer 31 Days Subsequent Surgery*	94.00%	100.00%	Mar-22		100.00%	Feb-22	P
39	Cancer 31 Days Subsequent Drug*	98.00%	100.00%	Mar-22		100.00%	Feb-22	P
40	Cancer 62 Days Urgent*	85.00%	77.32%	Mar-22		71.28%	Feb-22	F
41	Cancer 62 Days Screening*	90.00%	100.00%	Mar-22		66.67%	Feb-22	?
42	Ambulance Handovers within 15 minutes	65.00%	41.62%	Apr-22		43.07%	Mar-22	F
43	Ambulance Handovers within 30 minutes	95.00%	65.46%	Apr-22		62.66%	Mar-22	F
44	Ambulance Handovers within 60 minutes	100%	76.55%	Apr-22		74.18%	Mar-22	F
45	Discharge Summaries - % sent within 24hrs	95.00%	88.35%	Apr-22		89.88%	Mar-22	F
46	Discharge Summaries – Number NOT sent within 7 days	0	1	Apr-22		0	Mar-22	?
47	Cancelled Operations on the day for a non-clinical reasons	Under 2.00%	Data unavailable for April 2022.	Apr-22		0.00%	Mar-22	?
48	Cancelled Operations– Not offered a date for readmission within 28 days	0		Apr-22		5	Mar-22	?
49	Urgent Operations – Cancelled for a 2nd time	0	0	Apr-22		0	Mar-22	P

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 2

Statistical Process Control - Assurance & Variation

50	Super Stranded Patients	Trajectory TBC for 2022/23	142	Apr-22		135	Mar-22	
51	COVID-19 Recovery Elective (Inpatient/Daycase) - (Average)	104%	98.09%	Apr-22		124.26%	Mar-22	
52	COVID-19 Recovery Diagnostic Activity - (Average)	104%	61.84%	Apr-22		113.49%	Mar-22	
53	COVID-19 Recovery Outpatient Activity	104%	86.44%	Apr-22		120.67%	Mar-22	
54	% Outpatient Appointments delivered remotely	25.00%	11.67%	Apr-22		11.91%	Mar-22	
55	% of Patients seen in the fracture clinic within 72 hours	95.00%	11.36%	Apr-22		15.56%	Mar-22	
56	Advice & Guidance (A&G) Activity Levels	N/A	346	Apr-22		-	Mar-22	
57	Patient Initiated Follow Up (PIFU) Activity Levels	N/A	24	Apr-22		21	Mar-22	
58	% of zero-day length of stay admissions (as a proportion of total)	Please note: This indicator is under development.						
59	Average time in department ED	N/A	30	Apr-22		20	Mar-22	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 2

Statistical Process Control - Assurance & Variation

		Latest				Previous		Assurance
	WORKFORCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
60	Supporting Attendance	4.20%	7.44%	Apr-22		7.18%	Mar-22	F
61	Welcome Back Conversations	85.00%	58.51%	Apr-22	L	61.96%	Mar-22	F
62	Recruitment Timeframe (Days)	65	76	Apr-22		76	Mar-22	F
63	Vacancy Rates	9.00%	10.10%	Apr-22		10.58%	Mar-22	?
64	Retention	86.00%	83.21%	Apr-22		83.29%	Mar-22	F
65	Turnover	13.00%	15.99%	Apr-22		16.34%	Mar-22	F
66	Bank & Agency Reliance	9.00%	16.15%	Apr-22		19.00%	Mar-22	F
67	Monthly Pay Spend (Contracted & Non-Contracted)	£19,984,961.00	£20,894,075.54	Apr-22		£20,621,043.48	Mar-22	?
68	Core/Mandatory Training	85.00%	84.61%	Apr-22	H	85.47%	Mar-22	?
69	Role Specific Training	85.00%	91.26%	Apr-22	No SPC	91.35%	Mar-22	No SPC

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 2

Statistical Process Control - Assurance & Variation

70	Safeguarding Training	77.00%	69.97%	Apr-22	No SPC	73.04%	Mar-22	No SPC
71	% Workforce carrying out an Apprenticeship Qualification	2.30%	2.23%	Apr-22	No SPC	3.54%	Mar-22	No SPC
72	PDR Compliance	65.00%	59.39%	Apr-22		61.94%	Mar-22	?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 2

Statistical Process Control - Assurance & Variation

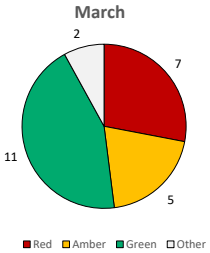
		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
73	Trust Financial Position £m	-2.02	-2.07	Apr-22		0.21	Mar-22	?
74	Cash Balance £m	33.73	40.55	Apr-22		44.70	Mar-22	P
75	Capital Programme Spend £m (Cumulative)	0.97	0.71	Apr-22	No SPC	19.15	Mar-22	No SPC
76	Better Payment Practice Code	95%	93%	Apr-22		89%	Mar-22	F
77	Use of Resources Rating	Please note: This indicator is currently suspended. The Trust is awaiting further guidance from NHSE/I.						
78	Cost Improvement Programme – Performance (In Year) £m	0.68	0.59	Apr-22	No SPC	-	Mar-22	No SPC
79	Cost Improvement Programme – Forecast (Recurrent) £m	6.50	-	Apr-22	No SPC	-	Mar-22	No SPC

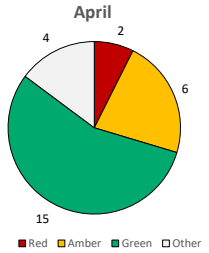
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Integrated Dashboard - April 2022

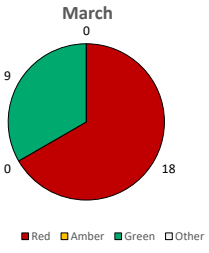
Appendix 3

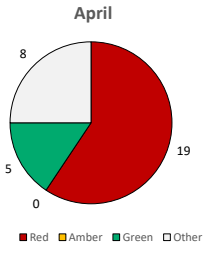
Quality Improvement



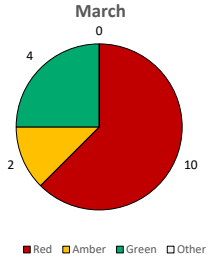


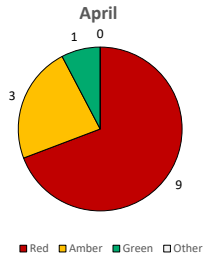
Access & Performance



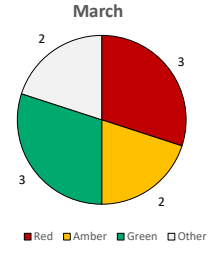


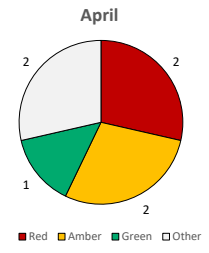
Workforce





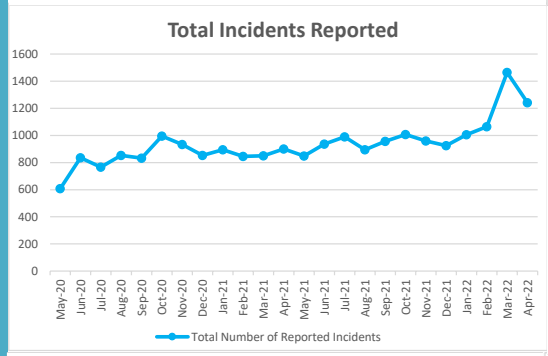
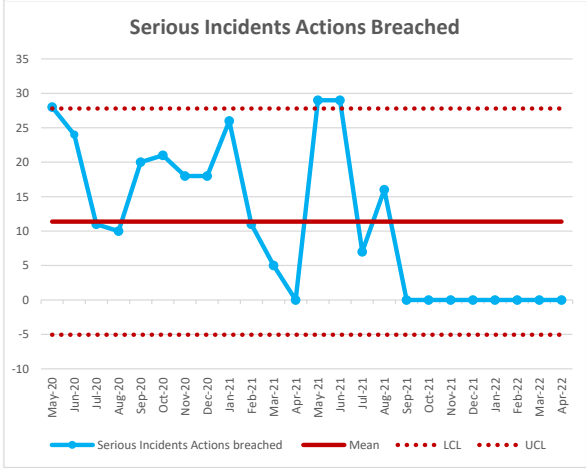
Finance





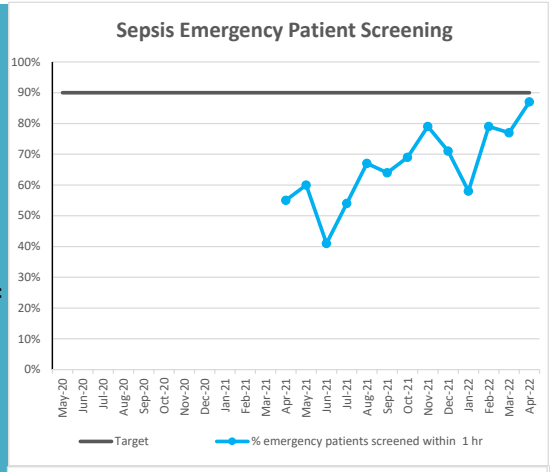
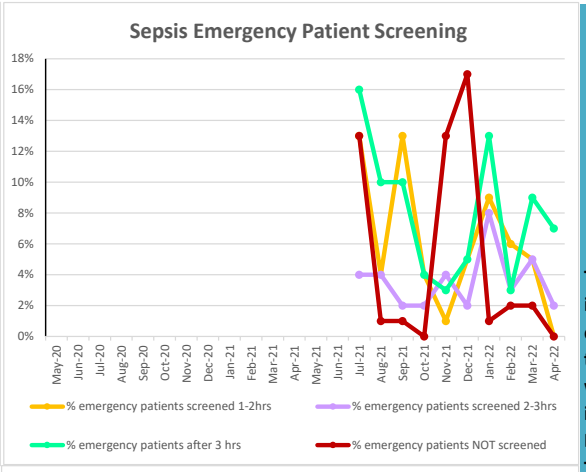
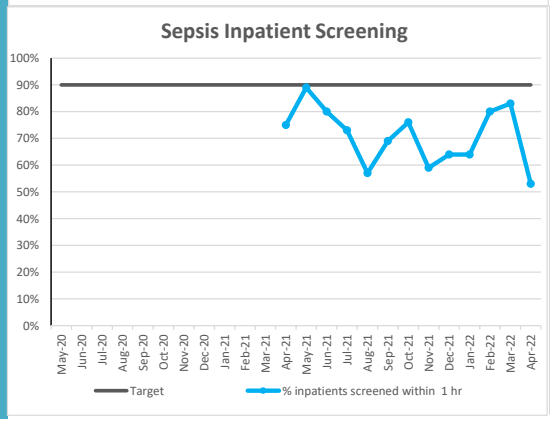
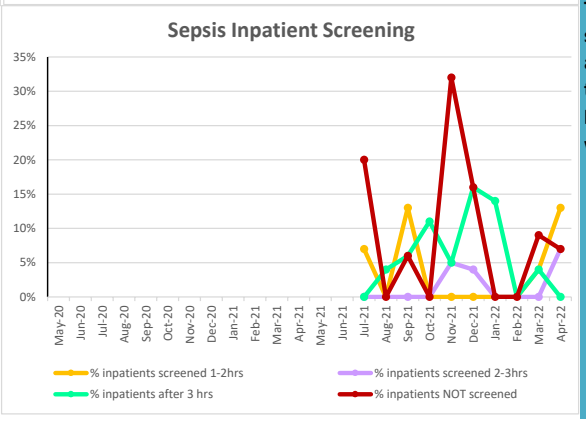
Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Incidents **Red: Open incidents outside 40 day timeframe.** **Green: Open incident within timeframe of 40 days.**	 	**have been sent to the relevant department, no concerns noted with those incidents open over 20 days.**	

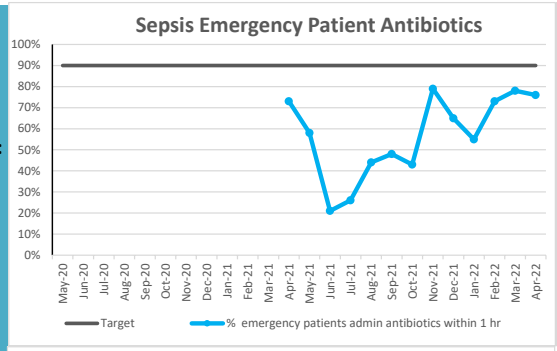
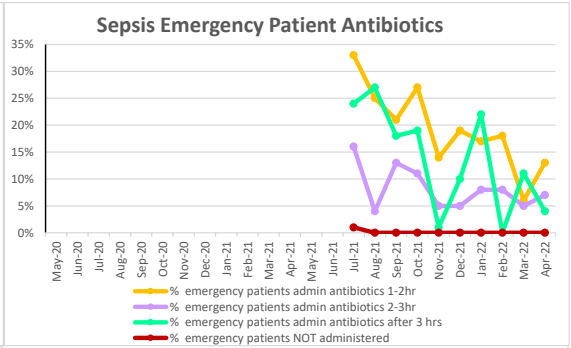
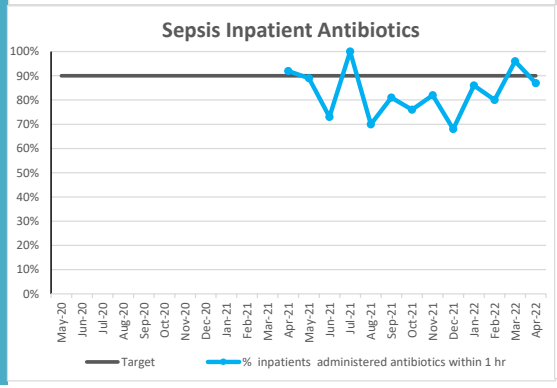
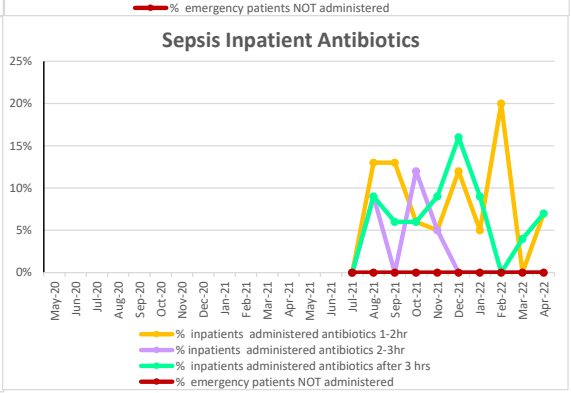
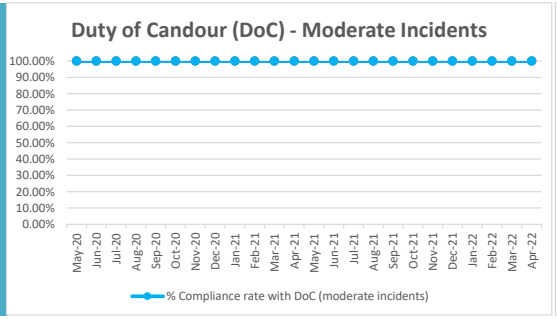
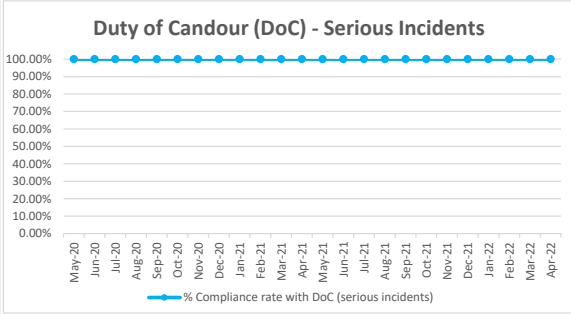
Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

Quality Improvement - Trust Position

	Trust Performance	Trend		What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Sepsis % screening for all emergency patients. Green: 90% or above Amber: 75% 89% Red: Below 75%	The Trust achieved: • 87.00% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. • 53.00% screening for all inpatients with suspected sepsis within 1 hour.			The increase in patient attendances in the Emergency Department has contributed to the ability of the team to complete assessments within the 1 hour timeframe. An increase in compliance within the Emergency Department is evident. The number of inpatients not screened in April is 8 out of 15 audited. A validation review of these cases has demonstrated no harm and why the delay occurred, which is currently being reviewed.	Training for junior doctor induction will incorporate lessons learned from audits and incidents, demonstrate how to access the sepsis screening tool on Lorenzo and re-iterate the elements of sepsis screening and importance of the 'Golden Hour'. Work is ongoing to replace the Trusts Sepsis Clinical Leads. Patient Safety Nurses reinforce to staff reasons for not obtaining or delay in obtaining lactate or blood cultures should be documented clearly on the sepsis pathway and escalated to a doctor or nurse in charge. Sepsis screening remains a focus for improvement for both in patients and those in the Emergency Department.
Sepsis % screening for all inpatients Green: 90% or above Amber: 75% 89% Red: Below 75%					

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

Quality Improvement - Trust Position

	Trust Performance	Trend		What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Sepsis % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag Green: 90% or above Amber: 75% 89% Red: Below 75%	The Trust achieved: • 76.00% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made. • 87.00% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.			The higher demand in the Emergency Department has impacted on the compliance with antibiotic treatment within an hour. 2 inpatients did not receive antibiotics within an hour, no harm occurred.	A 'sepsis clock' is to be trialled in the Emergency Department as a visual way of tackling delay in administration of antibiotics as part of Quality Improvement measures. Sepsis improvement meetings continue bi-weekly. Daily review of E-observations are carried out to ensure red flags are responded to timely.
Sepsis % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis Green: 90% or above Amber: 75% 89% Red: Below 75%					
CQC Duty of Candour Red: <100% Green: 100%	The Trust achieved 100% for Duty of Candour in month.			There is no variance, the Trust remains 100% compliant.	Robust weekly monitoring is undertaken by the Patient Safety Manager to ensure compliance is maintained.

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

Quality Improvement - Trust Position

Trust Performance

Healthcare Acquired Infections
MRSA
Red: 1 or more
Green: 0

Healthcare Acquired Infections CDI
Red 37 or more

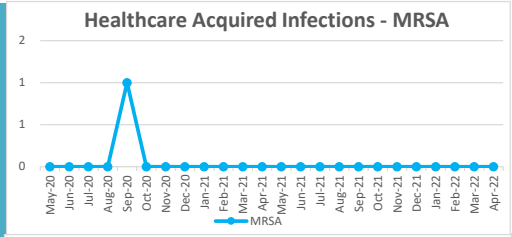
Healthcare Acquired Infections Ecoli
Red 57 or moe
Klebsiella
Red 19 or more
PA
Red 6 or more

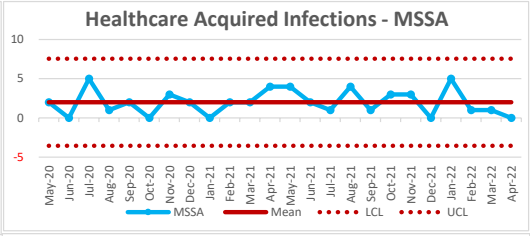
Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks

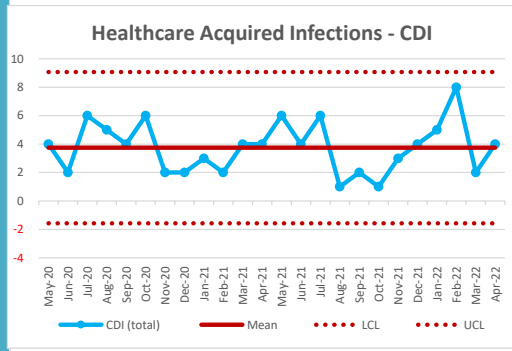
MRSA: 0 Cases in April, 0 Cases YTD.
CDI: 4 Cases in April, 4 Cases YTD.
E-Coli: 6 Cases in April, 6 Cases YTD.
Klebsiella: 1 Case in April, 1 Case YTD.
P. aeruginosa: 0 Cases in April, 0 Cases YTD.
COVID-19:
22 day 8-14 cases probable healthcare associated cases
27 cases 15+ days definite healthcare associated
4 COVID-19 outbreaks

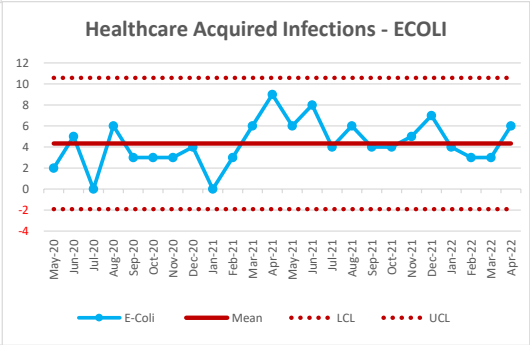
RR1275

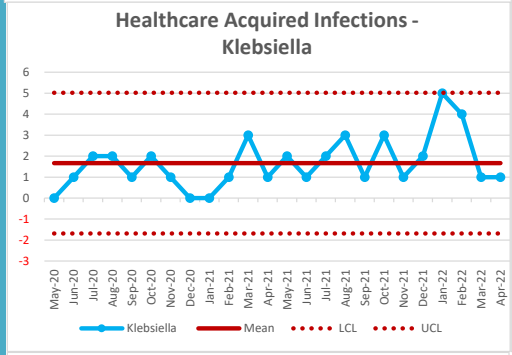
Trend

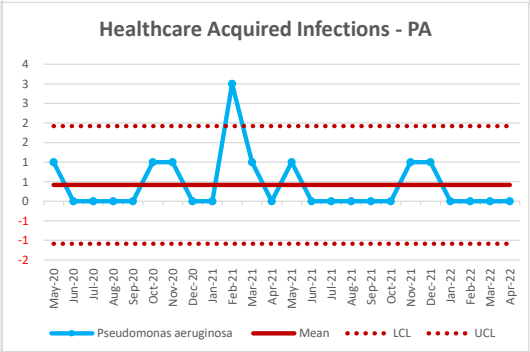


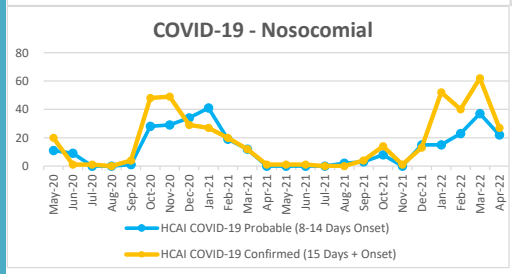


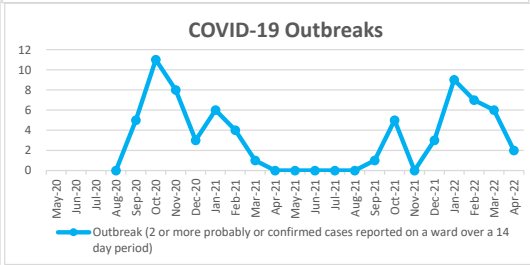












What are the reasons for the variation and what is the impact?

MRSA cases are on trajectory.

There is a Antimicrobial stewardship focus at post-take ward rounds and areas with lower antibiotic formulary compliance. Increased in use of hydrogen peroxide vapour decontamination.

The change in the apportionment rule has increased the number of GNBSI cases apportioned to the Trust.
Work has been carried out with the Quality Academy to implement improvements in patient care.

The Trust has seen a reduction in the number of patients being admitted with COVID-19.

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

Action plans are in place for the prevention of HCAIs with a focus on invasive device management.

Continue with the current CDI prevention strategy and also look at use of proton pump inhibitor medication with the Gastroenterology Team.
Continue focus on environmental hygiene and hand hygiene promotion strategy for patients and staff.
Continue review of root cause analysis investigations to identify learning.

Quality Academy support is in place with 8 wards engaged in a collaborative. Focus areas include hydration, continence management, care of urethral catheters, hand hygiene and UTI detection and management. The UTI pathway has been revised and will be launched at Grand Round in May 2022. Audit of Klebsiella spp. cases commenced to identify any areas for care improvement.

Close liaison with the operational teams to support patient placement. Outbreak Control Groups have convened to manage outbreaks to prevent transmission to additional patients and staff.

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

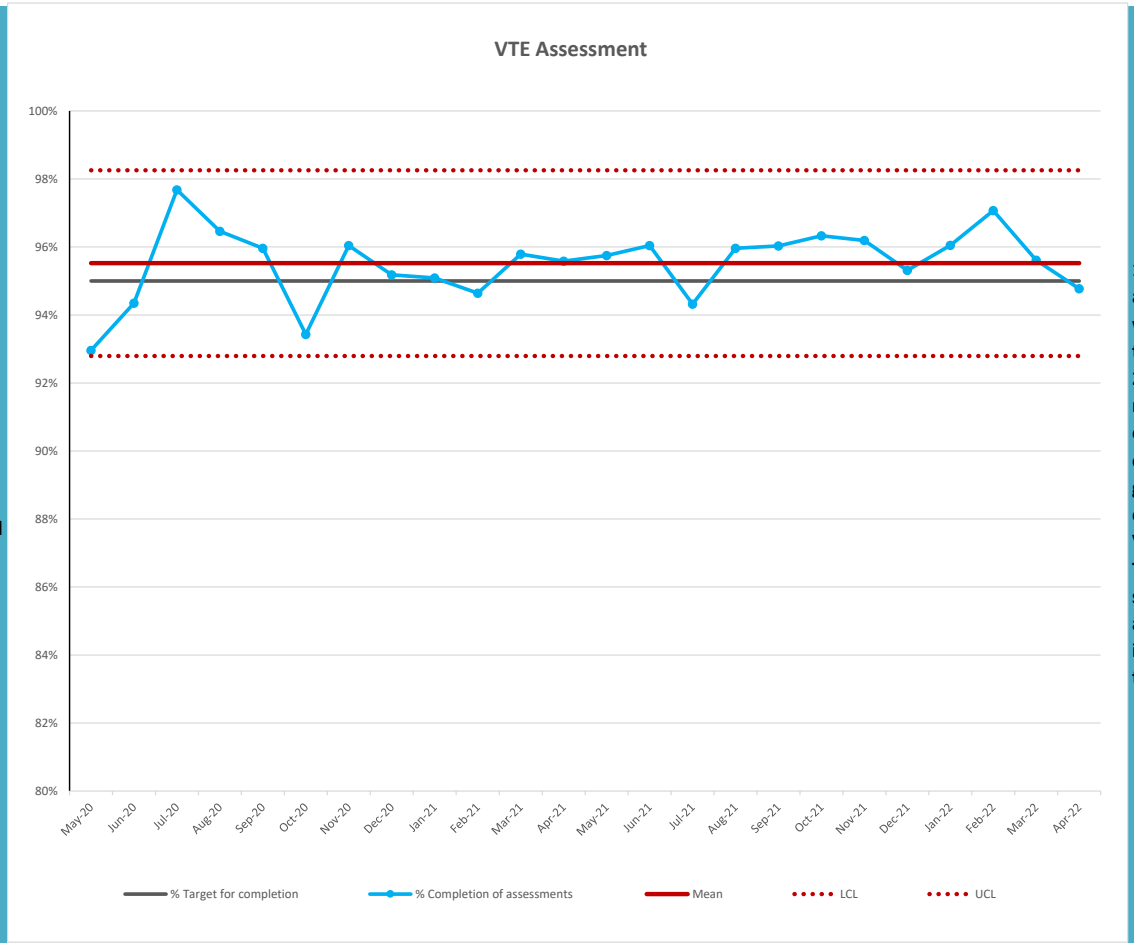
Quality Improvement - Trust Position

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

VTE Assessment

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

The Trust achieved below the required target at 94.77 % for VTE assessments in April, however this position is reported on a quarterly basis.

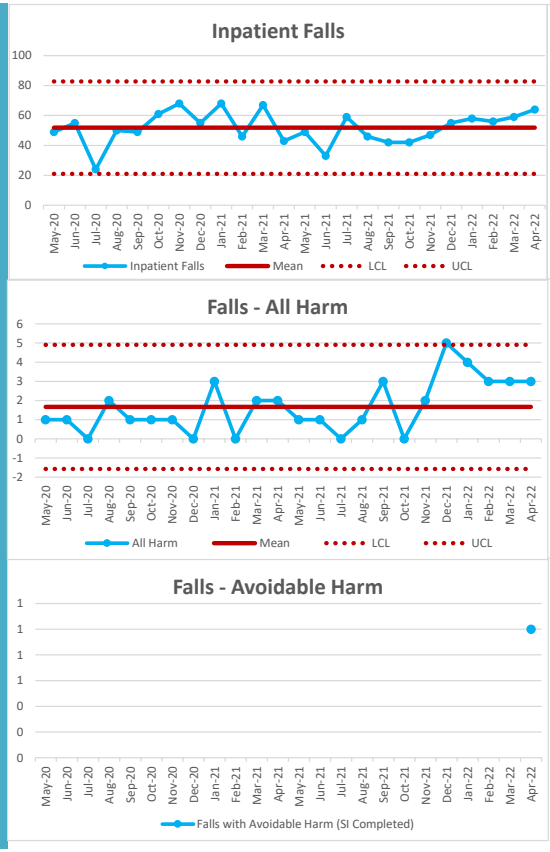


1. 16 additional VTE risk assessments in the month of April were required to hit the 95.00% target.
2. However, if the guidance on the national VTE data collection is to be changed to within 14 hours compliance of VTE RA, there is still a gap to reach 95% compliance. Data obtained in April was 89.06% for all VTE RA completed within 14 hours. This could have been due to significant increase in recent ED attendances with the subsequent increased workload on the medical team in completion of VTE RA.

Current systems in place to improve VTE compliance:
Use of the standardised RWW CDC initial clinical assessment and ward round forms incorporated with VTE risk assessment form is the key driving force for this improvement and the message getting across to the junior/senior doctors for compliance within 14 hours of admission.
Future proactive approach/plan to improve VTE compliance within 14 hours of admission:
1. To continue to raise the awareness of mandatory VTE RA through all opportunistic communications sent out to all doctors/nursing staff.
2. To provide data on the number needed to comply to all CBUs with CBU specific data at monthly clinical governance meetings to take the ownership by the CBU to improve overall VTE risk assessment compliance.
3. To work with the Planned Care Group for similar standardised clerking and PTWR form adapted to suit the surgical specialties to improve overall trustwide VTE compliance.

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

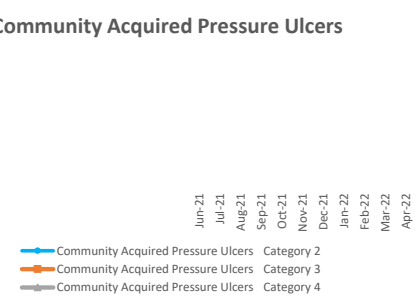
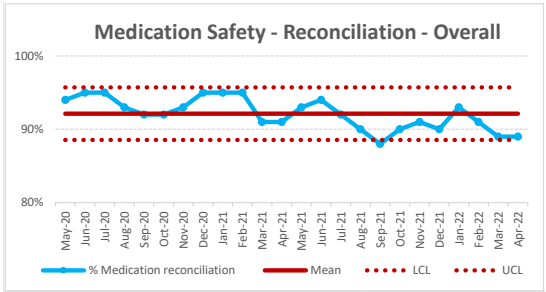
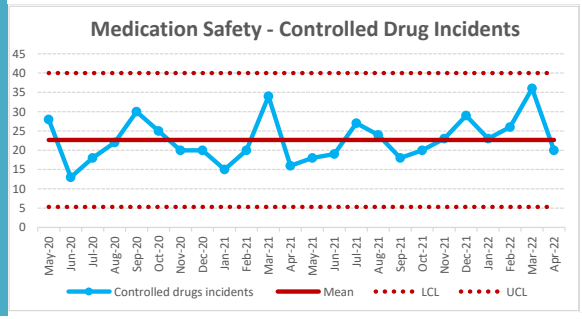
Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Total number of Inpatient Falls & harm levels Red: <10% decrease from 21/22 Amber: 10 19% decrease from 21/22 Green 20% or more decrease from 21/22 (590 Inpatient Falls in 2021/22)		The dependency of the patients, increased staff workload due to open escalated beds and staff sickness has contributed to the number of falls in month. Inconsistencies in the quality of risk assessment is also a contributing factor.	Staff management of patients requiring enhanced care is overseen by the senior teams, extra staff are requested to prevent harm occurring. Falls walkarounds continue with immediate feedback to provide support to the clinical teams for improvement. Wards A9 and A7 are being closely supported to reduce falls by Patient Safety and the Quality Academy due to their increased incidence of falls in April. Senior Clinical Leaders ward reviews will restart in May and a focus of improvement led by the Associate Chief/Chief of Nursing is in place.

80 total falls were reported in April. 64 of these falls were inpatient falls. 1 of these inpatient falls resulted in moderate harm and has progressed to an SI.

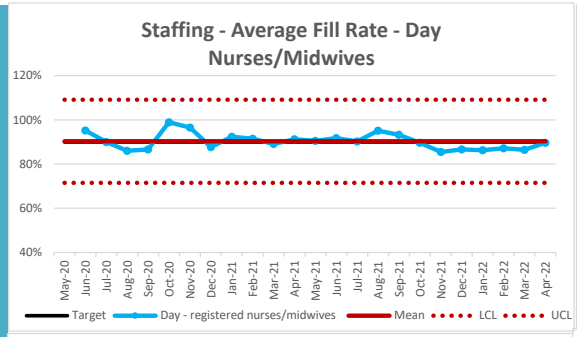
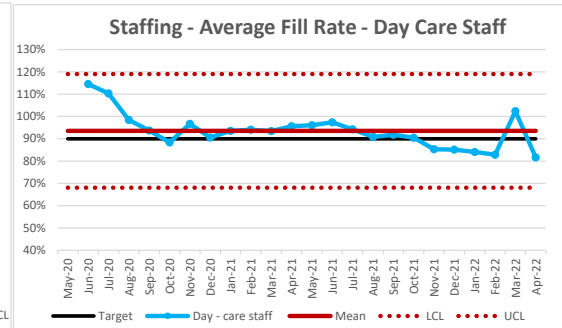
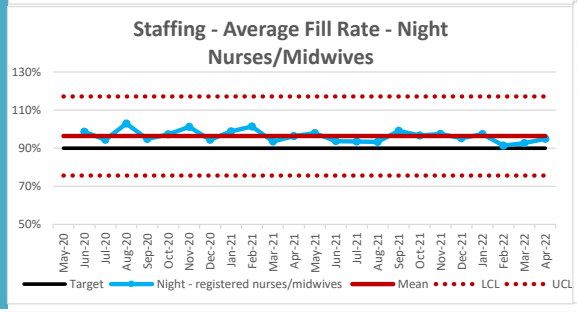
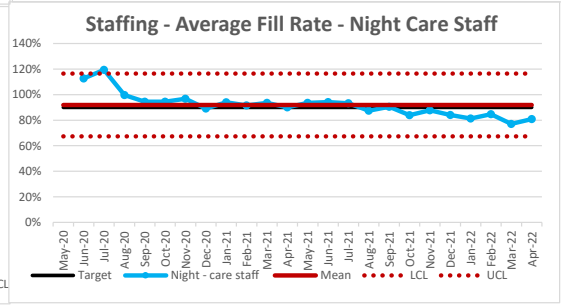
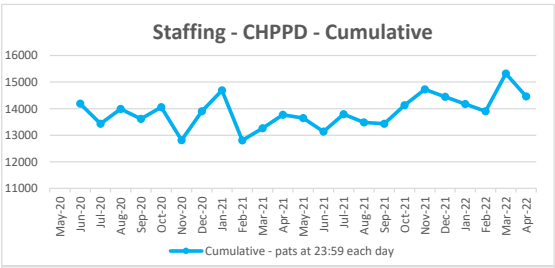
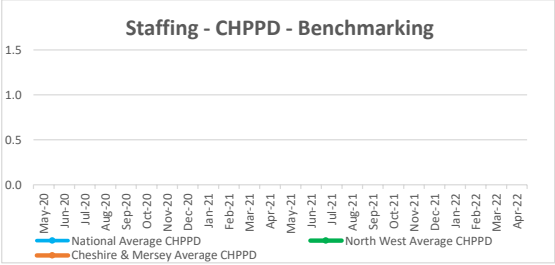
Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Pressure Ulcers Based on 91 in 2021/22 Red: 4% reduction or below Amber: 5% 9% reduction Green: 10% reduction or above.	There were 10 hospital acquired category 2 pressure ulcers and 2 hospital acquired category 3 in April 2022.		Variation in the standard of risk assessment, prolonged length of time in the Emergency Department and the care prescribed for ongoing management of patients with devices in place has contributed to the number of pressure ulcers	To support prevention of skin damage in the Emergency Department, pressure reducing trolley toppers are in use. Specific improvement plans in place for ward areas of higher incidence. Improvement work underway supported by Essential Healthcare. Face to face general pressure ulcer prevention and specific device training in place.
Medication Safety Reconciliation within 24 hours Red: below 60% Amber: 60% 79% Green: 80% or above	The Trust achieved 64.00% for medicines reconciliation within 24 hours and 89.00% for overall medicines reconciliation. There were 20 controlled drug incidents, this is at normal levels.	 	% medicines reconciliation achieved within 24 hours continues to be adversely impacted by the system pressures / discharges and bank holidays in month. Staff absences within the team have also had an impact. The overall number of medicines reconciliation was maintained by filling rota gaps through use of staff overtime/additional hours, compliance is expected to improve as new staff commence in post. Data quality issues identified during review of the patients who did not receive a medicines reconciliation have been reported to Digital Services. The majority of controlled drug incidents are documentation related. The number of CD incidents recorded correlates with the number of CD audits performed (issues identified are reported). No CD audits were scheduled in April.	Further staff recruitment has taken place this month, recruitment for new posts is underway. With staff in post and use of real time data (new database), work will focus on undertaking MRs closer to the front door and raising overall % in Surgical Specialties & Women's & Childrens. A review of patients who did not receive a medicines reconciliation is undertaken to assess/report risk/harm. Improvements needed in the use of controlled drug registers at ward level: CD documentation featured as a hot topic in March, single point lessons were distributed. Monthly self-assessment and quarterly CD audits continue. Areas where improvements are needed are to be provided with support.

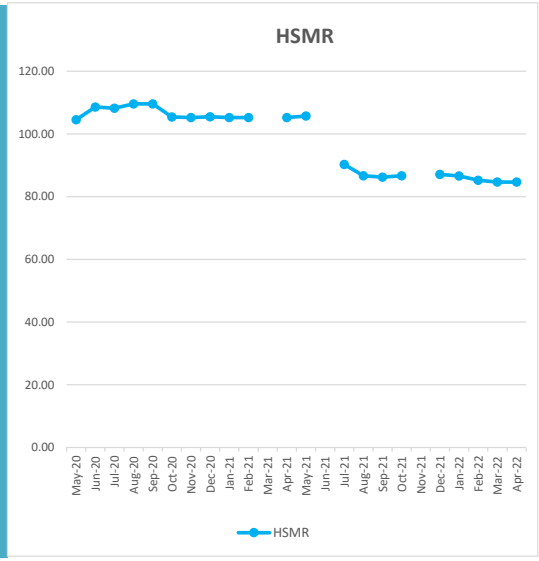
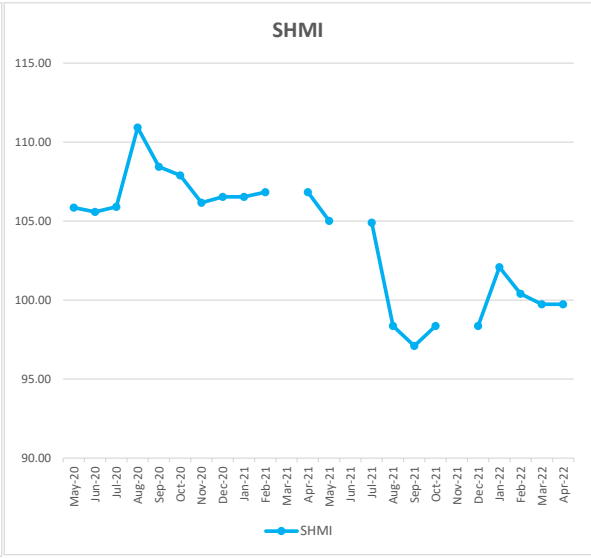
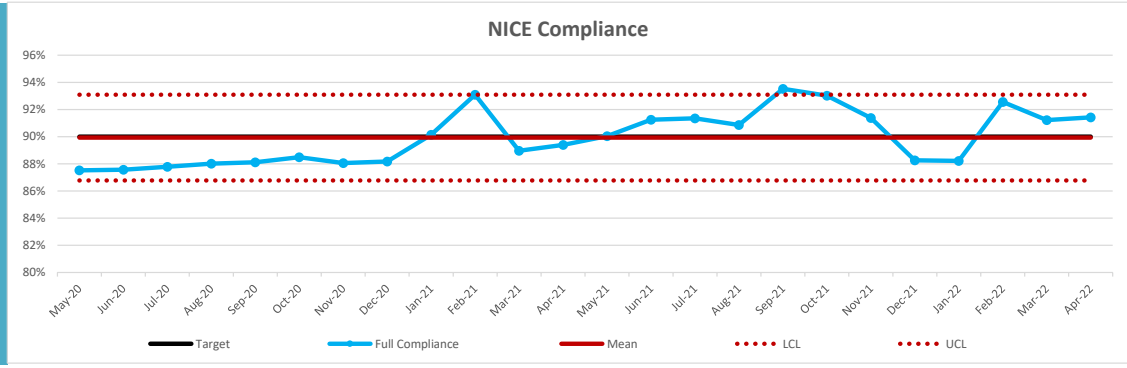
Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Staffing Average Fill Rate Red: 0 79% Amber: 80 89% Green: 90 100%	In April 2022, the average staffing fill rates were: Day (Nurses/Midwife) 89.62% Day (Care Staff) 81.64% Night (Nurses/Midwife) 94.94% Night (Care Staff) 80.85% RR115 RR1108	   	Escalation beds are in use across the Trust, vacancies and increased staff absence due to COVID-19 related reasons remains a driver for variation.	All wards have senior nurse oversight and twice daily review by a matron and lead nurse to ensure staffing levels are appropriate. An acuity and dependency audit will be completed in June across the Trust and a current review of staffing levels in the areas where increased harm has occurred is underway within the Care Groups. Substantive recruitment into B3 is required as a priority. Recruitment programmes for health care assistants (HCA's) and registered nurses are in place with oversight of progress via the Deputy Chief Nurse.
Staffing Care Hours Per Patient Day (CHPPD) Red: Below 6.0 Amber: 6.0 7.8 Green: 7.9 or More	In April 2022, the average CHPPD were: Nurse/Midwife: 4.5 hours Care Staff: 3.0 hours Overall: 7.5 hours	 	CHPPD was 7.5 and has been impacted by gaps in staffing due to vacancies, sickness and the requirement to staff escalation wards.	Staffing levels against acuity/dependency demand are reviewed by the matrons and lead nurses and a daily lead for staffing. Focussed recruitment has taken place for the Emergency Department. 30 International Nurses will be joining the Trust in 2 x cohorts in May and July 2022.

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

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Mortality ratio HSMR Red: Greater than expected Green: As or under expected Mortality ratio SHMI Red: Greater than expected Green: As or under expected	SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 84.64. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 99.74.	 	No variation. HSMR and SHMI remain within expected range. NB: The gaps in the chart relate to the time periods whereby our external provider (HED) did not produce a report with the HSMR/SHMI.	Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning. SHMI and HSMR continues to reduce month on month.
NICE Compliance Red: Below 75% Amber: 75% to 89% Green: 90% or Above	The Trust achieved 91.42% in month.		The Trust has met the target of achieving over 90.00% overall compliance. Medical care remains below the 90.00% target however their compliance has improved by 3.00% when compared to last month. Focused work continues.	The Clinical Effectiveness Manager is working closely with leads to complete the outstanding guidelines. A review of partial compliant guidance is ongoing to ensure action plans are in place with robust monitoring mechanisms.

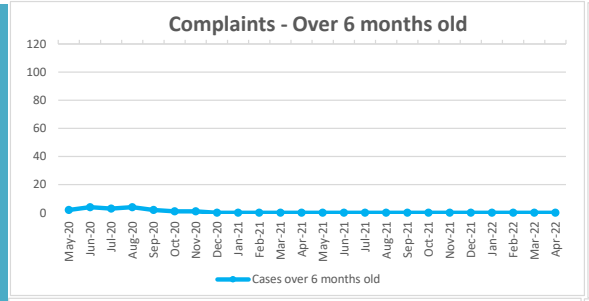
Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

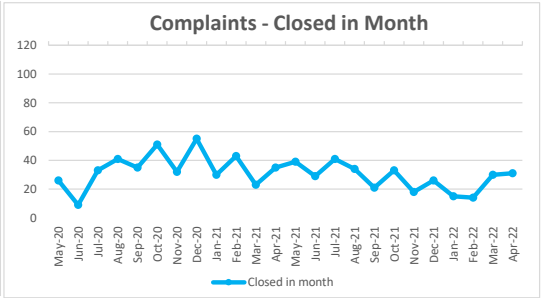
Quality Improvement - Trust Position

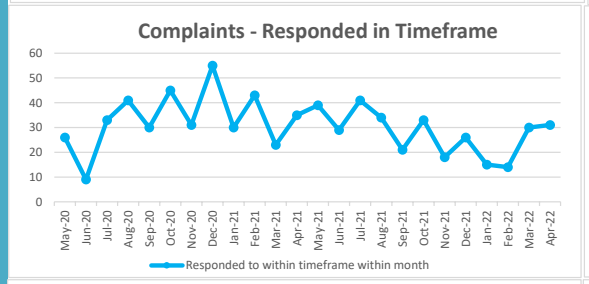
Trust Performance

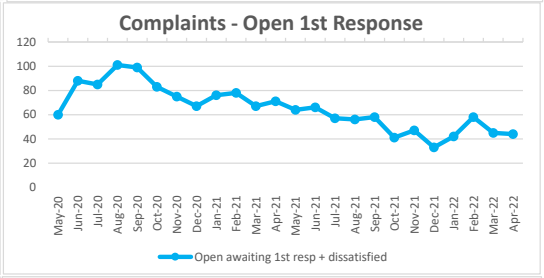
Complaints
Red: Complaints over 6 months old/69% or less responded to within the timeframe
Amber: No complaints over 6 months old, 70% 89% responded to within the timeframe
Green: No backlog, 90% responded to within the timeframe.

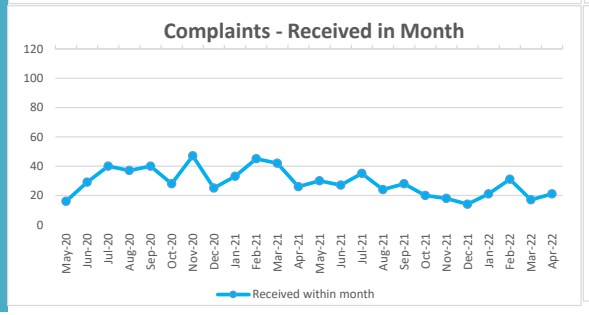
Trend

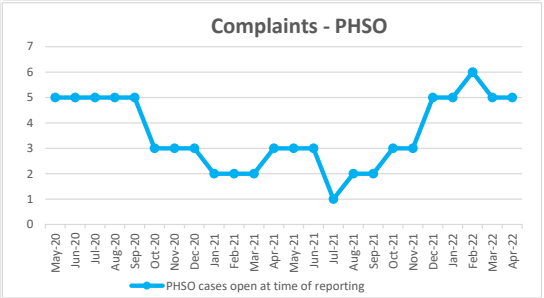












In April 2022, 21 new complaints were received to the Trust which was an increase from the previous month. There have been 4 dissatisfied received in month, which is an increase of 4 from previous month. These have been reviewed by the Associate Director of Governance and Director of Governance to review any trends emerging.

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

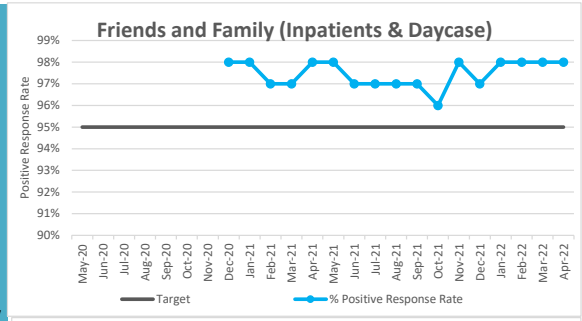
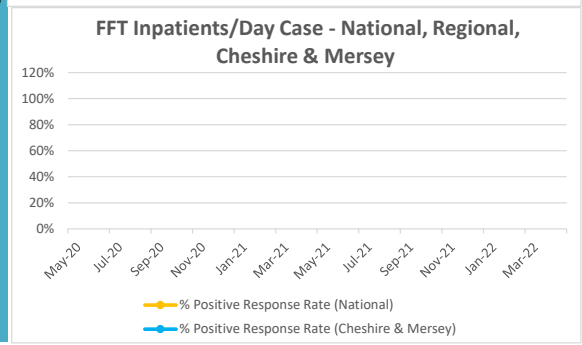
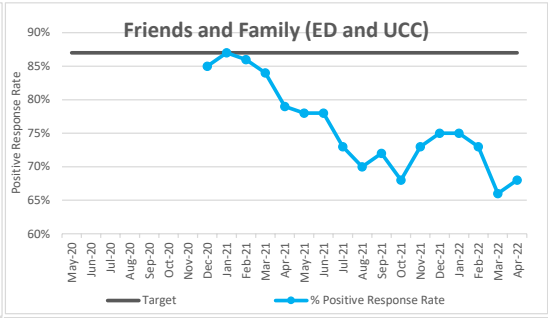
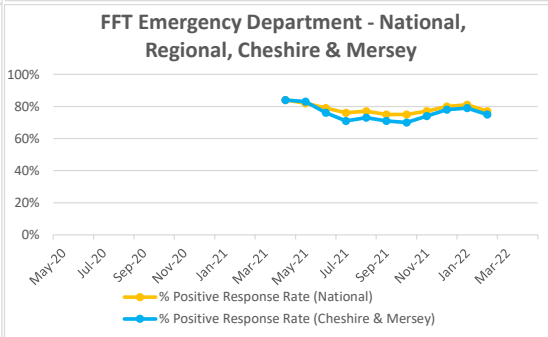
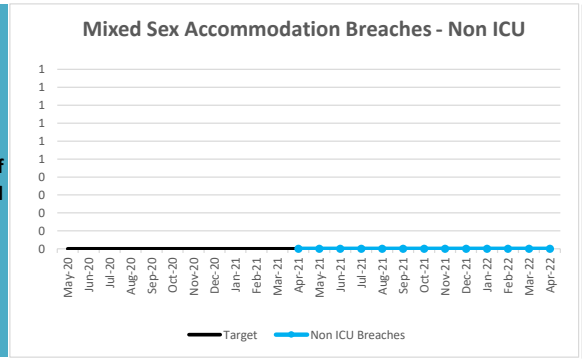
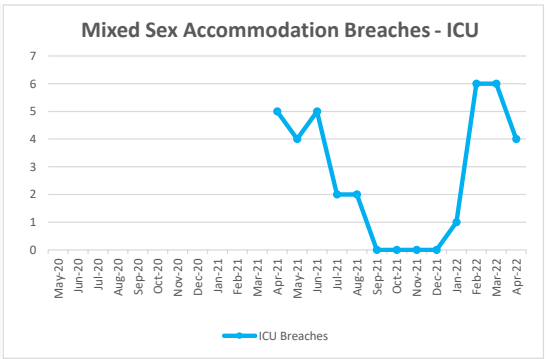
There continues to be no complaints over 6 months old, and all complaints are responded to within timeframe. There has been an increase in the number of formal complaints received with 58 currently open on the system. No new PHSO cases received during last reporting period. Number open remains at 5.
Number of PALS received has reduced since last reporting period by 80. The Trusts remains within range for the closure of PALS at 2.2 days

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

The Complaints Toolkit has now been completed and a training package is being developed. Training dates for the CBUs have commenced.

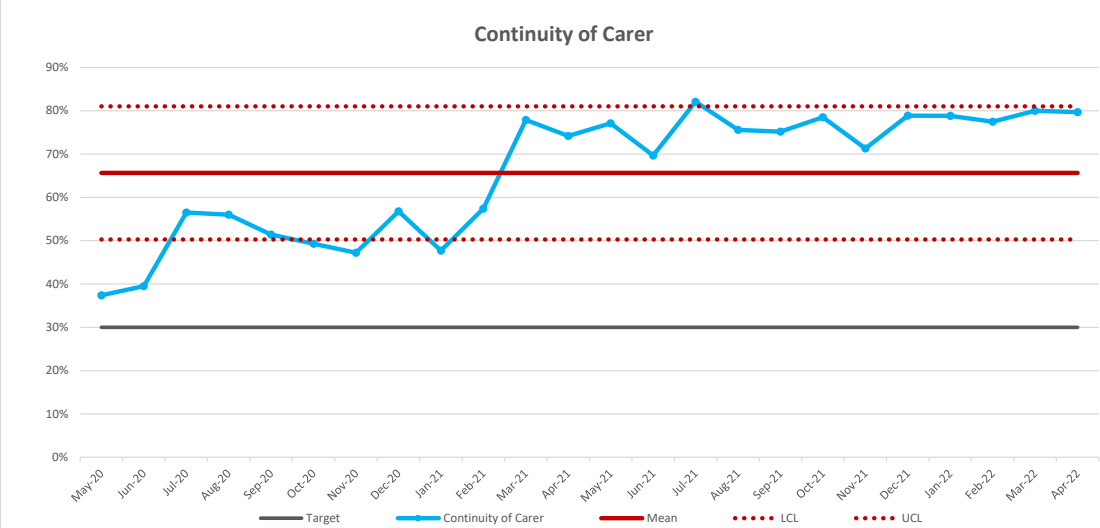
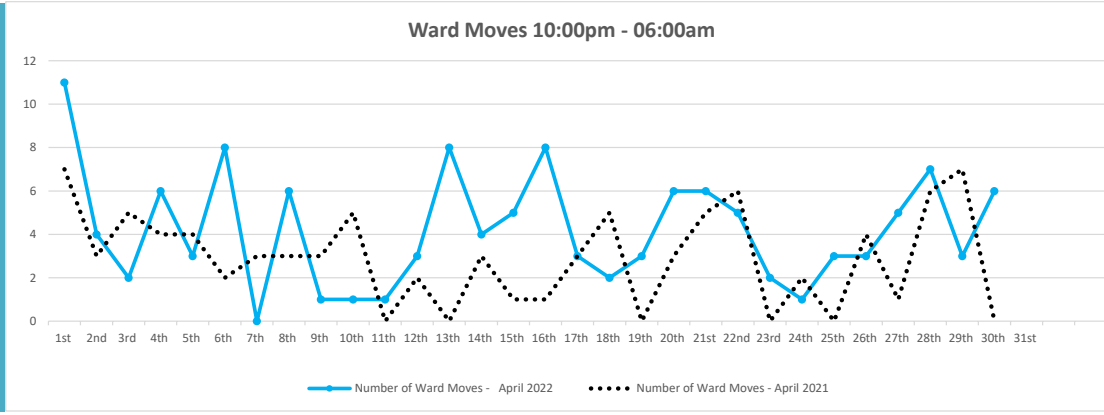
Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

Quality Improvement - Trust Position

	Trust Performance	Trend		What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more Friends and Family (ED and UCC) Red: Less than 87% Green: 87% or more	The Trust achieved 98.00% in month for Inpatient & Day case FFT and 68.00% for ED/UCC FFT.	 	 	ED/UCC - The Trust achieved 68.00% positive feedback in Friends and Family Test results in April 2022, an improved position compared to previous month. Inpatient/Day Case - The Trust achieved 98.00% positive recommendation rate in April 2022.	A CQC mock inspection was undertaken in March 2022 with subsequent actions to address patient experience, including a review into the reintroduction of patient visiting in the Emergency Department currently underway. Inpatient/Day Case – Patient Experience Sub-Committee continues to monitor feedback and subsequent themes on a monthly basis. The Trust continues to be highly recommended through the FFT responses for Inpatients and Outpatients.
Mixed Sex Accommodation Breaches (Non ITU Only) Red: 1 or more Green: Zero	There were 0 mixed sex accommodation incidents outside of the ITU during April 2022. There were 4 MSA incidents within the ITU.			There were 4 mixed sex accommodation breaches reported in April 2022 in the Intensive Care Unit, impacted by the activity within the Trust. There were zero breaches within any other ward area.	Work continues to reduce the number of mixed sex breaches via the patient flow, operational and clinical teams. Priority to step down to ward areas is given to patients in ICU as part of managing patient flow through the Trust.

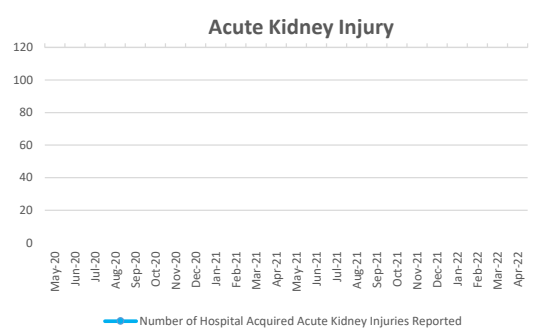
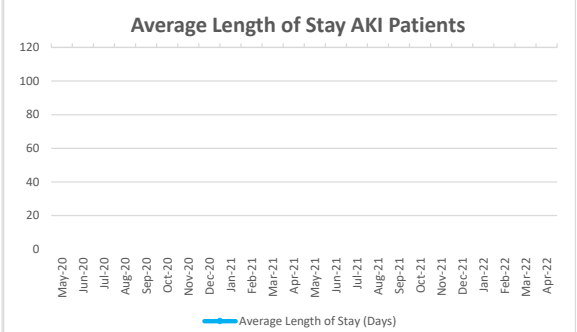
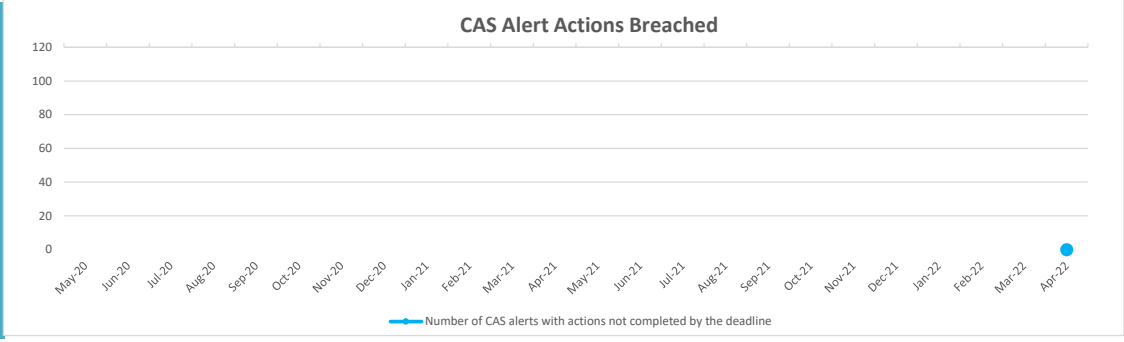
Key:
System Oversight Framework (SOF) | Risk Register (RR116)
Care Quality Commission (CQC) | Trust Strategy (S)

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Continuity of Carer Green: 51% or Above Amber: 35% 50% Red: below 35%	The Trust achieved 79.70% onto a Continuity of Carer pathway (including intrapartum care) in April 2022.		In April 2022, 100% of Warrington & Halton women are booked onto a MCoC pathway, if 'out of area' bookings are included the figure is 79.7% as we cannot provide the postnatal aspect of the pathway. 100% of in area and 86.9% of all BME women were booked onto a MCoC pathway.	WHH continues to work towards ensuring women booked on a pathway receive continuity across the pathway. Updated national guidance was published in October 2021 in relation to Continuity of Carer and a revised action plan is being prepared to reflect the new recommendations. At present WHH are unable to collect accurate data in relation to women in the most deprived areas. This will be resolved with the implementation of Badgernet, however as all in-area women are booked onto a MCoC pathway, the team are confident this includes >51% of women in the most deprived deciles.
Ward Moves between 10:00pm and 06:00am	There was a total of 126 ward moves between 10pm-6am in April 2022 compared to 88 in April 2021.		There is an increase in patient moves after 10pm for this month. The increase is due to managing increased activity throughout the Trust.	Operational and clinical teams work together to minimise the movement of patients after 10pm. The alert notification system is in place for patients with learning disability or mental health needs and is monitored by the senior nurses to ensure no inappropriate moves occur.

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

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Acute Kidney Injury Green: Less than previous month Red: More than previous month	This indicator is under development.	 	This indicator is under development.	Data is unavailable in month.
CAS Alerts Green All relevant CAS Alerts actioned within timescales Red Applicable CAS Alert not actioned within the timescale.	There were 0 CAS alerts with breached actions in month.		There is no variance from the previous month as no alerts have been breached.	CAS alerts are monitored via the Trusts Health Safety Sub-Committee and Medical Devices Group. Action plans and monitoring arrangements are reviewed weekly by the Health & Safety Department.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Access & Performance - Trust Position

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

Diagnostic Waiting Times 6 Weeks

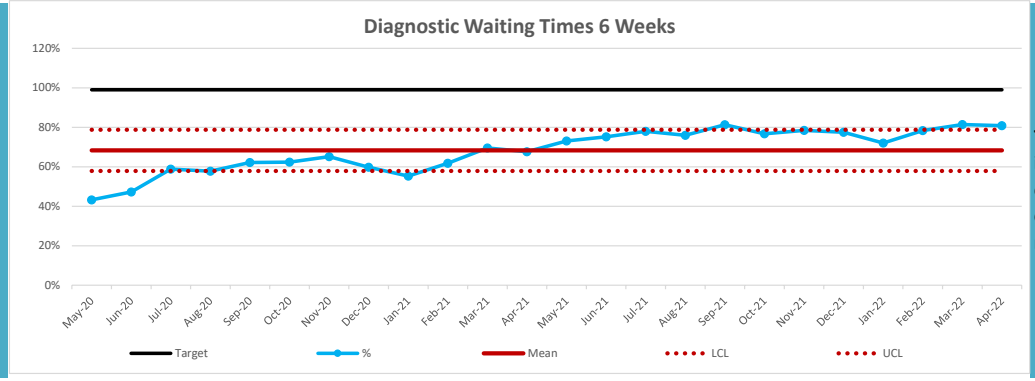
Diagnostic Waiting Times 6 Weeks

Red: Less than 99%
Green: 99% or above

SOF CQC

The Trust achieved 80.83% in month.

RR1215 RR1125



The diagnostic standard was not achieved in April 2022, this was due to the impact of the COVID-19 pandemic. The position continues to be manged in line with the recovery trajectory.

A recovery plan has been agreed and patients are being clinically prioritised accordingly in line with national guidance. The recovery plan is demonstrating that the actions agreed are delivering recovery with fewer breaches recorded as services are brought back online. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although there has been good progress in radiological modalities, challenges remain in Endoscopy, Cardiorespiratory, Cystoscopy and CT.

Referral to treatment Open Pathways

Referral to treatment Open Pathways

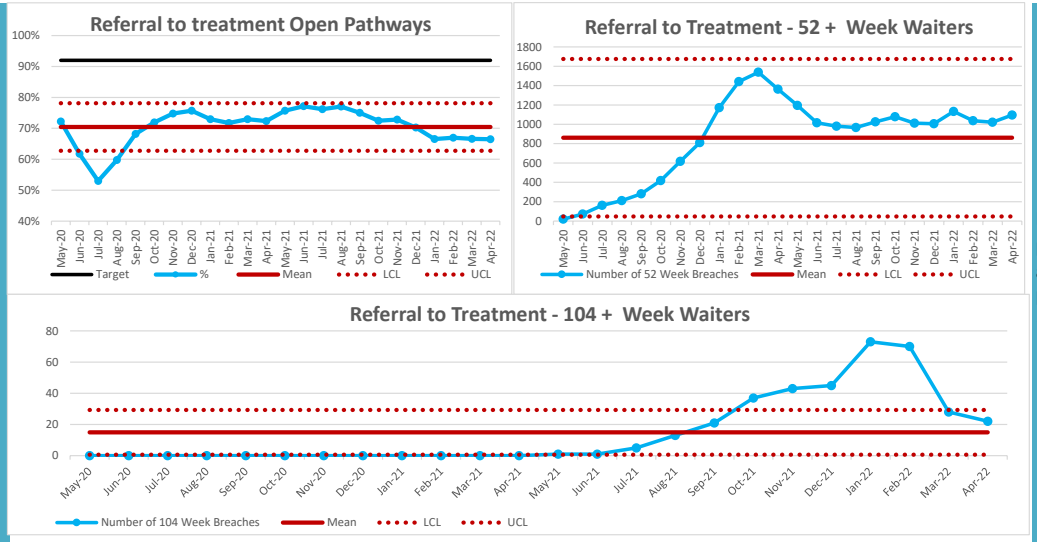
Red: Less than 92%
Green: 92% or above

RTT Number of patients waiting 104+ weeks
Green 0,
otherwise Red

SOF CQC

The Trust achieved 66.49% in month. There were 1096, 52 week breaches and 22, 104 week breaches in April 2022.

RR1125 RR1215



RTT performance, 52 and 104 week wait performance in April was compliant against the Trust's 2022/23 plan. Progress has been impacted by Wave 5/6 of COVID-19.

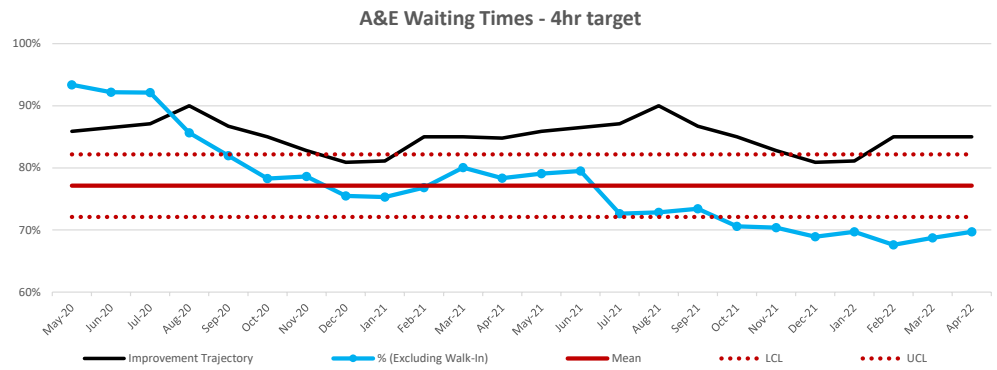
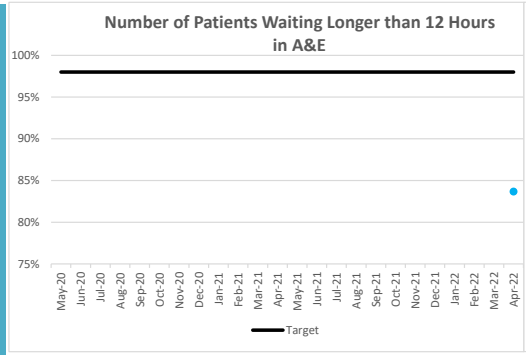
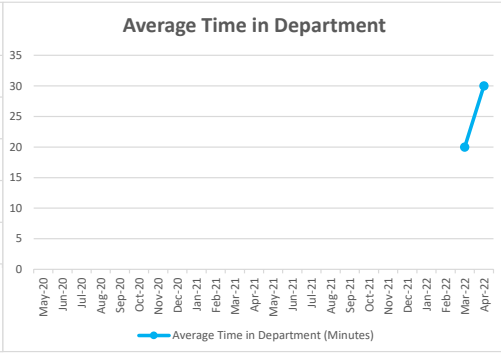
Recovery of the elective programme is taking place with:

- **Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients.**
- **Elective capacity has been restored at the Halton Elective Centre and the Captain Sir Tom Moore Centre.**
- **The Trust continues to utilise Independent Sector Capacity.**
- **Restoration and recovery plans for 2022/23 have been drawn up in line with Operational Planning Guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

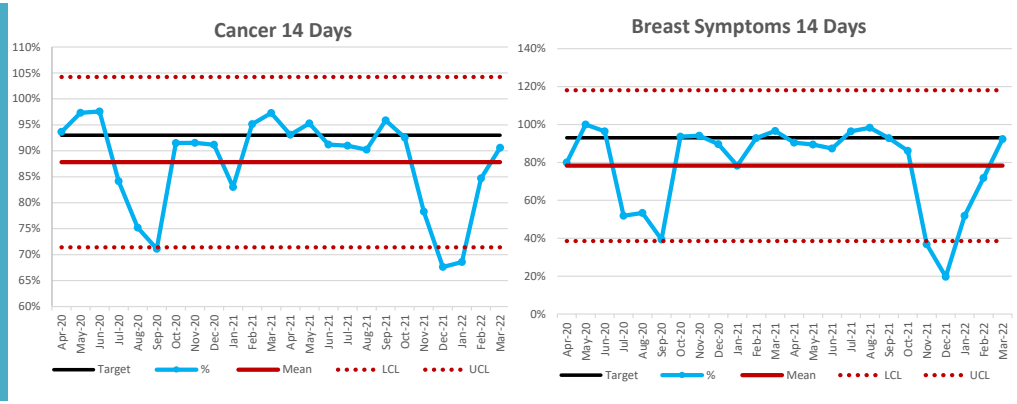
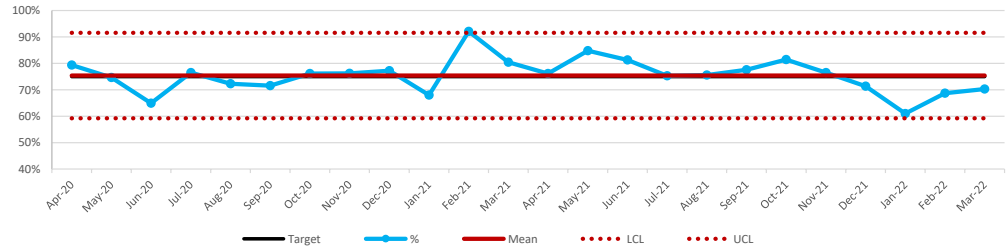
Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Four Hour Standard National Target Red: Less than 95% Green: 95% or above **Four Hour Standard Waiting Times - STP Trajectory** Red: Less than trajectory Green: Trajectory or above CQC The Trust achieved 69.72% excluding Widnes walk ins in month. RR224		There was slight improvement in Type 1 performance despite continuing high attends at A&E, a trend continuing to be seen across Cheshire & Merseyside. Bed occupancy at the Trust has continued to be over 90% during this period with an increase number patients with a LoS greater than 21 days, impacting flow and 4 hour performance. Additionally, Wave 6/COVID-19 occupancy has negatively impacted performance.	• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order 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 presentation to admission or discharge. Green 98% Red = >98% **Average time in department ED** There was 83.68% of patients waiting under 12 hours in A&E in month.	 	There has been a continued deterioration in 12 hour performance in April which is in line with the growing pressures during this period. This is also in line with the trend seen regionally and nationally. The Trust continues to perform well when compared to other Trusts against this standard. The key themes for the breaches are the continuing high urgent care attends and high occupancy restricting flow through ED.	The Trust will continue to monitor and manage compliance around the 12 hour standard.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

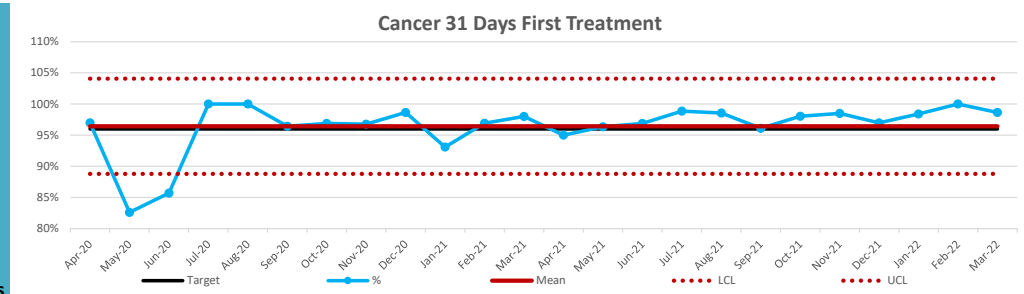
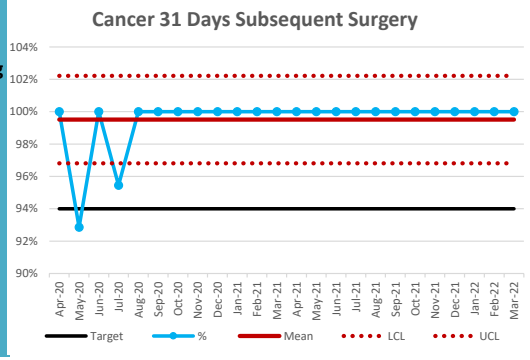
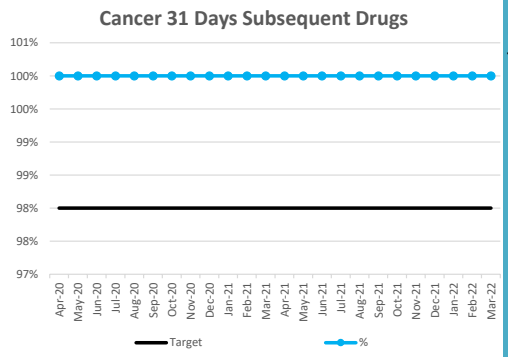
Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 14 Days Red: Less than 93% Green: 93% or above **Breast Symptoms 14 Days** Red: Less than 93% Green: 93% or above	SOF CQC **The Trust achieved 90.60% in March 2022 for Cancer 14 days and 92.31% in March 2022 for Breast Symptomatic.** RR1125		**Overall the 2 Week Wait narrowly missed the target in March with the continued impact of winter, Wave 5 and the starting of Wave 6. The previously reported deterioration in performance for Breast Symptomatic had fully recovered.**	**The Trust will continue to review capacity with clinical service restoration plans to support ongoing compliance against this standard.** **Performance against this standard is monitored via the Performance Review Group (PRG), the KPI sub-committee and the Clinical Services Recovery Oversight Group (CSOG).** **Targeted capacity and demand work has been initiated for the Breast service.**
28 Day Faster Cancer Diagnosis Standard Red: Less than 75% Green: 75% or above	SOF **The Trust achieved 70.27% in March 2022**		**The Trust failed the standard in March, albeit with an improving performance. This indicator is still being impacted by winter challenges, the previous breast symptomatic position and Wave 5 (COVID-19).**	**The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG) and the KPI Sub-Committee.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

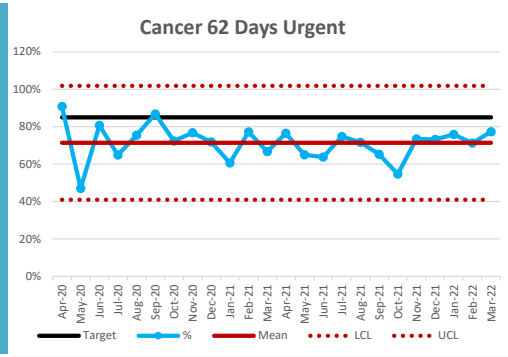
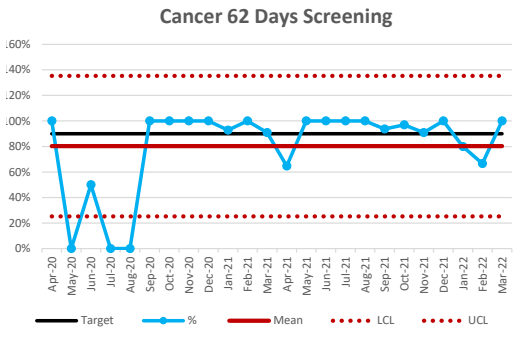
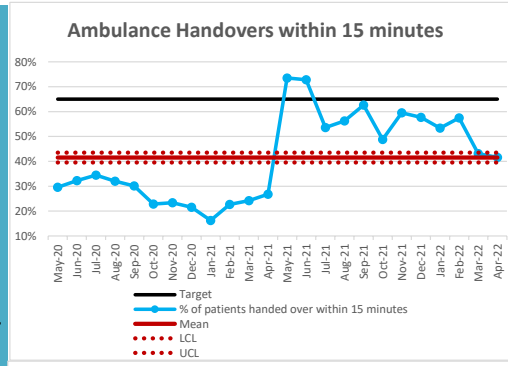
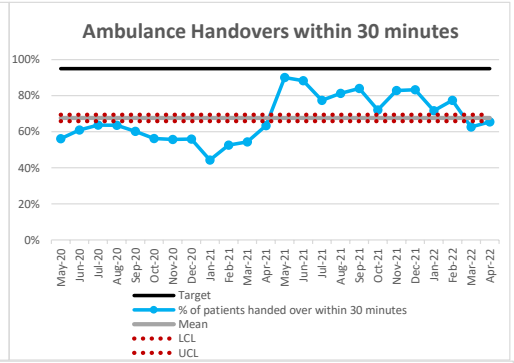
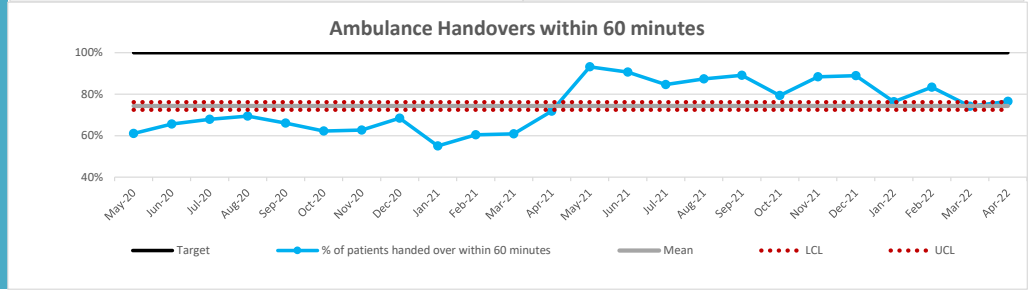
Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above **Cancer 31 Days Subsequent Surgery** Red: Less than 94% Green: 94% or above **Cancer 31 Days Subsequent Drug** Red: Less than 98% Green: 98% or above SOF CQC **The Trust achieved 98.65% for Cancer 31 days first treatment, 100% for surgery and 100% for drug treatment in March 2022.** RR1125	  	**The 31 day cancer target was achieved in March 2022. Good compliance against this standard continues to be tracked.**	**There remains a risk for performance due to the impact of the pandemic. Capacity is being reviewed in line with clinical service restoration plans.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

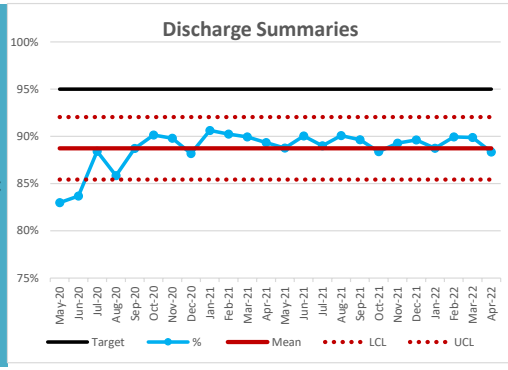
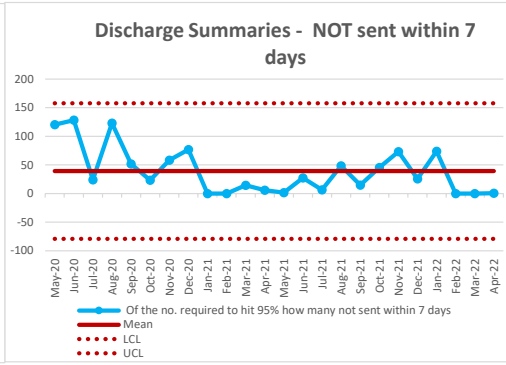
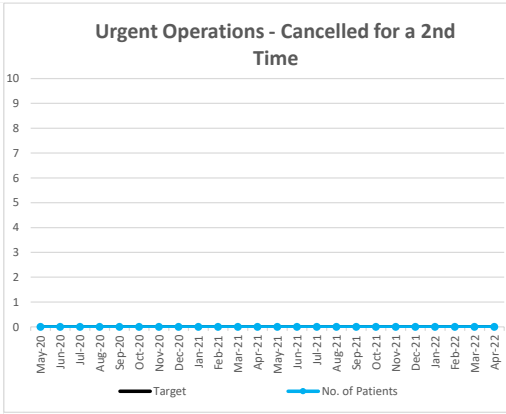
Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above **Cancer 62 Days Screening** Red: Less than 90% Green: 90% or above	SOF CQC **The Trust achieved 77.32% for Cancer 62 Day Urgent and 100.00% for Cancer 62 Day in March 2022.** RR1125	 	**The 62 day urgent target was not achieved in March 2022 despite an improving position. The Trust is meeting the Cheshire & Merseyside Cancer Alliance agreed trajectories for improvement.**	**There remains a risk for performance due to the impact of the pandemic.**
Ambulance Handovers within 15 minutes Red: Less than 65% Green: 65%+ **Ambulance Handovers within 30 minutes** Red: Less than 95% Green: 95%+ **Ambulance Handovers within 60 minutes** Red: Less than 100% Green: 100%	**In month 41.62% of patients were handed over within 15 minutes, 65.46% were handed over within 30 minutes and 76.55% were handed over within 60 minutes.** SOF	  	**Handover performance has improved following the improvement collaborative with the North West Ambulance Service (NWAS).**	**In May 2021, the Trust began a service improvement collaborative with NWAS to improve ambulance handover waiting times. The Trust will continue to work in partnership with the NWAS to identify and implement improvements.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

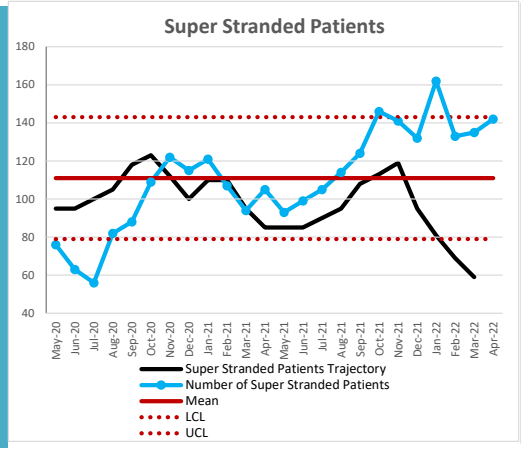
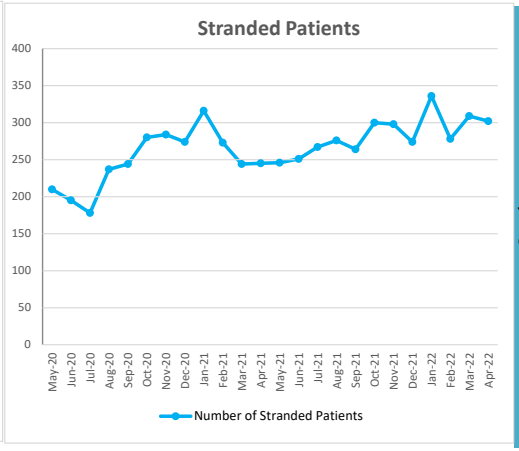
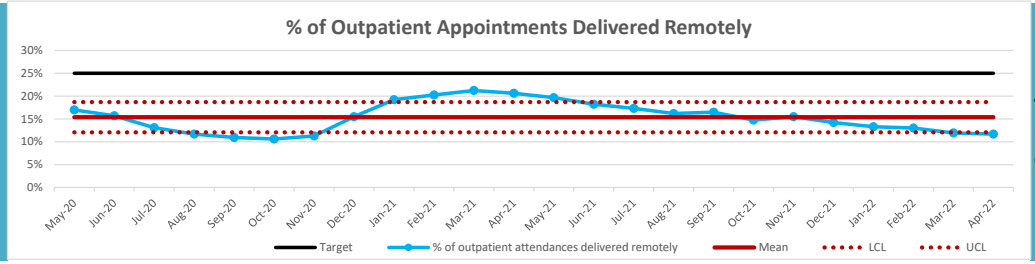
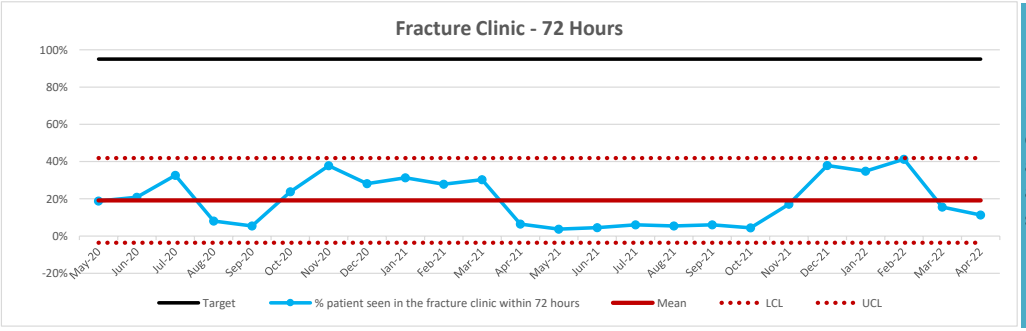
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Discharge Summaries % sent within 24hrs Red: Less than 95% Green: 95% or above **Discharge Summaries Number NOT sent within 7 days** Red: Above 0 Green: 0	**The Trust achieved 88.35% in month. There was 1 discharge summary not sent within 7 days required to meet the 95.00% threshold.**	 	**Performance of discharge summaries within 24 hours has been maintained despite Wave 6 challenges. The reporting logic for this metric has now been agreed.**	**The Performance Review Group (PRG) continues to monitor this standard to support improvements.**
Cancelled Operations on the day for a non-clinical reason Red: > 2% Green: < 2% **Urgent Operations Cancelled for a 2nd Time** Green 0 Red = > 0 **Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation** Red: Above zero	CQC **Cancelled operations data validation for April is in progress.**			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

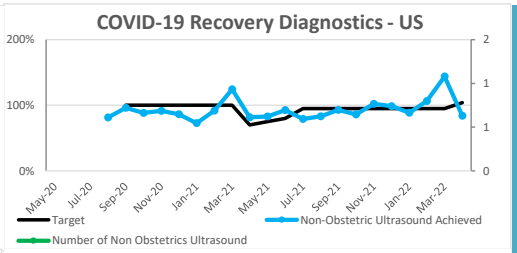
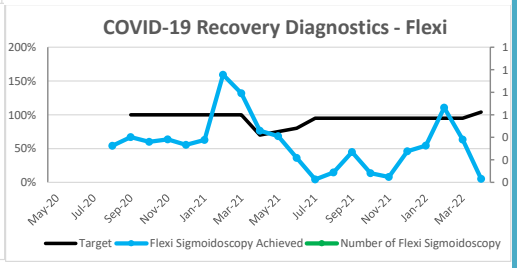
Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Super Stranded Patients **Green: Meeting Trajectory** **Red: Missing Trajectory**	**There were 302 stranded and 142 super stranded patients at the end of April 2022. A Superstranded Patient Trajectory has not yet been agreed for 2022/23.**	 	**The number of Super Stranded patients continues to remain high.**	**The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available throughout the pandemic.** **The Trust has introduced "Where's best next" Length of Stay meetings on a daily basis to support timely discharge.**
Outpatient Activity Delivered Remotely **Green 25% or more** **Red Less than 25%**	**11.67% of Outpatient Appointments were delivered remotely in month.**		**The Trust did not achieve the standard in month for % of outpatient appointments delivered remotely.**	**The Trust continues to identify opportunities to deliver additional outpatient activity remotely.**
Patients seen in the Fracture Clinic within 72 hours Green: 95% **Red: Less than 95%**	**11.36% of patients were seen in the Fracture Clinic within 72 hours in month.**		**Performance against the 72 hour standard deteriorated further into April. This is attributable to the impact of Wave 6 and associated sickness / impact on clinical services.**	**Fracture clinic performance has had a significant improvement in the last month, the % of patients now seen under 72 hours has increased considerably. The data on the fracture clinic dashboard shows an increase in compliance from April to May, from 15% to 76% respectively. This is being sustained by the introduction of the Virtual Fracture clinic (VFC) and will be further improved with the introduction of e-trauma software to support the VFC implementation in the coming weeks.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

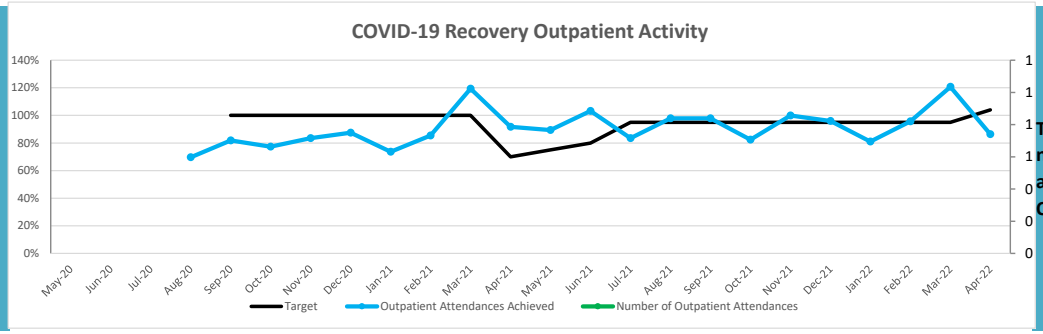
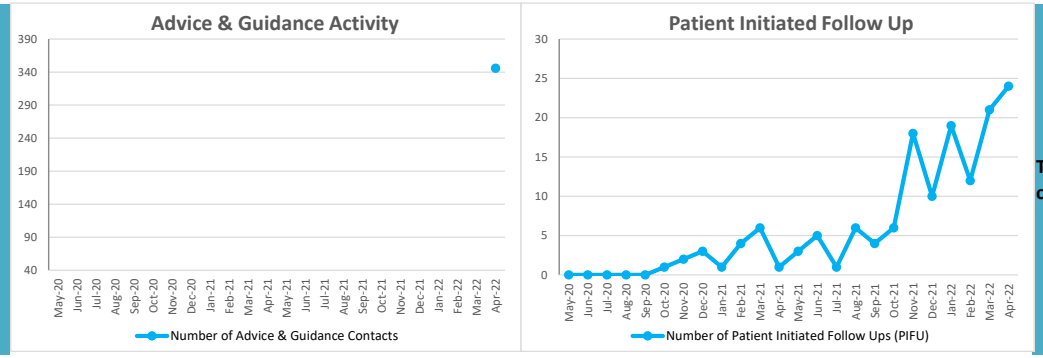
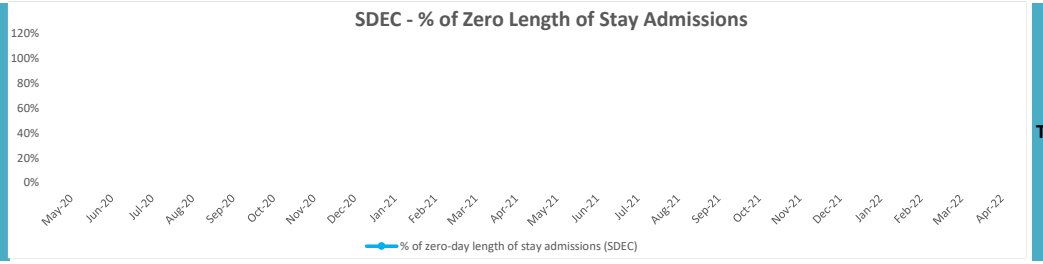
Key: Risk Register RR116 | System Oversight Framework SOF | Care Quality Commission CQC

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
COVID 19 Recovery Elective Activity RED Below Elective Recovery Target Green Elective Recovery Target % activity is against activity in the same month in 2019/20	SOF In April 2022, the Trust achieved the following % of activity against April 2020. This included 101.35% of Daycase Procedures and 94.82% of Inpatient Elective Procedures. RR1125			
COVID 19 Recovery Diagnostic Activity RED Below Elective Recovery Target Green Elective Recovery Target % activity is against activity in the same month in 2019/20	SOF In April 2022, the Trust achieved the following % of activity against April 2020. This included: 107.54% of MRI 117.13% of CT 83.93% of Non-Obstetric Ultrasound 5.15% of Flexi Sigmoidoscopy 13.13% of Colonoscopy 24.54% of Gastroscopy RR1125	 	The Trust did meet the diagnostic activity recovery trajectories for April 2022 across	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
COVID 19 Outpatient Activity RED Below Elective Recovery Target Green Elective Recovery Target % activity is against activity in the same month in 2019/20	SOF RR1125 In April 2022, the Trust achieved 86.44% of Outpatient activity against April 2020.		The April trajectory for Outpatients was not achieving due to the impact of Wave 6 and COVID-19 sickness, resulting in Outpatient Activity being stood down.	The Trust continues to restore clinical services in line with the national operating guidance.
Advice & Guidance (A&G) Activity Levels Patient Initiated Follow Up (PIFU) Activity Levels	The Trust completed 346 Advice & Guidance Contacts and 24 Patient Initiated Follow Ups in month.		The number PIFU and Advice & Guidance contacts continues to increase.	The Trust monitors progress weekly via PRG.
% of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions	This indicator is under development.		This indicator is under development.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

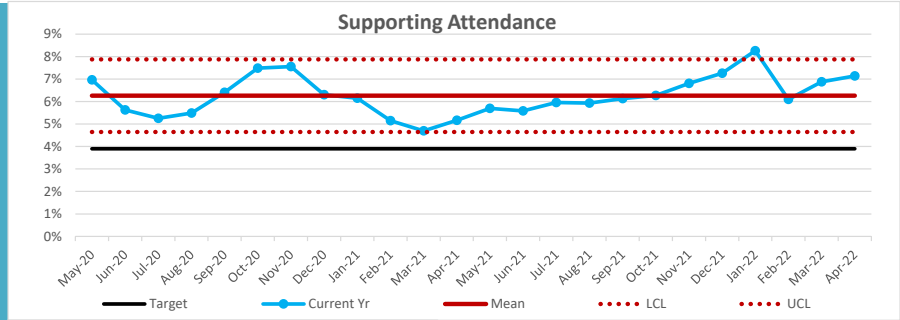
Key:
System Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

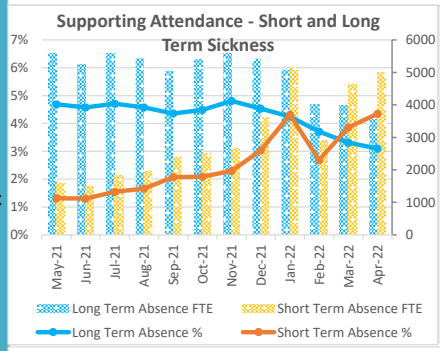
Trust Performance | **Trend** | **What are the reasons for the variation and what is the impact?** | **How are we going to improve the position (Short & Long Term)?**

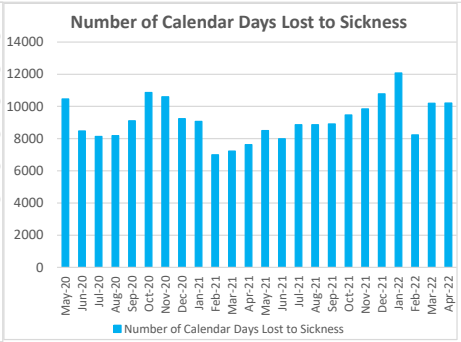
Supporting Attendance

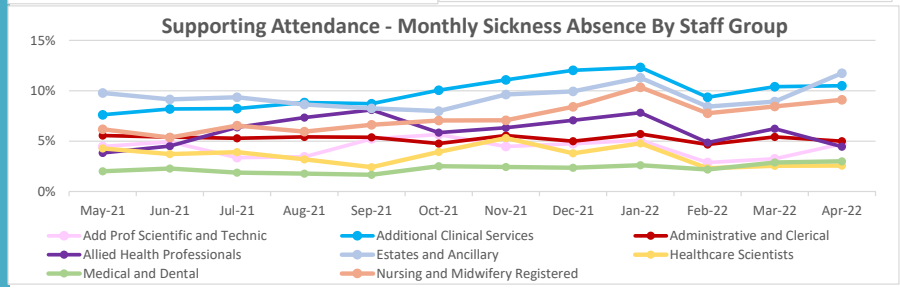
Red: Above 4.5%
Amber: 4.2% to 4.5%
Green: Below 4.2%

The Trust's sickness absence rate was 7.44% in month. There were 10,215 calendar days lost to sickness in month.









Sickness absence is 7.44% in April 2022.

Short term absence is 4.35% and 3.09% relates to long term absence.

Sickness absence in April 2021 was 5.46%.

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

The Supporting Attendance policy has been launched by the HR team in partnership with line managers and staff side partners. To support this work, which is part of wider project with NHSEI, a range of 1:1 management coaching sessions have been delivered to line managers and a number of bitesize briefings have been delivered within Care Group settings.

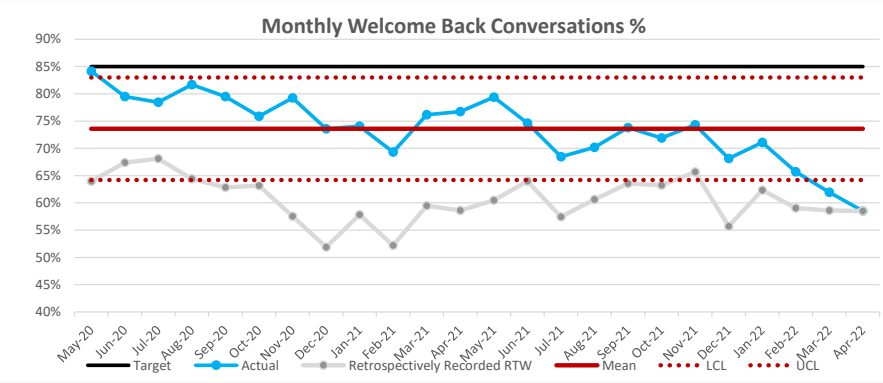
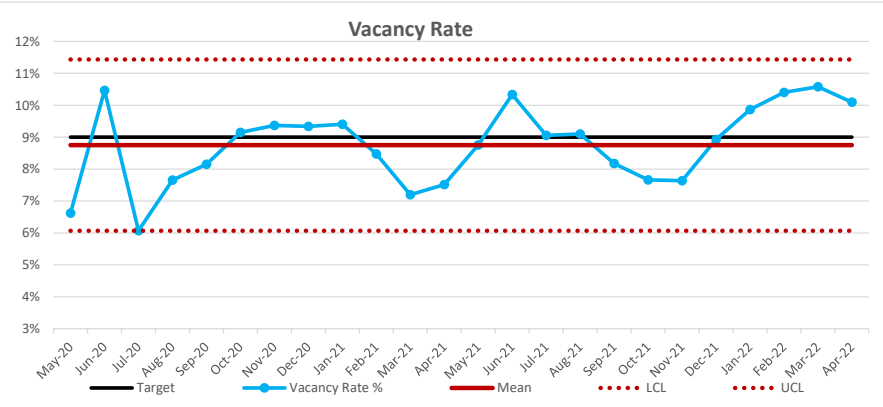
The new approach is also reflected in the updated Line Manager Development programme, where a full training session is available on Supporting Attendance and the ethos of supporting our workforce aligned to the learning from best practice organisations and feedback from our workforce.

The Occupational Health and Wellbeing team has continued to hold triangulation meetings with HR colleagues to review individuals under formal stages of Supporting Attendance Management and are developing bespoke interventions and enhanced support as required through case reviews.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Welcome Back Conversations Red: Below 75% Amber: 75% to 85% Green: Above 85%			
Welcome Back Conversation compliance was 58.51% in April 2022.		**Welcome Back compliance is 58.51% in April 2022.** **The previous months compliance has increased, as managers input historic Return to Work/Welcome Back Conversations that occurred but were not recorded on the system at the time. The 12-month compliance is 69.22%.**	**Specific support continues within areas of high sickness and low compliance.** **As part of Supporting Attendance project the RTWI has been refocused as Welcome Back Conversations. Bespoke training and one to one management coaching on Welcome Back Conversations is available and continues to be offered across all CBUs.** **In addition, there is full training available on the shift from Return to Work to "Welcome Back Conversations", which includes hints and tips on how to have those conversations focused on wellbeing and support for the individual.**
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or below			
The average number of working days to recruit is 76 days, based on the last 12 months average.		**Recruitment time to hire for April 2022 is 76 working days compared to 76 working days in April 2021. This includes notices periods.**	**The Recruitment team continues to engage with recruiting managers to ensure they are proactively considering recruitment timelines aligned to best practice.** **In addition, the team is promoting an inclusive recruitment approach, and supporting documentation. Training is available to support this. Once embedded further, an assessment will be made to understand the impact on attraction, supporting reduction in time to hire and potential retention within the organisation.** **It is anticipated that the development of NHS Jobs 3 will enable further options to improve time to hire – go live date is still delayed nationally.**
Vacancy Rates Red: 11% or Above Amber: 11% to 9% Green: 9% or Below			
UoR **The Trust's vacancy rate was 10.10% in March 2022.**		**The Trust headcount has reduced since February 2022 (which was the highest on record). This is due to an increase in the number of leavers.** **To improve attraction, the Trust's reward and benefit scheme has been updated and aligned to the "All About You" branding from both an internal and external perspective. The offer benchmarks very well against the national NHS "Health and Wellbeing Framework" and best practice identified from the staff engagement community of practice run by NHS Employers.** **Nursing, Medical and AHPs are all focusing on recruitment with various strategies in place to recruit into their vacancies. These range from targeted recruitment campaigns, early student engagement, recruiting into different clinical roles and growing our own workforce through staff development.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

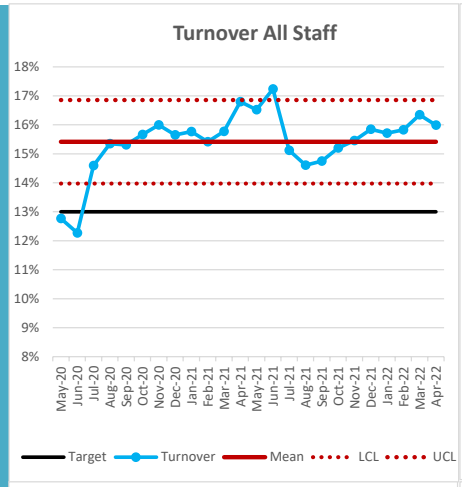
Key:
System Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

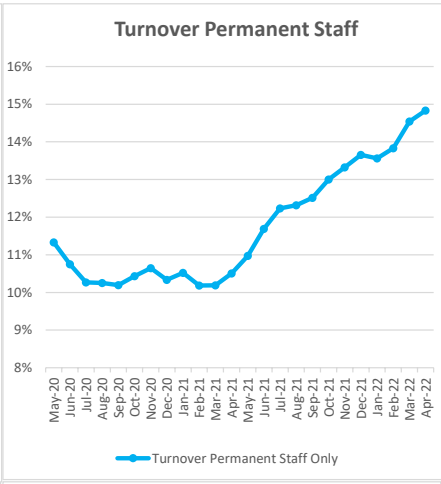
Trust Performance | **Trend** | **What are the reasons for the variation and what is the impact?** | **How are we going to improve the position (Short & Long Term)?**

Turnover

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

Turnover of All staff was 15.99% and Turnover of Permanent staff only was 14.83% in month.

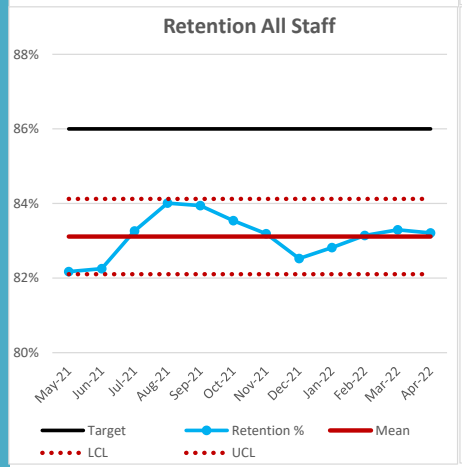


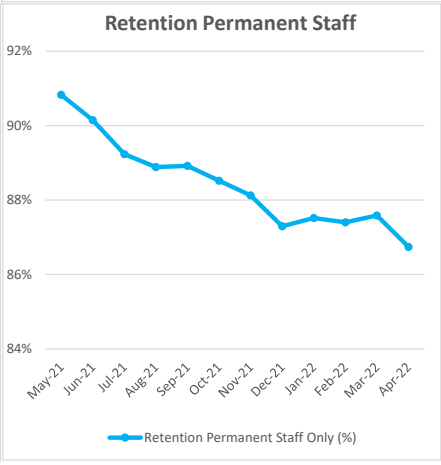


Retention

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

Retention of all staff was 83.21% and Retention of Permanent staff only was 86.74% in month.





Work-life balance continues to be the number one known reason people leave WHH, followed by retirement.

Work Life Balance

The Trust has joined the NHSEI Flex for Future programme and has established an Agile Working Task and Finish Group to develop a strategic approach to agile working and oversee any recommendations for implementation. The Task and Finish group had been paused but is now meeting again with representatives from all Care Groups and Staff Groups.

As a reminder the internal task and finish group will broadly follow the following objectives, based on the national programme:

1. Defining Flexible and Agile working. Understanding the legalities.
2. Understand the organisation's current Agile Working/Flexible Working culture.
3. Understand the systems available to support Flexible and Agile working
4. Develop an options appraisal for the WHH approach to Flexible and Agile working.
5. Develop material to support Flexible and Agile working promotion, training and toolkits.
6. Review Flexible and Agile working polices to align them to the agreed WHH approach.

Retirement

The Trust's pensions team reported a significant number of people delayed their retirement plans in 2020 and 2021, however, now a record numbers of individuals are choosing to retire.
It is worth noting a number of retirees do return to the workplace (retire and return) and are supported to do so, however these still count as a leaver for the purposes of retention and turnover.

Health, Wellbeing & Development

Throughout 2021, the Mental Wellbeing Team has been able to deliver:
- **2056 calls with staff accessing services themselves or managers seeking advice and support for their staff**
- **3842 emails with staff accessing services themselves or managers seeking advice and support for their staff**
- **3254 1:1 sessions or group setting interventions**

Working proactively to meet the demands of the Trust, over 40 areas have been supported delivering over 150 workshops and training sessions that are open to all staff and include group sessions on CBT, anxiety and resilience.
A further programme of work with Brathay has now been secured offering a 'lite' version over 2022 (without the residential aspect).
The Trust continues to work with Rugby League Cares, ex-professional rugby players that have gone on to specialise in wellbeing and counselling. They provide a range of physical and mental fitness offers to the workforce.
The Trusts first grief and menopause cafes have taken place which offer guided support sessions with both virtual and face to face offers each month.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

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

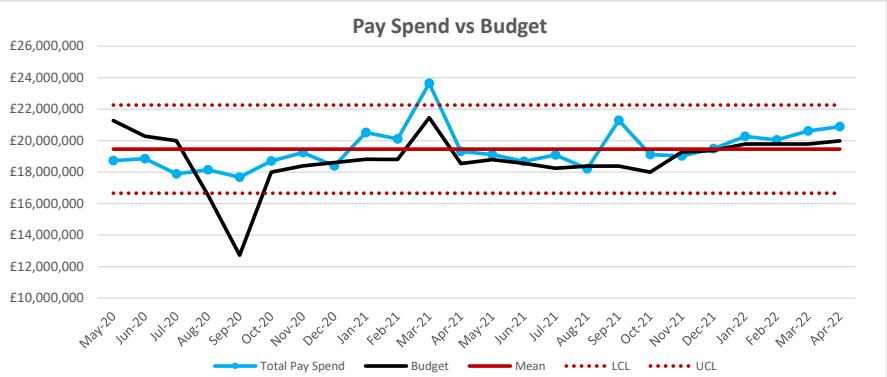
Pay

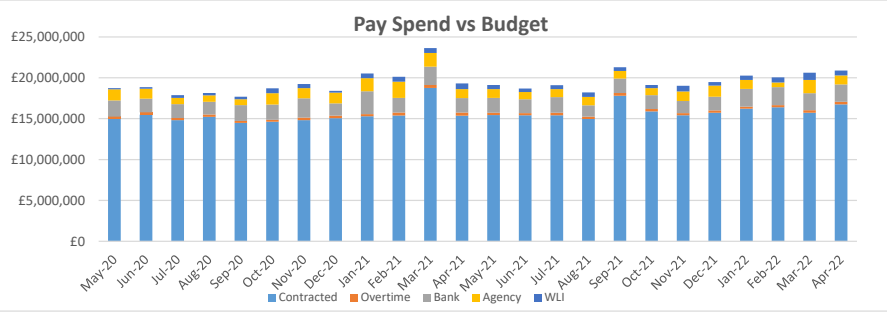
Red: Greater than Budget

Green: Less than Budget

UoR

Total pay spend in April 2022 was £20.9m against a budget of £20.0m.





Total pay spend in April 2022 was £20.9m against a budget of £20.0m.

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

- **£16.8m contracted**
- **£2.1m Bank**
- **£1.1m Agency**
- **£0.61m WLI**
- **£0.31m Overtime**

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

- **ECF process for non-clinical vacancies approval**
- **ECF process for bank and agency temporary staffing pay spend approval**

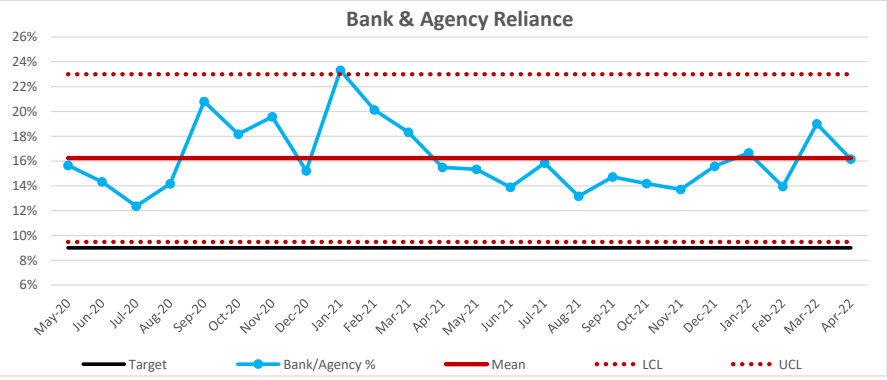
Through the Finance and Sustainability committee, compliance against our processes and rate cards continues to be monitored.

Bank and Agency Reliance

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

UoR

Bank and Agency Reliance was 16.15% in month.



Bank and Agency reliance peaked at 23.30% in January 2021. In April 2022, reliance is 16.15%.

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

A review and implementation of a rate escalation process is underway which aims to bring the rate of escalations down and add additional controls.

The WLI rates and process are also under review.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

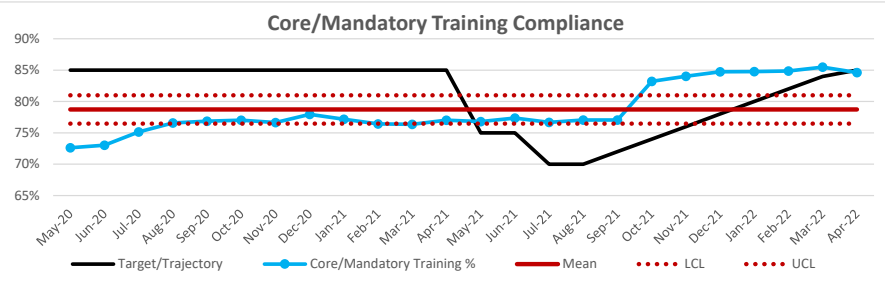
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Core/Mandatory Training

Red: Below 85%
Green: 85% or above

CQC

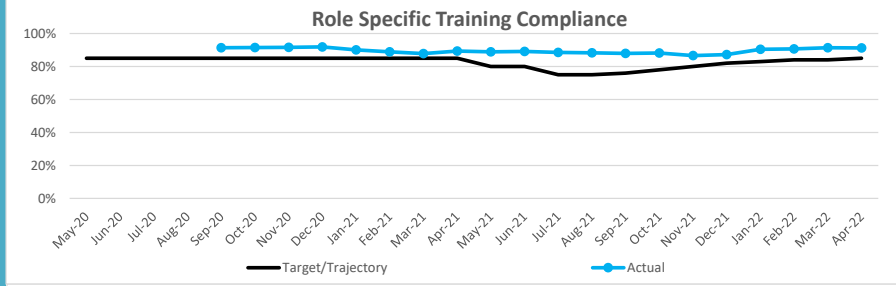
Core/Mandatory training compliance was 84.61% in month.



Role Specific Training

Red: Below 85%
Green: 85% or above

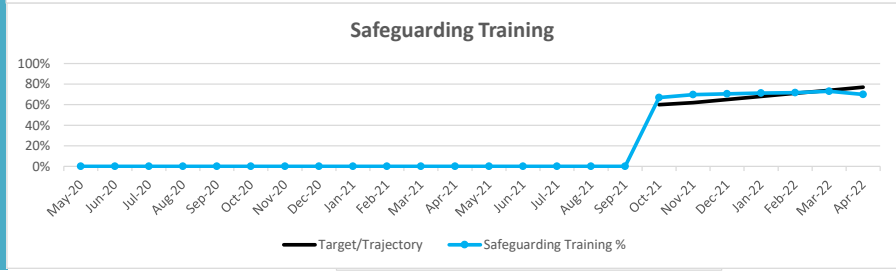
Role Specific Training compliance was 91.26% in month.



Safeguarding Training

Red: Below Trajectory
Green: Trajectory

Safeguarding Training compliance was 70.00% in month.



In April 2022 Mandatory Training compliance was 84.61%, this now excludes Safeguarding Training (Children's and Adults); Safeguarding compliance was 70.00%, and Role Specific Training compliance was 91.26%.

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

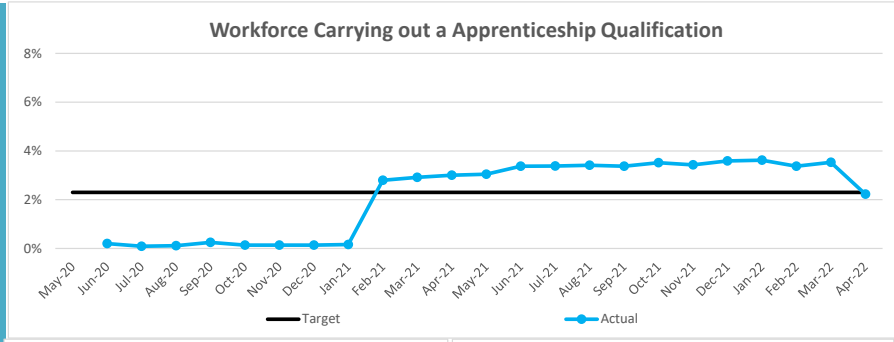
Key:
System Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

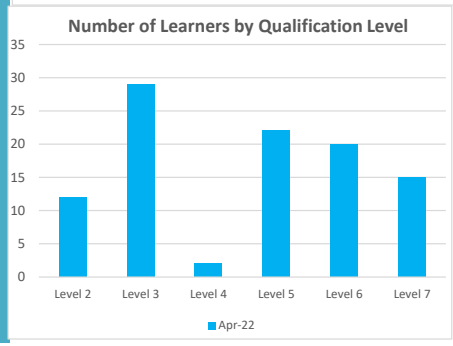
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

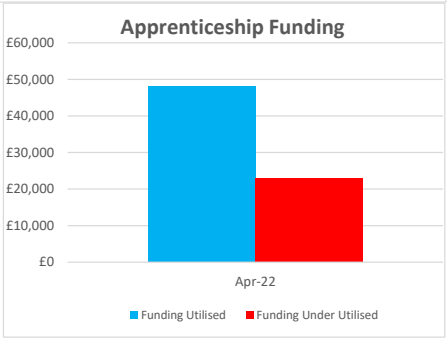
Workforce carrying out an Apprenticeship Qualification

Red: below 1.5%
Amber: 1.5% 2.2%
Green: 2.3% or above

2.23% of staff were carrying out a qualification in month.







2.23% of staff are carrying out a qualification, which is slightly below target. This indicator now provides greater detail on how the Trust is spending the apprenticeship levy by demonstrating both the range of course levels and a summary on the spent and unspent levy.

This detail will enable targeted actions to be developed and reported on in future reports.

<u>Information</u>
Level 2 is the equivalent of NVQ Level 7 is the equivalent of a Masters

Generally, the higher-level courses cost more, using more of the levy.

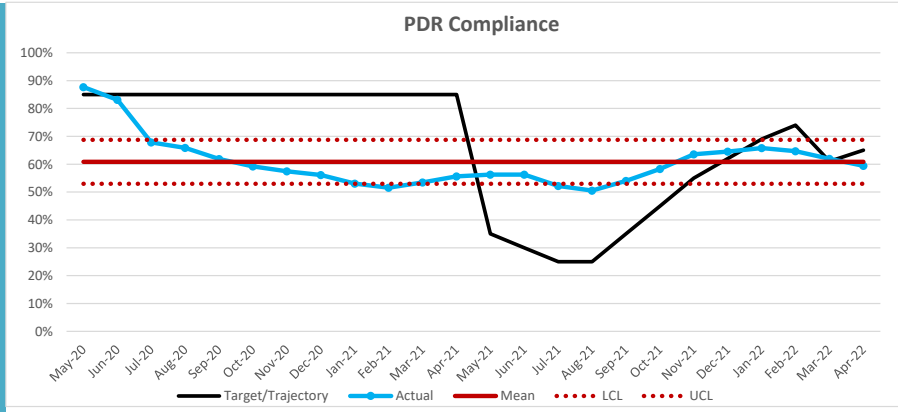
Levy that is unspent for 24 months is returned to the DoH.

The apprenticeship levy continues to be challenged for new recruitment episodes and the uptake of formal training.

PDR

Red: Below 85%
Green: 85% or above

PDR compliance was 59.39% in month.



In April 2022, PDR compliance was 59.39%

Currently PDR rates are below the trajectories.

An improvement trajectory to return to above target compliance has been in place since July 2021 and following Operational pressures and COVID, the trajectory has been reviewed and extended until July 2022. The Check In conversation has also been extended until July 2022.

The CBUs have been and continue to be, supported to develop trajectories to improve compliance, including use of the Wellbeing Check In conversation where appropriate, these are monitored through the Workforce governance structure.

PDR Appraisal training is available and widely promoted, the People Directorate are also hosting PDR Appraisal Training Drop-in & Q&A sessions (Monthly).

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
- SOF – System Oversight Framework
- UoR – Use of Resources Assessment
- RR116 – Risk Register
- SOF – Care Quality Commission
- UoR – Trust Strategy
- CQC
- ☆

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

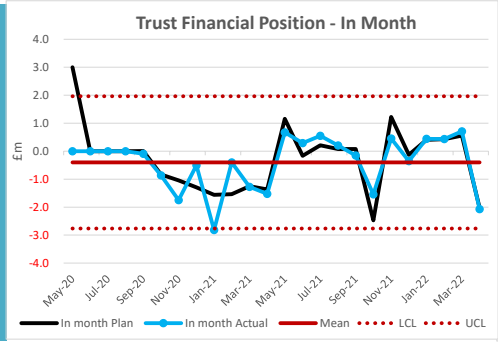
Trust Financial Position

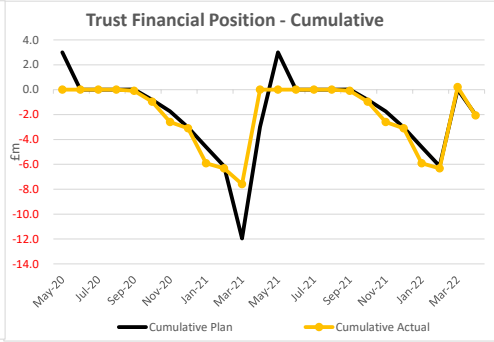
Red: Deficit Position
Amber: Actual on or better than planned but still in deficit
Green: Surplus Position

UoR SOF ☆

The Trust has recorded a deficit position of £2.07m which is worse than plan by £0.05m as at 30 April.

RR134





For the period ending 30 April 2022, the Trust has recorded a deficit of £2.07m, against a planned deficit of £2.02m. The position excludes £0.5m ERF offset with underspends in other areas of the organisation.

The Trust is forecasting a £16.8m deficit.

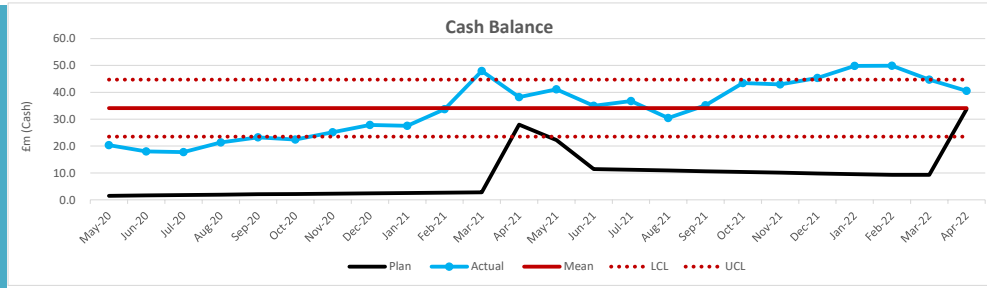
Cash Balance

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

UoR

The current cash balance is £40.6m.

RR134



The current cash balance is £40.6m which is £6.8m better than the initial cash plan. The current high cash balance is due to a delay in capital payments as invoices have not been received from suppliers/contractors.

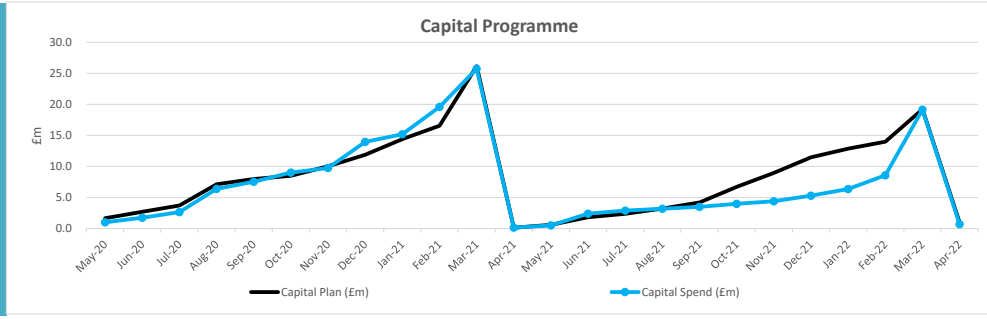
Payment of the capital creditors on receipt of invoices will get the cash back to plan.

Capital Programme

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

UoR

The year to date capital spend in month 1 was £0.71m.



The Trust funded annual capital plan is £12.8m of which £2.8m is the ED Plaza monies brokered to the C&M system in 2021/22. The actual spend year to date is £0.71m which is £0.26m below the planned spend of £0.97m. There are a further £10.2m of schemes planned which will be funded from external sources.

The capital programme is currently oversubscribed and the Trust has submitted several capital bids to the Cheshire & Mersey ICS and is awaiting the outcome.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
- SOF — System Oversight Framework
- UoR — Use of Resources Assessment
- RR116 — Risk Register
- SOF — Care Quality Commission
- UoR — Trust Strategy
- CQC
- ☆

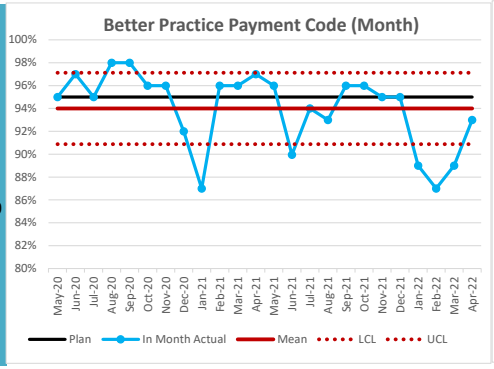
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

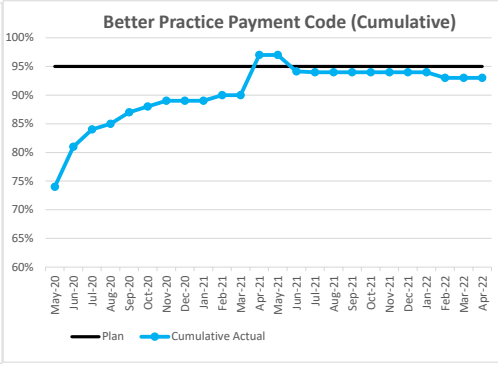
Better Payment Practice Code

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

UoR

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





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

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

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

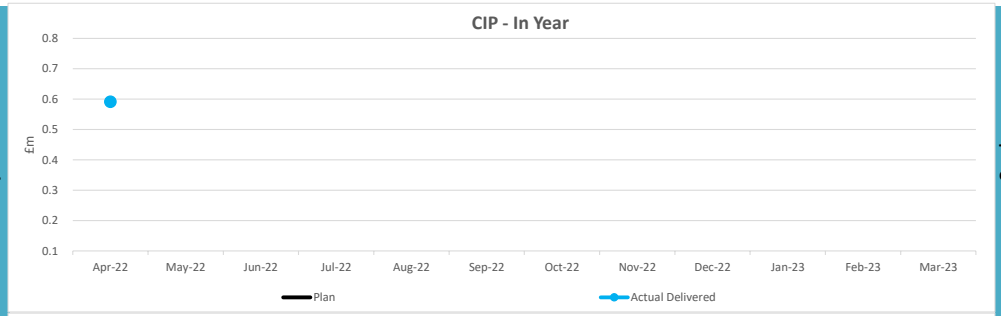
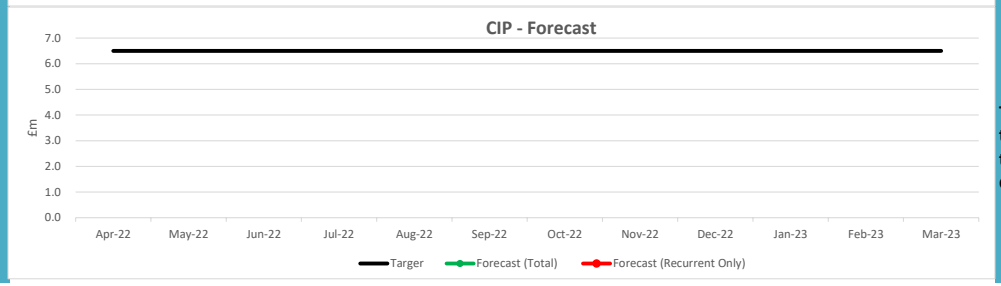
UoR

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
- SOF — System Oversight Framework
- UoR — Use of Resources Assessment
- RR116 — Risk Register
- CQC — Care Quality Commission
- Trust Strategy

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR **The year to date savings are £0.6m.**		**The year to date savings are £0.6m against a plan of £0.7m.**	**CIP progress is reviewed on a weekly and monthly basis. The Medical Director is leading the GIRFT conversations with the Operational Teams supported by Finance and the Transformational Leads to drive greater efficiency across the Trust.**
The Trust is in the process of identifying recurrent CIP schemes for 2022/23.		**The Trust is working to identify recurrent CIP to the value of the £6.5m recurrent target (of the total CIP target of £14.0m). A key driver will be GIRFT efficiencies through out the Trust.**	**To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT is being used.**

Cost Improvement Programme In Year
Red: 0 70% Plan delivered YTD
Amber: 70 90% Plan delivered YTD
Green: >90% Plan delivered YTD

Cost Improvement Programme (Forecast)
Red: Forecast is less than 50% of annual target
Amber: Forecast is between 50% and 90% of the annual target
Green: Forecast is more than 90% of the annual target

Appendix 4 – Trust IPR Indicator Overview

Indicator	Detail
Quality	
Incidents	• Number of incidents reported in month. • Number of incidents open over 20 days and 40 days. • Number of serious incidents reported in month. • Number of serious incidents where actions have breached the timescale. • Number of never events reported in month.
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 the Trust contacts the patient or their family to advise of the incident; this has to be done 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. • MSSA, or methicillin-susceptible Staphylococcus aureus, is an infection caused by a type of bacteria commonly found on the skin. • Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. • Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections. • Klebsiella is a type of Gram-negative bacteria that can cause different types of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis. • Pseudomonas aeruginosa can cause infections in the blood, lungs (pneumonia), or other parts of the body after surgery.
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, however this indicator is reported quarterly.
Inpatient Falls & Harm Levels	• Total number of falls which have occurred in month. • Falls per 1000 bed days in month. • Total number of inpatient falls which have occurred in month. • Levels of harm reported as a result of a fall in month. • Level of avoidable harm which has occurred in month.
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. Pressure ulcers are reported by Category (2,3 & 4).
Medication Safety	Overview of the current position in relation to medication, to include: • Medication reconciliation within 24 hours. • Medication reconciliation throughout the inpatient stay. • Number of controlled drugs incidents. • Number medication incidents resulting in harm.

Staffing Average Fill Levels	• Percentage of planned verses actual fill rates for registered and non-registered staff by day and night. 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. This indicator monitors Trust compliance against NICE guidance.
Complaints	Overall review of the current complaints position including; • Number of complaints received in month. • Number of dissatisfied complaints in month. • Total number of open complaints in month. • Total number of cases over 6 months old in month. • Number of cases referred to the Parliamentary and Health Service Ombudsman (PHSO) in month. • Number of complaints responded to within timeframe in month. • Number of PALS complaints received and closed in month.
Friends and Family Test (Inpatient & Day Cases)	• Percentage of Inpatients and day case patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?
Friends and Family (ED and UCC)	• Percentage of AED (Accident and Emergency Department) patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?
Continuity of Carer	• Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives. This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience.
Sepsis	• To strengthen oversight of sepsis management in regard to treatment and screening. All patients should be screened within 1 hour and if necessary administered anti-biotics within 1 hour.
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.

Acute Kidney Injury	• Number of hospital acquired Acute Kidney Injuries (AKI) in month. • Average Length of Stay (LoS) of patients within a AKI.
National Patient Safety Alerts not completed by deadline	• Number of CAS (Central Alerts System) alerts with actions not completed by the deadline.
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.
RTT Open Pathways and 52 & 104 week waits	• Percentage of incomplete pathways waiting within 18 weeks. • Number of patients waiting over 52 weeks. • Number of patients waiting over 104 weeks.
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.
A&E Waiting Times Over 12 Hours (Decision to Admit to Admission)	• % of patients who has experienced a wait in A&E longer than 12 hours from the presentation to admission, transfer or discharge.
Average Time in Department (ED)	• How long on average a patient stays within the emergency department (ED).
Cancer 14 Days	• All patients need to receive their first appointment for cancer within 14 days of urgent referral.
Breast Symptoms – 14 Days	• All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.
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.
Cancer 31 Days - First Treatment	• All patients to receive first treatment for cancer within 31 days of decision to treat.
Cancer 31 Days - Subsequent Surgery	• All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery.
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.
Cancer 62 Days - Urgent	• All patients to receive first treatment for cancer within 62 days of an urgent referral.
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.
Ambulance Handovers 15	• % of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).
Ambulance Handovers 30 – 60 minutes	• % of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).
Ambulance Handovers – more than 60 minutes	• % of ambulance handovers that took place within 60 minutes (based on the data recorded 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.
COVID-19 Recovery Diagnostics	• % of Diagnostic Activity against the same period in 2019/20.
COVID-19 Recovery Outpatients	• % of Outpatient Activity against the same period in 2019/20.
Fracture Clinic	• The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.
% Outpatient Attendances Delivered Remotely	• Part of the transformation of outpatient care, this indicator will monitor the % of outpatient appointments delivered remotely via telephone or video consultation.
Advice & Guidance (A&G) Activity Levels	• Number of Advice & Guidance contacts in month.
Patient Initiated Follow Up (PIFU) Activity Levels	• Number of Patient Initiated Follow Ups (PIFU) in month.
% of zero-day length of stay admissions (SDEC)	• % of zero length of stay admission (SDEC).
Workforce	
Supporting Attendance	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year.
Welcome Back Conversations	A review of the completed monthly return to work interviews.
Recruitment Timeframe	A measurement of the average number of days it is taking to recruit into posts.
Vacancy Rates	% of Trust vacancies against whole time equivalent.
Retention	Staff retention rate % over the last 12 months.
Turnover	A review of the turnover % over the last 12 months.
Bank & Agency Reliance	The Trust reliance on bank/agency staff.
Pay Spend – Contracted and Non-Contracted	A review of Contracted and Non-Contacted pay against budget.
Core/Mandatory Training	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation.
Role Specific Training	A summary of role specific training compliance.
Safeguarding Training	A summary of safeguarding training compliance.
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.
Cash Balance	The cash balance at month end compared to plan.
Capital Programme	Capital expenditure compared to plan.
Better Payment Practice Code	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
Use of Resources (Finance)	Suspended – awaiting further guidance from NHSE/I
Cost Improvement Programme – Plans in Progress in Year	Cost savings schemes in-year compared to plan.
Cost Improvement Programme – Recurrent)	Cost savings schemes recurrent compared to plan.

Appendix 5 - Statistical Process Control

1.0 What is SPC?

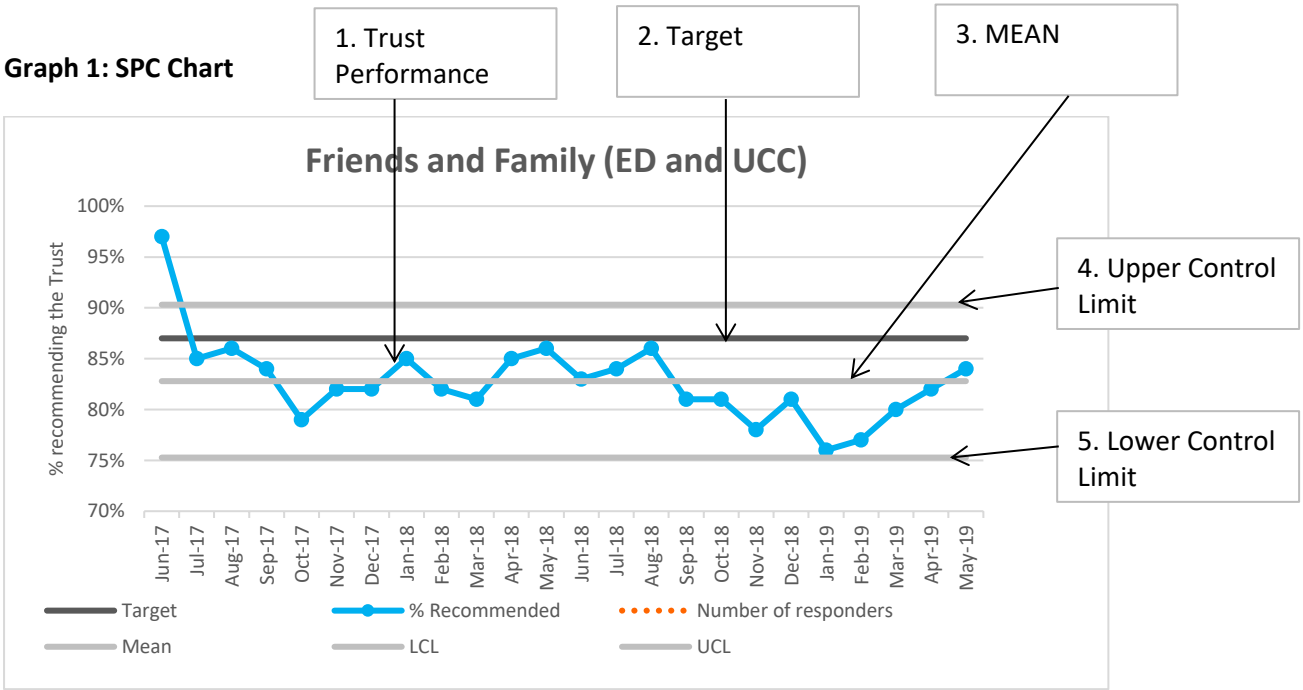
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

2.0 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 trends or patterns.
- 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

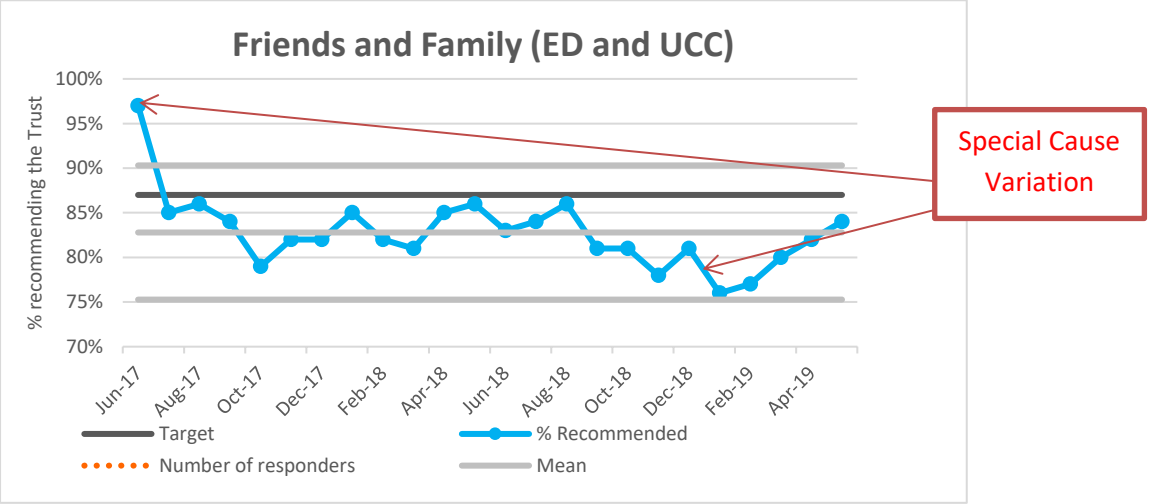


2.1 Interpreting a SPC Chart

There are 3 main rules to interpreting a SPC chart, if one of these rules is broken, this means that there is special cause variation present and that the process is not in control and requires investigation. Please note that breaching a rule 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.

Graph 2: Outlining Special Cause Variation



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 is possible for a process to be within control but not meeting the target.

3.0 Making Data Count Assurance & Variation Icons

For 2022/23 the Trust has introduced the "Making Data Count" variation and assurance icons. These can be found in Appendix 2. Each indicator (where relevant) has been given one of the three assurance icons and one of the five variation icons which is based solely on the data and the SPC rules. Ideally the assurance icon should be blue "P" icon which notes the indicator is consistently passing its target over the last 6 months. Again, ideally the variation icon should be either the grey "common cause variation" icon or a blue "H" or "L" icon noting improving variation. The orange icons note potential concern.

Table 1: Making Data Count Assurance & Variation Icons

Assurance			Variation		
					
Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target	Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

3.1 Business Rules

- Where there are not enough data points for an SPC chart, the target is based on a cumulative position (e.g. an annual target) or SPC is not appropriate, a "No SPC" icon is utilised as outlined below.

- Assurance icons are based on the last 6 months. E.g. if the Trust has consistently passed a target in the last 6 months the blue "P" icon will be used.
- The Variation icon is based on the last data point. If the last data point means that the one of the SPC rules described in section 2.1 of this appendix is broken, the appropriate coloured "H" or "L" icons will be used to indicate special cause variation. The variation is common cause, the grey common cause variation icon will be used.

Appendix 6

Income Statement, Activity Summary and Use of Resources Ratings as at 30th April 2022

Income Statement	Annual	Month			Year to date		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
NHS Clinical Income							
Elective Spells	32,872	2,496	1,932	-564	2,496	1,932	-564
Elective Excess Bed Days	352	26	0	-26	26	0	-26
Non Elective Spells	73,714	5,241	6,267	1,026	5,241	6,267	1,026
Non Elective Bed Days	2,001	143	165	22	143	165	22
Non Elective Excess Bed Days	2,865	204	21	-183	204	21	-183
Outpatient Attendances	43,350	3,446	2,964	-482	3,446	2,964	-482
Accident & Emergency Attendances	16,393	1,392	1,453	61	1,392	1,453	61
Other Activity	68,946	7,933	7,981	47	7,933	7,981	47
COVID Top up Income (Liverpool CCG)	43,579	2,792	2,792	0	2,792	2,792	0
Sub total	**284,072**	**23,674**	**23,575**	**-99**	**23,674**	**23,575**	**-99**
Non NHS Clinical Income							
Private Patients	0	0	0	0	0	0	0
Non NHS Overseas Patients	0	0	1	1	0	1	1
Other non protected	996	83	21	-62	83	21	-62
Sub total	**996**	**83**	**22**	**-61**	**83**	**22**	**-61**
Other Operating Income							
Training & Education	**9,093**	**758**	**758**	**0**	758	758	0
Donations and Grants	2,910	566	0	-566	566	0	-566
Miscellaneous Income	12,532	961	1,292	331	961	1,292	331
Sub total	**24,535**	**2,285**	**2,050**	**-235**	**2,285**	**2,050**	**-235**
Total Operating Income	**309,604**	**26,042**	**25,647**	**-395**	**26,042**	**25,647**	**-395**
Operating Expenses							
Employee Benefit Expenses	-234,434	-19,985	-20,439	-455	-19,985	-20,439	-455
Drugs	-17,585	-1,481	-1,655	-174	-1,481	-1,655	-174
Clinical Supplies and Services	-20,415	-1,761	-1,650	111	-1,761	-1,650	111
Non Clinical Supplies	-32,995	-2,763	-2,584	179	-2,763	-2,584	179
Depreciation and Amortisation	-13,703	-1,142	-1,066	76	-1,142	-1,066	76
Net Impairments (DEL)	0	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0	0
Total Operating Expenses	**-319,132**	**-27,132**	**-27,395**	**-262**	**-27,132**	**-27,395**	**-262**
Operating Surplus / (Deficit)	**-9,528**	**-1,090**	**-1,747**	**-657**	**-1,090**	**-1,747**	**-657**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	0	0	0	0	0
Interest Income	108	9	31	22	9	31	22
Interest Expenses	-154	-13	-16	-3	-13	-16	-3
PDC Dividends	-4,506	-376	-376	0	-376	-376	0
Total Non Operating Income and Expenses	**-4,552**	**-379**	**-360**	**19**	**-379**	**-360**	**19**
Surplus / (Deficit) - as per Accounts	**-14,080**	**-1,470**	**-2,108**	**-638**	**-1,470**	**-2,108**	**-638**
Adjustments to Financial Performance							
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0	0	0	0
Less Donations & Grants Income	-2,910	-566	0	566	-566	0	566
Add Depreciation on Donated & Granted Assets	192	16	39	23	16	39	23
Total Adjustments to Financial Performance	**-2,718**	**-550**	**39**	**589**	**-550**	**39**	**589**
Adjusted Surplus / (Deficit) as per NHSI Return	**-16,798**	**-2,020**	**-2,068**	**-48**	**-2,020**	**-2,068**	**-48**

Activity Summary	Planned	Planned	Actual	Variance	Planned	Actual	Variance
Elective Spells		2,563	2,170	-393	2,563	2,170	-393
Elective Excess Bed Days		84	0	-84	84	0	-84
Non Elective Spells		3,201	2,249	-952	3,201	2,249	-952
Non Elective Bed Days		386	447	61	386	447	61
Non Elective Excess Bed Days		696	70	-626	696	70	-626
Outpatient Attendances		38,364	33,245	-5,119	38,364	33,245	-5,119
Accident & Emergency Attendances		9,253	9,628	375	9,253	9,628	375

Appendix 7: Capital Programme

Scheme Name	Approved Programme 2022/23 £000	Emergency Requests Mth 1 2022/23 £000	Proposed Budget Adjustments in Mth 1 2022/23 £000	PDC Adjustments in Mth1 2022/23 £000	Total Revised Budget 2022/23 £000
ESTATES					
ED Plaza	2,859				2,859
Paeds (Childrens Outpatients)	130				130
Urology (Estates)	240				240
ED Plaza further slippage	115				115
L Shaped Roof	129				129
Nurse Call Minor injuries	25				25
CMTC Replacement Emergency Lighting	72				72
ED Plaza - Dr Mess room (Exec Lead)	141				141
Breast Relocation of Breast Equipment (Kendrick to Bath Street)	30				30
Shopping City 21/22 underspend	35				35
Shopping City Retension of 2.5%	18				18
Appleton Ventilation Upgrade	300				300
Fire schemes deferred from 21/22	300				300
Estates Capital Staffing	260				260
Appleton Fire doors final phase	200				200
Dementia & Accessibility - Site Wide	200				200
Repairs to roads & footpaths across both sites	150				150
Fixed electrical testing site wide	150				150
Emergency lighting to stairwells and exits	115				115
Appleton Wing fire dampers final phase	100				100
CCTV Upgrade site wide	50				50
6 Facet Annual Survey Review	55				55
Replacement of AVSU's - part 2	40				40
Safe surface temperatures (radiators) final part	30				30
Annual Asbestos Site Management survey	30				30
ED Fire Barrier (actual work for above - added 28/02/2022)	125				125
Catering Upgrade	1,800				1,800
Removal of C21 Bathroom and installation of storage	24				24
Induction of Labour Ward (Lucy Gartside)	300				300
	0				0
	0				0
					0
Estates Total	8,023	0	0	0	8,023
IM&T					
005 Cisco Refresh (Phase 1)	22				22
007 IP Telephony	27				27
EPMA 1-4	8				8
Electronic Patient Record Procurement	50				50
Patient Flow (Tif)	10				10
Cisco Refresh Phase 2	817				817
IT Staffing	316				316
Tech Refresh 22/23	85				85
Halton SAN Refresh (DR site)	200				200
Network Switches - reduced network switches to £49k per HG 16.	49				49
Programme and Benefits Resource/Phase 2 Structure	165				165
EPR	155				155

New Maternity System - Extended Project Management Support	109				109
Comms Cabinets (Phase 3)	100				100
					0
Information Technology Total	**2,113**	**0**	**0**	**0**	**2,113**

MEDICAL EQUIPMENT					
Image Intensifer	78				78
Urology Equipment - Bladder Scanner	10				10
Video Laryngoscope	13				13
Decontamination Shelter	2				2
Hamilton Cold Vent	0				0
Radiology - Fluoroscopy Room (turnkey costs)	105				105
Mammography Equipment Replacement (enabling works only)	50				50
Video Laryngoscopes	77				77
Neonatal Scanner	104				104
Security - NEST/neonatal unit/C23/Paediatrics	50				50
Obstetric Portable Ultrasound Machine	27				27
UCC X-ray Turnkey costs	80				80
Microtomes and slide writers	25				25
Platelet Incubator / Agitator	8				8
Audiology ABR replacement	22				22
Resuscitaires	91				91
Replacement of the Pharmacy Automated Dispensing System	1,084				1,084
Spine Coil		19			19
					0
Medical Equipment Total	**1,826**	**19**	**0**	**0**	**1,845**

Total Trust Funded Capital	**11,962**	**19**	**0**	**0**	**11,981**

CONTINGENCY					
Prior Year Adjustments (VAT Rebates)	0				0
Contingency	802	(19)			783
	0				0
Contingency Total	**802**	**(19)**	**0**	**0**	**783**
Total Trust Funded Capital	**12,764**	**0**	**0**	**0**	**12,764**

Schemes that can only go ahead if Externally Funded					
Warrington Town Deal Health and Wellbeing Hub- Capital Works	2,560				2,560
Shopping City 21/22 underspend (added 04/02/2022)	350				350
Halton Elective Centre (TIF Funding/PDC)	1,367				1,367
Community Diagnostic Centre (CDC) - Estates	2,400				2,400
Community Diagnostic Centre (CDC) - Equipment	3,510				3,510
Total Externally Funded	**10,187**	**0**	**0**	**0**	**10,187**
Grand Total	**22,149**	**0**	**0**	**0**	**22,951**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/55 (a)**			
SUBJECT:	**Safe Staffing Assurance Report – December 2021 and January 2022**			
DATE OF MEETING:	25 May 2022			
AUTHOR(S):	Ali Kennah, Deputy Chief Nurse#			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.			
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	*		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	#115 Failure to provide adequate staffing levels in some specialities and wards.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper details ward staffing data for the months of February and March 2022. Ward staffing data continues to be systematically reviewed to ensure the wards and departments are safely staffed. Mitigation was provided and associated actions put in place when a ward was below 90%, minimum staffing percentage of planned staffing levels. Registered nurse and midwife sickness absence in the month of February was recorded at 6.95%. Sickness data in March increased to 7.24%. In the month of February 11 of the 21 wards were above 90% target fill rate and in the month of March there were 9 wards. To ensure safe staffing levels are maintained, mitigation and responsive plans were implemented to ensure that there is safe delivery of patient care. Care hours per patient day (CHPPD) in February was 7.2 and 7.1 in March, with a year-to-date rate 7.6. This report provides assurance that the Trust is safely staffed, and staffing is monitored as appropriate.			
PURPOSE: *(please select as appropriate)*	Information *	Approval	To note *	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	**Strategic People Committee**		
	Agenda Ref.	SPC/22/05/55		
	Date of meeting	18th May 2022		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Safe Staffing Assurance Report – February & March 2022	AGENDA REF:	BM/22/05/55(a)

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report – February and March 2022.

The purpose of this report is to provide assurance with regard to the nursing and midwifery ward staffing levels during the months of February and March 2022. The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 and in their recommendations in 2018, that Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability.

Due to the continued increased absences within the nursing and midwifery staff groups across the Trust as a result of COVID-19, existing measures in place to support safe staffing, such as the pay incentive scheme, were extended until the end of February 2022. A paper was presented to Trust Board in January 2022 outlining the measures in place and the results of a benchmark exercise completed to provide assurance of the plans for safe staffing in line with NHSE/I recommendations (Appendix 1).

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

2. KEY ELEMENTS

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

During the months of February and March 2022 ward staffing data continued to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels.

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

In the month of February and March 2022, 11 of the 21 wards were above their planned 90% target of registered nursing staff for the day shift (Appendix 2&3). To ensure safe staffing levels, mitigation and

responsive plans were implemented by the senior nursing team based on acuity and activity for the areas that did not meet 90%.

Red Flags

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

Care Hours Per Patient Day (CHPPD)

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

Table 1 illustrates the monthly CHPPD data. In the month of February 2022 CHPPD was recorded at 7.2 and March 2022 recorded at 7.1 with a 2021/22 YTD figure of 7.6.

Safer Staffing returns 2016/17 onwards - For Transformation's Nursing R&R KPIs Report

CBU	(All)	Spec1	(All)
Site Name	(All)	Spec2	(All)
Ward	(All)		

		Data			
Finyear	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2021/22	Apr	13769	4.4	3.3	7.7
	May	13645	4.6	3.5	8.1
	Jun	13134	4.5	3.4	7.9
	Jul	13964	4.4	3.3	7.6
	Aug	13479	4.7	3.3	8.0
	Sep	13428	4.5	3.3	7.8
	Oct	14131	4.5	3.1	7.6
	Nov	14726	4.3	3.0	7.3
	Dec	14448	4.7	2.9	7.7
	Jan	14174	4.8	3.1	7.9
	Feb	13901	4.3	2.9	7.2
	Mar	15320	4.3	2.8	7.1
2021/22 Total		168119	4.5	3.1	7.6

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

Staffing Levels and Harm

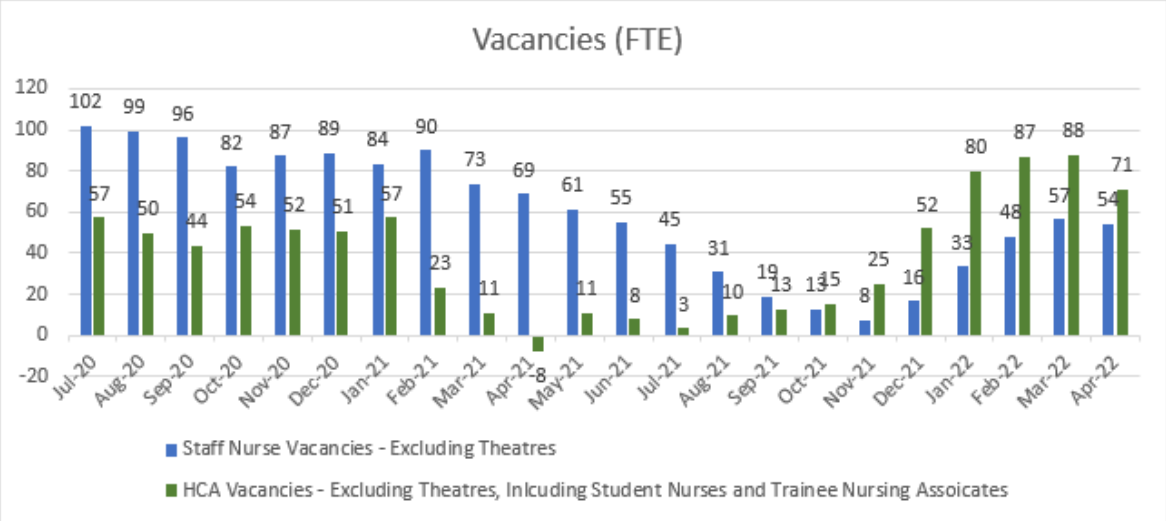
Triangulation of staffing levels with reported harm for 2021/2022 was presented at May Quality Assurance Committee and demonstrates an increase in harm in relation to reduced staffing levels (Appendix 4).

- Falls with harm increased by 75% (14 in 2021-2022, 8 recorded 2020-2021)
- Pressure ulcers increased by 10.8% (92 in 2021-2022, 83 recorded in 2020-2021)
- 135% Increase in moderate harm in Emergency Department (33 reported in 2021-22, 14 reported in 2020-2021)
- Up to 53 escalation beds opened at any one time
- Increased 12 hour breaches in ED
- Increased patients with no right to reside
- RED Flag system to escalate staffing concerns
- RAG status in place to record level of staffing
- Twice daily acuity and dependency review by senior nurse of RAG status and red flags
- 63% of red flags unresolved in Q3 and Q4- which is when the highest concentration of harms have occurred.
- Unresolved red flags are monitored during the day and evening by senior nursing teams.

Sickness/Absence total with COVID 19 Isolation	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March
RN/Midwife	6.62%	6.54%	6.03%	7.75%	6.55%	7.24%	7.18%	7.83%	8.98%	10.50%	7.78%	8.36%
HCA	9.5%	10.18%	10.50%	10.91%	10.50%	10.06%	12.72%	13.58%	13.79%	12.56%	9.76%	11.38%

Vacancy Summary

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



HCSW Vacancies

February and March 2022 vacancy data shows an increase in HCSW vacancies however, the bed reconfiguration and B18 business case have contributed to the rise in numbers, recruitment plans are in place. Following successful general Trust recruitment during February and March the most recent HCSW vacancy data (25/4/22) is outlined below. Shortlisting has taken place with 22 candidates being interviewed on the 5th May 2022. In addition, there has been a further 15 CSWD's who have commenced their 6-month training in the trust in March 2022. This number will help us to ensure we have a pool of recruits ready to place as the turnover rate for HCA's is approximately 8 per month.

Overall Vacancy (**includes Theatre**)	101.40	Figure reported externally via PWR
B3 (unfunded vacancies)	-14.08	As a temporary ward B3 only has funding until June 2022, this number represents both gaps on B3 for HCSW and across the Trust to backfill B3
Started in post W/C 26.4.22	-8	An increase in induction capacity is being explored
In recruitment process	-61	Close monitoring of this group weekly
CSWD recently passed 6-month training	-6	Will be placed in HCSW posts
Total vacancies as at 26/4/22	**12.32**	**Next recruitment planned for 5th May**

The Trust is part of the Health Care Support Workers (HCSW) programme with NHSE/ with continuous recruitment ongoing with bi-weekly shortlisting and interviewing and weekly external reporting to NHSE/I to monitor progress.

Registered Nursing Vacancies

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

Registered nurse vacancies as at 26/4/22

Overall Vacancy	76
Within Recruitment Process	-23.59
Overseas recruitment	-30
Total vacancies as at 17/3/22	**22.44**

Overseas recruitment

A business case to request non recurrent funding of **£345,500** to enable the Trust to secure 30 additional international nurses as part of the Cheshire International Recruitment Collaborative (CIRC) which is led by Mid Cheshire Hospitals NHS Foundation Trust (MCH) was approved in April 2022.

The 30 nurses will be recruited in 3 cohorts commencing in May, July and September 2022.

To date, 16 of the 30 have been interviewed and have offers, further interviews are planned.

Cohort	Expected cohort size	No. Employment offers made
Cohort 8 – July 2022	15	15
Cohort 8 – September 2022	15	1

The Trust has recruited four refugee nurses from Lebanon working in a healthcare assistant (HCA) role.

Care Group Establishments

Unplanned Care Group

Following a repurposing of beds on A1 to create the Enhanced Care Unit (ECU), it was necessary to review the nurse staffing establishment resulting in a potential increase to the current nurse staffing model. The costings for this are being calculated within the care group as part of a wider review of nurse staffing establishments across unplanned care. This review includes ITU in relation to how WHH compares with GPICS Intensive Care Society Standards for Staffing and ward staffing in line with noted increases in acuity and dependency in several areas. This remains under review.

Planned Care Group

Ward B3 remains open at Halton as a facility to step down patients from Warrington site, who meet the criteria as less acute. This ward has no funded nursing establishment and as a result staff have been taken from other areas across the Trust to provide safe levels of care leaving areas reliant on temporary staffing. The costs to fund this ward going forward are currently being calculated. There is an urgent requirement to agree this funding.

Escalation Beds

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

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

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

Temporary Staffing

The Trust is currently working with NHS Professionals (NHSP) and have launched the Agency Managed Service (AMS) project which went live date of the 1st of April 2022. The aim is to remove the responsibility of managing agencies from NHS Trusts, drive performance, efficiency, and cost reduction. NHSP will take over full responsibility for agency management within the Trust including contract management, performance management, relationship management and cascade management. This project does not include off framework agencies. Below is the off-framework fill during February and March with the target of zero usage unless in extreme circumstances from the 1st April onwards.

Tables below outline the number of off-framework shifts and where utilised during February and March 2022.

February 2022	A+E	ITU	C21	Cath lab	B18	C20	A4	A7	A8	A9	ACCU	B12	HSU	Total
Thornbury	46													46
Green Staff		610		12	92	12	12	12	12	12	12	12	12	810

March 2022	A+E	ITU	B3	Cath Lab	AMU	A8	C20	A5	B18	A4	K25	A6	A9	ACCU	C21	Total
Thornbury	36		25	35	12.5	12.5	12.5	12	25	12.5						183
Green Staff	9	534				4			69		12	12	23	35	12	710

The above usage of off-framework agency is reflective of the gaps in staffing associated with higher total absence during the reporting period.

Sickness Absence (without COVID isolation) – February and March 2022

Registered nurse and midwife sickness absence in the month of February 2022 was recorded at 6.95% showing an increase in March 2022 to 7.24%. The cost of bank/agency cover of qualified nursing sickness (at usual bank/agency fill rates) was £292,091 in February and £302,194 for March as detailed in the tables 4 and 5 below.

Table 4 - Registered nurse and midwifery sickness cover – February 2022

	Feb-22
Contracted Nursing WTE (Band 5to 7)	1,004.72
% Sickness	6.95%
WTE Equivalent of Sickness	69.83
NHSP Fill Rate	78%
WTE Covered by Temporary Staffing	54.26
Cost at Average NHSP Rates	***292,091***

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

	Mar-22
Contracted Nursing WTE (Band 5to 7)	999.12
% Sickness	7.24%
WTE Equivalent of Sickness	72.34
NHSP Fill Rate	78%
WTE Covered by Temporary Staffing	56.13
Cost at Average NHSP Rates	***302,194***

Maternity Staffing

- Current vacancy position of 9.18 Clinical MW 3.0WTE Leadership & Management 1.8 WTE Specialist Midwives with recruitment plans in place.
- Ockenden Part Two report released on 31st March which focuses on safe staffing levels and specific roles to support the sustainability of midwives. Women's and Children's CBU has recruited to specialist Retention midwife and already has a Clinical Skills Midwife to support student midwives.
- Staffing is reviewed daily as a minimum and reported locally and regionally at the Cheshire and Mersey Gold Command Meeting. Where possible each maternity provider within Cheshire and Mersey will offer mutual aid to prevent units going in to divert.
- The latest Birth Rate Plus review has identified WHH ratio is 1:24 in line with NICE recommendations
- Maternity services are escalated in accordance with the Cheshire and Mersey Escalation and Divert Policy (2021)
- The maternity unit was put on Divert on 13th March due to acuity and staffing levels
- Currently in the process of implementing Birth Rate Plus App reporting system for birthing environments and maternity ward. Birth Rate Plus is a tool used to assess safe staffing levels and acuity.

Paediatrics and Neonatal Unit

- A piece of work has been undertaken by the CBU and funding sourced to increase the HCA staffing for the Paediatric Outpatients Department as a result of the increase of clinical space within the redevelopment.
- Successful succession planning ensured the appointment of a new Children's Outpatient Manager and a new Band 6 Children's Outpatient Manager.
- Daily sitreps continue to be submitted to the Cheshire and Mersey Paediatric Network, this report notes acuity and staffing levels as well as HDU capacity, Covid 19 and RSV admissions.
- February and March saw increased and unprecedented absence of workforce due to COVID19. This was managed by flexibility of our current staff, agency and NHSP bank shifts which was support by the Trusts Senior Nursing Team.
- The Neonatal Critical Care Review has identified funding for 2023/24 which will focus on "Quality Roles".

Therapy

- Recruitment and retention remain a priority for therapies, we are continuing to review vacancies and skill mix across services. The Occupational and Physiotherapy turner over remains high and we continue with a monthly recruitment drive.
- Part of the retention programme includes a grow your own model and we continue to engage with therapy service leads and staff to promote apprenticeships.
- Total vacancies across therapy groups is 40.92 with recruitment planning in place.
- Business case in progress to correctly fund current staff model, the business case will not increase the establishment.

Theatre

- At present theatres are reviewing staff requirements following covid-19, this includes leadership 7 days per week and ODP requirement levels following the increasing acute demands from the trust with critical care and AED sick patients.
- Maternity service has been funded for elective activity, staffing models are being reviewed in line with NatSSIPs to provide safe staffing levels of care 24hrs across 7 days. The new modelling costs are currently being calculated.
- Recruitment and retention on a national scale demonstrates shortfalls in theatre staff due to retirement or lost to agencies. Theatre managers across the Northwest come together to discuss for future workforce planning.
- We have engaged in the oversea recruitment which has been positive in our theatres.
- We have a shortfall in ODPs in Whh theatres and have a recruitment team within theatres to work on this monthly. We are at present looking at different staffing models and training to cover these shortfalls such as training anaesthetic nurses in Bolton university but awaiting this availability. Funding for this will have to come from a business case before commencing this training.
- With 35% of the theatre staffing over 50yrs plus and thinking of retirement plans we need to over recruit in succession plans exercise especially in the senior staff. We are working on this and will provide a business case to future proof theatre staffing.

- We are working on structure for progression from band 2 upwards and have theatre hierarchy model to support this.

3. RECOMMENDATIONS

The Trust Board is asked to note the contents of the report.

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/05/55 b		Trust Board	DATE OF MEETING	25 May 2022

Date of Meeting	5 April 2022
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

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

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/22/04/85	**Hot Topic – Cancer Inequalities**	The Committee received a presentation relating to Cancer Inequalities and the variation in referrals from first treatment, sex, geographic location and age. The following was noted; • A C&M inequalities forward plan had been formed for the basis of 9 pillars of C&M Cancer Alliance Inequalities Strategy. • Data was shared regarding 28-day Fast Diagnostics which showed a good rate of achievement but had slipped in December due to delays in Breast services. • It was noted the importance of ensuring a links with Primary Care at certain points in the process.	**The Committee discussed the report and received good assurance**	**Patient Safety & Clinical Effectiveness Sub-Committee**
QAC/22/02/86	**Deep Dive/Service Review – 12 Hour Breaches**	The Committee received a presentation which focussed on patients breaching 12 Hour DTA Standard, and the following was of particular note: • The Trust had managed its position well. • Zero tolerance position in relation to breaches in place; • The ED Incident profile was not specifically related to 12-hour breaches. • Information was shared across the region on a daily basis with other Trusts reporting similar difficulties	**The Committee discussed the report and received moderate assurance.**	**Clinical Recovery Oversight Committee (monthly)**

		• Governance for Rapid Incident Reviews (RIR) had been completed with no harm identified to date.		
QAC/22/04/88	**Sepsis High Level Update**	The Committee received an update report outlining current compliance rates, an update from the deep dive presented in January 2022 and the measures in place to improve practice. The Committee particularly noted the improving picture across 3 of the 4 indicators for February. Sepsis continues to be high on the agenda and a mock CQC inspection would be undertaken on 4 April 2022 in order to reinforce to need to continue to focus in this area.	**The Committee noted and discussed the report and received a good level of assurance.** **It was agreed a bi-monthly update would be provided.**	**Quality Assurance Committee – June 2022**
QAC/22/04/95	**Histopathology**	The Committee received an update was provided on the risks and mitigations in place to reduce risks to clinical pathways to the Histopathology services and noted the critical staffing pressures for the staff. Of particular note was: • WHH is part of the Cheshire & Merseyside Pathology Network, with a 3-hub operating model agreed, but not yet implemented. • WHH have reached out to the Network requesting mutual aid support and an agreement that St Helens and Knowsley NHS Trust (STHK) would provide initial support. • Nationally there was a shortage of histopathologists. • Issues had arisen affecting a number of pathways such as lung and cervical cytology. • It was noted the contracts team needed to ensure a formal contract was in place between the Trust and STHK with clear specifications of what was expected as part of the contract. And a risk would be added in relation to this.	**The Committee discussed and noted the update and received limited assurance at this stage.**	**Quality Assurance Committee – May 2022**

The Committee also received the following items:

QAC/22/04/84 – Patient Story – A warm welcome isn't just 'Hello'
QAC/22/04/89 - Move to Outstanding Action Plan Update

Matters for Approval
QAC/22/04/90 – Strategic Risk Register & BAF

Papers to Discuss and Note for Assurance

QAC/22/04/93 – Maternity Update including Women's Experience of Maternity Care Survey 2021
QAC/22/04/94 – Learning Disabilities Mortality Review (LeDeR) this was deferred until the May meeting.

Papers to Note for Assurance

QAC/22/04/96 – DNACPR 6 Month Position
QAC/22/04/97 – Quality Dashboard

High Level Briefing Report

QAC/22/05/98 – Patient Safety & Clinical Effectiveness Sub Committee
QAC/22/05/99 – Infection Control Sub Committee
QAC/22/05/100 – Safeguarding Sub Committee
QAC/22/05/101 – Patient Experience Sub Committee
QAC/22/05/102 – Health & Safety Sub Committee
QAC/22/05/103 – Complaints Quality Assurance Sub Committee
QAC/22/05/104 – Equality, Diversity & Inclusion Sub-Committee

Closing

It was noted the Committee Effectiveness Review had been completed.
The Terms of Reference had been amended, changing Job Titles for some members of the Committee, and these were approved.

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/05/55 b		Trust Board	DATE OF MEETING	25 May 2022

Date of Meeting	3 May 2022
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Cliff Richards
Was the meeting quorate?	Yes

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

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/22/05/112	**Hot Topic – Safe Staffing & Review of the Harm Profile**	The Committee received a presentation regarding Safe Staffing and Review of the Harm Profile, in particular noting the relationship between staffing and harm. The following areas were highlighted and noted: • Falls with harm, pressure ulcers and moderate harm in ED had all increased during 2021-22. • There had been up to 53 escalation beds opened at any one with time; • Increase in the number of patients with 'no right to reside' • Increase in incident reporting in ED • In relation to mitigation there were a number of plans in place which included senior nurse oversight at staffing meetings, NHSE/I staffing assurance framework, out of hours matron rota, utilisation of no ward based nurses and AHP's, senior nurse flexibility and bank/agency usage. • There were plans in place to support this issue going forward which included associate chief nurse improvement plans, safety ward rounds, recruitment and	**The Committee discussed the report and received moderate assurance**	**QAC - Ongoing**

		retention programme, periodic pay incentives, block bookings with NHSP, HCA recruitment programme, plans to increase student capacity, agency managed service, trainee nurse associate programme and development opportunities for all bands.		
QAC/22/05/113	**Deep Dive/Service Review – Hospital Associated Deconditioning**	The Committee received a presentation which focussed on Hospital Associated Deconditioning which related to older adults admitted to hospital who were at risk of not being able to return home safely, leading to gridlock whilst waiting for intermediate care support. The following areas were of particular note: • A 10 day length of stay in hospital could result in loss in aerobic activity, 10 years ageing to the musculoskeletal system, 20-40% stretch loss within the first week, increase in dependent on discharge and reduce risk of transferring to a nursing home. • A number of projects had been implemented which included an active ward based on principles of moving medicine/active hospitals, a focus on getting patients more active in hospital, information, education and exercise and the Trust moving towards becoming an Active Hospital. • Next steps would include restarting the established steering group, continue to work with and develop falls change package, stakeholder engagement mapping, spread planning towards Active Wards and linking to quality priority-prevention of deconditioning.	**The Committee discussed the presentation and received good assurance.**	
QAC/22/05/120	**Maternity Update – ATAIN Q4**	The Committee received a report providing an overall quarterly update on maternity & neonatal services. The Committee noted: • WHH has implemented 95% of the 7 Immediate Essential Actions (IEA's) outlined in Part One of Ockenden Report; • Analysis of Ockenden part two under way; • The national ATAIN trajectory was 6% with the Trust rate for Q4 at 5.6% and an annual rate of 5.9%, a significant improvement from last year's rate.	**The Committee noted the update and approved the Action Plan, receiving good assurance.**	**Trust Board - 25 May 2022**

QAC/22/05/121	**Histopathology Update**	The Committee received an update on Histopathology and noted that there were still concerns regarding pressures within the service due to staff shortages and concerns regarding the contract and turnaround times being included as part of the SLA.	**The Committee noted the update and received moderate assurance. An update would be received at the meeting in June.**	**QAC - 7 June 2022**

The Committee also received the following items:

Matters for Approval
QAC/22/05/114 – BAF & Strategic Risk Register
QAC 22/05/115 - Extension of Patient ED&I Strategy
QAC/22/05/116 – Quality Account
QAC/22/05/117 – Enabling Strategies Update
QAC/22/05/118 – Infection and Prevention Control Strategy

Papers to Discuss and Note for Assurance
QAC/22/05/124 – Q4 SI & Complaints Report
QAC/22/05/125 – Q4 Learning from Experience Report
QAC/22/05/126- Q4 DIPC Infection Control
QAC/22/05/127 – Bi-Monthly IPC BAF
QAC/22/05/128 – Q4 Quality Priorities
QAC/22/05/129 – Q4 Clinical Audit Report

QAC/22/05/130 – Dementia Strategy Quarterly Report
QAC/22/05/131 – Q4 Learning from Deaths
QAC/22/05/132 – Q4 Fit Testing Compliance
QAC/22/05/133 – Q4 Quality Improvement Progress Report

QAC/22/05/134 – Q4 CIP Plans
QAC/22/05/135 – Key Discussion point from Clinical Recovery Oversight Committee (CROC)

High Level Briefing Report
QAC/22/05/136 – Patient Safety & Clinical Effectiveness Sub Committee
QAC/22/05/137 – Infection Control Sub Committee
QAC/22/05/138 – Risk Review Group
QAC/22/05/139 – IG & Corporate Records
QAC/22/05/140 – Palliative and End of Life Steering Group

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/05/55		Trust Board	DATE OF MEETING	25th May 2022

Date of Meeting	18 May 2022
Name of Meeting & Chair	Strategic People Committee, Julie Jarman
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
SPC/22/05/45	**Staff Network Update – Multi Ethnic Staff Network**	The Committee received a thought provoking presentation which shared the Networks successes, ambitions and challenges. We particularly noted the contribution of the staff network to the good rates of Covid vaccination for ethnic minority staff and communities, and the reciprocal mentoring project.	**The Committee noted the presentation and the assurance provided**	
SPC/22/05/48	**Hot Topic – Agency Reliance**	The Committee received a presentation which focussed on Agency Reliance. In summary: • WHH Agency usage benchmarks well compared to North West Acute Trusts but is slightly above national average (Source: Model Hospital) • Work between 2018 and 2020 had a positive impact on Agency spend • The flexibility of temporary staffing enables the Trust to respond safely to COVID and increases in activity • Trend analysis on use of agency workers highlights around half our agency use is due to 'hard to recruit' and half is due to 'additional demand, sickness and the pandemic combined'. • Deep dive highlights different plans, across Staff Groups, thus demonstrating various approaches to reducing reliance on agency staff	**The Committee noted the presentation.** **Existing plans provided moderate assurance and further actions were agreed. Relevant topics such as retention will be put on the agenda for future meetings.**	**SPC July 2022**

		• Escalated clinical areas and increase in acuity levels of patient's clinical conditions impacting on use of temporary workforce. Consideration to whether these escalated unfunded areas can be 'switched off' or whether substantive recruitment should be considered.
		• Driving efficient and effective use of eRostering key – currently used within Nursing departments including theatres. Further roll out across AHPs and Medical Workforce scheduled.
		• Concerns relate to:
		  ○ National labour shortages in certain specialities
		  ○ Continued increase in activity vs Trust capacity
		  ○ Absence rates
		  ○ Deanery gaps and national student numbers
		
		Actions
		• Review Temporary Staffing Establishment Control Processes
		• Executive members to raise the requirement for a system wide approach to temporary staffing rate cards within Strategic Executive Oversight Group.		

SPC/22/05/49	**BAF & Risk Register - Staff**	The Committee received a paper which provided an update on the Risk 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* The discussion considered if the above BAF risk is the highest risk for the committee to consider. It was noted Execs are reviewing the existing management and assurance processes related to all Trust Risk. A paper to go to SEOG. SPC will review the workforce related risks following the review.	**The Committee discussed the report and received moderate assurance.**	**SPC July 2022**

SPC/22/05/50	**Terms of Reference**	The Committee received the Terms of Reference for approval. Minor changes were suggested, which will be approved through Chairs actions.	**The Committee received the terms of reference and will approve via Chairs action**	**SPC July 2022**
SPC/22/05/52	**Chief People Officer Report**	The Committee received the report and are escalating the following **for information**: **COVID-19 Workforce Risk Assessments** The Trust has aligned the COVID Isolation, Testing and Risk Assessment process to the newly published guidance from UK Security Health Agency (UKSHA) and the Government in terms of "Living with COVID-19". For staff who are both Vulnerable to COVID and working with Aerosol Generated Procedures, the Trust is required to consider reasonable adjustments, however all other staff can return to their full duties, within their substantive role. The Risk Assessment reporting will also conclude in line with these updates. The Trust is now recognised as a Disability Confident Leader – Level 3, previously at Level 2. **Disability Confident Leader** Trust Accredited in April 2022 **NHS Coronavirus Life Assurance Scheme** Scheme closed on 31 March 2022	**The Committee noted the report and received assurance.**	**Complete**

The Committee also received the following items:

Matters for Approval

SPC/22/05/51 - Policies and Procedures Report – Polices ratified:

- Secondment Policy / Special Leave Policy / Annual Leave Policy / Shared Parental Leave Policy & Health Clearance Policy

Papers to Discuss and Note for Assurance

SPC/22/05/53 - Move to Outstanding Red Flags Report
SPC/22/05/54 - Employee Relations Report
SPC/22/05/55 - Bi-Monthly Safe Staffing Assurance Report
SPC/22/05/56 - Guardian of Safe Working Q4 Report, Safe Working Hours Jnr Doctors in Training
SPC/22/05/57 - Local Induction Temporary Medical Staff
SPC/22/05/58 - WHH GMC Enhanced Monitoring Update including exit mapping

High Level Briefing Report

SPC/22/05/59 - Operational People Committee
SPC/22/05/60 – Workforce Equality Diversity & Inclusion Sub Committee
SPC/22/05/61 - Workforce Recovery Steering Group

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/05/55 (d)		TRUST BOARD OF DIRECTORS	DATE OF MEETING	25 May 2022

Date of Meeting	**20 April 2022**
Name of Meeting + Chair	**Finance and Sustainability Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
		Matters to discuss and note for assurance		
FSC/22/04/60	Corporate Performance Report	The Committee considered and reviewed the report noting: - • 4hr performance excluded Widnes walk-in activity: 68.72% against 95% standard • 66.60% against RTT • Cancer 62 day standard missed, 31 day achieved and 2 week expected to be achieved in April • Noted further detail are covered in CROC	The Committee **noted** the report	FSC May 2022
FSC/22/04/61	Pay Assurance Report	The Committee considered and reviewed the report noting: - • Vacancies increased by 7 FTE this month to 484 vacancies • Temporary staff breakdown shows 38% relates to vacancies, 36% due to workload increases (extra beds and ED) and 11% COVID-19	The Committee **noted** the report.	FSC May 2022

		• Compliance with the Trust rate card in March 2022 is 68% • Agency staffing – compliance against the NHSI rate card remains low 13% (NHSE/I)		
FSC/22/04/62	WLI	The Committee received the presentation on WLI MIAA actions noting:- • All actions complete except 1, linked to authorisation restrictions on Patchwork and the policy is not yet signed off • MIAA will follow up • Escalation of additional WLI payments post April is required	The Committee **noted** the update	FSC May 2022
FSC/22/04/63	Monthly CIP	The Committee considered and reviewed the monthly CIP noting: - • Above plan at the end of March with £5.4m delivered • Overachievement of £0.5m against £4.9m • £3.8m CIP is non-recurrent which is a pressure for 2022/23 • Actions for establishing CIP plans for next year.	The Committee **noted** the CIP report	FSC May 2022
FSC/22/04/64	COVID-19 Expenditure	The Committee considered and reviewed the quarterly COVID-19 expenditure noting: - • Annual spend of £7.8m • The need to reduce costs further in 2022/23 as funding reduces	The Committee **noted** the COVID-19 report	FSC July 2022
FSC/22/04/65	Digital Services Board Report	The Committee considered and reviewed the report noting:- • Anti-virus protection is currently operating at a reduced level on the PACS system • Dedalus notification that Lorenzo will be replaced by ORBIS U • The outcome of the EPCMS procurement exercise has not yet been confirmed • The Badgernet Maternity EPR system go live 3rd May 2022	The Committee **noted** the report	FSC May 2022

FSC/22/04/66	Monthly Finance report	The Committee considered the report and capital proposals. Key points to note included: • Draft position of £0.2m surplus (with adjustments) • Accounts will say £1.276m deficit as per Appendix C of the paper • Adjustments include the removal of an asset under construction • CIP achieved – reliance on non recurrent items • Approved the changes in the capital plan and noted the achievement the plan • Noted escalation of the level of cost improvement programme	The Committee **noted** the update, **approved** in the changes in the capital plan up to 31/3/22 and **escalate** concerns on the level of CIP schemes for 2022/23	FSC May 2022 Trust Board April 2022
FSC/22/04/67	2022/23 Planning Update	The Committee considered and reviewed the presentation noting: - • Activity and workforce figures and finances planned for 2022/23. • £19.2m deficit • Aim for 4% increase in activity on 19/20 • Need to hit zero 104 week waits but expect to increase 52 weeks wait • Workforce – 1.77% increase in workforce driven by cost pressures and business cases, • 3.8% CIP target £11.7m - Recurrent CIP delivery is going to be a significant challenge. Request to increase further to £13m • Capital – original plan submitted to Trust Board was £12.8m – CPG may need to look at managing plan over 18mths if we don't get the full CDEL. • Note latest planning gap of £19.2m • Note the risk in the position – ERF & CIP • Support of draft 2022/23 budget • Support 2022/23 capital proposal	The Committee **noted** the presentation and **support** the draft 2022/23 budget and capital proposal	FSC April 2022
FSC/22/04/68	Capital Expenditure Update	a) Capital Position The Committee considered and reviewed the presentation noting: - • Noted the schemes final values and the carry forward to 2022/23	The Committee **noted** the update	Trust Board April 2022

		• Will continue to monitor schemes over £500k from 2021/22 until complete • Noted the risk of continued rising cost of materials and the potential impact on 2022/23 plan		FSC May 2022
FSC/22/04/69	Proposal to stepdown of Brexit Subgroup	The Committee considered the proposal noting the request to step the meeting down.	The Committee **approved** the stepdown	
FSC/22/04/70	Risk Register & BAF	The Committee noted the report noting: - • Reduce BREXIT from 12 to 4 and de-escalate down to department register • Request to change the wording to reflect current position on the EPR risk	The Committee **noted** the Risk Register and BAF report	FSC May 2022

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/05		TRUST BOARD OF DIRECTORS	DATE OF MEETING	25 May 2022

Date of Meeting	**19 May 2022**
Name of Meeting + Chair	**Finance and Sustainability Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
		Matters to discuss and note for assurance		
FSC/22/05/77	Pay Assurance	The Committee considered and reviewed the report noting: - • Reasons for using bank and agency to be reviewed • Agency ceiling being reintroduced nationally • Requirements of agency and bank for safety and impact of the redeployment of staff • Significant gaps in junior doctors rotas • Monitoring of annual leave booked, taken and outstanding will be produced monthly at CBU level to support monitoring the finance risk	The Committee **noted** the report	FSC June 2022

FSC/22/05/78	CIP & GIRFT	The Committee considered and reviewed the monthly CIP & GIRFT report noting: - • Target of £14m for 2022/23 in 2 parts • Timescales for whole of CIP to be identified in plans needed • Delivery is key and needed at pace	The Committee **noted** the report.	FSC June 2022
FSC/22/05/79	Indicative Cost of Harm	The Committee received the report noting the areas as follows:- • Inpatient Falls • Healthcare Acquired Infections (MRSA, CDI, Ecoli) • Pressure Ulcers • The position is similar to the previous year	The Committee **noted** the report	FSC May 2023
FSC/22/05/80	Benefits realisation	The Committee noted the quarterly report: • Noted the progress • Discussion the international nursing, reduction in agency usage and the changing context	The Committee **noted** the quarterly report	FSC August 2022
FSC/22/05/81	EPCMS	The Committee considered the presentation outlining current challenges to the process and the changing context.	The Committee **noted** the update	Board May 2022
FSC/22/05/82	Medical Staffing Review	The Committee considered presentation noting:- • Overview of cost pressures and discussed the need to get the business cases through the governance process quickly • Varying compliance to medical rate card – non compliance during times of escalation. Escalation approval process put in place • Two stage de-escalation process	The Committee **noted** the report	FSC August 2022

		• Considered the risk of reduction rate		
FSC/22/05/83	Service Line Reporting	The Committee considered the report noting:- • The PLICS data is being used to support the CIP / GIRFT agenda • The increase in cost per attendance since 2019/20	The Committee **noted** the update	FSC August 2022
FSC/22/05/84	Digital Services Report	The Committee considered the report noting • Anti-virus protection is currently operating at a reduced level on the PACS system • Dedalus notification that Lorenzo will be replaced by ORBIS U (the Trust Board Secretary was asked to review the risk register rating in respect of this position) • The outcome of the EPCMS procurement exercise has not yet been confirmed • The Badgernet Maternity EPR system go live 3rd May 2022	The Committee **noted** the update	FSC June 2022
FSC/22/05/85	WLI MIAA Audit Review	The Committee noted the update • Working through new authorisation and monitoring process and will feedback next month	The Committee **noted** the update	FSC June 2022
FSC/22/05/87	Monthly Finance report	The Committee considered the report and capital proposals. Key points to note included: • Month 1 position of £2.07m deficit • Did not achieve ERF in month 1 (based on draft figures) • CIP off plan in month 1 • Pay overspend in month 1 • C&M put forward deficit position based predominantly on inflation above the level funded within contracts and LUHFT opening costs. There is a residual £40m deficit to be apportioned across the system • Update on national webinar to resubmit plans in June which will include additional inflation support, with a need to reflect new IPC recommendations, from Q3 deliver CIP recurrently, apply cap on the rate for agency and ceiling reintroduced, audit of agency processes, take part in national pay and non pay initiatives. • Still draft activity baseline, final baseline not confirmed.	The Committee **noted** the update	FSC June 2022 Trust Board May 2022

		• Discussed the triangulation to CROC information of staff sickness in April and the impact on April activity • Capital is slightly behind plan and highlighted the Paediatrics and Urology schemes slippage from May to August 2022		
FSC/22/05/88	Halton Elective Business Case	The Committee considered and supported the presentation noting: - • The scheme is made up of three elements which are: 1. An additional theatre and new day case unit 2. Relocation of existing Endoscopy TSSU 3. Upgrade of vacant ward capacity to full ward specifications • Note this is internal refurbishment only therefore no planning considerations. The scheme is £8.5m split over 3 years currently indicative costings not yet out to tender but does include a contingency. The Trust should consider cost of materials and labour. • Ability to staff the area was considered	The Committee **noted** the presentation and **support** the business case to be presented to Board for approval	Trust Board May 2022
FSC/22/05/89	CDC	The Committee considered and reviewed the presentation noting: - • Halton part of Phase 2 • Intending to submit 2 bids under each under £15m, Fast track case and Full CDC • Bids include revenue request • Considered timelines and governance • The Chair asked for comments from each Executive present comments included:- Activity and capacity numbers for each bid needs to be understood along with income for extra activity. Digital considerations with the level of radiology equipment investment. More clinical oversight to review workforce modelling. Recognise the workforce challenges. • Further analysis being undertaken to understand revenue impact once revenue support is withdrawn and demand analysis, and how the scheme aligns with the new hospital programme	The Committee **noted** the overview presentation and happy to support direction of travel. Suggest due to scale and impact might need an additional session to give the Board the necessary assurance before we seek approval from Board	Additional FSC / Board session TBC possibly 9th June

		• Supported project management post to oversee delivery		
FSC/22/05/90	PP	The Committee considered and reviewed the policy noting: - • Executive team received last week, policy review group in May and then back to FSC in June. • This Committees involvement in Private Patients is to ensure a robust system is in place to obtain necessary reimbursement	The Committee **noted** the updated policy	FSC June 2022
FSC/22/05/91	Capital Expenditure Update	The Committee considered and reviewed the presentation noting: - • The current plan for 2022/23 £23m and the overcommitment against the CDEL • The additional bids submitted • The schemes moved between 2021/22 and 2022/23 • Month 1 position is underspent and the current contingency level • The progress of the schemes over £500k • Noted the risk of continued rising cost of materials and the potential impact on 2022/23 plan • Catering business case considered and supported to be presented at Board • Capital templates require updating to clarify cost risk more clearly and the mitigations proposed by CPG	The Committee **noted** the update and **supported** the catering business case to be presented to Trust Board	FSC June 2022 Trust Board May 2022
FSC/22/05/92	Committee Chair's Annual Report	The Committee considered the Chairs annual report	The Committee **noted and supported** the report	
FSC/22/05/93	Risk Register & BAF	The Committee considered the report noting: - • Approval of reducing the risk rating for risk 1290 linked to BREXIT • Risk 1372 description has been updated and further review is now required following todays meeting • The EPR risk was added • Continuity of care data risk was closed	The Committee **noted** the Risk Register and BAF report	FSC June 2022

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/05/55 (h)	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	25 May 2022

Date of Meeting	28 April 2022
Name of Meeting & Chair	Audit Committee, Chaired by Michael O' Connor
Was the meeting quorate?	Yes

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

Agenda Reference	Agenda Item	Issue and Lead Officer	Recommendation / Assurance/mandate to receiving body	Follow up/ Review date
AC/22/04/28	**Internal Audit Progress Report**	The Committee received a report setting out the outcomes of the reviews that have been completed since the last Audit Committee. The Committee particularly noted: Two reports have been issued; • Patient Discharge Review – Substantial Assurance • Assurance Framework – Phase 2 Review Three reviews are in progress; • Mortality Review (Draft Report issued) • Clinical Safety Assurance Review (Fieldwork Complete) • DSPT – (Fieldwork in progress) Proposed changes to the current year plan for 2022/23 were noted.	**The Committee reviewed and approved the proposed changes and received good assurance.**	**Audit Committee August 2022**
AC/22/04/29	**Head of internal Audit Opinion**	The Committee received a report detailing the Head of Internal Audit Opinion. It was noted that the basis for forming the opinion was: • An assessment of the design and operation of the underpinning Assurance Framework and supporting processes.	**The Committee reviewed the report, noting the overall opinion of substantial assurance.**	**Audit Committee April 2023**

		• An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account the relative materiality of systems reviewed and management's progress in respect of addressing control weaknesses identified. • An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented. The overall for the period 1st April 2021 to 31st March 2022 is: **Substantial Assurance:** can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.		
AC/22/04/31	**External Audit Plan 2021/22 & Audit Risk Assessment**	The Committee approved the audit plan setting out The 2021/22 audit plan sets out Grant Thornton's approach and fees for the external audit, including the financial statements audit, the value for money approach, and other work in respect of the annual report, remuneration report and whole of government accounts consolidation schedules.	**The Committee approved the plan**	**n/a**
AC/22/04/36	**Going Concern Report**	The Committee received and approved the preparation of the accounts on the Going Concern basis statement in Section 7 of the report	**The Committee approved the Going Concern Statement and received good assurance.**	**Audit Committee 16 June 2022**
AC/22/04/37	**Draft Annual Governance Statement**	The draft Annual Governance Statement was received, it was noted this was the first iteration to be included in the Annual Report.	**The Committee noted the draft statement.**	**Audit Committee 16 June 2022**
AC/22/04/39	**Draft Unaudited Accounts & Financial Statements**	The Committee received the draft of the Unaudited Accounts and Financial Statements which would be reviewed and approved at the year end Audit Committee meeting in June.	**The Committee noted the draft accounts and financial statements.**	**Audit Committee 16 June 2022**

Other items included on the agenda were:

AC/22/04/25 – Update from Chairs – FSC, SPC, QAC, CFC and CROC
AC/22/04/26 – Changes and updates to the BAF
AC/22/04/28 - Internal Audit Progress Report on Follow-up Actions
AC/22/04/30 – Internal Audit Charter Annual Report
AC/22/04/32 – Final Annual Counter Fraud Plan was approved
AC/22/04/33 – Annual Counter Fraud Annual Report
AC/22/04/34 – Review of losses & special payments
AC/22/04/35 – Review of quotation and tender waivers
AC/22/04/38 – Draft Annual report
AC/22/04/40 - Private Patient Action Plan

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/05/55 h		TRUST BOARD OF DIRECTORS	DATE OF MEETING	25 May 2022

Date of Meeting	**26 April 2022**
Name of Meeting + Chair	**Clinical Recovery Oversight Committee (CROC) Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
CROC/22/04/37	Harm Profile update	• 351 patients have a 52+ week wait and require a harm review. • 1034 patients have a wait of less than 52 weeks and require a harm review to be undertaken. • There has been a total of 3919 harm reviews completed. • Further narrative to be included at the next meeting around cause of harm to patients.	The Committee noted the update	Next CROC
CROC/2022/04/38	Waiting List updates	<u>RTT update:</u> • Total RTT Waiting list size 23339 (this does not include ASI and RAS patients) slightly lower than the H2 submitted estimate 23579 Including ASI, RAS. • H2 plans have been achieved. Priority Code update – Key Points • Increase in the amount of patients upgraded to a P2. These are mostly coming from harm reviews being conducted. • There is a national steer to ensure there are no patients waiting >104 weeks by the end of Mar 2022. Although	The Committee noted the report.	Next CROC

		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: Key Issues</u> • >104 day over trajectory by 3 patients although this is in line with normal fluctuations pre COVID. These patients are Colorectal and Urology and have been complex patients with co morbidities and COVID positive during their diagnostics. • >62 trajectory currently 22 patients which is 7 over trajectory, recovering from an increase in delayed diagnostics during January and February due to COVID, increased staff sickness, delays within pathology. • Continued good compliance against 31 day target. • 28 day FDS performance has been affected by the increased number of breast 2ww breaches early in the year and is expected to be affected by delays within the pathology department. • Latest 62 day reported performance for February is 70.7% against an operational standard of 85%. • Continued increase in 2ww referrals over and above pre pandemic levels. Breast 2ww referrals in particular have been very high and capacity has not been able to meet demand. This has led to failure of the 2ww standard in October, November, December, January, February. Work is ongoing to ensure that enough capacity is in place to deliver a recovered position by March 2022. Breast position has recovered and is performing well. <u>Diagnostics;</u> **Radiology** –		

		• Current backlog 146 cases compared to 209 cases in March, all cases reviewed/prioritised, leaving non-urgent over six weeks only. • Current compliance 97.6%, March was 95.5% with a target of 99%. **Endoscopy –** • During March have continued with WLI activity and the waiting list has reduced by 142 patients in month. • WHH working with C&M Endoscopy network on mutual aid projects to reduce waiting lists across the region. • Units being monitored on utilisation performance via Thrive with an aim to achieve 12 points per list. **Cardio Respiratory:** • Increase in overall aggregate performance from January 2022. • High sickness in December/January. • Lost full time Echo Locum in January 2022. • There was a 2-month delay in clinical coding affecting inpatient activity. **Outpatients;** • Outpatient Activity Planning in development. • 10 Specialties Live; Cardiology, Urology, ENT, Ophthalmology, Gastroenterology, Gynaecology, Rheumatology, Respiratory and Physiotherapy. • 2.65% of outpatient discharged to PIFU in March against national target for March of 2%. • Maintain remote outpatient attendance at 25% or above to March 2023. • Remote outpatient attendances fell below 25% in March 2022. • Video Clinics have been relaunched through the Trust to deliver outpatient clinics, engagement with clinicians has		

		commenced to encourage further uptake of virtual consultations. Theatres; • TC noted the first meeting of the Theatre Productivity Group, since the pandemic, had taken place and the attendees, Terms of Reference and agenda were checked and confirmed as appropriate. The meeting would continue monthly; however, it would be reviewed as to whether it should take place bi-weekly.		
CROC/2022/04/41	2022-23 Planning Progress	• DM updated on the planning progress and noted submission would be the end of the week and once check and challenge had been received would make any minor amendments. • An amendment had been made in relation to achieving 104% across the year and target against PIFU and non-elective activity assumptions. • It was expected to see growth in waiting list and target of 104 week wait, along with 52 week wait, with no overall decrease seen until 2024.	The Committee noted the update	Next CROC
CROC/2022/04/42	Access to Recovery Fund update	• JH advised that the year had closed with ERF supporting the year end position at break even. • There was £7.6m ERF in current deficit position and there was an element of risk if the 104% was not achieved. It was hoped it would be achieved and therefore enable access to bid for further funding.	The Committee noted the update	Next CROC
CROC/2022/04/43	Cheshire & Merseyside update	DM advised the plan had not been signed off as everyone was still trying to make sense of the support around 104 weeks for those not meeting the target.	The Committee noted the update	Next CROC
CROC/2022/04/45	Six Months Committee	TA advised there would be survey circulated and encouraged members to complete to present the findings at the next meeting.	The Committee noted the update	Next CROC

	Effectiveness Review			
CROC/2022/04/46	Cycle of Business	An updated Cycle of Business was presented for approval, and it agreed that the Theatre Productivity Group minutes be added and reported monthly via minutes from the group. Corporate Performance report to be added to the Cycle of Business, rather than Finance and Sustainability Committee.	The Committee noted the update	Next CROC

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/05/57**	
SUBJECT:	**Maternity Update Report**	
DATE OF MEETING:	25th May 2022	
AUTHOR(S):	Catherine Owens, Director of Midwifery/Associate Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#1079** Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are assessed as only able to work on a non-respiratory pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper has been presented at Quality Assurance Committee and noted assurance following discussion in relation to the maternity update at Warrington and Halton Teaching Hospital (WHH). This	

	paper also includes more recent updates in relation to Maternity Incentive Scheme reporting timelines and guidance. Cheshire and Mersey Local Maternity System have introduced a new Board Reporting Template in March 2022 to standardise reporting mechanisms and maternity and neonatal information provided with Trust Boards in relation to the National Maternity Transformation and Safety Agenda. This paper has utilized this new reporting template. This paper provides an overall quarterly update on maternity and neonatal services covering the reporting period of 1st January 2022 to 31st March 2022 utilizing the new Cheshire and Mersey Local Maternity System Template and includes WHH position on: • Compliance with Ockenden Report Part One Maternity Incentive Scheme • Maternity Incentive Scheme Year 4 • Perinatal Quality Surveillance Model (PQSM) • The Perinatal Clinical Surveillance Quality Assurance Report • The Cheshire & Mersey Local Maternity & Neonatal System (LMNS) Clinical Outcome / Outlier Report • Serious Incidents / Comprehensive Incidents • Health Care Safety Investigation Branch (HSIB) • Care Quality Commission Review CQC • Safety Champion Report • Workforce: Maternity and Neonatal Staffing • Midwifery Continuity of Carer (CoC) • Quarter 4 2021/22 Perinatal Mortality Review • Learning from maternity claims complaints and incidents Report Please note some of this information has been shared previously with the Trust Board. The information has been included to present a Quarter overview and is being resubmitted to align the paper with future cycle of business / reports. **Key information to be noted:** MIS Year 4: New submission deadline has moved from June 2022 to 5th January 2023. Submission conditions include: • Trusts must achieve **all** ten maternity safety actions. • The declaration form is submitted to Trust Board with an accompanying joint presentation detailing maternity safety actions by the Head of Midwifery and Clinical Director for Maternity Services • The Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:

	The Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered. In addition, The CEO of the Trust will ensure that the Accountable Officer (AO) for their Clinical Commissioning Group/Integrated Care System (CCG/ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution **Perinatal Mortality Review Rates** WHH stillbirth rate for Q4 2021/22 was 1.54 per 1000 births. WHH Mean rate 3.1/1000 births. MBRRACE-UK national rate 3.51/1000 births. WHH Neonatal Mortality rate for Q4 is pending due to awaiting Operational Delivery Network data which is 2 months behind. WHH Q3 Mean Neonatal Mortality Rate is currently 0.8 per 1000 births. National MBRRACE Neonatal Mortality rate is 1.64 per 1000 births. **Avoiding Term Admission into Neonatal Unit** WHH current Avoiding Term Admissions to Neonatal Unit for the period of 1st April 2021 to 31st March 2022 is 5.9% Nataional trajectory is 6% North West Operational Delivery Network is 5.6%. WHH is on a trajectory to meet NWODN target as illustrated in Q3 ATAIN rate of 5.2% and Q4 ATAIN rate of 5.6%.			
PURPOSE: ***(please select as appropriate)***	Information	Approval x	To note x	Decision
RECOMMENDATION:	The Trust Board is asked to receive and approve the Maternity Quarterly Update paper as per Maternity Incentive Scheme Year 4 and Ockenden recommendations			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/22/05/120		
	Date of meeting	3rd May 2022		
	Summary of Outcome	Noted and Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Quarter 4 Maternity Update	AGENDA REF:	BM/22/05/57

1. BACKGROUND/CONTEXT

All maternity providers are requested to update the Board of Directors each quarter on its progress in embedding the Maternity Transformation and national safety agendas which includes:

- The Maternity Incentive Scheme Year 4 and its 10 Safety Actions/Standards
- Serious Incidents between 1st January 2022 and 31st March 2022
- Ockenden Part 1 and its 7 Immediate Essential Actions
- Ockenden Part 2 (Final) and the 15 Immediate Essential Actions

Cheshire and Mersey Local Maternity System (LMS) have introduced a new reporting template in March 2022 to standardise the reporting process and information shared across the LMS.

The following report will provide the Trust Board of Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) with the Maternity Update covering the reporting period of Quarter 4 for the period from 1st January 2022 to 31st March 2022.

The update will be provided using the new Cheshire and Mersey Template.

2. KEY ELEMENTS

2.1 Compliance with the Immediate and Essential Actions (IEAs) outlined in Part One of the Ockenden Report

WHH has implemented 95% of the 7 Immediate Essential Actions (IEA's) outlined in Part One of Ockenden Report. A position paper was presented to the Executive Team on Thursday 13th April 2022 where its findings were approved. It was noted the remaining 5% compliance is on a trajectory to be completed by 30th June 2022. No risks have been identified.

The following table summarises the 7 IEA's and WHH position:

Immediate Essential Action	Provider report compliance	April 2022 compliance	Comments
1: Enhanced safety	100%	100%	
2: Listening to women and families	88%	95%	Pending final MVP sign off re action plan. Will be presented to QAC in June 2022 for sign off. Regional submission requested July 2022
3: Staff training and working together	89%	100%	
4: Managing complex pregnancy	93%	100%	
5: Risk assessment throughout pregnancy	87%	100%	
6: Monitoring fetal well being	83%	100%	
7: Informed consent	57%	95%	Require MVP Sign off re: Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites. Next MVP meeting 29th April to review actions
Additional elements	70%	95%	Re Audit to demonstrate all guidelines are in date. All guidelines and dates monitored monthly at W&C governance. Pending audit of guidelines in date to be undertaken.

Ockenden Part Two Report (Final) was released on 30th March 2022 which recommended the implementation of an additional 15 Immediate Essential Actions which incorporates 92 further actions. Analysis of this report is being undertaken by Women's and Children's Clinical Business Unit and a Ockenden Part Two Oversight Group has been set up to enable the operationalisation of the implementation of its actions. The group will meet bimonthly and will be monitored at W&C CBU Governance. The action plan will also be monitored through Committee and the Quality Assurance Committee.

a. Maternity Incentive Scheme (MIS)

The current pandemic and subsequent associated challenges faced by the National Health Service (NHS) led to NHS Resolution (NHSR) notifying WHH on the 23rd December 2021 of a minimum 3 month pause in the initial MIS Year 4 reporting requirements; the pause was dated to 31st March 2022. Since the QAC meeting on the 3rd May 2022 NHS Resolution has

released new guidance The Scheme submission deadline has been extended from June 2022 to 5th January 2023. Interim safety actions have also been reviewed and extended.

New Maternity Incentive Scheme Recommendations as per NHS Resolutions guidance:

Maternity incentive scheme year four: conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (nhsr.mis@nhs.net) by 12 noon on Thursday 5 January 2023 and must comply with the following conditions:

- Trusts must achieve **all** ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing maternity safety action by the Head of Midwifery and Clinical Director for Maternity Services
- The Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:
  - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
  - There are no reports covering either year 2021/22 or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before Thursday 5 January 2023.
- The Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- In addition, The CEO of the Trust will ensure that the Accountable Officer (AO) for their Clinical Commissioning Group/Integrated Care System (CCG/ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution

  Note: CCG functions will be subsumed into integrated care systems, with CCGs ceasing to exist as statutory organisations by July 2022.

MIS is monitored through the W&C CBU Governance meeting and updates also presented to QAC. In preparation of submitting the evidence of the MIS safety standards Warrington and Halton Teaching Hospital (WHH) is undertaking an external audit by on 13th June 2022.

The review will be limited to the following MIS safety actions:

• Safety action 1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

• Safety action 2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

• Safety action 10. Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22**?**

The findings of this review will be reported to QAC and the Trust Board.

Since the initial pause of submission deadlines WHH have continued to embed the recommended 10 Safety Actions which includes reporting to Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Health and Safety Investigation Branch (HSIB) and submit data to NHS Digital Maternity Services Data Set (MSDS).

WHH is on a trajectory to achieve 100% compliance however some challenges continue which have been escalated previously to Quality Assurance Committee (QAC). The following table summarises WHH MIS Year 4 position and RAG rated:

MIS Safety Action	Standard	On Track	Comments
1	Are you using the National Perinatal Maternal Review Tool to review perinatal deaths to the required standard?	Yes	WHH mean Stillbirth Rate from 1st April 2021 to March 31st 2022 is 3.10/1000 MBRRACE average rate 3.51/1000 WHH mean Neonatal Mortality Rate from 1st April 2021 to March 31st 2022 is 0.8/1000 MBRRACE average 1.54/1000 Quarter 4 PMRT audit underway.
2	Are you submitting data to the Maternity Service Data Set (MSDS) to the required standard?	Yes	Please see below
3	Can you demonstrate you have Transitional Care (TC) services to minimise separation of mothers and babies & support recommendations to Avoiding Term Admission to Neonatal Unit (ATAIN)	Yes	Please see below WHH Q4 ATAIN Rate is 5.6% 2021/22 ATAIN rate 5.9% National Target 6% NWODN target 5.6%
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	Undertaking RCOG audit ACSA accreditation in March 2022
5	Effective system of Midwifery workforce planning to the required standard?	Yes	Birth Rate Plus report identified Midwifery Birth ratio of 1:24.6 in February 2022
6	Can you demonstrate compliance with all 5 elements	Yes	All 5 elements have been embedded into maternity services. MSDS challenges re

	of the Saving Babies Lives Version 2 Care Bundle?		smoking data
7	Can you demonstrate you have a mechanism for gathering service user feedback & you work with service users through Maternity Voice Partnership to co-produce local services	Yes	Annual MVP report submitted to Board on 30th March. Pending MVP sign off re MVP action plan & evidence of accessibility, information and co-production.
8	Can you evidence a local training plan is in place to ensure 6 core competency framework over next 3 years	Yes	Training plan in place. Plan reviewed & revised monthly re impact of COVID and staffing.
9	Can you demonstrate that the trust safety champions are meeting bimonthly with Board level champions to escalate local issues	Yes	Fully embedded
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch and NHSR Early Notification Scheme for 2021/22	Yes	100% reported

- *Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?*

The current database, Lorenzo, presents some operability challenges which have been escalated at previous QAC meetings. The maternity service is about to implement Badgernet as its new maternity database system which will significantly improve maternity reporting mechanisms and centralise maternity documentation to one platform. Badgernet will go live on the 3rd May; despite the implementation of Badgernet and its reassurance of quality data, it is imperative the legacy data of existing records are exported. Subsequently the current MSDS challenges need addressing for WHH to be compliant.

Body Mass Index (BMI) is recorded on Lorenzo however Lorenzo does not have a process for extracting and submitting the MSDS data, thus WHH is showing as not achieved on the National Maternity Dashboard. Maternity Digital Midwives at WHH are in discussion with system providers Dedalus to develop an additional reporting mechanism to achieve compliance.

Since NHS Resolution released its new reporting guidance and schedules on 6th May 2022, Women's and Children's Clinical Business Unit (W&C CBU) is able to provide reassurance this should be achieved due to the implementation of Badgernet in May 2022. W&C CBU is working with WHH Chief Information Officer Tom Poulter to review data extraction from Badgernet and address any concerns identified.

SA2: MSDS is being reviewed by MIAA as part of the external compliance audit which will help to provide assurance this standard will be met.

- *Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?*

Transitional Care (TC) has been fully implemented and is audited quarterly. Quarter 3 TC audit identified interoperability challenges and subsequent poor recording of data. Currently data can be captured on Lorenzo, White Board and Neonatal Badgernet. A task and finish group has been set up to prospectively monitor and audit care of babies on the TC pathway. Quarter 4 audit is underway. Badgernet will eliminate data challenges related to TC

All MIS activity is monitored weekly at W&C CBU MIS meeting and monthly via W&C CBU Governance meeting. Badgernet has gone live on the 3rd May which will significantly improve data collection and assurance.

- *Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies Lives care bundle version 2?*

Element 1 relates to smoking in pregnancy. WHH reports 90% compliance with the recording of Carbon Monoxide (CO) measurement at booking via Lorenzo data system.

CO measurement at 36 weeks gestation is also required as part of the MSDS dataset. The National Maternity Dashboard for Smoking in Pregnancy is reporting WHH as 'not achieved'. WHH has a hybrid system which includes paper and an electronic process. Data extraction from Lorenzo reports WHH has 30-40% electronic submission compliance. WHH Chief Information Officer, Dr Tom Poulter is working with the maternity digital team to address this challenge.

A data improvement task and finish group are monitoring compliance and further initiatives are being developed to improve electronic reporting compliance. Local audit of CO recording is underway to monitor compliance however there will need to be a sustained improvement following the implementation of Badgernet to ensure improvement in MSDS data quality reporting

2.3 Perinatal Quality Surveillance Model (PQSM)

The Cheshire and Mersey LMS have introduced a Standard Operating Procedure (SOP) in March 2022 titled:

Standard Operating Procedure (SOP) describes how the Perinatal Clinical Quality Surveillance model is embedded in the ICS governance structure and signed off by the ICS

The SOP aims to facilitate the standardisation and oversight of perinatal clinical quality.
The national dashboard will report each provider as having red or green compliance against national targets. There are no amber parameters.
WHH PQSM Dashboard and has RAG rated WHH as Red for the following components of the dashboard:

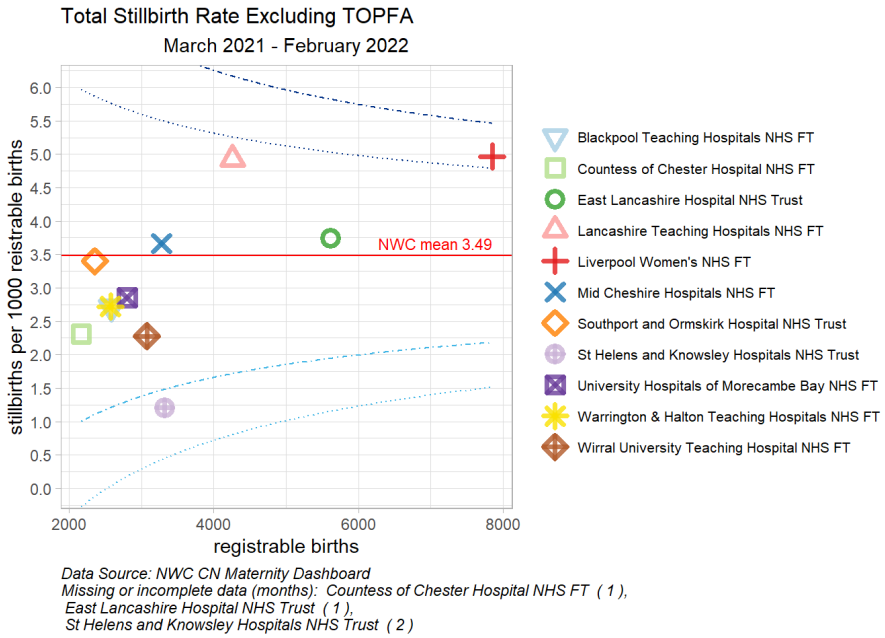
Still Birth Rate:

WHH stillbirth rate for Q4 2021/22 was 1.54 per 1000 births. WHH Mean rate 3.1/1000 births. MBRRACE-UK national rate 3.51/1000 births. Subsequently this data identifies WHH in a good position.

Annual Stillbirth rate:

Quarter	WHH Stillbirth Rate Per 1000 total births
MBRRACE UK National Rate 3.51 per 1000 total births	
Q1 2021/22	3.30
Q2 2021/22	1.48
Q3 2021/22	4.46
Q4 2021/22	1.54
Mean	**3.1**

Total Stillbirth Rate Excluding Termination of Pregnancy for Fetal abnormality (TOPFA)



Data Source: NWC CN Maternity Dashboard
Missing or incomplete data (months): Countess of Chester Hospital NHS FT (1),
East Lancashire Hospital NHS Trust (1),
St Helens and Knowsley Hospitals NHS Trust (2)

Run Chart for Total Stillbirth Rates Excluding TOPFA

Avoiding Term Admission to Neonatal Unit:
Percentage of Term Admissions to Neonatal Unit reports WHH as Red RAG rated for 7 out of 11 months data. WHH current Avoiding Term Admissions to Neonatal Unit for the period of 1st April 2021 to 31st March 2022 is 5.9% Nataional trajectory is 6% North West Operational Delivery Network is 5.6%. WHH is on a trajectory to meet NWODN target as illustrated in Q3 ATAIN rate of 5.2% and Q4 ATAIN rate of 5.6%.These would RAG Raate WHH as Green in Q3 and Q4 however Red for annual rate for C&M LMNS

W&C CBU would like to note the significant improvement made in 2021/2022 to reduce ATAIN rate.

Training Compliance:

Maternity services training compliance has been affected by the impact of COVID 19 and absence rates. The training plan is monitored monthly at the W&C CBU governance meeting and new dates booked when a training session has been cancelled to keep staffing levels safe and to avoid the escalation and or divert of services. Cancellation of any training is authorised by the senior leadership team following extensive review of the rota, specialist midwives supporting clinical activity and team leaders working in the clinical setting. Currently Badgernet training is prioritized to facilitate the go live date in May. Once complete this will release additional training opportunities to catch up on other cancelled training sessions.

WHH extract from PQSM Dashboard

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training														
Percentage of staff attending K2/CTG training	**90(%)**	78.5(%)					87(%)	80(%)	84(%)	73(%)	74.5(%)		75(%)	76(%)
Percentage CTG competency assessment all staff groups	**90(%)**	67(%)					82(%)	73(%)	64(%)	64(%)	53(%)		69(%)	63(%)
Percentage PROMPT / Emergency MDT training all staff groups	**90(%)**	73(%)					85.6(%)		88.23(%)		73(%)		73(%)	
Percentage Core competency framework	**90(%)**						(%)	(%)	(%)	(%)	(%)			

1:1 Care in Labour:

WHH is reported as red on the Northwest Coast Maternity Dashboard and outlier for not providing 100% 1:1 care in labour as recommended by National Institute for Clinical Excellence

A red flag system is embedded within WHH maternity services which reports a range of sub optimal clinical situations directly to the maternity bleep holder. The Birth Site Coordinator reports all occasions where 1:1 care is not provided to the Maternity Bleep holder via the Red Flag system. The red flag reports are reviewed by the Women's and Children's Clinical Business Unit Governance Meeting. A recent Red Flag audit for the period of June 2021 to February 2022 has reported 5 episodes when 1:1 care was escalated and acted upon in accordance with local escalation pathway.

1:1 care in labour is not a mandatory field within the current Lorenzo data system. On investigation of this data, we have identified missing data on the system which correlates with the red flag reports. To improve the reporting of 1:1 care this finding has been added to the maternity safety brief and included in Badgernet training to ensure this key metric is captured in future data.

2.4 The Perinatal Clinical Surveillance Quality Assurance Report

No exceptions as per section:

The Perinatal Clinical Surveillance Quality Assurance Report includes key metrics against the following themes:

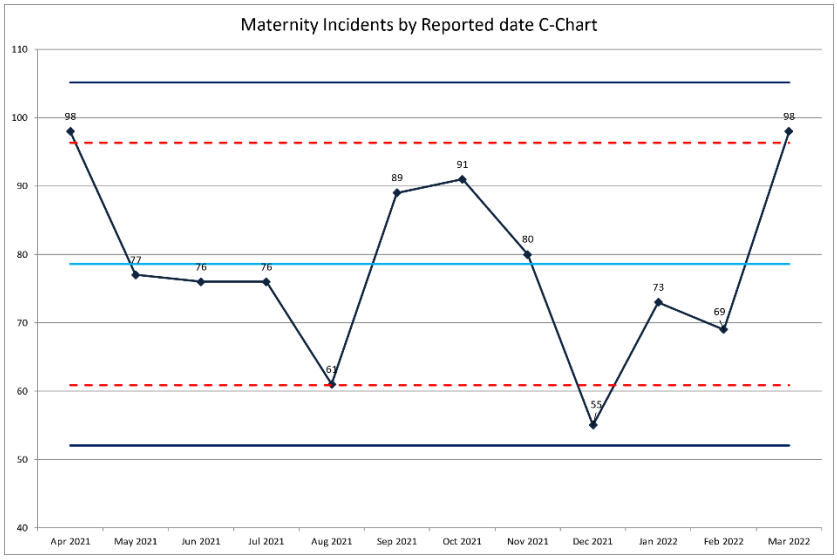
- Clinical care reported as being within in normal variation
- Service user and staff feedback: Please refer to National CQC findings re service user feedback. Pending findings of staff survey
- Leadership and relationships: Retention midwife and Consultant Midwife commenced their roles in April
- Safety and learning culture within normal variation

- **Incident reporting**

240 incidents maternity incidents reported in Quarter 4.

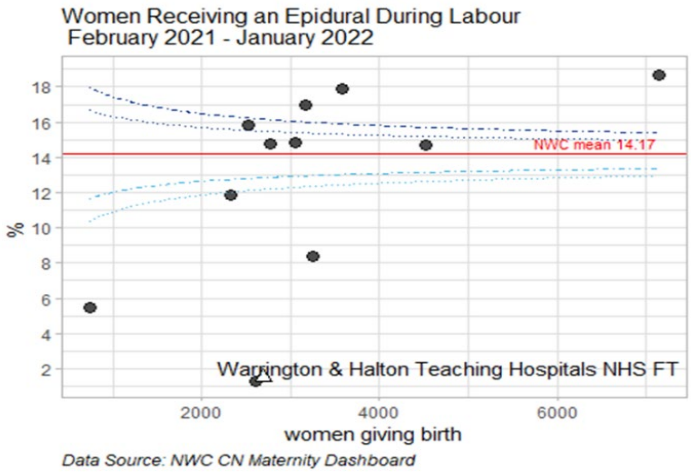
Averaging 80 incidents reports per month

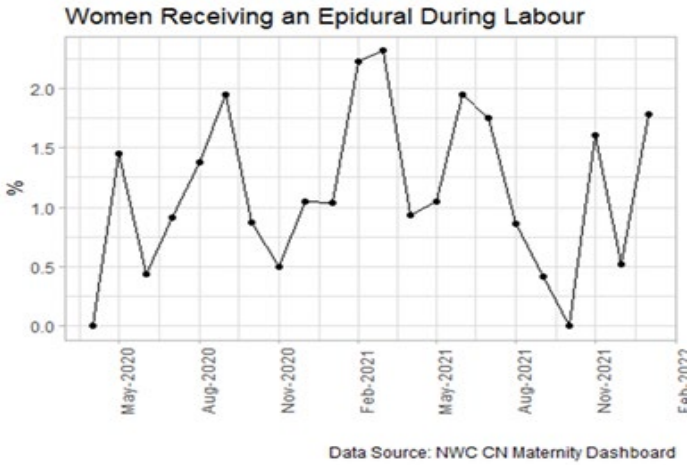
Row Labels	1 - Negligible / None	2 - Minor	3 - Moderate	Grand Total
January	70	1	2	73
February	65	4		69
March	94	4		98
Grand Total	229	9	2	240



2.5 The Cheshire & Mersey LMNS Clinical Outcome / Outlier Report

WHH have been reported on the Northwest Coast Maternity Dashboard as having very low epidural rates as indicated in the following graph:





In response to the Local Maternity System request to confirm its epidural data WHH have reviewed NHS digital statistics which notes the national epidural rate for the year 20-21 as 18.8%

WHH has undertaken a manual audit of the same time period which concludes the number of epidurals sited in 2021 were 318. When calculated against the 2592 number of births this equates to WHH having an epidural rate of 12.26%; a variance of 6.54% from the national epidural rate average of 18.8% and 1.95% from the mean epidural average of 14.21% within the NW Coast dashboard.

The audit findings concluded a technical challenge within its current data system Lorenzo, which has identified inaccuracies within the epidural data field and how this is extracted. Data reporting will be improved with the implementation of Badgernet in May 2022.

WHH maternity services offer 24/7 anesthetic cover and formed part of the recent Anesthesia Clinical Services Accreditation (ACSA) standards which was assessed in March 2022.

3.3 Serious Incidents

Serious incidents (SIs) continue to be reported monthly on the regional dashboard by all maternity providers in C&M and in Lancashire and South Cumbria. SIs are also reported to the LMS with the QSSG having further oversight of all SI's across the region. (A Cheshire and Merseyside SI panel is being established.)

During Q4 two SI were opened:

1. Related to Notification of a maternal death of a woman, 6 months following the birth of her baby. Reported to MBBRACE
2. Related to Maternity divert on 13th March 2022 due to acuity.

During Q4 two SI were closed:

Divert 1 occurred on 28th October 2021 due to reduced staffing levels. Reported as Negligible/No harm

Divert 2 occurred on 31st October 2021 due to reduced staffing levels Reported as Negligible/no harm

The Cheshire and Mersey Escalation and Divert Policy was implemented which captures narrative and learning following maternity divert. Since the October maternity diverts W&C CBU have strengthened the pathway further by introducing a proforma when the unit is in amber status to capture measures undertaken to avert divert. In the event this cannot be prevented the unit will then escalate to the executive on call who then will enable further support where appropriate, give permission to go on divert and facilitate executive to executive communication with local maternity providers.

All maternity diverts are STEIS reported and investigated using WHH governance process which includes review by the W&C CBU triumpherite and WHH Meeting of Harm

3.4 Health Care Safety Investigation Branch (HSIB)

HSIB undertake independent investigations into incidents within maternity services which fall under defined criteria that include maternal deaths, stillbirths and babies that require cooling.

3.41 HSBI Report table

HSIB Maternity Investigations Update Warrington and Halton Hospitals NHS Foundation Trust Team: North West Team Leader: Samantha Ladd Link MI: Karen Armsden Week ending: 1 April 2022	HSIB HEALTHCARE SAFETY INVESTIGATION BRANCH

Executive Summary

Cases to date	
Total referrals	18
Referrals / cases rejected	5
Total investigations to date	13
Total investigations completed	12
Current active cases	1
Exception reporting	None

18 referrals to HSIB have been made between November 2019 – April 2022
1 new case was reported to HSIB in March 2022 and is currently being investigated. Investigations can take 6 months to complete. The current investigation is in relation to a baby requiring cooling.

SA10: HSIB will be audited by MIAA on 16th June 2022

3.5 Care Quality Commission CQC Review

CQC rating as Good

The National Maternity CQC Survey was released into the public domain in February 2022. The Maternity Voice Partnership Chair, stakeholders, members and W&C CBU are working collaboratively to prioritise the findings of the survey. A draft action plan has been developed with the MVP members and key stakeholders which will be confirmed at the next MVP meeting on 29th April 2022.

The Maternity Survey Action plan will be monitored by W&C CBU Governance meeting, QAC and Patient Experience Sub Committee. Working collaboratively with the MVP also relates to MIS Safety Action 7 standard

3.6 Safety Champion Report

During the Quarter 4 reporting period Maternity and Neonatal Safety Champions Update Reports have been presented to Quality Assurance Committee monthly by exception. All papers have then been shared with the Board of Directors as per Ockenden and MIS Year 4 recommendations and include:

- Ockenden Part One Position Paper in January 2022
- Ockenden Update re Maternity Self-Assessment Tool position paper In March 2022
- Maternity Incentive Scheme Updates January, February and March 2022
- Perinatal Mortality Review Tool Quarter 3 audit 2021/22 report in March 2022
- Avoiding Term Admissions to Neonatal Units (ATAIN) Quarter 3 report
- Birth Rate Plus Report April 2022
- Maternity Voice partnership update and annual report
- CQC National Maternity Survey Findings in March 2022

The Maternity and Neonatal Safety Champions undertake a monthly listening event by walking around the maternity and neonatal unit. This facilitates Ward to Board and Board to Ward communication. During this period, the Maternity and Neonatal Safety Champions have assisted the W&C CBU to secure funding for new Neonatal resusitaires and Birthing Beds on the Birth Suite. These were delivered in February and are now being enjoyed by the women and the team.

A quarterly Maternity and Neonatal Maternity Champions Newsletter is also produced to share hot topics discussed, CBU learning from incidents and key performance indicators.

All newsletters are shared at W&C CBU Governance Meeting and circulated to all clinical staff members.

4. Workforce: Maternity and Neonatal Staffing

Birth Rate Plus is a nationally recognised Acuity / Staffing tool used to assess safe staffing levels in maternity services. WHH have recently undertaken a review of midwifery staffing within the maternity service at the Trust and received its report in February 2022. The key findings of the report were presented to QAC in April 2022. It was noted:

- Total Midwife to Birth ratio is 1:24 which is in line with the national midwifery staffing ambition.
- Total number of Clinical MW 106.09wte
- Total number Specialist MW 10.61 WTE

The biannual staffing review is currently being undertaken and will be reported to QAC in June 2022.

C&M LMS is currently funding an upgrade of the Birthrate Plus acuity tool currently used on

birth suite to assess acuity. The upgrade will incorporate an app which will record acuity within the birthing and maternity ward environment. The app will link into the regional status and provide oversight of maternity activity across Cheshire and Mersey. WHH is awaiting an installation date.

Neonatal staffing is monitored by the regional Neonatal Operational Delivery Network (NODN) and the establishment currently aligns with the acuity, capacity, and demand of the service.

5. Midwifery Continuity of Carer (CoC)

Following on from Better Births in 2016 the Maternity Transformation Programme has supported the roll-out of a revised model of midwifery care – Continuity of Carer. The benefits of a woman being cared for by the same team of midwives throughout her pregnancy, including the delivery and following, cannot be underestimated. Clinical outcomes are

improved with this model of care, with women reporting positive birth experiences with the woman less likely to experience postnatal illness.

Currently WHH has 6 Continuity teams which includes Team Lunar who provides care to women wishing to birth their baby at home and Team River who support our most vulnerable families across Warrington.

Ockenden Part Two Report was released on 30th March 2022 where it recommended providers to review its COC model and consider pausing future development until safe staffing was assured. W&C CBU reviews its staffing on a daily basis and where staffing levels have been identified as suboptimal maternity services have a robust process to manage and escalate concerns; where appropriate and safe to do so services will be stepped down or diverted using WHH governance processes and executive agreement.

W&C CBU is currently reviewing and appraising its options and impact to women, services and organisation should staffing levels become unsafe to continue COC.

C&M LMS have requested each provider submits its updated CoC action plan by 15th June 2022. WHH CoC action plan is currently being reviewed and will be shared with QAC in June for approval prior to sharing. WHH is monitoring COC to ensure staffing levels remain safe. This is monitored through W&C CBU governance meeting and a new Ockenden Part Two Oversight Group which will meet bimonthly.

6. Quarter 4 2021/22 Perinatal Mortality Review Report

WHH reported four babies to MBRRACE-UK between 01/01/2022 – 31/03/2022.

- 2 babies were early neonatal deaths, one baby born at 20 weeks gestation and one baby born at 21+4 weeks gestation. The deaths were notified, and surveillance completed. MBRRACE advised the use of the perinatal mortality review tool is not

supported at this gestation. Both cases were reported to Child Development Overview Panel (CDOP)

- 1 baby born at 35 weeks gestation was a late neonatal death at three weeks of age. The baby's death has been notified to MBRRACE and surveillance completed. A PMRT review of care provided to the family will be scheduled. The infant's death has also been notified to the Child Death Overview Panel (CDOP) and the Coroner.

- 1 baby was born stillborn at 25+2 weeks gestation. PMRT review for this baby is scheduled for 1st April 2022

- WHH stillbirth rate for Q4 2021/22 was 1.54 per 1000 births. WHH Mean rate 3.1/1000 births. MBRRACE-UK national rate 3.51/1000 births.

- WHH Annual rate from the 1stJanuary 2021/ to 31st 12 2021 is 2.3 per 1000. This is not a national reporting timeline. This data was included to evidence the importance of reviewing a wider timeline due to the impact small numbers have on statistics.

- WHH Neonatal Mortality rate for Q4 is yet to be reported as awaiting data from Operational Delivery Network (ODN). While we will have WHH data, any WHH babies which have been transferred to another neonatal unit and then sadly died, also needs to be captured in the report. Due to the constraints of GDPR we await the ODN data which reports 2 months previously.

- WHH Q3 Mean Neonatal Mortality Rate is currently 0.8 per 1000 births. National MBRRACE Neonatal Mortality rate is 1.64 per 1000 births. Which was reported to QAC in March 2022.

A comprehensive quarter 4 perinatal mortality review audit report is being collated and will be presented to the Quality Assurance Committee when all the quarter 4 perinatal mortality and morbidity figures are available.

7. Learning from maternity claims complaints and incidents

Safety Action 9 of year 4 MIS requires maternity, neonatal and Trust Board Safety Champions to review the Trusts Claims Scorecard as reported by NHS Resolution alongside incident and complaint data with the aim of targeting interventions to improve patient safety,

- Maternity claims data reported by NHS Resolution from 01/04/2011 – 31/03/21 has been reviewed

There were 430 claims against the Trust during this period of which 35 were maternity claims.

The maternity claims represent the highest value and the fourth highest number of clinical negligence claims reported to NHS Litigation Authority.

Currently there are 12 maternity claims open and 20 maternity claims have been closed.

The total value of all claims is £125, 240, 26
The total value of maternity claims is £81,311,010

Of the claims closed, 60% (12 claims) have not incurred damages for the Trust, with an average claims value of £4,122

Of the settled claims with damages which related to pain 40% (8 claims) have an average claims value of £89,943

3. MONITORING/REPORTING ROUTES

The content of this report is monitored locally through Women's and Children's Governance Meeting. Content is also monitored by the Cheshire and Mersey Local Maternity Dashboard and Northwest Operational Delivery Network.

This paper will be updated using the C&M LMNS template on a quarterly basis.

4. MONITORING/REPORTING ROUTES

The contents of this paper are shared primarily with W&C CBU Governance meeting followed by QAC before final presentation to the Trust Board.

5. ASSURANCE COMMITTEE

QAC

6. RECOMMENDATIONS

The Trust Board is requested to receive this paper for information and approve its contents as per MIS and Ockenden recommendations.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/58**	
SUBJECT:	**2021/22 SIRO (Senior Information Risk Owner) Report**	
DATE OF MEETING:	25 May 2022	
AUTHOR(S):	Tom Poulter, Chief Information Officer and SIRO Mark Ashton, Information Governance and Corporate Records Manager Stephen Deacon, Head of Digital Compliance	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
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)***	#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. #145 a. Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This assurance report is provided on behalf of the Senior Information Risk Owner (SIRO) who has executive responsibility for information risk and information assets. In order to demonstrate compliance with the NHS Digital Data Security and Protection Toolkit (DSPT) standards, and to ensure the Board is adequately briefed on information risks, it is necessary to provide a report detailing identified information risks and progress against the DSPT standards more generally. The report outlines the self-assessed performance, informed by MIAA review, against the standards in the DSPT. The Trust continues to perform well against the standards, continuously working to reduce risk and improve processes. The report includes a view on the standards which the Trust is unable to currently comply with, based on tighter national guidance aimed at raising the bar in the NHS in the area of Information Governance and Cyber Security. It is anticipated that the June 2022 DSPT submission to NHS Digital will reflect this position with a likely overall rating of "Approaching Standards" for 2021/22. Robust plans are being put in place to ensure all necessary actions will be completed to maximise the likelihood of the 2022/23 submission achieving a "Standards Met".	

	The Senior Information Risk Owner is required to act as an advocate for information risk on the Trust Board and is responsible for providing appropriate Information Governance content for inclusion in the Quality Account Statement and the Annual Report.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note ✓	Decision
RECOMMENDATION:	The Board is asked to: Note and approve the contents of the report. Receive assurance that SIRO responsibilities are being fulfilled effectively.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 31-Law Enforcement			

REPORT TO BOARD OF DIRECTORS

SUBJECT	SIRO Report	AGENDA REF:	BM/22/05/58

1. BACKGROUND/CONTEXT

The objective of this SIRO report is to inform the Board of progress against the Data Security and Protection Work programme for the period 2021/22. It contains a quantitative and qualitative analysis (using information obtained from the Datix risk and incident system, CareCERT dashboard, ITHealth Assurance Dashboard, Data Security and Protection Toolkit, MIAA audit reports, and the minutes of the Information Governance and Records Sub-Committee).

Organisations that have access to NHS patient information must provide assurances that best practice data security and protection mechanisms are in place. The report includes a summary of key outstanding issues and clarifies the planned actions to resolve these.

The purpose of the report is to ensure that the Board understands how the strategic business goals of the organisation may be impacted by information risks and the steps being taken to mitigate those risks. The Trust's Senior Information Risk Owner position is currently held by the Chief Information Officer. The SIRO position became a key element of the new Chief Information Officer's role on commencement of employment with the Trust in August 2021. The SIRO is responsible for the provision of assurance to the Board that information risks are adequately managed.

2. KEY ELEMENTS

The assurance section of the report is divided into six distinct areas. The relevance of each section is described below.

- **Information Governance Framework**

In line with the requirements of Assertion 1 within the DSPT the Trust must demonstrate that there are clear lines of responsibility and accountability to named individuals for data security. It must also demonstrate that data security direction is set at Board level and is translated into effective organisation practices.

The Information Governance (IG) Framework describes the structure in place to manage the burgeoning data security agenda and the key staff involved in that process.

- **Information Risk Analysis**

The Trust must demonstrate that robust processes are in place to understand and manage identified and significant risks to sensitive information and services. The information risk analysis element of this report describes the arrangements in place to manage such risks.

- **Data Security and Protection Toolkit Performance**

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool which allows the Trust to measure its performance against the National Data Guardian's 10 data security standards. Annual submission of a baseline and final DSPT assessment to NHS Digital is a mandatory requirement.

The DSPT performance section of this report articulates the current compliance position, areas of weakness, and the proposed June 2022 DSPT submission.

- **Cyber Security Arrangements**

Cyber threats are now ever-present, and when set against a backdrop of heightened tensions with Russia, all of the UK's vital infrastructure (Operators of Essential Services) are operating at a heightened cyber threat level despite the lack of threat intelligence to indicate an impending attack. The Trust works with both NHS Digital and NHS England, in conjunction with the National Cyber-Security Centre, to deploy specialist products, manage cyber risk and to repel cyber-attacks. In line with Assertion 6 of the DSP Toolkit the Trust must have robust arrangements in place to identify and resist cyber-attacks. In addition, the Trust must demonstrate that it is responsive to security advice and alerts provided by NHS Digital.

This section of the report describes the arrangements in place to protect the Trust's IT infrastructure and information systems from cyber-attack.

- **Externally Reported Data Security Incidents**

In line with Assertion 6 of the DSP Toolkit the Trust must have a procedure in place to ensure that data security and protection incidents are managed and reported appropriately.

This section of the report contains detail related to 2021/22 data security incidents deemed of the requisite severity for reporting via the DSP Toolkit incident reporting tool. In some cases, incidents will have been escalated to the Information Commissioner's Office, the Department of Health and Social Care and NHS England.

- **The Role of the SIRO & the Trust's Caldicott Guardian**

In line with DSP Toolkit Assertion 1, the Trust must have a Board-level individual who has overall accountability for the security of networks and information systems. This individual is known as the Senior Information Risk Owner.

In addition to the SIRO all NHS organisations must have a Caldicott Guardian. The Caldicott Guardian is responsible for protecting the confidentiality of health and care information and making sure it is used properly.

This section of the report explains how both the SIRO and Caldicott Guardian fulfil their roles and demonstrates that they are active and participating in the Trust's data security and protection agenda.

3. SUMMARY OF ASSURANCE

3.1 Information Governance Framework

The Trust's DSP annual work plan (cycle of business) details the standing agenda items which are included at each meeting of the Information Governance and Records Sub-Committee (IGRSC). The cycle of business for 2022/23 was reviewed and approved in February 2022.

The (IGRSC) meets on a bi-monthly basis and is chaired by the Trust's Chief Information Officer (SIRO) and is attended by the Caldicott Guardian (Executive Medical Director).

Key Information Governance staff members are:

- SIRO (Chief Information Officer)
- Caldicott Guardian (Executive Medical Director)
- Head of Digital Compliance - Stephen Deacon
- Information Governance and Corporate Records Manager/DPO - Mark Ashton

The Information Governance and Records Sub-Committee reports directly to the Quality Assurance Committee and its core members include:

- SIRO (CIO)
- Caldicott Guardian (Medical Director)
- Deputy CIO
- Head of Digital Compliance
- Information Governance and Corporate Records Manager
- Medical Records Manager
- Head of Enterprise Solutions
- Lead Nurse for Nurse Staffing & Workforce Improvement (Clinical Safety Officer)
- RA (Smartcard) Lead
- Information Asset Owners (key systems)

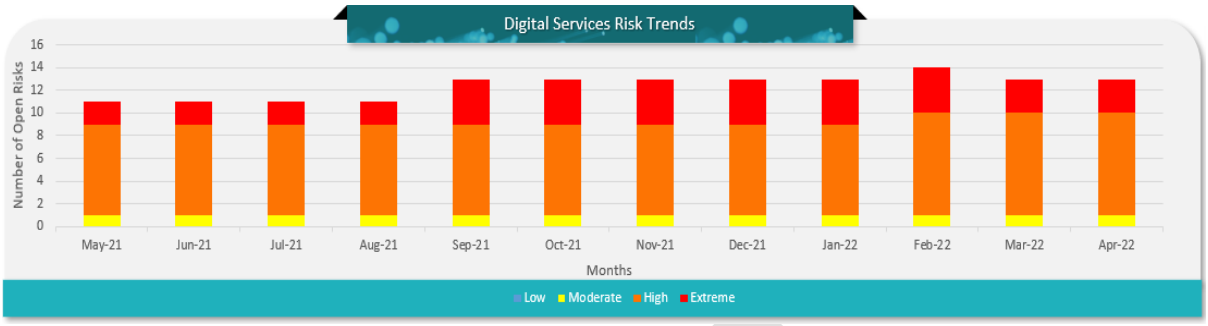
In addition to the IGRSC's bi-monthly reporting obligations to the Quality Assurance Committee the Audit Committee will be provided with Information Governance related audits conducted by Mersey Internal Audit Agency. Most notably this will include the annual Data Security and Protection Toolkit Assurance Review.

3.2 Information Risk Analysis

The Head of Digital Compliance manages data security risks within the Datix risk/incident system for Digital Services. The Digital Services risk management process ensures that risk management is structured according to Trust policy and risks are regularly reviewed at the Digital Services Risk Review meeting. The Digital Services Risk Review Group meets on a monthly basis. Digital Services are also represented at the Trust's Risk Review Group to review risks each quarter.

Digital Services risks and mitigating actions are scrutinised by the Trust's Risk Review Group. All Information Governance/Cyber risks are also included as a standing agenda item at the IGRSC. Risk information is then escalated to the Quality Assurance Committee.

The graph below indicates Digital Services Risk trends over the previous 12-month period with the total risk score remaining fairly constant during 2021/22. We have seen a trend in fewer extreme and a slight rise in moderate risks since February 22. 4 risks were closed, and 6 new risks were added to the Digital Services risk register in the last 12 months.



The Cyber/IG-based risks are:

Risk Description	Outstanding Actions	Rating
FAILURE TO deliver essential Digital services (cyber-attack) **CAUSED BY** a successfully executed Cyber Attack, resulting in loss of access to data and vital IT systems **RESULTING IN** potential patient harm, loss in productivity, damage to the Trust reputation and possible income losses and regulatory fines of up to 4% of the Trusts annual turnover.	• Migrate all Windows Server 2003 and 2008 to 2016 • Migrate endpoints devices to Windows 10 • Turn on end user device firewalls, to help limit a spread of an infected device infected other devices on the internal network • On call Arrangements for cyber-Security • Business case for SQL Server 2012 • Enable Anti-Virus on PACS Cluster Nodes	12
FAILURE TO prevent unauthorised access to electronic person identifiable data **CAUSED BY** smartcard and password sharing **RESULTING IN** invalidation of electronic clinical systems audit trail data and a breach of confidentially.	• Recommence ward audits post to maintain improved standards • Review the plan to use virtual smartcards, to mitigate the bad practice of leaving smartcards in smartcard readers	9
FAILURE TO secure paper medical records in clinical areas **CAUSED BY** poor housekeeping **RESULTING IN** potential breaches of confidentiality	• Recommence ward audits post to maintain improved standards	6
FAILURE TO implement the requisite NIS Directive (Networks and Information Systems) policies, procedures and processes **CAUSED BY** lack of resources and monies **RESULTING IN** potential unplanned downtime for systems without resilience, possible income losses, interruption to service, patient harm and regulatory fines of up to 4% of the Trusts annual turnover.	• Load balancer needs to be tested • Data workflow to be remapped	12

3.3 Data Security and Protection Toolkit (DSPT) Performance

Launched in 2018, the DSP Toolkit is the means by which the Trust can assess its level of compliance with the National Data Guardian's 10 standards and NHS Digital's guidance for GDPR compliance. The Trust must undertake assessments against the NHS Digital Data Security and Protection Toolkit on an annual basis. This requirement is documented within Information Standards Notice Amd 71/2020 published under section 250 of the Health and Social Care Act 2012.

Subject to ongoing development, the DSPT currently comprises 38 assertions which break down into a number of evidence items dependant on the category type of the NHS organisation. There are four category types within the current DSPT:

- Category 1-NHS Trusts
- Category 2-CCGs, CSUs, and ALBs
- Category 3-Others
- Category 4-GPs

There are a total of 142 evidence items specified for NHS Trusts (category 1). 110 of these items are mandatory and the evidence items are divided into 10 domains which mirror the National Data Guardian's 10 security standards. These are:

- Personal Confidential Data
- Staff Responsibilities
- Training
- Managing Data Access
- Process Reviews
- Responding to Incidents
- Continuity Planning
- Unsupported Systems
- IT Protection
- Accountable Suppliers

The Trust's 2021/22 Data Security and Protection Toolkit assessment is currently being carried out by Mersey Internal Audit Agency and consists of two phases. The first phase, conducted in March 2022, consisted of a readiness review which was designed to assess the Trust's preparedness for the DSPT final submission which must be made by 30th June 2022.

The second phase of the 2022 IG assurance audit process, consisting of a progress review, commences in May. The finalised report will include the following ratings:

- MIAA's confidence level in the veracity of the DSPT self-assessment carried out
- MIAA risk rating of the WHH data security and data protection control environment

The MIAA DSPT review will be conducted in line with the assessment methodology for independent assessment and internal audit providers published by NHS Digital in September 2020.

June 2022 DSPT Submission

The final submission of the 2021/22 DSPT assessment to NHS Digital must take place by June 30th 2022. Following submission and audit/assurance processes, each trust is awarded an overall DSPT status category as follows:

- Not Published
- Standards Not Met
- Approaching Standards
- Standards Met
- Standards Exceeded

Final publication assessment scores reported by organisations are used by the Care Quality Commission for use as part of the Well Led inspection.

Since the launch of the DSPT in 2018 the trust has made good progress in moving from "Standards Not Met" to "Approaching Standards", with comprehensive action plans in place and agreed with MIAA and the DSPT team where appropriate.

The Information Governance and Records Sub-Committee were aiming to achieve "Standards Met" for the 2021/22 submission, however, primarily due to staffing capacity issues within both the wider clinical workforce and more specifically in IT Services, the five standards summarised below are unlikely to be fully completed by end of June 2022. As such the expectation is that the trust will be rated as "Approaching Standards" in the final 2021/22 submission.

DSPT Evidence Item	Action Required	Owner(s)
3.2.1 (Mandatory) Have at least 95% of all staff, completed their annual Data Security Awareness Training?	Reach the NHSD 95% target of staff completing the annual Data Security by the following methods: - ESR Training - Face-to-face for non-PC users - Communications from Medical Director to CBU management teams - Professional leads encouraging staff to complete their training	M. Ashton (in conjunction with Education)
4.1.2 (Mandatory) Does the organisation understand who has access to personal and confidential data through your systems, including any systems which do not support individual logins?	Agree key system approach based on clear criteria for business critical systems Digital Optimisation Group and the Event Planning Group to agree the key systems.	S. Deacon/M. Ashton

8.1.3 (Mandatory) Devices that are running out-of-date unsupported software and no longer receive security updates (patches) are removed from the network, or the software in question is uninstalled. Where this is not possible, the device should be isolated and have limited connectivity to the network, and the risk assessed, documented, accepted, and signed off by the SIRO.	Migrate from unsupported Windows Server 2003/2008 (3 systems left to migrate) Migrate from unsupported Windows 7 (2 systems to migrate) If devices cannot be migrated, mitigations put in place	S. Deacon/ M. Ashton (in conjunction with Digital Services technical team)
8.4.2 (Mandatory) All infrastructure is running operating systems and software packages that are patched regularly, and as a minimum in vendor support.	As per 8.1.3	S. Deacon/ M. Ashton (in conjunction with Digital Services technical team)
9.7.6 (Mandatory) Do all of your desktop and laptop computers have personal firewalls (or equivalent) enabled and configured to block unapproved connections by default?	Enable personal firewalls on all laptop and desktop devices A phased rollout of the personal firewalls has begun.	S. Deacon (in conjunction with Digital Services technical team)

Whilst these mandatory standards are approaching completion the 95% Data Security training target, full deployment of personal firewalls and the eradication of unsupported software present challenges. However, robust plans have been put in place to ensure these areas are accelerated for completion during 2022/23 with arrangements being put in place to maintain ongoing compliance.

The risk of not achieving full compliance (i.e. “Standards Met”) with all mandatory DSPT requirements in 2021/22 is extant, but the Information Governance and Records Sub-Committee are confident in the trust’s ability to achieve a “Standards Met” categorisation for the 2022/23 submission, to be made in June 2023. This target has been set as part of the digital strategy refresh and IGSCR annual planning activity and will be communicated to managers and staff as appropriate, ensuring organisation-wide buy in to achieve the challenging training compliance level.

3.4 Cyber Security Arrangements

3.4.1 CareCERT Alerts

All Trusts are required to act upon any critical and high security cyber alerts issued by NHS Digital. Such Cyber Security Bulletins are called CareCERT alerts and organisations are required to confirm that they have taken the requisite action, or have sought support from NHS Digital, if they are unable to do so. Any issues are escalated to the SIRO.

The Trust has procured the ITHealth Assurance Dashboard Solution which consolidates all areas of WHH cyber security into a single, real-time view including our status in respect of WHH responses to the NHSD issued security CareCERT alerts. The ITHealth Assurance Dashboard gives complete visibility of what is happening within the Trust’s network. It significantly increases our understanding of the

security risks we face, and levels of compliance at both a local and national NHS Digital level. Most importantly it provides the IT Team with confidence in the assurance provided to the Board on the security of our IT infrastructure and any risks identified. 81% of mandatory cyber-related requirements contained on the DSP Toolkit can be satisfied by the use of the IT Health Assurance Dashboard.

The below tracker details the CareCERTS issued and actioned. The Green bar indicates all CareCERTS issued. The red bar indicates actions completed by the Trust and the blue bar indicates outstanding actions since June 2020. Numbers of outstanding actions do fluctuate dependent upon cyber threat levels. Of the outstanding careCERT's 4 are high risk, each having a small number of devices that need the updates. We are working with ITHealth to ensure these are resolved within the next few weeks. With other mitigations in place, including Anti-virus, Advanced Threat Protection and two boundary firewalls, the risk is low.

CareCERTS security alerts issued are prioritised according to their severity level. When a high level CareCERT alert is received the Trust has 48 hours to respond and 14 days to action and close the alert. Since June 2020, the Trust has received 8 high severity CareCERT alerts and has closed 100% of these with only one being closed outside the requisite 14-day period as mitigations were put in place to ensure the downtime to ED and wards was kept to a minimum whilst our virtual environment was patched.

Month	Outstanding CareCERTS	Completed CareCERTS	Total CareCERTS Issued
September	7	6	13
October	10	9	19
November	8	11	19
December	7	12	19
January	10	10	20
February	12	15	27
March	9	13	22
April	8	13	21
May	7	11	18

3.4.2 Desktop and Server Operating System Patching

Windows updates allow for fixes to known flaws in Microsoft products and operating systems. The fixes, known as patches, are modifications to software and hardware to help improve performance, reliability, and security. There is a patching regime operated routinely on a monthly basis. The patching for both desktop and servers is automated by the use of automated patching software. All critical security patching is up to date with the exception of unsupported software.

3.4.3 Migration from Unsupported Operating Systems and Applications

All software will eventually become out of date, after which point, ideally, it should not be used. Using obsolete software compounds two related problems:

- Software will no longer receive security updates from its developers, increasing the likelihood that exploitable vulnerabilities will become known by attackers.
- Latest security mitigations are not present in older software, increasing the impact of vulnerabilities, making exploitation more likely to succeed, and making detection of any exploitation more difficult.

The Trust have migrated all but 2 of desktop machines from unsupported Windows 7 to the latest Windows 10 operating system. The Trust have migrated all but 3 of the unsupported Windows Server 2008 servers to Windows Server 2016 and have extended support for Windows 2008 whilst the migration is completed. The Trust completed the Office 2010 to Office 365 migration in mid 2021.

3.4.4 Server Migration Status - May 2022

2008 Servers

Total	Completed	% Complete	Migration Completion Due Date
79	76	96%	December 22

***** 2008 servers are currently supported and will receive security patches until March 2023

Servers awaiting migration fall into the category of being more problematic to migrate for several reasons. This can be attributable to systems held on servers requiring often complex data migration work to migrate data into new versions of systems which are compatible with newer server operating systems.

3.4.5 External Security Rating (Bitsight)

The Trust uses an external software system which calculates a security score and benchmarks the Trust against other organisations within the Healthcare/Wellness industry in 20 major security risk categories. The below graphic details our security rating trend over the last year. The Trust is in the upper range of the security score with a rating of 780 (Advanced) which places the Trust within the top 25% of benchmarked healthcare organisations. Alongside signing up with the National Cyber Security Centre (NCSC) early warning system, notifying us of a potential cyber-attack.

The WHH Digital Services team is a part of the regional Cyber Security Group. This group is a collaboration between the NHS organisations operating within the Cheshire and Merseyside Health and Care Partnership (HCP) boundaries. It aims to improve the collective protection from, response to, and recovery from, cyber-attack, to assure the secure delivery of digital systems both within and between the individual organisations.

In conjunction with the regional Cyber Security Group, Digital Services is also part of the Cyber Associates Network (CAN). Being a member of the CAN provides enhanced knowledge-sharing, professional development, and networking with peers in health and care. Members also have the chance to influence national cyber security across the system by supporting NHS Digital's Data Security Centre (DSC) and NHS England in developing new products, services, policies, and strategies.

3.4.6 Monthly Network Penetration Tests

The Digital Services team have engaged a company to perform 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.

Vulnerabilities identified during network penetration tests are escalated to both Digital Board and the Information Governance and Records Sub-Committee. Reporting of these vulnerabilities includes a severity score and proposed actions for resolution. We have reduced several vulnerabilities by decommissioning two systems using TLS 1.1 (a data transfer protocol).

3.4.7 NHS Secure Boundary

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.

In January 2021, the Trust extended the NHS Secure Boundary service to our Internet connection. This strengthens the Trust's cyber-security defences. 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.

Since the installation of the NHS Secure Boundary service, we had several queries regarding the legitimacy of some of the Trust's network traffic. However, all traffic queried has been legitimate activity from approved Trust-based systems.

3.5 Externally Reported Data Security Incidents

The table below contains details of data security and protection incidents reported to the Information Commissioner's Office in the 2021/22 financial year. This information is also included in the annual information governance statement contained within the Trust's annual report.

Incidents are reported via the Data Security and Protection Toolkit incident reporting system and escalated to the ICO if they satisfy the requisite severity criteria. The ICO has taken no further action against the Trust in relation to incidents reported during the 2021/22 period.

Data security and protection incidents are routinely reviewed at the Information Governance and Records Sub-Committee. A bi-monthly report is produced from the Datix system and included as part of the annual work plan at each meeting of the IGRSC. The Information Governance and Corporate Records Manager liaises with the ICO to provide all the information required to conclude each incident within the timescales requested by the ICO.

ICO Reportable Incidents 2021/22

NHS Digital Reference Data Loss Incidents escalated to ICO 2021/22	Date Reported	Detail	Information Commissioner's Office Decision
23885	05/05/2021	A staff member posted a picture taken on a mobile phone on the Trust's premises on Facebook. The image contained a name, a partial address and the name of some generic medication relating to a service user.	No further action deemed necessary by the ICO.
25171	16/08/21	A District Nurse referral letter was sent to an incorrect recipient. The letter contained clinical detail and identifiable material (name, address, DOB telephone number) relating to a Urology patient at the Trust.	No further action deemed necessary by the ICO.
25233	20/08/21	Child attended urgent care setting with a minor finger injury following 111 call. Incorrect patient pulled from national spine and demographics then incorrectly edited nationally therefore editing GP details. Information then sent to GP of incorrect patient regarding attendance.	No further action deemed necessary by the ICO.
26796	25/01/2022	A child attended accident and emergency in care of their father. A restraining order is in place preventing the father from having contact with the mother and/or knowing the mother's address. The father was shown the mother's address by accident and emergency department staff when asked to confirm the address as there were two on the system, the mother's address, and the father's	No further action deemed necessary by the ICO.

		address. This has led to the father now being aware of the mother's address.	
26882	01/02/2022	As part of a subject access request response a patient has been sent the notes of another data subject.	Awaiting ICO response.
27081	17/02/2022	Received a telephone call from a patient's mother to say that she had also received a copy of another child's letter along with her own child.	No further action deemed necessary by the ICO.
27083	17/02/2022	A lady booked with the Trust's maternity department online and completed a form and provided her correct address. The Trust's ultrasound department then sent her dating scan appointment letter to the mother's former partner's house.	No further action deemed necessary by the ICO.
27253	03/03/2022	Patient sent another patient's details and contacted the patient in question directly to alert her.	Awaiting ICO response.
27345	10/03/2022	Inappropriate access was made by a doctor to records held in the national summary care record system.	ICO concluded that the Trust was not the data controller of information in this system. No further action taken.

3.6 The Role of the SIRO and the Trust's Caldicott Guardian

SIRO

All NHS Trusts must have a Board-level individual who supports implementation of international and government standards for information management and security.

SIRO Responsibilities:

- Accountable for information security
- Drives corporate policy on information security
- Champions information security at Board level

Caldicott Guardian

The Caldicott Guardian is responsible for protecting the confidentiality of health and care information and making sure it is used properly.

Caldicott Guardian Responsibilities:

- Supports work on information sharing and advises on confidentiality issues
- Actively involved in development of data security and protection frameworks to attain the highest possible standards of the protection of person identifiable information
- Advocate for the data security and protection agenda at Board level

Both the SIRO and Caldicott Guardian are actively involved in the work of the Trusts Information Governance and Records Sub-Committee. The Information Governance and Corporate Records Sub-Committee's objective is to support the Information Governance and corporate records agenda, and to provide the Quality Assurance Committee with the assurance that effective Information Governance best practice mechanisms are in place within the organisation.

The table below provides examples of SIRO and Caldicott Guardian activity in 2021/22 to support the data security and protection agenda.

Data Protection Impact Assessments are completed for new / amended processing use cases of Personal Information and signed off	• SIRO and CG actively involved in approving DPIAs for new systems and processes.
IG skills and knowledge are kept up to date	• CG registered with NHSD in December 2021 • SIRO registered with NHSD in December 2021 • Board level Cyber Security training provided to the Trust Board in October 2021 • SIRO completed training provided by NHSD approved Templar Executives in March 2022
The Board is informed of confidentiality concerns	• SIRO and CG attend the IGRSC and scrutinise reports provided to the QAC Confidentiality incidents report is a standing agenda item at IGCRSC • SIRO and CG are routinely informed of incidents escalated via the DSP Toolkit incident reporting system and of incidents escalated to ICO
Arrangements for confidentiality and data protection are monitored	• Confidentiality audits conducted are provided to IGRSC attended by SIRO and CG. • Confidentiality audits performed in clinical areas to support CQC KLoE 6 evidence provided to SIRO and CG. • Approval of Information Sharing Agreements entered is sought from CG and records kept of approved ISAs.
Staff are provided with clear guidelines and procedures	• Alerts, guidance, and policies issued are approved by SIRO and CG as core members of the IGRSC.
Identified improvements to confidentiality processes are implemented	• Lessons learned from IG incidents scrutinised by CG and SIRO and escalated to Quality Assurance Committee. • Actions identified to improve confidentiality processes in audits undertaken approved by CG.

4. RECOMMENDATIONS

The Board is asked to:

- Note and approve the contents of the report, including the expected overall status of "Approaching Standards" for the 2021/22 DSPT submission. The Trust Board is also asked to note the organisation-wide support required to meet the 95% data security training compliance target, as a pre-requisite for achieving the "Standards Met" target in 2022/23
- Receive assurance that SIRO responsibilities are being fulfilled effectively

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/05/59**	
SUBJECT:	**Engagement Dashboard Annual Update**	
DATE OF MEETING:	25 May 2022	
AUTHOR(S):	Alison Aspinall, Senior Communications and Engagement Manager	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications & Engagement	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	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):***	**The Engagement dashboard, in its new format, is presented for the full year 2021-22. It is now linked to the CQC's Well Led Framework (KLOE 7) and incorporates Engagement and Involvement activity for the first time. The dashboard provides metrics relating to:** 1. Level of success in managing the Trust's reputation in the media and across digital and social platforms 2. Our engagement and involvement with patients, staff and public via our social media channels 3. The Trust's website and levels engagement with this key platform including patient enquiries via our website 4. Patient/public feedback on the independent platforms (recent addition of GOOGLE) 5. NEW Patient and Public Involvement and Participation, including our new Experts by Experience programme 6. NEW Staff Communications **Key items to note for the year:** 1. **Covid-19 data from our hospitals** remains a key item of interest among our local and regional media. There were 133K unique visitors to this page in year. We continue to publish key Covid-	

19 stats on our website at 1pm daily which are reported on weekly in local outlets.

2. **Media**
   In year we hosted a number of broadcast news teams to coincide with national issues including Sky News, BBC, Ch5 News and ITV. Key themes included Covid-19, recovery, waiting lists – where each time WHH was able to tell good stories and feature our teams delivering excellent patient care – echoed by our patients.
3. **Website traffic** remains steadily above 40K visitors per month – this is a sizeable increase since we moved to our mobile-enabled platform. The website is currently undergoing upgrades to support improved accessibility features following an audit in year.
4. **Patient/visitor enquiries** handled through the website totalled 2,642 in year. We had hoped to deploy our 'Chatbot' digital web assistant in year which has been developed in partnership with Alder Hey, however issues with their license has delayed deployment – the Chatbot supports web visitors to find information more easily.
5. **WHHNHS Social Media** – remains very active and engaging with our social channels reaching an audience of over 4.4m in the year, with a combined following of 26K
6. **Patient Feedback**
   During the year we saw negligible change in activity on the key feedback channels on the previous year (NHS Choices, Care Opinion and I Want Great Care), however
   Google reviews are becoming much more commonly used, accounting for 30% of all patient feedback through public channels. In year Google ratings for Warrington were 3.2*, Halton 3.8* and Captain Sir Tom Moore 4.6*
   Healthwatch Halton and Healthwatch Warrington both collect ratings on care and in year Warrington rated 3* based on 17 reviews, Halton Hospital is at 4.5* from 64 reviews, RUTC is at 4.5* from 18 reviews
7. **Engaging with and Involving our community**
   This is a new metric and reports on engagement and involvement with our patients, public and wider community. In year we held two formal public consultations in partnership with our commissioners on the reconfiguration of breast services in Halton, Knowsley, St Helen's and Warrington. The second related to the deployment of some outpatient services at Runcorn Shopping City. Both consultations were well supported by our communities.
   Now that the Covid-19 restrictions are easing we plan to do much more engagement and involvement in 2022-23.
8. **Staff Communications and Engagement**
   We have introduced this dashboard as a snaptshot of engagement with the Trust's key communication channels. The CEO's morning message 'GMWHH' continues to be extremely popular with many 'guest editors' now contributing. Similarly the

	CEO's monthly Team Brief continues to see at least as three times the number of staff attending now that the brief is hosted virtually with similar strong engagement in the Q&A session.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the Engagement dashboard and new metrics linked to KLOE7 in the CQC's Well Led framework.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors		
	Agenda Ref.	COG 22/05/25		
	Date of meeting	12/05/2022		
	Summary of Outcome	Item noted with positive feedback		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

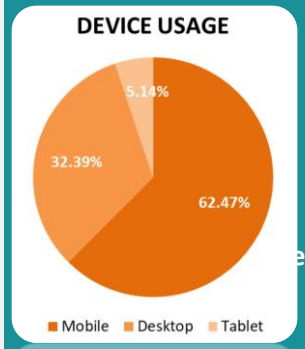
WHH Communications, Engagement and Involvement Dashboard

April 2021- March 22

‘Well-Led’ KLOE 7:
Communicating with the Public

Metric

1. **Media coverage**
2. **Visits to the public website**



Website visits	345,318
/	149,258
/Covid-19 status	133,411
/Maternity	35,173
/Contact us	32,845
/Services	28,014
/Blood test clinic	24,997
/Ward contact numbers	24,129
/Work at WHH	23,708

Actions / Comments

1. Media coverage*

Media coverage was largely positive in during 2021-2022, mainly attributed to the new hospital additions include ED Plaza, Breast Screening Unit, Health Hub and Habab Centre

Top positive news stories:

- *The New ED Plaza*
- *New Breast screening centre in Halton*
- *Runcorn Shopping City Health Hub*

Most viewed/shared negative news stories:

- *Rise in A&E admissions*
- *Free NHS car parking ending*

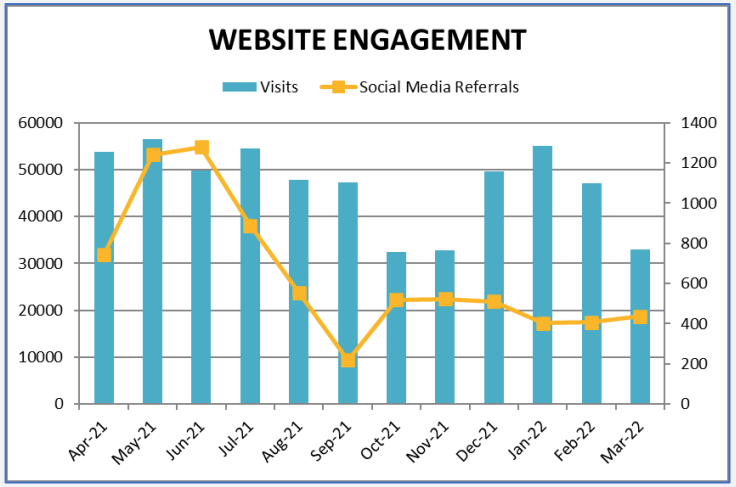
2. Traffic on the Public Website:

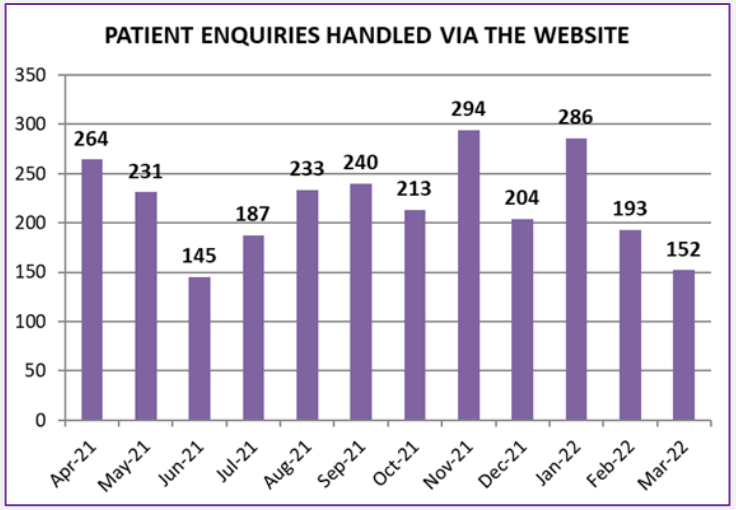
- This year ‘COVID-19 current status’ was the most visited web page with 133,411 views. The peak was Tuesday 18 May 2021.
- 54.22% of visits came directly from Google
- Mobile and tablet devices account for over 90% of access
- We helped 2,642 enquirers through our website*

To note:

** During Q3 we suspended our media monitoring service and changed supplier which became active in Feb 2021-2022. This meant we were able to formally measure 2,419 media articles/broadcast items about the Trust (compared with full year of 3,506 in 2021*

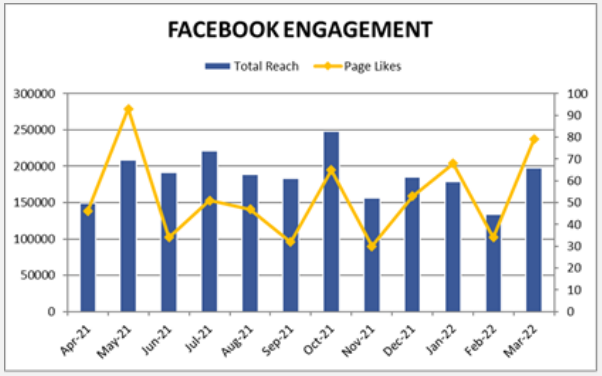
*** We had hoped to deploy our ‘Chatbot’ digital web assistant in year which has been developed in partnership with Alder Hey, however issues with their license has delayed deployment – the Chatbot supports web visitors to find information more easily.*

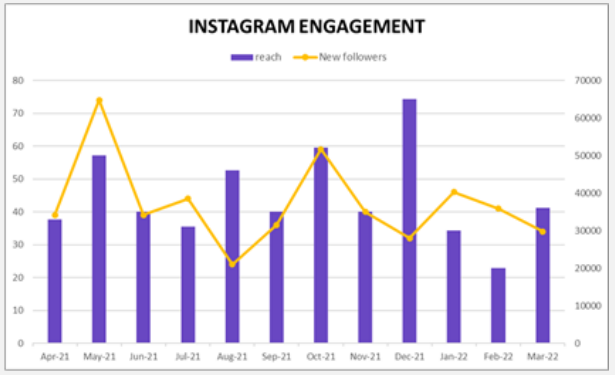


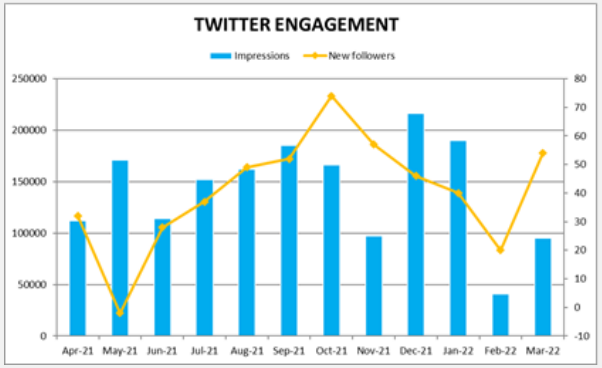


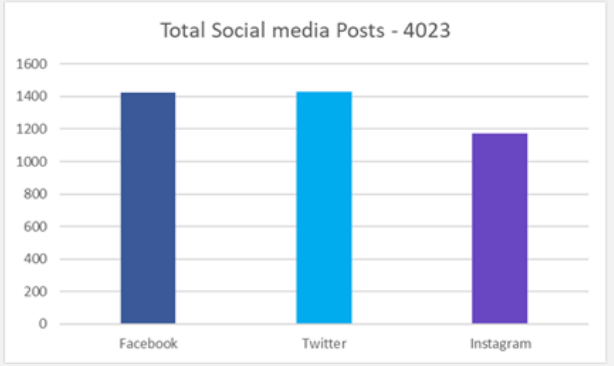
‘Well-Led’ KLOE 7: Communicating with the public

Metric	Social media posts, engagement and sentiment
Current Performance	This year, there were a total of 4,023 social posts across three social media channels (Facebook, Twitter and Instagram) WHH social media channels reached an audience of over 4.4m, with a combined following of 26k
Top Posts for Engagement	 



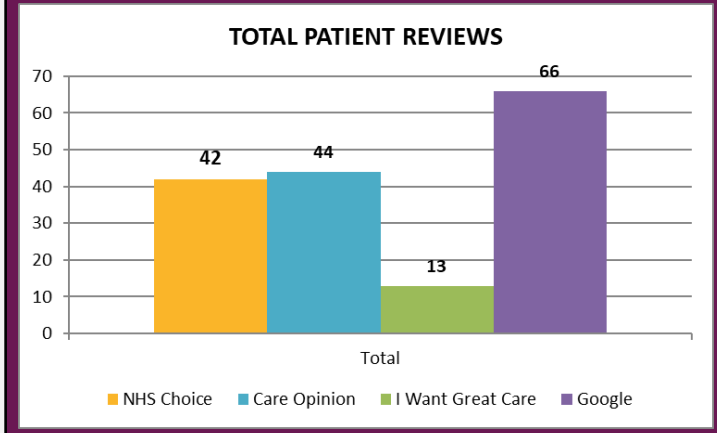


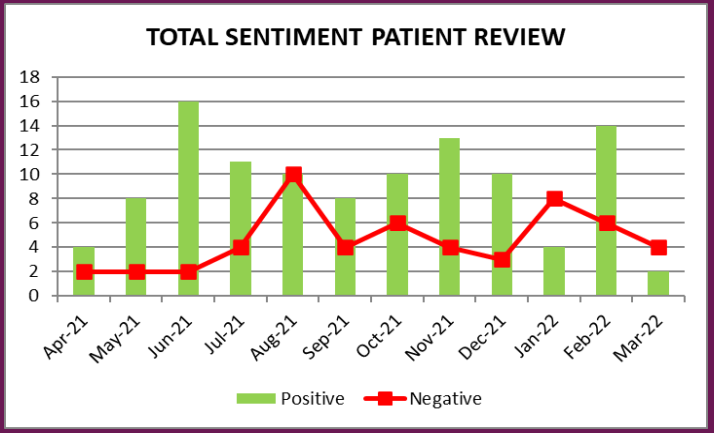


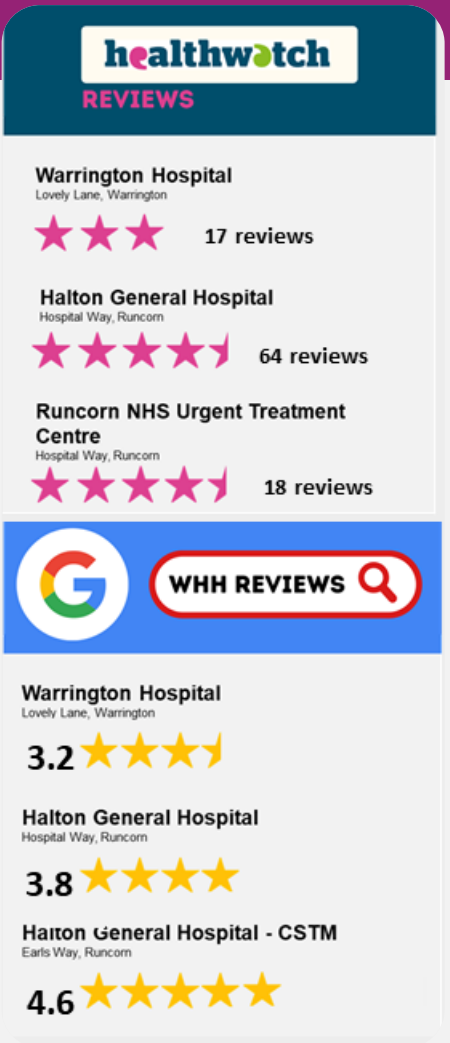


‘Well-Led’ KLOE 7 Metrics : Patient engagement through public channels and media

Metric	**ENGAGEMENT WITH FEEDBACK CHANNELS** Feedback include channels in the public domain : Google reviews, NHS Choices, I want Great Care, Healthwatch Halton and Healthwatch Warrington (combined feedback shown)
Current Performance	In 2021-22 there were 165 reviews about the Trust of which 66% were positive.
Actions / Comments	**Top online source for public feedback:** Google reviews **General Theme:** A&E and Car Parking receive the most reviews





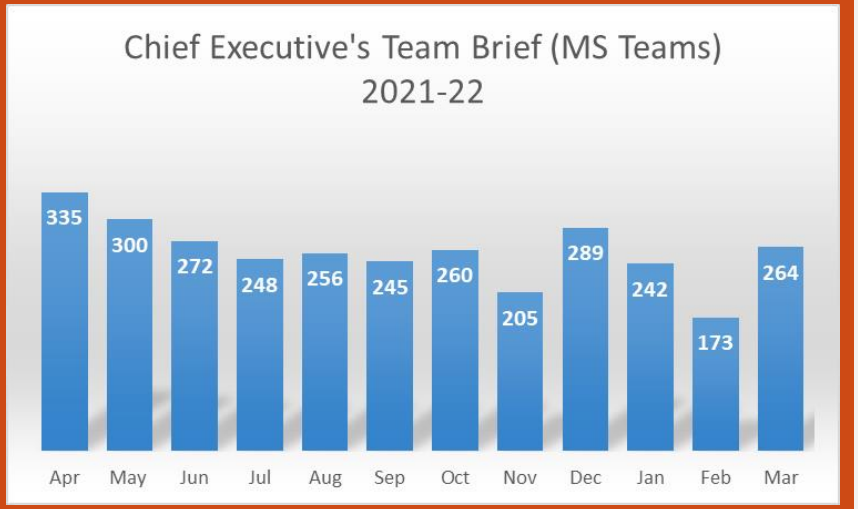


‘Well-Led’ KLOE 7Metrics: Engaging with and Involving our community

Metric	Engagement opportunities
Current Performance	**Public Consultations:** **Runcorn Shopping City** – a public consultation exercise was conducted from 7th May 2021 to 18th June 2021 to seek views from patients, carers, staff, public advocacy groups and partners, including health scrutiny committee on proposals to create an Outpatients Hub at this venue, which informed the proposals for the final plans. Views were sought via an online survey, printed consultation documents, face to face conversations in the service and virtual consultation services. This followed engagement with partners and advocacy groups to help inform the plans prior to consultation. **Reconfiguration of Breast Services (phase 1)** – a public consultation was carried out to seek views on proposals to reconfigure and consolidate breast screening, assessment and symptomatic services at a new Breast Care Centre at Halton Hospital’s Captain Sir Tom Moore Building. The views and support from the consultation and prior engagement informed the decision to proceed with the proposals to create a centre of excellence in Halton. **Engagement:** #DAD2021 was an opportunity to talk about awareness raising programmes, education on supporting your own health and wellbeing, opportunities for work and “What Matters to You”. At Patient Experience and Inclusion we focused on the experiences of our community who use our hospitals and services whilst discussing present and future projects to improve the quality of experience our patients, service users, their carers, families and public have at WHH. • Warrington Disability Awareness Day – September 2021 This was our largest exhibition from WHH so far, we had representatives from Patient Experience and Inclusion, Community Engagement, WHH Charity, Diabetes, Apprenticeships, Breast Screening, Maternity and Strategy. The day was focused on “Promoting Independence Throughout Life and Work”. • Annual Members Meeting which was held on MS teams in November 2021 **Building social Value:** **Nurse/AHPs recruitment** Emergency Department Nurse Recruitment event – more than 90 prospective nurse colleagues booked onto an event at the Village Hotel, Warrington on 28th October 2021, to support recruitment and promotion of opportunities within our Warrington Emergency Department. Following an extensive social media and online recruitment campaign 32 interviews were held on the day and conditional job offers made.

‘Well-Led’ Metrics : Communicating with staff

Metric	**Engagement with Staff Communication Channels** Trust-wide staff communications channels include: • The Daily Safety Brief • Good Morning WHH from the CEO • The Week • A closed staff-only Facebook group WHH People • Monthly Team Brief • Extranet announcements • (NEW) Staff App – currently being trialled by 50+ staff
Current Performance	**TEAM BRIEF TOTAL ENGAGEMENT FOR 2021-22 - Attendance** • 2pm slot - 2777 • 7pm slot - 248 • Watched on catch up – 64 • April saw the highest attendance (no specific ‘hot topic’ Questions asked • 2pm Brief - 228 • 7pm Brief - 2 • March saw the highest engagement with 97 questions asked – most asked question referring to the return of car parking charges for staff **MEMBERS ON WHH PEOPLE FB PAGE** 609 staff members, December saw an increase of 9% due to the Thank You Awards 2021. Most active date was TYA 2021 20/12/2021 with 499 members reached. **STAFF APP – NEW – COMING SOON – proposed metrics** • App downloads (this will be cumulative) • Most viewed pages



186 of 306

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/60**	
SUBJECT:	**NHS Staff Opinion Survey**	
DATE OF MEETING:	25th May 2022	
AUTHOR(S):	Ruth Heggie, Head of OD, Learning and Culture	
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	 X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF)	**#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an overview of the annual NHS Staff Survey results for the organisation from 2021 which are aligned to the NHS People Promises as set out in the NHS People Plan. The survey took place between September and November 2021 during the COVID-19 pandemic and the start of an extremely difficult Winter period. In the 2021 survey, the organisation's response rate was 40% which equated to 1,744 members of staff and an improvement of 4% in comparison with the previous year. This paper provides the information that will be presented in an interactive format to inform the workforce of the results and more importantly what will happen as a result of workforce feedback.	

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

RECOMMENDATION:	Trust Board is asked to note the annual staff survey results including what the organisation has learned from feedback and what improvements will be made as a result of workforce feedback.	
PREVIOUSLY CONSIDERED BY:	**Committee**	N/A
	Agenda Ref.	N/A
	Date of meeting	N/A
	Summary of Outcome	N/A
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

NHS Staff Survey 2021

Our Results

Contents

Introduction

The staff survey takes place each year across all NHS organisations and is an opportunity for every staff voice to count.

This year for the first time the survey has been aligned to the NHS People Promise allowing us to see where we are doing well and where we need to make improvements against each element of the promise.

This booklet sets out our results for the 2021 survey and highlights the actions that we will be taking based upon what you have told us.

Foreword –Michelle Cloney Chief People Officer:

The annual staff survey results give a snapshot of how you were feeling in the autumn 2021. At that time, we were 18 months into the pandemic, in the middle of planning and providing elective recovery work whilst continuing to meet the high demand for non-COVID care, and at the start of the emerging Omicron variant wave. So, when reading the results please remember this context ……and reflect on the fact that the results show, colleagues continuing to step up and look after one another in the face of the pressure, with more people benefiting from extra health and wellbeing provision and bespoke line manager support than in previous years.

Our annual staff survey remains an opportunity for you to share your experiences of working here at the Trust and the results help us to make the improvements you would wish to see. In addition to the things you tell us are important to you, we will also:

- maintain our attention on health and wellbeing provision available to all,
- prepare and train line managers to have meaningful health and wellbeing conversations with you,
- create greater opportunities for agile and flexible working,
- provide access to mental health and occupational health services,
- continue to recruit and grow the workforce,
- build on new ways of working and teamworking deployed during the pandemic, and
- ensure that the work you do is meaningful and rewarding.

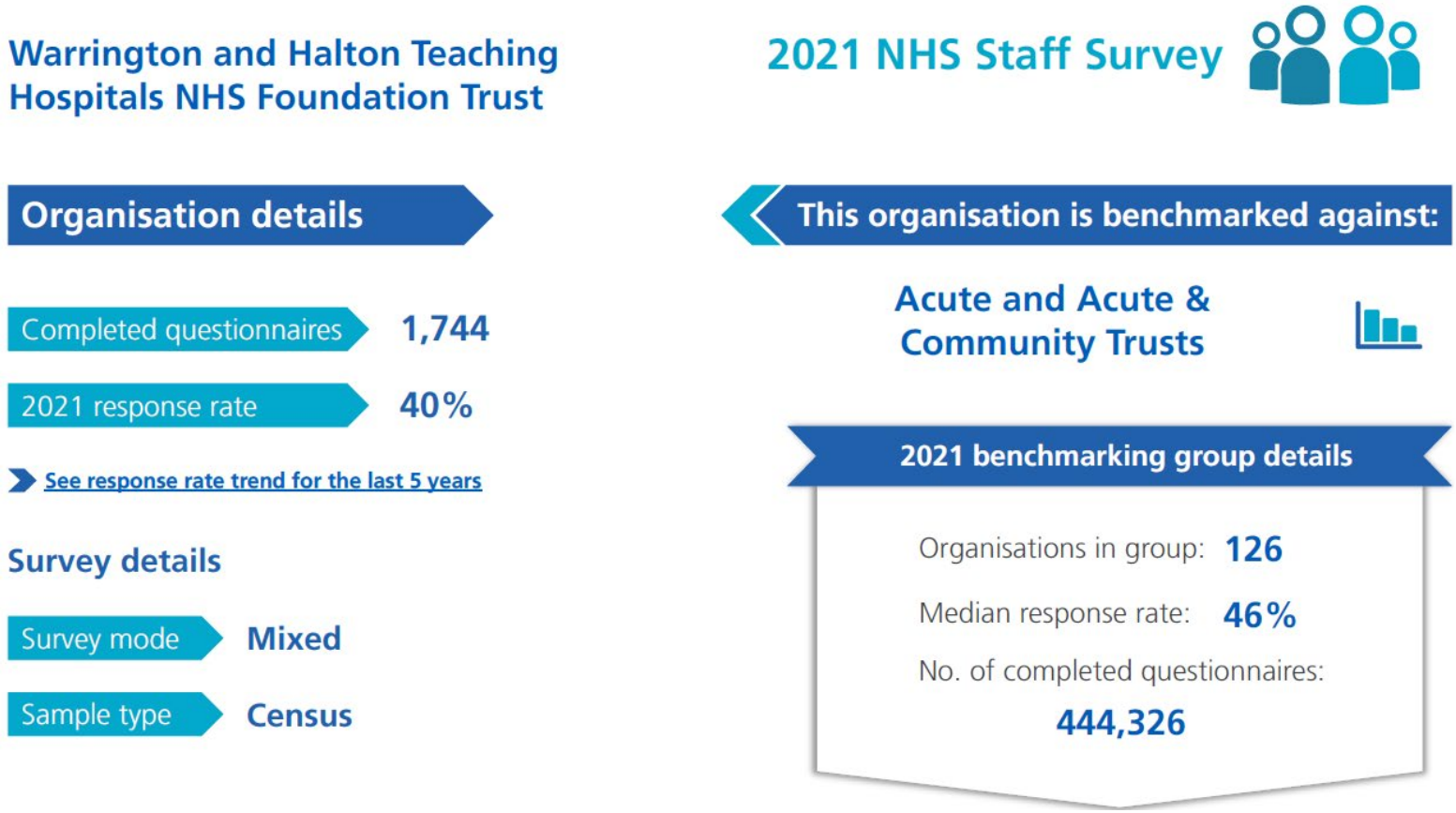
I would like to say a big and very sincere thank you to you all for the way you each continue to respond with compassion, skill and professionalism, and look forward to building on the good work shared in the results and improve those results were we need to.

Using the results set out in this booklet to guide areas for improvement we will be inviting representatives from each CBU/corporate service to a staff survey drop-in session to create a plan of action bespoke to each area.

It really is important that we hear what you have told us and act upon your feedback.

In this booklet you will also find links to our new Trust '***People Strategy'*** and '***Workforce Equality Diversity and Inclusion Strategy'*** which further outlines are ambition to support you to be outstanding, to work in a culture of compassionate leadership that fosters psychological safety, and you feel able and confident to bring your whole self to work.

WHH Staff Survey



2021 NHS Staff Survey Results

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

All of the themes are scored on a scale of 0 to 10, where a higher score is more positive than a lower score.

1744 staff responded = **40%** of our workforce

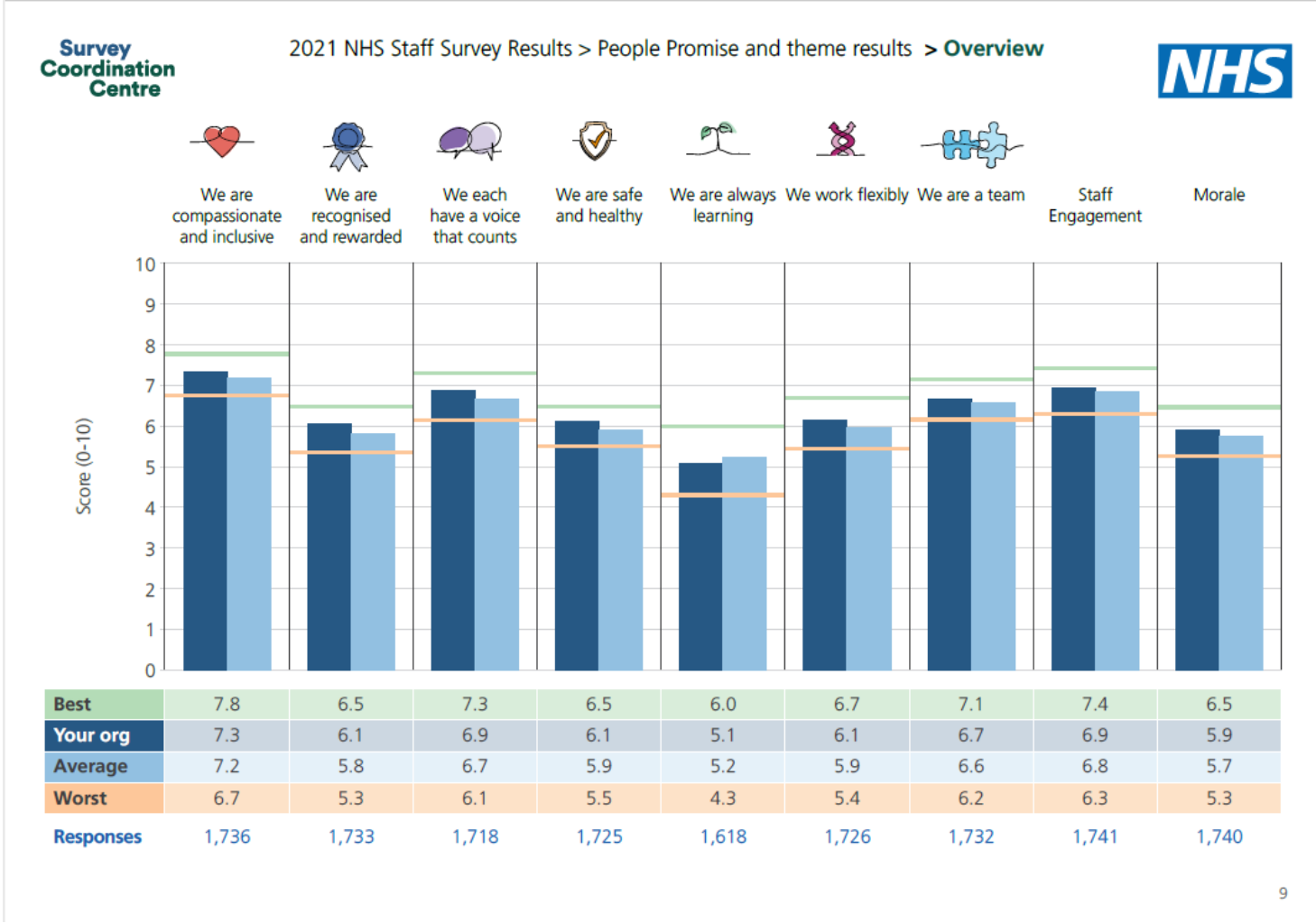
Better than average acute trust score

Same as average acute trust score

Lower than average acute trust score

@WHHPeople Search for WHH People

Results on a page:



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.3	6.1	6.9	6.1	5.1	6.1	6.7	6.9	5.9
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,736	1,733	1,718	1,725	1,618	1,726	1,732	1,741	1,740

9

The NHS People Promise

"The NHS is an extraordinary, world-class service. Together we have achieved, and continue to achieve, the extraordinary. We should all feel proud of this.

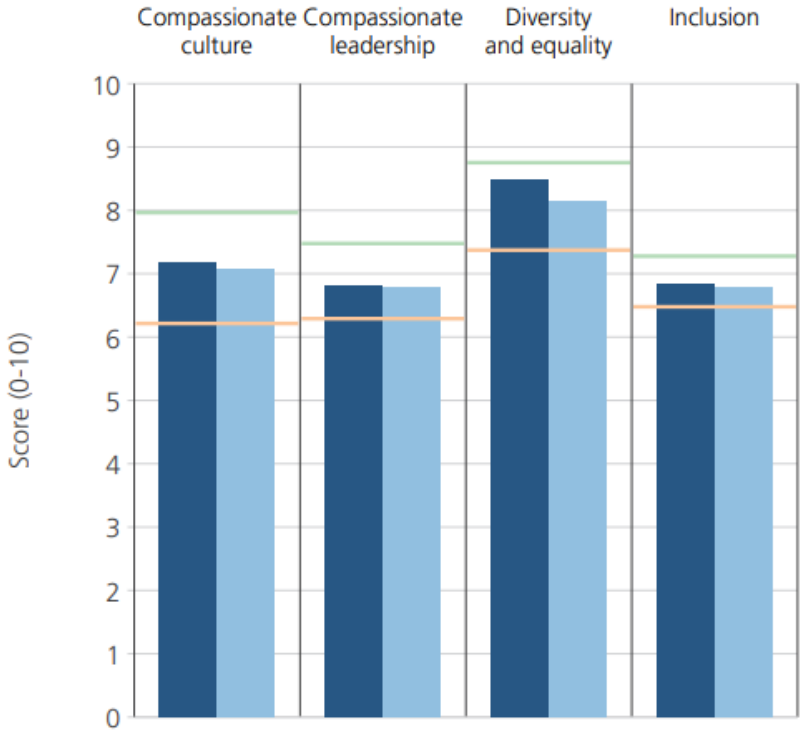
We want our culture to be positive, compassionate, and inclusive – and we all have our part to play"

This year the key themes of the staff survey have been based around the seven areas of the people promise:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

We are Compassionate and Inclusive

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Best	8.0	7.5	8.8	7.3
Your org	7.2	6.8	8.5	6.8
Average	7.1	6.8	8.1	6.8
Worst	6.2	6.3	7.4	6.5
Responses	1,733	1,735	1,737	1,726

We do not tolerate any form of discrimination, bullying or violence.

We are open and inclusive.

We make the NHS a place where we all feel we belong.

Together, WE make the NHS the best place to work. We are the NHS.

Our WHH results (in the dark blue) show that we score just above average for this area, with diversity and equality our best scoring element of this section.

What we have learned: That the changes made from previous years survey results are having a positive impact such as changing our WHH values and developing our staff networks

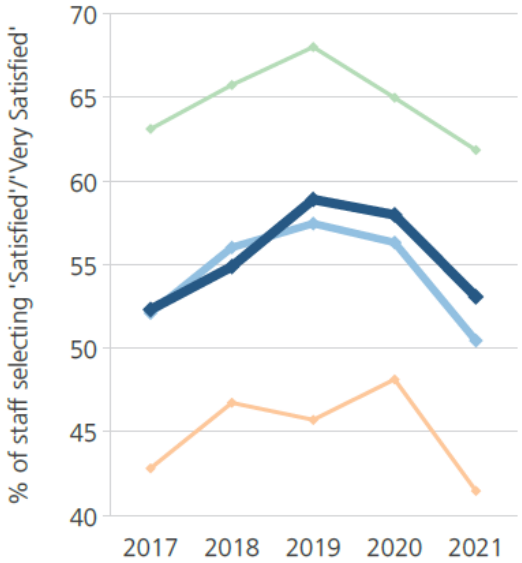
What we are doing next: Compassionate culture and leadership supports in provide excellence in care, we will be continuing to deliver development opportunities to support this. Inclusive and Kind will continue to be a key focus in all we do.

We are Recognised and Rewarded

Survey Coordination Centre

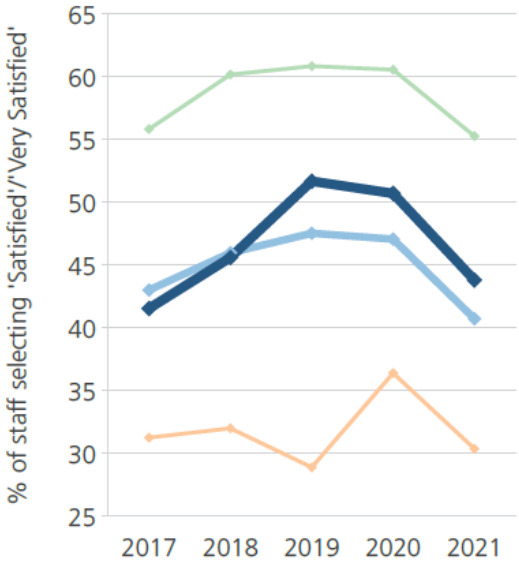
2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are recognised and rewarded**

Q4a
The recognition I get for good work



	2017	2018	2019	2020	2021
Best	63.1%	65.8%	68.0%	65.0%	61.9%
Your org	52.3%	54.9%	58.9%	58.0%	53.1%
Average	52.1%	56.0%	57.5%	56.3%	50.5%
Worst	42.8%	46.7%	45.7%	48.1%	41.5%
Responses	1,790	1,976	2,123	1,484	1,732

Q4b
The extent to which my organisation values my work



	2017	2018	2019	2020	2021
Best	55.8%	60.2%	60.8%	60.6%	55.2%
Your org	41.5%	45.6%	51.7%	50.7%	43.8%
Average	43.0%	45.9%	47.5%	47.0%	40.7%
Worst	31.2%	31.9%	28.8%	36.3%	30.3%
Responses	1,781	1,969	2,115	1,478	1,727

Best	4
Your org	3
Average	3
Worst	2
Responses	

A simple thank you for our day-to-day work

Formal recognition for our dedication,

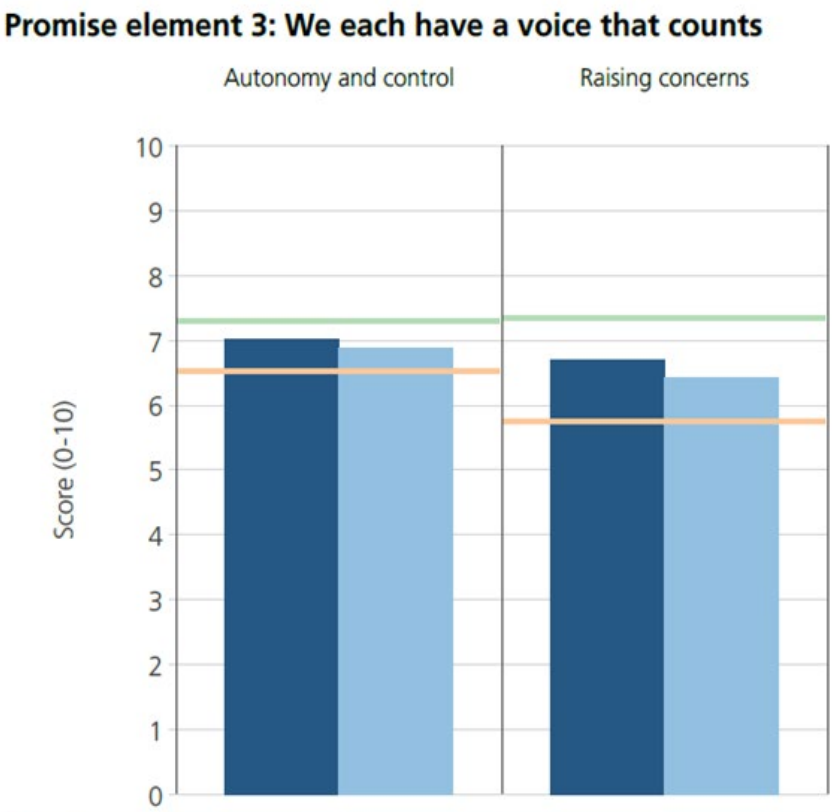
Fair salary for our contribution

We are recognised and rewarded

What we have learned: We have learned that our workforce value gratitude and recognition and that a thank you for a job well done goes a long way. That living our values are important no matter what the role or position in the organisation.

What we are doing next: Renewing our Long Service and Retirement reward and recognition offer. Seeking to understand from our staff what is important to them in feeling supported, included, and valued.

We Each Have a Voice That Counts



	Autonomy and control	Raising concerns
Best	7.3	7.3
Your org	7.0	6.7
Average	6.9	6.4
Worst	6.5	5.7
Responses	1,737	1,723

We all feel safe and confident to speak up.

We take the time to really listen to understand the hopes and fears that lie behind the words

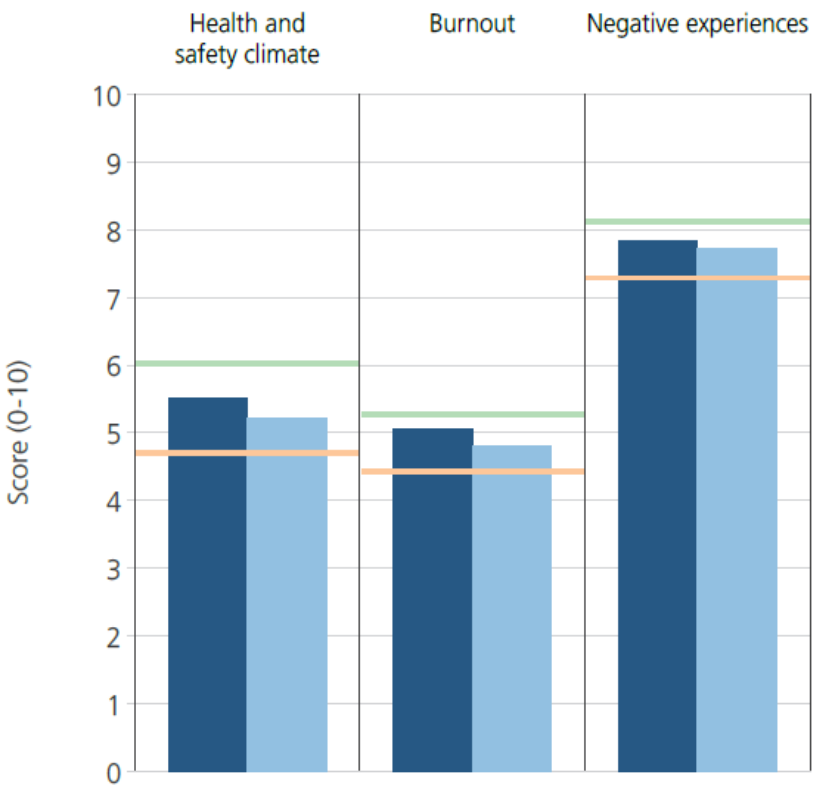
Our WHH scores show that we are doing well in this area though there is room for improvement to further a culture that fosters psychological safety

What we have learned: Our workforce feels confident to raise concerns however further improvement in this area can be made.

What we are doing next: We need to continue to make sure everyone has the opportunity to be heard in a forum that allows for this to happen, that we encourage everyone to speak up. We are also continuing to develop our Freedom to Speak up Champions across the organisation.

We are Safe and Healthy

Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Best	6.0	5.3	8.1
Your org	5.5	5.0	7.8
Average	5.2	4.8	7.7
Worst	4.7	4.4	7.3
Responses	1,738	1,737	1,736

We look after ourselves and each other.

Wellbeing is our business and our priority – and if we are unwell, we are supported to get the help we need.

We have what we need to deliver the best possible care – from clean safe spaces to rest in, to the right technology.

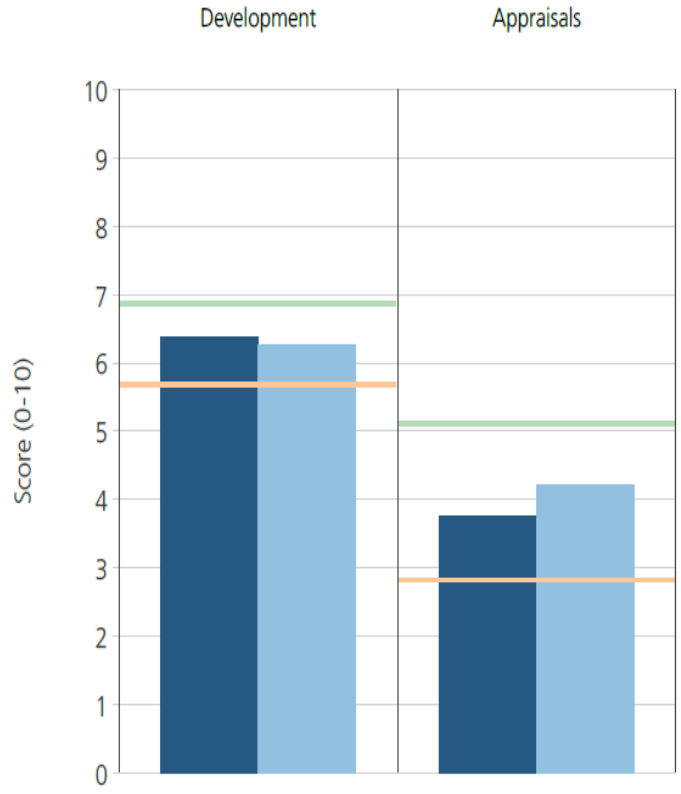
Our WHH scores show that this is an area for us to focus on for improvement.

What we have learned: We need to ensure we all feel safe at work, reducing the number of negative experiences and focusing on the wellbeing of our workforce.

What we are doing next: We are continuing to review and improve our staff facilities. Are wellbeing programmes continue to grow and will support in preventing staff burnout

We are Always Learning

Promise element 5: We are always learning



	Development	Appraisals
Best	6.9	5.1
Your org	6.4	3.8
Average	6.3	4.2
Worst	5.7	2.8
Responses	1,736	1,622

Opportunities to learn and develop are plentiful, and we are all supported to reach our potential.

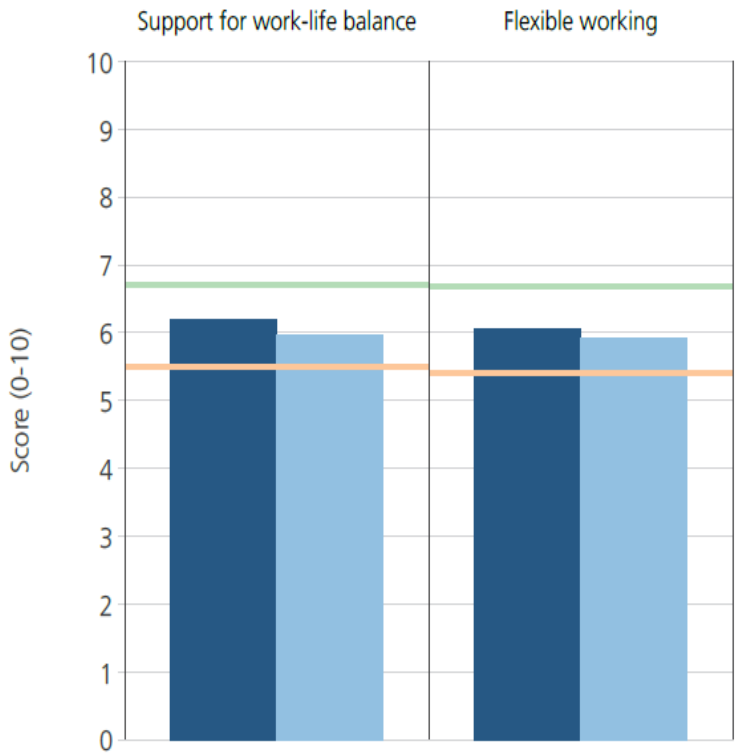
- We have equal access to opportunities.
  - We attract, develop, and retain talented people from all backgrounds.

Our WHH scores show that this is an area where significant improvement is required.

- **What we have learned:** Our workforce needs to be supported in their development and learning and to realise their ambition and potential in their chosen career path.
- **What we are doing next:** We will provide targeted support for appraisals across all departments in WHH, supporting development plans to be in place for everyone with a quality evidenced based People Development and learning offer to enable this. Informed through and responsive to the feedback from our workforce feedback

We Work Flexibly

Promise element 6: We work flexibly



	Support for work-life balance	Flexible working
Best	6.7	6.7
Your org	6.2	6.1
Average	6.0	5.9
Worst	5.5	5.4
Responses	1,737	1,730

We do not have to sacrifice our family, our friends, or our interests for work.

We have predictable and flexible working patterns – and, if we do need to take time off, we are supported to do so.

Our WHH scores show that this is an area where we are performing on average with other similar organisations and will be focussed to improve over the next 12 months.

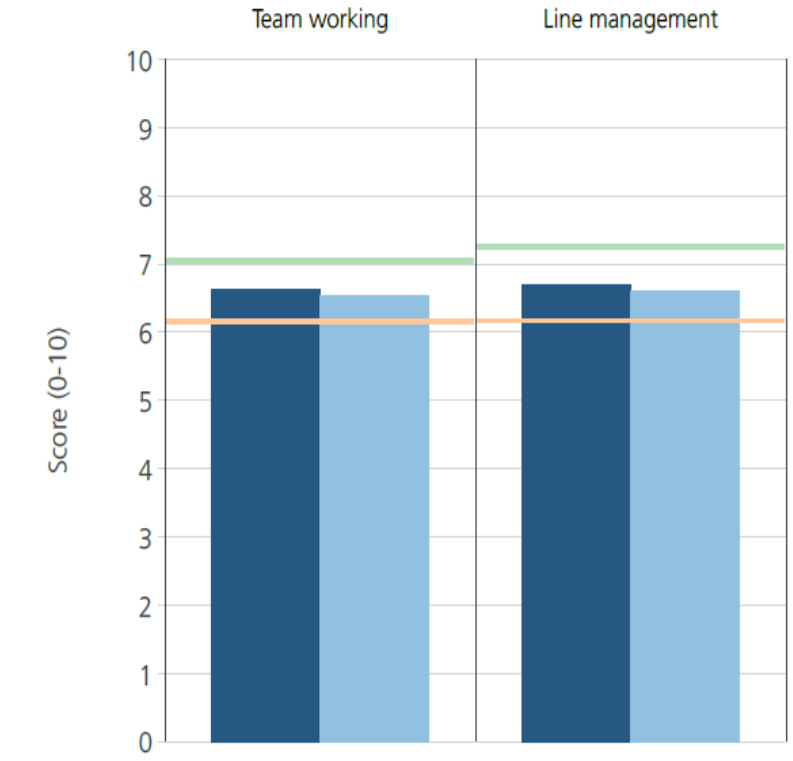
What we have learned: We have recognised the need to support flexible and agile working and that work life balance is essential to keeping our workforce in work and well

What we are doing next: We will continue to support flexible and agile and look to find how we can further support everyone in achieving their balance between work and home. The organisation is part of the Flex for NHS programme, and a multi-disciplinary working group will be set up to progress the approach to agile and flexible working within the organisation based on best practice and evidence.

202 of 306

We are a Team

Promise element 7: We are a team



	Team working	Line management
Best	7.0	7.3
Your org	6.6	6.7
Average	6.5	6.6
Worst	6.2	6.2
Responses	1,736	1,736

First and foremost, we are one huge, diverse, and growing team, united by a desire to provide the very best care.

We learn from each other, support each other, and take time to celebrate successes.

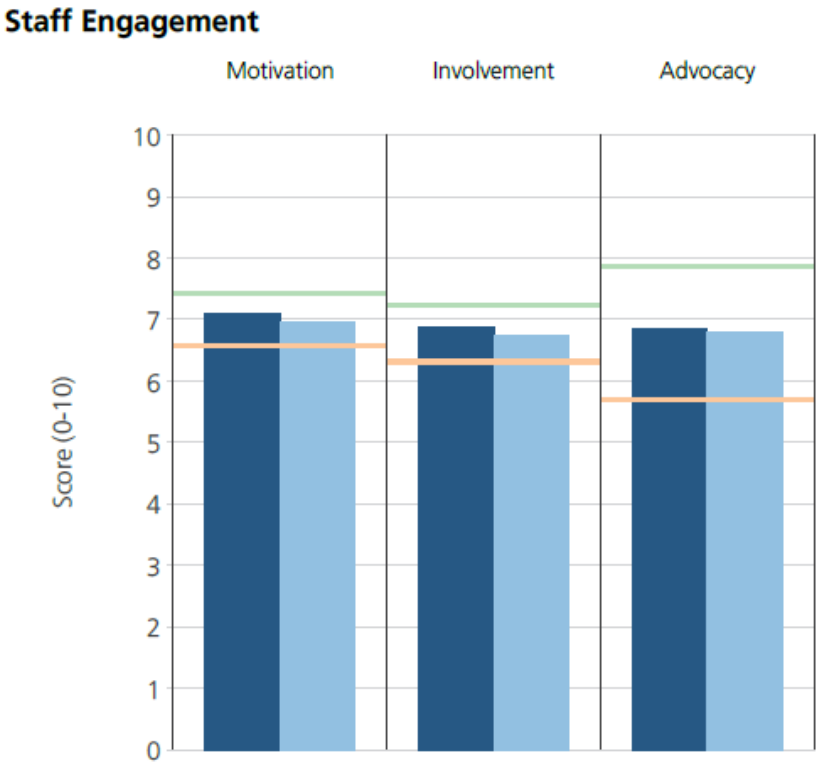
Our WHH scores show that this is an area where we are performing on average with other similar organisations and will be focussed to improve over the next 12 months.

What we have learned: We have learned that supporting our teams and leaders through a period of recovery is essential in supporting our workforce

What we are doing next: Launching a line manager programme to support our managers and leaders to grow and develop in their roles. Continuing to offer a wide range of team development and support across the organisation. Please contact the People Development teams for more details.

203 of 306

Staff Engagement



	Motivation	Involvement	Advocacy
Best	7.4	7.2	7.9
Your org	7.1	6.9	6.8
Average	7.0	6.7	6.8
Worst	6.6	6.3	5.7
Responses	1,726	1,738	1,735

Our WHH scores are in relation to Motivation (look forward to work and being enthusiastic about your job), Involvement (opportunities to make suggestions and improvements) and Advocacy (recommending the trust as a place of work or care).

What we have learned: We have learned that we each have a voice that counts, listening and acting upon the voice of our staff is of great importance and we continue to seek ways of listening and understanding how our workforce feel in WHH.

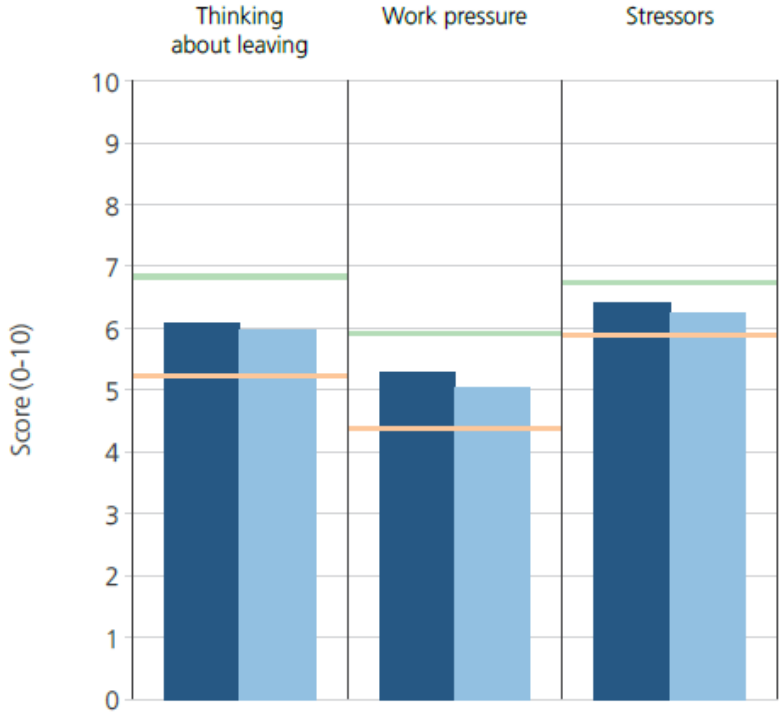
What we are doing next:

We want to continue to provide a range of opportunities for our workforce to be engaged and motivated to be at work with growing staff networks, engagement and wellbeing activities and continuing to use the NHS People Pulse to give further opportunity for staff to feedback.

204 of 306

Morale

Morale



	Thinking about leaving	Work pressure	Stressors
Best	6.8	5.9	6.7
Your org	6.1	5.3	6.4
Average	6.0	5.0	6.2
Worst	5.2	4.4	5.9
Responses	1,737	1,738	1,734

Our WHH scores show how the different aspects of morale are viewed. This includes how happy people are in their jobs and if they are looking to work elsewhere. Workplace pressure in meeting conflicting demands and having the resources available to do the job required and Stressors which looks at workplace relationships and freedom in decision making.

What we have learned: We have learned that we need to support people to be in work and well and to feel able to being their whole-selves into work

What we are doing next: We are supporting our line mangers with the new Supporting Attendance policy looking at how we help people return to work. We have Occupational Health and Wellbeing Hub offers. Our WHH 2022-25 People Strategy has a clear focus on cultivating psychological safety which supports in innovation, the bringing forward of new ideas and speaking up.

Our People and Workforce Equality Diversion Strategies

The WHH People and Workforce Equality Diversity (WEDI) and Inclusion Strategies have been refreshed and re-launched for 2022.

These strategies set out how we will continue to support out workforce and are also written to reflect the NHS People Promise. We will use the staff Survey as a way of seeing how well we are doing against our goals set out in the strategies.

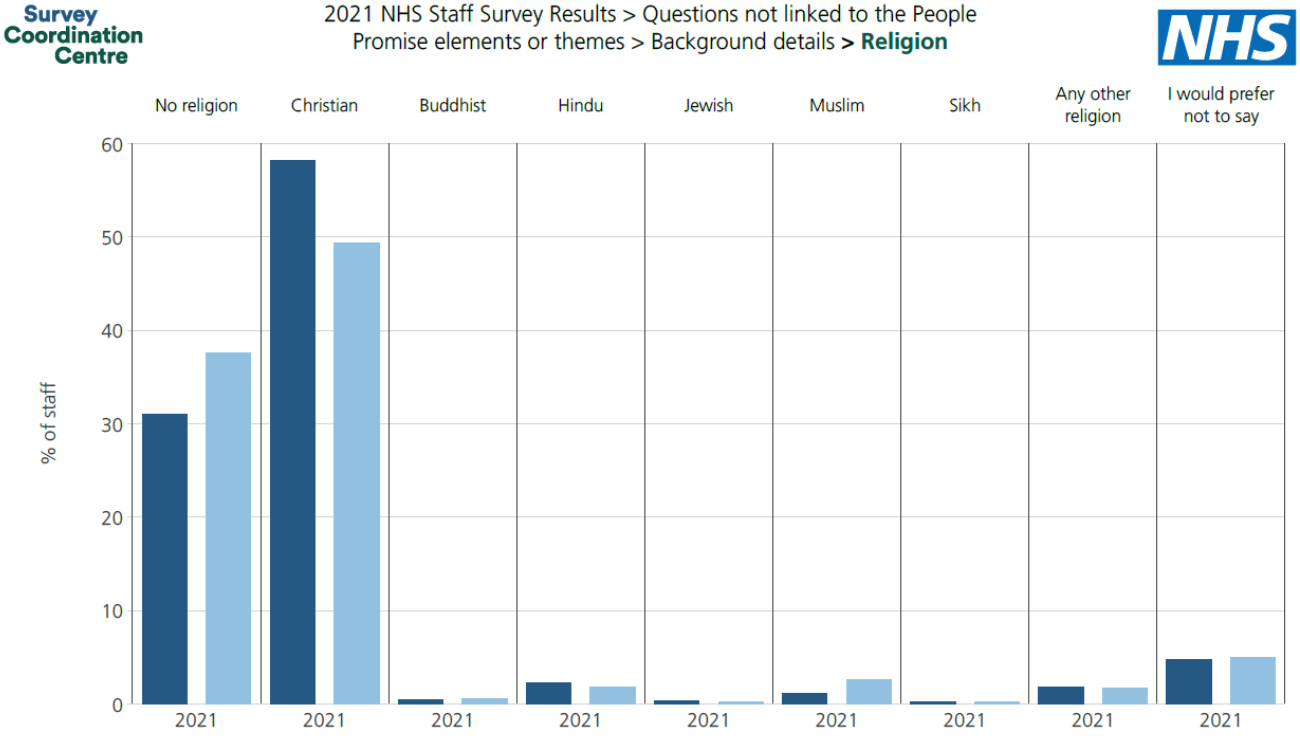
You can find the strategies here:

WHH PEOPLE STRATEGY 2022-2025

Workforce Equality, Diversity and Inclusion Strategy 2022-2025

Equality Diversion and Inclusion Data by Group

The staff survey offers our staff the opportunity to identify their protected characteristic when answering our questions, all responses are anonymous, and the following data demonstrates the cross-section of voices that we have heard from in the 2021 survey.



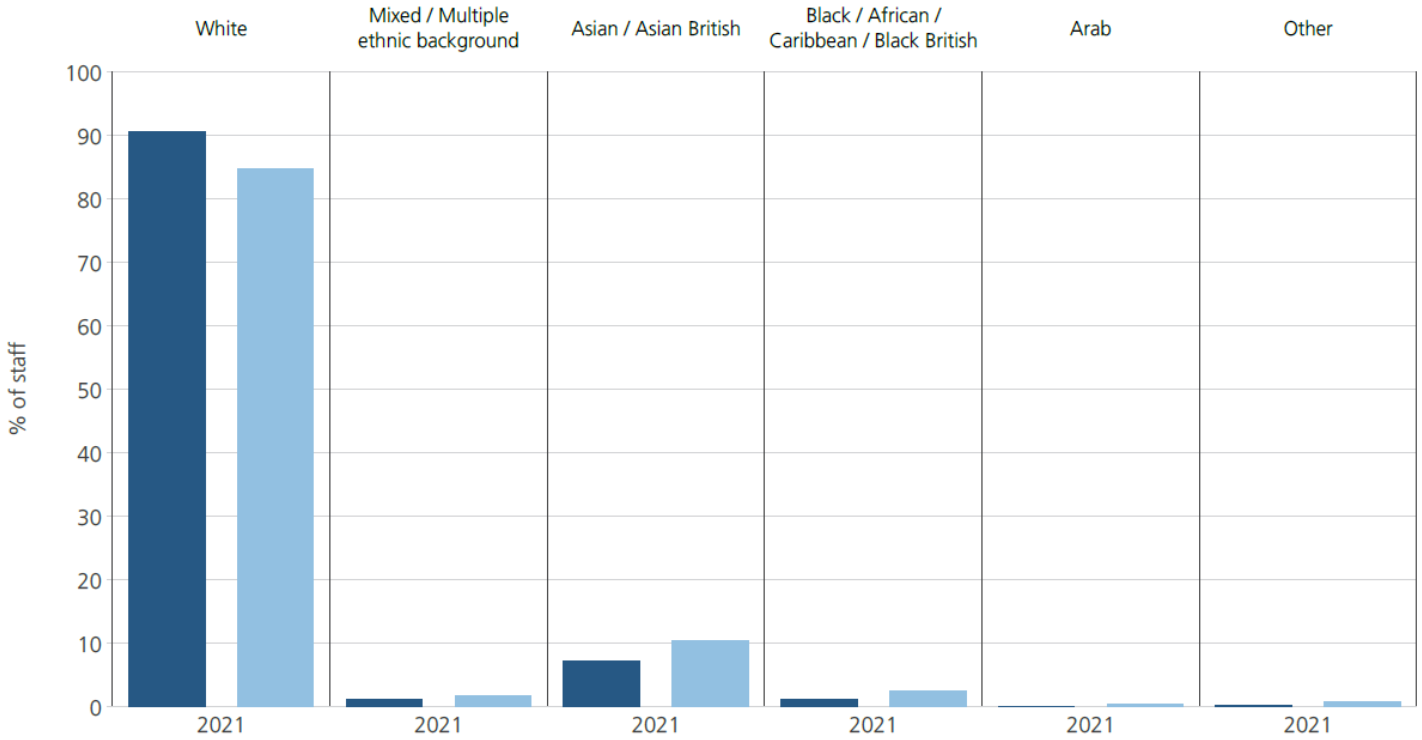
	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any other religion	I would prefer not to say
Your org	31.0%	58.2%	0.4%	2.3%	0.3%	1.1%	0.2%	1.8%	4.8%
Average	37.6%	49.4%	0.6%	1.8%	0.2%	2.6%	0.2%	1.7%	5.0%
Responses	1,720	1,720	1,720	1,720	1,720	1,720	1,720	1,720	1,720

Religion:

- 58.2% or our workforce stated their religion to be Christian
- 31.0% reported having no religion
- With Hindu (2%) and Muslim (1.1)

Survey Coordination Centre

2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details > **Ethnicity**



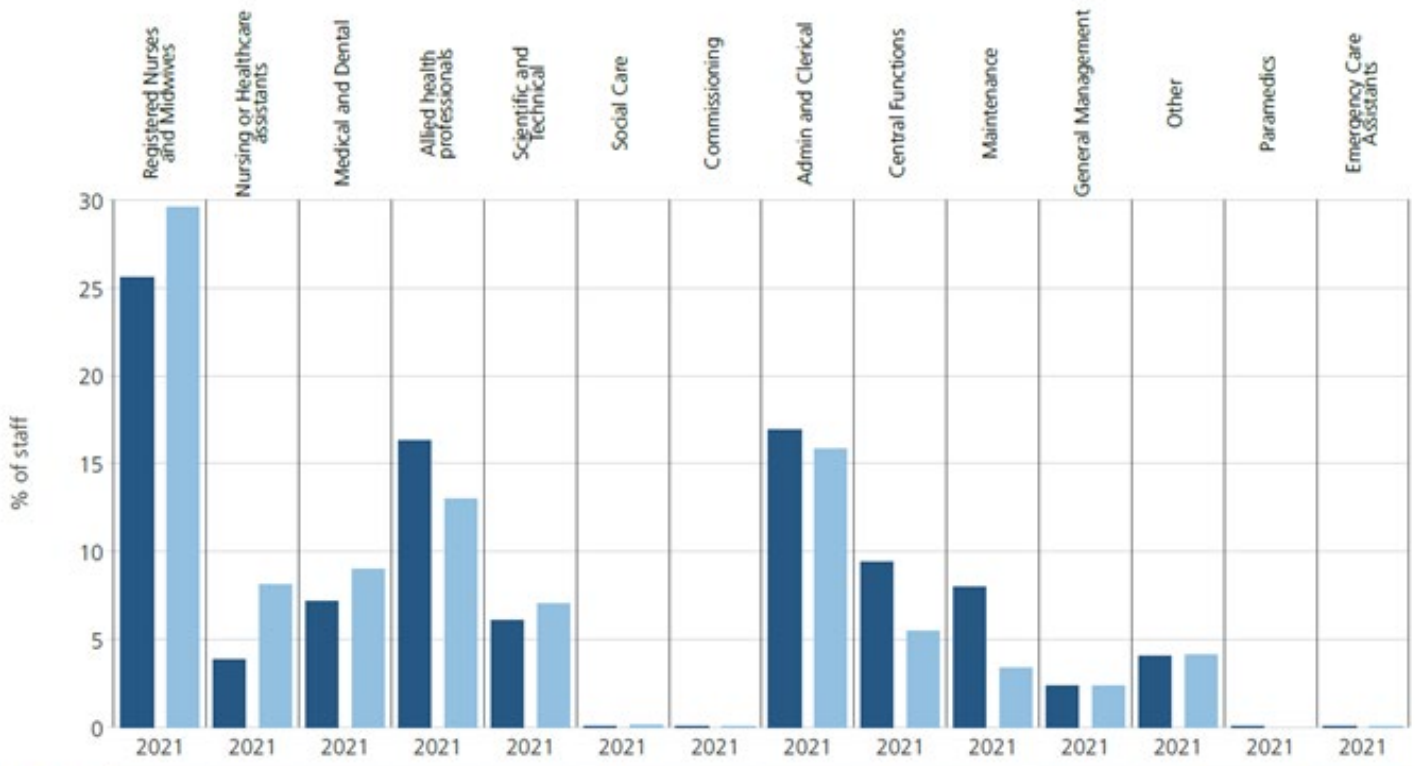
	White	Mixed / Multiple ethnic background	Asian / Asian British	Black / African / Caribbean / Black British	Arab	Other
Your org	90.6%	1.0%	7.1%	1.0%	0.1%	0.2%
Average	84.7%	1.8%	10.3%	2.4%	0.4%	0.7%
Responses	1,725	1,725	1,725	1,725	1,725	1,725

Ethnicity:

- 7.1% of our workforce identify as Asian/Asian British
- 1% of our workforce identity as Black/African/Caribbean/Black British
- 90.6% of our workforce identify as White.

Survey Coordination Centre

2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details > **Occupational group**



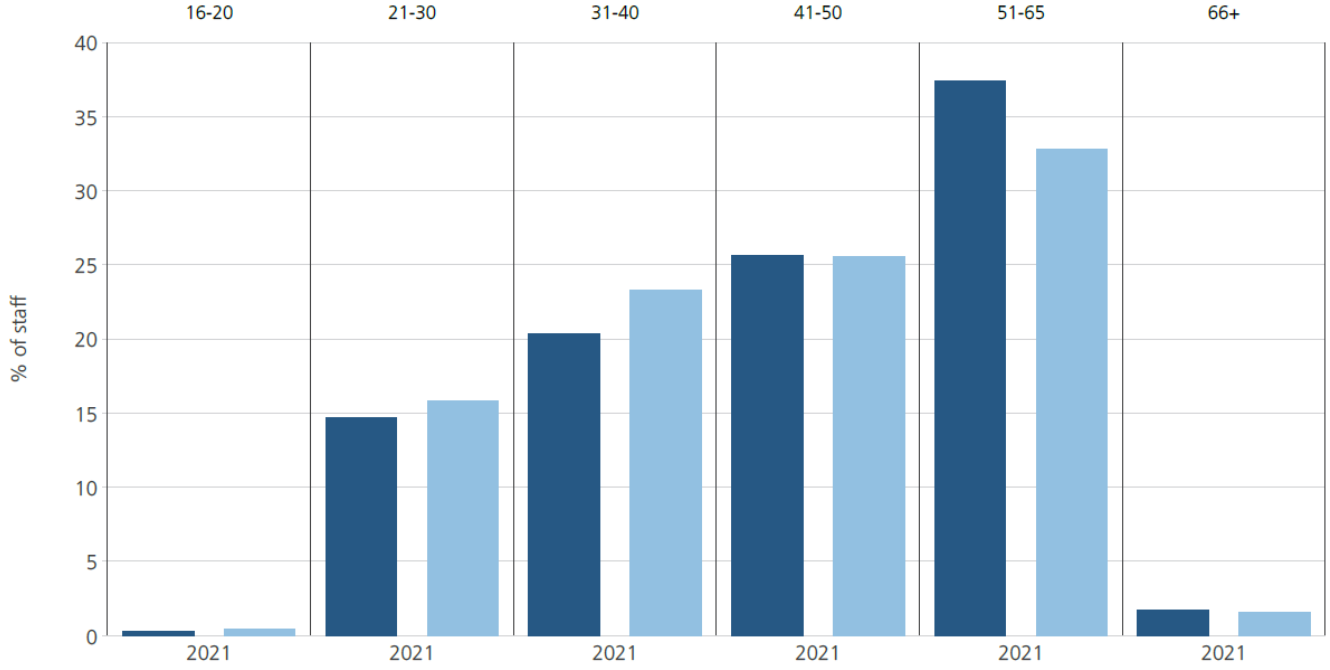
	Registered Nurses and Midwives	Nursing or Healthcare assistants	Medical and Dental	Allied health professionals	Scientific and Technical	Social Care	Commissioning	Admin and Clerical	Central Functions	Maintenance	General Management	Other	Paramedics	Emergency Care Assistants
Your org	25.6%	3.9%	7.2%	16.3%	6.1%	0.1%	0.1%	16.9%	9.4%	8.0%	2.3%	4.1%	0.1%	0.1%
Average	29.6%	8.1%	9.0%	13.0%	7.1%	0.1%	0.1%	15.9%	5.5%	3.4%	2.4%	4.1%	0.0%	0.0%
Responses	1,703	1,703	1,703	1,703	1,703	1,703	1,703	1,703	1,703	1,703	1,703	1,703	1,703	1,703

Occupation Group:

- 25.6% of those that responded are Nursing and Midwifery colleagues
- With Admin and Clerical (16.9%) and AHPs at (16.3%) the next highest responders

Survey Coordination Centre

2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details > **Age**



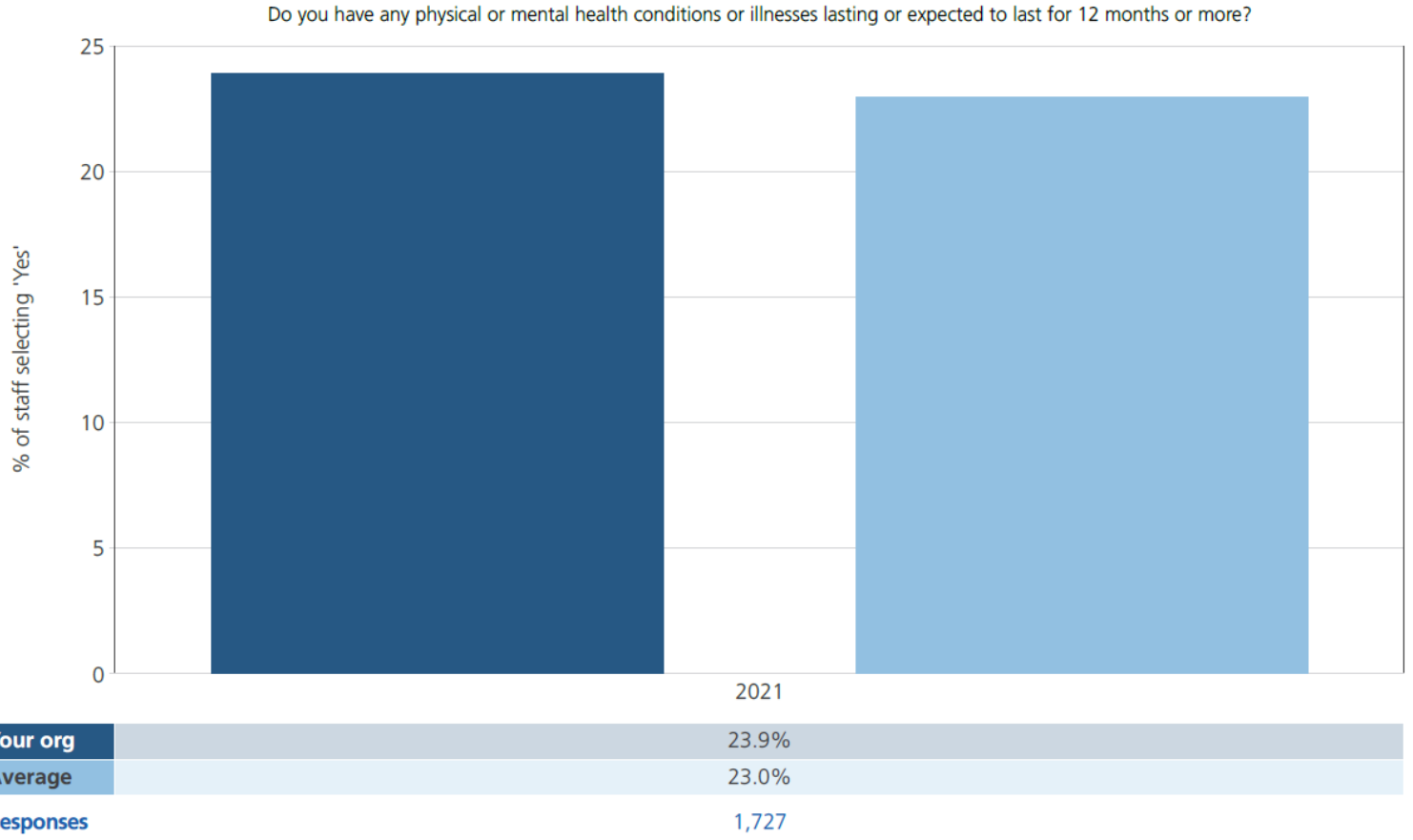
	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.3%	14.7%	20.3%	25.6%	37.4%	1.7%
Average	0.4%	15.8%	23.3%	25.6%	32.8%	1.5%
Responses	1,713	1,713	1,713	1,713	1,713	1,713

Age:

- 37.4% of our workforce are aged between 51- 65
- With 0.3% aged 16-20 and 1.7% over 66 years old.

Survey Coordination Centre

2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details > **Long lasting health condition or illness**



Your org	23.9%
Average	23.0%
Responses	1,727

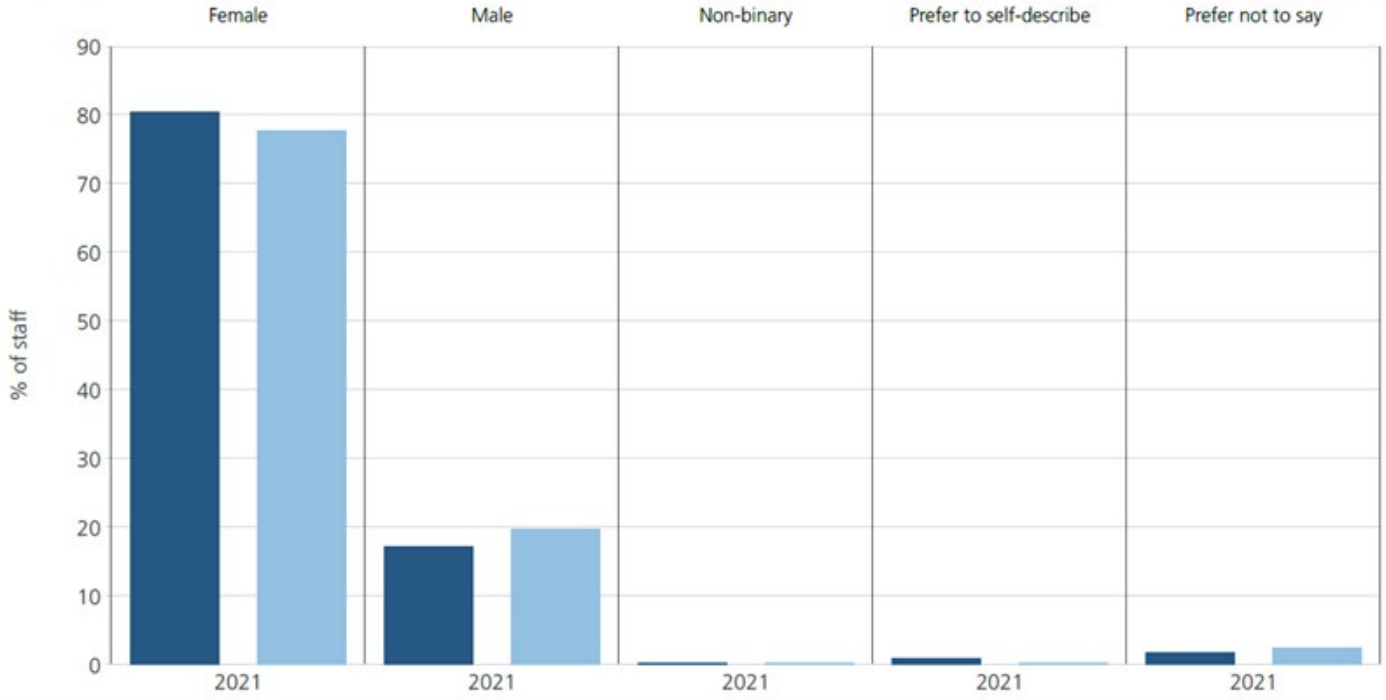
Long Lasting Health Condition or Illness:

- From 1727 responses 23.9% of our workforce report living with a long-term health condition

211 of 306

Survey Coordination Centre

2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details > **Gender**



	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say
Your org	80.4%	17.0%	0.1%	0.8%	1.7%
Average	77.8%	19.6%	0.1%	0.2%	2.3%
Responses	1,733	1,733	1,733	1,733	1,733

Gender:

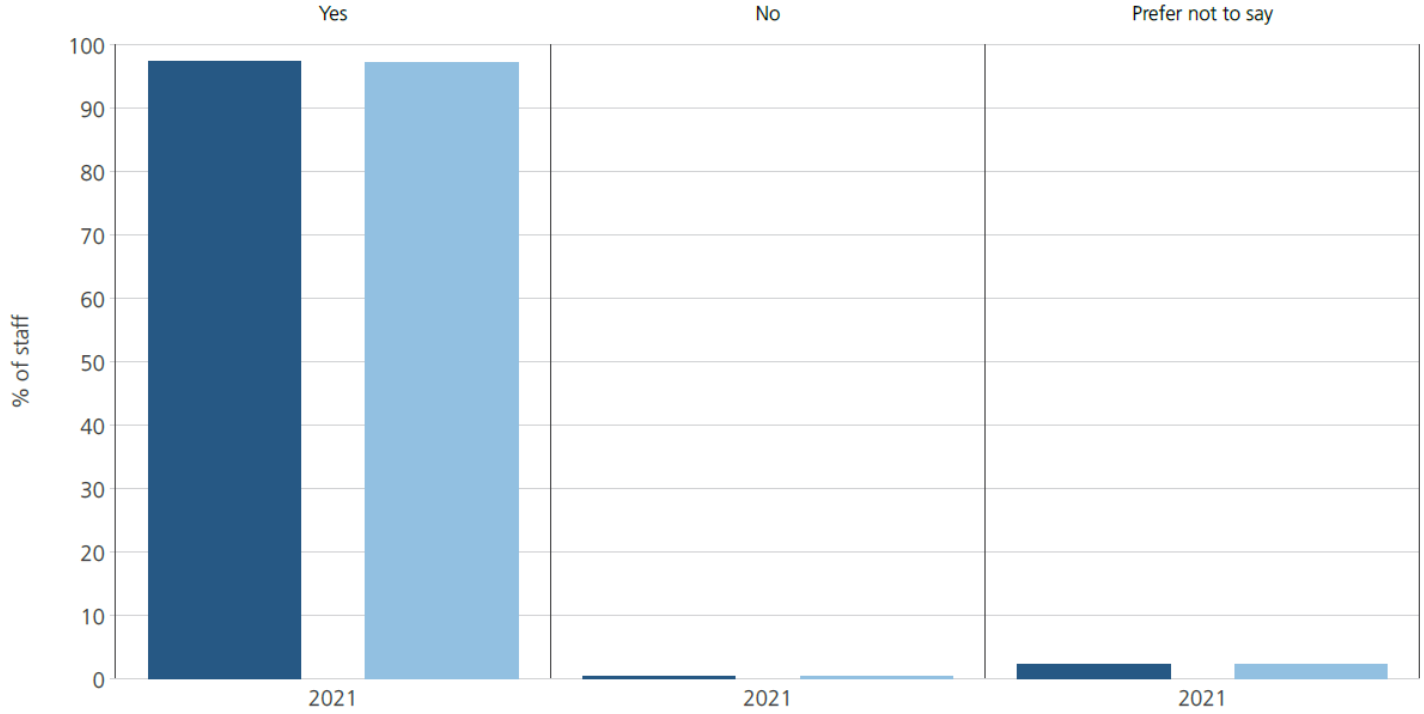
80.4% of respondents identify as female

With 0.1% identifying as non-binary and 0.8% preferring to self-describe their gender identity.

212 of 306

Survey Coordination Centre

2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details **> Is your gender identity the same as the sex you were registered at birth?**



	Yes	No	Prefer not to say
Your org	97.4%	0.5%	2.2%
Average	97.2%	0.4%	2.3%
Responses	1,520	1,520	1,520

Gender Identify:

- 0.5% of our workforce gender identity was difference than that registered at birth
- 97.4% of the workforce's gender identity remained the same as at birth

213 of 306

If you have questions or comments about this booklet or would like to find out more about our staff survey, please contact - whh.wearewhh@nhs.net

WHH People

@WHHPeople

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/61**	
SUBJECT:	**Use of Resource Assessment (UoRA) Update – Q4 2021/22**	
DATE OF MEETING:	25th May 2022	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
	Alice Forkgen, Associate Director of Finance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer and Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	#115 Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. #134 Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid, and this puts into question if the Trust is a going concern. #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust continues to progress improvement in its Use of Resources both internally and in collaboration with system wide partners, however COVID-19 has impacted progress. This paper outlines the current status of the Use of Resources Dashboard. It should be noted that a number of the indicators have not been updated on the Model Hospital.	

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

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

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

REPORT TO THE BOARD OF DIRECTORS

SUBJECT	Use of Resource Assessment (UoRA) Update – Q4 2021/22	AGENDA REF:	BM/22/05/61

1. BACKGROUND/CONTEXT

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

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

2. KEY ELEMENTS

This paper presents the update for Quarter 4 2021/22. Progress has been impacted by the COVID-19 pandemic. Performance against each UoRA KLOE is set out in **Appendix 1**, the full detail for each KLOE indicator can be found in **Appendix 2**.

The following movements have taken place on the UoRA Dashboard since Quarter 3:

- Pre-Procedure Non Elective Bed Days – the Trust has moved from Red to Green for this indicator.
- Staff Retention – the Trust has moved from Red to Green for this indicator – however the data including the Trust position and the national median is very high compared to the Trust's own data. The Trust has raised this with the model hospital.

Future of Use of Resources Assessments

Informal communications from NHSE/I has suggested that Use of Resources Assessments will restart in Q3 2021/22. The format of the assessments has not yet been agreed although it is anticipated that a new set of UoRA metrics will be published by NHSE/I. The Trust awaits formal communications.

Corporate Benchmarking

The corporate benchmarking report (based on 2020/21 data) is in the process of being reviewed with Deputy/Associate Directors within corporate services. A full report will be included within the Use of Resources Report to the Board in July 2022. High level findings include:

- Trust Overview – The previous benchmarking exercise was undertaken in 2018/19 (pre-COVID-19). There has been an overall increase of £0.36m in corporate costs, however, costs per £100m income has reduced by £1.26m. This reflects the change in

the NHS financial regime and additional income received due to COVID-19. The Trust's total income in 2020/21 was £317m compared with £243m in 2018/19.

- The cost per £100m income for all the corporate functions has improved since the 2018/19 review.
- Finance costs – overall cost per £100m income is at the same level as the ICS lower quartile, however there are some opportunities in relation to the national lower quartile. Capital costs appear to be significantly higher, however this is reflective of the increase of the capital programme. Finance Specific IT Systems and Ledger costs are also higher, however this in relation to the treatment of SBS (Outsourced Technical Services) costs. PMO costs have reduced, however these costs have moved to Operational Services.
- Governance & Risk – overall cost per £100m is comparable to the ICS lower quartile and the national median. Clinical Governance, Risk Management Services, Clinical Audit and Corporate Governance all appear to have opportunities when compared to national lower quartile.
- HR Function - overall cost per £100m is comparable to the ICS lower quartile and the national median. Non-Clinical Occupational Health & Wellbeing and Education and Organisational Development appear to have opportunities when compared to national lower quartile.
- Payroll – overall cost per £100m is at the ICS lower quartile and the national median, however, there are still some opportunities when comparing sub-functions to the national and ICS lower quartile. E.g., Payroll Service Development.
- IM&T Function - overall cost per £100m is better than both the ICS and the national lower quartiles. There are some opportunities when comparing sub-functions, in particular within Paper Medical Records, Clinical Coding, Applications Purchase/Management and Information Services.
- Procurement – overall cost per £100m are above the ICS and national median. Therefore, there are a number of potential opportunities when compared to the national and ICS lower quartile. In particular Receipt and Distribution.
- The corporate benchmarking is purely a comparison of cost per £100m and does not take into account any other factors such as quality, productivity, outcomes or the level of risk managed.

3. RECOMMENDATIONS

The Board of Directors is asked to:

1. Note the contents of this report.

Andrea McGee
Chief Finance Officer and Deputy Chief Executive
18th May 2022

Appendix 1 – Benchmarking Performance against the National Median

KLOE Indicator	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
KLOE 1 Clinical															
Pre-Procedure Elective Bed Days	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q4 2021/22
Pre-Procedure Non-Elective Bed Days	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22	Q2 20221/22	Q4 2021/22
Emergency Readmission (30 Days)	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q4 2021/22
Did Not Attend (DNA) Rate	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q4 2021/22
KLOE 2 People															
Staff Retention Rate	June 2018	September 2018	December 2018	December 2018	December 2018	December 2018	March 2020	March 2020	June 2020	Sept 2020	December 2020	March 2021	March 2021	September 2021	February 2022
Staff Sickness	May 2018	August 2018	November 2018	November 2018	June 2019	October 2019	March 2020	March 2020	June 2020	Sept 2020	January 2021	March 2021	June 2021	September 2021	February 2022
KLOE 3 Clinical Support Services															
Top 10 Medicines - Percentage Delivery of Savings	March 2018	March 2018	March 2018	March 2018	September 2019	November 2019	March 2020	March 2020	August 2020	November 2020	February 2021	May 2021	July 2021	July 2021	July 2021
Pathology - Overall Costs Per Test	Q4 2017/18	Q4 2017/18	Q2 2018/19	Q2 2018/19	Q4 2018/19	Q2 2019/20	Q3 2019/20	Q3 2019/20	Q3 2019/20	Q1 2020/21	Q3 2020/21	Q4 2020/21	Q4 2020/21	Q2 2021/22	Q3 2021/22
Radiology Cost Per Report	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	2020/21	2020/21	2020/21
KLOE 4 Corporate Services															
Finance Costs per £100m Turnover	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2020/21	2020/21
Human Resource Costs per £100m Turnover	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2020/21	2020/21

Procurement Process Efficiency and Price Performance Score Clinics															
Estates Costs Per m2															

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

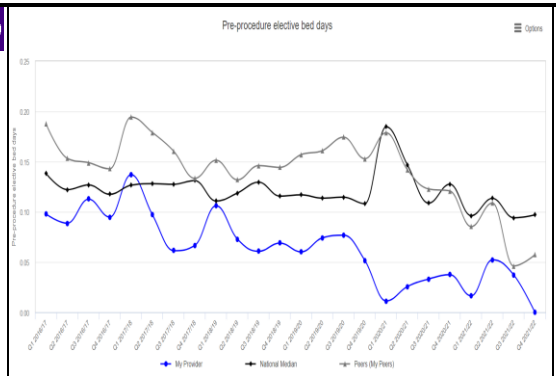
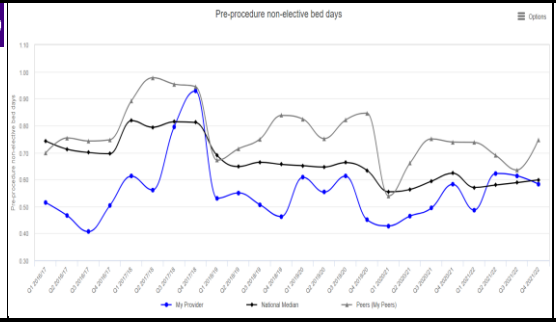
Green on the Model Hospital (Better than the National Median)
Red on the Model Hospital (Worse than the National Median)
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q4 2021/22

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

KLOE 1: Clinical/Operational

KLOE Operational Lead: Zoe Harris

Pre Procedure Elective Bed Days - The number of bed days between the elective admission date and the date that the procedure taken place.	**National Median: 0.10 days** **Q4 2021/22** **Peer Median: 0.06 days** **Target: Maintain** **Best Quartile: 0.05 days** **WHH Position:** **0.00 days** **Ranking:** **01/09 Peer Group** **Quartile:** **1 (Best)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		**The Trust is performing in the best quartile for this metric and is performing better than the national and peer medians.** The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme supported the reduction in theatre cancellations and in improving productivity and efficiency. The position has been sustained throughout the COVID-19 pandemic and continues to be monitored.
Pre Procedure Non Elective Bed Days - The number of bed days between an emergency admission date and the date the procedure taken place.	**National Median: 0.60 days** **Q4 2021/22** **Peer Median: 0.75 days** **Target: Best Quartile** **Best Quartile: 0.41 days** **WHH Position:** **0.58 days** **Ranking:** **03/09 Peer Group** **Quartile:** **2 (2nd Best)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		**The Trust is performing better than the national and peer medians.** The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme supported the reduction in theatre cancellations and in improving productivity and efficiency. The position continues to be monitored. There is a significant proportion of diagnostic procedures within medical specialties data. The data is currently under review to ensure accuracy of reporting.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

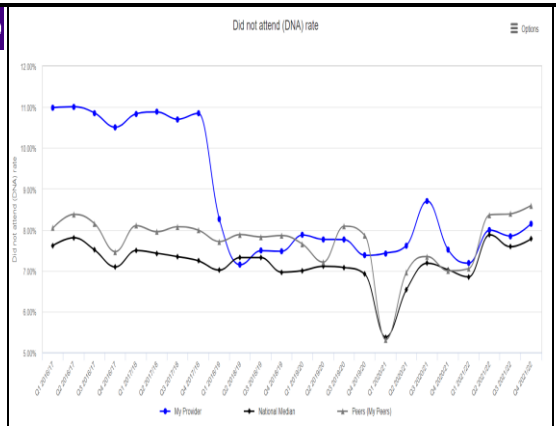
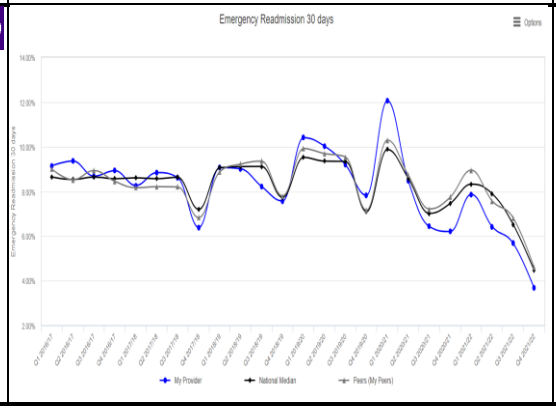
Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

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

Use of Resources Assessment Dashboard - Q4 2021/22

Action/ Recommendation	Benchmarking/Progress		Trend	Narrative - Warranted/Unwarranted & Justifiable
Did Not Attend Rate - Rate of patients not attending their outpatient appointment	**National Median: 7.78%** **Peer Median: 8.59%** **Best Quartile: 6.26%** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q4 2021/22** **Target: National Median** **8.15%** **03/09 Peer Group** **3 (2nd Worse)**		**The Trust is performing worse than the national median but is performing better than the peer median.** The Trust has utlised several initiatives to support improvement in the DNA rate. This has proved challenging during the COVID-19 pandemic and the Trust continues to see seasonal variation and variances between specialties. The Trust has established the Outpatient Recovery Improvement Group incorporating 5 workstreams; Risk Stratification, Workforce, Performance & KPIs, Operational and Access Policy. DNA performance is monitored through the Performance & KPI workstream. The Access policy and the DNA policy have been reviewed and individual CBUs are monitoring frequent DNAs to ensure that these patients are clinically reviewed for potential discharge. Patient Initiated Follow Ups (PIFU) are also being utilised and will reduce DNAs.
Emergency Readmission Rates (30 Days) - This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay. Admissions for cancer and obstetrics are excluded as they may be part of the patient's care plan.	**National Median: 4.47%** **Peer Median: 4.59%** **Best Quartile: 3.51%** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q4 2021/22** **Target: Maintain** **3.67%** **02/09 Peer Group** **2 (2nd Best)**		**The Trust is performing better than national and peer medians** Every effort is made when discharging a patient to ensure that the discharge is appropriate. Readmissions are reviewed by the clinical directors to understand any inappropriate discharges and to ensure lessons are learned. The Trust is fully engaged with GIRFT (Getting It Right First Time) and continues to use intelligence to make improvements in efficiencies and in the quality of services.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

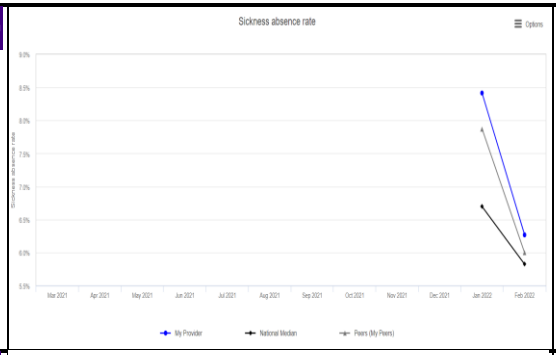
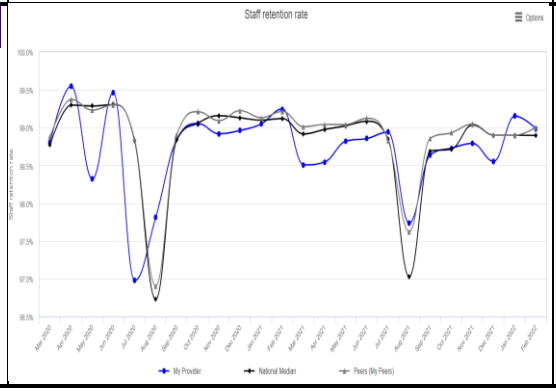
Green on the Model Hospital (Better than the National Median)
Red on the Model Hospital (Worse than the National Median)
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q4 2021/22

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

KLOE 2: People

KLOE Operational Lead: Carl Roberts

Staff Sickness - Percentage of staff FTE sick days.	**National Median: 5.8%** **February 2022** **Peer Median: 6.00%** **Target: 4.2%** **Best Quartile: 5.1%** **WHH Position:** **6.30%** **Ranking:** **06/10 Peer Group** **Quartile:** **3 (2nd Worse)** **Monitoring: Trust Board, SPC** **Source: HSCIC - NHS Digital iView Stability Index**		**The Trust is performing worse than the national and peer medians.** Following a successful NHSE/I bid, an improvement project has commenced. Engagement with the Trust's Supporting Absence Task and Finish Group is positive with nominations for attendees across the care groups and specialities.
Staff Retention Rate - The percentage of staff that remained stable over 12 months period.	**National Median: 98.9%** **February 2022** **Peer Median: 99.0%** **Target: National Median** **Best Quartile: 99.2%** **WHH Position:** **99.00%** **Ranking:** **04/10 Peer Group** **Quartile:** **3 (2nd Best)** **Monitoring: Board/SPC** **Source: HSCIC - NHS Digital iView Stability Index**		**The Trust is performing better than the national median and in line with the peer median.** The Trust's reward and benefit scheme has been benchmarked with regional and national colleagues via NHS Employers and Health & Wellbeing leads across Cheshire & Mersey.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

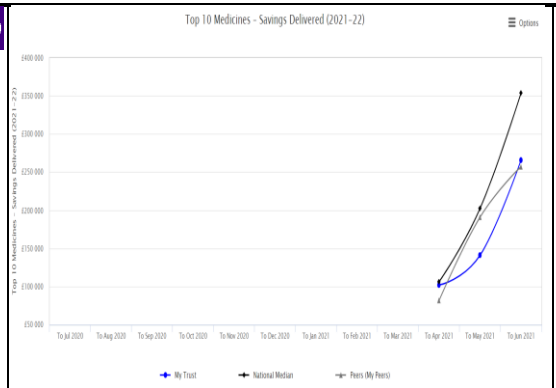
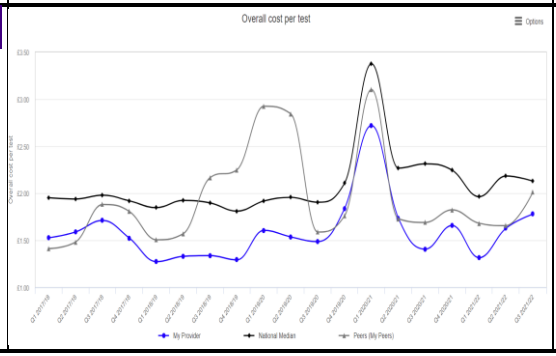
Green on the Model Hospital (Better than the National Median)
Red on the Model Hospital (Worse than the National Median)
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q4 2021/22

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

KLOE 3: Clinical Support

KLOE Operational Lead: Diane Matthew
KLOE Operational Lead: Neil Gaskell
KLOE Operational Lead: Mark Jones

Top 10 Medicines - Percentage Delivery of Savings (Pharmacy)	**Benchmark: £125k** **July 2021** **Peer Median: £356k** **Target: Benchmark** **Best Quartile: N/A** **WHH Position:** **£311k** **Ranking:** **Quartile:** **N/A** **Monitoring: Medicines Governance Committee** **Source: Rx-Info Define© (processed by Model Hospital)**		**The Trust is performing better than the national benchmark.** The Trust is exceeding the national benchmark and has achieved savings of £311k as of July 2021 (this is the latest available information on the Model Hospital). The Pharmacy Team are working with Finance colleagues to review savings for 2021/22. The Trust maintains low drug costs in comparison with the national median e.g. £326/Weighted Activity Unit (WAU) compared with £687/WAU for Acute Trusts. Medicines optimisation remains a prioritised workstream. Processes continue to be aligned between the Trust, CCGs/ICS and the Pan Mersey Area Prescribing Committee. Collaboration is ongoing to ensure opportunities for further improvements are identified. WHH is engaged in a ICS level medicines optimisation workstream which will look to collaborate on medicines efficiencies across the network.
Pathology - Cost Per Test - The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items.	**National Median: £2.13** **Q3 2021/22** **Peer Median: £2.01** **Target: Maintain** **Best Quartile: £1.81** **WHH Position:** **£1.78** **Ranking:** **1/4 Peer Group** **Quartile:** **1 (Best)** **Monitoring: Pathology Business Meeting** **Source: NHSI Q Pathology Data Collection 21/22**		**The Trust is performing better than the national and peer medians and is in the best quartile for this metric.** Overall the Trust's pathology service is efficient with the use of streamlined processes, technology and procurement opportunities. The Trust continues to perform well with regards to overall cost per test during the recovery period following the COVID-19 pandemic.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

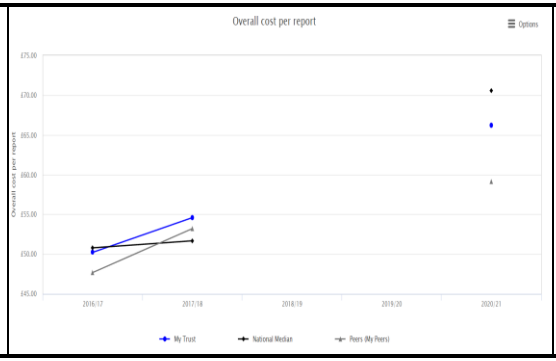
Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

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

Use of Resources Assessment Dashboard - Q4 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Imaging - Cost Per Report - Total cost of reporting one image, irrespective of modality	**National Median: £70.59** **2020/21** **Peer Median: £59.10** **Target: Maintain** **Best Quartile: £55.93** **WHH Position:** **£66.19** **Ranking:** **8/10 Peer Group** **Quartile:** **2 (2nd Best)** **Monitoring:** **Source: NHS Imaging Productivity Data Collection (Annual)**		**The Trust Imaging Cost Per Report is better than the national median.** The Trust has invested significantly in diagnostic equipment which has enabled the Trust to reduce its outsourcing of radiology including vascular. . This metric now reflects: 1. The move to bring Vascular Ultrasound in house in March 2021. 2. An increase utilisation of Radiographer Reporting within the department. 3. The cessation of outsourcing of reporting in early 2020.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

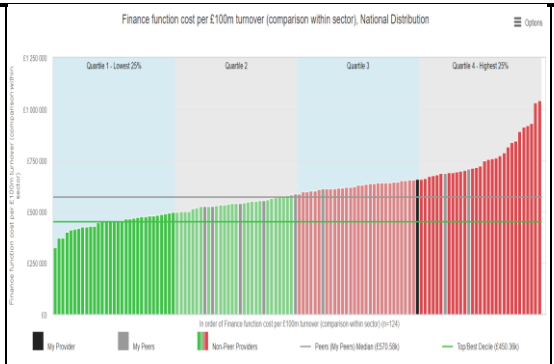
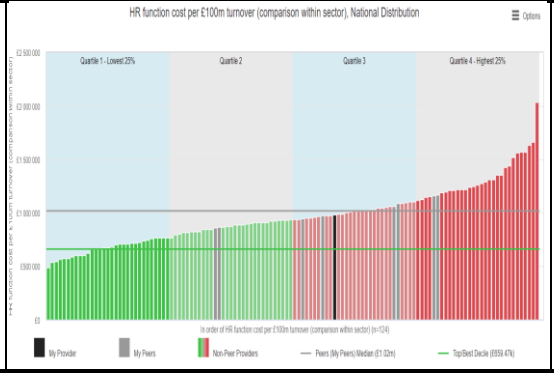
Green on the Model Hospital (Better than the National Median)
Red on the Model Hospital (Worse than the National Median)
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q4 2021/22

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

KLOE 4: Corporate Services

Finance — KLOE Operational Lead: Jane Hurst
Procurement — KLOE Operational Lead: Alison Parker
HR & OD — KLOE Operational Lead: Carl Roberts
Estates & Facilities — KLOE Operational Lead: Ian Wright

Finance Costs per £100m Income - Total finance cost divided by trust turnover multiplied by a £100m	**National Median: £636k** **Peer Median: £570k** **Best Quartile: £586k** **WHH Position: £658k** **Ranking: 7/9 Peer Group** **Quartile: 3 (2nd Worse)** **Monitoring: FSC** **Source: Trust consolidated annual accounts and NHSI improvement 20/21 data collection template**	**2020/21** **Target: Benchmark**		**The Trusts Finance costs per £100m income are higher than the national and peer medians based on national benchmarking data from 2020/21**. The Trust has improved from £838k to £658k cost per £100m income which is £22k worse than the national median and £77k worse than the peer median. The Trust is reviewing the benchmarking data to understand the areas of variation and areas of improvement. A review by sub-function is being undertaken.
Human Resource Costs per £100m Income - HR is made up of a number of sub compartments taken into consideration when considering total HR costs per £100m turnover.	**National Median: £936k** **Peer Median: £1.02m** **Best Quartile: £888k** **WHH Position: £980k** **Ranking: 5/11 Peer Group** **Quartile: 3 (2nd Worse)** **Monitoring: SPC** **Source: Trust consolidated annual accounts and NHSI improvement 20/21 data collection template**	**2020/21** **Target: Benchmark**		**The Trusts HR costs per £100m income are higher than the national median and lower than the peer median based on national benchmarking data for 2020/21.** The Trust is reviewing the benchmarking data to understand the areas of variation and areas of improvement.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

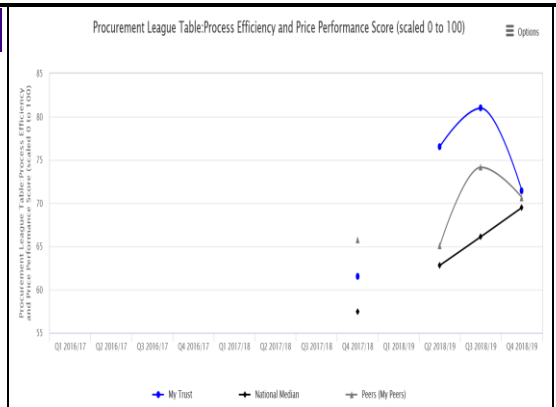
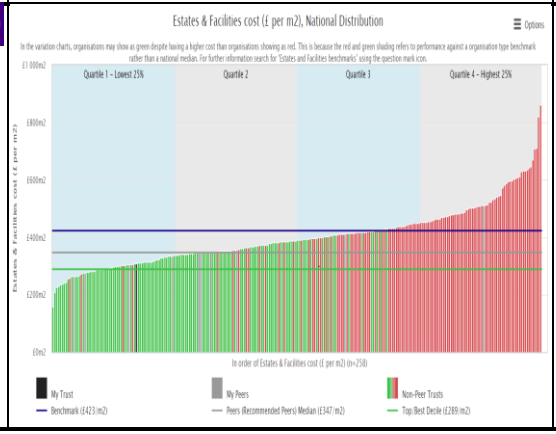
Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

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

Use of Resources Assessment Dashboard - Q4 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Procurement Process Efficiency and Price Performance Score - This measure provides an overall view of how efficient and how effective an NHS Provider is in it's procurement process and price performance, respectively, when compared to other NHS providers.	**National Median: 56** **Q2 2019/20** **Peer Median: 44.7** **Target: 72** **Best Quartile: 72** **WHH Position:** **61** **Ranking:** **4/11 Peer Group** **Quartile:** **3 (2nd Best)** **Source: Purchase Price Index and Benchmark (PPIB) tool**		**The Trust is performing better the national and peer medians for the Procurement Process Score.** Procurement metric reporting recommenced in February 2022 and the Trust now submits data monthly. The Trust is awaiting the model hospital to be updated which is expected in Q1 2022/23. Once this has been updated, the data will be analysed to understand the current position.
Estates & Facilities Costs (£ per m2) - The total estates and facilities running costs is the total cost of running the estate in an NHS trust including, staff and overhead costs. In-house and out-sourced costs, including PFI costs, will be included.	**Benchmark: £423** **2020/21** **Peer Median: £347** **Target: Maintain** **Best Quartile: £321** **WHH Position:** **£308** **Ranking:** **4/11 Peer Group** **Quartile:** **1 (Best)** **Monitoring: Estates and Facilities Operational Group** **Source: ERIC 2020-21 Total Estates and Facilities Running Costs**		**The Trust Estates and Facilities costs are better than the national benchmark and the peer median.** The Trust has invested year on year to reduce backlog maintenance. The Trust has received the outcome of the ERIC return (for 2020/21) and the Trust continues to benchmark well in overall Estates & Facilities costs.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

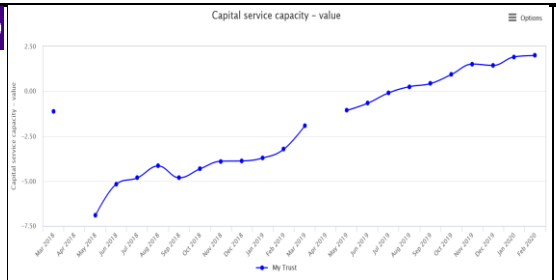
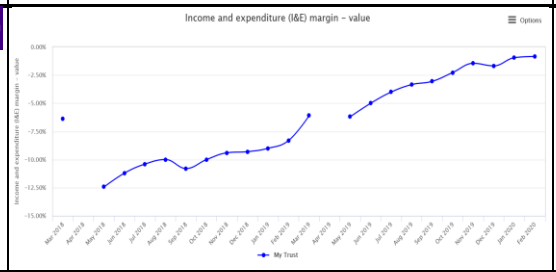
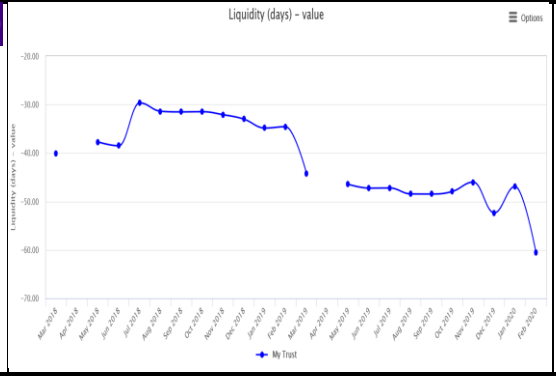
Green on the Model Hospital (Better than the National Median)
Red on the Model Hospital (Worse than the National Median)
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q4 2021/22

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

KLOE 5: Finance

KLOE Operational Lead: Jane Hurst

Capital Services Capacity - The degree to which the provider's generated income covers its financial obligations	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 1.99 (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		Use of Resource (Finance) reporting has been suspended since March 2020. As of M12 2021/22, the Trust's Capital service capacity is 3.22 which means the Trust is able to cover its financial obligations.
Income & Expenditure Margin - The income and expenditure surplus or deficit, divided by total revenue.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital -0.85% (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		As at M12 2021/22, the Trust's I&E Margin is 0.1% which means the Trust control total surplus is slightly better than breakeven position.
Liquidity (Days) - Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital -66.53 (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		The Trust liquidity days are 14.07 as of M12 2021/22. This is positive and means that the Trust can promptly pay suppliers. As at M12, the cumulative Trust performance against the Better Practice Payment Code was 93%.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

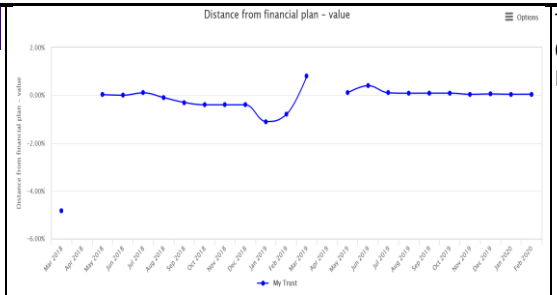
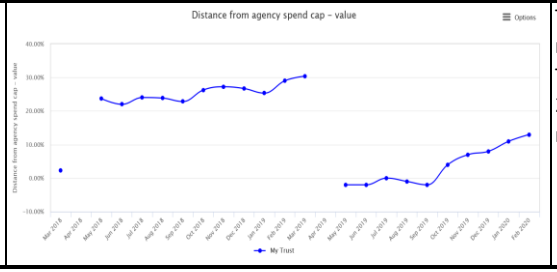
Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

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

Use of Resources Assessment Dashboard - Q4 2021/22

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Distance from Financial Plan - Year-to-date actual I&E margin in comparison to year-to-date plan I&E margin. I&E margin calculated on a control total basis. Measure is in percentage points.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 0.04% (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		Throughout 2021/22 the Trust has remained broadly on plan, as at M12 the Trust is 0.1% from plan. In year the ongoing COVID-19 costs and increases in drug costs have been offset by slippage on schemes and underspends on some budget lines.
Agency Spend - Cap Value - The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 13.00% (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		There is no agency cap for 2021/22, however the Trust continues to closely monitor agency spending for both business as usual and COVID-19 requirements. The agency costs are £12.7m of which £1.6m related to COVID-19 in 2021/22. For 2022/23 the People Directorate will continue to work with operational teams to reduce the use of agency staffing where appropriate.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q4 2021/22

KLOE/Area	Action Lead(s)	Action Plan
Clinical/ Operational - Operational Efficiency	**Zoe Harris**	• Progression of collaboration opportunities through mutual aid/SLAs to maximise use of assets. • Virtual Enhanced Care – review and re-design of processes to improve patient care/experience. Expansion of the use of virtual clinics both within outpatients and inpatient virtual wards. • ED plaza development - phase 1 (ED Ambulatory Assessment Service) is to open in June 2022. This will improve patient flow. • COVID-19 Elective Recovery – recovery programme for the Trust to achieve the elective activity plan for 2022/23. • DNA - Patient Initiated follow up is live in the majority of specialties. Further actions to be identified to improve the DNA rate. • The Operational Services are developing CIP schemes for 2022/23.
People - Sickness	**Carl Roberts**	• The Absence Task and Finish Group, first met in December 2021 with a continued focus on employee Health and Wellbeing. • Focus on interventions for staff living in Halton and Warrington, working with local community partners. • The HR Business Partner Team is providing ongoing support to operational managers in managing sickness absence. This includes advisory support in relation to policy and attendance, welfare, and sickness stage meetings/hearings. • The HR team is working with the Christie NHS Foundation Trust to understand their Return to Work processes. Alongside this review, the HR team continues to support CBUs through bespoke Return to Work training, which has had a positive impact on Return to Work compliance. This training will be incorporated into the new line manager training programme to be launched in Q1 2022/23. • The new Supporting Attendance policy has been published and is currently in the launch phase with managers and staff side partners; facilitated by HR team. • The Supporting Attendance project work with NHSEI is ongoing and is currently focusing on individual management coaching and bitesize briefings on the new Supporting Attendance Policy. • Full training sessions are planned within the Line Management Developments program, which will commence in Q1 2022/23. • As part of Supporting Attendance project the Return to Work Interviews have been refocused as Welcome Back Conversations. • A focused Welcome Back Conversation workshop will also be offered as a short training opportunity within the essential skills for managers program. • The Occupational Health and Wellbeing Team hold triangulation meetings with HR colleagues to review individuals who are under the formal stages of Supporting Attendance Management, to progress the case through enhancing support and/or developing interventions.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q4 2021/22

KLOE/Area	Action Lead(s)	Action Plan
People - Retention	**Carl Roberts**	**Retention:** • A line manager development programme is being implemented. A task and finish group has been set up to share the proposed development programme and will seek feedback. Implementation of a career development programme pilot with staff networks is being rolled out Trustwide. The new line manager programme is nearing completion with an anticipated launch date in Q1 2022/23. • Work with NHSE/I "Flex for the Future" programme to look at how we can improve both agile and flexible working throughout the organisation is underway. • Team development offers includes; bringing teams back together, leadership offers, and leadership circles. The identification and implementation of a Talent Management framework for WHH, which will be "Scope for Growth" the NHSE/I Talent management approach. • A staff facilities task and finish group has been established to review the current staff facilities based national recommendations and to develop a strategic plan to improve.
People - Staff Costs per WAU	**Carl Roberts**	**Staff Costs per WAU:** • The workforce review group Terms of Reference will be reviewed to include the assessment of high vacancies/high temporary staffing spend and will develop action plans to address. • Expansion of the International Recruitment Programme to cover Medics, AHPs, Operating Department Practitioners - no further opportunities have been identified at this time, however the Trust has approved a business case for an additional 30 international nurses for 2022/23.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q4 2021/22

KLOE/Area	Action Lead(s)	Action Plan
Clinical Support - Pharmacy	**Diane Matthew**	**Savings on Medicines:** Continued focus on Homecare services and Biosimilar switching. **Job Planning:** Undertake internal review of job plans within the pharmacy establishment. The Pharmacy Team is awaiting an allocation of system licences in order to progress. **GP Connect:** Implementation of GP connect, enabling the Trust to see a list of medications prescribed by the GP which links into the Trust EPR, reducing the risk of selection errors when prescribing medication in hospital which also improves safety. Anticipated implementation by Q2 2022/23. The HTML version of GP connect is currently being tested. **TCAM:** Transfer of medication prescription details to a patients nominated community pharmacy to inform of discharge prescription details. There is a 2022/23 CQUIN around the implementation of TCAM. **ePMA 1 & 2:** The Trust continues to implement ePMA with the last speciality (Neonatal) to be scoped by the end of Q1 2022/23. The Trust is awaiting the formulary sign off and confirmation of equipment before ePMA can be implemented within neonatal services. **ePMA Part 3:** Dose Range Checking - Testing and planning of rollout is anticipated by the end of Q1 2022/23. **ePMA: Part 4:** Integration with JAC system (Stock Control) upgrade released in 2021/22 and progression of testing is underway, there has been some delays in the Trust gaining access to the test system around integration. Therefore it is anticipated that the testing will be completed by Q1 2022/23. Part 4 provides some functionality to digitize the supply side of medicines, however full close loop is not available (ability to see ward stock levels and warn when stock levels needs to be replenished). **Clinical Research Network:** Halton Clinical Trials Unit is functioning, and the recruitment of pharmacy posts is in progress with interviews taken place. • A new pharmacy robot on the Halton site and a replacement pharmacy robot on the Warrington site in order to improve efficiencies and reduce waste - this is included on the 2022/23 Capital programme. The timeframes include identifying a supplier in Q3 2022/23 with implementation in Q4 2022/23 - Q1 2023/24. • The Trust has approved a Business Case for Pharmacy Phase 2 7 day working within ED in order to bring medicines reconciliation closer to beginning of the patient's pathway. The Trust is in the process of recruiting to these posts. This will improve medicines reconciliation earlier in the inpatient episode which will also improve safety.
Clinical Support - Radiology	**Mark Jones**	**Radiology Efficiencies:** • The Trust has installed a new MRI machine which will mean the Trust is able to repatriate cardiac MRI and reduce the use of outsourced mobile MRI from June 2022. • Cheshire & Mersey ICS is carrying out a review of how data is recorded and reported across the network to ensure like for like comparisons. This has been paused due to COVID-19. • The department will continue to keep reporting outsourcing at zero. • The Trust is investing in replacing the Cardiac Cath Lab equipment - due for completion June 2022 and the Fluoroscopy room with a go live in June 2022 which will support a small increase in capacity. • The Trust was successful in an expression of interest to become a Community Diagnostic Centre (CDC), the business case is currently under development and will be reviewed by FSC and the Trust Board in due course, with national sign off and funds to be drawn down by August 2022.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q4 2021/22

KLOE/Area	Action Lead(s)	Action Plan
Clinical Support - Pathology	**Neil Gaskell**	**Pathology Network:** The Trust continues to work with the Pathology Network and specifically with STHK around the future of pathology services across Cheshire & Mersey. A number of options are being explored. A second review of the PID (WHH & STHK) has taken place and the Trust is awaiting a response. A number of risks have been identified around Finance, Logistics and Operations. Further detail has been requested from the Network to understand how these risks can be mitigated. Process mapping of the current service is underway. A post has been created to support the collaborative work between STHK and WHH with a longer term strategy across C&M. The Manchester Transformation Unit has been commissioned to write a business case for the Cheshire & Mersey Pathology Network to be complete by Q2 2022/23. **Digital Pathology:** The Pathology Network has funded the implementation of a digital pathology solution that allows the scanning and visualisation of microscopic tissue slides for diagnosis. The solution works similarly to tried and tested PACS technology. The network is looking at using a single LIMS supplier in C&M. WHH received £800k in March 2022 for digital capacity for Pathology and Radiology. **Pathology Efficiency & Quality:** • The Trust will pilot the phlebotomy and transfusion application, this will improve patient safety by taking the sample at bedside using the electronic identification system which matches the patient request to the wrist band reducing the risk of taking the wrong blood from the wrong patient and therefore issuing the wrong results. Future options around efficiencies relating to the Phlebotomy application will be explored. The phlebotomy application is being utilised in Outpatients, further work is taking place. This will be followed by Halton, Community services and Wards. Following on from the outpatient pilot a number of changes to the application is taking place to improve usability. • The Pathology Team will carry out a review of cost per test and benchmark against the actual costs in Q3 2022/23. • The Trust has engaged with suppliers and Halton CCG to electronically book patient appointments for Phlebotomy which will reduce paper and improve patient experience and referrals. A project manager has been assigned with monthly project meetings in place. This is part of the Trust's Digital Operational Group's agenda and will be picked up in 2022/23 once a new project manager is identified. • E-Task management system – the Trust utilises its e task management system out of hours to inform acute clinical areas of critical abnormal pathology results. This utilises an interfaces between the Trust pathology systems and e-task management providing real-time alerts which improves efficiency and patient safety. Currently this is only used in Acute services out of hours, however future options to expand in other areas (excluding A&E and Maternity). Awaiting for suppliers to complete some development work in Q1 2022/23 prior to a future rollout. • Demand Management - removal of Vitamin D testing (where clinically appropriate) at a saving of between £30k - £40k, Intelligent Liver Function Test (iLFT) - reduction of referrals into secondary care by using diagnostics tests utlising a algorithm with a recommended pathway. • The pathology team is exploring opportunities to provide pathology services to third sector and private organisations in order to generate additional income.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q4 2021/22

KLOE/Area	Action Lead(s)	Action Plan
Corporate - Estates	**Ian Wright**	**Strategic Cost Reduction:** • Explore and develop further collaboration opportunities (impacted by COVID-19). • Review of Facilities Management Contracts at C&M Level (Energy, Linen, Post and Decontamination). A plan has been developed for a collaborative approach across C&M as current contracts expire. There are opportunities to tender collaboratively to reduce costs. • Progression/Expansion of agile working to reduce floor space (this has been accelerated by COVID-19, however due to social distancing requirements, the ability to remove desks has been affected). **Energy Saving Schemes:** • Internal replacement of emergency lighting to improve efficiency is an ongoing programme within capital developments. • Capital spend on projects that will reduce critical infrastructure risk and long term estates maintenance costs. **Collaboration & Sustainability:** • Continued monitoring of critical infrastructure risk and how this has had an impact on estates maintenance costs. • The Trust has commissioned a deep dive review in the CHP (Combined Heat & Power) contract to ensure the Trust is gaining value of money and expert advice - actions are being progressed throughout 2022/23.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q4 2021/22

KLOE/Area	Action Lead(s)	Action Plan
Corporate - Procurement	**Alison Parker**	**Procurement Efficiency** • Development of a high-level ICS Procurement Plan to deliver actions with the Procurement Target Operating Model (PTOM) steering group. The Trust is part of a C&M Metrics Group which collectively agreed on the submission at C&M Level (monthly). Progress is measured against a 34 point action plan. The action plans has various dimensions that is expected to be delivered against. PTOM dimension groups have been established. The Trust's Associate Director of Procurement is heading up the data analytics dimension. The data analytics dimension will include a review of catalogue demand across the ICS, tail end spend across the ICS (anything under £5k with a supplier), and review High Cost Excluded Tariff Devices to see if there is potential for savings to be realised. • The Trust has developed a savings tracker on behalf of procurement across the ICS - which is reported into Directors of Finance and the existing CAS (Collaboration at Scale Board). • Further work is being undertaken to develop a collaborative contract register. • Re-engage with SBS regarding the implementation of Edge for Health (a cloud based platform which improves efficiency between Trusts and suppliers). This has been placed on hold by SBS, the Trust is awaiting next steps. • The Trust has re-engaged with Supply Chain Co-ordination Limited (SCCL) to develop a C&M wide strategy for the delivery of savings from the category towers which was presented to the C&M procurement committee in September 2021. Additional development is required, this has been escalated. • Six Monthly Basis - Every six months the top 500 purchased products based on the total spend of the Trust (% Variance for Top 500 Product Metric) will be run comparing the data to the; lowest floor price, C&M Trusts, NHSE/I Peer Group. This will serve two purposes; support the delivery of savings and support work required in line with model hospital requirements. Saving opportunities will be reviewed on a monthly basis focusing on those with the highest opportunity until all 500 opportunities have been exhausted. This exercise will then be repeated. • Catalogue Benchmarking - The Trust has 309 catalogues in place covering 42,471 product lines. Catalogue Benchmarking is to be undertaken on a rolling monthly basis comparing our catalogue prices to those prices paid across the NHS.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q4 2021/22

KLOE/Area	Action Lead(s)	Action Plan
Finance	**Jane Hurst**	**Financial Planning, Sustainability & Controls:** • The Trust will continue to monitor and assess emerging guidance to ensure compliance. Financial performance is closely monitored and variation from plan is addressed in a timely manner. • Continued scrutiny and governance on capital schemes over £0.5m. • The Trust is worked with the system to deliver a breakeven position in 2021/22 • Support the development of CIP schemes in 2022/23 and monitoring of Quality Impact Assessments. A new approach to CIP and GIRFT has been agreed with support from the Medical Director. • Analysis of corporate benchmarking data to identify opportunities for efficiencies. • Quarterly monitoring of benefits realisation of investments. • Increase scrutiny and governance over retrospective waivers. • Action plan to achieve level 3 Future Focused Finance accreditation. • Ringfenced cash to support the EPCMS (Electronic Patient Care Management System). • Development of an updated Financial Strategy to support the delivery of financial sustainability. It is anticipated this will be presented to the Trust Board for approval in May 2022.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/62**	
SUBJECT:	**Bi-monthly Strategy Programme Highlight Report**	
DATE OF MEETING:	25 May 2022	
AUTHOR(S):	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):*	The following Strategy Programme Highlight Report provides a progress update on key strategic projects and initiatives that underpin WHH's Quality, People and Sustainability (QPS) Aims and Objectives.	

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

RECOMMENDATION:	It is recommended that Trust Board note the report for information.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors
	Agenda Ref.	
	Date of meeting	12/05/2022
	Summary of Outcome	Noted for assurance
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Section 43 – prejudice to commercial interests	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Bi-monthly Strategy report	AGENDA REF:	BM/22/05/62

1. BACKGROUND/CONTEXT

This report summarises the progress of key strategic projects which underpin WHH's Quality, People and Sustainability (QPS) Aims and Objectives. It is intended to be a useful reference point for regular updates.

2. KEY ELEMENTS

The Strategy Programme Highlight Report consists of the following elements:

- The stakeholder engagement log provides a snapshot of external stakeholder engagement over the 2-month period. It is not a comprehensive list of all stakeholders engaged and does not include the extensive stakeholder engagement via regular external meetings and forums
- Issues for escalation to FSC/Trust Board.
- Individual project updates, including budget updates, key milestones (RAG rated), progress since the last report, risks
- Details of how the overall Trust Strategy is being developed
- Description of strategic opportunities that are in the pipeline

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Trust Board to note the information contained within the report.

4. MONITORING/REPORTING ROUTES

Key strategic projects report to the Strategy and a Greener WHH sub-committee which reports to FSC and then through to Trust Board.

5. TIMELINES

This report is produced bi-monthly and circulated to the Finance and Sustainability Committee and Trust Board quarterly.

6. RECOMMENDATIONS

It is recommended that the Trust Board members note the report for information.

Strategy Programme Highlight Report - April 2022

5	Warrington Town Deal	LG	SB/CL	
6	Runcorn Town Deal	LG	CM	
7	Runcorn Shopping City	LG	CM	
8	New Hospitals Programme	LG	KJ/RO'D	
9	WHH Green Plan	IW	VR	
10	Warrington Wider Estates Review	LG	RO'D	
11	Halton Blocks	LG	CM/RO'D	
12	Breast Service Reconfiguration – Phase 2	LG	CL	
13	C&M Pathology Network	LG	KJ/VR	
14	Community Diagnostic Centre	LG	SB	
15	Health & Care System Reconfiguration	LG	KJ/SB/CM	
16	Health & Social Care Academy	WVRC	SB/CL	
17	Partnership with Local Hospices	LG	SB	
18	Academic Collaboration with University of Chester	KSJ/PF	SB/VR	
19	Anchor Programme Development	LG	KJ	

Key code	

Page	Project	SRO	Strategy Lead	Status
20	Prevention Pledge	LG	CM	
21	Development of Overall Trust Strategy	LG	SB	

This strategy report provides a progress update on key strategic projects and initiatives that underpin WHH's Quality, People and Sustainability (QPS) Aims and Objectives.

The stakeholder engagement log provides a snapshot of external stakeholder engagement over the 2 month period. It is not a comprehensive list of all stakeholders engaged and does not include the extensive stakeholder engagement via regular external meetings and forums.

Should further information be required on any projects contained within the report, please contact the strategy team directly.

Key code	

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement	Outcome [if applicable]
Lisa Sculpher	Strategic Estates, NHSEI	Warrington Wider Estates Review and New Hospitals Programme	Input refreshed site feasibility for new hospitals
Nick Armstrong	Strategic Estates, Warrington CCG	Warrington Wider Estates Review	Agreed to support discussion on how the asset map will support Place priorities
		Breast Screening phase 2 financial support for the project from CCG	Ongoing, capital split agreed. Ongoing revenue contribution in negotiation.
Chris Baker	NWAS	Warrington Wider Estates Review	Discussion regarding the project, what it entails and NWAS Strategies that could be included
Thara Raj	Director of Public Health, WBC	Warrington Town Deal, Chair of Stakeholder and Engagement group	Ongoing input and support of the project.
Tracey Cole	Diagnostics Programme Director	Cheshire and Merseyside Pathology Network	Discussed direction of travel for network
Anton Fields	Head of Business Intelligence, WBC	Town Deal Health and Wellbeing Hub – Grant Funding Agreement	Finalise Grant Funding Agreement for Health & Wellbeing Hub funding with WBC
Laurence Pullan	Head of Communications, WBC	Discussion around integration with the Living Well brand. Comms plan to be delivered in partnership.	Living Well brand development. Development of Comms plan for the Health & Wellbeing Hub
Paul Swanwick	Head of Finance (Cheshire & Merseyside)	Discussion on CSFs for New Hospitals site feasibility work	Inputted into CSFs and underpinning scoring mechanism
John McCabe	Divisional Medical Director (Surgery and Clinical Support) – STHK	ENT Collaboration with STHK	Agreed approach to progress identification of new ways of working in collaboration to support service sustainability
Julie Howson	Healthwatch Warrington	New Hospitals Programme and opportunities for Warrington	Discussions ongoing about incorporating patient views into New Hospitals Programme
Steve Park	Director of Growth, WBC	Warrington Wider Estates	Discussion on WBC Strategies to include in the delivery plan

Stakeholder Engagement Log

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement	Outcome [if applicable]
Nichola Newton	Principal and Chief Executive, Warrington and Vale Royal College	Site visit to new Health and Social Care Academy on the college site, Winwick Road.	Strengthen links between WHH and the College.
Ian Triplow	CDC Programme Director Cheshire & Merseyside	Scoping potential for a Community Diagnostic Centre in Warrington/Halton	Ian is advising on next steps and looking to provide further info/data from across C&M
Dan Burdett	Regional Partnership Director (North West), NHS Property Services	Further discussions around potential to partner with NHSPS on Warrington Town Deal Hub project	Positive discussions. Opportunity identified and now working with NHSPS to look at how this might work in practice.
Dave McNicholl	CEO, Warrington Youth Zone	Potential to connect developing WHH paediatric diabetes offer into wider Warrington place-based services	Closer links established to ensure the Youth Zone and Hub support and complement each other.
Steve Cullen	CEO, Citizen's Advice Warrington	Update on Health & Wellbeing Hub	Confirmation of CAB's desire to be involved with the Hub project.
Michael Crilly	Director of Social Inclusion, Merseycare	Understand and develop links between Health & Wellbeing Hub and Merseycare Life Rooms	Links created between 2 initiatives and improved understanding around how the 2 models might work together.
Sarah Quinn	COO, Bridgewater	Future revenue funding arrangements for the Health & Wellbeing Hub	Improved clarity around Bridgewater's ongoing and longer-term commitment to the Health & Wellbeing Hub project
Sonya Currey	CEO, St Rocco's Hospice	Follow up to partnership working discussions and update on Health & Wellbeing Hub	Confirmation of St Rocco's desire to be involved with the Hub project.
Chris Lyons	Director of Strategic Programmes and Development, Merseycare	Understand links between Health & Wellbeing Hub and Merseycare Life Rooms	Merseycare supportive of developing both projects. Further conversations with Life Rooms leadership team
Wesley Rourke	Operations Director, Halton Borough Council	Regular catch up with senior HBC representatives	Strengthen links between WHH and Halton Council.
Linda Buckley	MD Provider Collaborative, Cheshire & Merseyside	Regular catch up with Provider Collaborative leadership	Maintain visibility around regional strategic developments.

Warrington Town Deal

Project Overview

WHH is leading a major project to develop a system-wide Health & Wellbeing Hub in Warrington Town Centre. The project forms part of the Town Deal programme, which covers 7 different infrastructure projects across Warrington, funded as part of the Government's "levelling up" agenda. The Health & Wellbeing Hub will be designed to target and address health inequalities in Warrington by providing a range of services focussed on prevention and early intervention in a town centre location with close proximity to the areas of the town with the highest levels of deprivation. The Hub will be a space where providers from across mental and physical health, social care and the third sector can come together to deliver integrated services, support and learn from one another for the collective benefit of the local population.

Progress since last report

-NHS Property Services have been appointed to undertake 3 aspects of this project:

1) Negotiate the lease on the preferred option location choice building with the private landlord
2) Provide consultancy services around the design and build phases of the project
3) Potentially hold the head lease on the building and make suitable arrangements to sub lease to WHH (subject to acceptable lease contract).

-Work continues around the naming of the hub, with public and stakeholder opinion being sought.

-The Grant Funding Agreement is due to go before Board for approval in March which will enable funds to be released from WBC to the Trust in financial year 22/23.

-Lease negotiations have commenced with the private landlord.

-Hub service provision has been re visited with the aim of identifying linked, supporting and complementary services to align with the hub ethos.

Financial Implications/ Budget Update

Total project value is £3.1m, which is funded via central government. Ongoing revenue implications and how they will be covered across all system partners are to be confirmed.

Upcoming Key Milestones	Date	Status	Comments
Design team working up to stage 4	Jun-22		Although delayed by appointment of NHSPS as a partner this should still be on schedule
Appoint design partner to complete design stage 4	Mar-22		Can commence immediately following approval of NHSPS as a contracted partner
Implement project mobilisation infrastructure	Mar 22		Should be completed by end of March/ Early April

Stakeholders' engagement

Multiple stakeholders from across health, local authority and third sector.

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Formal agreement to be reached with all partners around ongoing financial and management arrangements of the Hub.	Significant impact on project if agreement is not reached. Alternative options will need to be considered.	20	All partners fully engaged in discussions around possible options and impacts.	12
Failure to spend the funding within required timeframes	Potential for current year and subsequent funding to be withdrawn if not spent in line with projections.	18	Extended funding availability period negotiated into GFA.	6

Project Overview

WHH is a key partner within Runcorn Old Town's submission to the Town Deal Investment Fund, with an overall opportunity to bring up to £25m to the town. The health projects being forwarded at this stage include:
Community Health Hub – to deliver diagnostic and potentially other services from a hub location in Runcorn

The project is being developed in partnership with a range of health and care providers across Runcorn, including Bridgewater and Halton Borough Council. The scheme includes a flexible education element designed in partnership with Riverside College.

Progress since last report

Specification refined following extensive stakeholder engagement.

Initial designs received 14/3/22

Building located (Runcorn Old Town Library) in partnership with Halton Borough Council.

Initial meeting with business case consultants undertaken

Financial Implications/ Budget Update

Total value of project as submitted through Runcorn Town Deal Programme: £3.89mil (across 5 years). Town Deal contribution: £2.85mil. Providers, including education, Council and Health bodies expected to meet remaining project costs of: £1.04m (across 5 years)

Upcoming Key Milestones	Date	Status	Comments
Local stakeholders to sign off business case	May-22		Amion have been appointed to develop the business cases for the programme. The project team is working to provide them with the required information
Business case submission to Town Deal Board	Jun-22		
Construction commencement	Apr-23		

Stakeholders' engagement

Multiple stakeholders from across health, local authority and third sector, including Head of Runcorn Primary Care Network, Third Sector Commissioning Manager and Local Council

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Failure to: secure funding Caused by: Government rejecting business case Resulting in: failure of project	Failure of project, no health and education hub	10	Strong governance, oversight and local engagement, sound project management and lessons learned from similar	5

Runcorn Shopping City

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

The Runcorn Shopping City programme aims to utilise void space in Runcorn Shopping City to deliver health and wellbeing services closer to community in line with the NHS Long Term Plan.

The scheme includes a refurbishment of retail space to re-purpose for access to hospital services, including audiology, ophthalmology and dietetics. This programme is part funded by Liverpool City Region Combined Authority.

Progress since last report

Completion of all legal documents pending handover once remedial works within unit 42 are complete

Completion of remedial works within the unit

Procurement processes underway to obtain FFE items

Site surveys begun on site prior to unit handover

Agreement on lease of space and formal sign off in March.

Financial Implications/ Budget Update

Total Programme Costs: £844.5k, funded via:

Internal Trust Capital Programme: £494.5k
Donated income: £350k (via LCR Town Centre Commission)

Upcoming Key Milestones	Date	Status	Comments
Contractors Onsite	Feb-22		Surveys have been undertaken ahead of invasive work
Unit handover	May-22		
Service Delivery	May-22		Delayed to June due so delays with legal processes

Stakeholders' engagement

Internal engagement ongoing through regular catch ups

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Failure to: Occupy unit on schedule Caused by: Delays to removal of asbestos by landlord Resulting in: Project delay	Delay to project, difficulties securing funding	15	Escalation through Halton Borough Council	10

Project Overview

Development of new WHH hospital estate and infrastructure.

Within Warrington, this is the development of a new hospital for Warrington, either on the current site or elsewhere in the town.

Within Halton this is the redevelopment of the Halton Hospital site, including extending CMTC and releasing land to support Health and Wellbeing Campus vision.

Progress since last report

Work ongoing with PA Consulting, supported by the internal project team to further develop the benefits case and financial and economic modelling for the Strategic Outline Case. Work expected to be completed by end of April 2022, alongside wider SOC refresh

Refresh of SOC content underway to enhance the case for change with emerging examples, such as links to the Green Agenda and case studies.

Communication plans, supported by partners, in place to support promotion of case of need and wider key messages. Key messages were delivered to the Prime Minister during his recent visit to Warrington Hospital.

A refresh of the site feasibility study has commenced to help narrow doing the preferred option to one single site. Key stakeholders are being engaged to input into the emerging criteria and a process has been developed to allow key stakeholders to individually score the shortlisted sites against 'critical success factors'.

Financial Implications/ Budget Update

Financial phasing of costings for overall programme completed by Turner & Townsend in October 2021 and reviewed by Edge in December 21.
Agreed capital funding to progress with financial affordability model and benefits enhancement work has been spent as planned.

Upcoming Key Milestones	Date	Status	Comments
Outcome received from EOI stage	Spring-22		Results will determine next steps in the comms plan and project direction
Refresh of the Warrington and Halton Strategic Outline Cases due to Internal Review	April -22		On track

Stakeholders' engagement

NWAS, WBC, CCG and key Local Partners will be given the option to score our shortlisted options to help us to conclude a 'preferred way forward'.

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
The required investment may not be available if unsuccessful with the EOI process	May lead to scope of implementation being limited to meet an affordability envelope, reducing the benefits able	12	Request for funding via internal capital. Exploring opportunities for external funding and buy in from C&M for investment	12

WHH Green Plan

Project Overview

The NHS has set the target to achieve net zero by 2040. The "For a Greener NHS" campaign was launched in 2020 by NHS England. While this is a nationally mandated programme, the Trust has a strategic commitment to developing and expanding on its role as an anchor organisation. The Green Plan will form a core pillar of this programme.

WHH has worked in partnership with WRM Sustainability to assess the Trust's current position and develop an implementation plan to achieve our emissions targets.

Progress since last report

Green Plan to go before Trust Board on 30th March for approval.

Version two of the ICS green plan has been received and comments from WHH provided. The final version is expected at the beginning of April 2022.

A framework has been developed in collaboration with the Quality Improvement team to capture and record staff initiatives aligned to the plan.

The Zero Carbon Patient pilot has been launched and cardiology patients are being invited to participate as experts by experience. Their journeys through treatment will be mapped to calculate the carbon footprint and identify ways to reduce it.

Financial Implications/ Budget Update

TBC. Significant investment will be required to enhance Trust estates to meet required carbon savings.

Upcoming Key Milestones	Date	Status	Comments
Approval of Green Plan at Trust Board	March-22		
Launch Green Plan across Trust	April- 22		

Stakeholders' engagement

stakeholder engagement.

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Insufficient funding to enable deliver against actions e.g. estate improvements, technological solutions	Do not achieve required reductions in emissions	20	Capital pressures to be assessed and logged via Capital Planning Group	
Capacity and expertise – prog lead required to oversee and progress plan supported by technical expert	Do not achieve required reductions in emissions	15	Explore funding recurrent roles to provide Sustainability and Technical Lead	

Warrington Wider Estates Review

Project Overview

The Trust, in partnership with Halton Borough Council and Warrington Borough Council, submitted a bid to the One Public Estate Programme in November 2020, via the Liverpool City Region Combined Authority, partly to:

- Review the wider estate across the Warrington region, and produce a shared delivery plan, recommendations and opportunities to improve utilisation of buildings, with an end product of a framework to utilise estate asset database to enable informed decisions on future use, configuration and occupancy

AIM: To get more from collective public sector assets, and take a strategic approach to asset management.

Progress since last report

Weekly Meetings with Archus/Turner and Townsend, WHH Project Leads (Rachel and Kelly), as well as Nick Armstrong, Lisa Sculpher and Arthur Pritchard are in place.

Turner and Townsend have conducted stakeholder interviews following the 'request for information' documents being received. All together 27 organisations are participating in the project with varying levels of Estates and Strategic data coming through. A final push for partner information is underway.

A workshop on the Data Asset Map has been planned for the end of March 22 with a separate delivery report being drafted by Turner and Townsend.

Internal conversations have taken place with Specialties to look at future opportunities to deliver WHH services out in the community.

Financial Implications/ Budget Update

Total costs (inc. VAT) = £42,637
Externally funded via One Public Estate 8 funding agreement

Upcoming Key Milestones	Date	Status	Comments
Partner engagement complete	March-22		Stakeholder engagement underway but original timeline slipped due to partner capacity
Asset database created	March-22		First review of the Asset Map received with amendments being made

Stakeholders' engagement

Nick Armstrong – Warrington CCG
Arthur Pritchard – Warrington Borough Council
Chris Baker and David McNichol – NWAS
Laura Mount – PCN Clinical Lead

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Partner capacity to complete information requests to schedule	Delay of delivery	12	Good engagement and buy-in from compelling vision	8
Technical queries around database hosting and enabling external access to refresh the database remain unresolved.	The potential solution may require capital investment and/or capacity from WHH to support a refresh.	12	Technical queries around database hosting being discussed at project meeting and options being developed with IT.	Under Review

Project Overview

The Trust has been engaged with local partners, including Halton Borough Council, since 2016 in contributing to regeneration schemes within Halton Lea. This is reflected within the Trust's New Hospitals Programme, which outlined a bold and exciting future for the site as the Halton Hospital and Wellbeing Campus.

The Trust and its local partners are now keen to identify how best the Halton Blocks could be used to generate social value in line with the regeneration plans of the area, as well as providing a financial benefit to the Trust if developed and / or disposed in some form.

Progress since last report

Engagement has commenced with all occupants of the Blocks.

Discussions with strategic partners, including NHSE/I and Homes England, underway to identify opportunities for potential accommodation

Soft marketing undertaken with care home providers and other complementary service providers around potential uses of the c. 2 acres of land currently occupied by the blocks to understand opportunities around land release and income generation.

Financial Implications/ Budget Update

Total costs (inc. VAT) = £44,733.60
Externally funded via One Public Estate 8 funding agreement

Upcoming Key Milestones	Date	Status	Comments
Schedule of accommodation to be produced outlining service requirements for occupation outside of Blocks	Apr-22		
External opportunities for accommodation to be identified	Apr-22		
Sign off Appraisal Paper, including costed options and detailed delivery plan	May-22		

Stakeholders' engagement

Engagement has taken place with the below services: Accommodation; HR; Payroll and Pensions; IT; Skills Development Network; Health and Safety; Medical Education; Respiratory

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Internal capacity to complete information requests to schedule	Delay of delivery	12	Good engagement and buy-in from compelling vision and Executive awareness	4

Breast Service Reconfiguration – Phase 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

Warrington, Halton, St Helens and Knowsley Breast Screening Service (WHSKBSS) provides routine breast screening, diagnostic and onward referral services to around 92,000 people from across the 4 boroughs. In the summer of 2021 the Breast Assessment and Symptomatic clinics relocated from Warrington Hospital to Halton Hospital's Captain Sir Tom Moore building, where a new £2.1m Breast Centre has been created in part of the Trust's flagship estate. Phase 2 of the project plans to consolidate and expand Breast Screening Services at Bath St Warrington and relocate Breast Screening services from Kendrick Wing Warrington Hospital. This would improve WHSKBSS by increasing staffing efficiencies, using more modern facilities and increasing the physical space available to carry out the screening.

Progress since last report

- The proposed changes to the service were shared at Halton Health Scrutiny and St Helens and Knowsley Health Scrutiny Committee, with the proposals being well received.
- Cheshire West and Chester and Cheshire East Councils thanked the Trust for sharing the plans, but due to the low number of residents that it would impact decided it was unnecessary to be shared at their Scrutiny Committee meetings.
- A new and improved design for the breast screening unit has been proposed by WHH clinical team. This will have additional cost implications for CHP who are seeking the additional funding
- The ongoing revenue funding of the unit will be supported by Warrington and Halton CCG, the arrangements of which have been agreed between the two parties.
- The 6% on off Capital charge will be shared between the Trust and the CCG
- The Project timeframe will be pushed back due to the changes in the design and the additional works necessary to complete this.

Next steps:

- Agree a design based on the new footprint

Financial Implications/ Budget Update

The renovation works for this project are being financed and completed by Renova. As such, the Trust do not share any of the financial risk surrounding the renovation element of the project. Funds secured for the first phase of the project included £30,000 for relocation of existing mammography equipment from Kendrick Wing to Bath Street.

Upcoming Key Milestones	Date	Status	Comments
Sign off PID	Feb-22		Awaiting agreement from clinical team on revised floorplans and designs.
Project completed and allocated capital for this financial year spent.	Sep-22		Likely to be October now due to increased refurbishment works
Public consultation completed and reported to CCGs	Jun-23		Public consultation period commenced in May following local elections.

Stakeholders' engagement

Ian Butterworth- Project manager, Fulcrum
Libby Doherty- Regional Property Contracts Manager CHP
Nick Armstrong- NHS Warrington and Halton CCG Estates Lead

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Disruption to current service caused by build works	Reduced number of appointments available	9	Produce a contingency plan and liaise closely with build team to minimise risk	6

Cheshire & Merseyside Pathology Network

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

The transformation of the provision of pathology services in Cheshire & Merseyside by restructuring pathology services to generate levels of efficiency savings to the local health economy whilst maintaining and improving high quality standards.

Progress since last report

Discussions have commenced at Network level to bring in external resource to accelerate production of the FBC, which within the scope will include our collaboration with STHK. The Trust has confirmed support for the approach and awaiting confirmation of processes and timelines.

Revised governance for development of the TOMs by speciality with STHK had been outline and will be implemented imminently.

Staffing risks within histopathology have been escalated to the network and a solution achieved through STHK outlined to mitigate the impact. Work is underway to understand the impact of the solution of safety and performance and will progress through internal governance for scrutiny and approval.

A request has been made for the key programme milestones to be reprofiled and agreed. Discussions are underway with Tracey Cole to progress.

Financial Implications/ Budget Update

Financial implications to be worked up through development of Collaboration Agreement to Business Case.

Upcoming Key Milestones	Date	Status	Comments
Sign off of Collaboration Agreement at Cheshire and Merseyside HCP.	Nov-20		Collaboration agreement reviewed but not formally approved.
Circulation of Strategic Network Document	Dec-21		Document received and next steps are emerging.
Risk and Gain Share Principles agreed	Jun-21		Paused pending network direction on next steps

Stakeholders' engagement

Tracey Cole – Diagnostics Programme Director, C&M HCP

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Cellular Pathology – Cohort of Pathologists nearing retirement.	Shortage of staff in service and difficulties in recruiting until service configuration confirmed.	16	Mitigations to be discussed at next steering group.	Pending

Project Overview

As part of the national strategic direction to create Community Diagnostics Centres (CDC) across England, there is a real opportunity to develop an out-of-hospital diagnostic model to serve the populations of Warrington and Halton. This will be a regional resource rather than serving an individual organisation.

Funding for the development and implementation of a CDC was announced by the Government in Autumn 2021 and is likely to be made available in mid-2022.

Progress since last report

The initial high level proposal to develop a CDC on the Halton site was submitted to the C&M regional team in early February 2022. The proposal sets out 2 options for either a large scale new build or a substantial refurbishment of part of the Nightingale building on the Halton site to potentially accommodate the Trust's outpatient (non-acute) diagnostic activity as well as creating additional capacity to take activity from across the wider C&M region.

The regional team have incorporated the Halton proposal into a regional plan covering the whole of Cheshire & Merseyside, which has been submitted to the national CDC programme team.

Early indications suggest that the Halton proposal has been well received and we now await formal guidance around next steps. This is likely to require the completion of a short form business case by May 2022

Financial Implications/ Budget Update

£52m capital available across 3 years from 22/23 for programme across Cheshire & Merseyside. Revenue funding allocation to support mobilisation still to be confirmed.

Upcoming Key Milestones	Date	Status	Comments
Recruit Project Lead to take forward CDC case	Apr-22		Potentially need to proceed "at risk" financially due to profile of when funding for the project may become available.
Formal feedback from regional CDC team to proceed to next stage of business case development	Apr-22		
Production of short form business case for a Halton CDC.	May-22		

Stakeholders' engagement

Ian Triplow – Programme Director, Cheshire & Merseyside H&CP

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Availability of workforce across multiple specialties to staff a potential large scale CDC in the short to medium term	Will significantly impact on ability to operate enhanced capacity.	20	National discussions re: workforce development strategy.	12

252 of 306

Health & Care System Reconfiguration

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

Subject to the passage of the Health and Care Bill into law, Integrated Care Systems (ICS) were due to be established, on 1st April 2022 comprising an Integrated Care Board (ICB) to discharge NHS functions and duties and an Integrated Care Partnership (ICP) comprised of health and care partners across the ICS, both will work collaboratively to: improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access, enhance productivity and value for money and help the NHS support broader social and economic development During this transition, WHH is working with system leaders to ensure organisational prioritises and interests are understood at region and relationships developed to support attainment of organisational objectives.

Progress since last report

Governance structures, alongside place delegation and routes for joint commissioning are emerging. During this process, work continues to understand the implications for the Trust across system and place and to influence as appropriate. Key actions progressed include:-

- Work continues to ensure Trust representation during transition and to ensure influence is in place across any associated workstreams.
- The ICS stakeholder matrix is being refreshed to ensure changes are captured and relationships are in place with key individuals.
- An update on development of the Cheshire and Merseyside ICS, is being developed for February Board.

The date when integrated care systems go live will be delayed until July 22.

Financial Implications/ Budget Update

The ICS will be the regional commissioning Body through which finances will flow. Relationships may influence the status of WHH at region and any financial benefits derived by will be captured and quantified.

Upcoming Key Milestones	Date	Status	Comments
Recruitment and selection completed for ICB	Dec-21		CEO appointed, other ICB roles in progress.
NHS bodies and ICS Partnerships to be ready to operate in shadow form.	Dec-21		Timeline for ICS transition has been extended nationally until July 22
NHS bodies and ICS Partnerships to be ready to operate in shadow form.	Dec-21		Timeline for ICS transition has been extended nationally until July 22

Stakeholders' engagement

C&M ICS
Warrington Together Place Based Board
One Halton Place Based Board

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Lack of ICS/Place-based governance	May hinder progress in some areas of work, particularly some collaborative strategic projects.	12	Establishing interim governance arrangements, incorporating multi partner sign off processes, to enable	8

Health & Social Care Academy

Project Overview

The Trust is working closely with another local anchor institution, Warrington and Vale Royal College, to develop a Health & Social Care Academy on the college's main campus in Warrington.

The project is led by the college team and forms part of the Town Deal programme but WHH is a key partner and will play a fundamental role in helping shape the curriculum and identify the areas of greatest need in terms of the health and social care workforce in future.

Progress since last report

Joint oversight committee meetings with the Health and Wellbeing hub are ongoing to ensure synergy across both projects. The college Principal attends these meeting.

Debbie Howard, represents WHH at the HSCA steering group meetings

HSCA focus steering group meetings are ongoing with direct input into shaping the curriculum to meet the Trust's needs by the Trust's Head of Education and Wellbeing.

Meeting with WHH HR and education teams to discuss workforce planning and the opportunity for the Trust to influence the College's new curriculum to meet any identified upcoming skills gaps.

Site visit was conducted to share learning of the Town Deal projects and the Health and Social Care Academy and to develop an understanding of the continued development of the curriculum.

Financial Implications/ Budget Update

N/A

Upcoming Key Milestones	Date	Status	Comments
Curriculum decided upon and to enter the College's approval process	Mar-22		
Site visit CL and SB to engage with the Health and Social Care Academy manager Amy Yorke and share learning of Town Deal projects	Mar 22		

Stakeholders' engagement

Nichola Newton – Principal, Warrington & Vale Royal College
Tracy Jones- Project Manager
Amy Yorke- HSCA Manager
Laura Williams- Director of Student Support and Inclusion

Risk description	Impact	Risk score	Mitigations	Mitigated risk score

Partnership Working with Local Hospices

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

As part of the development of Place-Based integrated care across Warrington the Trust is developing partnerships with other local anchor institutions to support and strengthen core aspects of each organisation's operations and add social value.

Two of these local anchor institutions are St Rocco's Hospice and Halton Haven Hospice, with whom we are looking at ways to improve communication, pathways, recruitment and staff training/education for end of life services across Warrington and Halton.

Progress since last report

Meeting between WHH CIO and St Rocco's MD to discuss and identify areas for improvement with regards data/info sharing to support improved end of life care. Agreed actions for CIO to explore data sharing agreements to improve access to WHH information systems for St Rocco's clinical teams.

Linked St Rocco's COO with WHH senior HR team to explore potential for WHH to provide occupational health support to the Hospice.

Site visit to Halton Haven and meeting with Hospice CEO set up to open discussions around opportunities for improved partnership working between the 2 organisations.

Financial Implications/ Budget Update

Partnership is not necessarily financially motivated but any financial benefits derived by either organisation will be captured and quantified.

Upcoming Key Milestones	Date	Status	Comments
Data sharing agreements in place and St Rocco's staff set up with appropriate access to WHH systems	May-22		
Site visit and initial meeting with CEO @ Halton Haven	Apr-22		

Stakeholders' engagement

Sonya Curry – CEO, St Rocco's
Sara Black – COO, St Rocco's
Esraa Sulaivany – Med Dir, St Rocco's

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Capacity within palliative care team team to lead collaboration and improvements	Delay to delivery of improvements in joined up care	16	Strategy team to support and facilitate as far as possible	9

Academic Collaboration with University of Chester

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

As part of the development of Place-Based integrated care across Warrington the Trust is developing partnerships with other local anchor institutions to support and strengthen core aspects of each organisation's operations and add social value.

One of those local anchor institutions is the University of Chester, with whom we are looking at ways to improve education and training/development for both partners as well as access and entry to employment into health sector roles for the local population.

Progress since last report

A list of opportunities for partnership working have been identified and an initial programme of work subsequently compiled. The specific outcome required from each individual project has been agreed and a named individual from both WHH and University of Chester have been identified to take each individual project forward.

Meetings have taken place with identified stakeholders from WHH and University of Chester. Outputs and next steps have been agreed.

Further discussions is required between leads to confirm what resource is required to deliver the opportunities, and how we can work collaboratively to access external funding. A paper will be presented to the Executive Group.

Financial Implications/ Budget Update

TBC as programme develops

Upcoming Key Milestones	Date	Status	Comments
Update paper to Executive Group	April-22		
Meeting with leads from WHH and UoC to confirm the ask and resource required.	April 22		

Stakeholders' engagement

John Alcolado – Executive Dean, University of Chester
Jill Pye – Research, Evidence & Knowledge Manager, University of Chester

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
TBC when programme is developed				

Anchor Programme Development

Project Overview

As an anchor institution, WHH has an opportunity to positively influence the health and wellbeing of the patients we service and the local communities we are part of. The anchor programme seeks to ensure we use our position and influence to work with others in responsible ways, to have an even greater impact on the wider factors that create happy, healthy and thriving communities.

Collectively the Trusts strategic projects support delivery of the ambitions of the anchor programme

Progress since last report

A review of progress against anchor objectives has been completed and work is underway to develop to identify key milestones from individual workstreams delivery plans.

Conversations are ongoing with Public Health Teams across Warrington and Halton to explore a collaborative approach to population health management and to develop a proposal for ICS funding to take a programme of work forward.

A communications plan for anchor is in development and will link with the launch of the Green Plan and mechanisms for staff to get involved have been agreed.

Discussions have commenced with Children and Maternity to reenergise the first 1000 days work and create greater links with the system. A governance process is in discussion to agree a revised workplan and recommit to delivery.

New anchor priorities have been identified and presented to execs for approval.

Financial Implications/ Budget Update

Finances are manged at project level.

Upcoming Key Milestones	Date	Status	Comments
Agree a way to harness the potential of staff to contribute to anchor objectives	Apr-22		To be launched in April
Agree a suite of metrics to measure the impact of projects	April-22		Will link into emerging Anchor charter and metrics being developed by ICS. There may be some slippage of timescale on this.

Stakeholders' engagement

Thara Raj – Director of Public Health, Warrington Borough Council
Ifeoma Onyia – Interim Director of Public Health, Halton Borough Council
Ailsa Gaskill-Jones – CBU Matron, Women and Childrens

Risk description	Impact	Risk score	Mitigations	Mitigated risk score

Prevention Pledge

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

In 2021 the Trust was accepted as a pilot site in the roll out of the Prevention Pledge, a set of commitments developed to ensure NHS Trusts:

- meet sub-regional prevention priorities (Marmot):-
- develop role as anchor institutions & system leaders
- deliver Making Every Contact Count at scale
- meet ambitions/commitments set out in the NHS Long-term Plan
- drive a cultural shift towards prevention and empowering staff, patients & public

Progress since last report

Trust participated in a Community of Practice meeting with all other Prevention Pledge sites.

Communications plan developed to refresh messaging around smoking cessation to staff and visitors.

Input into a review conducted by UCL in association with CHAMPS to ascertain the impacts of organisations adopting the pledge across the region.

Much of the work described within the prevention pledge commitment is picked up through the other projects contained within this report.

Financial Implications/ Budget Update

N/A

Upcoming Key Milestones	Date	Status	Comments
Report detailing Pledge effectiveness at scale	Apr 2022		Conducted by UCL in association with CHAMPS
Work to commence to redesign Smoking Cessation pathways within Trust	Apr 2022		Standardised pathway being promoted via ICP

Stakeholders' engagement

Ongoing through linked projects.

Risk description	Impact	Risk score	Mitigations	Mitigated risk score

Development of Overall Trust Strategy

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

Development and subsequent delivery of overall WHH Trust strategy.

Support to the development, delivery and governance of enabling strategies, clinical strategies, and strategic priorities.

Progress since last report

Trust strategy review booklet content agreed with Exec team. Awaiting input from designer to create booklet.

Trust Strategy Map detailing how strategic vision and priorities map down to individual projects has been approved and is available on the Trust extranet.

Plans developed to launch a series of sessions with CBU teams to understand key strategic objectives for clinical specialty teams and specialty responses to key organisational strategic priorities.

Financial Implications/ Budget Update

No financial implications

Upcoming Key Milestones	Date	Status	Comments
Trust mid-point strategy review booklet to be published.	Mar-22		Final designs and narrative to be completed in May.
Launch programme of work and CBU discussions to refresh clinical strategy	Apr-22		

Stakeholders' engagement

Broad internal, external and public engagement was undertaken to inform the development of the Trust's strategy. Clinical strategy priorities are refreshed annually by CBU and clinical teams.

Risk description	Impact	Risk score	Mitigations	Mitigated risk score

Overview

This section describes the strategic opportunities that are currently in the pipeline and are in the process of being explored/assessed for the potential to progress by the Strategy Team.

Proposal Name	Brief Description	Strategy Lead	Stage of Development	Comments
Population Health Management	Opportunity to develop proposal for ICS/ICP funding to secure investment in population health at place level. This would be in the form of a role join supervised post with Warrington Borough Council.		Scoping	Paper in development and to be considered in April 22.
Warrington Wolves Community Hub	Potential opportunity to collaborate with Rugby club on new training facility with associated health and wellbeing facilities.	LG/CM	Scoping	Shared our views and opportunities with Will Woan, who has been commissioned by Warrington Wolves to develop initial proposal with a view to securing funding.
Warrington Peace Centre	Discussions taking place between the Trust, Warrington Borough Council, Warrington and Vale Royal College, and the Peace Foundation around potential future use of the Peace Centre.	LG/CM	Opportunity pushed back to 22/23	Agreement that Warrington Borough Council to assess immediate opportunity to utilise location for in-borough provision of post 16 and post 18 SEN. Following that assessment, should there be any potential capacity, the Trust will explore any additional opportunity.
Improved utilisation of UTC in Halton, in partnership with GPs and community services	Initial meeting held with GPs and Bridgewater, agreed priority.	CM	Initial scoping	Discussions ongoing with various teams/organisations around who is best placed to lead this review and the overall project.
Respiratory One Stop Shop	Explore potential to establish a one stop shop to confirm diagnosis of COPD/review those with suspected COPD/review medications and ensure they're optimised and suitable for current condition. This was piloted previously in Widnes	R'OD	Initial scoping	Clinicians engaged and interest confirmed to develop opportunity further in the Town Deal Hubs (Warrington and Halton)

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/63**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	25th May 2022	
AUTHOR(S):	John Culshaw, Trust Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Since the last meeting: • No new risks have been added; • The ratings of two risks have been updated; • The description of one risk on the BAF has been amended; • One risk has been de-escalated from the BAF to a Departmental Risk Register. Notable updates to existing risks are also included in the paper.	
PURPOSE: *(please select as appropriate)*	Information / Approval ✓ / To note / Decision	
RECOMMENDATION:	The Trust Board is asked to discuss and approve the changes and updates to the Board Assurance Framework.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC 22/05/114
	Date of meeting	03.05.2022
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework and Strategic Risk Register report	AGENDA REF:	BM/22/05/63

1. BACKGROUND/CONTEXT

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

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

2. KEY ELEMENTS

2.1 New Risks

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

2.2 Amendment to Risk Ratings

Since the last meeting, the ratings of two risks have been amended.

I. Following support at the Risk Review Group on 12th April 2022, and support from the Finance & Sustainability Committee on 19th April 2022, it was agreed at the Quality Assurance Committee on 3rd May 2022 to reduce the rating of risk **#1290** (detailed below) from **12** to **4.**

ID	Risk description	Rating (previous)	Rating (current)	Risk Register	Executive Lead	Monitoring Committee
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 and clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.	12	4	BAF	Andrea McGee	Finance & Sustainability Committee

The proposal to reduce the risk to the target risk rating is a result of the current national position and the lack of consequences experienced following the EU Exit deal in December 2020.

II. Following a review and refresh of risk **#125** (detailed below), it was agreed at the Quality Assurance Committee on 3rd May 2022 to the reduce the rating of the risk from **16** to **15.** The previous rating was 4x4 (Likelihood x consequence) with the updated rating 3x5 (Likelihood x consequence). The 'Likelihood' rating is reduced due to the controls and assurances in place and minimal impact experienced on critical services.

ID	Risk description	Rating (previous)	Rating (current)	Risk Register	Executive Lead
125	Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	16	15	BAF	Dan Moore

2.3 Amendments to descriptions

Since the last meeting and following discussion and support at the Risk Review Group on 12th April 2022, and support from the Finance & Sustainability Committee on 19th April 2022, it was agreed at the Quality Assurance Committee on 3rd May 2022 to amend the description of risk **#1372** as described below to better reflect current and changing circumstances in respect of the delivery of the Electronic Patient Record solution

Risk #1372

Previous: *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

New: *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

- *A failure to develop an affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits*

- *A failure to garner ICS and NHSE support to progress the EPR business case*

- *A failure to deliver Managed Convergence in line with emergent national policy and the ICS Convergence strategy (in development)*

RESULTING IN (sequentially) – a continuation of the Trust's challenges with the incumbent EPR, Lorenzo (as identified in the Strategic Outline Case), potential for a costly extension to the existing Lorenzo contract or the highly retrograde step of returning to paper systems as Lorenzo will be at end of life at or before the end of the tactical contract extension

2.4 De-escalation of Risks

Since the last meeting and following discussion and support at the Risk Review Group on 12th April 2022, and support from the Finance & Sustainability Committee on 19th April 2022, it was agreed at the Quality Assurance Committee on 3rd May 2022 to de-escalate risk **#1290** to the departmental risk register for continued monitoring as there are some slight uncertainties

about future data flows and procurement will continue to monitor price changes. This is in additional to the reduction in risk rating as described in section 2.2

2.5 Existing Risks - Updates

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

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
224	Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience.	• Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. • Senior Dr at Triage Function. • Extended Minor Injuries and Minor Illness functions • ED Plaza due for completion at the end of Quarter 1. Plan to be operational in July 2022 • Plan being worked up to utilise what will be the be old CAU as an additional area to support urgent care and decompression of A&E • Plans being progresses to procure and install a new CT scanner co-located in the main body of the ED department. Planned for the end of Quarter 3 / Winter. This will support increases urgent care pathway efficiency in the ED • Phlebotomy business case approved (5th May) to support earlier decision making and flow in AMU to support flow out of the ED for acute medical patients.	25	No impact on risk rating
1215	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	• Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists. • Working in collaboration with system partners to increase adult social care capacity for pathway 1 & 2 categories of patients. This will in turn create additional capacity for managing the pandemic, restoration & recovery in Q3 2022/23 • New Clinical Treatment Suite opened in the Nightingale Building in May 2022 (capital investment of £145K) to support the reduction in chronic pain waiting lists an increase theatre	25	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		capacity to support restoration and recovery.		
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	• Increase in Trust WLI rate extended until 31.05.2022 to support restoration and recovery. Business Case to support the increase in to 2023/24 currently in development and planned to be presented to the Trust Board in May 2022 • New Clinical Treatment Suite opened in the Nightingale Building in May 2022 (capital investment of £145K) to support the reduction in chronic pain waiting lists an increase theatre capacity to support restoration and recovery.	20	No impact on risk rating
134	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that future loans will be required which would raise the question if the Trust is a going concern.	<u>Assurances</u> • Revised approach to GIRFT/CIP. Leadership form Executive Medical Director and joint reporting to F&SC introduced. • Financial strategy developed to support improvement in financial sustainability to be submitted to the Trust Board for approval in May 2022 <u>Gaps</u> • Risk that capital needs exceed capital funding resources available. ICS allocate capital resources and currently going through bidding process to secure funding required for the 2022/23 Capital Programme • Increased threat of fraud as a consequence of global instability (e.g. conflict in Ukraine) • Uncertainty of the Trust allocation from the Cheshire & Merseyside Integrated Care Board and future reconfiguration of funding • Cheshire & Merseyside system is required to break-even and currently has a deficit • Current financial plan shows deficit of £16.7m	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
1114	FAILURE TO provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, CAUSED BY increasing and competing demands upon finite staffing resources who lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber attack, RESULTING IN poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	• WHHT return for assurance re cyber security to NHS England (March 22) • Cisco Phase 2 business case being approved (for financial year 22/23). Providing the procurement mini tender is done on time and the orders are place in advance and there are no other world-wide changes happen impacting on supplies, kit will be delivered and installed within 22/23. • The extension of the mainstream support for SQL Server 2012 will end on 12 July 2022	20	No impact on risk rating
1125	Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance	• Capital Works for new procedure room to be completed in April 2022. This will release an additional 10 Theatre session per week to support recovery. • Increase in Trust WLI rate agreed until 31.05.2022 to support restoration and recovery. Business Case to support the increase in to 2023/24 currently in development • Halton to become a Community Diagnostic Centre (CDC) as part of the second tranche of national funding. This would be situated on the Halton Campus. • The Trust has been successful in being selected for a Targeted Investment Fund (TIF) bid. This will be ratified in May 2022 • Capital Works for new procedure room completed in April 2022 and no live. This will release an additional 10 Theatre session per week to support recovery.	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
1372	FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case	• The procurement process has progressed and the outcome to identify a preferred supplier is currently undergoing validation • ORMIS business case to support theatres module to Execs WC 4/4/22 – in phase with Lorenzo contract extension • Limited assurance regarding ICS and NHSE sign off OBC and support for progression to FBC • ICS approach to delivering managed convergence remains unclear • Lorenzo is at end of life and moving forwards is unlikely to see significant future development or enhancements	20	No impact on risk rating
1579	Failure of the Trusts ability to transfer patients with time critical urgent care needs to specialist units able to deliver time critical specialist interventions (Primary PCI, Hyperacute Stroke Intervention, Emergency Vascular Surgery, Major Trauma services etc) CAUSED BY an inability of the North West Ambulance Service, to provide the expected response times for critical transfers due to overwhelming demand on ambulance services, RESULTING IN a delay in transfer and thus potential severe patient harm due to the inability to access time critical specialist interventions without undue delay	• Implementation of a new handover escalation process in times of high demand went live in April 2022 with support from AQuA	16	No impact on risk rating
125	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.	**Controls** • Annual capital funding is allocated to business critical, mandated and statutory estates projects • Planned Maintenance Program • Reactive maintenance process **Assurances** • Non funded capital schemes are risk rated and monitored through the above group • Cleanliness monitoring identifies estates issues that are addressed		No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		through the estates building officer • Ventilation Group – gives assurance on the appropriate levels of trust wide ventilation approves upgrades and new installations **Gaps** • Limited capital funding to address backlog • Compliance – evidencing compliance in line with national guidelines and mandated returns (Premises Assurance model) PAM) • Estates staffing - recruitment and retention of trade staff due to banding of technical trades being lower than local and national peers		

* A full review of the assurance, gaps and actionsof risk **#1134** has taken place since the last meeting and the complete updated risk is detailed in Appendix 1

3 RECOMMENDATIONS

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

Board Assurance Framework

Board Assurance Framework

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

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	Daniel Moore	Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience.	1	25 (5x5)	8 (2x4)	TBC	Clinical Recovery Oversight Committee
1215	Daniel Moore	Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm	1	25 (5x5)	6 (3x2)	TBC	Quality Assurance Committee
1273	Daniel Moore	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.	1	25 (5x5)	5 (5x1)	TBC	Quality Assurance Committee
115	Kimberley Salmon-Jamieson	Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.	1	20 (5x4)	12 (4x3)	TBC	Quality Assurance Committee
1275	Kimberley Salmon-Jamieson	Failure to prevent Nosocomial Infection caused by high transmitability of variant strains, waning effect of vaccines, asymptomatic carriage (staff or patients), false negative test results, high local community prevalence.	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
1289	Daniel Moore	Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
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	Paul Fitzsimmons	FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR) RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	1	20 (5x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1125	Daniel Moore	Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance	1	20 (5x4)	8 (2x4)	TBC	Clinical Recovery Oversight Committee
1079	Kimberley Salmon-Jamieson	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.	1	20(4x5)	2 (1x2)	TBC	Quality Assurance Committee
1372	Paul Fitzsimmons	FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY - A failure to develop an affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits	3	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee

Board Assurance Framework

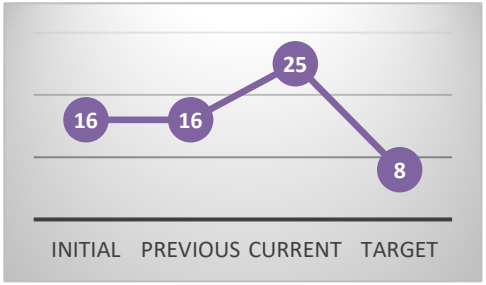
		- A failure to garner ICS and NHSE support to progress the EPR business case - A failure to deliver Managed Convergence in line with emergent national policy and the ICS Convergence strategy (in development) RESULTING IN (sequentially) – a continuation of the Trust's challenges with the incumbent EPR, Lorenzo (as identified in the Strategic Outline Case), potential for a costly extension to the existing Lorenzo contract or the highly retrograde step of returning to paper systems as Lorenzo will be at end of life at or before the end of the tactical contract extension					
1579	Daniel Moore	Failure of the Trusts ability to transfer patients with time critical urgent care needs to specialist units able to deliver time critical specialist interventions (Primary PCI, Hyperacute Stroke Intervention, Emergency Vascular Surgery, Major Trauma services etc) CAUSED BY an inability of the North West Ambulance Service, to provide the expected response times for critical transfers due to overwhelming demand on ambulance services, RESULTING IN a delay in transfer and thus potential severe patient harm due to the inability to access time critical specialist interventions without undue delay	1	16 (4x4)	8 (2x4)	TBC	Quality Assurance Committee
1233	Paul Fitzsimmons	FAILURE TO review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed CAUSED BY Combined Assessment Unit (CAU) frequently being bedded with inpatients due to overcrowding in the ED and an excess demand for inpatient beds RESULTING IN a lack of surgical assessment bed capacity, poor patient experience, delays in treating surgical patients and increased admissions to the surgical bed base.	1	16 (4x4)	6 (2x3)	TBC	Quality Assurance Committee
1108	Kimberley Salmon-Jamieson	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are assessed as only able to work on a non-respiratory pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	1	16 (4x4)	4 (4x1)	TBC	Quality Assurance Committee
145	Simon Constable	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient	3	15 (3x5)	8 (4x2)	TBC	Executive Management Team

Board Assurance Framework

		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.					
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	15 (3x5)	4 (4x1)	TBC	Executive Management Team

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

Board Assurance Framework

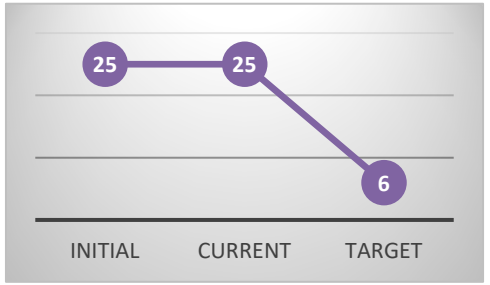
Risk ID:	224	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience.			**Initial:**	16(4x4)
				Current:	25(5x5)
				Target:	8 (2 x 4)
Assurance Details:	•Regular Trust Wide Capacity meetings led by the Senior Site Manager for the day •Systemwide relationships including social care, community, mental health and CCGs •Discharge Lounge/Patient Flow Team/Silver Command •ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing •Controller •Private Ambulance Transport to complement patient providers out of hours •FAU/Hub operational from June 2018 - Now operating 5 days per week. •Discharge Lounge opened 26th November 2018 •Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance. •System actions agreed supporting the Winter Plan •Further development of Rapid Response to avoid admission •Increase IMC provided by the system such as the opening of the Lilycross site •Increase IMC at home •Regular monitored at the Mid Mersey A&E Board •Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. •Trust is working with ECIST on a number of Long Length of Stay & Flow improvement projects •ECIST is supporting effective deployment of the national discharge policy •Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. •The Trust participates at the system & regional UEC improvement meeting on each Wednesday •Redeveloped ED 'at a glance' dashboard •Trust implemented NHS 111 first successfully in August 2020 allowing for directly bookable ED appointments •Board approval of capital plan to build new £5m purpose built acute Medical Ambulatory Care area aka ED Plaza •Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings •Integrated discharge Team now in place •Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients •ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised. •Respiratory Ambulatory Care Facility agreed by CCG •Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved •Collaborative working with Orthopaedics in management ok MSK Minor injuries via Minor's Stream •Reinstated CAU 24/7 •Upgrade to Minor's resulting in Oxygen points in all cubicles •Non-Elective flow activity now above 2019/20 activity levels for type 1 & 3 •Operation Re-set undertaken at the end of May 2021 to support flow and discharge •ED Response Group established in August 2021, clinically led by Dr Vondy to review internal ED processes. •Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly. •Monthly Focus on Flow weeks scheduled every month until July 2022 • Additional Senior Manager on call support a weekends					

Board Assurance Framework

	• Successful bid for c£618k to support urgent care pressure in H2 • ED Plaza due for completion at the end of Quarter 1. Plan to be operational in July 2022 • Command & Control initiative in place since 8th December 2022 and ongoing to support pathway 0 and pathway 1 discharges. This is creating necessary capacity to support wave 5. This is in line with national guidance. • w/c 3rd January 2022 Ward B4 at Halton converted to provide additional G&A capacity (additional 27 beds) and flow in ED • To support capacity for Wave 5, elective activity moved to CSTM Halton facility to protect elective programme • Senior Dr at Triage Function. • Extended Minor Injuries and Minor Illness functions • Plan being worked up to utilise what will be the be old CAU as an additional area to support urgent care and decompression of A&E • Plans being progresses to procure and install a new CT scanner co-located in the main body of the ED department. Planned for the end of Quarter 3 / Winter. This will support increases urgent care pathway efficiency in the ED • Phlebotomy business case approved (5th May) to support earlier decision making and flow in AMU to support flow out of the ED for acute medical patients.	
Assurance Gaps:	•Staffing pressure created as a direct result of COVID-19 Global pandemic. •Confirmed exponential growth in types 1 & 3 as a result of population nedd and lack of access to Primary Care	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12 hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Silver Command and SMOC (out of hours) and Executive on Call.	Field-Delaney, Sheila	30/06/2022	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG	Field-Delaney, Sheila	30/06/2022	

Board Assurance Framework

Risk ID:	1215	**Executive Lead:**	Dan Moore	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to deliver the capacity required caused by the on-going COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm			**Initial:** 25 (5x5) **Current:** 25 (5x5) **Target:** 6 (3x2)
Assurance Details:	• Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery • Operational planning to be monitored by Cheshire & Merseyside 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. • Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments Radiology • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Department has been supported by the Trust through £380K recurrent funding to recruit additional staff. Advert out 11th June 2020. Recruiting 4 Radiographers, 2 Sonographers, 2 Healthcare Assistants. • Additional staff will support additional capacity through extended working days across all scanners – currently unable to achieve this due to Covid-19 demands. • 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. Unplanned care • The emergency department has been reconfigured to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics in line with Royal College of Emergency Medicine (RCEM) guidance. • Minor injuries is provided in an area in close proximity but separate to the main emergency department. This has provided an opportunity to use the old minors department as Majors 2 to support management of surge demand and avoidance of corridor care. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • In patient capacity is reviewed with the patient flow and CBU teams daily to ensure that there is adequate capacity for all patient groups to be admitted. • ITU business continuity plans have been agreed to escalate critical care as and when required. • Clinic templates have been revised to ensure social distancing measures are in place and patients are not brought to a face to face appointment unless clinically indicated. Virtual appointments are in place (telephone and video) for use where this is clinically appropriate. • Suspected cancer, cancer and clinically urgent patients are allocated out patients and diagnostic appointments as a priority. • 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.			

Board Assurance Framework

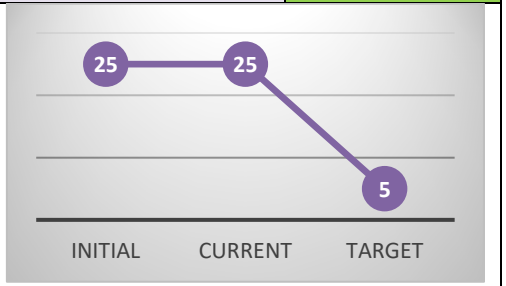
	• NHS 111 First pilot went live on 8th September 2020 to reduce attendances to the emergency department and to support the planning of activity in a more streamlined way to reduce overcrowding and risk of nosocomial infection. • Business Case for ED Plaza Scheme approved in 2021/22 Capital Plan • Reconfiguration of Paediatric ED completed and operational • Phase 2 ED Plaza commenced in October 2021. And due for completion in May 2022 • Deployment of Bioquell Pods in ICU live and operational Planned Care • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery. • All elective patients have been clinically reviewed and categorised in line with national guidance. • Suspected cancer, cancer and clinically urgent patients are treated as a priority. • Theatre capacity has been reviewed and additional capacity is now available with the de-escalation of the theatre PODs • The Halton site is being developed as a covid secure site and will be run as an Elective Centre. • Elective Surgery Standard Operating Procedure (SOP) in place • Capacity identified and being utilised at spire Healthcare • Clinical Services Oversight Group (CSOG) established • Clinical Recovery Oversight Committee (CROC) established • Clean/green pathways have been developed for those priority 2 patients (cancer & urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward 5 on the Warrington site. This pathway is set to commence w/c 8th February and replaces the B18 pathway. • A separate pathway has been developed for Emergency surgery and future plans and bed base has been agreed as part of the ward reconfiguration process. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Workforce plans are continually reviewed to ensure that all wards and teams are staffed safely. • Waiting lists are reviewed through the performance review group weekly • Weekly theatre scheduling to ensure listing of patients in line with national guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021 • Continued use of the independent sector (Spire Cheshire) under new contract in 2021/22 with support from the CCG. • Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists. • Working in collaboration with system partners to increase adult social care capacity for pathway 1 & 2 categories of patients. This will in turn create additional capacity for managing the pandemic, restoration & recovery in Q3 2022/23 • New Clinical Treatment Suite opened in the Nightingale Building in May 2022 (capital investment of £145K) to support the reduction in chronic pain waiting lists an increase theatre capacity to support restoration and recovery.	
Assurance Gaps:	Radiology 1. Harm may be caused due to the incompleteness of clinical information on a referral. This may also be compounded by the referrer incorrectly entering the wrong priority code on the referral. • It is thought that the letter to the referrer will highlight the exam has been delayed and that the provision of a direct link to the Radiology Consultant team by phone/email will allow these cases to be expedited where appropriate. 2. Harm may be caused by the delay of a routine examination where there is an unlikley serious pathological finding present. • This risk is present in all routine exmas as the waiting time for routine diagnostic imaging is up to 6 weeks as per national targets. This risk is hightened due to Covid-19 and the reduced capacity at present. It is thought the letter to the patient advising to contact their Doctor with any concern will reduce this risk. Unplanned care 1. Estates work is required to complete the segregation of paediatric patients in the emergency department.	

Board Assurance Framework

	• 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
Build ED Plaza	Completion of ED Plaza building works	Complete Building work	Sharon Kilkenny	30/06/2022	
Working with wider system on wider sustainability	Working in collaboration with system partners to increase adult social care capacity for pathway 1 & 2 categories of patients.	Complete plan	Dan Moore	30/06/2022	
Build Urinary Investigation Unit & Paediatric Outpatients (one footprint)	Complete building works	Complete Building work	Val Doyle	31/08/22	

Board Assurance Framework

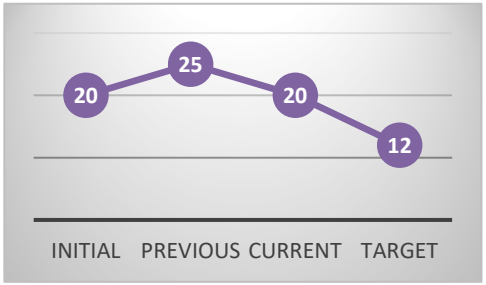
Risk ID:	1273	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to provide timely patient discharge caused by system-wide 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. Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly. Monthly Focus on Flow weeks scheduled every month until July 2022 Daily bed meetings organised by the Director of Operations & Performance to provide timely and effective benefits to patient flow Approval of IMC business case which will support a reduction in frailty length of stay and admission avoidance through geriatric input in to the Emergency Department. 500-700 additional domiciliary care hours to be released from w/c 6th December 2021 to support reducing long length of stay and super stranded patients Command & Control initiative in place since 8th December 2022 and ongoing to support pathway 0 and pathway 1 discharges. This is creating necessary capacity to support wave 5. This is in line with national guidance. w/c 10th January 2022, the Trust is supporting system designation of the Lilycross facility as being able to receive COVID positive patients. This is supporting wave 5 bed capacity. Working closely with Warrington Borough Council on a short, medium and long term solution to community bed capacity, matching demand to capacity. An increase in capacity in the community and a decrease in community prevalence and transmission has resulted in almost all the Care Homes in Warrington & Halton to be open. This has seen a decrease in the number of super stranded patients form a peak of 170 to 115 (03.03.22) Revenue investment to be proposed to increase the Hospital Discharge Team . This would increase the number of discharges and reduced length of stay. Working with system partners to double the amount of intermediate care at home capacity by Quarter 3 2022/23				
Assurance Gaps:	Delays in discharge caused by adherence to Covid-19 infection control pathways and the patient's Covid-19 status.				

Board Assurance Framework

	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
Improve discharge planning skills & knowledge	Undertake educational sessions to improve discharge planning skills & knowledge as part of Focus on Flow sessions	Complete educational sessions	William, Caroline	30/01/2022	25/01/2022
Improve quality and effectiveness of Board Rounds	Undertake educational session to improve quality and effectiveness of Board Rounds to help support reductions in length of saty	Complete educational sessions	Harris, Zoe	30/01/2022	25/01/2022

Board Assurance Framework

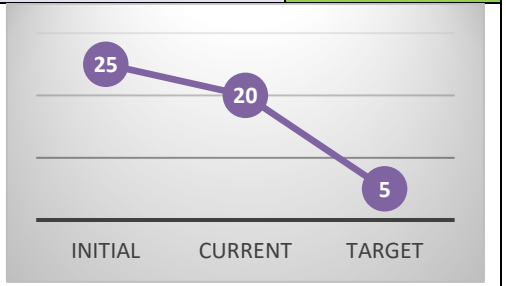
Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	12 (4x3)
Assurance Details:	• This is first, robust staffing escalation process across WHH to manage staffing daily – This is the forum for responsive staff management and deployment during the COVID 19 pandemic • Lead Nurse identified daily to co-ordinate staffing supported by a senior nurse rota 7 days a week 8am – 8pm • 4 hourly update shared as part of Gold Command template • Recruitment / media plan produced and recruitment campaign ongoing – vacancy reduction plan in place including RN/ODP/HCSW • Rolling advert for RN's continue. Students who were redeployed to the Trust during the COVID 19 pandemic have been offered substantive posts • National staffing guidance has been utilised to inform new staffing models • Care Hours Per Patient Day (CHPPD) currently 7.6 (Year to date position 7.8) • Monthly workforce information produced via workforce dashboard. Information is reviewed and monitored at the Workforce Group Chaired by the Deputy Chief Nurse • Wards & departments use E-Roster and Safecare data to support staffing ratio management and 'in time' daily management of safe staffing • Proactive student nurse campaign in train <u>Recruitment Assurances</u> • Rolling advert for B5 Nurses recommenced 23rd November 2021 and closed on 31st January with interviews taking place 18th February 2022. • AED recruitment day completed on 28th October with 17 candidates successfully appointed. Maintained contact with candidates through Seasons greetings cards, Newsletter and a meet and greet session. • Combined WHH RN and AHP recruitment day held 28th January with 29 Nurses appointed across UEC, Medical and IMC CBUs. • Career advice events in local schools and colleges • Production of monthly and bi-annual staffing reports received by the Trust Board • The Trust has now successfully placed 96 International Nurses. • From 7th January 4 Refugee Nurses have commenced their training and due to start on their wards from 14th February 2022. HCA • NHSI HCSW winter pressure funding received to support with recruitment and retention of new to care candidates. Weekly monitoring on progress and reporting to NHSI in place. Work now ongoing for pastoral support of new recruits to improve turnover rate in this group. Interviews took place 24th & 26th January 2022 with a total of 17 candidates appointed. Further interviews to take place on 21st February 2022. • Aim for all vacancies to be recruited into with the support of HR, Education and Workforce Improvement Lead. • WHH careers open day held 19th October 2021 to showcase support the Trust offers to HCSW – attendance from local colleges and public				

Board Assurance Framework

	• Working in partnership with Rugby League Cares with a view to arrange further careers/recruitment open day for HCSW. Bi-monthly meetings take place • Supporting NHSP with the CSWD/PSS programme and monitoring number of staff who have successfully been appointed <u>Retention Assurances</u> • Workforce Dashboard reporting monthly in relation to leavers • WHH Nursing retention plan to be refreshed for 2022 • 'Transfer Window' implemented allowing staff to move to other specialties without having to apply for role • Registered Nurse Turnover 13.61% • International nurses have all been placed (95 in total) on wards. COVID-19 Assurances • Implemented a graduated and planned nurse staffing response to the COVID-19 Pandemic. • Revised staffing models for the expansion of critical care capacity, acute and supportive respiratory wards • Strengthened daily staffing meetings chaired by the Deputy Chief Nurse for senior oversight • Increased use of temporary staffing through NHSP and off framework agencies – close monitoring arrangements in place – incentives Jan and Feb • Implementation of NHSP incentive scheme for staff to improve fill rates – update monitored weekly • Increased incidence of COVID-19 Omicron variant is leading to increased staff absence. Plans are in place to reduce activity to ensure staff are available from elective areas to support affected areas. • Incentives have been offered to staff able to work increased hours via NHSP – Extended to the end of February 2022 • Minimum ward staffing numbers assessment completed • Non-ward based when possible	
Assurance Gaps:	• Increase staffing pressure due to ongoing use of temporary winter wards (B3, B4 & K25) for which there is no funded establishment • Recruitment Gaps • 0 RN Vacancies in September 21. ED & B18 are recruiting RNs for increased capacity. • Retention Gaps • 13.91% nursing turnover • Significant staffing absences from Dec 2021 due to the increased transmission rate of the Omicron variant • Awaiting C21 business case completion • 55 escalated bed and super stranded patient position in Trust	

Recommendation					Completion Date
WHH to review international nurse recruitment to support registered nurse vacancy fill.	Targeted recruitment campaign	International nurse recruitment programme in place. Develop a business case. Agreement to join GTECH in partnership with WWL. Business case agreed for 30 nurses. Task and finish group established to support the recruitment campaign and welcome nurses to WHH Application for bid to access financial support for the programme.	Kennah, Ali	31/03/2022	

Board Assurance Framework

Risk ID:	1275	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to prevent Nosocomial Infection caused by high transmitability of variant strains, waning effect of vaccines, asymptomatic carriage (staff or patients), false negative test results, high local community prevalence.			**Initial:** 25 (5x5) **Current:** 20 (4x5) **Target:** 5 (5x1)
Assurance Details:	Restricted site access is in place to reduce the risk of COVID19 transmission. Triage and testing on admission. COVID19 incidents are monitored daily. Risk assessments are in place in all Wards/Departments and rest rooms and being revised as per hierarchies of control Mask stations and santiser is in place at all entrances and designated points throughout the Trust. Agile working policy is in place Information technology infrastructure is in place to support remote working. Risk assessment in place to support safe visiting where appropriate. PPE is monitored daily. Providing and maintaining a clean environment that facilitates the prevention and control of infections. Communications through TWSB to staff reinforcing social distancing measures Environmental Safety Action plan in place reported by exception to Silver Infection Control Outbreak meetings held with lessons learned shared across the Trust Signage and written information in place to support social distancing practices Retractable screens between beds spaces in ED PPE audits completed weekly on wards and increased frequency during outbreaks PPE & Swabbing Champions identified Clear curtains are in place all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. Process for assurance of 3 and 5 day swabs in place Bioquell Pods now in place in ICU Bioquell Pods now in place in ED Bioquell Pods now in place B18 Trust completed learning from Nosocomial outbreaks sessions. COVID-19 quality metrics in place Cohorting of COVID-19 positive patients recommenced Programme of OH screening for employees in place for symptomatic and asymptomatic employees with housegold contact. Revised guidance in place for respiratory and non-respiratory pathway Testing amended to included Influenza A&B & RSV. Agreed patient flow pathways based on results of screening. IPC Team liaison with clinical teams on AGP precautions FFP3 fit testing programme in place Staff training in safe donning and doffing of PPE – included in mandatory training			
Assurance Gaps:	Non-compliance with social distancing & PPE Non-adherence to Trust Staff isolation policy Mask station not present at all entrances Cleanliness score (on small number of ward items) sit just below 95% Increased transmission rate of the Omicron variant Site-wide assessment of ventilation (mechanical and manual) – in progress Small percentage of unvaccinated staff – under revision - VCOD Low uptake of LAMP/asymptomatic staff testing – LFD testing by some staff but not centrally reported			

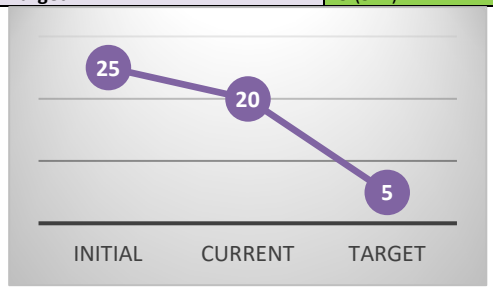
Board Assurance Framework

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Health and Safety inspections to include the monitoring of social distancing and ensure hand sanitiser and masks are located at each entrance.	Findings from inspections reported to the Health & Safety Sub-Committee Health and Safety inspections continue on an 8 week programme.	Health and Safety inspections to be carried out.	Kennah, Ali	31.03.2022	
Design of mask stations to be reviewed	Design of mask stations to be reviewed	Review to be undertaken	Kennah, Ali	31.03.2022	
Review Nurse cleaning roles & responsibilities	Reviewed as part of a Task & Finish Group to implement revised cleanliness standards	Agree roles and reseponsibilities	McGreal, Julie	31.03.2022	
Review ventilation – mechanical and manual	Site-wide survey to assess compliance with HTM.	Review ventilation – mechanical and manual	Wright, Ian	31.03.2022	

Board Assurance Framework

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

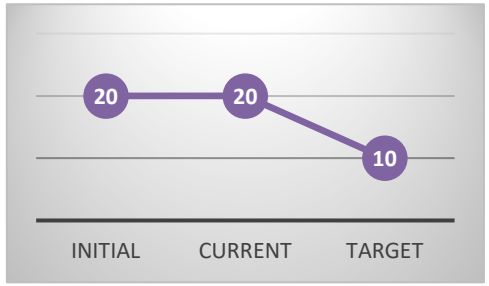
Waiting lists monitored and measured weekly
Post Anaesthetic Care Unit (PACU) remains open and operational
Continue to undertake harm review process and triangulate with waiting list process and Priority 2 patients
Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 104 weeks
Continue to ensure urgent cancers are prioritised in line with national guidance
Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site.
Bioquell Pods in ED live and operational
B18 footprint development to support improved Respiratory & Critical response to peaks in the pandemic is underway and set to complete in September 2021.
Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee.
Safe staffing levels reviewed daily. If necessary this may mean a review of clinical services to support the release of staff on a temporary basis.
The re-start of the Warrington site green pathway commenced w/c 8th February in the newly established ward A5 elective footprint. At present this supports cancer and other green pathways on the Warrington site
Clinical Recovery Oversight Committee (CROC) established
Clinical Services Oversight Group (CSOG) established
Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery.
B18 opened in October 2021
Respiratory nursing business case approved to support step down of respiratory patients from ICU to B18 earlier in their care pathway thus creating ICU capacity to support planned care
Additional ultrasound contract awarded to start in January 2022
Successful bid of c£3m to support elective recovery in H2
All priority/urgent cancer P1 and P2 elective plans have been maintained through wave 5
To support capacity for Wave 5, elective activity moved to CSTM Halton facility to protect elective programme
Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments
Increase in Trust WLI rate extended until 31.05.2022 to support restoration and recovery. Business Case to support the increase in to 2023/24 currently in development and planned to be presented to the Trust Board in May 2022
Additional echo activity as per the H2 elective fund plan starting w/e 12th February 2022 delivery an additional c104 echos per week.
New Clinical Treatment Suite opened in the Nightingale Building in May 2022 (capital investment of £145K) to support the reduction in chronic pain waiting lists an increase theatre capacity to support restoration and 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 Business Case to increase WLI rate for 2023/24	Develop Business Case	Dan Moore	31.05.2022	

Board Assurance Framework

Risk ID:	134	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that future loans will be required which would raise the question if the Trust is a going concern.			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	10 (5x2)
Assurance Details:	•Core financial policies controls in place across the Trust •Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Resources Group (CRG) oversee financial planning established overseeing financial planning •Regular review at Executive team meeting and development sessions •Annual plan development process • Achieved Break Even in 2021/22 subject to Audit • Delivered 2021/22 Capital Plan • Unqualified audit opinion (2020/21) •Corporate Trustee Charities Commission Checklist, reporting annually through Board •Monitoring of charitable funds income and annual assessment of investment and reserves policies •Regular updates to Executive Team, FSC and Trust Board • Workshop undertaken with - Exec, CBU, Corporate to review 2022/23 cost pressures • Workshops undertaken 2022/2023 budget setting •Completed MIAA Governance Checklist received by Audit Committee •Capital Plan 2021/22 approved by Trust Board on 31st March 2021 (£19.75m) •Capital Plan 2022/23 approved by Trust Board on 30th March 2022 •c£34m cash support secured in the form of PDC in March 2021 •Monthly Report to Executive Team Meeting and FRG includes review of outstanding MIAA recommendations and actions. The report also highlights the number of retrospective waivers compared to the same period in 2019/20. •Capital is reported monthly detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. Business cases for capital schemes over £550k are approved by the Trust Board. •Phase 3 of the Health Infrastructure Programme (HIP) announced. WHH submitted an Expression of Interest (EOI) in September 2021. WHH assessed & submitted by Cheshire & Merseyside Health & Care Partnership to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&M • TIF funding application to support recovery at Halton / CSTM c£8m over 3 years • Latest guidance from MIAA Counter Fraud Team circulated • Clinical Review Oversight Committee (CROC) established to provide oversight and assurance on recovery performance. • Revised approach to GIRFT/CIP. Leadership form Executive Medical Director and joint reporting to F&SC introduced. • Financial strategy developed to support improvement in financial sustainability to be submitted to the Trust Board for approval in May 2022				
Assurance Gaps:	•Non-recurrent and unidentified CIP presents a risk to in-year and future year financial position. •No external funding support for Halton Healthy New Town or Warrington Hospital new build. •Risk that capital needs exceed capital funding resources available. ICS allocate capital resources and currently going through bidding process to secure funding required for the 2022/23 Capital Programme • Increased threat of fraud as a consequence of global instability (e.g. conflict in Ukraine) • Uncertainty of the Trust allocation from the Cheshire & Merseyside Integrated Care Board and future reconfiguration of funding • Cheshire & Merseyside system is required to break-even and currently has a deficit				

Board Assurance Framework

	• ERF Funding is not guaranteed and is non-recurrent and 2022/23 Operational Plan assumes achievement of £7.6m ERF • Risk of unforeseen costs due to further COVID-19 surge • Availability of social care to support the current super stranded position (currently c25% of bed base) • Forecast non-recurrent CIP c£3m for 2021/22 will present a pressure for the 2022/23 budget • Current financial plan shows deficit of £16.7m

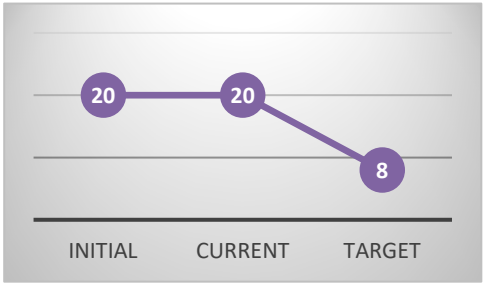
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Realtime oversight of delivery of operational performance to secure ERF	Create weekly Oversight Group	Create weekly Oversight Group	McGee, Andrea & Moore, Dan	31.05.2022	
Submit Bids to ICB for Capital	Submit Bids	Submit Bids	Forkgen, Alice	30.06.2022	
Targetted Investment Fund (TIF) Business case to be submitted	Submit Business Case	Submit Business Case	Parker, Janet	31.05.2022	
Identify CIP to support delivery of the overall financial plan	Identify CIP	Establish Leadership and oversight with the Executive Medical Director and meeting with Care Groups. Joint reporting to F&SC	McGee, Andrea & Fitzsimmons, Paul	30.03.2023	

Board Assurance Framework

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

Assurance Details:

- Trust continues to be challenged by high sickness absence rates nationally the North West has higher sickness absence rates. North West Acute Trusts make up 45% of quartile 4 - Highest 25% for sickness absence nationally. WHH currently sit in quartile 3 nationally and rank 10th out of 20 for North West Trusts.
- Overall absence rate is 7.19% for March 2022 and March 2021 absence rate was 5.00%.
- The Trust has recently concluded a programme with support from NHSI/E which was used to deliver a 4-month project to launch the WHH Supporting Attendance Policy
- New Supporting Attendance Policy has been live since February 2022
    - Preventative measures continue to be implemented including;
        - Occupational Health and Wellbeing interventions
        - COVID Booster Campaign
        - Flu Vaccination Campaign
        - Asymptomatic staff testing
- The Trust continues to promote the importance of Return to Work interviews to support attendance and bespoke Manager training has been undertaken in pilot areas with high levels of return to work non-compliance. These have now been rebranded to Welcome Back Conversations, to promote the supportive tone of these converstations.
- Extensive communications via Trust Safety Huddle and global emails to promote use of PPE, social distancing and compliance with environmental risk assessments.
- The UK Health Security Agency issued guidance on 30th March 2022 following up the government's white paper on Living with Covid-19. This guidance is for staff and managers and provides updates guidance for health and social care staff if they develop any of the main COVID-19 symptoms, receive a positive LFD test result or are identified as a contact of a COVID-19 case. It also updates the guidance on repeat/routine testing for COVID-19 for staff in health and social care settings
- COVID vaccine programme continues with good uptake from across the workforce, with monitoring arrangements in place.
- COVID-19 Workforce Recovery Steering Group continues.
- In March 2022 the overall vacancy rate was 10.58%
- Reliance on bank and agency staff increased 19% compared to a peak of 23.3% in Jan 2021
- The Supporting Attendance policy has been published with a focus on supporting individuals within the workplace. The policy has been launched by the HR team in partnership with line managers and staff side partners. To support this work, which is part of wider project with NHSEI, a range of 1:1 management coaching sessions have been delivered to line managers and a number of bitesize briefings have been delivered within Care Group settings.
- Occupational Health and Wellbeing continue to hold triangulation meetings with HR colleagues to review individuals who are under the formal stages Supporting Attendance Management, to progress the case through enhancing support and/or developing interventions.
- The Trusts wellbeing offers continue to be well utilised, supporting people to remain in work. The Trust received national recognition for our Check In conversation and local recognition for our Health and Wellbeing Hub.
- Throughout 2021, the Mental Wellbeing Team have been able to deliver:
- 2056 calls with staff accessing services themselves or managers seeking advice and support for their staff
- 3842 emails with staff accessing services themselves or managers seeking advice and support for their staff
- 3254 1:1 sessions or group setting interventions



Board Assurance Framework

	• In additional over 40 areas have been supported delivering over 150 workshops and training sessions on topics such as CBT, anxiety and resilience.
	• Following the evaluation of the Brathay programme, where 90% recorded an improvement in their mental wellbeing, a further programme of work has now been secured offering a 'lite' version over 2022.
	• Rugby League Cares have been supporting WHH since July 2021, providing a range of physical and mental fitness offers to our workforce.
	• Grief and menopause cafes have also been setup to offer guided support sessions both virtually and face to face
	• The guidance from UKSHA published on the 1st April regarding decreasing the spread of respiratory infections, including COVID-19 in the workplace states that there is no longer a requirement for employers to explicitly consider COVID-19 in statutory health and safety risk assessments with a reduction in individuals who are considered to be at higher risk of COVID-19, which was published by UKSHA on the 4th April 2022.
	  • In line with these updates the COVID Risk Assessment process has been reviewed to align to the Living with COVID principles and the updated COVID vulnerabilities:
	  • Blood cancer (Leukaemia or Lymphoma)
	  • Weakened immune system due to treatment (such as steroid medication, biological therapy, chemotherapy or radiotherapy)
	  • Organ or bone marrow transplant
	  • A condition that means that individuals have a high risk of getting infections
	  • Down's syndrome
	  • Sickle Cell disease
	  • Pregnancy
	  • Chronic kidney disease
	  • Severe liver disease
	  • Certain autoimmune or inflammatory conditions (such as rheumatoid arthritis or inflammatory bowel disease)
	  • HIV or AIDs
	  • A condition affecting the brain or nerves (such as Multiple Sclerosis, Motor Neurone Disease, Huntingdon's, Myasthenia Gravis
	  • Only Staff who are both Vulnerable to COVID and working with Aerosol Generated Procedures, are required to consider reasonable adjustments, all other Staff can return to their full duties, within their substantive role.	

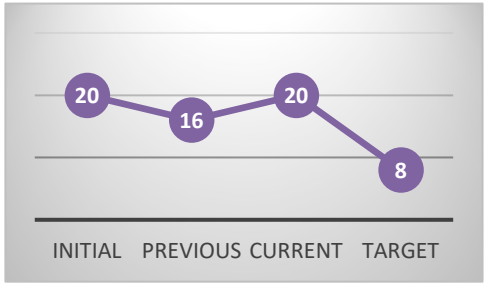
Assurance Gaps:	• Continued lack of national/regional clarity of the management of long covid in the context of the National agreement. • Administrative & Clerical and Estates & Ancillary staff are still experiencing over 1% absence rate related to COVID-19 • Additional Clinical Services and Nursing & Midwifery staff are still experiencing over 2% absence rate related to COVID-19. This impacts requirements for temporary staffing.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Embed the changes to COVID testing, isolation and Risk Assessments	Communicate the Living with COVID changes and check in with Leaders to check understanding	• Drop-In sessions available for leaders • Trust wide communications	Roberts, Carl	31/05/2022	
Continue the promotion and development of Wellbeing interventions/initiatives.	To further enhance the wellbeing offer	• Embed a 'lite' version of the Brathay offer in 2022 • Ongoing evaluation of the Mental Health Wellbeing team offers • Expansion of the education programme to include a focus on CBT	Patel, Rebecca	30/08/2022	

Board Assurance Framework

		and trauma sessions including bespoke sessions for specific teams			
Improve the Education offer for Leaders to support them supporting their Staff to remain healthy in work	Offer a range of Supporting Attendance educational offers to ensure they are accessible and conducive to the range of leadership experience/skills.	• Continue the 1:1 bespoke training sessions • Enhance the bitesize training offers to improve their accessibility Embed a Supporting Attendance development session as part of a wider Leadership Development offer	Hilton, Laura	30/08/2022	

Board Assurance Framework

	1114	**Executive Lead:**	Fitzsimmons, Paul		
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage..			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	8 (2x4)
Assurance Details:	**Assurance:** • **Digital Governance Structure** including weekly structured Senior Leadership Team meetings, Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Data Standards Group reporting to the Information Governance and Corporate Records Sub-Committee with escalations to the Quality Assurance Committee and onwards to the Digital Board, which itself submits highlights to the QAC and resource go to FSC. The **Quality Assurance Committee report provides** assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Cyber Essentials Plus/Audit Actions/IG training figures). • **Digital annual IT audit** plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with progress monitored at the Trust Audit Committee. • **Trust benchmarking** activities including Use of Resources reviews (Model Hospital). • ITHealth Assurance Dashboard is live, monthly external penetration testing is now in place using NHS Digital's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. (March 2021) • Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital (December 21) • WHHT return for assurance re cyber security to NHS England (March 22) • Cisco Phase 2 business case being approved (for financial year 22/23). Providing the procurement mini tender is done on time and the orders are place in advance and there are no other world-wide changes happen impacting on supplies, kit will be delivered and installed within 22/23. **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 • Remote devices no longer bypassing the web proxy • Active Directory password set to expire again (covid working from home-related). • Fully recruit to the Digital Service restructure Phase 1 restructure • Outcome of the second Phishing exercise by NHS Digital, communications have been sent out to staff members who entered details for awareness.	
Assurance Gaps:	**Gaps In Assurance:** • Mostly achieving of mandated compliance with DSPT, incorporating CE+ (moderate assurance given by MIAA for the standards audited and substantial in respect of the veracity of the self-assessment) **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Current performance of Lorenzo and whether migration to the cloud will provide any benefit. • Development of staff behaviours to protect data evidenced via reduced IG incident report levels, impacted training due to Covid-19 pandemic. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Not all Windows Server 2003 server will be migrated to Windows Server 2016 before the N365 agreement starts. (1 out of 77 servers are at risk of not being migrated in time. The system at risk is Medicorr.) • No local device (PC & laptop) based firewalls in use while on site, dependant on the site boundary firewalls • Using generic logins staff usernames and passwords are stored in browser when selecting "remember me" • No dedicated logging tool to pull all key logs together and provide useable alerts. MIAA to review processes and tools (July 21) •Using no longer supported Exchange 2010 email system for mail archive • Using SharePoint 2010 for the Hub • Lack of process to check antivirus alerts in console. MIAA to review processes and tools (July 21) • Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security).. • No controls in place for Bluetooth connectivity. • No agreed patching schedule for network equipment with the Trust. • Temporarily Uninstalled Mcafee on PACS servers for 1 week (10/03/22) • The extension of the mainstream support for SQL Server 2012 will end on 12 July 2022	

Recommendation					Completion Date
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	Migrate all 2003 and 2008 servers to 2016.	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to Windows Server 2016 • Extend Support for Windows Server 2008 until Feb 2022 NB: Windows Server 2003 is out of support; however, Windows Server 2008 is still in support until March 22. [All simple migrations have been completed by IT Services. A report was	Deacon, Stephen	31/05/2022	

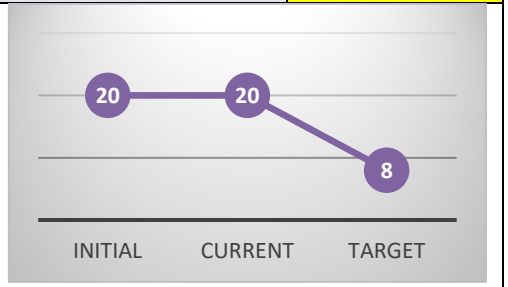
Board Assurance Framework

Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system). [Delivers: Best Practice]		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.]			
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. (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)	Waterfield, Tracie	30/06/2022	
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	Deacon, Stephen	31/05/2022	

Board Assurance Framework

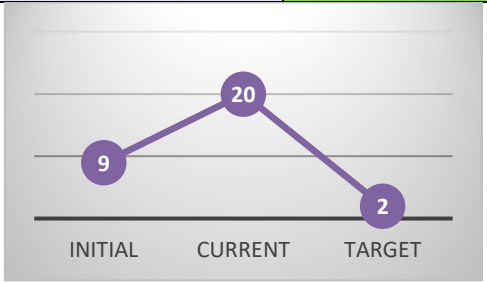
		Phase turn on / turn on [Meeting set up for 03/09/21]			
Business case for SQL Server 2012	Business case for SQL Server 2012	To be part of the new N365 agreement. NHS Digital Need to provide the financial plans before local Trust can renew the agreement.	Waterfield, Tracie	31/05/2022	
Cisco Phase 2 upgrade to replace aging network equipment	Approve the business case Complete mini tender Place orders in advance Delivery of equipment Install and configure equipment	New equipment has been installed and used.	Waterfield, Tracie	31/03/2023	

Board Assurance Framework

Risk ID:	1125	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	8 (2x4)
Assurance Details:	• Following national EPRR guidance for Cancer & RTT • All patient referrals are being prioritised due to clinical need • Rejected referrals are following recognised procedures particularly ensuring all have a clinical review to determine outcome • Moved a high proportion of OPD activity to virtual. • One elective theatre maintained for cancer and clinically urgent cases • Maintaining monthly reporting for each external standard • Discussed at the NED led Clinical Recovery Oversight Committee (CROC) • Discussed at the Clinical Services Oversight Group (CSOG) • Constitutional Standard Performance reporting to the Finance & Sustainability Committee (F&SC) • Executive attendance at the weekly Elective Restoration meeting for Cheshire & Merseyside. Linked with the ICS Governance Structure • H2 planning linked to restoration & recovery agreed with NHSE/I • Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments • Additional echo activity as per the H" elective fund plan starting w/e 12th February 2022 delivery an additional c104 echos per week. • Increase in Trust WLI rate agreed until 31.05.2022 to support restoration and recovery. Business Case to support the increase in to 2023/24 currently in development • Halton to become a Community Diagnostic Centre (CDC) as part of the second tranche of national funding. This would be situated on the Halton Campus. • The Trust has been successful in being selected for a Targeted Investment Fund (TIF) bid. This will be ratified in May 2022 • Capital Works for new procedure room completed in April 2022 and no live. This will release an additional 10 Theatre session per week to support recovery.				
Assurance Gaps:	Some weekly reporting reduced as per guidance				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop Business Case	Develop Business Case to increase WLI rate for 2023/24	Develop Business Case	Dan Moore	30.04.2022	

Board Assurance Framework

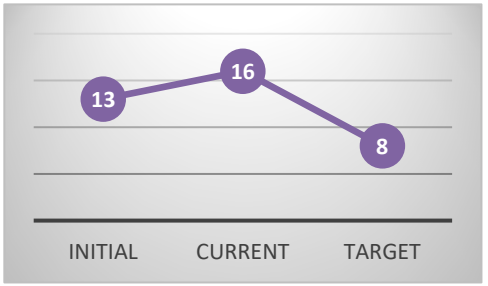
Risk ID:	1079	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.			**Initial:** 9 (3x3) **Current:** 20 (4x5) **Target:** 2 (2x1)
Assurance Details:	Chief Nurse, medical director and head of safety and risk aware of system issue Digital IT paper to QAC and PSCE in collaboration with IT director to highlight system failures and inoperability Paper based backup systems introduced Additional administration in significantly affected areas Site visit to MBFT for lessons learnt in improving system Miro meeting with IT manager to look for interim solutions Scoping new systems with procurement Capital funding meeting attended to seek funds to support alternative maternity specific system New mobile phones for community to support hot spotting in areas with no connectivity IT visited community clinics with Lorenzo connectivity issues Support from lead midwife for IT to ensure data quality. Data is cross-checked to ensure that accurate data is submitted for screening and Payment By Results Quick reference guides have been created for users to improve data quality related to erroneous input Off line version of Lorenzo to assist Community midwives to input real time data and reduce errors (LCM) Support currently in place to cleanse historical data In order to ensure health visitors are notified, the previous paper based system has been replaced with an electronic notification system, with a fail safe in place to ensure no patients are not notified to the appropriate service. AN electronic HV notification has been set up and tested in Warringotn and new are ow working with IT teams in Halton CCG to replicate the elctronic notification system we have in Warrington. Presentation provided by prospective suppliers on 18th December 2020 Clevermed identified as the preferred supplier in February 2021 EPR Strategic Outline Case supported by the Trust Board in December 2020 Temporary fix for CTG archiving agreed and fitted in December 2020 with review in January & February 2021 Following completion of supplier decision making process, implementation due to complete in May Digital Maternity board in place to ensure full oversight is provided. Weekly digital transformation meetings in place to progress operational actions. Staff training schedule initiated to ensure all staff can be supported during the implementation phase. Increased training sessions may pose a potential staffing pressure and risk in terms of COVID/Omicron variant status and potential reduction in staffing. Off line working on Lorenzo launched in January 2022 to mitigate risk prior to Badgernet implementation in May . This will support implementation of Maternity Incentive Scheme Safety Action 2 : MSDS submission			
Assurance Gaps:	Lack of connectivity to ensure that systems can operate Lack of data to provide internet hotspot			

Board Assurance Framework

	The current digital solution is contributing to poor data quality and its detrimental care quality and activity income effects, poor staff moral and concerns by regulators Work related stress due to additional hours required to achieve correct level of data inputting leading to sickness absence Lack of assurance that all women are captured for both operational clinical and financial ends. This leads to uncaptured activity and risk to safety if women are not entered onto the system appropriate due to the above Loss of income due to poor data quality. The cross checking is dependent on time being available for the team to complete this time consuming task Ineffective use of midwifery time- midwives continuing to report excessive additional effort to correct omissions and inaccuracies, impacting upon carer/woman relationship and data quality, and leading to concerns that the current situation may impact the Trust's aspirations to achieve outstanding status.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Implementation of new EPR system	New EPR is fully in use and all training completed	Implementation plan Training of staff on new EPR.	Arya, Dr Rita	31/05/2022	

Board Assurance Framework

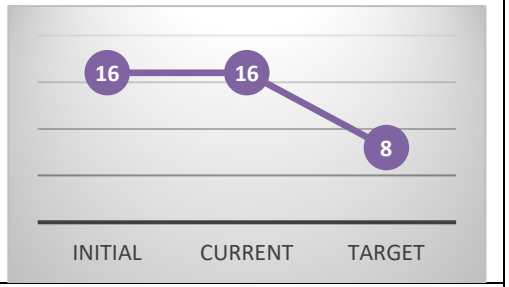
Risk ID:	1372	**Executive Lead:**	Paul Fitzsimmons	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY - A failure to develop an affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits - A failure to garner ICS and NHSE support to progress the EPR business case - A failure to deliver Managed Convergence in line with emergent national policy and the ICS Convergence strategy (in development) RESULTING IN (sequentially) – a continuation of the Trust's challenges with the incumbent EPR, Lorenzo (as identified in the Strategic Outline Case), potential for a costly extension to the existing Lorenzo contract or the highly retrograde step of returning to paper systems as Lorenzo will be at end of life at or before the end of the tactical contract extension			**Initial:**	12 (3 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)
Assurance Details:	Assurance: • Trust Board approved Outline Business Case has moved the project to the Outline Business Case stage • The procurement process has progressed and the outcome to identify a preferred supplier is currently undergoing validation • EPR Project B oard (and escalation/assurance through Digital and Trust Boards) • Regular, documented conference call with NHSE, NHSX and NHSD • ORMIS business case to support theatres module to Execs WC 4/4/22 – in phase with Lorenzo contract extension Controls: • Approved business case for a new 3 (+2) year tactical Lorenzo contract in support of time required to complete the procurement and deployment • Trust financial modelling includes 3 – 5 year Lorenzo costs • Implementation of approved Principle CCIO and Associate CCIOs to support the business case production • Pre-procurement market engagement with supply chain, against a pre-agreed discussion framework, to inform further costs and benefits opportunities for OBC • Project Manager assigned. • Financial modelling of realistic collaboration options to provide genuine 5, 10 and 15 year options to control whole life costs • Identification of further realistic cash releasing benefits • Contracts for tactical solution signed				
Assurance Gaps:	Gaps In Assurance: • Limited assurance regarding ICS and NHSE sign off OBC and support for progression to FBC • ICS approach to delivering managed convergence remains unclear Gaps In Controls: • Deployment of dedicated Maternity EPR and thus avoidance of the associated risks . Go live date in May 2022 • Lorenzo is at end of life and moving forwards is unlikely to see significant future development or enhancements				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Presentation of OBC v3 to Executive Team	Presentation of OBC v3 to Executive Team	Review the contents of OBC v3 Presentation of OBC v3 to Executive Team in May 22	Caisley, Sue	31/05/2022	
ORMIS theatres management module contract extension to allow theatres to continue to operate	ORMIS theatres management module contract extension	Approval at Executive Group for ORMIS contract extension in parallel to Lorenzo contract exetnsion	Fitzsimmons, Paul	31/05/2022	

Board Assurance Framework

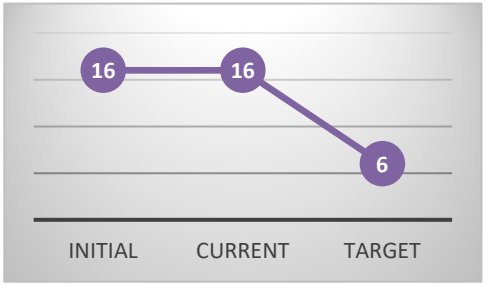
MD, CFO and CIO to meet with ICS and Regional NHSE/I counterparts to discuss next steps to progress procurement	Clarify ICS position with regards to EPR procurement process and 'managed convergence'	Meet ICS and NHSE/I	Fitzsimmons, Paul	31/05/2022	
Dedalus to replace Lorenzo EPR with ORBIS A comprehensive impact assessment to be completed asap, with regards to the implications for BAU and strategic EPR plans	Dedalus to replace Lorenzo EPR with ORBIS	A comprehensive impact assessment to be completed asap, with regards to the implications for BAU and strategic EPR plans	Caisley, Sue	31/05/2022	

Board Assurance Framework

Risk ID:	1579	**Executive Lead:**	Daniel Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure of the Trusts ability to transfer patients with time critical urgent care needs to specialist units able to deliver time critical specialist interventions (Primary PCI, Hyperacute Stroke Intervention, Emergency Vascular Surgery, Major Trauma services etc) CAUSED BY an inability of the North West Ambulance Service, to provide the expected response times for critical transfers due to overwhelming demand on ambulance services, RESULTING IN a delay in transfer and thus potential severe patient harm due to the inability to access time critical specialist interventions without undue delay			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)
Assurance Details:	• LHCH PPCI pathways have been adjusted to give guidance for patients not being transferred for more than 120 minutes. • UEC are following the escalation process to the ROC/NWAS Control room to discuss patients transfer needs on an individual basis. • All SMOCs and Silver Command are aware of the escalation process. • With regards to trauma issues, UEC have raised this at the regional network meeting. For assurance a high level paper is presented to Trust Wide Trauma Group and Patient Safety and Clinical Effectiveness Sub Committee. • Trust continues to perform well against the ambulance handover times thus supporting the ambulance service • Implementation of a new handover escalation process in times of high demand went live in April 2022 with support from AQuA				
Assurance Gaps:	NWAS assess there response times based upon current active and waiting calls when there regional activity is high. However, there is still significant delays.				

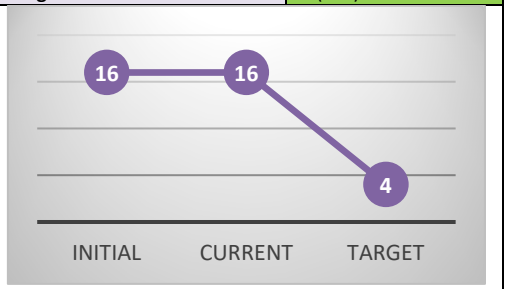
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Implement new escalated ambulance handover process	Work with NWAS to support the development of a regional escalated handover process.	Implement new escalated ambulance handover process	Sharon Kilkenny	30.04.2022	05.04.2022

Board Assurance Framework

Risk ID:	1233	**Executive Lead:**	Paul Fitzsimmons	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	FAILURE TO review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed CAUSED BY Combined Assessment Unit (CAU) frequently being bedded with inpatients due to overcrowding in the ED and an excess demand for inpatient beds RESULTING IN a lack of surgical assessment bed capacity, poor patient experience, delays in treating surgical patients and increased admissions to the surgical bed base.			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	6 (2 x 3)
Assurance Details:	Assurance: • CAU assessment capacity and availability considered on a thrice daily basis in bed meetings • CAU assessment capacity status considered at twice weekly Tactical Board • Regular CAU steering group meetings will continue to review effectiveness of controls Controls • Ensuring CAU assessment capacity is preserved or reinstated is a standing priority at bed meetings and Tactical Board • Other escalation areas bedded before escalation to bed CAU • A surgical ambulatory nurse co-ordinator supports surgical emergency admission patient flow • New ways of surgical working implemented 17/1/22 to mitigate risk by pulling patients requiring operative intervention directly to theatres from the ED and CAU to avoid delays to surgery caused by a lack of beds • Completion of the ED plaza will negate this risk as the dedicated assessment areas in the ED plaza cannot be bedded and as such surgical assessment capacity will be preserved				
Assurance Gaps:	Gaps in Controls • An admission avoidance clinic is set up but cannot be utilised effectively as no alternative assessment area is available to bring patients back to when CAU is bedded. • During periods of excess bed demand CAU is very likely to be a bedded area limiting the availability for the surgeons to review any admission avoidance patients. • Surgeons may struggle to find assessment areas in ED to treat patients • Any delay in the ED Plaza program will delay the resolution of this risk				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Completion of ED plaza	Increased dedicated assessment capacity delivered in ED plaza	Completion of ED plaza	Wright, Ian	30/06/2022	

Board Assurance Framework

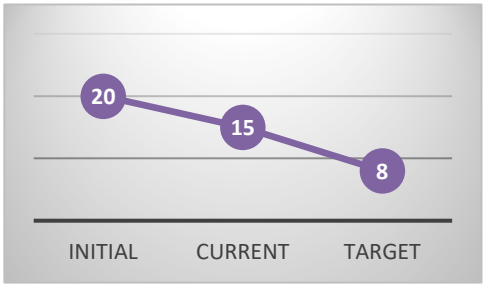
Risk ID:	1108	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are assessed as only able to work on a non-respiratory pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.			**Initial:**	16 (4x4)
				Current:	16 (4x4)
				Target:	4 (4x1)
Assurance Details:	Provided listening events and 1:1 meetings for all staff. This has resulted in accumulated feedback to identify key themes to be addressed. Review of all processes. Interim Head of Midwifery in post New CBU manager appointed and in post. Appointment of 9.2 WTE midwives. Daily staff meetings taking place to intensively monitor staffing. NHSP and agency staff are being used to back fill shifts where possible. Nursing staff utilised for C23 when it is not possible for a midwife to fill the post. When short staffed on C23, an extra maternity support worker is asked to work. NICE staffing red flags linked to Safecare implemented at beginning of June 2021 Midwifery management team strengthened – Two matrons in acting posts until end September 2021 All additional 9.2 WTE Midwives in post. Midwives redeployed across the unit as appropriate 1:1 care rate currently @ c92% Birth suite Manager appointed and in post 9th June 2021 Additional 3 Band 7 Birth suite Co-ordinators appointed 1st Feb 2021. Interview for permanent posts 27th June 2021 Birthrate plus full review funded by Local Maternity System to be carried out by 31st Dec 2021 3 X Interim managers extended until 30th June 2021 Board approved 6 recurrent additional band 7 WTE midwife posts and 1.58 band 6 WTE in March 2021 to support the roll out of the Continuity of Carer model – recruitment on going Daily staffing meeting and redeployment of staff to maintain safe staffing levels Birth Rate plus review has been undertaken and awaiting draft report end of October. This will incorporate Halton staffing and acuity in the report. Midwifery Staffing challenges continue and reviewed daily. Cheshire and Mersey Escalation and Divert Policy updated to support internal and external escalation. Weekly LMS gold command staffing meeting to identify staffing hotspots and need for mutual aid. Staffing vacancies appointed awaiting start date. 11 members of staff are still being supported to work in a green pathway, as per Occupational Health risk assessment and recommendations. The NHS is awaiting a national week commencing 28th February. Daily SITREP to LMS Submitted Gold Command meetings returned to weekly 21/2/22 Staffing continued to be monitored daily by senior team.				
Assurance Gaps:	Potential for uncertainty across the services as a result of COVID-19 pandemic Short term sickness 1 matron in maternity - 1 matron has stepped down Covid pressures remain and are exacerbated by the current annual leave absences this is a regional and national concern. Gold command and a daily / weekly sit rep has been created. Transfer of maternity service from Halton to WHH from 1st November 2021 including staff transfer and need to complete local induction which will add to current staffing pressures. Current absence/sick rate 8.47% and vacancy rate increased to 6.21%				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Continue to review staffing on a regular basis with daily reviews, and monitor vacancy rates closely to ensure prompt recruitment to any midwifery vacancies. Birth rate plus is currently in progress to be completed by the end September.	Actions to monitor staffing	daily reviews	Owens, Catherine	28/02/22	

Board Assurance Framework

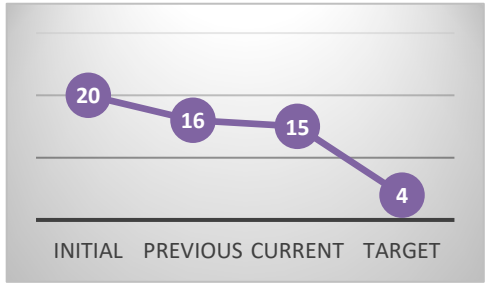
Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.			**Initial:**	20 (5x4)
				Current:	15 (5x3)
				Target:	8 (4x2)
Assurance Details:	The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the C&M Health and Care Partnership plans. The Trust has developed effective clinical networking and integrated partnership arrangements. Some examples include: - The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. - Council and CCG in both Warrington & Halton supportive of development of new hospitals. Agreement with key stakeholders to progress single programme and proceed with OBC development. - Agreement of sustainability contract with Warrington CCG and subsequently Warrington & HaltonSystem Financial Recovery Plan - Regular Strategy updates are provided to the Council of Governors - Clinical strategy wide engagement - Clinical Strategy approved by Trust Board - CBU specialty level strategies complete and incorporated in business plans. - Initial talks held with Elective Care C&M Lead in relation to the suitability of Halton as a potential Elective Care Hub. Opportunity to accelerate elective hub as part of Covid recovery - Trust has met with Cheshire & Merseyside leads for Women's and Children's review to demonstrate strength of local Women's and Children's services and help inform outcomes of regional review. - Breast Centre of Excellence opened to consolidate breast screening in Warrington but to commence in April 2022 - DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. Phase 3 of the HIP announced. WHH submitted an Expression of Interest (EOI) in September 2021 - Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. - Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside. Currently options for further development do not include any option where WHH is a hub. All options proposed include Essential Services Labs (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESLs. Pathology OBC supported by the Trust Board - Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services to commence from summer 2022. - Director of Strategy invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington				

Board Assurance Framework

	- Town Deal plan for Warrington submitted. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £22.1m funding approved for the Town investment plan, including £3.1m for the Health & Wellbeing Hub and £1m for the Health & Social Care Academy. - The Trust is leading the development of the detailed plan for the Health & Wellbeing Hub. - Strategy refresh completed and approved at Trust Board to confirm 2020/21 priorities. - Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. - In February 2021 the Government White Paper, "Integration and Innovation: working together to improve health and social care for all - The Department of Health and Social Care's legislative proposals for a Health and Care Bill" was published. - The Trust Board agreed in March 2021 that a transaction between BCH and WHH is no longer required, given that the White Paper enables an acceleration of place-based integration including all commissioners and providers. - The Trust has been awarded Social Value Award status recognising the contribution to the outcomes of local populations. It is one of only two organisations in Cheshire & Merseyside to receive the award. - £90k funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington - WHH commenced a focussed programme of work on addressing health inequalities, the green agenda and our role as an anchor instiution. Initial work recognised as the exemplary within Cheshire & Merseyside. - Consistent Trust representation within Cheshire & Merseyside ICS to support transition to ICS. WHH CEO appointed as Head for Clinical Pathways within C&M. - Trust representation on newley established place based Boards within both Warrington & Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected. - WHH assessed & submitted by Cheshire & Merseyside Health & Care Partnership to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&M	
Assurance Gaps:	Risk to securing capital funding to progress new hospitals Sefl assessments of both Warrington & Halton hospitals place based governance development indicate that Halton is 'emerging' (stage 2 of 4) and Warrington is establishes (stage 3 of 4). There is a requirement to further develp as places to ensure both boroughs can benefit from potential future autonomy.	

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

Board Assurance Framework

Risk ID:	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:** 15 (3x5) **Target:** 3 (3x1)
Assurance Details:	**Controls:** Annual capital funding is allocated to business critical, mandated and statutory estates projects Planned Maintenance Program Reactive maintenance process 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 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:** Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers Non funded capital schemes are risk rated and monitoired through the above group 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 with subsequent action plan 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 Cleanliness monitoring identifies estates issues that are addressed through the estates building officer Ventilation Group – gives assurance on the appropriate levels of trustwide ventilation in particular approves upgrades and new installations			
Assurance Gaps:	Limited capital funding to address backlog Compliance – evidencing compliance in line with national guidelines and mandated returns (Premises Assurance model) PAM) Estates staffing - recruitment and retention of trade staff due to banding of technical trades being lower than local and national peers 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 unforseen and emergency maintenance in I&E budget Threat to the delivery of capital schemes due to the pandemic e.g. manufacturing delays, additional costs of construction relating to IPC guidelines and the unavailability of an appropriately skilled workforce.			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Upgrade Warrington kitchen facilities	Following a review of the kitchen facilities at Warringotn Hospital. An improvement plan in place to progress	Complete upgrade of kitchen facilities	Ian Wright	31/12/2022	
Develop estates maintenance compliance monitoring tools	Integrate performance and compliance into0 routing estates maintenance operations	Head of compliance and performance in post in April 2022 and will develop initiatives, processes and protocols to drive estates maintenance performance and in turn improve compliance against	Ian Wright	31/03/2023	

Board Assurance Framework

		recommended guidelines and internal KPIs			
Complete premises Assurance Model for 22/23	Complete and submit PAMS to NHSEEI	Identify gaps and workplan for 22/23 compliance improvement plan	Ian Wright	31/10/2022	
Apply for additional capital from ICS	Submit bid for additional 22/23 backlog capital from C&M ICS	Provide capital finance team with information to submit bid to regional finance team	Ian Wright	31/05/2022	