WHH Board of Directors Meeting Part 1

Wednesday 29 July 2020
9.30am-12.30pm
Via MS Teams

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

Wednesday 29 July 2020 time 09.30am -12.30pm

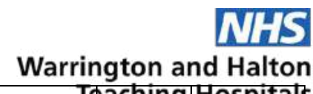
Via Microsoft Teams

Due to the ongoing Covid-19 (coronavirus) outbreak, the Trust is following current Government guidance to avoid, wherever possible, large gatherings of all but essential staff. Therefore we will hold this Trust Board meeting in a closed session, all papers and subsequent minutes will be made available on the website as usual.

REF BM/20/07	ITEM	PRESENTER	PURPOSE	TIME	
BM/20/07/ 62	Engagement Story – Fixing Broken Windows	Clive Lewis	Presentation	09.30	N/A
	BREAK – 10.30-10.35				
BM/20/07/ 63	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	10.35	Verb
BM/20/07/ 64 PAGE 23	Minutes of the previous meeting held on 27 May 2020	Steve McGuirk, Chairman	Decision	10:37	Encl
BM/20/07/ 65 PAGE 35	Actions & Matters Arising	Steve McGuirk, Chairman	Assurance	10:40	Encl
BM/20/07/ 66 PAGE 38	Chief Executive's Report (a) Summy of Provider Board Papers	Simon Constable, Chief Executive	Assurance	10:45	Encl
BM/20/07/ 67	Chairman's Report	Steve McGuirk, Chairman	Information	10.55	Verb

Quality People Sustainability

BM/20/07/ 68PAGE 48	COVID-19 Performance Summary Report and Situation Report	Simon Constable Chief Executive	To note for Assurance	11.00	Enc
BM/20/07/ 69 aiPAGE 70	Integrated Performance Dashboard and Committee Assurance Reports	All Executive Directors	To note for assurance	11.05	Enc
(a) ii	IPR Key Issues - Quality, Access & Performance	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO Alex Crowe, Executive Medical Director Chris Evans Chief Operating Officer			Enc
(a) iii PAGE 130	- Committee Assurance report Quality Assurance Committee (7.07.2020)	Margaret Bamforth, Non-Executive Director			Enc
(b) i	- People	Michelle Cloney Chief People Officer			Enc
(b) ii PAGE 135	- Committee Assurance report Strategic People Committee (22.07.2020)	Anita Wainwright, Non-Executive Director			Enc
(c) i	- Sustainability	Andrea McGee Chief Finance Officer & Deputy CEO			Enc
(c) ii PAGE 138	- Committee Assurance report Finance and Sustainability Committee (17.06.2020 + 22.07.2020)	Terry Atherton, Non-Executive Director			Enc



(d) PAGE 143	Committee Assurance report Audit Committee (17.06.2020)	Ian Jones, Non-Executive Director			Enc

BM/20/07/ 70 PAGE 146	Infection Prevention & Control Board Assurance Framework	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	To note for assurance	12.00	Enc
BM/20/07/ 71 PAGE 197	Moving to Outstanding Action Plan update	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	To note for assurance	12.05	Enc

Sustainability

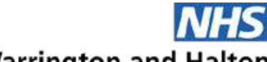
BM/20/07/ 72PAGE 201	Quarterly Progress on Carter Q4 (def from May) + Q1 Report Recommendations and Use of Resource Assessment	Andrea McGee Chief Finance Officer & Deputy CEO	To note for assurance	12.10	Enc

GOVERNANCE

BM/20/07/ 74 PAGE 244	Strategic Risk Register + BAF	John Culshaw Trust Secretary	To note for assurance	12.25	Enc

MATTERS FOR APPROVAL/RATIFICATION (supplementary Pack)

	ITEM	Lead (s)				
BM/20/07/ 75	Complaints Annual Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	**Committee** **Agenda Ref.** **Date of meeting** **Summary of Outcome**	Quality Assurance Cttee QAC/20/07/96 7 July 2020 **Approved**		Enc
BM/20/07/ 76	Safeguarding Annual Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	**Committee** **Agenda Ref.** **Date of meeting** **Summary of Outcome**	Quality Assurance Cttee QAC/20/07/95 7 July 2020 **Approved**		Enc
BM/20/07/ 77	Risk Management Strategy Annual Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	**Committee** **Agenda Ref.** **Date of meeting** **Summary of Outcome**	Quality Assurance Cttee QAC/20/07/100 7 July 2020 **Approved**		Enc
BM/20/07/ 78	Health + Safety Annual Report	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	**Committee** **Agenda Ref.** **Date of meeting** **Summary of Outcome**	Quality Assurance Cttee QAC/20/07/98 7 July 2020 **Approved**		Enc
BM/20/07/ 79	Quality Strategy Annual Update	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO	**Committee** **Agenda Ref.** **Date of meeting** **Summary**	Quality Assurance Cttee QAC/20/07/99 7 July 2020 **Approved**		Enc
BM/20/07/ 80	Medicines Management + Controlled Drugs Annual Report	Alex Crowe, Executive Medical Director	**Committee** **Agenda Ref.** **Date of meeting** **Summary of Outcome**	Quality Assurance Cttee QAC/20/07/101 7 July 2020 **Approved**		Enc



BM/20/07/ 81	**Quality Committee Chairs Annual Report**	**John Culshaw** **Trust Secretary**	**Committee** **Agenda Ref.** **Date of meeting** **Summary of Outcome**	**Quality Assurance Cttee** **QAC/20/07/102** **7 July 2020** **Approved**		**Enc**
BM/20/07/ 82	**Microsoft N365 Licensing**	**Phillip James** **Chief Information Officer**	**Committee** **Agenda Ref.** **Date of meeting** **Summary**	C19SEOG/20/580 14 July 2020 **Approved**		
BM/20/07/ 83	**Charitable Funds Committee – Governing Document (Terms of Reference)**	**Pat McLaren** **Director of Communications & Engagement**	**Committee** **Agenda Ref.** **Date of meeting** **Summary**	Charitable Funds Committee CFC/20/06/19 4 June 2020 **Approved**		**Enc**

MATTERS FOR NOTING FOR ASSURANCE (in supplementary pack)

	ITEM	**Lead (s)**				
BM/20/07/ 85	**Emergency Preparedness Resilience and Response (EPRR) Annual Report 2019/20**	**Chris Evans** **Chief Operating Officer**	**Committee** **Agenda Ref.** **Date of meeting** **Summary of Outcome**	N/A		**Enc**
BM/20/07/ 86	**Learning From Experience Q4 report**	**Kimberley Salmon-Jamieson** **Chief Nurse & Deputy CEO**	**Committee** **Agenda Ref.** **Date of meeting** **Summary of Outcome**	Quality Assurance Cttee QAC/20/07/108 7 July 2020 **Noted**		**Enc**
BM/20/07/ 87	**Patient Experience Strategy Annual Review**	**Kimberley Salmon-Jamieson** **Chief Nurse & Deputy CEO**	**Committee** **Agenda Ref.** **Date of meeting** **Summary of Outcome**	Quality Assurance Cttee QAC/20/07/91 7 July 2020 **Approved**		**Enc**
BM/20/07/ 88	**Mortality Review Q4 report**	**Alex Crowe** **Executive Medical Director**	**Committee** **Agenda Ref.** **Date of meeting** **Summary of Outcome**	Quality Assurance Cttee QAC/20/07/112 7 July 2020 **Noted**		**Enc**

	Any Other Business	**Steve McGuirk, Chairman**	**N/A**	**16:55**	**Ver**
	Date of next meeting: Wednesday 30 September 2020,				

Conflicts of Interest

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

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

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

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

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

Interests fall into the following categories:

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

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

GLOSSARY OF TERMS

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

FIXING BROKEN WINDOWS

Moving organisations forward
in the context of **Black Lives Matter**.

A paper on options for
Chief Executives and leadership teams.

Mr Clive Lewis OBE DL
Chief Executive

June 2020

CONTEXT

Recently, we have witnessed many of the world's population reach a tipping point in relation to issues of race and inequality. The combination of feeling unheard over the years, a growing number of cases of injustice, the death of George Floyd and a young man with a mobile phone in Minnesota have all collided to culminate in a moment of critical mass.

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A tipping point is usually reached when an idea, trend or social behaviour crosses a threshold, tips and spreads like wildfire[1]

In a number of ways, the response we have seen is akin to the outpouring of support for the 'Me Too' movement in 2019. The elevated profile of the Black Lives Matter campaign led by iconoclastic supporters poses a real challenge for executives who lead increasingly diverse organisations. Even the word 'BAME' has become offensive for some. A tipping point is usually reached when an idea, trend or social behaviour crosses a threshold, tips and spreads like wildfire[1]. A number of organisations have responded by posting messages of support on corporate websites. Some social media responses have included comments such as 'Thanks for your message of support, now please send me an image of your executive team'. This response demonstrates that people want to see action rather than more deliberation. Failure to act is likely to have a deleterious effect on the employee and industrial relations taxonomy. The problem for established organisations may not be that they do not realise that the world has changed. Rather, instead of seeking to change behaviour they might demonstrate active inertia – where organisations do what they always did, only more energetically than before. This is only likely lead to dissonance, employee disengagement and can be one of the main reasons why good organisations fail.

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Never has the concept of VUCA been more applicable. VUCA is a term that was developed by the US military in the 1990s to reflect the volatile, uncertain, complex and ambiguous environments in which decisions have to be made on the battlefield. It is equally applicable to corporate organisations. In the model, volatility is defined as a state of dynamic instability. This is often brought about by drastic, violent and rapid shifts in the environment or the rapid emergence of challenges arising without warning and requiring immediate attention. Following the path of the of the unforeseen Covid-19 pandemic, the Black Lives Matter campaign fits this description. Leading when the environment is volatile requires clear and effective communication. Fast decision making might become essential and so it is important that the information on which decisions are to be taken is updated as rapidly as possible.

Globis is frequently invited to offer support where situations of dysfunction, discrimination, bias or unfairness exist. Sometimes these cases relate to issues of gender, disability, age or sexual orientation. Right now, issues are overwhelmingly about race. A repeated unwillingness or inability to deal with circumstances of inequity can lead to organisations becoming toxic or to an erosion of trust. In low trust environments everything takes more time and financial costs are higher. Where cultures are not underpinned by egalitarianism employees may well experience a constant sense of injustice that can lead to feelings of chronic embitterment. Chronic embitterment is an emotion encompassing persistent feelings of being let down, insulted and of being revengeful but helpless[2].

John Watson[3], one of the founders of behaviourism suggested that behaviour is completely malleable and that it can be shaped into anything in the right environment. We are sure there are many Chief Executives and Chief Human Resources Officers who wish it was that simple.

> Chronic embitterment is an emotion encompassing persistent feelings of being let down, insulted and of being revengeful but helpless[2]

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SOLUTIONS

The purpose of this short paper is to outline five hallmarks Chief Executives and leadership teams might follow in order to avoid a discombobulated response to current events and achieve stickiness in positive change at the individual, team and organisational level.

HALLMARK		WHAT IT MEANS
ACKNOWLEDGEMENT		» An indication that voices have been heard » Led by CEO and executive team » Demonstrates confident vulnerability of key players » Creates a platform for rebuilding trust
PROVIDE A PSYCHOLOGICALLY SAFE SPACE		» Allows people to speak without fear of retribution » Enhances learning and performance » Prevents the ‘circular firing squad’ » Helps to unleash trust, openness, resilience and growth
EQUIP LINE MANAGERS		» Play a key role in fixing broken windows quickly » Ensures team behaviour is consistent with organisational values » Provides a continual process of goal setting, dialogue and feedback » Helps to close personal blind spots
EMBRACE ORGANISATION DIAGNOSIS		» Prevents sticking plasters » Draws on evidence-based science » Resolves systemic problems » Highlights levels of change readiness
DELIVER CIVILITY TRAINING		» The pedagogy helps to understand the connections between power, ontology, behaviour, emotions and experience » Focuses on working together as homogeneous groups » Helps to pivot towards unconscious inclusion » Builds levels of productivity

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1
ACKNOWLEDGEMENT

For many organisations acknowledging that there is a problem is a good place to start. Public acknowledgement sends the message that voices have been heard and provides an indication that action will follow. But, follow it must. Acknowledgement should be a matter for all members of the executive team, led by the CEO. One of the important aspects of leadership in rebuilding trust is to demonstrate confident vulnerability. Trust cannot be restored overnight. It requires shared experiences over time, multiple instances of credible follow-through and an enhanced insight of team members.

Page 13 of 283
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2

PROVIDE A PSYCHOLOGICALLY SAFE SPACE TO TALK

People will want to express how they feel as a result of events that have played out in Minnesota and reverberated around the world. To be in a psychologically safe environment means being able to say what you think without fear of retribution. People learn and perform best when they feel psychologically safe. In environments where one feels unsure or hesitant about suggesting or trying new ideas, we find that learning and creativity become suppressed. Frequently in organisations, when something goes wrong, we look for those we can point the finger at. Instant blame and criticism can lead to what has been called a 'circular firing squad'. Cultures based on this methodology will also see that it has subtle but measurable consequences, undermining our capacity to learn. In increasing punishment, openness is reduced and owning up for mistakes or past misdemeanours is driven underground. Combatting this tendency will unleash trust, openness, resilience and growth. A correlation between the psychological safety of teams and levels of productivity has been regularly proven. A safe space might include setting up a BAME network group where experiences can be shared. However, constant talk without action only adds to levels of frustration. In addition, setting up 1:1 coaching provision to allow colleagues to process how they will respond rather than react to events would prove to be a good investment.

> To be in a psychologically safe environment means being able to say what you think without fear of retribution.

Page 14 of 283

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3
EQUIP LINE MANAGERS

Many line managers lack the relevant skills and experience to deal with situations appropriately as they arise. Drawing on what social scientists refer to as the broken windows theory[4], line managers play a vital role in stepping in to repair damaged relationships quickly before further damage occurs. The theory suggests that if a window in a building is broken and is left unrepaired, all the rest of the windows will soon be broken.

One unrepaired broken window sends a signal that no one cares. A successful strategy for preventing rambunctious remonstrations or to avoid being deceived by artificial harmony is to address problems when they are small. The unchecked practice of minor incivilities day after day could contribute to more general cultural degradation.

A recent survey from the CIPD found that 35% of employees were 'neutral to dissatisfied' with the relationship they had with their line manager[5]. A line manager's ability to ensure the way a team behaves is consistent with organisational values is vital. Organisations need to rely on line managers to engage in a continual process of goal setting, dialogue and feedback. If line managers are ill-equipped to deal with the demands of working in diverse environments, it could lead to role conflict. Providing support through tools such as psychometrics to help reveal blind spots is a helpful step.

> Organisations need to rely on line managers to engage in a continual process of goal setting, dialogue and feedback.

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4
EMBRACE ORGANISATION DIAGNOSIS

Organisation Diagnosis (OD) holds little influence in many organisations. The functions that are carried out under the guise of OD are often merely a plaster covering a gaping wound. If the wound continues to bleed with only patches to stop it, it will never be enough. When executed properly, OD should be an evidence-based practice underpinned by science. The content of OD should be very much about organisation mission and purpose, strategy, leadership, management behaviour, and ultimately about culture change. OD should have a place at the top of an organisation and leadership has a responsibility to give it the attention it deserves.

OD takes the measure of an organisation's starting point, painting a picture that will show where potential problems could arise or where weaknesses need to be addressed. Evidence based diagnosis is likely to include data collection, data interpretation, preliminary diagnoses and final diagnoses. Empirically based interventions should be commissioned to address problems that have been identified. OD is critical to the initiatives of change, as well as the change readiness of people[6].

Attempting to solve systemic problems will be a long haul that will require the commitment of financial and human resources. A mixed methods research approach will provide an organisation with a source of rich information. It is unlikely that any real progress will be made before a 12-month period has expired. Defining metrics should be based on what is right for your organisation. Examples might include:

» Recruitment
» Promotions to leadership positions
» The number of people experiencing training interventions
» Matching the employee profile to the customer, patient or student base

Re-running research after 12-months will help to assess whether interventions are working. It is important to test interventions and track progress to narrow down causes and symptoms of problems. Following these processes brings an element of scientific testing into the corporate environment, creating ways to interpret symptoms so that the right treatment can be administered.

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Empirically based interventions should be commissioned to address problems that have been identified.

Page 17 of 283
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5
DELIVER CIVILITY AND RESPECT TRAINING

It may seem a given that delivering equality and diversity, or unconscious bias, training is a prerequisite considering the context. Things have moved on here. Even where unconscious bias training has the theoretical potential to change behaviour it will depend on the type of racism or discrimination being encountered. The evidence that the training works is weak. We recommend training on civility. Civility training is powerful. It draws on the concept of figurational sociology which relates to the composition of humans as interdependent rather than independent beings. The pedagogy helps us understand the connections between power, ontology, behaviour, emotions and experience. It focuses on inclusion and the benefits of treating each other with civility and respect by working together as homogeneous groups irrespective of which characteristic of the 9 equality strands one might sit under. It also inspires people to work harder. The costs of incivility are enormous.

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Page 18 of 283

Civility pays. It is a potent behaviour that helps to enhance your influence and effectiveness. It is unique in the sense that it elicits both warmth and competence – two of the characteristics that account for positive impressions[7]. Workplace civility is behaviour that helps to preserve the norms for mutual respect at work; it comprises behaviours that are fundamental to positively relating with another, building relationships and empathising.

Organisations suffer a reduction in profitability where there is incivility. There is also an impact on managers' time as they are required to deal with the grievance or investigation that can be associated with uncivil behaviour. Civility training has a robust business case and is helping to level the playing field on treating all colleagues equally and with respect. It is our view that Civility training will displace equality and diversity training within a few years from now.

The findings of a recent survey of workers who had been on the receiving end of incivility are shown below.[8]

SURVEY OF WORKERS ON THE END OF INCIVILITY

Page 19 of 283
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IN CLOSING

This paper is not recommended as a one size fits all solution for all organisations. It might be that some of the five hallmarks are more appropriate than others. The paper is intended to be a document that prompts discussion at the executive level which leads to appropriate action. If you would like our assistance to help you think through and implement solutions, please get in touch.

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ABOUT THE AUTHOR

Mr Clive Lewis OBE DL is the founder and Chief Executive of Globis Mediation Group.
He is a business psychologist specialising in individual, team and organisation behaviour. He has worked with chief executives and leadership teams for over 15 years. He is the author of 17 books. His next book 'Toxic: A Guide to Rebuilding Respect and Tolerance in a Hostile Workplace' will be published by Bloomsbury in February 2021.

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DRAFT

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 27 May 2020 Trust Conference Room, Warrington Hospital	
Present	
Steve McGuirk (SMcG)	Chairman, via Teleconference
Simon Constable (SC)	Chief Executive (to Chair meeting at the request of the Chairman)
Terry Atherton (TA)	Deputy Chair, Non-Executive Director, via Teleconference
Margaret Bamforth (MB)	Non-Executive Director, via Teleconference
Alex Crowe (AC)	Acting Medical Director & Chief Clinical Information Officer
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director, via Teleconference
Andrea McGee (AMcG)	Director of Finance & Deputy Chief Executive
Cliff Richards (CR)	Non-Executive Director, via Teleconference
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse & Deputy Chief Executive and Director of Infection Prevention and Control (DIPC)
Anita Wainwright (AW)	Non-Executive Director, via Teleconference
In Attendance	
Michelle Cloney (MC)	Director of HR & Organisational Development
Lucy Gardner (LG)	Director of Strategy
Phillip James (PJ)	Chief Information Officer
Pat McLaren (PMcL)	Director of Community Engagement + Fundraising
Dan Moore (DM)	Director of Operations and Performance
John Culshaw (JC)	Trust Secretary
Julie Burke	Secretary to The Trust Board
Observing	Norman Holding, Public Governor, via Teleconference
	Paul Bradshaw, Public Governor
Apologies	Chris Evans, Chief Operating Officer

BM/20/05/43	**Welcome, Apologies & Declarations of Interest** The Chairman welcomed all to the meeting. Apologies noted above. The Board observed a minutes silence in memory of Joselito (Jo) Habab RN, Trauma Nurse Coordinator who had sadly passed away on 21 May. A well supported minutes silence had been observed at Warrington and Halton sites on 22 May, with Jo's wife and son joining the minutes silence at Warrington. A book of condolence had been opened. It was noted that MC and AC declarations relating to Joint HR&OD and Acting Executive MD posts with WHH and Bridgewater no longer apply. No other declarations in relation to the agenda were noted. Question and answers raised prior to the meeting had been circulated, and will be incorporated into the minutes and appended as a formal record of proceedings.
BM/20/05/44	**Minutes of the meeting held 25 March 2020** Page 3 – to read N&M PPE was running at a very low level on 26 March 2020. Only ITU had ran out of gowns, 56 boxes masks and gowns have arrived this morning (Solway small masks and gowns) There is one Datix related to the staff member on ITU. With this amendment, the minutes of 25 March 2020 were agreed as an accurate record.
BM/20/05/45	**Actions and Matters Arising. Action log and rolling actions paused due to COVID-19**

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

	Pandemic were noted.
BM/20/05/46	**Chief Executive's report** The CEO referred to his report, adding that a number of the items will be addressed in other items in today's meeting. He also corrected page 3 of his report to read "WHH has been operating within safe limits over the past few weeks. We have not suffered from any stock-outs of any Personal Protective Equipment (PPE), although there was a single incident in ITU which was fully mitigated in March 2020 (this was DATIX reported and managed accordingly) – this was not Trust-wide." **The Board noted the report.**
BM/20/05/47	**Chairman's Report** The Chair reported internal meetings continue with NED Assurance Committee meetings, Board and Council of Governors, externally he continues to keep in touch with local partners and stakeholders. Positive Council of Governors meeting held virtually in May, very high attendance, Chairs Q&A session to be reinstated virtually. • **The Board noted the report.**
BM/20/05/48	**COVID-19 Major Incident WHH responses and situation report** The CEO referred to the situation report and updates provided for Clinical Care, Operational + Facilities, Patient Safety and Experience, Maternity, Workforce, Clinical Governance, Corporate Governance, Infection Prevention and Control, HR, Staff Welfare, Digital, Finance and Communications and invited comments. **Clinical Care** CR enquired about the testing regime and progress for 1 hour and 4 hour testing. SC explained that 1 hour Cephid testing via Cephid platform is in place, ready to go live 4 hour testing will be on Panther platform providing larger capacity to support testing capabilities at WHH. DM further explained the Recovery Board on 26 May 2020 had approved introduction of Panther platform for testing in mid-June to provide 4 hour capability to carry out all COVID-19 testing in-house. Current Rapid testing, circa 15 swabs per day which is supporting patient flow and patients on Cancer and Elective programmes. This testing is undertaken in specific circumstances with a clear decision making process in place. AC added that false negative rate approximately 30% and that testing will be enhanced when testing for antibodies and antigen commences In addition SMcG had raised the following questions prior to the meeting and Chief Nurse/Deputy CEO and Acting Executive Medical Director had provided responses: <u>**Q1**: Page 26 0f 196 - I presume that bullet point 1 – SOP for endoscopy/laparoscopy to support Recovery is saying that a new SOP for endoscopy etc has been developed? Can we clarify that it has been signed off and it has agreed clinically?</u> ***R: by AC** confirmed that Standard Operating Procedures (SOPs) for endoscopy/ laparoscopy have been clinically agreed and signed off by Tactical Group meeting.* <u>**Q2:** Does bullet point 5 - *Advancing Quality Alliance Innovation Report; positive for clinicians*- refer to the Aqua draft report shared last week? Can the next steps in terms of sharing the report be clarified? We mentioned a 'board session' to debate but presumably</u>

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you would also want to share anyway?
***R: by KSJ** - it does refer to the AQuA report and it forms part of the wider Governance work. There will be awareness and briefing sessions for all staff, delivery via CBU and Recovery Team, and the report will be shared in the Quality Assurance Committee (QAC). It will be broken down in to a learning framework and this will be shared with the Board.*

Q3; Please clarify the meaning of the final bullet point – *Anticipated 'Drive Through' ambulatory ECG monitor service*
***R: by AC** This is a clinical service in cardiology to assess patients who have history to suggest potentially abnormal heart rate/rhythm and to fit patients with a 24 hour or 7 day monitor to assess heart rate/rhythm further*.

Operational and Estates
SMcG had raised the following question prior to the meeting and Director of Operations and Performance had responded:

Q4: Page 27 of 196. Can we be clear whether our goal is to have outpatient consulting - by default - video consultation? It is appreciated it is not always going to be possible.
***R: by DM** - The ambition is, where appropriate, to have a virtual review (either telephone or video) as the primary method to undertake a safe patient consultation. The feedback from clinicians to date has been overwhelmingly positive. Early patient feedback has also indicated support for the use of virtual appointments. As suggested by the question, a virtual appointment might not always be appropriate and therefore work is underway to ensure the outpatient service can safely accommodate face to face appointments when required*

Patient and Safety Experience
SMcG had raised the following question prior to the meeting and Chief Nurse/Deputy CEO and Chief Information Officer had responded:
Q5: Page 28 of 196 - bullet point 8 – *CNST Safety Action – Digital Maternity Record Standard – Current DXC target is Lorenzo version 2.49 due to be deployed 23 October 2020 -* what do "CNST' and 'DXC' stand for?
The same point is also repeated on Page 29 of 196 – Does this mean that there is an upgrade to Lorenzo required in order for us to meet the new maternity standard and that the upgrade is scheduled for October? Is this on track and within the existing budget or attributed to COVID-19?

***R: KSJ and PJ** - Yes an EPR upgrade is required and the target date is based upon current supplier responses.*
- *COVID is not anticipated to delay this upgrade and it is within current EPR budgets.*
- *Lorenzo 2.19 will need to be active and in place by 23rd October 2020, for tracking Continuity of Carer or the required trajectory will be missed.*
- *CNST is the **C**linical **N**egligence **S**cheme for **T**rusts, in this instance related to Maternity services. (https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/).*
- *Thus the dataset we are being asked to capture and submit is aimed at monitoring how safe our Maternity services are, i.e. "supports the delivery of safer maternity care through …. trusts contributions to the CNST.".*
- *DXC is the name of our Lorenzo Electronic Patient Record supplier (www.dxc.com)*

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	Clinical Governance MB referred to Service Changes, the number of high (41) and very high risks (6) and how these are being monitored and how risk is being assessed in real-time. MB also asked if any Service changes had been reversed. KSJ explained that a Recovery proforma is in place, each risk is assessed and assigned. Oversight is at Tactical and Recovery Board to review service performance. DM and Deputy Director Governance, LA developing associated risk plan. Oversight of management of risks at Recovery Board within specialties. Recovery leads assigned for ownership of risks in their own areas, with additional oversight by LA and DM and feedback through CBU Leadership teams. KSJ further explained that a Governance Assurance framework has been developed how all elements are viewed, received and overseen. KSJ further explained that 238 had been taken down and being matched with process to put current services back on line. 16 had been taken to Recovery Board last week and CBU Triumvirate to ensure that all appropriate health and safety and staff welfare requirements are in place before services are re-started. Approval sign off is by CE as the Incident Commander and herself as DIPC and overseen by DM and LA. Service Change Governance Framework is in place and report to be provided to July QAC, as requested at April Board meeting. Maternity AW referred to Home Birth Service which had been below 1% before the service paused and the C&M Still Birth Review. KSJ explained Home Birth Service had been paused primarily to ensure safety of ladies and the high absence within Community Midwifery team at the time. The C&M Still Birth Review is being taken forward by and data reviewed by Maternity Network (LMS), there had been an increase of 38 across C&M January-April. All WHH data had been submitted. In relation to two born before arrivals (BBA) early review of data, ladies had not received care at WHH, the Trust is part of the review and will instigate any learning as appropriate. There were no further questions were raised from Board members.
BM/20/05/49 (b)	**COVID-19 Performance Summary** SC introduced the report, recording thanks to the Business Intelligence Team in developing the report and data analysis. SMcG referred to the scale of deaths data (Page 6) and if there was comparable work being undertaken in the North West (NW). SC explained there are always caveats when looking at crude death data for in and out of hospital due to different testing regimes across different organisations. The Funnel Plot (page 7) reflects that NW picture and confidence intervals for the number of deaths associated with number of in-patients. The data is anonymised by the Regional Team. AW asked about the positive outliers. SC further explained this is due to relatively low death rate compared to number of cases admitted, but need to take into different testing regimes in different organisations. Whilst providing early assurance that WHH is not an outlier, SC further explained that it will

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take longer to understand all the data across the region.

SC attends the weekly NW Mortality Cell reviewing data at NW level and is meeting with C&M Medical Directors to support understanding of outcomes within C&M analysing qualitative and quantitative data.

CR commented the data was useful to move to next stage of recovery, if there should be an indicator for this and if the range of change would be different for each Trust. SC commented that future reports will include number of new cases per day which would be taken into consideration. There would not be a clear 'switch on' to introduce services, all would need to through appropriate risk assessments and what is happening locally, regionally and nationally if cases began to increase would have to be taken into consideration.

SMcG added that NHSE/I perspective is each system will progress its own plans due to system capacity issues, through C&M Cell framework, utilising Nightingale Hospital Manchester to support surge in demand. NEDs asked if there is any intelligence to speculation of another surge in Autumn/early Winter and different regional lockdown measures. This would be predicated on how easing of lockdown measures are implemented, SAGE modelling /advice, co-ordinated at C&M local system and cell level, the Trust being agile to respond to local, regional and national directives alongside partners/ stakeholders across the health economy.

With the release of March 2020 data (first cut available in June and second cut available in July), the Coronavirus patient impact will become more evident. April and May 2020 data will be released together in August. Both confirmed and suspected COVID-19 patients will be identifiable in the HES data via diagnostic coding.

- NHS Digital has confirmed they will initially look to exclude COVID-19 activity from the SHMI in the short-term. HED will follow suit. The CCS group under which COVID-19 sits (259 – residual codes unclassified), falls outside the 56 CCS groups included in the standard HSMR. It will be available in the HSMR (All) figures.
- Mortality Review Group (MRG) met in March 2020 as per MRG TOR. MRG met in April 2020 with amended TOR in light of COVID Pandemic. Further MRG by Microsoft Teams 19.5.20. April 2020 Structured Judgement Reviews (as per established guidance) include 14 patient deaths with COVID. Further COVID focused review in progress.

In relation to in-hospital deaths and C&M Infection Control, KSJ explained some hospitals had had outbreaks during the Pandemic. There had been 1 outbreak at Halton which is being taken through appropriate investigation route. In C&M, there had been a number of outbreaks at Wirral and St Helens & Knowsley Hospitals.

There were no further questions were raised from Board members.

Post meeting note: Correction noted in report circulated. Pg 12 Trust outcomes, information included day cases, ambulatory care and assessment units as these patients are admitted to the Trust (10577). Amendment to include patients admitted overnight for a total of 4748 during reporting period (2.03.2020-23.05.2020)

- **The Board reviewed and discussed the report.**

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BM/20/05/49 (a)	**IPR Dashboard and IPR Key Issues** **Workforce** CR asked for detail relating to Apprenticeship Levy compliance 45% in April against a target of 85%. MC explained utilisation of this Levy is in line with national guidance. WHH continues to support Apprentices where possible, and for some complex learning frameworks, ie Advanced Nurse Practitioner (ANP), working with clinical education team and specific education providers including Health Education England to maximise Apprenticeship opportunities. Trusts in C&M collectively have challenged restrictions during the Pandemic to achieve trajectory whilst not being penalised. Mandatory Training - SMcG referred to pause in face to face mandatory training and for assurance that all staff had and will have undertaken the appropriate mandatory training when services recommence. MC explained the Mandatory Training Programme had been reviewed, supported at SEOG approving continuation of E-Learning mandatory training and essential skills training in line with national guidance. Clear guidance for specific training required where staff have been redeployed. Additional essential training had been implemented, ie FIT testing. A reference paper had been received the previous week within SEOG to restart elements of mandatory and essential training. Classroom training will be small numbers to ensure safe environment, adhering to social distancing measures, alongside E-Learning. AW asked what the key issues were with Return to Work compliance (57.79%). MC explained this was multifactorial, ensuring appropriate risk assessments and support was in place for staff returning to work. Measures in place include a register of staff that are shielded, risk assessments undertaken and roles/work they could undertake as the Trust moves to recovery phase. Working with staff side to ensure support in place for staff returning from sickness across a number of areas including technology, 'keeping in touch day' as services are re-established before confirming individual's their return to work. MC further explained a Risk Reduction Framework is being developed for a future Strategic Executive Oversight Group (SEOG), Tactical Group, Strategic People Committee (SPC) and QAC to provide assurance to NEDs that data is being collected and reviewed including how staff are being deployed, risk assessments in place to support this and, as services are re-established. MC advised data collection process for Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) had been paused nationally due to COVID Pandemic. Additional national guidance received 20 May, due to the critical importance of workforce equality, data collection will be between the 6 July to 31 August 2020, which will be reported to September SPC and September Trust Board. SMcG referred to Staff Opinion Survey Paper and figure of 26% of BAME staff experiencing bullying and harassment and what measures were in place to support this cohort of staff. MC explained a Trust BAME network had been established pre-COVID which had continued to be promoted during the Pandemic alongside support measures for staff and continued promotion of FTSU process. In addition, the Board was reminded of the letter sent from SC to all BAME staff outlining our specific support to them including the intention to undertake an individual risk assessment.

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	Access and Performance Ambulance Handovers – April data not available. SMcG asked if the Trust is still collecting data to ensure safe handover of patients and when will data collection restart. DM reassured the Board that WHH continues to manage patient flow with expeditious arrival process working alongside NWAS colleagues. The Trust review daily Ambulance Handover data from NWAS and WHH remains within 30 minute standard with no deterioration of performance. **Sustainability** TA observed the £25m underlying deficit and impact of future contractual arrangements if move away from block contracts. Activity data reviewed at FSC on 20 May 2002 reflects impact on elective activity when Elective programme ceased nationally and potential 18-24 month recovery period. • **The Board noted the Trust had received a top up of £2.5m to achieve breakeven position.** • **The Board noted the COVID-19 capital approved as an emergency by the Director of Finance and Deputy Chief Executive.** There were no further questions raised as queries had been addressed in the previous item. Chairs Committee Assurance reports were noted.
BM/20/05/50	**Operational Plan 2020-2021 and Capital Plan** AMcG provided an overview of proposed changes that will be required to the original Capital Plan for 2020-21 due to changes in Capital Regime which had been discussed in the April Board and at the Private session earlier in the day. - Draft Operational Plan approved by Board in February deficit plan of £26.1m and non-COVID Capital Programme of £14.73m. - March 2020, the Board informed operational planning round for 2020-21 had been suspended due to COVID-19. - Revised Income and Expenditure plan prepared, key movements in month 1-4 loss of car park income £0.5m, reduction in CIP £1.2m, COVID expenditure £17.3m, reduction in elective £1.1m, provision in months 5-12 for winter £0.5m - Revised Capital Plan reviewed and to be submitted to C&M Health & Care Partnership 29 May 2020, C&M currently oversubscribed for C&M by £25.2m out of a £196.8m envelope. COVID capital is excluded from this envelope. - Cash flow – assumes retrospective top up ends July 2020 and creditor payment terms continue at 7 days; SMcG asked if there was any indication of a change in contractual arrangements from Tariff /PBR perspective; where Trusts may delay start in services will there be any financial levers applied to speed up the process; and aspirations for Halton Centre AMcG explained there is no indication of PBR contract for 2021-22. In relation to financial levers, levers are likely to be implemented to support cost controls with audits of costs, control mechanisms and approval processes for COVID expenditure. Providers are being supported to implement recovery plans to deliver activity. SC explained work on-going to progress a mutual aid scheme to restart services as all Trusts have different requirements. As a health care system Trusts will need to work together, co-ordinated through the Hospital Cell framework to step up activity, share capacity to support

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	COVID and non-COVID and support neighbouring Trusts so as not to further exacerbate health inequalities. SC further explained that aspirations to maximise utilisation of Halton as an 'Elective Centre' are supported in C&M. Next steps will be to submit a revised Capital Plan to be submitted to NHSE/I 29 May 2020 and Budget Book to be amended for sign off by Budget Holders. • **The Board approved the proposed amendments to the Operational Plan for 2020-21.**
BM/20/05/51	**Strategic Risk Register and Board Assurance Framework (BAF)** The report was taken as read and JC highlighted the following for the Board to review and consider: Three new COVID related risks had been added to the BAF, approved at the QAC on 5 May 2020, Risk#1124 (PPE) at a rating of 25, Risk #1134 (staffing) at a rating of 20, Risk #1126 (oxygen ventilation) at a rating of 15. There had been no amendments to the ratings of any risks; there had been no amendments to the descriptions of any risks on the BAF and there had been no risks de-escalated from the BAF since the last meeting. Also included in the report were notable updates to existing risks. Following earlier discussions relating to postponement of the HENW visit, JC proposed to review Risk #241 at the Risk Review Group on 1 June 2020 if this should remain on the BAF. Reflecting on earlier discussions, SMcG asked if consideration for a new strategic risk could be given in relation to restart of services, including narrative to reflect potential impact of confidence of patients returning to the hospital. KSJ and JC to review outside of the meeting as part of a wider strategic risk. • **The Board reviewed and noted the BAF and Strategic Risk Register.** • **The Board approved the changes to the BAF.** • **Risk Review Group to review Risk #241 on 29 May**
BM/20/05/52	**Infection Control Board Assurance Framework (BAF)** The report was taken as read by KSJ highlighted key points to note: - Framework had been provided by Chief Nursing Officer as a temperature check based on 10 criteria using Health & Social Care Act. Framework is monitored through the Infection Control Sub Committee and QAC. This is taking place alongside parallel work relating to safety and environment in the Trust. SMcG acknowledged there would be evidence behind this information but asked for more granularity relating to "At Risk" group following conversations earlier in the meeting relating to work being undertaken in the Trust. MC to forward information to KSJ. Post meeting information for recording: - The organisation has the best score of 9.4 for equality, diversity and inclusion when compared with other acute trusts nationally. - Staff feel that the organisation acts fairly in relation to career progression or development irrespective of protected characteristic with a 1% increase from 2018. - Individuals experiencing discrimination on the basis of ethnicity has decreased by 3.6%

D R A F T

	and is 17% better than the average acute trust score nationally. - There has been an increase in discrimination on the grounds of gender, disability and age which is an area for development. **The Board noted the report.**
MATTERS FOR APPROVAL	
BM/20/05/53	**Escalation of Ward K25 – for ratification** • **The Board ratified the hire of K25 portacabin for up to 2 years from 6.04.2020 and the procurement of an alternative via capital during 20201-22 which had been previously reviewed, discussed and approved at the SEOG and NED Assurance Committee.**
BM/20/05/55	**Review of Scheme of Reservation and Delegation (SORD) and Standing Financial Instructions (SFIs)** This proposal had been reviewed, discussed and subsequently supported at Governance meetings that had been established during the COVID-19 pandemic, the Strategic Oversight Executive Group on 14 April 2020 and the NED Assurance Committee on17 April 2020. • **The Board ratified the amendment to the SoRD to allow the Director of Finance + Deputy CEO and Chief Executive Officer to approve COVID related capital.**
BM/20/05/56	**Compliance with Trust Licence** **The Board reviewed the Self-Certification and approved compliance with NHS Conditions General Condition G6 and Continuity of Service CoS7 of the NHS Provider Licence and publication on the Trust website**.

MATTERS FOR NOTING FOR ASSURANCE	
BM/20/05/56	**Guardian of Safe Working Q4 Report.** This report had been reviewed and discussed at the Strategic People Committee on 20 May 2020. • **The Board noted the report.**
BM/20/05/57	**Finance and Sustainability Committee Terms of Reference and Cycle of Business 2020-21** These documents had been reviewed, discussed and approved at the Finance and Sustainability Committee on 18 March 2020. **The Board noted the report.**
BM/20/05/58	**Staff Opinion Survey – key elements of 2019-20 staff survey** This report had been reviewed and discussed at the SPC on 18 March 2020 and reported to Trust Board 25 March 2020 in the Committee Chairs Assurance Report. MC highlighted the following to note: WHH was in 20% of acute organisations nationally for management of Equality, Diversity and Inclusion pre COVID pandemic resulting in support for ED&I agenda and measures to be put in place to enhance and improve current arrangements. The Chair invited questions for attendees: MB asked for update relating to use of side rooms and single rooms as the Trust moves into recovery phase and any difficulties anticipated. KSJ explained building of new side rooms and Supported Palliative Care unit (location to be determined) will support release of additional side rooms. Future considerations will include how to manage positive patients and support Supported Care Ward for End of Life Patients. COO is progressing a wider piece of work to look at the original footprint of all

D R A F T

	specialties and any changes in bed base to free up rooms will be managed through CBU leadership teams. Funding for Supported Care Ward (£1m) is within Capital Programme, to be approved by NHSE/I. PJ – referred to possibility of exploring potential opportunities with external manufacturing companies in production of plastic screens which had been successful at another Trust. PJ to discuss with colleagues outside of the meeting. CR referred to BAME bullying and harassment and if this was from staff, patients or a combination. MC explained the survey is a national survey conducted with the workforce only and is anonymous, however a comparison is undertaken of year on year data. MC acknowledged there is still significant work required to fully engage and support staff across all groups through networks currently in place, ie BAME Network, FTSU. Format of future NHS Staff Surveys to be confirmation, if it changes, organisations will be unable to compare year on year data for a longitudinal comparison. • **The Board noted the report.**
BM/20/05/60	**Personal Protective Equipment Report** **The Board noted the report.**
BM/20/05/61	**Annual SIRO Report** • **The Board approved the Terms of Reference and Cycle of Business which had been approved at the Audit Committee on 20 February 2020.**
	Any Other Business The Board approved delegated authority to Year End Audit Committee 17 June 2020 to sign off Annual Report and Final Accounts for 2019-20.
	Next meeting to be held: Wednesday 29 July 2020

Signed ………………………………………………………………… Date ……………………………………………………………….

Chairman ……..

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BOARD OF DIRECTORS

Pre-meeting Questions and Responses

Date of Meeting: 27 May 2020

Q1: COVID SitReport - ***Clinical Care update*** Page 26 0f 196 - I presume that bullet point 1 – ***SOP for endoscopy/laparoscopy to support Recovery*** is saying that a new SOP for endoscopy etc has been developed? But can we clarify that it has been signed off and it has agreed clinically?	**Proposer: Steve McGuirk, Chairman**

Answer Provided by: Dr Alex Crowe, Acting Executive Medical Director

I can confirm that Standard Operating Procedures (SOPs) for endoscopy/laparoscopy have been clinically agreed and signed off by Tactical Group meeting.

Q2: COVID SitReport - ***Clinical Care Update*** Does bullet point 5 - ***Advancing Quality Alliance Innovation Report; positive for clinicians-*** refer to the Aqua draft report shared last week? Can the next steps in terms of sharing the report be clarified? We mentioned a 'board session' to debate but presumably you would also want to share anyway?	**Proposer: Steve McGuirk, Chairman**

Answer Provided by: Kimberley Salmon-Jamieson, Deputy Chief Nurse and Deputy CEO

It does refer to the AQuA report and it forms part of the wider Governance work. There will be awareness and briefing sessions for all staff, delivery via CBU and Recovery Team, the report will be shared in the Quality Assurance Committee. It will be broken down in to a learning framework and this will be shared with the Board.

Q3: COVID SitReport - ***Clinical Care update*** For clarity, please clarify the meaning of the final bullet point – *Anticipated 'Drive Through'* ***ambulatory ECG monitor*** *service*	**Proposer: Steve McGuirk, Chairman**

Answer Provided by: Dr Alex Crowe, Acting Exec Medical Director

This is a clinical service in cardiology to assess patients who have history to suggest potentially abnormal heart rate/rhythm and to fit patients with a 24 hour or 7 day monitor to assess heart rate/rhythm further.

Q4: COVID SitRep - Operational and Estates 2. Page 27 of 196. Can we be clear whether our goal is to have outpatient consulting - by default - video consultation? It is appreciated it is not always going to be possible.	**Proposer: Steve McGuirk, Chairman**

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Answer Provided by: Dan Moore, Director of Operations and Performance

The ambition is, where appropriate, to have a virtual review (either telephone or video) as the primary method to undertake a safe patient consultation. The feedback from clinicians to date has been overwhelmingly positive. Early patient feedback has also indicated support for the use of virtual appointments. As suggested by the question, a virtual appointment might not always be appropriate and therefore work is underway to ensure the outpatient service can safely accommodate face to face appointments when required

Q5: COVID SitRep – Patient Safety and Experience Page 28 of 196 - bullet point 8 – ***CNST Safety Action – Digital Maternity Record Standard – Current DXC target is Lorenzo version 2.49 due to be deployed 23 October 2020 -*** what do “CNST’ and ‘DXC’ stand for? The same point is also repeated on Page 29 of 196 – Does this mean that there is an upgrade to Lorenzo required in order for us to meet the new maternity standard and that the upgrade is scheduled for October? Is this on track and within the existing budget or attributed to COVID-19?	**Proposer: Steve McGuirk, Chairman**

Answer Provided by: Phill James, Chief Information Officer and Kimberley Salmon-Jamieson, Deputy Chief Nurse and Deputy CEO

Yes an EPR upgrade is required and the target date is based upon current supplier responses. COVID is not anticipated to delay this upgrade and it is within current EPR budgets.

Lorenzo 2.19 will need to be active and in place by 23rd October 2020, for tracking Continuity of Carer or the required trajectory will be missed.

CNST is the **C**linical **N**egligence **S**cheme for **T**rusts, in this instance related to Maternity services. (https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/).
Thus the dataset we are being asked to capture and submit is aimed at monitoring how safe our Maternity services are, i.e. *“supports the delivery of safer maternity care through …. trusts contributions to the CNST”.*

DXC is the name of our Lorenzo Electronic Patient Record supplier (www.dxc.com)

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BOARD OF DIRECTORS ACTION LOG

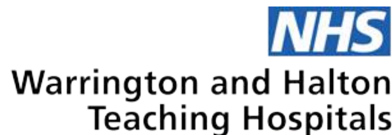
AGENDA REFERENCE	BM/20/07/65	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	29 July 2020

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
EBM/20/04/14	29.04.2020	COVID-19 Update - Service Change Forms	Service Change Report to July QAC	**Chief Nurse & Deputy CEO**	**Board 29.07.2020**		To be reported through QAC Committee Assurance Report to July Board.	

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/20/01/10	29.01.2020	Digital Strategy	Medical Electronic Handover presentation to future QAC and reported to Board through Key Issues	**Executive Medical Director**	**QAC 04.08.2020 Board 30.09.2020**		25.032020 Date for presentation to QAC to be confirmed. Action on hold due to COVID-19 Pandemic. 15.07.2020 update received at August QAC, to be reported in Committee Assurance Report in September.	
BM/18/07/57	26.05.2020	Junior Doctor/Trainee Engagement update Trello)	6 mth update presentation.	**Executive Medical Director + CCIO**	**Paused nationally 2020, date TBC**		14.01.2019. Deferred to March 27.03.2019. Referred to future BTO 29.05.2019. Update to September Board to include results from GMC survey results. 06.09.2019. Deferred to November Board due to deferred HEE visit. 18.11.2019. Deferred to January Board due to HEE visit. 13.01.2020 Date of HEE visit still to be confirmed. 9.03.2020 HEE visits cancelled	



							on 3 occasions. HEE visit confirmed for 22.5.2020. Verbal update to May Board 27.05.2020 Visit cancelled. HEE visits paused due to COVID, future date to be confirmed	
BM/20/05/49	27.05.2020	IPR – People	Reduction strategy, to future SPC and QAC and reported through Committee Assurance Reports	**Chief People Officer**	**Date TBC**			

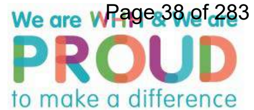
3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/20/01/07	29.01.2020	IPR Dashboard – Quality indicators	Board to be updated on Ecoli benchmark findings via QAC Key Issues Report	**Chief Nurse & Deputy CEO**		**July 2020**	25.03.2020. Action on hold due to COVID-19 Pandemic. Report to QAC 032020 ADIPC is the Acute Trust representative on the GNBSI/Sepsis/HCAI/IPC Programme Board for C&M Acute Trust Targets not published due to Covid-19 National target of 25% reduction by 2021 and 50% reduction by 2024 Trust GNBSI reduction Action Plan revised and submitted to ICSC in July 2020.	
BM/20/01/07	29.01.2020	IPR Dashboard – Quality indicators	IPR to be amended to show trend line for WHH for CDiff cases and unavoidable cases signed off by the CCG.	**Chief Nurse & Deputy CEO Chief Finance Officer & Deputy CEO**			25.03.2020. Action on hold due to COVID-19 Pandemic. In progress – CDT CCG meetings on hold throughout Covid-19 20 cases outstanding for review from 2019/2020 CCG CDT Review Panel Meetings date to be reconvened in August.	

BM/20/05/51	27.05.2020	BAF and Strategic Risk Register	Risk relating to delay of electives/recovery and impact of public confidence to be considered at Risk Review Group 29 May 2020.	**Trust Secretary**		**29.05.2020**	Added to current BAF on today's agenda..	

RAG Key

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



REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/20/07/66			
SUBJECT:	**Chief Executive's Briefing**			
DATE OF MEETING:	29th July 2020			
AUTHOR(S):	Simon Constable, Chief Executive			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: *(Please select as appropriate)*	SO1 We will…Always put our patients first through high quality, safe care and an excellent patient experience. ✓ SO2 We will…Be the best place to work with a diverse, engaged workforce that is fit for the future. ✓ SO3 We will...Work in partnership to design and provide high quality, financially sustainable services. ✓			
LINK TO BAF RISK:	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

SUBJECT	Chief Executive's Briefing	AGENDA REF:	BM/20/07/66

1) BACKGROUND/CONTEXT

This report provides the Trust Board with an overview of matters on a range of strategic and operational issues since the last meeting on 27th May 2020, some of which are not covered elsewhere on the agenda for this meeting.

2) KEY ELEMENTS

2.1 Briefings shared with the Board since the last meeting

There have been no new briefings since the last meeting.

2.2 Key issues

2.2.1 Current COVID-19 situation

As at the time of writing, 22nd July 2020, we have a total of 9 COVID-19 inpatients at WHH – 6 fewer than one week previously; 8 of these 9 patients have been retested during their stay and are now COVID-19 negative, which makes the current swab-positive number of COVID-19 positive inpatients actually 1.

Since March, we have performed 12004 COVID-19 tests on patients; 1192 have been positive in total. We have discharged a total of 381 patients with COVID-19 to continue their recovery at home. Sadly, a total of 136 patients have died in our care. No patient has died with COVID-19 in our hospitals since 9th July 2020.

Since March, we have performed 1424 COVID-19 tests on staff; 387 have been positive in total (this will include repeat tests). We have completed 411 BAME Risk Assessments (100%) with a Quality Assurance process also now complete. We have also launched an online risk assessment process for all staff. This starts with a self-assessment.

In terms of PPE stock, based on estimated current usage, we have 145 days' worth of FFP3 masks, 12 days' worth of Fluid Resistant Surgical Masks, 95 days' worth of gowns, 27 days' worth of gloves and 7 days' worth of aprons. Mutual aid with other C&M/NW organisations is available, in both directions.

2.2.2 Staff COVID-19 Antibody testing

We started rolling out our COVID-19 antibody testing programme for both staff and patients on 29th May, and since then 4458 members of staff (and volunteers) have been tested, and of those 16.5% have tested positive, in keeping with the Cheshire & Merseyside position overall for NHS staff. The significance of a positive result is uncertain. There is no strong evidence yet to suggest that those who have had the virus and have antibodies detected develop long-lasting immunity which would prevent them from getting the virus again. It does not change clinical management and must not change our behaviour with PPE or social

distancing. Antibody testing at this stage is useful primarily to improve our understanding about the virus, and therefore at this moment in time it is predominantly a research tool.

WHH has been serviced by both our own laboratory and Liverpool Clinical Laboratories, using Roche testing kits at the present time, with our own lab taking over fully.

2.2.3 Recovery Care Groups

On 1st June 2020 the Recovery Care Groups were formed to focus on operational recovery from the unprecedented effects of COVID-19.

The Planned Care Group objectives are:

- Restarting elective surgery – with all the safety processes required to enable this
- Develop an Elective Centre – increase surgical capacity on the Halton site with dedicated 'green' pathways
- Brilliant basics – ensure governance processes and performance measures are embedded and compliant to provide assurance of safe, quality care

The Unplanned Care Group objectives are:

- Bed reconfiguration
- Emergency Department capacity and flows
- Winter planning

Patients need to be able to trust that it is safe to come into hospital for surgery and it is key that we have the processes and pathways in place to instil this confidence. We started a 'green' pathway on B18 for urgent elective cancer patients at Warrington. This involves a designated 'green' theatre and recovery area. Since May, 150 patients have been cared for via this 'green' pathway. Work has begun to mirror this service within the CMTC at Halton (the now renamed Captain Sir Tom Moore Building, or TMB for short) for patients who require Trauma & Orthopaedic and Breast surgery. Confidence in the system has been demonstrated by patients themselves and the surgical teams caring for them. Patient and public involvement will be factored in to ensure that we are optimising our patient experience as we develop the Halton elective programme further.

Each service has to complete a recovery proforma detailing all aspects of the impact of switching the service back on. Progress so far includes Endoscopy, Trauma & Orthopaedic ambulatory, Trauma & Orthopaedic elective and outpatients. Also general surgery outpatients, oral surgery, orthodontic surgery, Audiology and Ophthalmology services. Moving forward, the Planned Care Group are in the midst of the development of a 4 bed Post Anaesthesia Care Unit (PACU) at TMB (CMTC) which will provide Level 1.5 Enhanced Care to enable patients with a higher anaesthetic risk to have their surgery there. There is also the commencement of elective surgery for Urology and ENT patients at TMB (CMTC), and the restart of paediatric elective surgery, Chronic Pain service and gynaecological surgery.

We undertook a bed reconfiguration at Warrington in the week commencing 13th July. This will support our patients being admitted to the right bed with the right medical and nursing input thus improving their patient experience whilst they live with us. The key changes are

– A9 is now a medical ward, B18 cares for our elective patients as they recover from their surgery in a COVID-secure environment as described above, A6 is our trauma and orthopaedic ward and C21 cares for our patients who are medically optimised for discharge.

2.2.4 Ward B1 at Halton Hospital

The Trust has worked closely with partners in primary, community and social care throughout the pandemic with long stay patients (ie those with a length of stay of >21 days) falling to an all-time low of 40 before settling at around 60 patients. This is a reduction of over 50% from the worst days in the Trust's year and provides a significantly enhanced experience for patients through this integrated working.

There is intermediate ('step down') care provision at Halton's ward B1 which is commissioned by Halton Borough Council and jointly funded by the Borough Council and NHS Halton Clinical Commissioning Group. Over recent weeks, thanks to this integrated working, the Halton commissioners have been able to free up additional capacity within community and home-care services with an emphasis on home-based re-ablement.

At time of writing there are no patients on B1 and staff are consequently being temporarily reassigned to support other wards. The plans for the long term, including the coming winter, are being discussed as part of winter-planning. As described above, Halton Hospital development features very heavily in the Trust's operational recovery plans and we are keen to make best use of our ability to separate patient flows across our two sites.

2.2.5 Pilot Projects – NHS111 First and Elective Surgery Home Testing

We have signed up as a Trust to be pilot sites to try out national initiatives before they are rolled out across the country.

The first is the Elective Surgery Home Testing Pilot. Elective patients will need to self-isolate before their procedure and be tested for COVID-19 within 48-72 hours of their procedure. To avoid them having to leave home and get a test elsewhere the protocol is that they book a home test online, have it delivered and collected and then come in and have their procedure when the result is available. We are one of first 7 trusts across the country participating in the pilot.

The second pilot is for non-elective emergency patients needing to access urgent and emergency care, including our ED. Three NW trusts are doing this with North West Ambulance Service; we are the only trust in Cheshire and Merseyside taking part in the NHS111 First Pilot, aiming to smooth out the peaks and troughs of patients coming to hospital but also making sure they go to the right place first with full access to hot clinics and assessment areas as well as booked appointments in the Emergency Department itself.

2.2.6 COVID-19 Clinical Research at WHH

It was announced in June from the RECOVERY clinical trial, based at the University of Oxford, that treatment with the low-cost steroid drug dexamethasone reduces death by up to one third in hospitalised patients with severe respiratory complications of COVID-19. Among participants receiving oxygen alone, the risk of death was reduced by 20%, and among participants receiving ventilation on ITU the risk of death was reduced by 35%.

In March of this year, the RECOVERY trial was established as a randomised clinical trial to test a range of potential treatments for COVID-19, including low-dose dexamethasone. Over 11,500 patients have been enrolled so far from hospitals all over the UK. WHH has been one of those hospitals – we enrolled our first patients on 21st April. On 8th June, recruitment to the dexamethasone arm was stopped since, in the view of the trial Steering Committee, sufficient patients had been enrolled to establish that the drug had a meaningful benefit.

These results are very significant. They have immediate implications around the world for the clinical treatment of many thousands of patients currently in hospital receiving oxygen. Such treatment will be recommended as standard care for hospitalised patients with COVID-19 receiving oxygen.

I am delighted that we have mobilised all that we can as a Trust to participate in this study, and I am grateful to all of those involved from the clinical teams, our clinical research team here, as well as Pharmacy.

2.2.7 Financial position

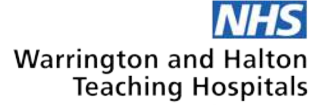
We were pleased to report a financial position of breakeven at the end of June. This was helped of course by the write off of our historic debt that came with the major financial reset of the NHS announced in the Spring as well as the top-up of COVID-19 expenditure that came with the request for us to do the right things for our patients and staff and not let financial constraints inhibit us doing this. We also got cash support to make sure we could pay our suppliers promptly. We were able to pay 95% of our suppliers promptly by the end of May, compared with only 34% at the end of March.

In terms of capital money for improvements in our facilities and equipment over the last few months, we have ordered smaller schemes and items to the value of £2.8m, and have requested approval for a further £1.8m. We are still awaiting decisions on bigger schemes designed to make us fitter for COVID-19 as we try and do normal work alongside playing 'catch up' in the midst of managing an infectious disease. In addition to our business-as-usual capital programme this year, these pending funding requests total £12.2m including developments for Halton and an Assessment Plaza at Warrington.

2.2.8 Senior Leadership Team Changes

On 29th May I was delighted to announce that after approximately six months in an 'acting' role, and following a competitive selection and appointments process that concluded on 28th May, Dr Alex Crowe was appointed as our Executive Medical Director. Dr Anne Robinson has been appointed as Deputy Medical Director.

Our Chief Operating Officer, Chris Evans, will leave us in September to join Portsmouth Hospitals NHS Trust as their Chief Operating Officer. While we are naturally disappointed to lose Chris, this is a fantastic achievement for him as he joins a significantly bigger trust, looking after a patient population of nearly 700,000 including hosting the largest of the UK's four military hospital units.



Daniel Moore, Director of Operations & Performance (Deputy COO), will become Acting Chief Operating Officer from the time of Chris' departure until further notice. In line with our well established succession plans, there will be a seamless handover and transition which will commence over the coming weeks. 'Backfill' arrangements for Dan's role as Director of Operations & Performance have already commenced.

2.2.9 Local political leadership communication

Over the last few months both the Chairman and myself 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. This is extremely important and helpful in the whole system response to the pandemic. I have also been in regular dialogue with all four of our local Westminster MPs – Derek Twigg MP (Halton), Mike Amesbury MP (Weaver Vale), Charlotte Nichols MP (Warrington North) and Andy Carter MP (Warrington South). I have been updating them on the WHH situation; similarly they have asked me questions on behalf of their constituents, and asked if they could do anything to assist us.

All have, unanimously, asked me to pass on their sincere thanks and good wishes to staff. Both Warrington MPs have also recorded this recognition and thanks in speeches made in various debates in the House of Commons in late June, as well as paying special tribute to Jo Habab.

2.2.10 Our Buildings

The ambition is for Kendrick Wing, in the wake of the fire two years ago, to become a dedicated management suite and administrative building with staff welfare, training and development part of its remit. It is a great building in many ways – and we cannot do without it - but it is not suited to 21st century patient care. Clinical services have already got (or will have soon) plans for relocation into other parts of our hospitals in due course.

This month I have also announced the renaming of the two hospital buildings on the Halton campus. As described above we have recommenced our planned care programme at Halton and the renaming is linked to the further development of Halton Hospital as an elective site, with more procedures carried out in what is deemed a 'COVID-secure' environment.

The Cheshire and Merseyside Treatment Centre (CMTC), our best and most modern piece of estate that we have at this time, will be known as the 'Captain Sir Tom Moore Building', honouring the centenarian who raised over £30m for NHS charities during the pandemic. The General Hospital building will be known as the 'Nightingale Building' in honour of the world's most famous nurse who celebrates a bicentennial anniversary in 2020 - the WHO Year of the Nurse and Midwife. These names were selected by staff in an online poll, with Captain Tom and Florence emerging as the most popular choice. The Captain Tom Foundation was approached for permission, and this was graciously given.

It is entirely appropriate that we are honouring two different individuals who have done so much in such unique ways. Their names will be forever associated with a positive human spirit in 2020.

2.2.11 A legacy for Jo Habab

In consultation with Jo's wife Michelle and son Dylan, as well as Jo's close friends and colleagues, we will ensure Jo Habab has a lasting legacy at WHH through the creation of a training and development fellowship as well as a dedicated clinical simulation suite named after him in a new clinical training facility in Kendrick Wing. We will continue to invest in clinical simulation as a means of learning new clinical skills and keeping them up-to-date in a team environment, and it seems absolutely perfect that Jo's name will live on in something that is in keeping with his role and approach to multi-professional learning and development over many years.

2.2.12 Award Nominations

We have been nominated for a number of awards. The prestigious Health Service Journal (HSJ) Patient Safety Awards celebrate the teams and individuals within the healthcare sector who are striving to improve hospital care in a number of ways. The ceremony will be held virtually in November this year. The annual awards are an opportunity for trusts to showcase their work at a national level on driving patient safety improvements. We have been shortlisted in the following three categories:

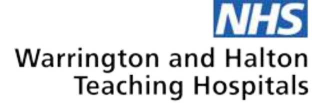
- Deteriorating Patients and Rapid Response Systems Award: 'THINK Delirium in Intensive Care'
- Service user engagement award: 'Hearing those hard to reach voices: using social media as a platform for engagement'
- Urgent and Trauma Care Safety Initiative: 'The Introduction of a Thoracic Injury Pathway to a Major Trauma Unit' and 'Improving patient safety by reducing length of stay in the Emergency Department'

We have also been shortlisted by the London Business School for the Innovation in Diversity award, a new category for 2020 in the COVID-19 pandemic for enterprises that rapidly repurposed existing assets or reconfigured their organisations to meet an urgent societal need, that radically changed their business model to survive the crisis or that mobilised to fill a new opportunity created by the crisis. Our innovative use of CPAP (continuous positive airway pressure) devices at scale on ICU, the 'black boxes' featured on Sky News a couple of months ago, has been nominated.

Finally, we have been nominated for a Patient Experience Network (PEN) Award for our volunteer-led Shared Reading programme enhancing patient experience as an integrated part of the Dementia 'Forget Me Not' ward, wards primarily associated with care of the elderly or children, and for those living with long term conditions such as cancer or living with the impact of a stroke.

I am especially delighted that all of these projects collectively touch all three key domains of quality of care – patient safety, clinical effectiveness and patient experience – and so many parts of the Trust in one way or another.

2.2.13 Retirements of longstanding employees



I have had the pleasure of attending two retirement events recently for members of staff with extremely long service; I have been able to officially wish very happy and healthy retirements to Marcia Anthony from Estates & Facilities and Margaret Hughes from the Bereavement Office on their very last day in the Trust. Between them they have had very nearly 100 years of long and varied careers in WHH. There are lots of words to describe such longevity – commitment, dedication and persistence amongst them. It was my privilege to thank them both and wish them well.

2.2.3 Employee Recognition

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

Chief Executive Award (May 2020): Microbiology Team

On 27th May I presented the Microbiology Team a Chief Executive Award for the pivotal role of the whole team (clinical and laboratory staff) in the ongoing WHH response to the COVID-19 pandemic. This has been an exceptional performance by the whole team at a very challenging time.

3) MEETINGS ATTENDED/ATTENDING

The following is a summary of key external stakeholder meetings I have attended since the in June and July 2020 since the last Trust Board Meeting (meetings generally taking place via conference call or MS Teams). It is not intended to be an exhaustive list.

- NHSE/I COVID-19 Telephone calls (Weekly)
- Warrington & Halton COVID-19 System Assurance Meeting (Weekly)
- C&M CEO Provider Group Calls (Biweekly)
- C&M Medical Directors Clinical Prioritisation & Mutual Aid meeting (Weekly)
- NHS 111 Oversight Group (Biweekly)
- Update calls with our local MPs: Andy Carter MP, Charlotte Nichols MP, Derek Twigg MP, Mike Amesbury MP
- David Parr, Chief Executive, Halton Borough Council
- Bed Capacity Planning NHSE/I (ad-hoc)
- NW Mortality Cell (weekly)
- Restoration Plan, Ann Marr, C&M Hospital Cell CEO Lead
- Health & Wellbeing Work Stream – Stronger Towns
- Warrington Health & Wellbeing Board
- Steve Broomhead, Chief Executive, Warrington Borough Council
- Dr Andy Davies, Clinical Chief Officer, NHS Warrington and Halton CCG

4) RECOMMENDATIONS

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

Summary of board papers – statutory bodies

Care Quality Commission board meeting: 15 July 2020

For more detail on any of the items outlined in this summary, please find the full agenda and papers available online.

Chief executive update:

- From September the CQC will be introducing a transitional methodology. This will draw on the 5 key questions it asked previously but will be much shorter. It will involve some visits and some remote assessment of data. This methodology will make use of the new technology platform the CQC created during COVID-19. The intention is to reduce the burden of things such as data provision.
- Frequency of inspections and type of rating system has not been decided yet, but the CQC are preparing to engage with public and provider groups over the autumn.
- CQC is slowly returning to business as usual but will continue to support local providers and systems who experience local lockdowns.

Chief inspector of hospitals

- The hospital inspections team undertook 12 onsite risk-based inspections in June. Trust reports due in June are:
  - East Kent Hospitals University NHS Foundation Trust
  - Torbay and South Devon NHS Foundation Trust
- The results of the adult inpatient survey were published on 2 July. The survey involved 143 NHS acute and NHS foundation trusts in England, who deliver adult inpatient services. At a national level, the survey results show that overall, most people had a good experience of inpatient care. Confidence and trust in doctors remained high and more people said they were treated with dignity and respect during their hospital stay.

Provider collaborative review programme

- The CQC aim to review each of the 43 system areas responses (ICS/STP) to COVID-19 through quarterly phases of PCR programme activity, and to identify where provider collaboration has worked well and to draw out details of best practice and innovative approaches.

Health Education England board meeting: 21 July 2020

For more detail on any of the items outlined in this summary, please find the full agenda and papers available online.

HEE Global Engagement - Executive Task and Finish Group: Final Report

- The task and finish group agreed the scope of HEE's work on Global Engagement should always be connected explicitly to the objectives of the NHS and linked to wider global policy context. The purpose of the project is to strengthen the health systems in England, working with partners to attract, educate and train an international health workforce.
- HEE want to ensure all activity is mutually beneficial and leads to more sustainable health systems in England and across the world. HEE aim to do through technical collaboration with other countries, ethical international recruitment programmes to address staff shortages in the NHS, and to increase the number and quality of global learning opportunities for NHS staff and learners.

HEE restart update

- HEE's Restart Programme refocuses HEE on priorities interrupted by the Covid-19 pandemic, whilst ensuring the organisation can learn from the experiences and challenges of the pandemic.
- HEE is working with partners to support the pandemic response through student volunteering, assessing the impact on completion, registration and progression and assessing the impact of COVID-19 on the pipeline of NHS professionals.
- HEE data shows that, at worst, 70% of nursing and midwifery students will complete on time.
- HEE are investing £10m in clinical placement expansion for programmes including nursing, midwifery, and AHP.
- HEE are supporting ICSs through 'System By Default', including Restoration and Recovery Planning; ensuring the key constraint of workforce and education capacity for future supply are factored into service planning

REPORT TO BOARD OF DIRECTORS

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="4">BM/20/07/68</td></tr>
<tr><td>SUBJECT:</td><td colspan="4">COVID-19 Performance Summary</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="4">29th July 2020</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="4">Dan Birtwistle, Deputy Head of Contracts & Performance</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="4">Simon Constable, Chief Executive</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:

(Please select as appropriate)</td><td colspan="4">SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. — x
SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. — x
SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services. — x</td></tr>
<tr><td>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):
(Please DELETE as appropriate)</td><td colspan="4">1126 – Failure to provide the required levels of oxygen for ventilators caused by system constraints, resulting in a lack of adequate oxygen flow at outlets.
1134 – Failure to provide adequate staffing caused by absence relating to COVID-19, resulting in resource challenges and an increase within the temporary staffing domain.</td></tr>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="4">The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily COVID-19 Executive Summary which outlines key information pertinent to the command and control of the situation. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where possible. This is the fourth iteration of this report which is part of the continuing development of understanding of demand, capacity and outcomes that will determine future strategic planning. Data up to 25th July 2020 is included. The report has been refreshed in line with the development of the COVID-19 Executive Summary.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval</td><td>To note
X</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to:
1. Note the contents of this report.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3">Choose an item.</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="3"></td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="3"></td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="3"></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="4">None</td></tr>
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Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

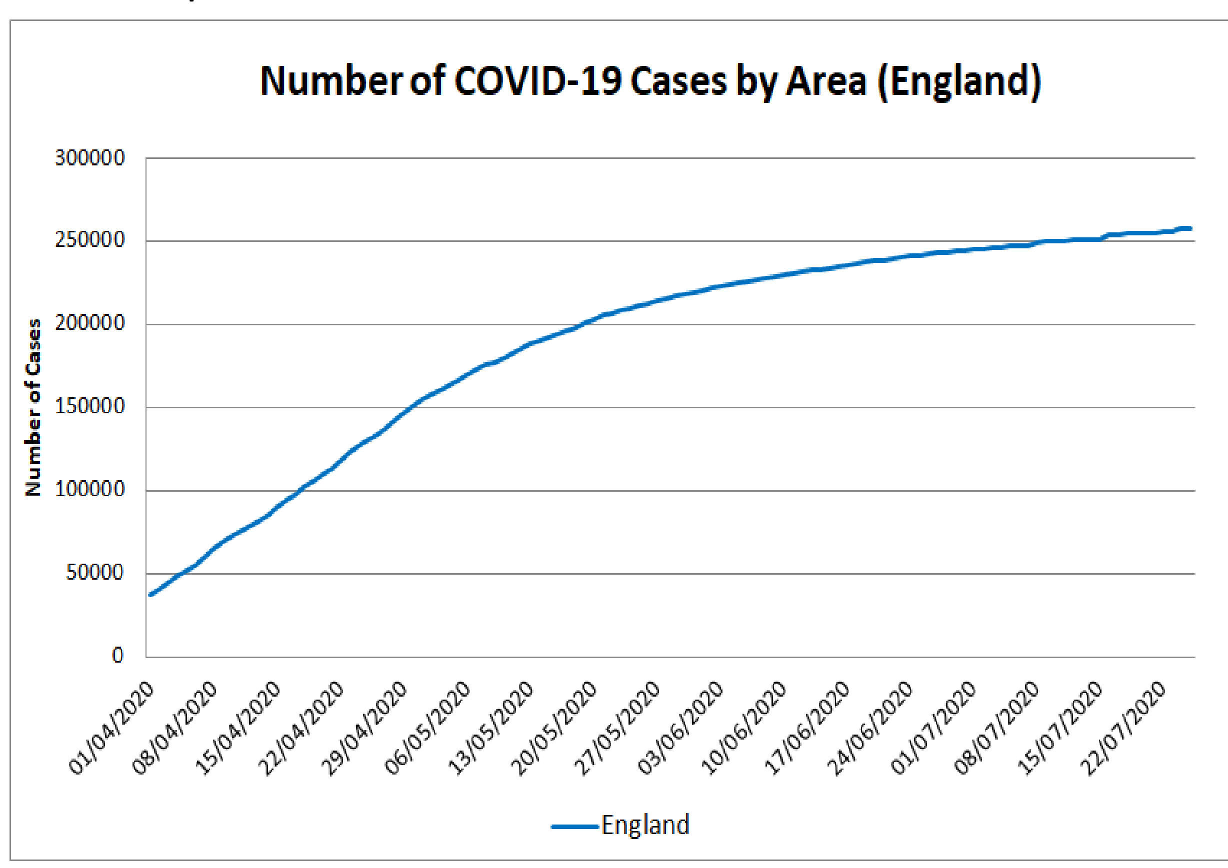
SUBJECT	COVID-19 Performance Summary	AGENDA REF:	BM/20/07/68

1. BACKGROUND/CONTEXT

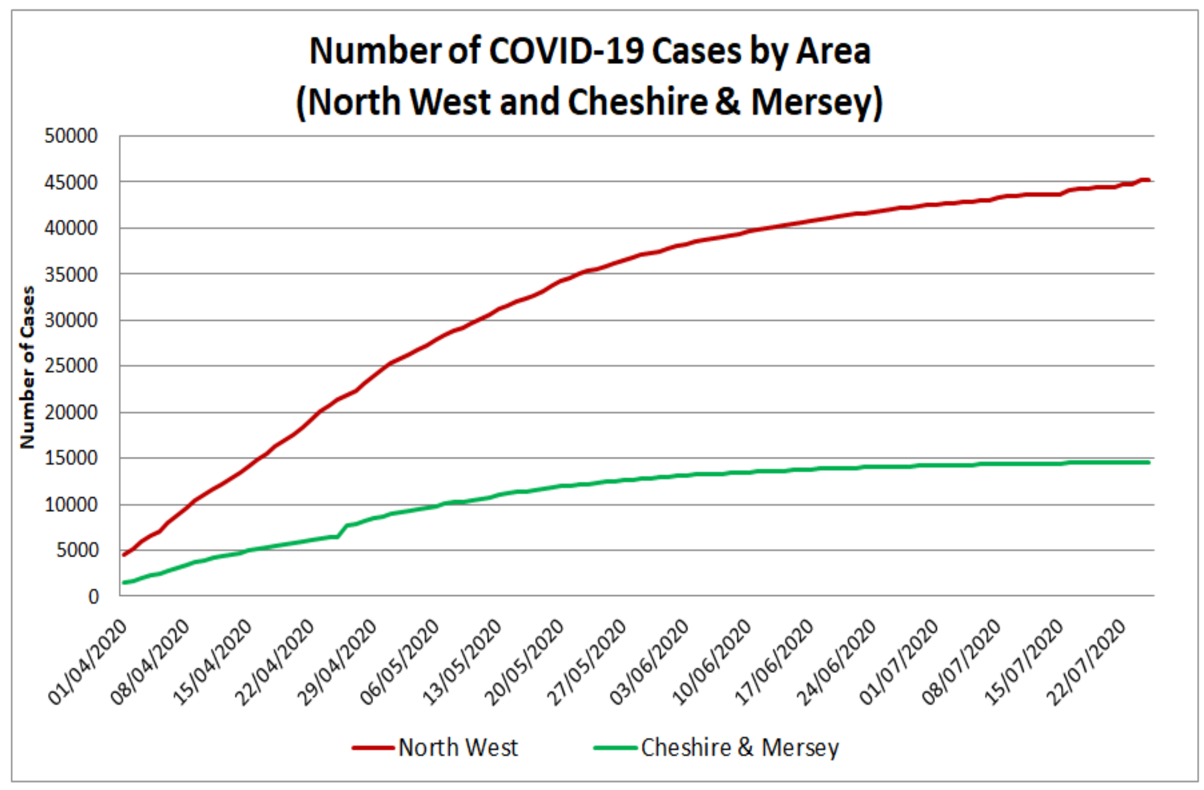
The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily COVID-19 Executive Summary which outlines key information pertinent to the command and control of the situation. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where possible. This is the third iteration of this report which is part of the continuing development of understanding of demand, capacity and outcomes that will determine future strategic planning. Data up to 25th July 2020 is included. The report has been refreshed in line with the development of the COVID-19 Executive Summary.

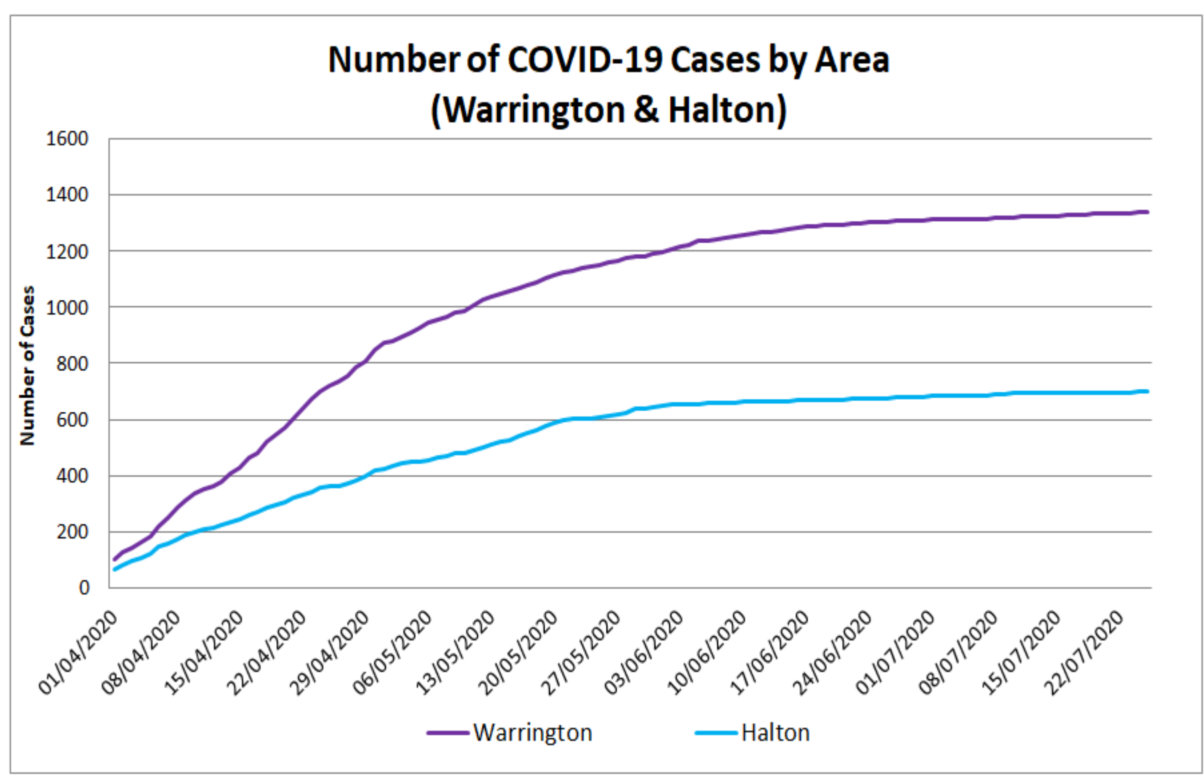
2. KEY ELEMENTS

Number of Reported Cases



NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

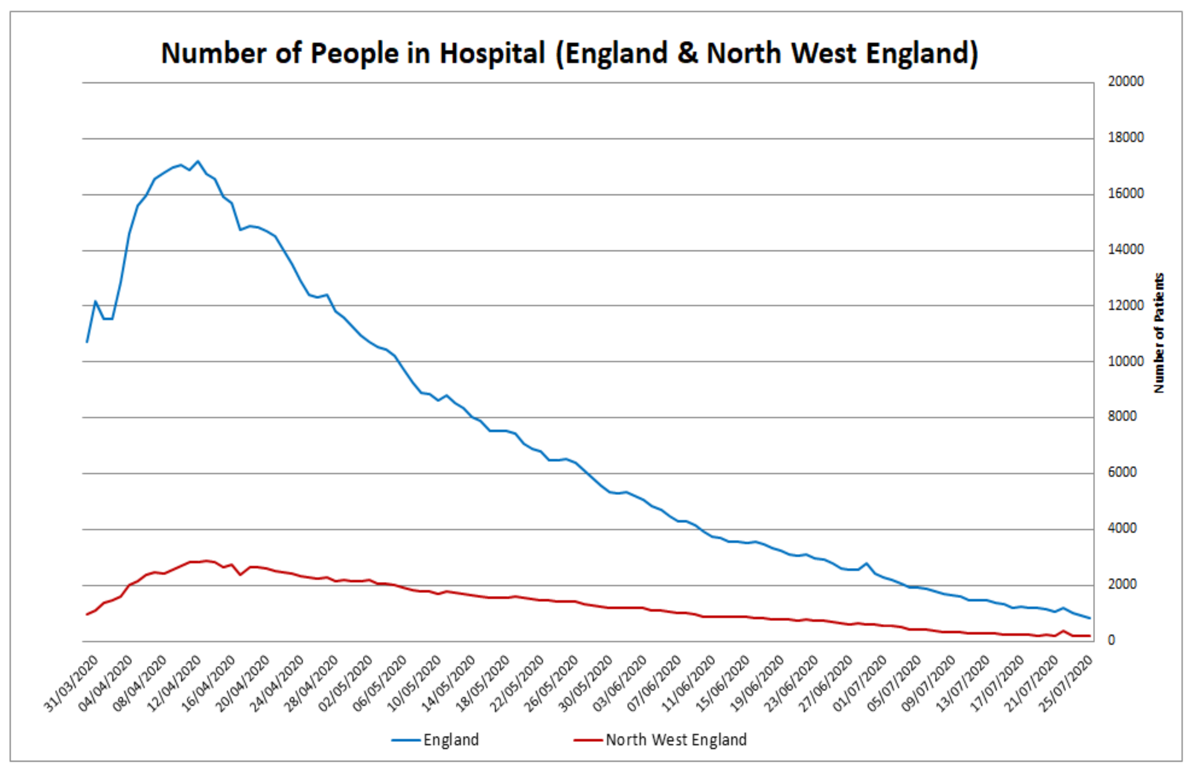


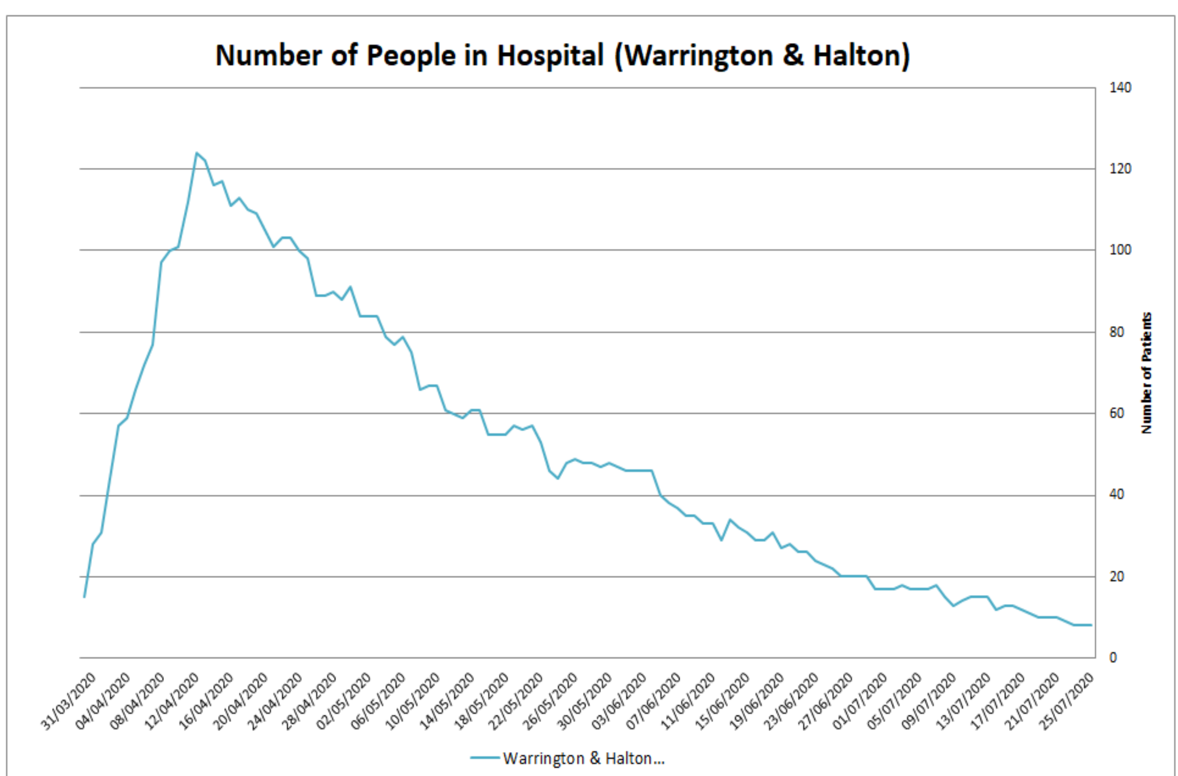


Narrative: As of 25/07/2020, there were 1338 cases of confirmed COVID-19 reported in Warrington and 698 cases reported in Halton. The trend is in line with the National, North West and Cheshire & Merseyside positions.
Source: https://coronavirus.data.gov.uk/

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Number of People in Hospital

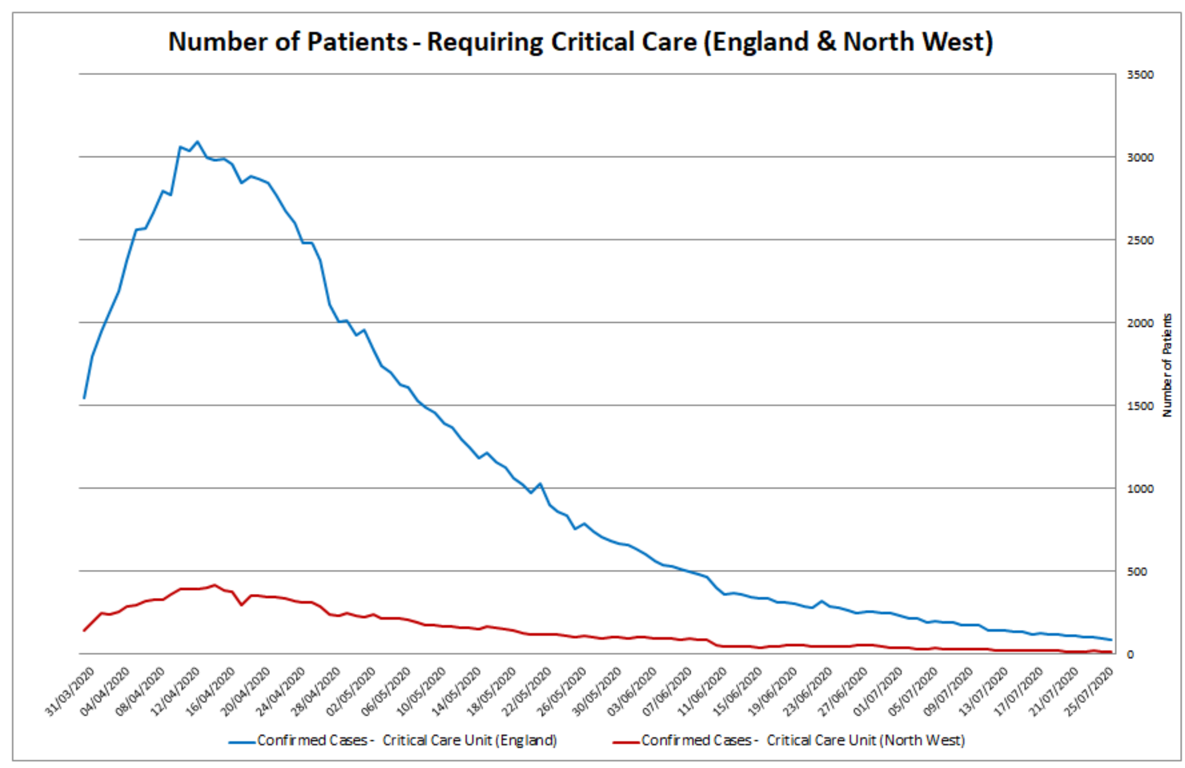


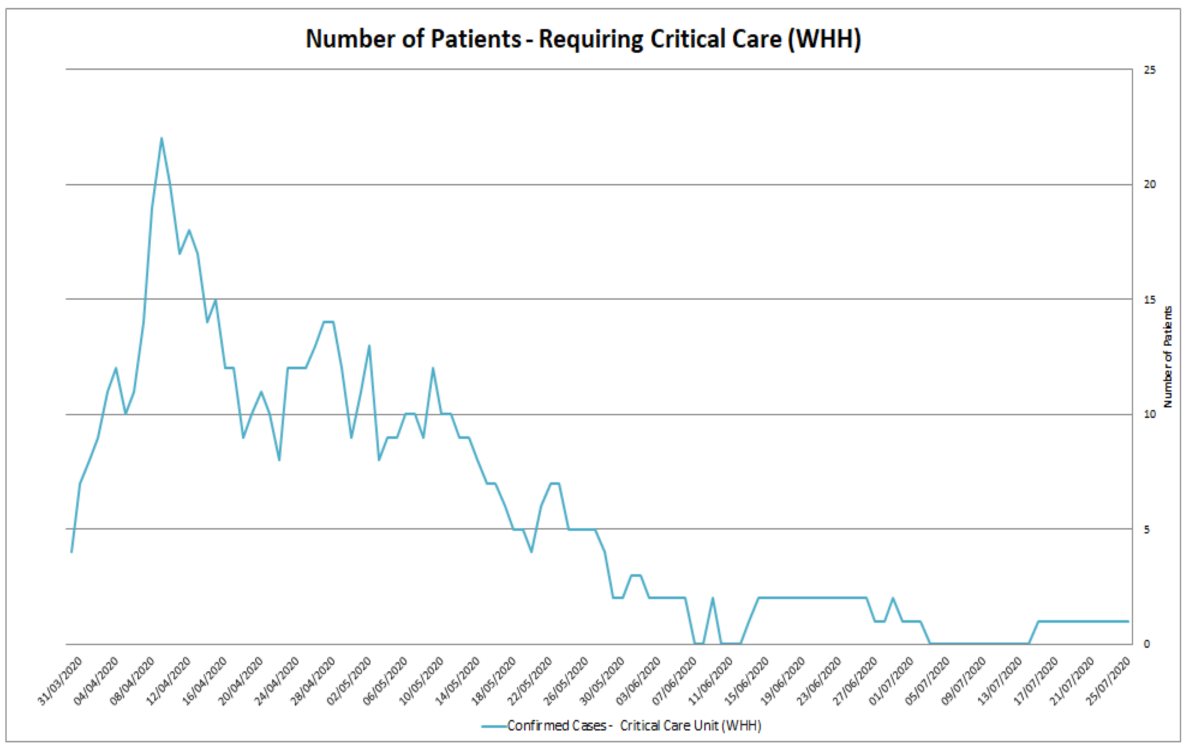


Narrative: As of 25/07/2020, there were 8 inpatients being treated by the Trust with confirmed COVID-19. The peak came on 12/04/2020 with 124 inpatients. The reduction is in line with the National and North West positions.

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

Number of Patients Requiring Critical Care

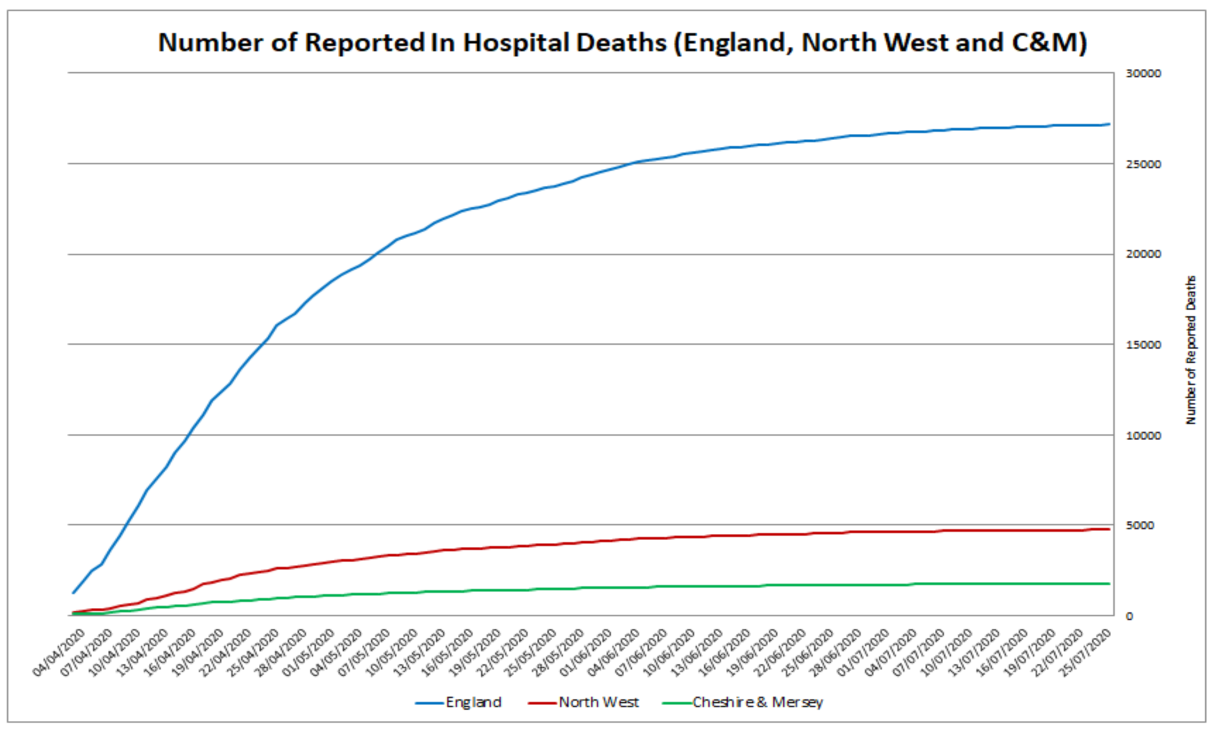


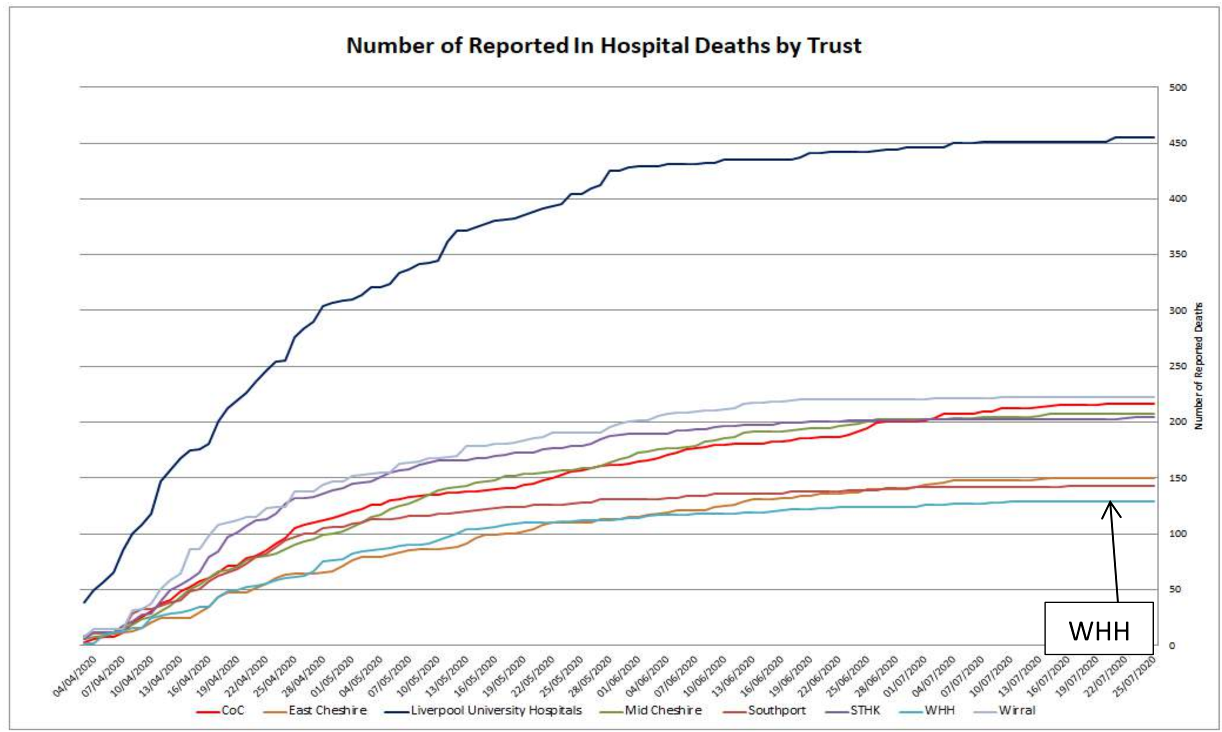


Narrative: As of 25/07/2020, there was 1 inpatient with confirmed COVID-19 and 0 inpatients with suspected COVID-19 in critical care. The Trust saw a peak of 22 patients on 09/04/2020. The reduction is in line with the England & North West positions.

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

Number of In-Hospital Deaths





Narrative: As of 25/07/2020, the Trust had reported 136 deaths of inpatients with confirmed COVID-19. The trend is in line with the North West and Cheshire & Mersey positions. From 02/03/2020 – 25/07/2020, the Trust recorded 432 inpatient deaths in total (all causes). Between March – July 2019, the Trust recorded a total of 428 deaths (all causes).

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

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

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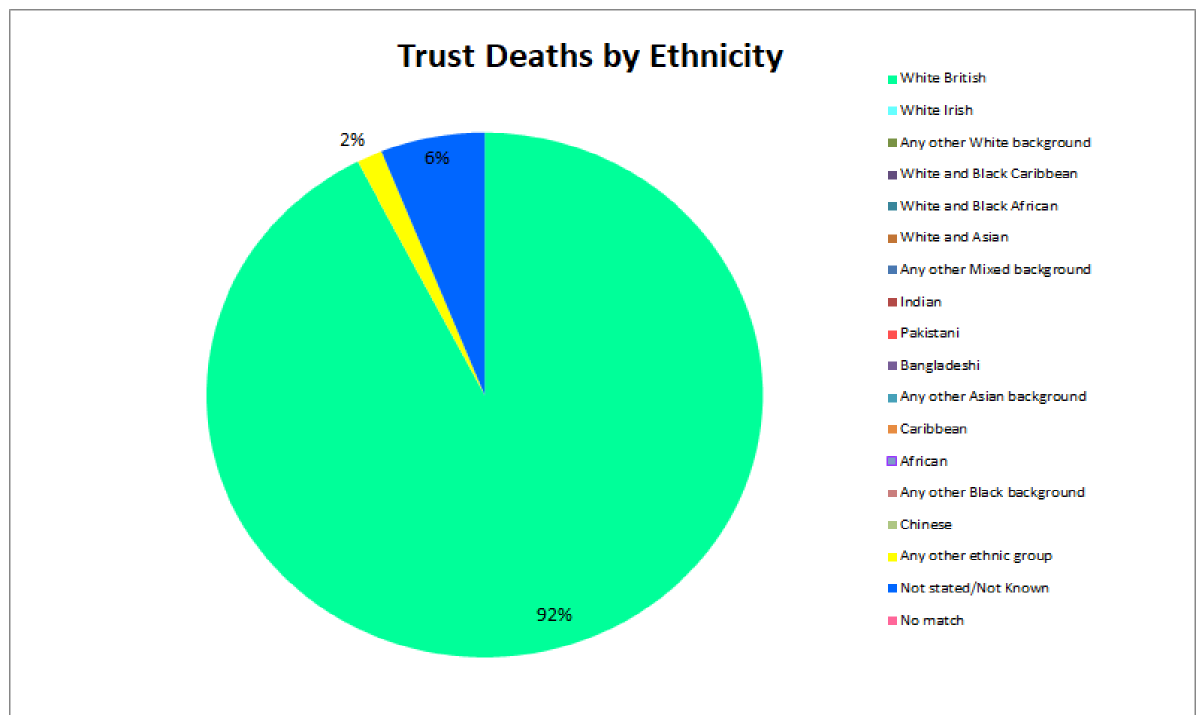
NHS Foundation Trust

Number of In Hospital Deaths (Ethnicity)



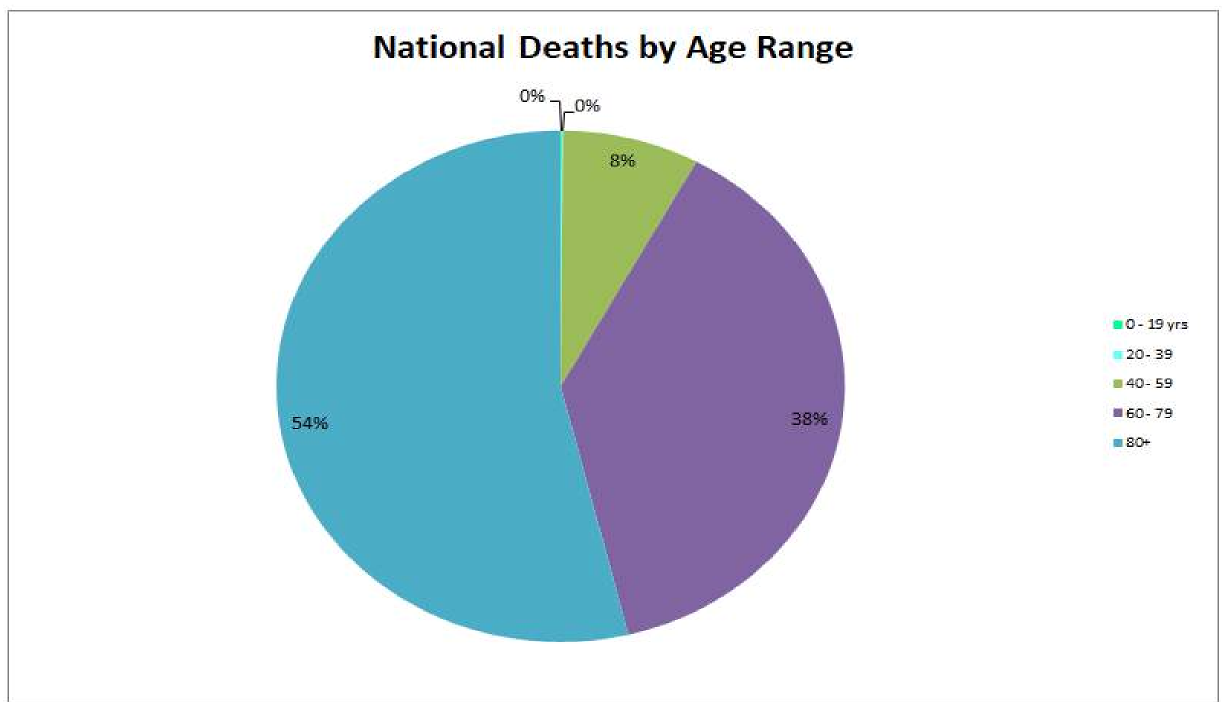
Narrative: As of 25/07/2020, 125 of the 136 reported deaths were patients who identified as "White British", with 8 patient's ethnicity "Not Stated" and 3 patient's ethnicity stated as "Any Other Mixed Background". The proportion of White British patient deaths is greater than the national position, however this is as expected when comparing the population of Warrington (96.00% White British) & Halton (98.00% White British).

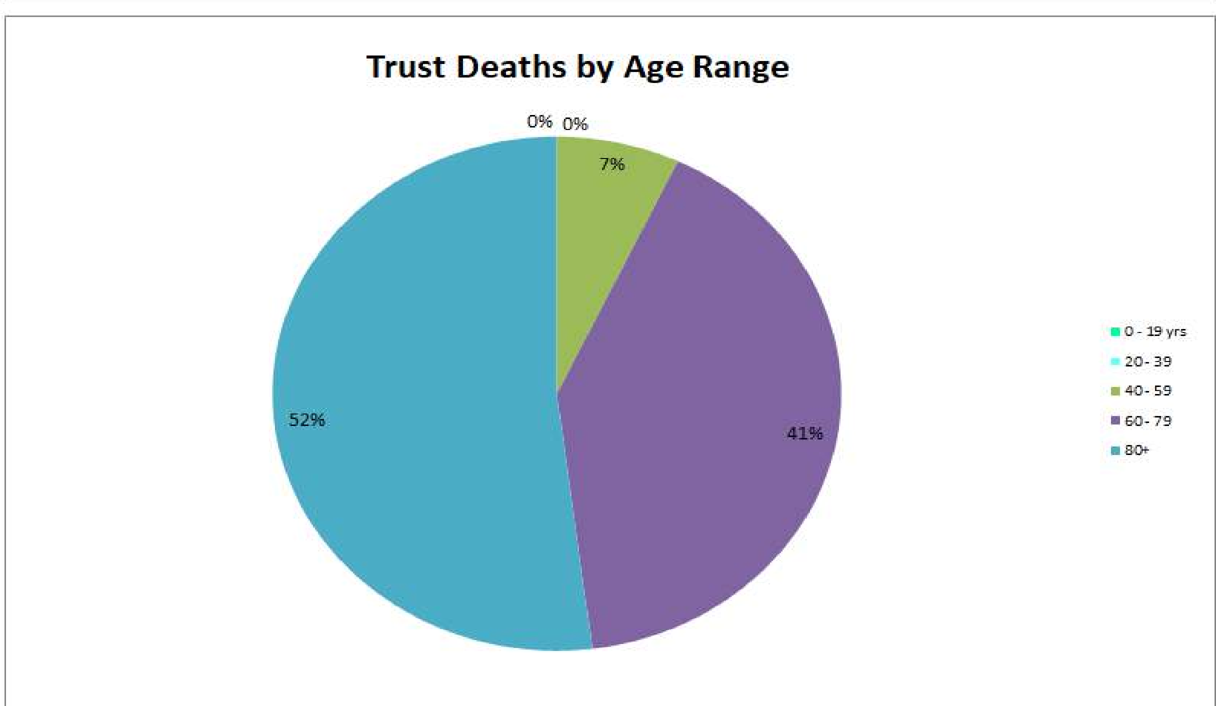
Notes: National data for COVID-19 deaths by ethnicity was not available at the time of writing, having previously been made available on the NHSE website.

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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Number of In Hospital Deaths (Age Range)



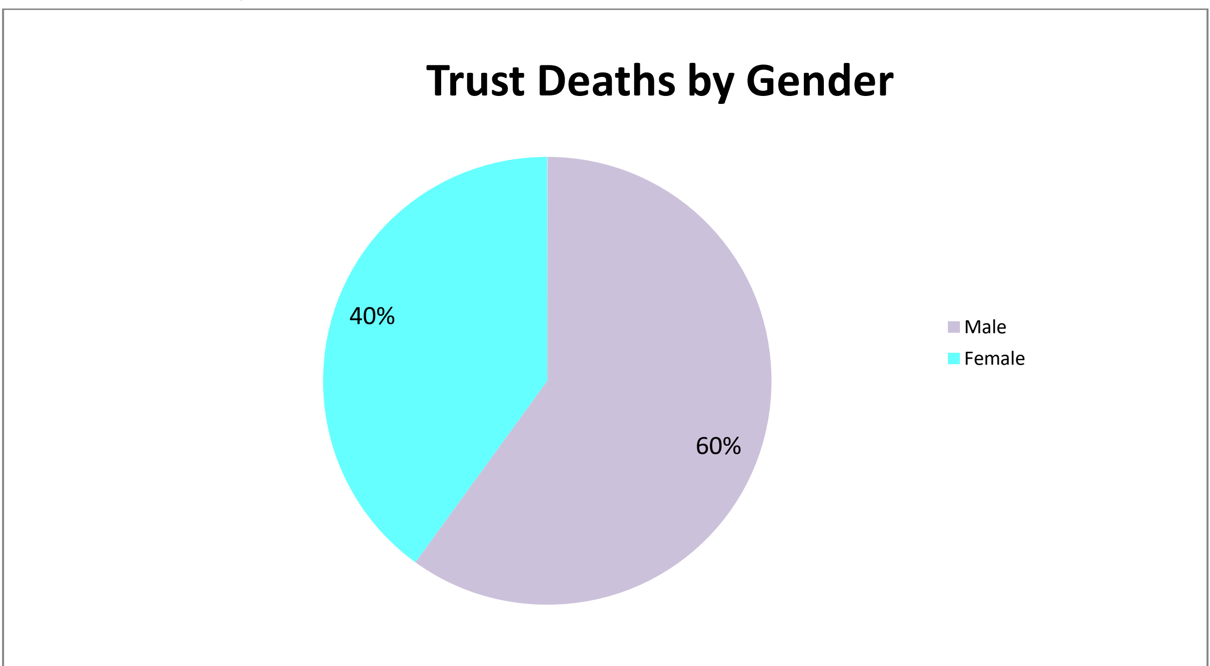


Narrative: As at 25/07/2020, 93.0% of COVID-19 related deaths were inpatients over the age of 60, which is line with the national position. The average age of death was 72 years.

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

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

Number of In Hospital Deaths (Gender)



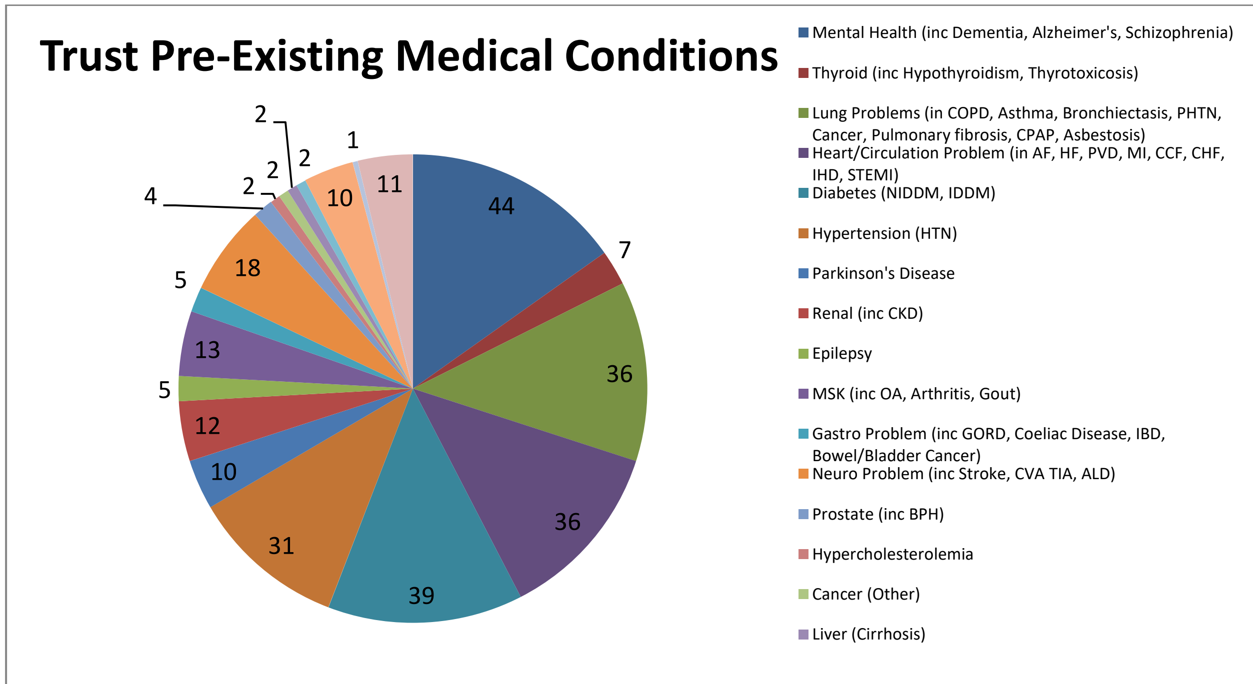
Narrative: As at 25/07/2020, 60.0% of COVID-19 deaths were male patients and 40.0% of deaths were female patients.

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

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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

In Hospital Deaths - Pre-Existing Medical Conditions



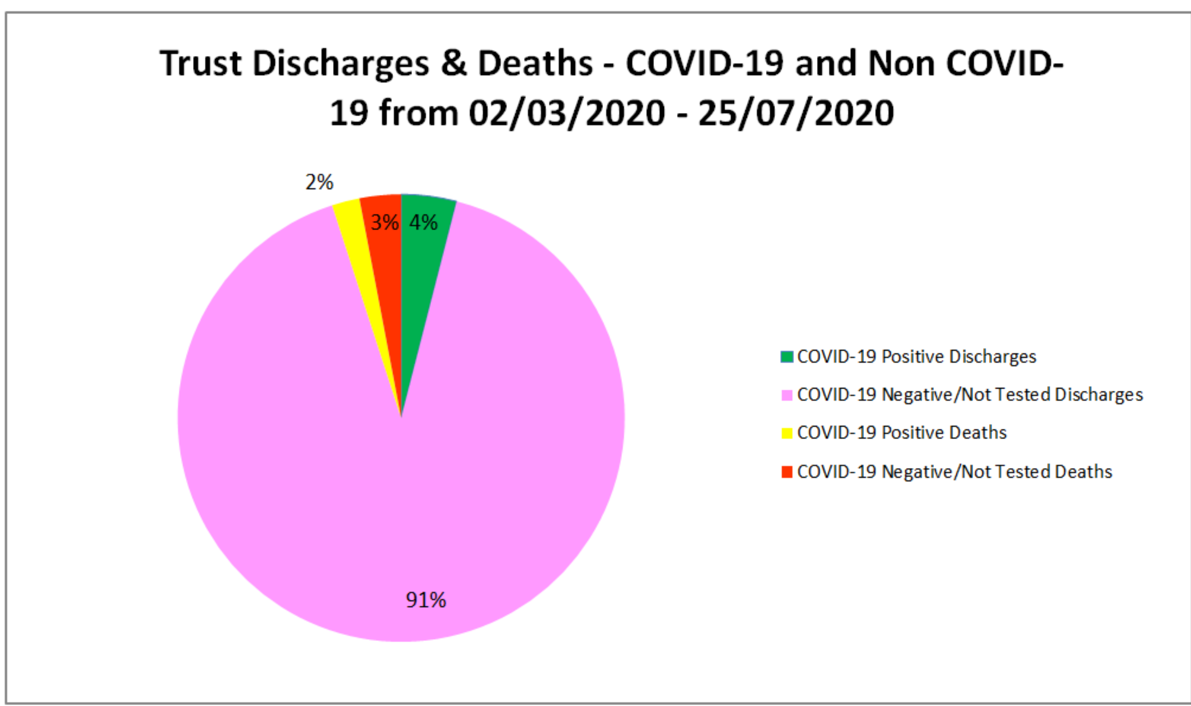
Narrative: As at 25/07/2020, 87.50% of Trust inpatients who have died as a result of COVID-19 had a pre-existing medical condition. The most common of these were Heart and Lung conditions in additional to organic mental health conditions such as Dementia and Alzheimer's.

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

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

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

Trust Outcomes

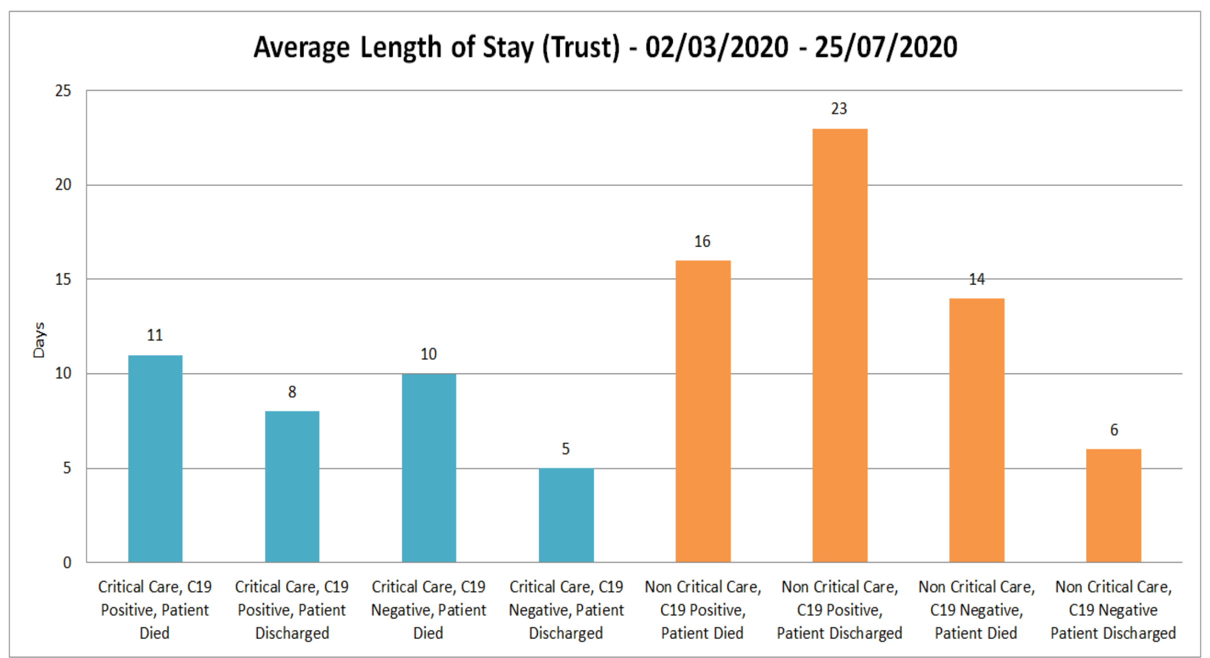


Narrative:

- Between 02/03/2020 – 25/07/2020, the Trust treated 8582 inpatients (any patient with at least 1 night stay). 498 (5.8%) of inpatients had tested positive for COVID-19.
- 95% of all patients were discharged from hospital.
- There were a total of 433 inpatients (all causes) who have died, this represents 5.04% of all inpatients.
- 136 inpatient deaths were related to COVID-19 which represented 1.58% of all inpatients, 31.40% of all inpatient deaths and 27.36% of all inpatients who had tested positive for COVID-19.
- 41 patients who have died and who had tested positive for COVID-19 were admitted from a care home (8.24% of all COVID-19 positive inpatients).

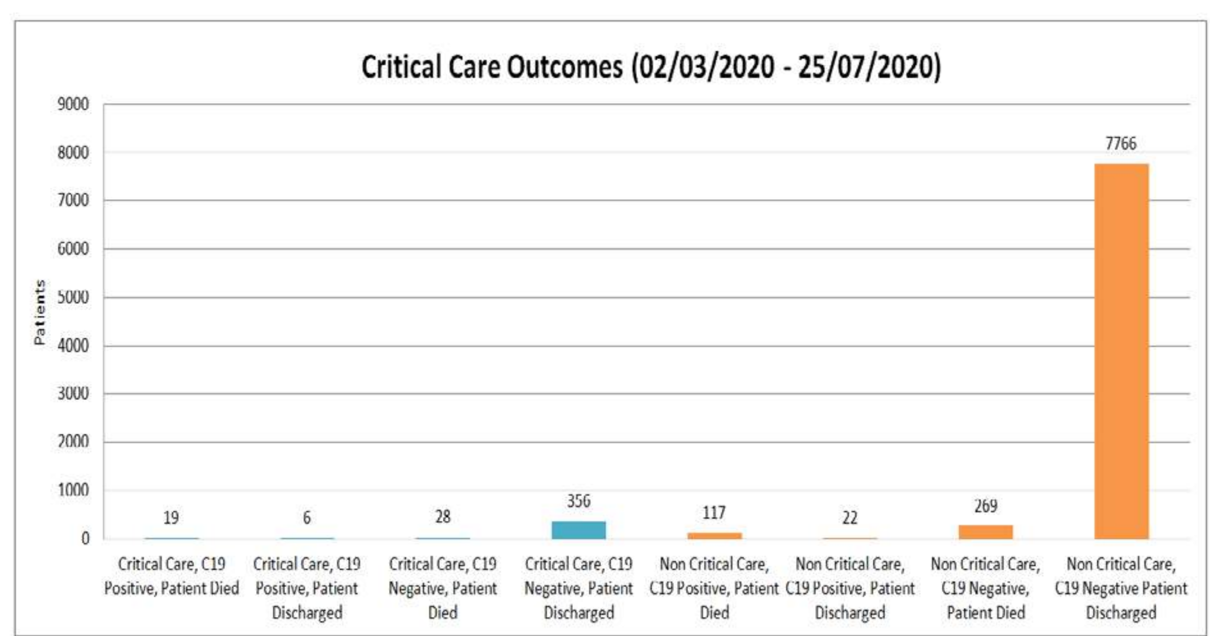
Source: Trust Data

Average Length of Stay



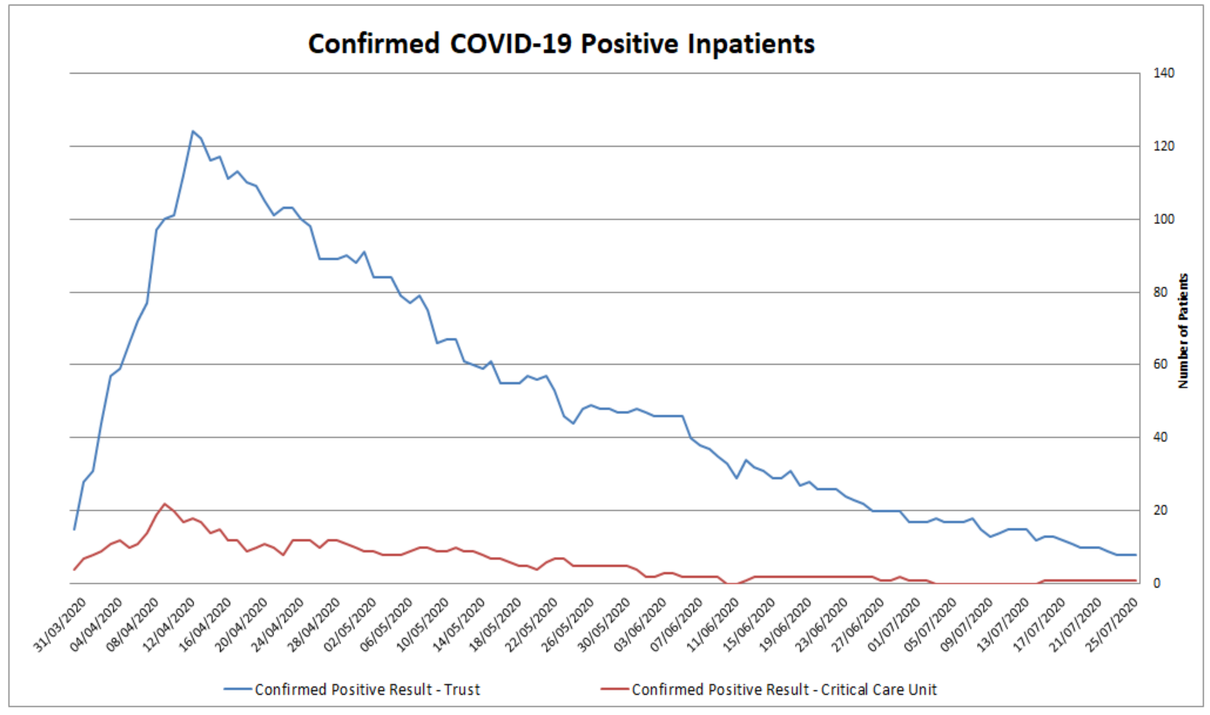
Narrative: From 02/03/2020 - 25/07/2020, the average length of stay for patients who had tested positive for COVID-19 was 16 days (8 days in critical care, 23 days non-critical care).
Source: Trust Data

Critical Care Outcomes

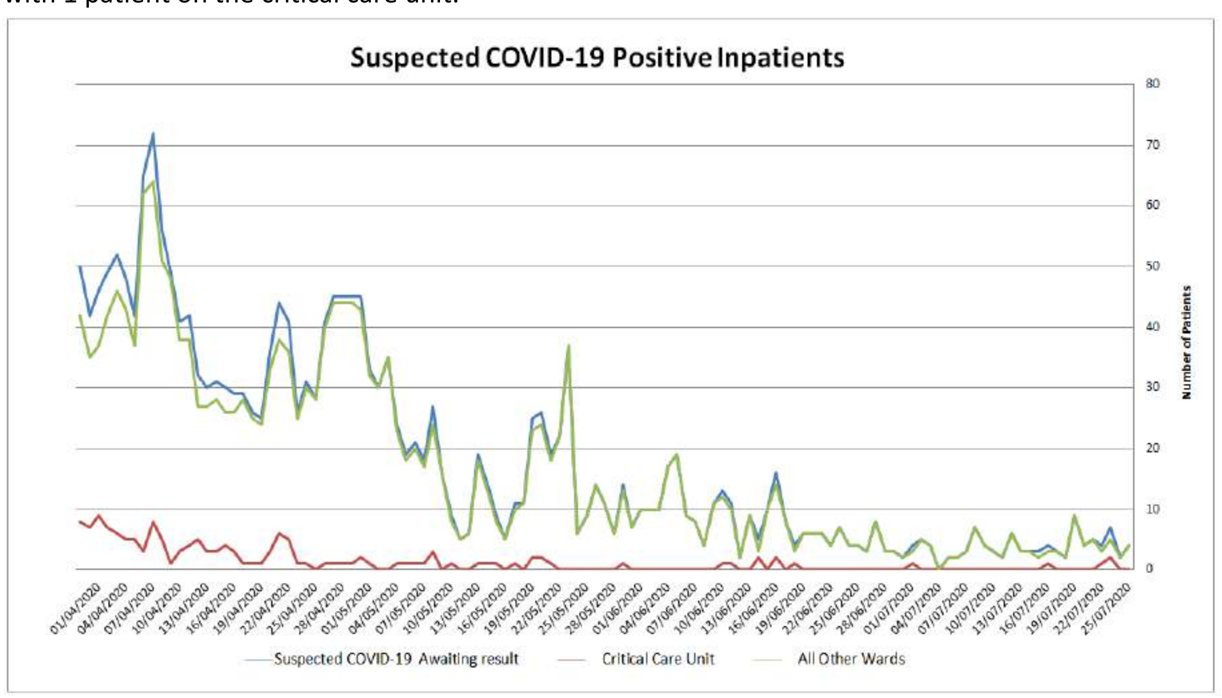


Narrative: From 02/03/2020 – 25/07/2020, there were 47 (19 COVID-19, 28 Non-COVID-19) critical care inpatient deaths and 28 critical care inpatient discharges (6 COVID-19, 22 Non-COVID-19).
Source: Trust Data

Confirmed Positive & Suspected Positive COVID-19 Patients



Narrative: As of 25/07/2020, there were 8 confirmed positive current inpatients with COVID-19 with 1 patient on the critical care unit.



Narrative: As of 25/07/2020, there were 4 current inpatients with suspected COVID-19 (0 in critical care), with a peak of suspected cases on 07/04/2020 at 72 cases. There are 42 asymptomatic patients awaiting a COVID-19 test result.

Source: Trust Data

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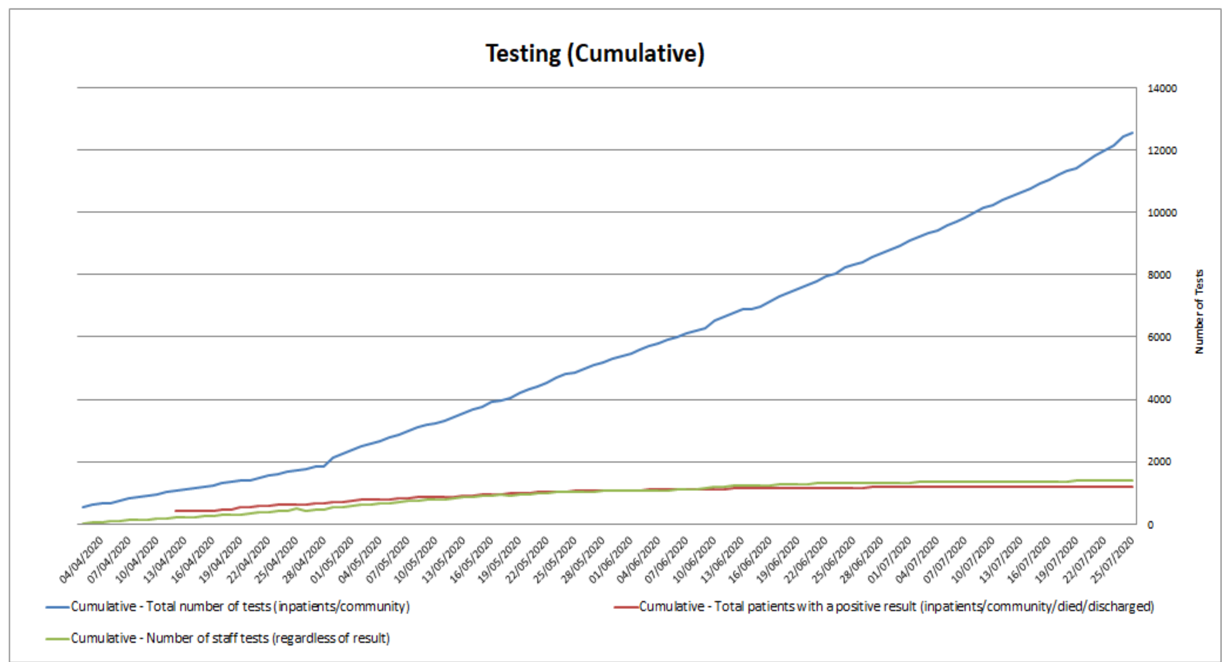
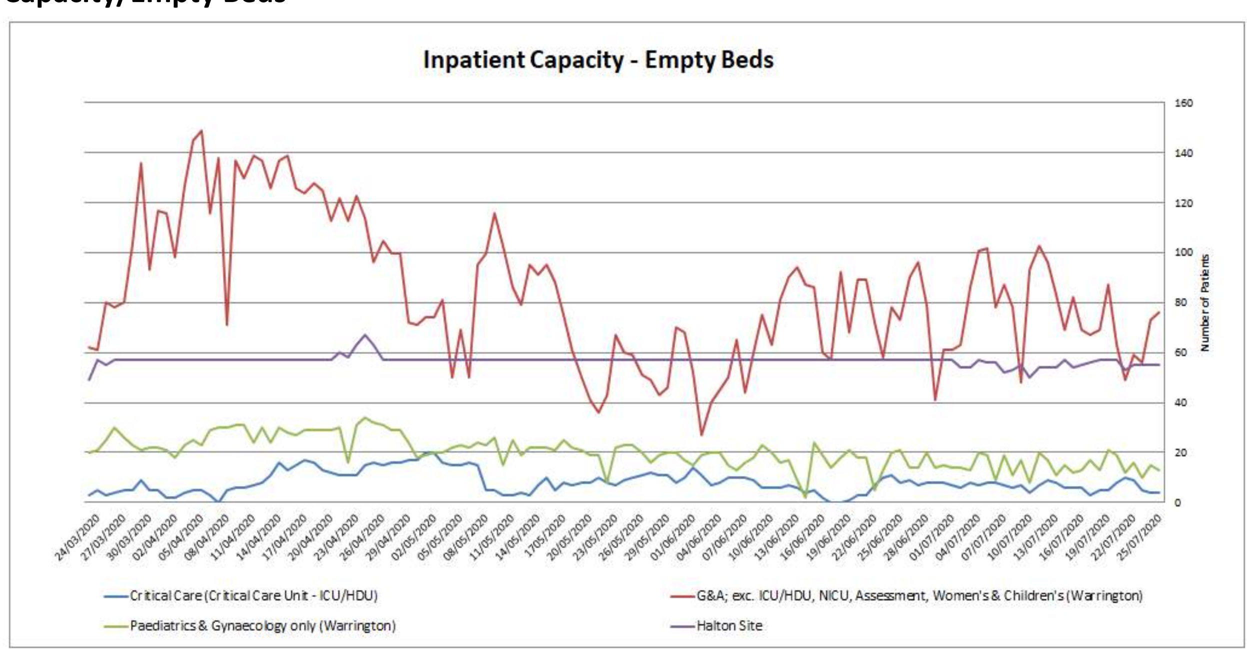
COVID-19 Testing



Narrative: As of 25/07/2020, 12571 patients (inpatients & community) have been tested and 1392 staff tests have been carried out. Of the 12571 patients tested, 1192 (9.48%) patients tested positive.

Source: Trust Data

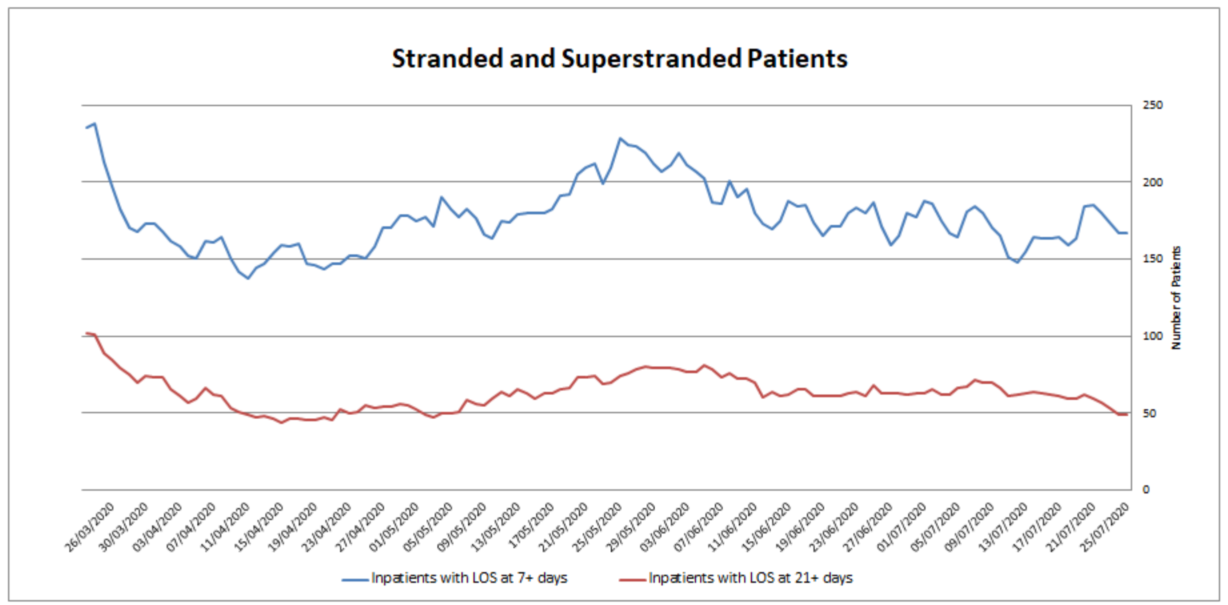
Capacity/Empty Beds



Narrative: Since 18/06/2020 when there were 0 available critical care beds, there has been a minimum of 3 critical care beds available upto 25/07/2020. There has been capacity available in all other areas of the hospital.

Source: Trust Data

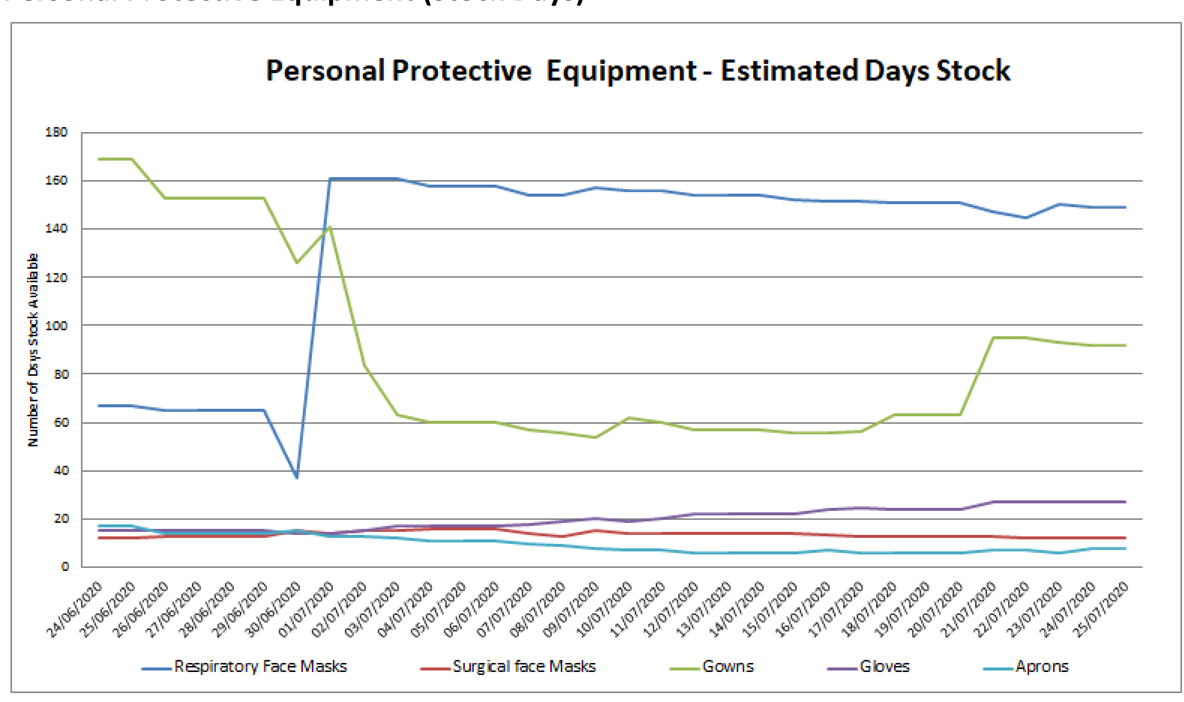
Stranded/Super Stranded Patients



Narrative: On 25/07/2020, there were 167 Stranded and 49 Super Stranded patients. This is the lowest number of super stranded patients since 15/04/2020 with 44.

Source: Trust Data

Personal Protective Equipment (Stock Days)



Narrative: The Trust closely monitors PPE stock on a daily basis and any concerns are escalated regionally and nationally. Between 21/06/2020 – 25/07/2020, the minimum stock levels of PPE was 8 days (Aprons).

Source: Trust Data

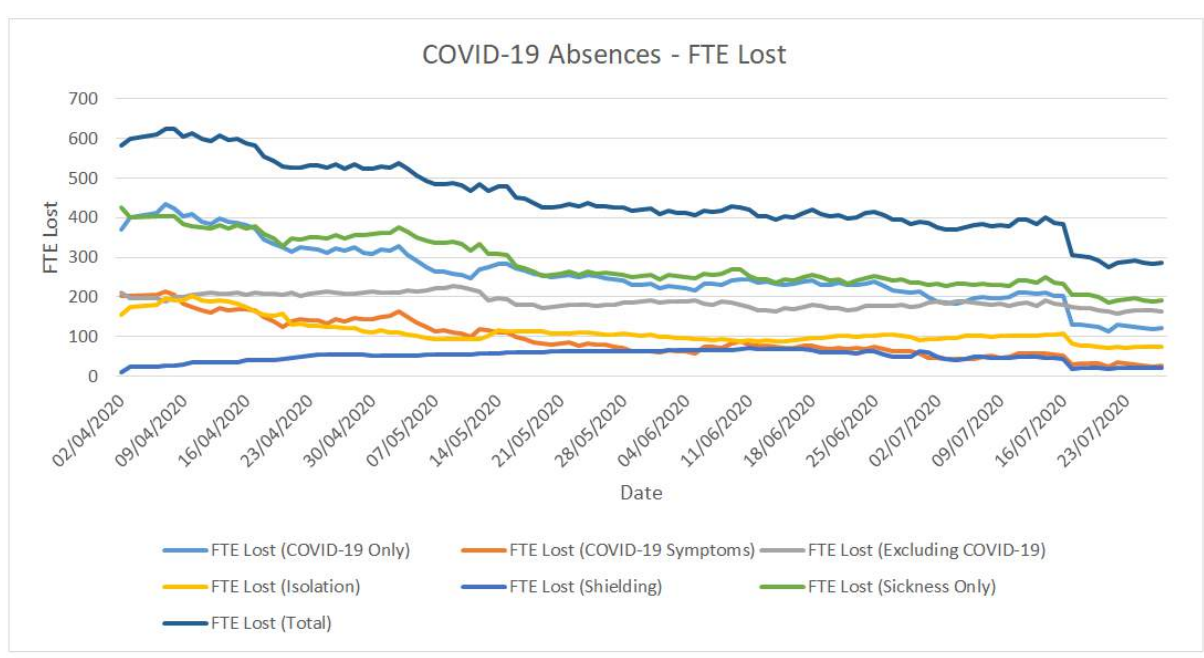
Hospital Onset COVID-19

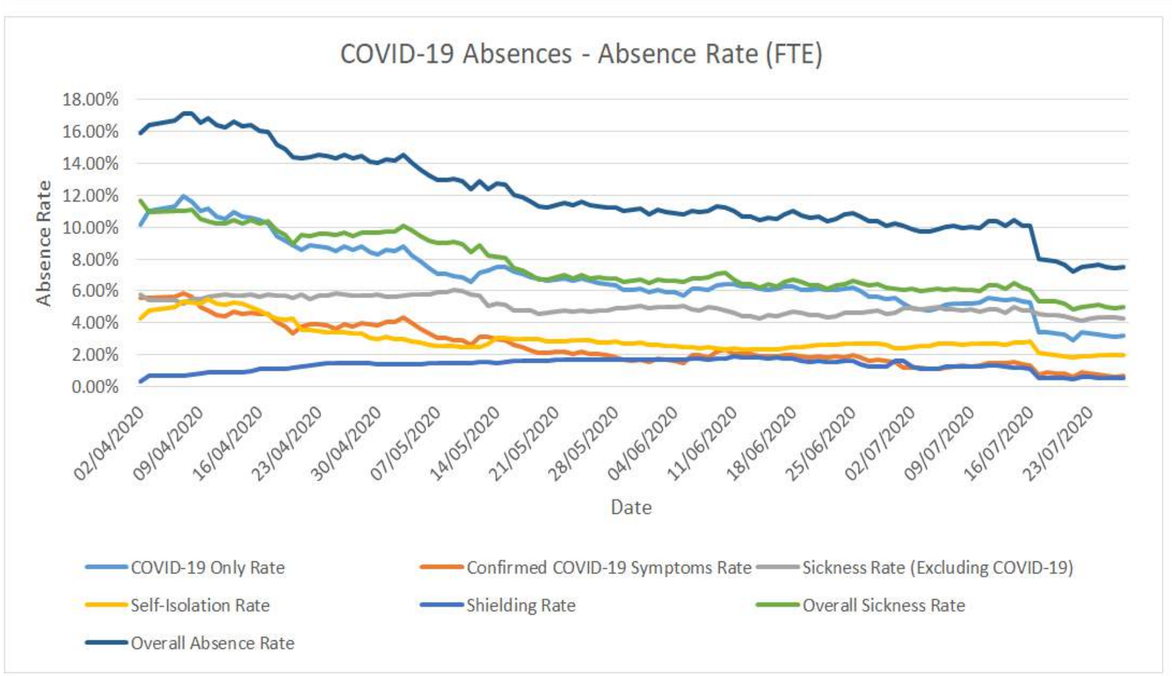
Standard	20/06/2020 - 25/07/2020
Number of inpatients with a Positive COVID diagnosis in the last 24 hrs	**8**
The number with a sample taken within 48hrs of admission	3
The number with a sample taken within 3-7 days of admission	3
The number with a sample taken within 8-14 days of admission	2
The number with a sample taken within 15+ days of admission	0

Narrative: Between 20/06/2020 – 25/07/2020, there were 8 current inpatients swab tested and diagnosed with COVID-19. Of these 3 had a sample taken within 48 hours of admission, 3 had a sample taken between 3-7 days, 2 had a sample taken between 8-14 days of admission and 0 had a sample taken 15 days after admission.

Source: Trust Data

Staff Sickness





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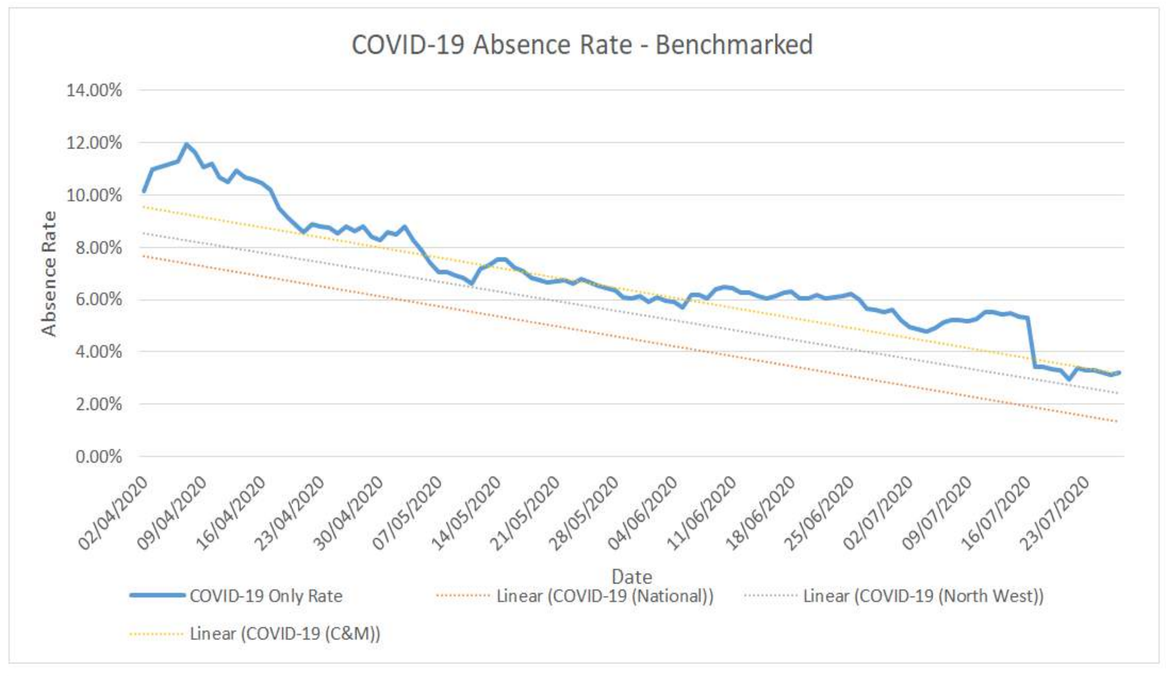
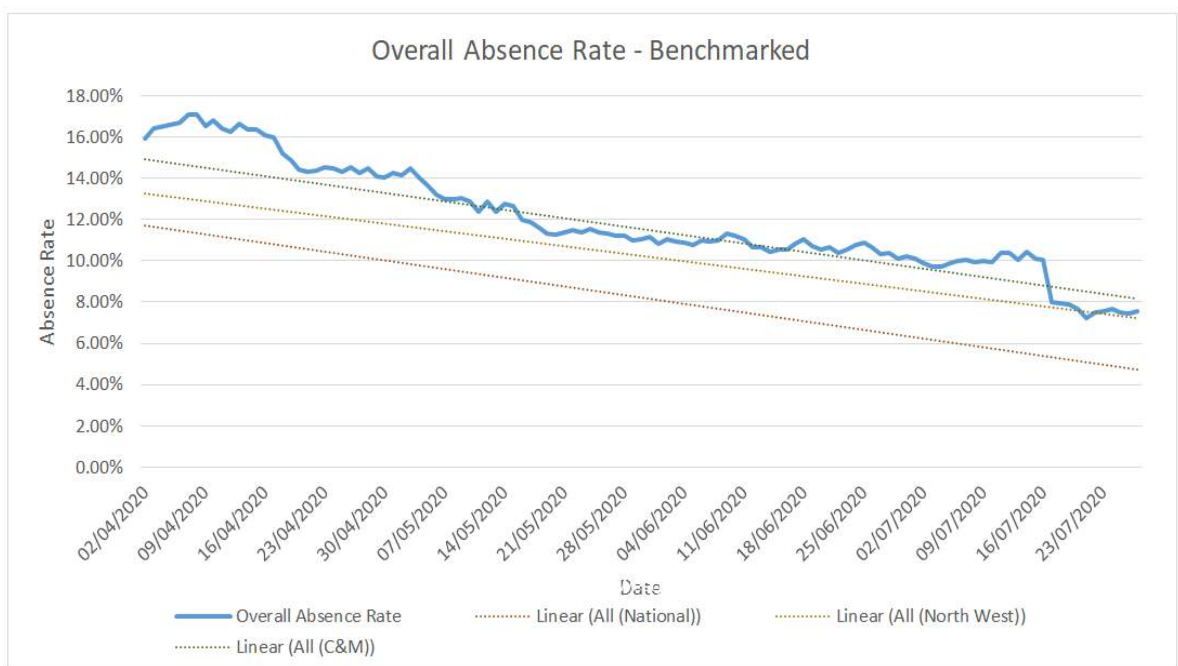
NHS Foundation Trust





Narrative: Non COVID-19 related sickness absence is 4.37% and has stabilised. COVID-19 related sickness absence has reduced to consistently below 1.00%, and is currently 0.78 % (24/07/2020). There has been a further reduction in the number of staff isolating from 93 FTE to 74.4 FTE (24/07/2020). Staff shielding for 12 weeks as reported in ESR is 21.24 FTE.

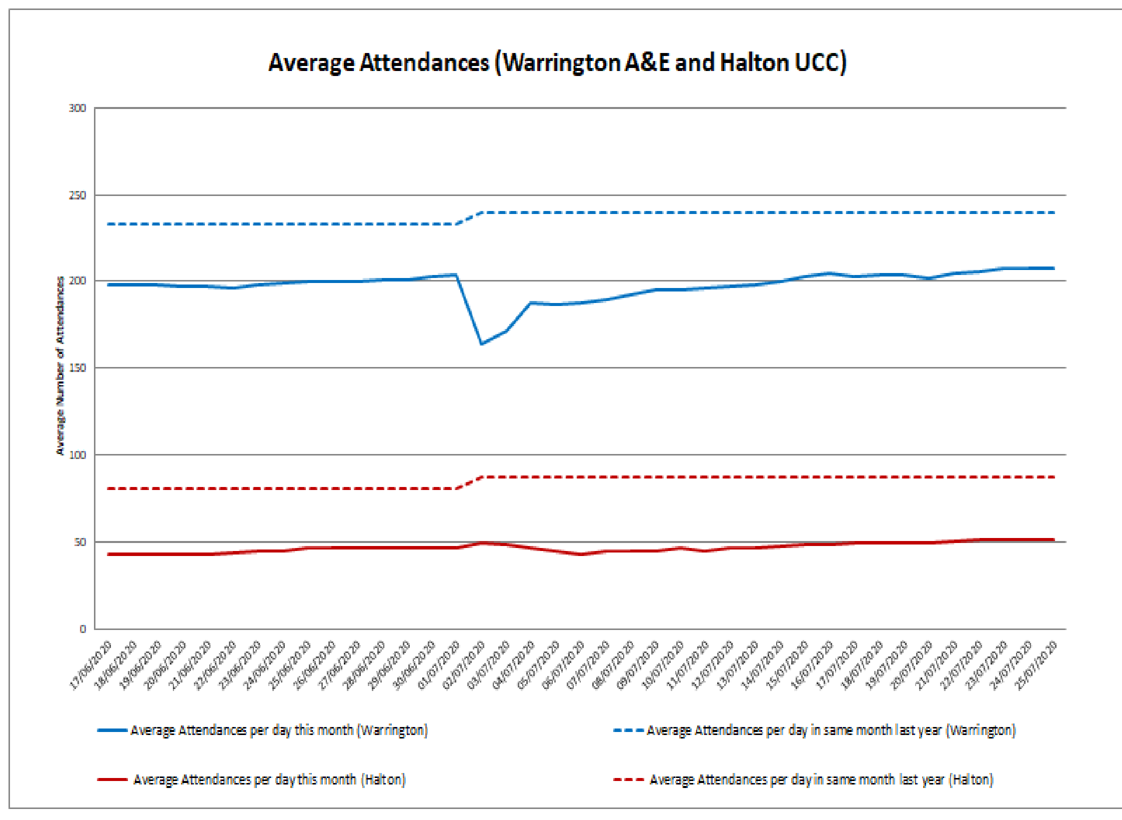
The North West has the highest overall absence rate (COVID-19 and Non-COVID-19) nationally at 7.7% and C&M has the highest in the North West reporting 9.1%.

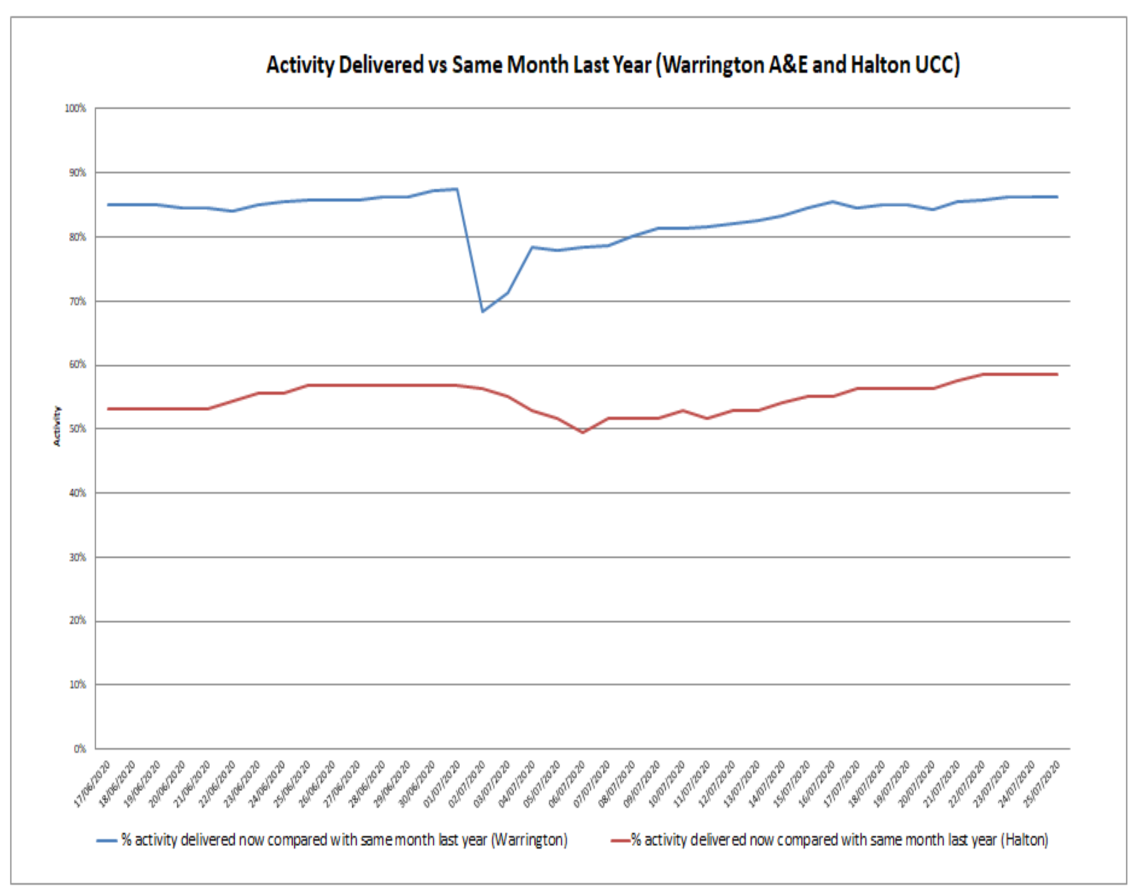
In comparison the Trust's overall absence has reduced to 7.65%, and the COVID-19 absence rate is 3.29% compared to a 4.1% average in C&M.

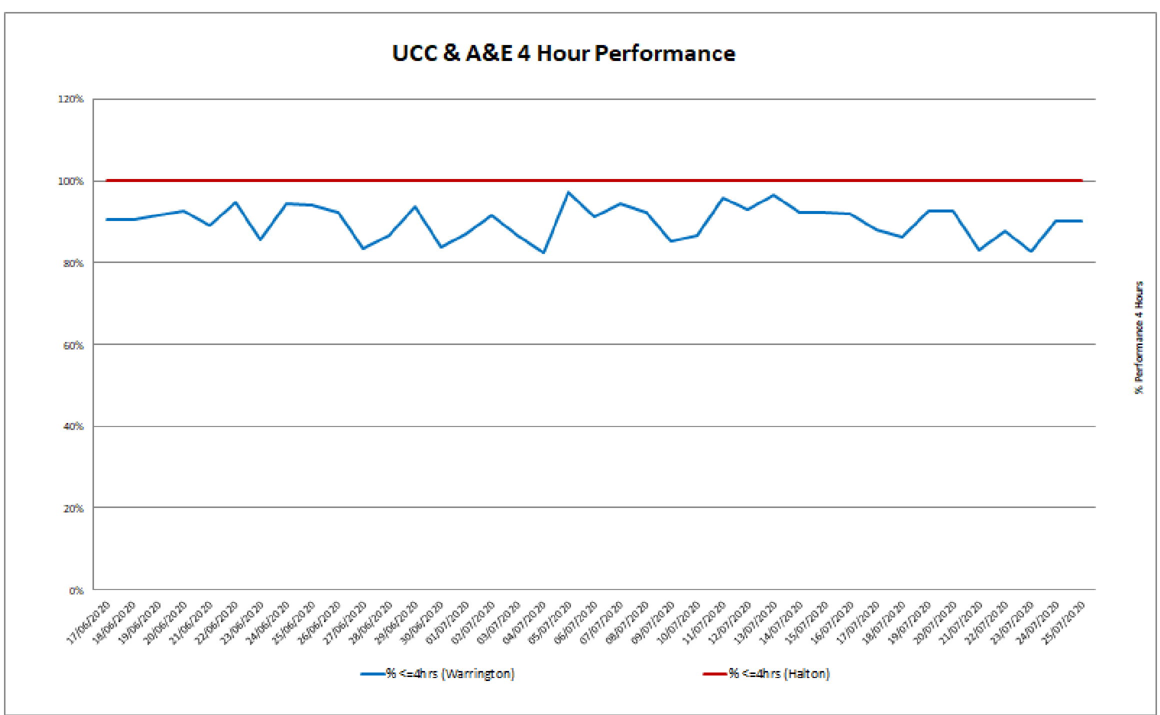
Note: The Walton Centre and The Clatterbridge Centre are included in the C&M averages, these specialist Trusts have low absence rates, reducing the whole C&M average.

Source: Trust Data

Urgent Care



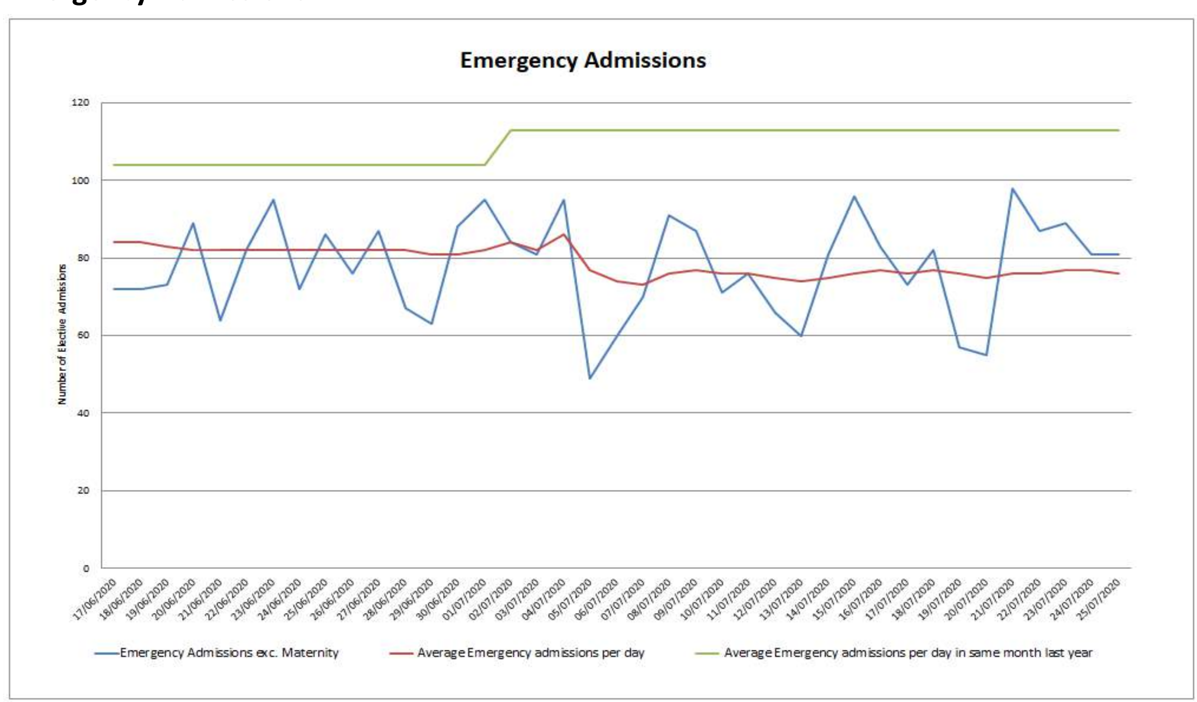




Narrative: The Trust has seen the number of A&E attendances increase since the start of the pandemic. Urgent Care activity for Warrington in June/July 2020 was c83% of activity in June/July 2019 and in Halton activity in June/July 2020 was c55% of activity in June/July 2019.

Source: Trust Data

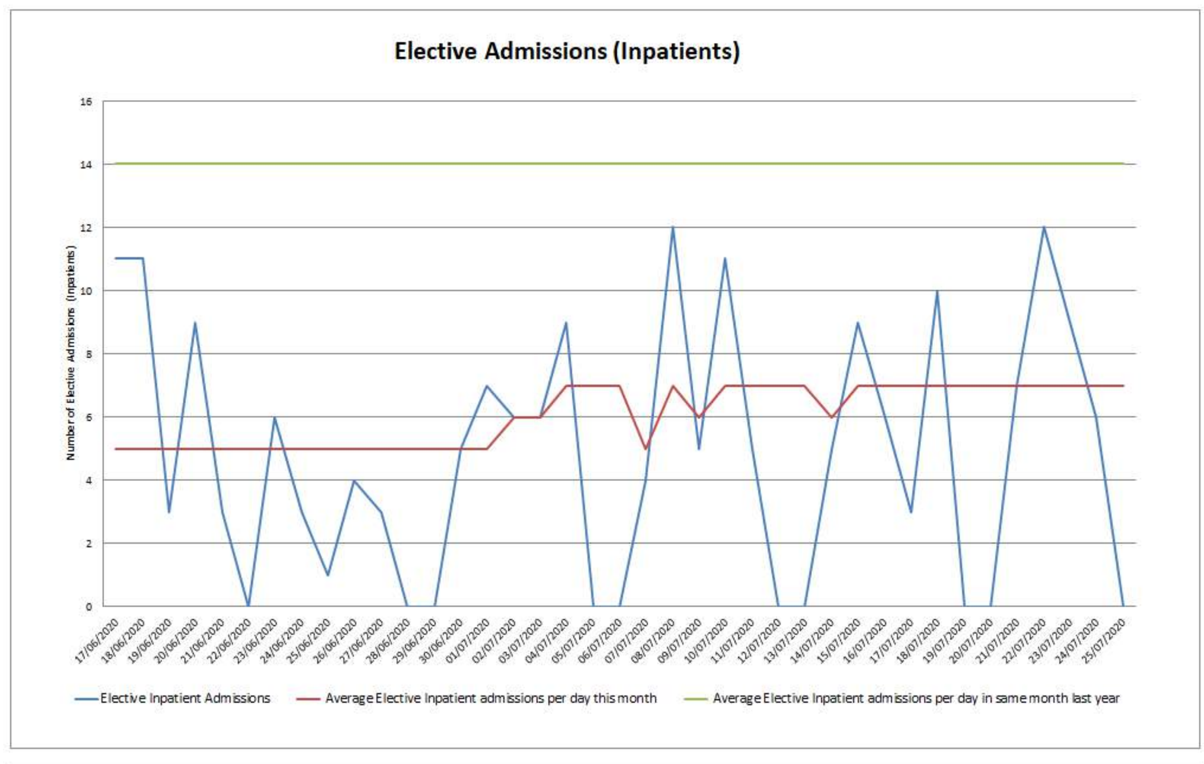
Emergency Admissions

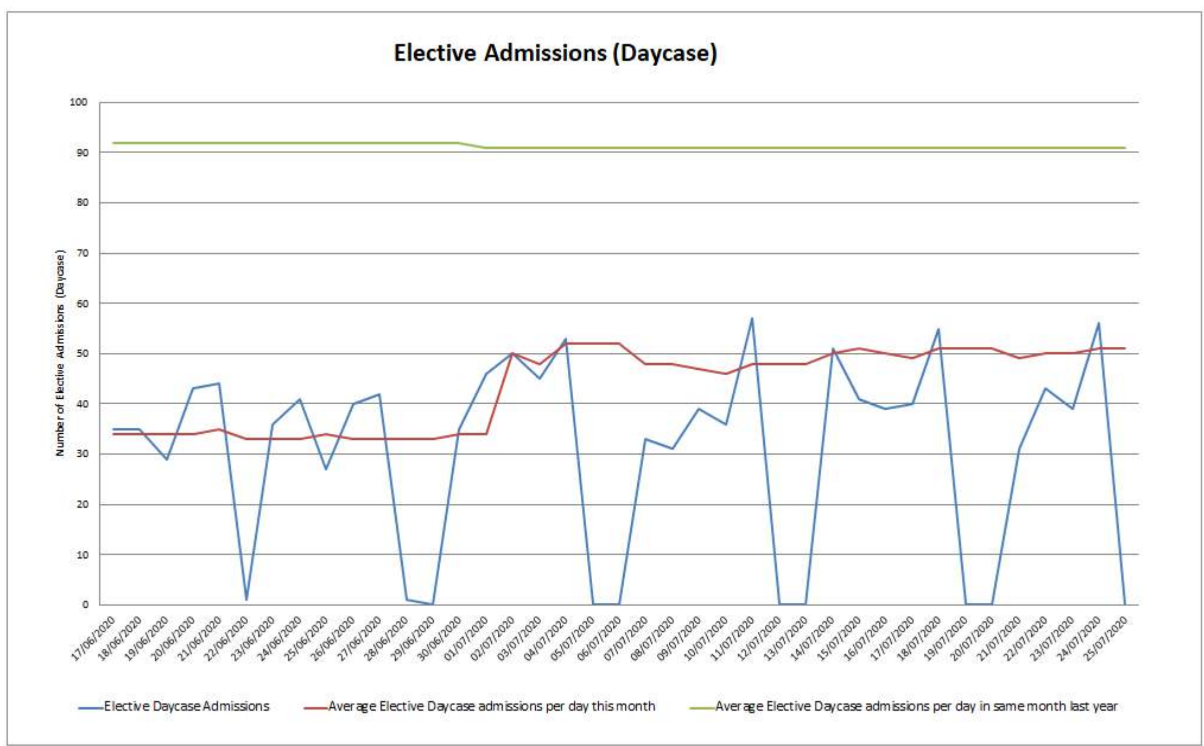


Narrative: The average number of emergency admissions in June/July 2020 was c67% of the average number of the average number of emergency admissions in June/July 2019.

Source: Trust Data

Elective Admissions



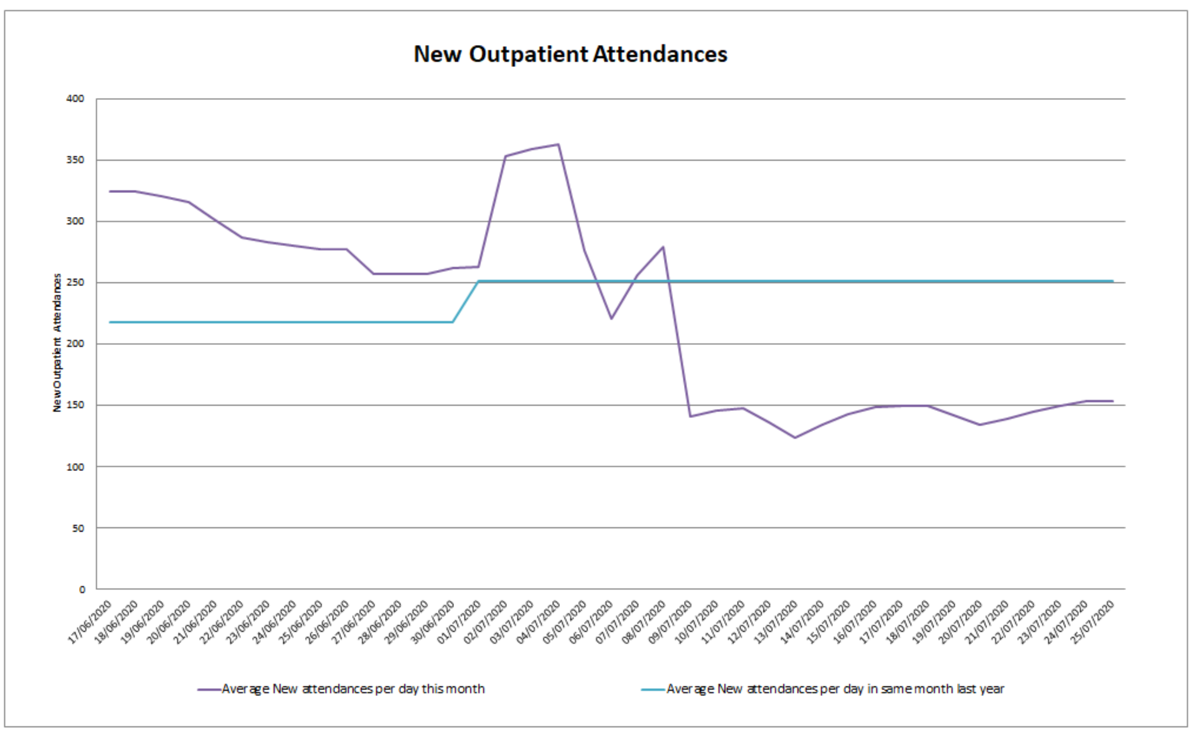


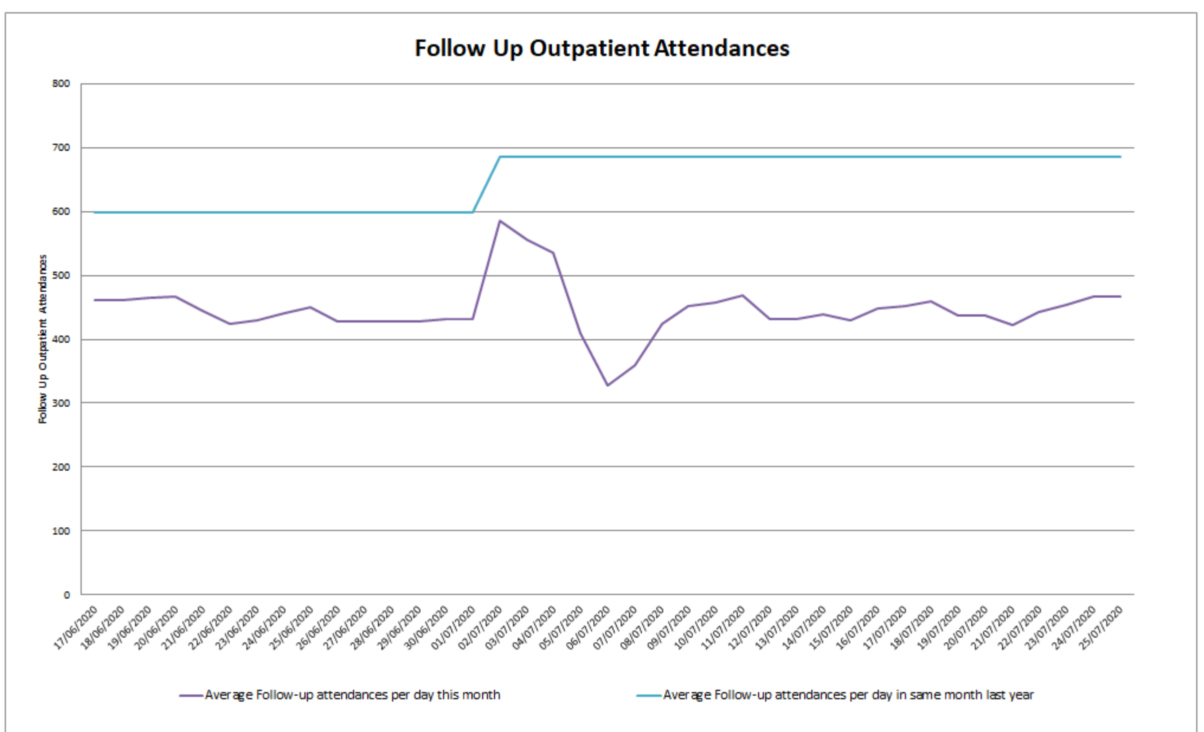
Narrative: The average number of elective inpatient admissions in June/July 2020 was c50% of the average number of elective inpatient admissions in June/July 2019.

The average number of elective daycase admissions in June/July 2020 was c56% of the average number of elective daycase admissions in June/July 2019.

Source: Trust Data

Outpatient Attendances





Narrative: The average number of new outpatient attendances in June/July 2020 was c61% of the average number of new outpatient attendances in June/July 2019.

The average number of follow up outpatient attendances in June/July 2020 was c68% of the average number of follow up outpatient attendances in June/July 2019.

Source: Trust Data

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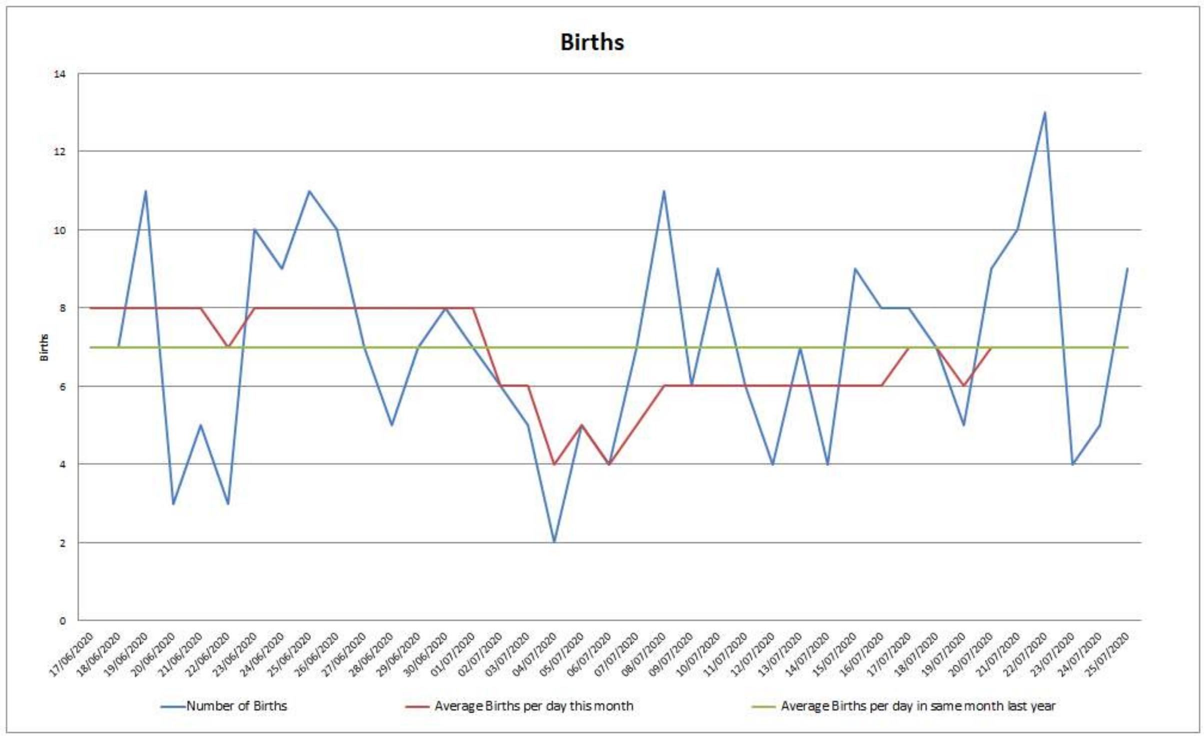
Births



Narrative: The average number of births in June/July 2020 was 100% of the average number of births in June/July 2020.
Source: Trust Data

3. CONCLUSION

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

4. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/20/07/69a	
SUBJECT:	**Integrated Performance Report Dashboard**	
DATE OF MEETING:	29th July 2020	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Andrea McGee - Chief Finance Officer and Deputy Chief Executive Chris Evans - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	x
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #224 Failure to meet the emergency access standard.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust has 68 IPR indicators which have been RAG rated in June as follows: **Red: 22 (from 19 in May)** **Amber: 8 (from 4 in May)** **Green: 30 (from 34 in May)** **Not RAG Rated: 8 (from 11 in May)** As a result of the COVID-19 pandemic, the Trust has not met the standards for RTT 18 weeks and 52 weeks, Diagnostics 6 weeks or Cancer 31/62 day standards. Prior to COVID-19, the Trust had consistently met these standards. The Trust has robust recovery plans with clinical prioritisation in place to address this. The Trust will continue to utilise independent sector support to address the backlog. Improvements have been seen within urgent care for the 4 hour standard and ambulance handovers, which the Trust will seek to maintain going forward. The Trust has ensured that processes remain in place to monitor and improve quality during the COVID-19 pandemic. Open Incidents are monitored, with progress tracked weekly via the Trust Meeting of Harm. CBUs continue to be supported to	

	ensure the timely closure of incidents.. Falls, Pressure Ulcers and Healthcare Acquired Infections continue to be monitored and action is taken to address any concerns as they arise. For the period ending 30 June 2020 the Trust has recorded a breakeven position. The position included a retrospective year to date top up of £9.0m (£2.5m April, £2.8m May and £3.7m June) to support COVID-19 expenditure and income loss of £11.4m year to date. Capital requests for Q1 relating to COVID-19 were £17.1m of which £2.8m was approved. Approval for the remaining £14.3m is anticipated from NHSE/I by the end of July. Controls are in place to ensure only those costs necessary are incurred in supporting the COVID-19 response and the recovery phase. The Trust continues to monitor the changing guidance relating to the financial regime and COVID-19 expenditure. The cash balance is £18.0m.
PURPOSE: ***(please select as appropriate)***	Information | Approval X | To note X | Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the contents of this report. 2. Note the COVID-19 capital approved as an emergency by the Chief Finance Officer & Deputy Chief Executive. 3. Approve the changes to the Capital plan increasing the contingency to enable new bids to be approved. 4. Approve the addition of a COVID-19 KPI to the Quality section of the IPR.

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee Finance & Sustainability Committee
	Agenda Ref.	QAC/20/07/116 FSC/20/05/70
	Date of meeting	QAC – 07/07/2020 FSC – 22/07/2020
	Summary of Outcome	QAC - Supported FSC - Supported
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report Dashboard	**AGENDA REF:**	BM/20/07/69a

1. BACKGROUND/CONTEXT

The RAG ratings for all 68 indicators from July 2019 to June 2020 is set out in **Appendix 1**. The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the Board with assurance in relation to the delivery of all Key Performance Indicators (KPIs) across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

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

Table 1: RAG Rating Movement

	May	**June**
Red	19	22
Amber	4	8
Green	34	30
Not RAG Rated	11	8
Total:	68	68

Due to validation and review timescales for Cancer, the RAG rating on the dashboard for these indicators is based on May's validated position.

Due to the impact of COVID-19, 8 indicators cannot be RAG rated in month, as the data is not available or not reportable. These are:

Quality

- Friends & Family Test (Inpatients & Daycases) – the FFT has been suspended nationally.
- Friends and Family Test (ED & UCC) – the FFT has been suspended nationally.
- CQC Insight Report – the CQC Insight Report has not been published.

Finance

- Use of Resource Rating – UoR rating is not reportable in Month 1-4. The Trust is awaiting further guidance from NHSE/I.
- CIP (In Year, Recurrent & Plans in Progress) – CIP has been suspended nationally with no requirement for delivery or reporting until at least 31 July 2020, the Trust is awaiting guidance on next steps.
- System Financial Position – system reporting is currently on hold.

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

Quality

Quality KPIs
There are 3 Quality indicators rated Red in June. This is an increase from 2 in May.

The 2 indicators rated Red in May, which have remained Red in June are as follows:

- Incidents: There were 21 open incidents over 40 days old at the end of June, an increase from 15 in May, against a target of 0. Performance has been impacted by the COVID-19 pandemic, as clinical areas have been required to focus upon providing direct patient care. All areas continue to be supported by the Governance Department and virtual meetings continue.
- VTE: The Trust achieved an average of 92.32% in Quarter 1 2020/21, this was an improvement from an average of 89.00% in Quarter 4 2019/20 against a target of 95.00%.

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

- Complaints – there were 4 complaints open over 6 months as at the end of June. This is an increase from 0 as at the end of May, against a target of 0.

Access and Performance

Access and Performance KPIs
There are 13 Access and Performance indicators rated Red in June, increased from 10 in May. Performance against these indicators has been significantly impacted by the COVID-19 pandemic.

The 8 indicators which were rated Red in May and remain Red in June are as follows:
- Diagnostic 6 Week Target – the Trust achieved 47.20% in June, an improvement from 43.25% in May, against a target of 99.00%.
- Referral to Treatment Open Pathways – the Trust achieved 61.78% in June, a reduction from 72.24% in May, against a target of 92.00%.
- Referral to Treatment 52+ Week Waiting – there were 73 patients waiting over 52 weeks in June, increased from 19 in May against a target of 0.
- A&E Waiting Times 4 hour National Target – the Trust achieved 92.16% (excluding Widnes Walk ins) in June, a reduction from May's position of 93.38%, against a target of 95.00%.
- Ambulance Handovers 30-60mins – there were 21 patients who experienced a delayed handover in June, this is an increase from 17 patients in May, against a target of 0.
- Discharge Summaries % sent within 24 hours – the Trust achieved 80.40% in June, an improvement from 73.97% in May, against a target of 95.00%.

- Discharge Summaries not sent within 7 days – there were 35 discharge summaries not sent within 7 days in order to meet the 95.00% threshold in June, a reduction from 42 in May against a target of 0.
  The Trust has experienced a technical issue with the IT systems which generate discharge summaries. This incident is being investigated. The Trust is working with the CCG to review the impact. Discharge summaries sent between May and July have been reviewed with 134 summaries reviewed and 27 outstanding. Of those reviewed, 1 incident of minor harm has been identified and is being managed appropriately.
- Cancelled Operations on the Day (non-clinical reasons, not rebooked within 28 days) – there was 1 patient whose operation was cancelled on the day and not rebooked within 28 days in June. This is a reduction from 11 in May, against a target of 0.

There are 5 indicators which have moved from Green to Red in month as follows:

- Cancer 28 Day Faster Diagnostic Standard – the Trust achieved 74.61% in May, a reduction from 79.39% in April, against a target of 75.00%.
- Cancer 31 Days First Treatment – the Trust achieved 82.61% in May, a reduction from 96.97% in April, against a target of 96.00%.
- Cancer 31 Days Surgery – the Trust achieved 92.86% in May, a reduction from 100% in April, against a target of 94.00%.
- Cancer 62 Days Urgent Treatment – the Trust achieved 47.06% in May, a reduction from 90.79% in April, against a target of 85.00%.
- Cancer 62 Days Screening - the Trust achieved 00.00% in May, a reduction from 100% in April, against a target of 90.00%. This was due to 1 breach, with 1 patient on the pathway. Screening programmes were suspended during the peak of the pandemic which has significantly impacted this cohort.

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

- Breast Symptomatic 14 Days – the Trust achieved 100.00% in May, an improvement from 80.00% in April, against a target of 90.00%.
- Ambulance Handovers 60+ minutes - there were 0 patients who experienced a delayed handover in June, this is an improvement from 1 patient in May, against a target of 0.

PEOPLE

Workforce KPIs

There are 4 Workforce indicators rated Red in June a reduction from 5 in May.

The 4 indicators which were Red in May and remain Red in June are as follows:

- Sickness Absence – The Trust's sickness absence was 5.73% in June an improvement from 7.33% in May, against a target of less than 4.20%. 0.97% of sickness absence related to COVID-19.
- Return to work – Trust compliance was 67.39% in June, decreased from 71.24% in May, against a target of 85.00%.

- Bank/Agency Reliance – The Trust's reliance was 15.64% in June, an improvement from 18.07% in May, against a target of less than 9.00%.
- Agency Shifts Compliant with the Cap – 42.35% of agency shifts were compliant with the cap in June, an improvement from 33.68% in May, against a target of over 49.00%.

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

- Agency Rate Card Compliance – 56.20% of agency shifts were compliant with the rate card in June, an improvement from 48.01% in May, against a target of over 60.00%.

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

- Vacancy Rates – the Trust vacancy rate was 10.47% in June, an increase from 6.62% in May, against a target of less than 9.00%.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 2 Finance & Sustainability indicators rated Red in June, reduced from 3 in May.

The 2 indicators which were Red in May and remain Red in June are as follows:

- Capital Programme – The actual spend is £0.6m which is £1.8m below the planned spend of £2.4m.
- Agency Spending – The actual spend in June was £1.2m which is £0.3m above the planned spend of £0.9m. £0.7m of agency spend was in relation to COVID-19.

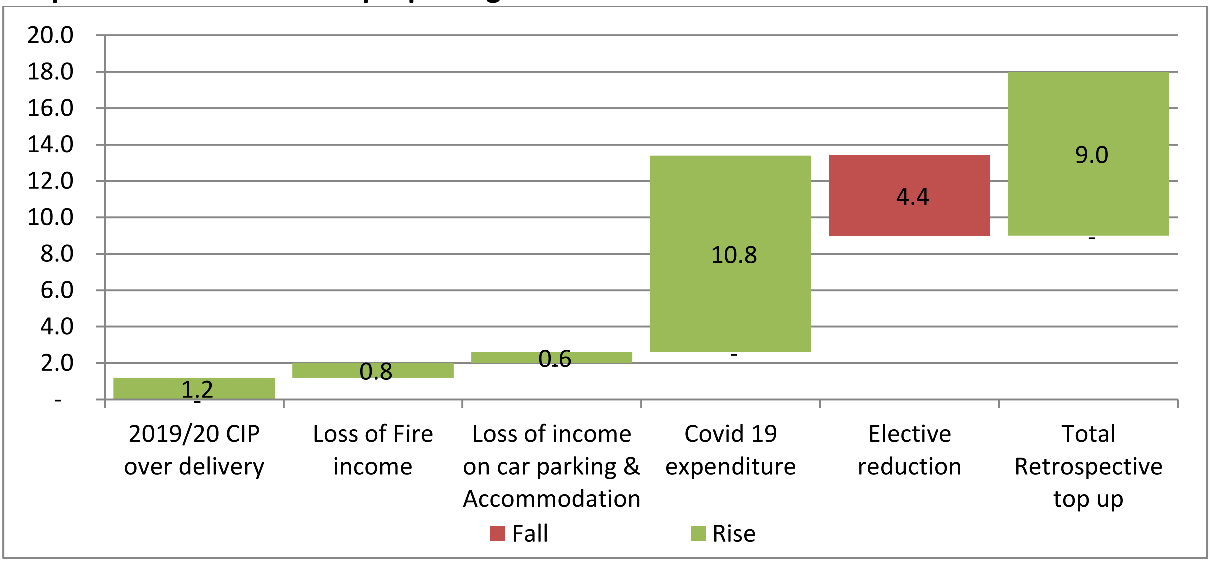
There is 1 indicator which has moved from Red to Amber in month as follows:

- Better Payment Practice Code (BPPC) – The Trust received additional income in April to facilitate the new guidelines to pay creditors within 7 days. As a result, performance of 97.00% has been achieved in June (81.00% cumulative), which was an improvement from 95.00% in May (74.00% cumulative). The target is 95.00% (cumulative).

The Income and Activity Statement for month 3 is attached in **Appendix 5**.

The Trust has received income based upon the run rate across months 8-10 2019/20. The Trust has required a top up of £9.0m to achieve breakeven. The key movements are shown in **Graph 1**.

Graph 1: Break Down of Top Up Bridge – Year to Date



Capital Programme

The revised capital programme was approved at the Trust Board in May 2020. **Table 1** provides details of the capital plan including COVID-19 and spend year to date.

Table 1 - Capital plan and spend year to date

Capital	Annual Plan	Plan To Date	Expenditure to Date	Variance Year to Date
	£0	**£0**	**£0**	**£0**
Core Programme	9,960	2,363	576	-1,787
Non COVID-19 Loan Programme	4,851	0	0	0
COVID-19 Capital Requests	17,224	0	0	0
Total Planned Capital Investment*	**32,035**	**2,363**	**576**	**-1,787**

*excludes a separate Seacole bid to NHSE/I for intermediate care beds.

The year to date spend is £1.8m below plan, the main underspends are in Estates of £1.3m. As a consequence of the underspend, an assessment has been requested of the core programme forecast. In addition to the plan for COVID-19 capital which was approved at the Board, the Trust has incurred COVID-19 capital expenditure which will require funding from NHSE/I.

Of the COVID-19 capital requests, £2.8m of capital was ordered prior to the requirements of external approval by NHSE/I. NHSE/I have to approve all COVID-19 related capital. Approval is anticipated by the end of July 2020.

For 2020/21, the Trust set a contingency of £0.17m. The Chief Finance Officer and Deputy Chief Executive has received and authorised the following emergency capital request:-

- Paediatric Ultrasound Transducer - £7k

Additionally, the following capital bids (**Table 2)** have been received to request support and funding from the Trust's capital contingency.

Table 2: Requests for funding from Contingency

	£000
IT Systems Backup Storage – additional sum in addition to main scheme to ensure adequate Trust IT storage capability	11
Audit Base Audiology – to protect potential income from patients being treated in private sector	53
Block 8 Halton Windows – replace window units at risk of falling out	30
Chapel Portakabin – to purchase currently leased item	21
Halton Trolleys – catering trolleys to replace failed units	40
Failed Chiller Works – ensure cooling for the mechanical ventilation system throughout CMTC does not fail	20
Radiology Call Centre – support appointment office as service demands increase	20
Total Bids	**195**

The requests have exceeded the contingency available by £0.02m and therefore given the current underspend on the internal capital plan, managers have been asked to assess the expected spend. **Table 3** highlights the changes requested for approval from the Board.

Table 3: Funding changes to increase Contingency

	£000
Backlog - Electrical Infrastructure Upgrade (Defer to 2021/22)	(200) *
Halton Residential Blocks 2 & 3 Fire Doors (Price reduction)	(2)
Total Contingency Contributions	**(202)**

* Estates have confirmed that as part of a review of any potential slippage to support wider capital pressures that they determined, of all the schemes, this scheme had the lowest risk and it would be mitigated by maintaining the switchgear and HV maintenance. Smaller

infrastructure works would continue, for example as part of the Kendrick scheme, executive corridor works and MRI extension.

The government has announced critical infrastructure funding. The Trust will therefore review backlog maintenance for all critical infrastructure requirements and will submit bids to this capital pot.

The approval of these changes would increase the Trust's contingency to £0.37m and therefore enable the approval of the requests highlighted in **Table 3**. If the £0.2m requests highlighted are approved, this would provide a remaining contingency of £0.17m.

The Board is requested to note the COVID-19 capital approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.
The Board is requested to approve the changes to the Capital plan increasing the contingency to enable new bids to be approved.

A draft revised capital programme is attached in **Appendix 6**.

KPI Changes
Healthcare Acquired Infections (COVID-19)
In order to provide assurance to the Board, it is proposed a new COVID-19 Healthcare Acquired Infections indicator is included in the Trust IPR. The new indicator will outline probable and confirmed Healthcare Acquired Infections (HCAIs) and any outbreaks of COVID-19. It was proposed this indicator will not be RAG rated in the interim due to the ongoing and changing situation. The new indicator was supported by the Quality Assurance Committee on 7 July 2020. A copy of the paper presented to the QAC is available in **Appendix 7**.

This addition will result in an increase in the overall number of indicators from 68 to 69.

The Trust Board is asked to approve the addition of a new KPI for COVID-19 Healthcare Acquired Infections.

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
- Trust Operational Board
- Strategic People Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.
2. Note the COVID-19 capital approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.
3. Approve the changes to the Capital plan increasing the contingency to enable new bids to be approved.
4. Approve the addition of a COVID-19 KPI to the Quality section of the IPR.

Appendix 1 – KPI RAG Rating July 2019 – June 2020

	KPI	Performance Improvement Direction	Jul 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20
	QUALITY													
1	Incidents	↓ (Incidents over 40 days old)	↑	↑	↓	↑	↑	↑	↓	↓	↑	↓	↓	↑
2	CAS Alerts	↓ (Alerts not actioned in time - 0)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
3	Duty of Candour	↓ (In month compliance)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
4	Healthcare Acquired Infections - MSRA	↓ (MRSA cases in month)	↔	↑	↔	↔	↔	↔	↔	↔	↔	↓	↔	↔
5	Healthcare Acquired Infections – Cdiff	↓ (Cdiff cases in month)	↔	↑	↓	↑	↓	↓	↑	↓	↑	↓	↓	↓
6	Healthcare Acquired Infections – Gram Neg	↓ (Gram Neg cases in month)	↓	↓	↑	↓	↑	↓	↑	↑	↑	↔	↑	↑
7	VTE Assessment	↑ (% Compliance)	↑	↑	↓	↑	↑	↓	↓	↓	↑	↑	↑	↑
8	Total Inpatient Falls & Harm Levels	↓ (No. of inpatient falls in month)	↓	↑	↑	↓	↑	↑	↓	↓	↑	↓	↑	↑
9	Pressure Ulcers	↓ (No. of pressure ulcers in month)	↔	↓	↑	↑	↑	↓	↓	↓	↑	↓	↑	↓
10	Medication Safety	↓ (Medicines reconciliation within 24 hours)	↑	↑	↔	↑	↑	↑	↑	↔	↑	↑	↑	↓
11	Staffing – Average Fill Rate	↑ (% staffing fill rates in month)	↓	↓	↑	↑	↓	↓	↑	↑	-	-	-	↑
12	Staffing – Care Hours Per Patient Day	↑ (overall CHPPD)	↔	↓	↑	↑	↑	↑	↓	↑	-	-	-	↑
13	Mortality ratio - HSMR	(Based on Ratio)	↑	↓	↔	↓	↑	↑	↑	↔	↓	↑	↑	↑
14	Mortality ratio - SHMI	(Based on Ratio)	↑	↔	↔	↓	↓	↑	↑	↔	↑	↓	↑	↓
15	NICE Compliance	↑ (compliance in month)	↑	↑	↓	↑	↓	↓	↓	↑	↔	↓	↔	↑
16	Complaints													
17	Friends & Family – Inpatients & Day cases	↑ (% recommending the Trust)	↓	↑	↑	↓	↑	↔	↓	↔	-	-	-	-
18	Friends & Family – ED and UCC	↑ (% recommending the Trust)	↔	↑	↓	↔	↓	↑	↑	↔	-	-	-	-
19	Mixed Sex Accommodation Breaches	↓ (Number of breaches)	↓	↑	↓	↑	↑	↓	↑	↔	↓	↓	↔	↔
20	Continuity of Carer	↑ (% Compliance)	↑	↑	↓	↑	↑	↓	↓	↑	↑	↑	↓	↑
21	CQC Insight Indicator Composite Score	↑ (Trust Score)	↔	↔	↑	↔	↔	↔	↔	↓	↔	-	-	-

Appendix 1 – KPI RAG Rating July 2019 – June 2020

	ACCESS & PERFORMANCE													
22	Diagnostic Waiting Times 6 Weeks	↑ (% Monthly Performance)	↑ (Green)	↑ (Green)	↓ (Green)	↑ (Green)	↑ (Green)	↓ (Green)	↑ (Green)	↑ (Green)	↓ (Red)	↓ (Red)	↑ (Red)	↑ (Red)
23	RTT - Open Pathways	↑ (% Monthly Performance)	↑ (Green)	↓ (Green)	↑ (Green)	↑ (Green)	↑ (Green)	↓ (Green)	↓ (Green)	↓ (Green)	↓ (Red)	↓ (Red)	↓ (Red)	↓ (Red)
24	RTT – Number Of Patients Waiting 52+ Weeks	↓ (Number of breaches – 0)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↑ (Red)	↑ (Red)	↑ (Red)
25	A&E Waiting Times – National Target	↑ (% Monthly Performance)	↑ (Red)	↑ (Red)	↓ (Red)	↓ (Red)	↓ (Red)	↓ (Red)	↑ (Red)	↑ (Red)	↑ (Red)	↑ (Red)	↑ (Red)	↓ (Red)
26	A&E Waiting Times – STP Trajectory	↑ (% Trajectory Performance)	↑ (Green)	↑ (Green)	↓ (Green)	↓ (Green)	↓ (Red)	↓ (Red)	↑ (Red)	↑ (Green)	↑ (Green)	↑ (Green)	↑ (Green)	↓ (Green)
27	A&E Waiting Times – Over 12 Hours	↓	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)
28	Cancer 14 Days	↑ (% Monthly Performance)	KPIs not reported during Faster Diagnostic Standard Pilot									↓ (Green)	↓ (Green)	↑ (Green)
29	Breast Symptoms 14 Days	↑ (% Monthly Performance)										↓ (Red)	↓ (Red)	↑ (Green)
30	Cancer 28 Day Faster Diagnostic	↑ (% Monthly Performance)										↓ (Green)	↓ (Green)	↓ (Red)
31	Cancer 31 Days First Treatment*	↑ (% Monthly Performance)	↑ (Green)	↑ (Green)	↑ (Green)	↓ (Green)	↑ (Green)	↑ (Green)	↓ (Green)	↓ (Green)	↑ (Green)	↓ (Green)	↑ (Green)	↓ (Red)
32	Cancer 31 Days Subsequent Surgery*	↑ (% Monthly Performance)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↓ (Red)
33	Cancer 31 Days Subsequent Drug*	↑ (% Monthly Performance)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)
34	Cancer 62 Days Urgent*	↑ (% Monthly Performance)	↓ (Green)	↓ (Green)	↓ (Green)	↑ (Green)	↑ (Green)	↑ (Green)	↑ (Green)	↓ (Green)	↓ (Red)	↑ (Green)	↑ (Green)	↓ (Red)
35	Cancer 62 Days Screening*	↑ (% Monthly Performance)	↓ (Green)	↑ (Green)	↓ (Green)	↑ (Green)	↓ (Green)	↓ (Red)	↑ (Green)	↓ (Green)	↑ (Green)	↑ (Green)	↑ (Green)	↓ (Red)
36	Ambulance Handovers 30 to <60 minutes	↓ (Number of patients)	↑ (Red)	↓ (Red)	↓ (Red)	↑ (Red)	↑ (Red)	↑ (Red)	↓ (Red)	↓ (Red)	↓ (Red)	↑ (Red)	↑ (Red)	↑ (Red)
37	Ambulance Handovers at 60 minutes or more	↓ (Number of patients)	↓ (Red)	↓ (Red)	↑ (Red)	↓ (Red)	↑ (Red)	↑ (Red)	↑ (Red)	↓ (Red)	↓ (Red)	↓ (Red)	↓ (Red)	↓ (Green)
38	Discharge Summaries - % sent within 24hrs	↑ (% Monthly Performance)	↑ (Red)	↓ (Red)	↓ (Red)	↑ (Red)	↓ (Red)	↓ (Red)	↑ (Red)	↓ (Red)	↑ (Red)	↓ (Red)	↓ (Red)	↑ (Red)
39	Discharge Summaries – Number NOT sent within 7 days	↓ (Number of patients)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↔ (Green)	↑ (Red)	↓ (Red)	↑ (Red)	↑ (Red)	↓ (Red)
40	Cancelled Operations on the day for a non-clinical reasons	↓ (Number of Cancellations)	↑ (Green)	↓ (Green)	↑ (Green)	↓ (Green)	↓ (Green)	↓ (Green)	↑ (Green)	↓ (Green)	↑ (Green)	↑ (Red)	↓ (Green)	↓ (Green)

Appendix 1 – KPI RAG Rating July 2019 – June 2020

41	**Cancelled Operations– Not offered a date for readmission within 28 days**	↓ **(Number of Cancellations – not rebooked)**	↑	↓	↓	↔	↔	↔	↑	↓	↑	↑	↓	↓
42	**Urgent Operations – Cancelled for a 2nd time**	↓ **(Number of patients)**	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
43	**Super Stranded Patients**	↓ **(Number of patients)**	↑	↑	↑	↓	↑	↓	↑	↓	↓	↓	↑	↓

Appendix 1 – KPI RAG Rating July 2019 – June 2020

	KPI		Jul 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20
	WORKFORCE													
44	Sickness Absence	↓ (% Monthly Performance)	↑	↓	↓	↑	↑	↑	↓	↓	↑	↑	↓	↓
45	Return to Work	↑ (% Monthly Performance)	↑	↓	↓	↓	↓	↓	↑	↓	↓	↓	↑	↓
46	Recruitment	↓ (Average Number of Days)	↑	↑	↓	↔	↓	↑	↑	↑	↓	↓	↑	↓
47	Vacancy Rates	↓ (% vacancy Rate)	↑	↓	↓	↓	↓	↓	↑	↑	↑	↓	↓	↑
48	Retention	↑ (% staff retention)	↑	↑	↑	↑	↑	↓	↓	↓	↑	↑	↓	↑
49	Turnover	↓ (% staff turnover)	↑	↓	↓	↑	↓	↑	↑	↓	↑	↓	↑	↓
50	Bank & Agency Reliance	↓ (% reliance on bank/agency)	↓	↑	↓	↓	↓	↓	↑	↑	↑	↑	↓	↓
51	Agency Shifts Compliant with the Cap	↑ (% compliant agency shifts)	↓	↑	↓	↓	↓	↑	↓	↑	↔	↓	↑	↑
52	Agency Rate Card Compliance	↑ (% compliant agency rate)											↓	↑
53	Monthly Pay Spend (Contracted & Non-Contracted)	↓ (% of budget spent)	↑	↓	↓	↑	↓	↓	↑	↓	↑	↑	↓	↓
54	Core/Mandatory Training	↑ (% Monthly Performance)	↑	↓	↓	↑	↑	↓	↑	↓	↑	↓	↓	↓
55	Role Specific Training	↑ (% Monthly Performance)											↓	↑
56	% Use of Apprenticeship Levy	↑ (% Monthly Performance)											↑	↔
57	% Workforce carrying out an Apprenticeship Qualification	↑ (% Monthly Performance)											↓	↓
58	PDR	↑ (% Monthly Performance)	↓	↓	↑	↑	↑	↓	↓	↑	↑	↑	↓	↓

Appendix 1 – KPI RAG Rating July 2019 – June 2020

	FINANCE													
59	Trust Financial Position	↑ (Cumulative against plan)	↑	↑	↑	↑	↓	↑	↑	↑	↑	↑	↔	↔
60	System Financial Position	↑ (Cumulative against plan)										-	-	-
61	Cash Balance	↑ (Balance against plan)	↑	↓	↓	↓	↑	↑	↓	↑	↓	↑	↑	↓
62	Capital Programme	↑ (Performance against plan)	↓	↓	↓	↑	↑	↑	↑	↑	↑	↑	↑	↑
63	Better Payment Practice Code	↑ (Monthly actual against plan)	↓	↔	↔	↑	↔	↑	↓	↓	↓	↑	↑	↑
64	Use of Resources Rating	↑ (Rating against plan)	↔	↔	↔	↔	↔	↔	↔	↔	↔	-	-	-
65	Agency Spending	↓ (Monthly planned vs actual)	↑	↓	↓	↑	↑	↑	↑	↑	↑	↑	↔	↔
66	Cost Improvement Programme – Performance to date	↑ (Monthly vs target)	↑	↑	↑	↑	↓	↓	↑	↑	↑	-	-	-
67	Cost Improvement Programme – Plans in Progress (In Year)	↑ (Monthly vs plan)	↑	↑	↑	↑	↑	↑	↓	↑	↓	-	-	-
68	Cost Improvement Programme – Plans in Progress (Recurrent)	↑ (Forecast)	↑	↓	↓	↓	↓	↓	↑	↑	↑	-	-	-

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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Integrated Dashboard - June 2020

Appendix 2

Key Points/Actions

Quality Improvement

May-20: Red 2, Amber 1, Green 13, Other 5
Jun-20: Red 3, Amber 2, Green 13, Other 3

There were 142 open incidents that require review and sign off, of which 21 have been open over 40 days. Compliance in relation to Duty of Candour remains 100% in month. Healthcare Acquired Infection objectives have not been published nationally. CDI reviews with the CCG have been delayed due to COVID-19. There were 2 cases of CDI (under review), 5 cases of E.coli and 1 case of Klebsiella reported in month. There were 4 category 2 pressure ulcers reported in month with no category 3 or 4 pressure ulcers reported. There were 63 falls, of which 55 were inpatient falls. Medication reconciliation within 24 hours has increased to 83.00% and overall reconciliation is at 95.00%. NICE compliance was at 87.75%. There were 0 mixed sex accommodation breaches in month. Continuity of Carer compliance has increased to 39.50%.

Access & Performance

May-20: Red 10, Amber 0, Green 12, Other 0
Jun-20: Red 13, Amber 0, Green 9, Other 0

Performance against many of the Access & Performance standards has been significantly impacted by COVID-19. The Trust did not achieve the RTT or the 6 week Diagnostic Standard in month. The Trust is in the process of implementing recovery plans to address this. There were 73 breaches of the 52 week wait RTT standard. The Trust did not meet the 4 hour A&E standard but did achieve the trajectory. Ambulance handovers performance was positive with no handovers taking place after 60 minutes. The Trust met the two week wait and breast symptomatic cancer standards, however did not achieve the 62 day or 31 day cancer treatment standards or 28 day faster diagnostic standard, this was due to positive action to utilise capacity around urgent cases. Discharge summary performance has improved for both 24 hours and 7 days. There was 1 patient whose operation was cancelled and not rebooked within 28 days, however the number of operations cancelled on the day for non clinical reasons overall was positive at 0.08%. The number of Stranded and Super Stranded patients remains positive.

Workforce

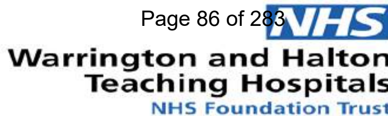
May-20: Red 5, Amber 3, Green 7, Other 0
Jun-20: Red 4, Amber 5, Green 6, Other 0

Trust sickness absence has improved to 5.73% in month. Return to work compliance has improved to 67.39%. Average recruitment timeframes over the 12 month rolling period are on target at 59 days. Turnover was at 11.61% and Retention is at 88.65% which remains positive. Vacancy rates were 10.47%. Bank and Agency reliance has improved to 15.64%. Core Skills Training compliance is just below target at 83.62% with Role Specific Training at 89.10%. PDR compliance in month was at 93.34%. Agency shift compliance against the pay cap was at 42.35%. Pay spend was £18.6m against a budget of £20.3m.

Finance

May-20: Red 3, Amber 0, Green 2, Other 5
Jun-20: Red 2, Amber 1, Green 2, Other 5

In June, the Trust recorded a breakeven position which included £11.4m COVID-19 expenditure and £9.0m retrospective top up. The cash balance at the end of the month was £18.0m. Internal capital spend was £0.6m which is £1.8m below the planned capital spend of £2.4m. Agency spend is £0.9m of which £0.7m relates to COVID-19. Better Practice Payment Code was 97.00% which is 2.00% above the target of 95.00%. This is a significant improvement on March's position due to the early receipt of block income,supporting the Trust to pay creditors within 7 days of receipt of goods and services.



Key:

Single Oversight Framework Risk Register

Care Quality Commission Trust Strategy

Quality Improvement - Trust Position

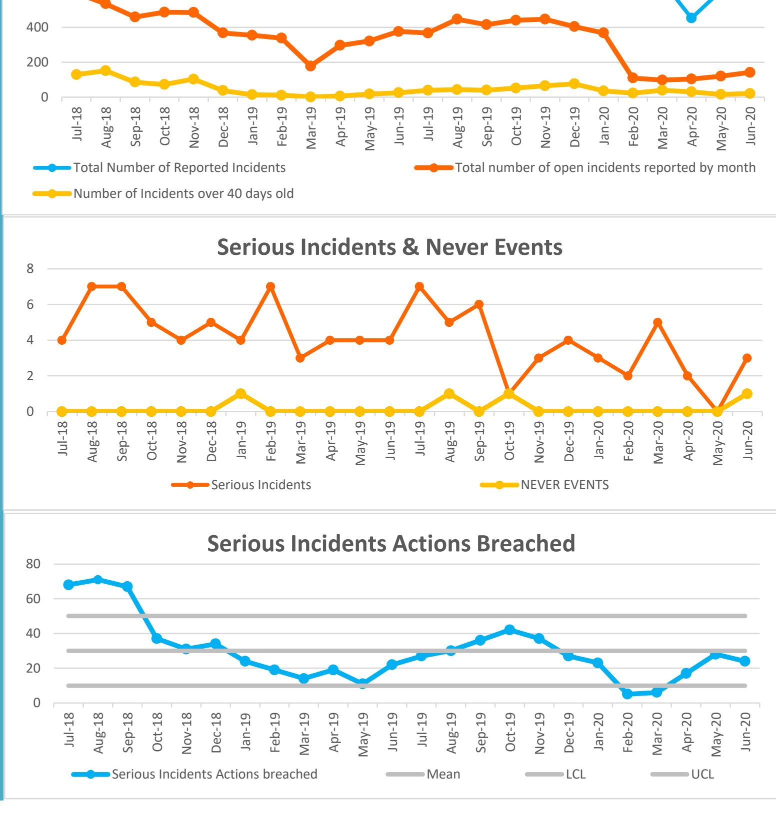
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Patient Safety

Incidents

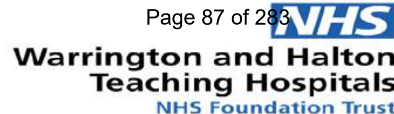
Red: Open incidents outside 40 day timeframe
Amber: Open incidents between 20 - 40 days old.
Green: Open incident within timeframe of 20 days.

There were 21 incidents over 40 days old open in June 2020 across the 7 CBUs. This is an increase of 6 compared to the previous month. This standard is continuously reviewed to ensure incidents are closed in a timely manner during the COVID-19 period.



There was 3 Serious Incidents reported in June 2020, including 1 Never Event. Whilst the Trust has seen a marked improvement over the past 12 months, actions and incidents continue to be a focus to ensure that they're reviewed and completed in a timely manner. This improvement has been driven by scrutiny at Patient Safety & Effectiveness Sub Committee and weekly Meeting of Harm.

Governance managers will continue to support the CBUs in reviewing and closing incidents and actions. This will be monitored by the Patient Safety Manager and the Deputy Director of Governance. Weekly oversight of incidents and actions is provided at the weekly Meeting of Harm.

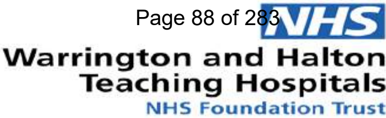


Key:

Single Oversight Framework	SOF	Risk Register	RR116
Care Quality Commission	CQC	Trust Strategy	S

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
CAS Alerts - Green - All relevant CAS Alerts actioned within timescales Red - Applicable CAS Alert not actioned within the timescale.	CQC **There were 10 new CAS Alerts received in month. There were no CAS alert actions which have breached the timescale in month.**	Central Alerts System (CAS) Alerts Number of New CAS Alerts Received in Month (Jul-18 to Jun-20)	**The Trust received 10 CAS alerts in month with no action breaches.**	**There is ongoing monitoring and oversight at the Health and Safety and Patient Safety and Effectiveness Sub-Committees to ensure the current position is sustained.**
Duty of Candour Red: <100% Green: 100%	CQC **The Trust achieved 100% for Duty of Candour in month.**	Duty of Candour (DoC) Number of serious incidents - DoC applies; Number of moderate harm incidents - DoC applies; % Compliance rate with DoC (serious incidents); % Compliance rate with DoC (moderate incidents) (Jul-18 to Jun-20)	**Compliance with Duty of Candour remains in line with Trust policy and continues to be supported through monitoring via the Datix system with oversight by the Clinical Governance Department.**	**Duty of Candour is monitored at the weekly Governance Oversight meeting by the Deputy Director of Governance to ensure that performance is sustained. Daily monitoring is provided by the Patient Safety Manager.**

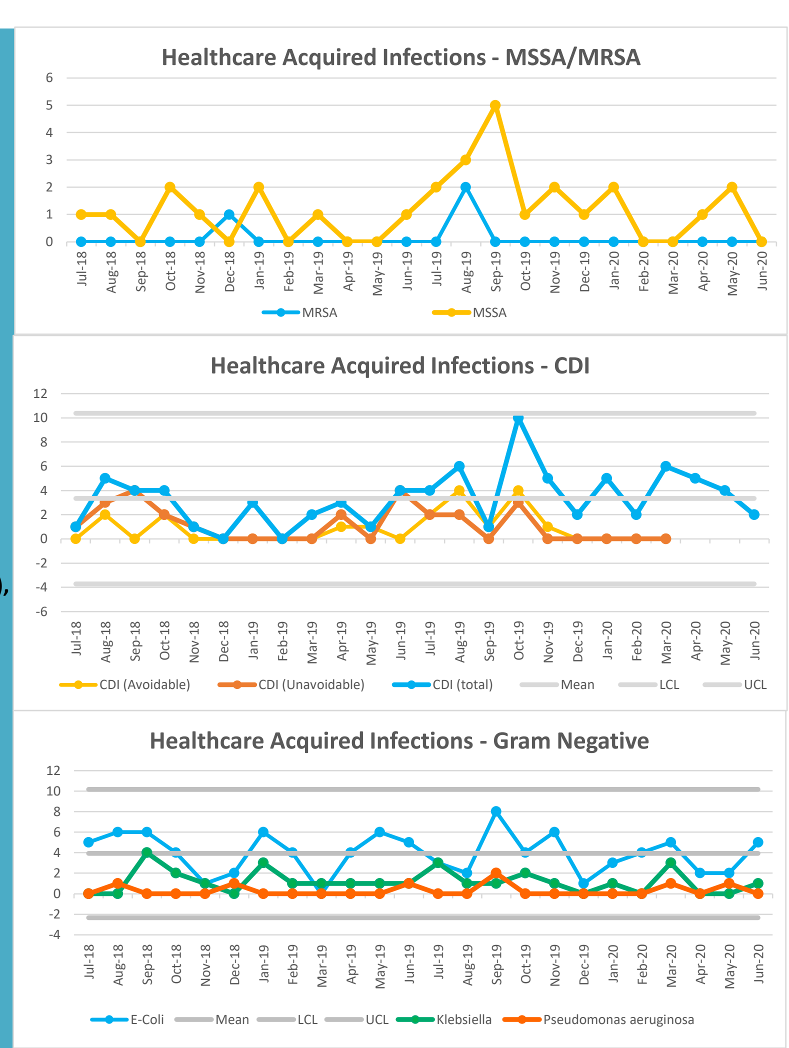


Key:

Single Oversight Framework — Risk Register

Care Quality Commission — Trust Strategy

Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Healthcare Acquired Infection (HCAI) objectives have not been published nationally by NHSE/I for Gram Negative or C. difficile. The current RAG rating is based on 2019/20 thresholds. There were 2 cases of CDI (under review), 5 cases of E.coli and 1 case of Klebsiella reported in June 2020.		There may be an increase in pneumonia cases following viral infection with SARS-CoV-2 (COVID-19). A different inpatient profile due to the COVID-19 pandemic will make comparisons with previous year's data difficult.	Action plans are in place for reduction of all Health Acquired Infections and will be applied throughout the recovery period. Plans will be reviewed and adapted according to Root Cause Analysis report findings.

Healthcare Acquired Infections

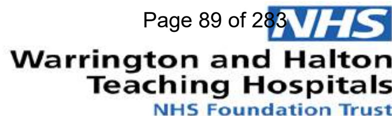
MRSA
Red: 1 or more
Green: 0

Healthcare Acquired Infections

C-Difficile
Red: 44+ per annum
Green: Less than 44 per annum

Healthcare Acquired Infections - Gram Negative

E-Coli
Red: 47+ per annum
Green: Less than 47 per annum
Pseudomonas aeruginosa & Klebsillea - No Threshold Set



Key:

Single Oversight Framework — SOF
Risk Register — RR116
Care Quality Commission — CQC
Trust Strategy — S

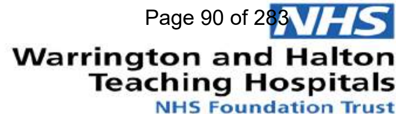
Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
SOF, S, RR128 The Trust achieved 92.32% for VTE assessments on average in Q1 2020/21.	VTE Assessment (chart)	The Trust achieved 92.32% for VTE assessments on average in Q1 2020/21. National Trajectory: The Trust is 2.68% below the current 95.00% target for VTE.	Focused work with clinical teams to improve compliance with the VTE electronic risk assessment process is in place. Daily progress updates are escalated to clinicians, supported by the Associate Medical Director to ensure completion of risk assessments.
CQC, S, RR120 There were a total of 63 falls in the month; of which 55 were inpatient falls. SPC - Falls are within common cause (expected) variation.	Falls - Inpatient & All (chart); Falls - Moderate, Severe & Death (chart)	The Trust recorded 1 severe harm incident as a result of a fall in June 2020. This is being investigated as a Serious Incident.	The Trust continues to review Falls daily at the COVID-19 Safety Response Meeting (which has temporarily replaced the Safety Huddle) and weekly at the Meeting of Harm. The Trust action plan has been updated to reflect the Trust Falls Quality priority for 2020/21.

VTE Assessment

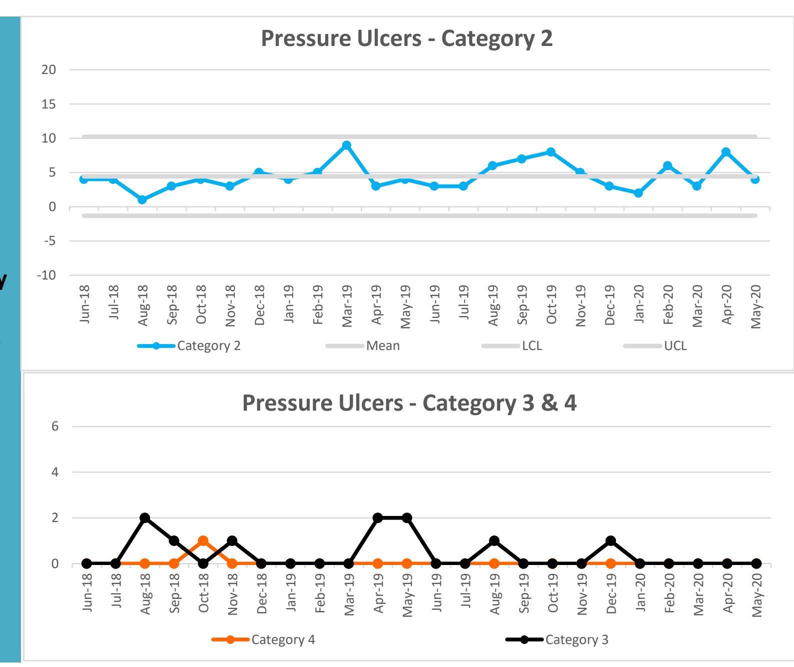
Red: <95%
Green: 95% or above based on previous months' figures due to timescales for validation of data

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

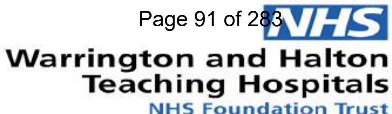


Key:
Single Oversight Framework SOF
Care Quality Commission CQC
Risk Register RR116
Trust Strategy S

Quality Improvement - Trust Position

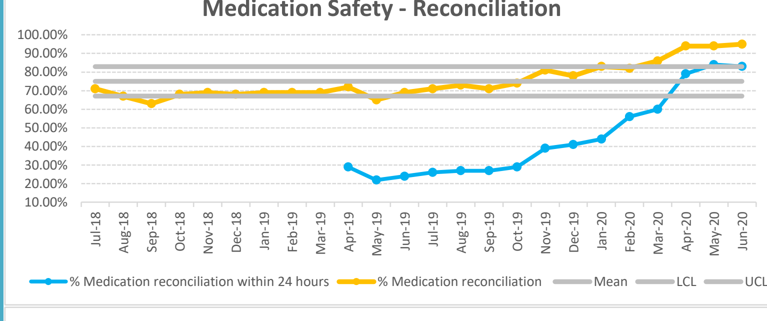
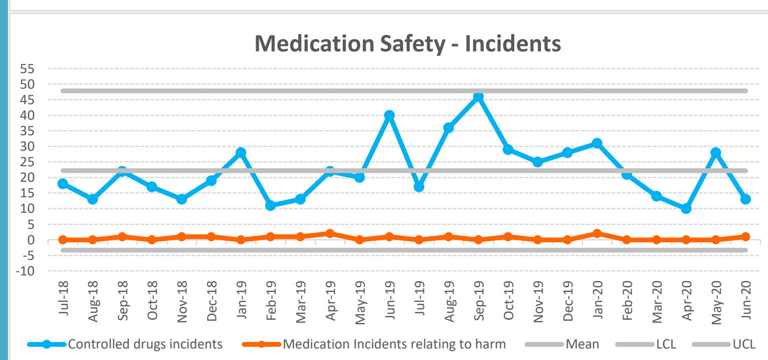
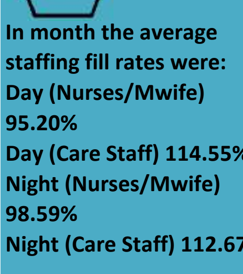
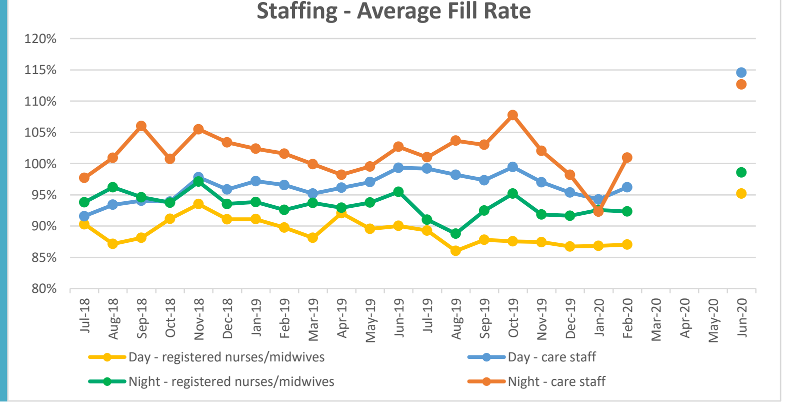
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
CQC There were 0 hospital acquired Category 4 pressure ulcers, 0 Category 3 pressure ulcers and 4 Category 2 pressure ulcers reported in month. SPC - Pressure ulcers are within common cause (expected) variation.		There is variation noted in initial and subsequent risk assessments and this is being investigated. Internal Variance Plan: The Trust has had a total of 15 category 2 pressure ulcers which year to date is within target for reduction.	Root Cause Analysis (RCA) of each pressure ulcer is completed and reviewed with wider lessons learned shared across the organisation via Trust wide Safety Briefing and newsletter during the COVID-19 pandemic.

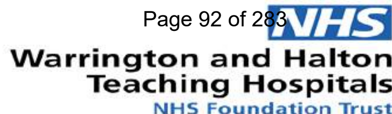
Pressure Ulcers
Based on 65 in 2019/20
Red: 4% reduction or below
Amber: 5%-9% reduction
Green: 10% reduction or above.



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

Quality Improvement - Trust Position

Trust Performance		Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Medication Safety Reconciliation within 24 hours Red: below 60% Amber: 60% - 79% Green: 80% or above	 Medication Reconciliation within 24hrs was 83.00% in June 2020. There was 1 incident of harm relating to medication safety and 13 controlled drug incidents in month.	 	Performance against both medicines reconciliation targets has improved during the COVID-19 pandemic. Factors influencing this: • More staff hours re-directed to ward-based clinical pharmacy. • Allocation of staff time to training aimed at managing the COVID-19 response. • Use of modified daily rotas with time allocations that reflect workload at ward level with tight control of staffing resources. • Flexible use of the work force across 7 days with an emphasis on supporting safe prescribing at weekends.	A 7 day services business case review is underway to support an effective distribution of staff to ward pharmacy services across 7 days. Staffing resources continue to be allocated for controlled drugs and medicines audits and reports i.e. medication safety related activities during the COVID-19 response.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	 In month the average staffing fill rates were: Day (Nurses/Mwife) 95.20% Day (Care Staff) 114.55% Night (Nurses/Mwife) 98.59% Night (Care Staff) 112.67%		Any individual ward that falls below 90.00% provides mitigation to ensure it is safe and that high quality care is consistently delivered in those areas.	The Trust continues to make progress in the Trust wide Recruitment and Retention Strategy which will improve the position further.



Key:

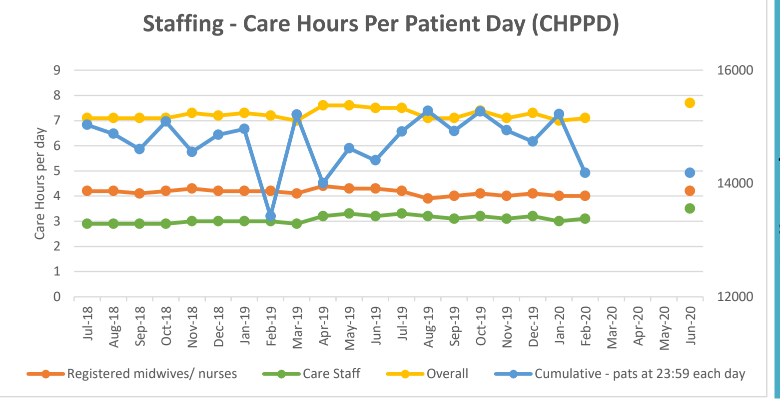
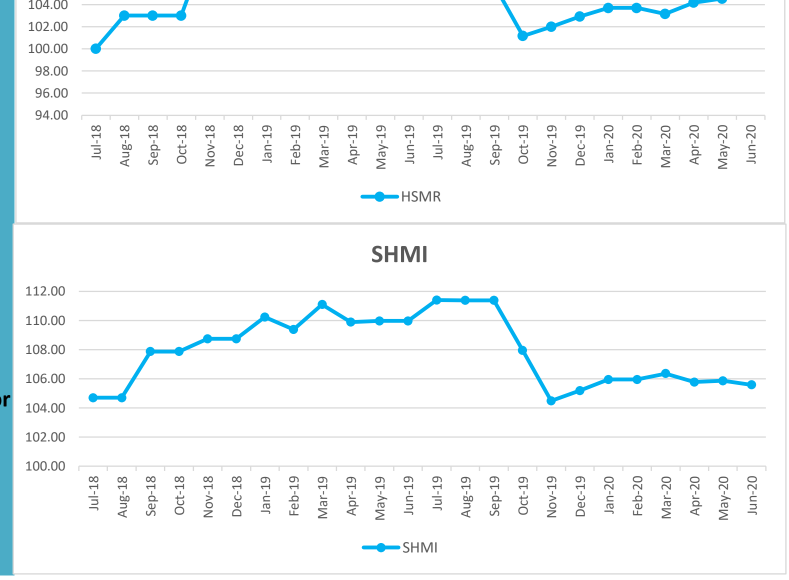
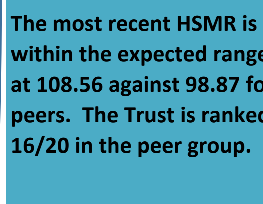
Single Oversight Framework — SOF

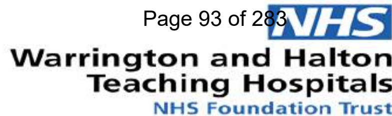
Risk Register — RR116

Care Quality Commission — CQC

Trust Strategy

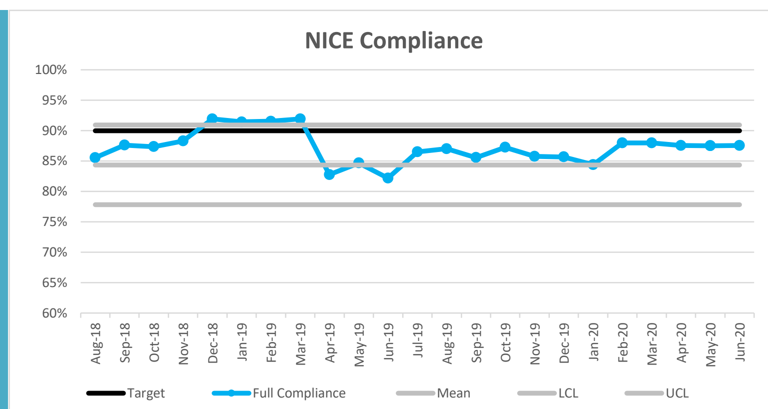
Quality Improvement - Trust Position

Trust Performance		Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Staffing - Care Hours Per Patient Day (CHPPD) Red: Below 6.0 Amber: 6.0 - 7.8 Green: 7.9 or More	RR115 In month, the average CHPPD were: Nurse/Midwife: 4.2 hours Care Staff: 3.5 hours Overall: 7.7 hours		National Trajectory: The Trust is 0.2 hours behind the national target of 7.9 for CHPPD. This standard continues to be monitored monthly by the Senior Nursing Team.	Ward staffing levels continue to be systematically reviewed, which includes Planned vs. Actual staffing levels. These are reported monthly as part of the Unify submission and any ward that falls below 90.00% provides mitigation to ensure safe, high quality care is consistently being delivered in those areas.
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	 The most recent HSMR is within the expected range at 108.56 against 98.87 for peers. The Trust is ranked 16/20 in the peer group.		The most recent HSMR is within the expected range. Work continues at the Mortality Review Group using the Structured Judgement Review tool. National Trajectory: The Trust is within the expected range for HSMR and is currently at 108.56.	Mortality reviews will continue to be undertaken alongside the governance incident process to ensure triangulation and learning. The process will continue to be overseen by the Trust Mortality Lead with escalation to the Deputy Director of Governance.
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	 The most recent SHMI is within the expected range at 105.59 against 105.44 for peers. The Trust is ranked 8/18 in the peer group.		The most recent SHMI is within the expected range. Work continues at Mortality Review Group using the Structured Judgement Review tool. National Trajectory: The Trust is within the expected range for SHMI and is currently at 105.59.	

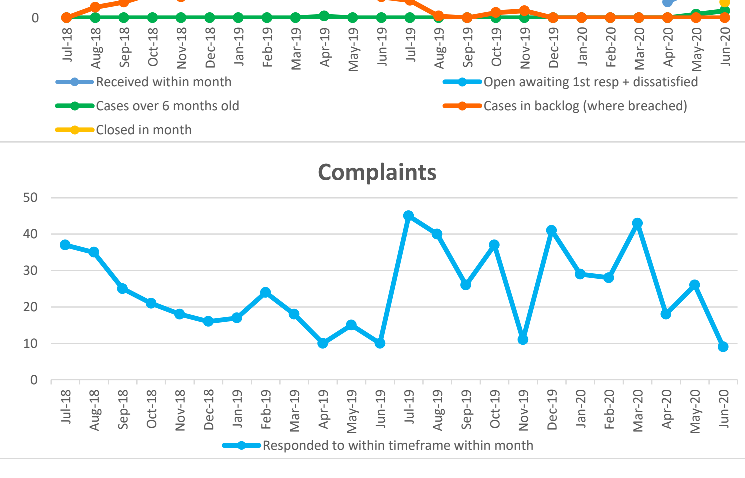


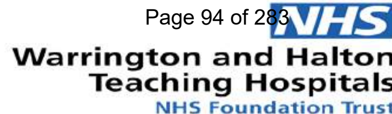
Key:
Single Oversight Framework — SOF
Care Quality Commission — CQC
Risk Register — RR116
Trust Strategy

Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
NICE Compliance Red: Below 75% Amber: 75% to 89% Green: 90% or Above SOF The Trust achieved 87.57% in month. SPC - There is evidence of special cause variation for NICE compliance. This is due to planned improvement work in NICE compliance.		Trust compliance is at 87.57%. An action plan is in place to reach the target of 90.00%. This has been impacted by COVID-19.	A recovery plan has been developed for implementation post COVID-19. This will be reported to Patient Safety and Clinical Effectiveness Sub-committee to evidence compliance.

Patient Experience

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Complaints Red: Complaints over 6 months old/69% or less responded to within the timeframe Amber: No complaints over 6 months old, 70% - 89% responded to within the timeframe Green: No backlog, 90% responded to within the timeframe. 4 of the 88 open complaints are now over 6 months old. This is a result of the pause on complaints during the COVID-19 pandemic.		As per the directive from NHSE/I the complaints process was paused during the period of 30 March to 22 June 2020. During this period the Trust continued to investigate high level complaints and respond where possible. In June 2020, 9 complaints were closed. To ensure that complaints are responded to in a timely manner and to prevent a backlog, the CBU's are working closely with the Complaints Team to respond to the complaints received prior to and during the COVID-19 pandemic. This process is being supported by the Executive Team.	The Head of Complaints, Claim and PALS will continue to work with the CBU's to ensure that responses are received by the complaints team within internal timeframes and will support staff to improve the quality of the responses.



Key:

Single Oversight Framework — SOF

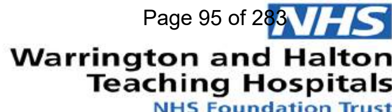
Risk Register — RR116

Care Quality Commission — CQC

Trust Strategy — S

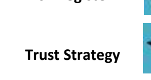
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	SOF CQC S The Friends and Family Test has been suspended as per NHSE/I COVID-19 pandemic guidance.			
Friends and Family (ED and UCC) Red: Less than 87% Green: 87% or more	SOF CQC S The Friends and Family Test has been suspended as per NHSE/I COVID-19 pandemic guidance.			



Key:

Single Oversight Framework — SOF | Risk Register — RR116
Care Quality Commission — CQC | Trust Strategy



Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	SOF There were 0 mixed sex accommodation breaches reported in month. SPC - Mixed Sex Accommodation Breaches are within common cause (expected) variation.	Mixed Sex Accommodation Breaches (chart: Target, Number of Breaches, Mean, LCL, UCL; Jul-18 to Jun-20)	There were 0 MSA breaches reported in June 2020. National Trajectory: The Trust has met the national target of 0.	Patients are cohorted to minimise breaches and step down is expedited as soon as is practicable. During COVID-19, additional bed capacity has facilitated the timely transfer of patients in line with clinical pathways.
Continuity of Carer Green: 35% or Above Amber: 25% - 34% Red: below 25%	The target for women being booked onto a continuity of carer pathway by March 2021 is over 51.00% (National). The Trust achieved 39.50% in June 2020.	Continuity of Carer (chart: Target, Continuity of Carer; Jul-18 to Jun)	The percentage of women booked onto a continuity of carer pathway in June was 39.50%.	A review is underway to look at new models of provision in relation to Continuity of Carer; any new model will require investment in staffing. The Homebirth team commenced, 14 new homebirth bookings was received in first 14 days.

CQC

CQC Insight Composite Score

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

CQC RR115

CQC Insight reporting has been suspended.

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	SOF CQC The Trust achieved 47.20% in month. SPC - There is evidence of special cause variation for Diagnostic Waiting Times, this relates to the impact of COVID-19 RR116	Diagnostic Waiting Times 6 Weeks	The diagnostic standard was not achieved in June 2020, this was due to the to the impact of the COVID-19 pandemic. The number of breaches significantly increased as services were suspended due to adherence to national guidance.	A recovery plan has now been agreed and patients are being clinically prioritised accordingly, in line with national guidance. The recovery plan is demonstrating that the actions agreed are delivering recovery with fewer breaches recorded as services are brought back on-line. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG).
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or above RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red	SOF CQC The Trust achieved 61.78% in month. There were 73, 52 week breaches in June 2020. SPC - There is evidence of special cause variation in RTT pathways, this relates to the impact of COVID-19. RR116	Referral to treatment Open Pathways	The Trust did not achieve the 18 week Referral to Treatment standard in June 2020. This was associated with the reduction of the elective programme due to COVID-19. The Trust ceased all routine work in April 2020 following national guidance to prepare capacity to manage anticipated demand from COVID-19.	Recovery of the elective programme is taking place with: • Urgent cancer and elective activity is being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of vulnerable patients. • Elective capacity has been restored at the Halton Elective Centre from the end of June and will continue to increase to take other specialties. • The Trust continues to utilise Spire Healthcare until the end of August although there is potential for this to continue following this period. • A paper on the management of patients on waiting lists has been shared with the Quality & Assurance (QAC) Committee in July 2020. An update report will be available for Patient Safety and Effectiveness Committee and QAC as a regular agenda item on these committees.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
SOF CQC Four Hour Standard - National Target Red: Less than 95% Green: 95% or Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory **The Trust achieved 92.16% excluding walk ins in month.** **SPC - There is special cause variation present in the Four Hour A&E standard.** RR224	A&E Waiting Times - 4hr target (Chart: Improvement Trajectory; % (Excluding Walk-In); Mean; LCL; UCL; Jul-18 to Jun-20; 60%–100%)	**There was a marginal reduction in performance compared to May 2020 achieving 92.16% (excluding Widnes Walk-in activity). However this is approximately a 10% improvement on the same period in 2019 (June 2019 - 81.48%). This performance was achieved despite a further increase in attendances from those seen in May 2020. The Warrington site saw 87.60% of attendances compared to the same period last year, which is highlighting that there is a return to normal levels of activity compared to the peak of the COVID-19 pandemic. However, this level of performance has been reliant upon the Trust being able to manage segregated flows throughout the department which has been successfully achieved.**	**• Pathway improvement to streamline the flow and allocation of beds to patients in ED and CAU continued throughout June 2020 on a 24/7 basis. A new ambulatory surgical pathway has been agreed to support surgical flow through the unit. • In response to COVID-19, additional in-patient capacity was made available to reduce the stranded and super stranded patients contributing to an improvement in bed occupancy. This has supported flow out of the ED in a timely manner. • Royal College of Emergency Medicine guidance, Resetting Emergency Department Care, was received on 6th May 2020 and outlines 5 recommendations. An action plan has been developed and will be monitored via the COVID-19 Recovery Group. • The bed reconfiguration programme of work is currently being implemented. This has identified the future utilisation of the medical and surgical capacity to ensure flow through the department is consistent.**
SOF The number of patients who has experienced a wait in A&E longer than 12 hours from the decision to admit. Green = 0 Red = > 0 **There were 0 patients waiting longer than 12 hours in A&E in month.**	Number of Patients Waiting Longer than 12 Hours in A&E (Chart: Target; No. of Patients; Jul-18 to Jun-20; 0–10)	**The Trust has achieved the standard of not having any patients waiting longer than 12 hours from the decision to admit in June 2020.** **This standard has been consistently achieved over time.**	**Maintain compliance against the 12 hour standard from the decision to admit.**

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Key:
Risk Register
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 14 Days Red: Less than 93% Green: 93% or above	SOF CQC The Trust achieved 97.33% in May 2020. SPC - Cancer 14 days is within common cause (expected) variation. RR116	Cancer 14 Days (chart: Target, %, Mean, LCL, UCL; Jun-18 to May-20)	The Trust achieved the 2 week wait standard in May 2020.	Two week waits are being actively monitored due to a reduction in capacity within the breast service following a consultant leaving the Trust in recent months. The team are working on a plan to increase the capacity which will require the use of a locum to support capacity whilst a longer term plan is developed and agreed. The June position looks favourable from early indications.
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	SOF CQC The Trust achieved 100% in May 2020. SPC - Breast Symptoms is within common cause (expected) variation. RR116	Breast Symptoms 14 Days (chart: Target, %, Mean, LCL, UCL; Jun-18 to May-20)	The Trust achieved the Breast Symptomatic Standard in May 2020.	
28 Day Faster Cancer Diagnosis Standard Red: Less than 75% Green: 75% or above	The Trust achieved 74.61% in May 2020.	Cancer 28 Day Faster Diagnostic Standard (chart: Target, %; Jun-18 to May-20)	The Trust continues to participate as the test site for the 28 day Faster Diagnosis standard as part of the clinical review of all cancer access standards. The Trust achieved 74.61% in May 2020 against a target of 75.00%. This was as a consequence to a number of patients being suspended throughout the COVID-19 pandemic and now returning to active management post the 28 day window.	Continue to maintain improvement against the FDS clinical review of standards pilot.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Key:
Risk Register
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

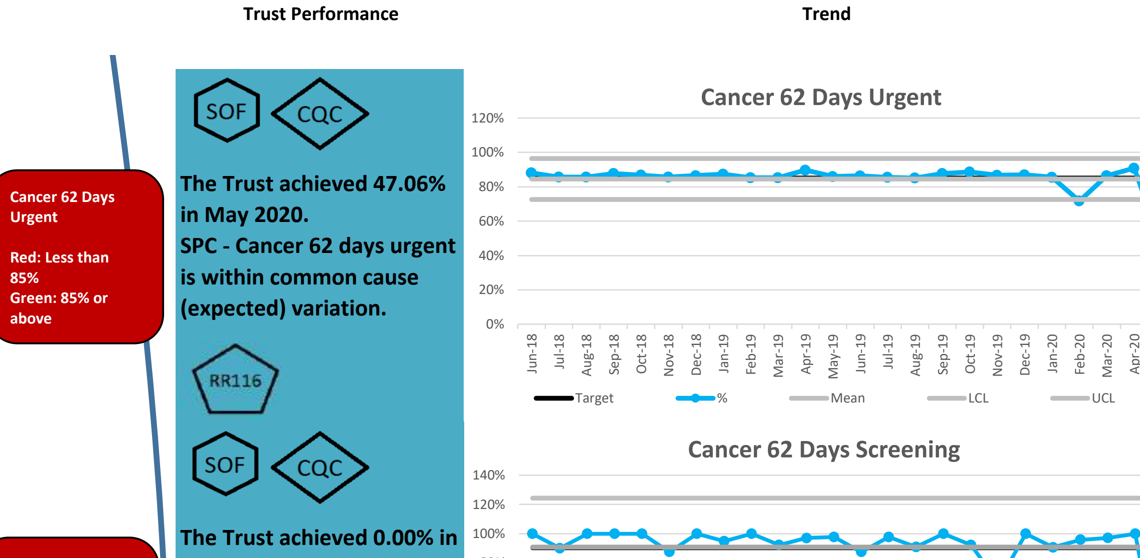
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	SOF CQC The Trust achieved 82.61% in May 2020. SPC - Cancer 31 days is within common cause (expected) variation. RR116	Cancer 31 Days First Treatment	The 62 day along with 31 day cancer targets were not achieved in May 2020 due to the level of surgical cases treated in the month which accounted for most all of the breeches recorded as previously suspended due to COVID-19. This was the result of a positive action to utilise the capacity to treat these urgent cases in the same month.	There remains a risk for performance for approximately the next 2-3 months due to the number of patients who had been diagnostic suspended and now returning to active management.
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	SOF CQC The Trust achieved 100% in May 2020. SPC - Cancer 31 days surgery is within common cause (expected) variation. RR116	Cancer 31 Days Subsequent Surgery		
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	SOF CQC The Trust achieved 100% in May 2020. SPC - Cancer 31 days drug is within common cause (expected) variation. RR116	Cancer 31 Days Subsequent Drugs	The Trust achieved 100% in May 2020.	Maintain compliance against the 31 day subsequent treatment (drug) standard.

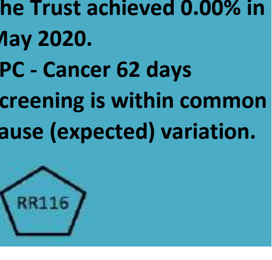
Warrington and Halton Teaching Hospitals NHS Foundation Trust

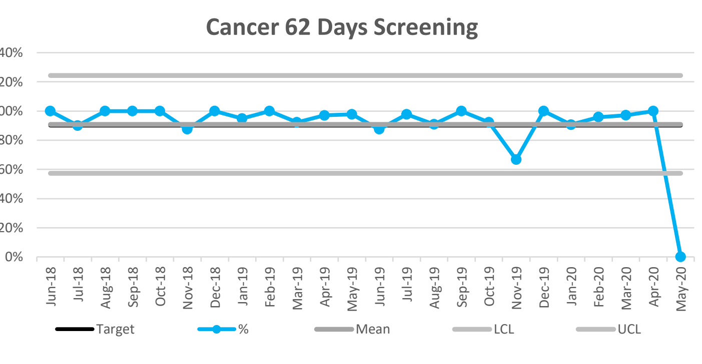
Access & Performance - Trust Position

Key:
Risk Register
Single Oversight Framework
Care Quality Commission

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above SOF CQC The Trust achieved 47.06% in May 2020. SPC - Cancer 62 days urgent is within common cause (expected) variation. RR116	Cancer 62 Days Urgent (chart)	The 62 day along with 31 day cancer targets were not achieved in May 2020 due to the level of surgical cases treated in the month which accounted for most all of the breaches recorded as previously suspended due to COVID-19. This was the result of a positive action to utilise the capacity to treat these urgent cases in the same month.	There remains a risk for performance for approximately the next 2-3 months due to the number of patients who had been diagnostic suspended and now returning to active management.
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above SOF CQC The Trust achieved 0.00% in May 2020. SPC - Cancer 62 days Screening is within common cause (expected) variation. RR116	Cancer 62 Days Screening (chart)		







Warrington and Halton Teaching Hospitals NHS Foundation Trust

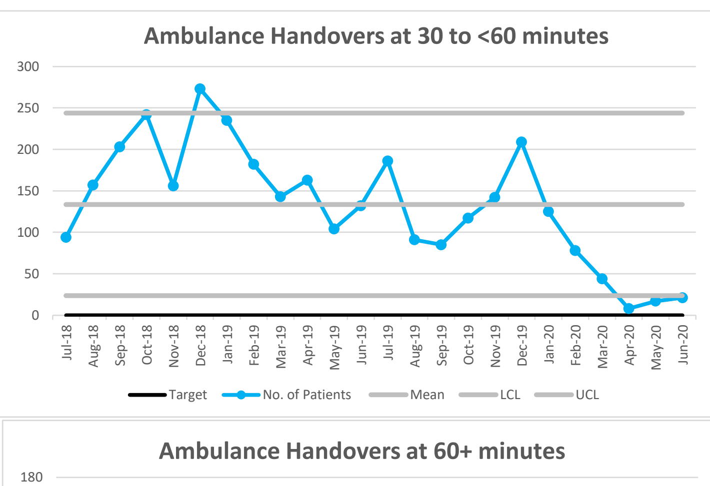
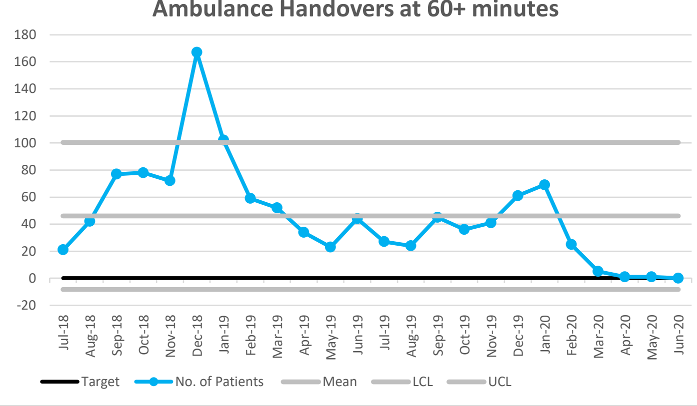
Key:

Risk Register

Single Oversight Framework

Care Quality Commission

Access & Performance - Trust Position

Trust Performance		Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Ambulance Handovers 30 to <60 minutes Red: More than 0 Green: 0	There were 21 patients waiting between 30 and 60 minutes for handover in month. SPC - There has previously been special cause variation present for Ambulance Handover Times however this has stabilised.		Performance against this standard remains positive. There has been significant improvements in the number of patients handed over between 0-15 & 0-30mins. There were 21 patients handed over between 30-60 mins (compared in 132 in the same period last year) and 0 patients handed over after 60 minutes (compared with 46 in the same period last year). The Trust has been able to maintain this performance with an increased number of conveyances since the beginning of the COVID-19 pandemic.	Regionally, the Trust continues to perform well compared to peers for over 60+ minute delays and continues to participate within the regional collaborative aimed at reducing delays during the winter period. The Trust will continue to work in partnership with the North West Ambulance Services to identify and implement improvements.
Ambulance Handovers at 60 minutes or more Red: More than 0 Green: 0	There were 0 patients waiting over 60 minutes for handover in month. SPC - There has previously been special cause variation present for Ambulance Handover Times however this has stabilised.			

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

Key:
Risk Register
Single Oversight Framework
Care Quality Commission

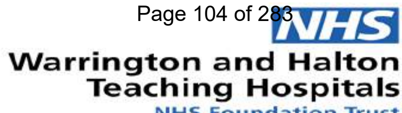
Trust Performance		Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	RR123 The Trust achieved 80.40% in month. SPC - There is evidence of special cause variation in Discharge Summaries sent within 24 hours.	Discharge Summaries (chart: Target, %, Mean, LCL, UCL; Jul-18 to Jun-20)	There has been an improvement in the number of discharge summaries sent within 24 hours in June. Performance is starting to return to pre COVID-19 levels. However, the standard remains a focus of the CBUs. There is weekly scrutiny at the PRG and monthly at the KPI meeting.	The Performance Review Group is currently undertaking a deep dive in to sub-specialties to support improvement in future months. A full review of the logic monitoring this standard is in the process of being completed to complement the work being taken forward via the PRG.
Discharge Summaries - Number NOT sent within 7 days Red: Above 0 Green: 0	RR123 There were 35 discharge summaries not sent within 7 days required to meet the 95.00% threshold.	Discharge Summaries - NOT sent within 7 days (chart: Of the no. required to hit 95% how many not sent within 7 days; Jul-18 to Jun-20)	The Trust did not achieve compliance against the 7 day discharge summary standard in June 2020.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

Key:
Risk Register
Single Oversight Framework
Care Quality Commission

Trust Performance		Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancelled Operations on the day for a non-clinical reason Red: > 2% Green: < 2%	CQC 0.08% operations were cancelled on the day for non clinical reasons in month.	Cancelled operations on the day for non-clinical reason (Target; % of Cancelled Operations; Jul-18 to Jun-20)	In June 2020, there was a further decrease in the number of cancelled operations on the day to 2 in June from 8 in May despite the increase in activity associated with the restoration of the urgent elective and cancer programme. These breeches were in Ophthalmology (1) and Oral Surgery (1).	Recovery of all activity as a consequence of the COVID-19 pandemic is being monitored via daily elective meetings, supported by Recovery Board and the Strategic Executive Oversight Group.
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	There was 1 cancelled operation on the day for non clinical reasons in month, where the patient was not booked in within 28 days.	Number of Cancelled operations on the day for non-clinical reason - Not offered date for readmission within 28 days (Target; Number of Patients; Jul-18 to Jun-20)	There was only 1 breach of the 28 day standard in June as there was no capacity available as a consequence of the COVID-19 pandemic in which to relist the patients within this timeframe.	
Urgent Operations - Cancelled for a 2nd Time Green = 0 Red = > 0	There were 0 urgent operations cancelled for a second time in month.	Urgent Operations - Cancelled for a 2nd Time (Target; No. of Patients; Jul-18 to Jun-20)	This is an additional standard to enhance monitoring of cancelled operations. The Trust continues to maintain this standard.	Maintain the standard that no urgent operation are cancelled for a second time.



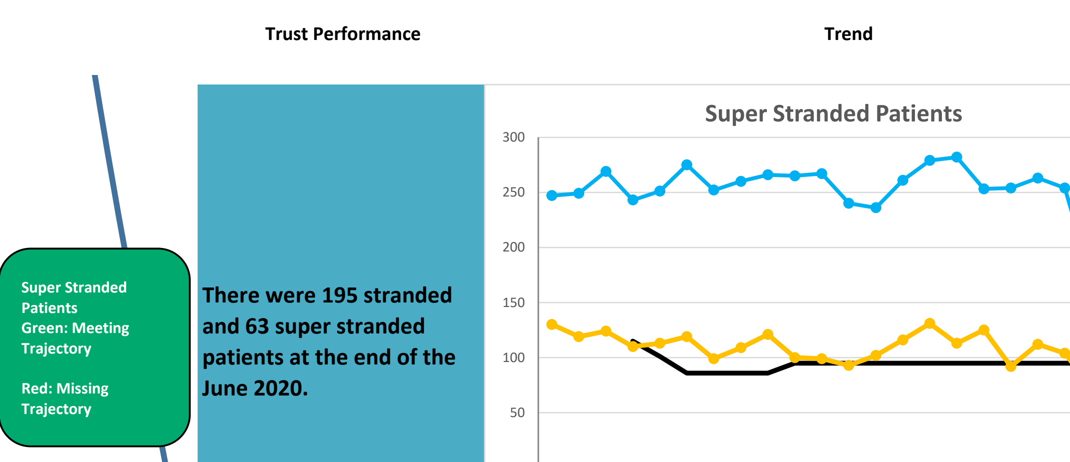
Access & Performance - Trust Position

Key:

Risk Register

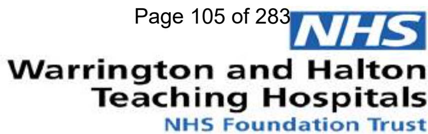
Single Oversight Framework

Care Quality Commission

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
There were 195 stranded and 63 super stranded patients at the end of the June 2020.		The number of Stranded and Super Stranded on the last day of the month decreased in June despite the increase in attendances and admissions that was seen throughout the Trust. In addition, work continued within the Care Home sector to ensure safe discharges were undertaken, which included COVID-19 swabbing prior to discharge.	The Trust is working in collaboration with partners from the Local Authorities and community providers to ensure community capacity has been available throughout the pandemic. This continues to the be the case with the Trust submitting a 'Seacole' bid to house up to 60 step-down beds on the Halton site as part of Cheshire & Merseyside commissioning 300 additional beds in this sector. The Length of Stay and Where Best Next meetings continue to be undertaken on a daily basis to support timely discharge.

Super Stranded Patients
Green: Meeting Trajectory

Red: Missing Trajectory



Workforce - Trust Position

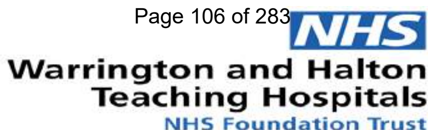
Key:

Single Oversight Framework Care Quality Commission

Use of Resources Assessment — Trust Strategy

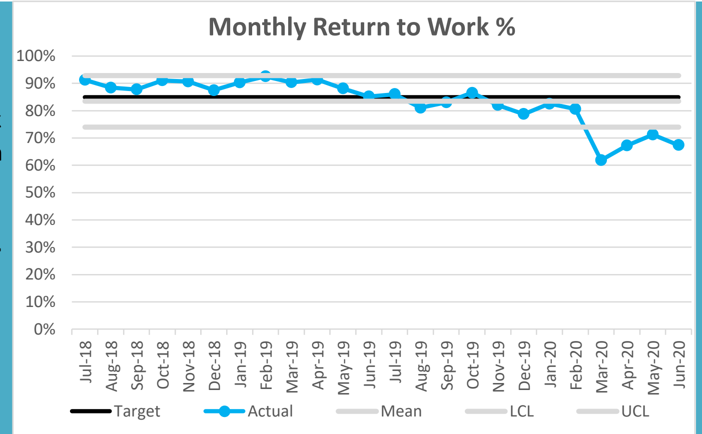
Risk Register

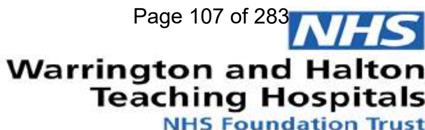
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2% UoR SOF S RR200 **The Trust's sickness absence was 5.73% in month.** **SPC - There is evidence of special cause variation for sickness absence.**	Monthly Sickness Absence (Target, Current Yr, Mean, LCL, UCL; Jul-18 to Jun-20) Monthly Sickness Absence (Long Term Absence FTE, Short Term Absence FTE, Long Term Absence %, Short Term Absence %; Jul-19 to Jun-20) Monthly Sickness Absence By Staff Group (Add Prof Scientific and Technic, Additional Clinical Services, Administrative and Clerical, Allied Health Professionals, Estates and Ancillary, Healthcare Scientists, Medical and Dental, Nursing and Midwifery Registered; Jul-19 to Jun-20)	**Trends indicate that sickness absence peaked in April 2020. There have been significant reduction in sickness absence in May and June 2020. The position in June 2020 was 5.73%.** **There was a reduction in both short term and long term sickness absence in month. Short term sickness reduced to 1.34%, which is in line with the pre-COVID position. Long term sickness absence reduced by 0.67%.** **There has been a reduction in COVID-related sickness absence from 4.11% in April 2020 to 0.97% in June 2020.** **There has also been a reduction in mental health related absence, which had been increasing since March and peaked at 2.07% in May 2020. This has reduced to 1.90% in June 2020.** **There has been a reduction in sickness absence across all staff groups, with the exception of Healthcare Scientists.**	**Please see the end of this Workforce dashboard for detail around actions taking place to address sickness absence.**



Workforce - Trust Position

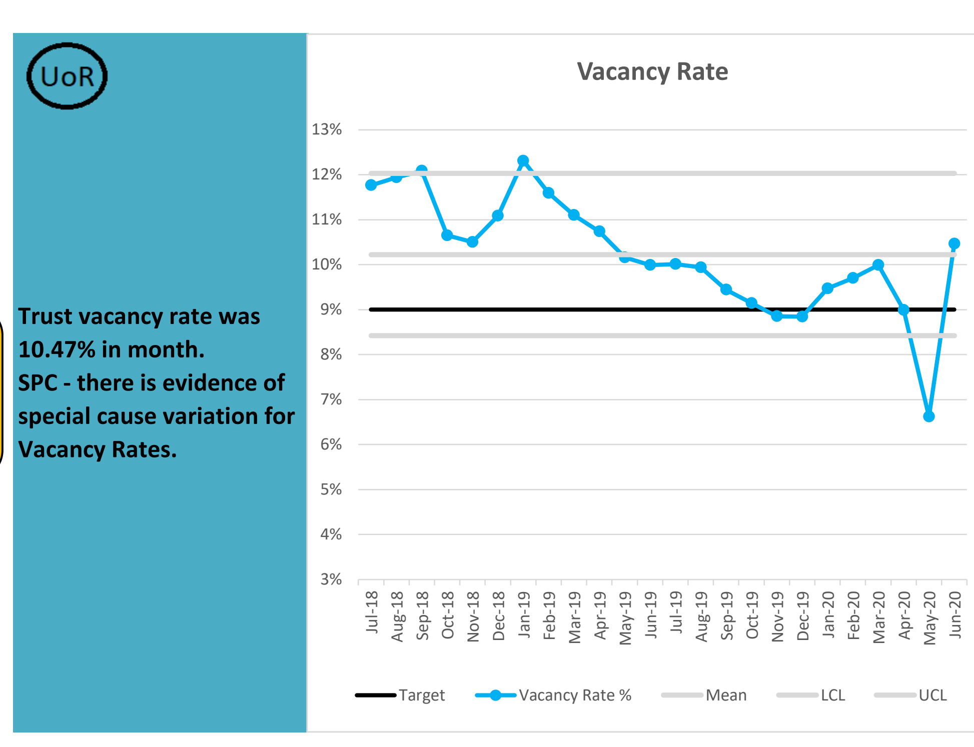
Key:
Single Oversight Framework (SOF)
Care Quality Commission (CQC)
Use of Resources Assessment (UoR)
Trust Strategy (S)
Risk Register (RR200)

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	The Trust's return to work compliance was 67.39% in month. SPC - There is evidence of special cause variation for Return to Work compliance.		Return to work interview compliance has reduced significantly due to pressures relating to COVID-19.	Return to work interviews remain a vital part of the support in place for our workforce and a review of this process will form part of workforce recovery planning.
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 59, based on the last 12 months average. SPC - Recruitment time is within common cause (expected) variation.		Recruitment time to hire has reduced to 59 days in June 2020. Following national guidance amendments have been made to the pre-employment check process to support speedier recruitment: • Verification of original documents: the Trust is now able to accept scanned and emailed copies of original documentary evidence for urgent appointments. • Fast Track DBS Checks – urgent appointments related to COVID-19 can obtain a fast-track check against the children's and/or adults barred lists, which will be turned around within 24 hours of DBS receiving it. • References and Employment History – seeking at least one reference from the individual's current or previous employer (previously had to cover last 3 years). Where it has not been practically possible for a reference to be obtained, recruitment decisions are based on what information can reasonably be obtained about the individual such as latest payslips verifying their last/current employment and position. • Work health assessments – fast track OH clearance has been sought, with a 24 hour turnaround. • Inductions are now weekly providing much more flexibility with start dates. • Conditional offer letters are now sent via email and requests the candidate to supply all the information required via email (enabled because of the changes to the Verification of original documents). Support is still given to those candidates unable to complete their checks via email. • Contractual change letters are now emailed using the information supplied on the contractual change form (ECF).	



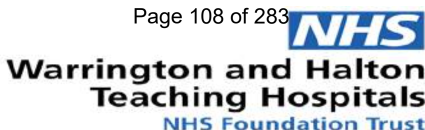
Workforce - Trust Position

Key:
Single Oversight Framework
Care Quality Commission
Use of Resources Assessment
Trust Strategy
Risk Register

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 Trust vacancy rate was 10.47% in month. SPC - there is evidence of special cause variation for Vacancy Rates.		Vacancy rates increased in June 2020. However this has been impacted by an increase in the COVID-19 budget and therefore further work is underway to review any actual increase in vacancies.	Recruitment has continued as per usual processes and an additional local campaign was instigated in April 2020 for Nursing, HCA, Domestic and Portering Staff. Additional groups of staff have been brought into the organisation, including: • Medical Students • Nursing Students • AHP Students • Medical 'Returners' • Nursing 'Returners' • AHP 'Returners' A Temporary Workforce Redeployment Hub has been established to support staffing levels by identifying staff who are available for redeployment and match them with demand. The hub has now exhausted all staff available for redeployment but remains in place to support the redeployment of shielding staff, where required, from 1 August 2020.

Vacancy Rates

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



Workforce - Trust Position

Key:
Single Oversight Framework
Care Quality Commission

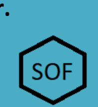
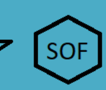
Use of Resources Assessment
Trust Strategy
Risk Register

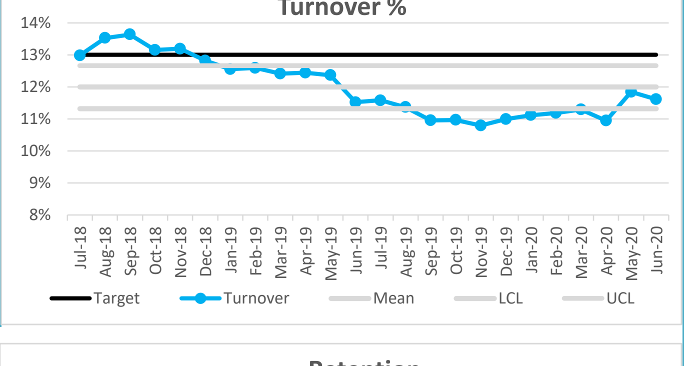
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Turnover

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

Trust turnover was 11.61% in month.
SPC - There is evidence of special cause variation for Turnover.



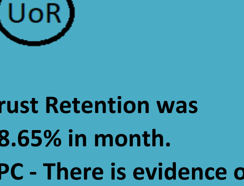
Turnover has remained below target (positive) and has reduced in month to 11.61%. There is less movement of staff during the pandemic, however the sustained improvement in turnover is linked to improved employee engagement (as evidenced by the 2019 Staff Survey results) and to the work undertaken as part of the NHSI Retention Programme.

Workforce recovery planning is in place and includes consideration relating to:

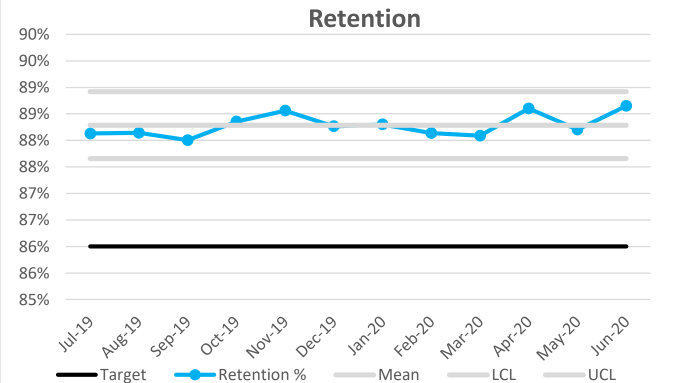
- **Proposals to make permanent the temporary changes to the Retirement Policy relating to the break in service and permanent contract upon return.**
- **A range of health and wellbeing interventions, based on evidence following pandemics and serious incidents.**
- **Supporting minority groups across the workforce such as Black Asian and Minority Ethnic staff and LGBTQ+ staff.**
- **Restarting training and development opportunities for staff.**

Retention

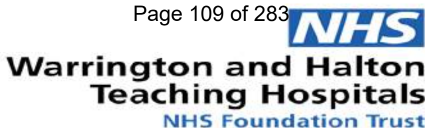
Red: Below 80%
Amber: 80% to 85%
Green: Above 86%



Trust Retention was 88.65% in month.
SPC - There is evidence of special cause variation for Retention.



Retention has remained above target (positive) and was 88.65% in June 2020. There is less movement of staff during the pandemic, however the sustained improvement in turnover is linked to improved employee engagement (as evidenced by the 2019 Staff Survey results) and to the work undertaken as part of the NHSI Retention Programme.



Key:

Single Oversight Framework — SOF

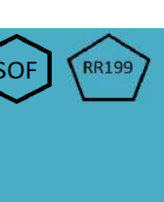
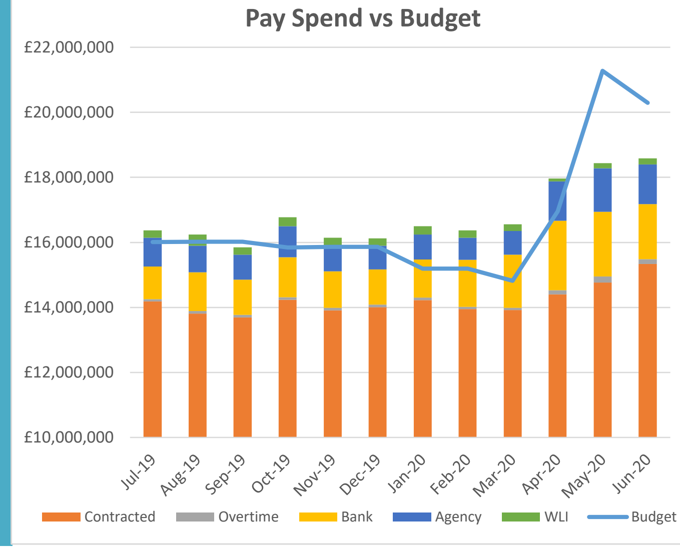
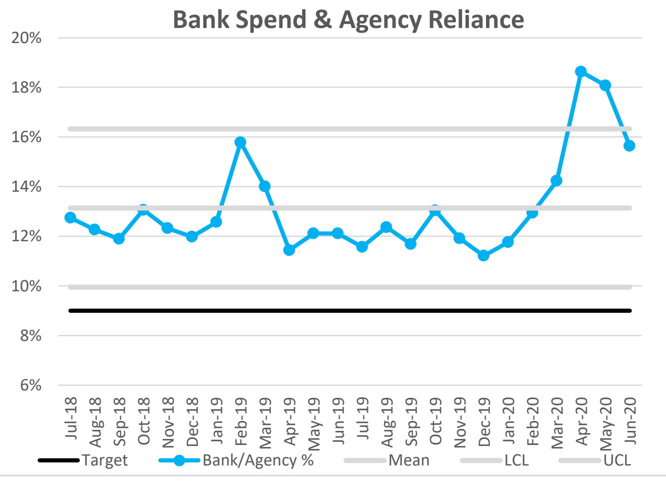
Care Quality Commission — CQC

Use of Resources Assessment — UoR

Trust Strategy

Risk Register — RR200

Workforce - 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)?
UoR SOF RR199  Trust pay was below budget in month.		Total pay spend in June 2020 was £18.6m against a budget of £20.3m. The total pay spend is broken down into the following elements: • £15.3m Contracted Pay (i.e. substantive staff) • £1.7m Bank Pay • £1.2m Agency Pay • £0.19m Waiting List Initiative (WLI) Pay • £0.153m Overtime Pay	Additional controls and challenge around pay spend have been identified, to support a reduction in premium pay: • Enhanced ECF process for non-clinical vacancies; • Expanded ECF process for some temporary staffing pay spend; • Implementation of the Cheshire and Mersey Rate Cards; • Introduction of Patchwork Medical Bank system; • Introduction of +Us Medical Agency System; • Introduction of central bank and agency team
UoR RR199 Bank and Agency Reliance reduced to 15.64% in month. SPC - Bank/Agency reliance is within common cause (expected) variation.		Both bank and agency spend have decreased in June 2020. Agency spend has been driven by a significant decrease in nursing staff agency spend of £0.22m. Bank spend has been driven by a reduction in nursing staff bank spend of £0.15m and in additional clinical services bank spend of £0.1m.	The Bank and Agency Team continue business as usual. Processes are in place to ensure appropriate sign off of the need for temporary staffing, the on-going negotiation of rates and recruitment onto the bank, which removes the requirement for an agency worker. In order to reduce agency spend through increased bank fill rate, the Patchwork system was implemented in February 2020. The Trust is working to enhance reporting relating to all elements of pay spend, including temporary staffing pay.

Pay

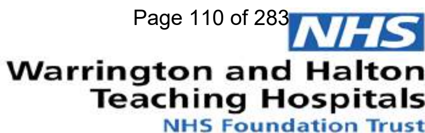
Red: Greater than Budget

Green: Less than Budget

Bank and Agency Reliance

Red: 11% or Above

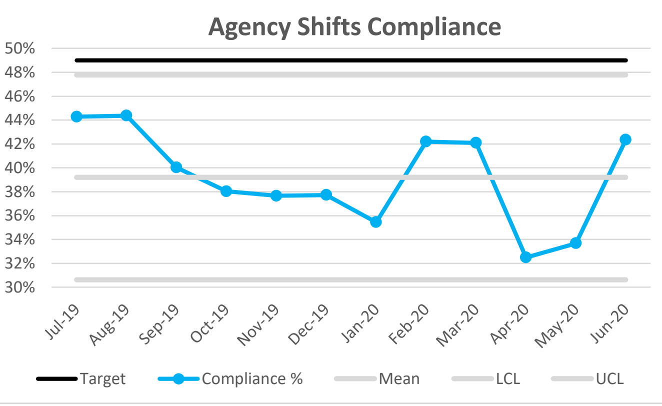
Amber: 11% to 9%



Workforce - Trust Position

Key:
Single Oversight Framework

Care Quality Commission
Use of Resources Assessment
Trust Strategy
Risk Register

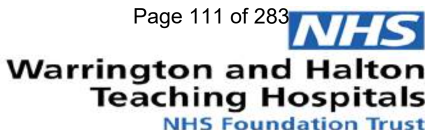
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR **Agency Rate Card Compliance was 56.20% in month.**	Agency Rate Card Compliance (chart: Target, Actual)	**The majority of shifts that are not compliant with the NHSI Price Cap relate to Medical staff agency bookings.**	**The central bank and agency team continue to negotiate rates down towards the Cheshire and Mersey Rate Card and the NHSI Price Cap compliance.** **Increasing medical bank usage will support improving the compliance.**
UoR **42.35% of shifts were compliant with the NHSI Price Cap.** **SPC - There is evidence of special cause variation within Agency Shift Compliance.**			

Agency Rate Card Compliance

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

Agency Shifts Compliant with the Cap

Red: below 49%
Green: above 49%



Workforce - Trust Position

Key:

Single Oversight Framework

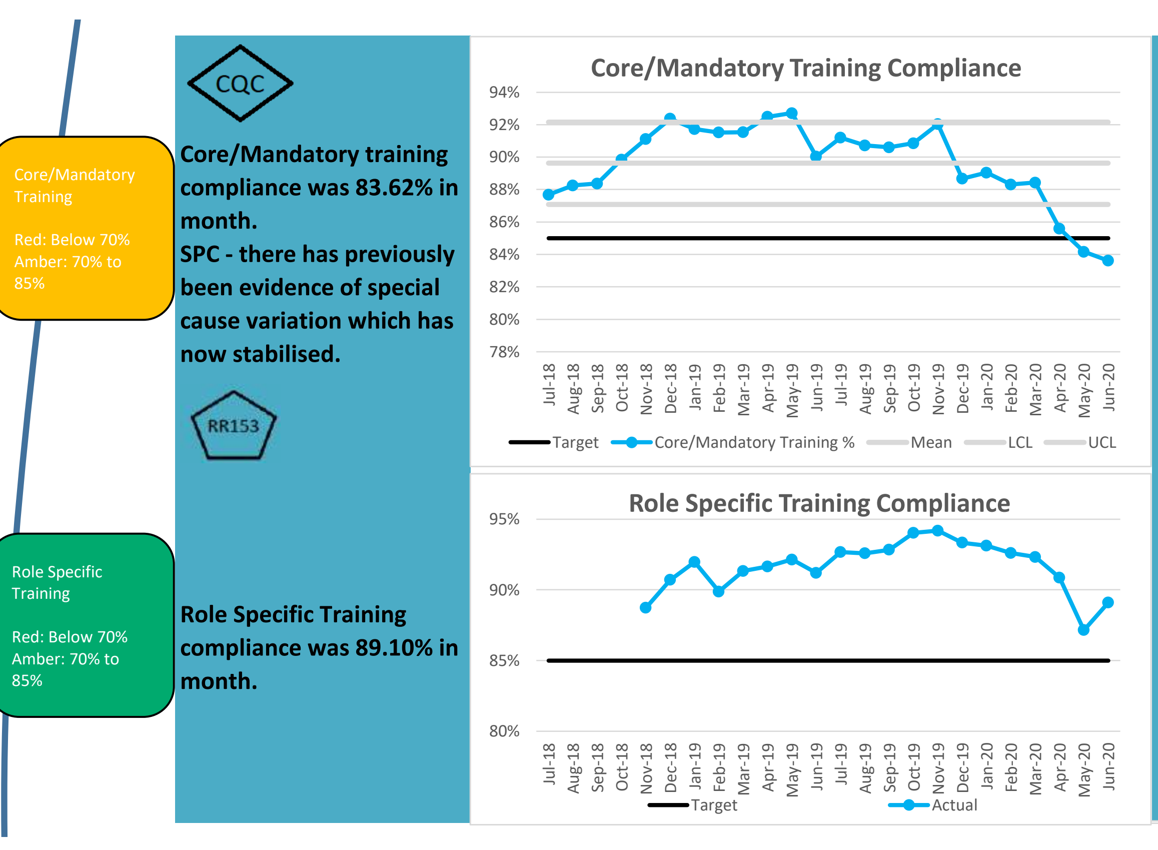
Care Quality Commission

Use of Resources Assessment UoR

Trust Strategy

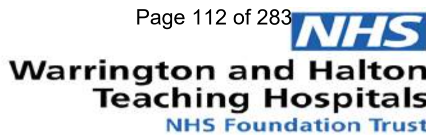
Risk Register RR200

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



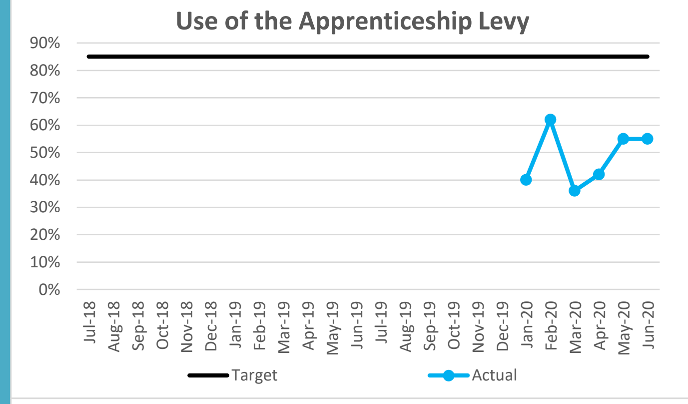
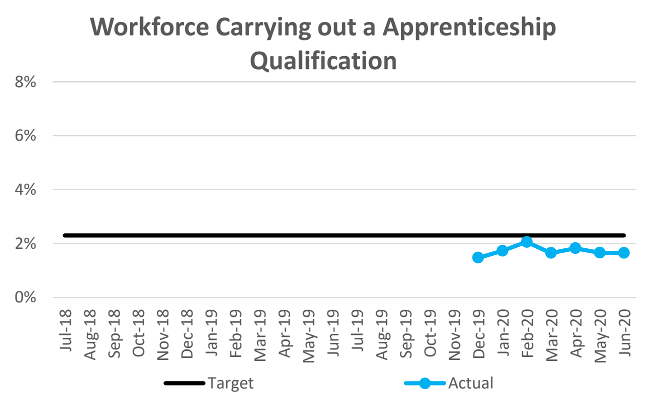
Role Specific and Mandatory Training were restarted in May 2020. The reduction in compliance relates to COVID-19 pressures across the Trust.

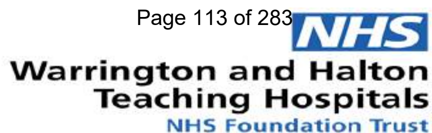
A significant amount of training is available online and historically, the Trust has achieved excellent compliance in this area. Where face-to-face sessions are required, these are available with social distancing measures in place and with an increased frequency where this can be facilitated by Subject Matter Experts.



Workforce - Trust Position

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

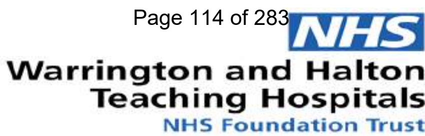
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Use of Apprenticeship Levy Red: below 50% Amber: 50-84% Green: 85% or above	**Use of the Apprenticeship Levy was 55.00% in month.**		**Use of the apprenticeship levy was at 55.00% and the percentage of the workforce carrying out a qualification was 1.65% in June 2020.**	**Utilisation of the apprenticeship levy remains a key enabler to workforce attraction, development and retention. All posts are reviewed for potential apprenticeship opportunities prior to advertisement and one to one support is provided to managers to explore all possible options. Currently, we have continued to sign staff up to apprenticeships that can be undertaken remotely.**
Workforce carrying out an Apprenticeship Qualification Red: below 1.5% Amber: 1.5% - 2.2% Green: 2.3% or	**Percentage of the workforce carrying out a qualification was 1.65% in month.**			



Workforce - Trust Position

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

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	S, CQC **PDR compliance was 93.34% in month.**	PDR Compliance (chart: Target, Actual; Jul-19 to Jun-20; 0%–120%)	**PDRs form an important part of learning and development for our workforce. However at the moment there is limited time to prepare for and carry out PDRs. With this in mind the Executive Team have taken a decision to give a three month extension to those who are due a PDR between March and June.**	**The current position regarding PDRs has been reviewed by the Executive Team and the extensions will not be continued beyond July 2020. In order to support workforce recovery, all managers have been asked to undertake a 1:1 'Catch Up' meeting with members of staff. The design and template for this meeting is based on learning from the Armed Forces and includes an opportunity to review objectives, in place of a full PDR.**



Key:

Single Oversight Framework Care Quality Commission

Use of Resources Assessment — Trust Strategy

Risk Register

Workforce - 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)?

Sickness Absence Actions

1. Occupational Health Support

The COVID-19 nursing advice line remains in place across 7 days per week. The OH Team are also undertaking 'business as usual' functions such as management referrals.

2. Staff Testing

COVID-19 testing continues to be available to staff, both on and off-site, booked via OH Team. In addition, the COVID-19 antibody test has been offered to all Trust staff and was taken up by over 4000. The test will be available to shielding staff via OH Team in August 2020.

3. Protecting Staff – Risk Assessments

An electronic COVID-19 Workforce Risk Assessment Tool has been launched. The tool is designed in line with national guidance and ensures that all staff are able to identify potential vulnerabilities and will be supported to have a risk assessment completed. The tool also enables daily reporting to accountable managers. There is a robust action plan in place relating to the roll out and embedding of workforce risk assessments and including individual communications to all staff members. Regular training is provided to managers on conducting a good quality workforce risk assessment and an audit process is in place.

The following information was submitted to NHS England on 17 July 2020 in line with national reporting arrangements:

Metric

Have you offered a risk Assessment to all staff? Yes

What % of all your staff have you Risk Assessed? 19.89%

What % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary? 61.10%

What % of risk assessment have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary? 94.04%

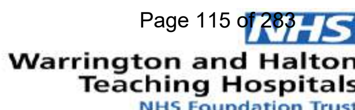
4. Workforce Recovery

Workforce recovery following the pandemic is likely to be long term and could significantly impact the health and wellbeing of our workforce. A range of interventions are either in place or are in development, based on evidence following pandemics and serious incidents. The following interventions are currently available to staff and managers:

- Health and Wellbeing booklet
- Health and Wellbeing Extranet Page
- Expansion of Mental Health First Aiders (+PFA)
- Care First Employee Assistance Programme
- Occupational Health Service
- Coaching
- Mental Health Drop in Sessions
- Facilitated Debrief Conversations
- Going Home Healthy
- MSK telephone clinics
- BAME Staff Network
- LGBTQ+ Staff Network
- Managers Guidance: Workforce Implications of Restarting Services
- COVID-19 Recovery Check In
- Self-Compassion at Work Programme
- Understanding each other as a team

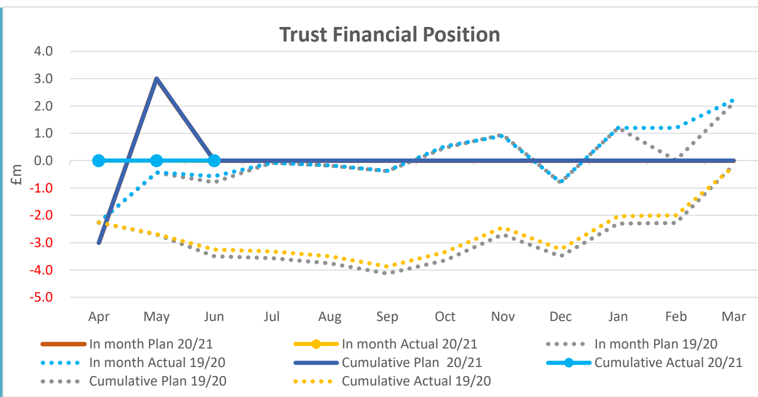
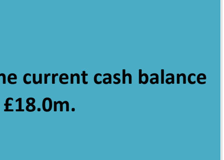
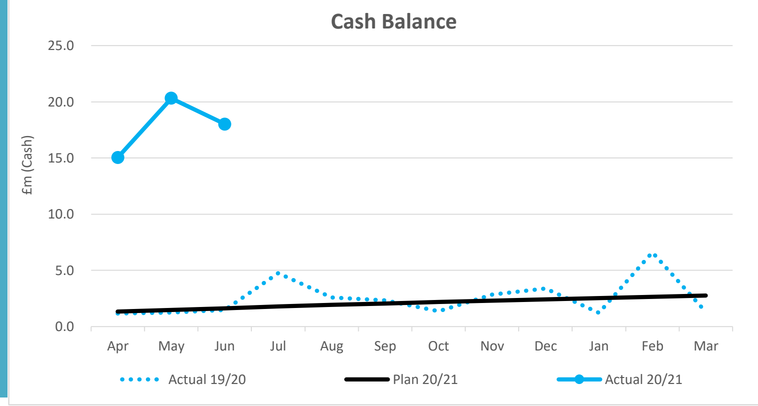
The following interventions will be live in either July or August 2020:

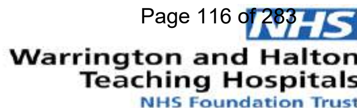
- Resilience Sessions (Virtual and Face to Face)
- Bite Size Wellbeing Sessions online
- Disabled Staff Network
- Outstanding Teams Principles Guide
- Coordinated Support Groups
- Mental Health and wellbeing hub
- Sharing Stories Sessions
- Bite Size On-line Master classes
- Bringing Teams Together' workshops
- Enhanced On-site Staff Counselling Service
- Compassionate Leadership Coaching Programme
- Understanding my Leadership Style



Key:
Single Oversight Framework
Care Quality Commission
Use of Resources Assessment
Trust Strategy
Risk Register

Finance & Sustainability - Trust Position

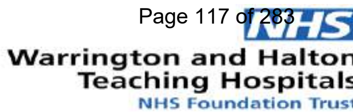
Trust Performance		Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Trust Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus Position	The Trust has achieved a breakeven position as at 30 June.		The Trust has achieved a breakeven position as at 30 June. This is supported by the changes in the financial regime due to the national COVID-19 response and the introduction of a top up system.	The Trust is applying national guidance as this emerges in relation to financial planning.
System Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus	System reporting is currently on hold.			
Cash Balance Red: Less than 90% or below minimum cash balance per NHSI Amber: Between 90% and 100% of planned cash balance Green: On or better than plan	 The current cash balance is £18.0m.		The current cash balance is £18.0m which is £16.4m better than plan. This is due to early receipt of block income and top ups as part of the new financial regime. The cash is to be used to achieve the new target of paying suppliers within 7 days for the receipt of goods and services.	The cash flow forecast has been remodelled based on the current financial regime to 31 July and will need to be updated as further guidance emerges.



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

Finance & Sustainability - 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)?
UoR SOF RR669 Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100% The actual capital spend in month is £0.6m.	Capital Programme (£m; Apr–Mar): Internally Funded & Confirmed PDC Plan 20/21; Internally Funded & Confirmed PDC 20/21 Capital Programme - COVID-19/Non COVID-19 (£m; Apr–Mar): COVID-19 Capital Spend 20/21; Non-COVID-19 Capital Spend 20/21	The core capital plan is £9.96m. Year to date, £0.6m has been spent against the plan of £1.8m The forecast for the core programme is under review. The core programme is supported by a loan programme of £4.8m. The Trust is working with NHSE/I to obtain the loan support. Capital requests for Q1 relating to COVID-19 were £17.1m of which £2.8m was approved. Approval for the remaining £14.3m is anticipated from NHSE/I by the end of July. This capital supports the recovery plans.	
UoR SOF Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or better In month, the Trust has paid 97% of suppliers within 30 days. This results in a cumulative performance of 81.00%.	Better Payment Practice Code (0%–120%; Apr–Mar): Target 19/20; Actual 19/20; Target 20/21; Actual 20/21; Cumulative 20/21	Performance of 97.00% is above the national standard of 95.00%, this is due to the additional month block payment.	Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments.

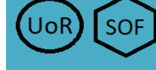


Finance & Sustainability - Trust Position

Key:
Single Oversight Framework
Care Quality Commission
Use of Resources Assessment
Trust Strategy
Risk Register

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

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



The Use of Resources Rating is not being reported in Month 1-4. The Trust is awaiting further guidance from NHSE/I.

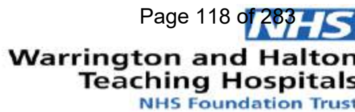
Agency Spending

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

The actual agency spend in month is £1.2m.

The spend of £1.2m is £0.3m above the plan of £0.9m. Of the total expenditure, £0.7m relates to COVID-19.

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



Finance & Sustainability - Trust Position

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

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cost Improvement Programme - In year performance to date Red: 0-70% Plan delivered YTD Amber: 70-90% Plan delivered YTD Green: >90% Plan delivered YTD	UoR			
Cost Improvement Programme - Plans in Progress - In Year Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	UoR			
Cost Improvement Programme - Plans in Progress - Recurrent Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	UoR			

CIP has been suspended nationally with no requirement for delivery and reporting until at least 31st July 2020, the Trust is awaiting guidance on next steps.

Appendix 3 – Trust IPR Indicator Overview

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

	quality healthcare and are the most prolific producer of clinical guidelines in the world.
Complaints	Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe.
Friends and Family Test (Inpatient & Day Cases)	Percentage of Inpatients and day case patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?
Friends and Family (ED and UCC)	Percentage of AED (Accident and Emergency Department) patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?
CQC Insight Composite Score	The CQC Insight report measures a range of performance metrics and gives an overall score based on the Trust's performance against these indicators. This is the CQC Insight Composite Score.
Continuity of Carer	Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives. This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience.
Access & Performance	
Diagnostic Waiting Times – 6 weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks.
RTT Open Pathways and 52 week waits	Percentage of incomplete pathways waiting within 18 weeks. The national target is 92%.
Four hour A&E Target and STP Trajectory	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95%
A&E Waiting Times Over 12 Hours (Decision to Admit to Admission)	The number of patients who has experienced a wait in A&E longer than 12 hours.
Cancer 14 Days	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%.
Breast Symptoms – 14 Days	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%.
Cancer – 28 Day Faster Diagnostic Standard	All patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis. The national target is 75%.
Cancer 31 Days - First Treatment	All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%.
Cancer 31 Days - Subsequent Surgery	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%.
Cancer 31 Days - Subsequent Drug	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%.
Cancer 62 Days - Urgent	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust’s STP Improvement trajectory.
Cancer 62 Days – Screening	All patients must wait no more than 62 days from referral from an NHS

	screening service to first definitive treatment for all cancers. The national target is 90%.
Ambulance Handovers 30 – 60 minutes	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system).
Ambulance Handovers – more than 60 minutes	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system).
Discharge Summaries – Sent within 24 hours	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge. This metric relates to Inpatient Discharges only.
Discharge Summaries – Not sent within 7 days	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge.
Cancelled operations on the day for non-clinical reasons	% of operations cancelled on the day or after admission for non-clinical reasons.
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
Urgent Operations – Cancelled for a 2nd Time	Number of urgent operations which have been cancelled for a 2nd time.
Super Stranded Patients	Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.
Workforce	
Sickness Absence	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and peer average.
Return to Work	A review of the completed monthly return to work interviews.
Recruitment	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks.
Vacancy Rates	% of Trust vacancies against whole time equivalent.
Retention	Staff retention rate % over the last 12 months.
Turnover	A review of the turnover percentage over the last 12 months.
Bank & Agency Reliance	The Trust reliance on bank/agency staff against the peer average.
Agency Shifts Compliant with the Price Cap	% of agency shifts compliant with the Trust cap against peer average.
Agency Rate Card Compliance	% of agency shifts which comply with the Cheshire & Mersey rate card.
Pay Spend – Contracted and Non-Contracted	A review of Contracted and Non-Contacted pay against budget.
Core/Mandatory Training	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and Safeguarding.
Role Specific Training	A summary of role specific training compliance.
Use of Apprenticeship Levy	% of the apprenticeship levy being utilised.
Workforce carrying out an Apprenticeship Qualification	% of the workforce carrying out an apprenticeship qualification.
Performance & Development Review (PDR)	A summary of the PDR compliance rate.

Finance	
Trust Financial Position	The Trust operating surplus or deficit compared to plan.
System Financial Position	The system operating surplus or deficit compared to plan.
Cash Balance	The cash balance at month end compared to plan (excluding cash relating to the hosting of the Sustainability and Transformation Partnership).
Capital Programme	Capital expenditure compared to plan (The capital plan has been increased to £10.2m as a result of additional funding from the Department of Health, Health Education England for equipment and building enhancements).
Better Payment Practice Code	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
Use of Resources Rating	Use of Resources Rating compared to plan.
Agency Spending	Agency spend compared to agency ceiling.
Cost Improvement Programme – In Year Performance	Cost savings schemes deliver Year to Date (YTD) compared to plan.
Cost Improvement Programme – Plans in Progress (In Year)	Cost savings schemes in-year compared to plan.
Cost Improvement Programme – Plans in Progress (Recurrent)	Cost savings schemes recurrent compared to plan.

Appendix 4 - Statistical Process Control

What is SPC?

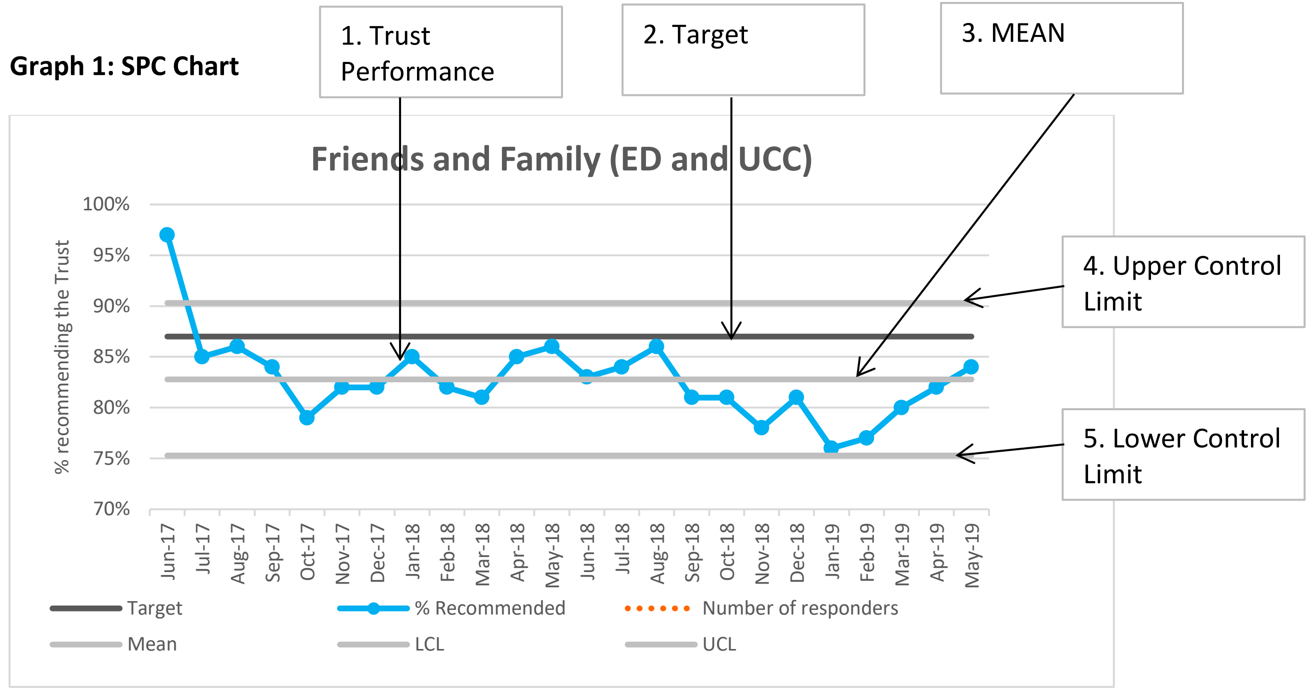
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

SPC Charts

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

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

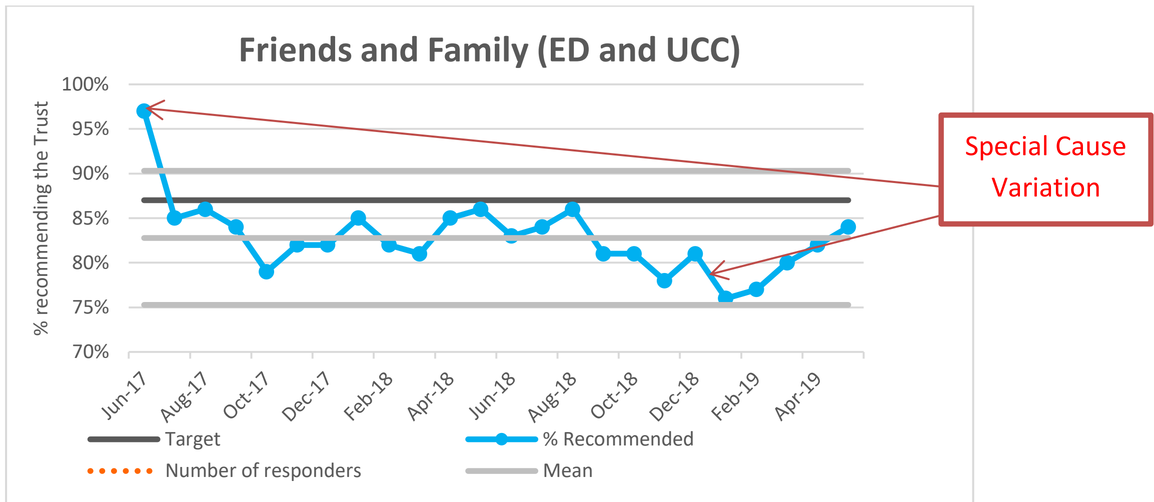
Graph 1: SPC Chart



Interpreting a SPC Chart

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

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



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

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

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

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

Appendix 5

Income Statement, Activity Summary and Use of Resources Ratings as at 30th June 2020

Income Statement	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income						
NHS Clinical Income						
Elective Spells	2,604	820	-1,784	7,597	1,906	-5,691
Elective Excess Bed Days	18	1	-18	55	1	-54
Non Elective Spells	5,999	5,607	-393	18,230	14,959	-3,271
Non Elective Bed Days	166	195	28	499	394	-105
Non Elective Excess Bed Days	105	75	-30	315	149	-166
Outpatient Attendances	3,062	2,018	-1,043	9,088	5,080	-4,008
Accident & Emergency Attendances	1,465	1,280	-185	4,385	3,386	-999
Other Activity	5,663	9,132	3,470	17,079	31,421	14,342
Sub total	**19,083**	**19,128**	**46**	**57,249**	**57,296**	**48**
Non NHS Clinical Income						
Private Patients	0	0	0	0	1	1
Non NHS Overseas Patients	6	7	1	18	13	-5
Other non protected	82	24	-58	246	87	-160
Sub total	**88**	**32**	**-57**	**264**	**101**	**-164**
Other Operating Income						
NHSE Top Up	1,866	1,866	0	5,598	5,598	0
Retrospective Income	4,563	3,729	-834	13,251	8,982	-4,269
Training & Education	679	680	0	2,038	2,039	1
Donations and Grants	0	0	0	0	0	0
Miscellaneous Income	536	355	-181	1,605	1,810	204
Sub total	**7,644**	**6,630**	**-1,014**	**22,492**	**18,429**	**-4,064**
Total Operating Income	**26,815**	**25,790**	**-1,025**	**80,005**	**75,826**	**-4,180**
Operating Expenses						
Employee Benefit Expenses	-20,290	-18,584	1,706	-58,522	-54,976	3,546
Drugs	-1,233	-1,228	5	-3,705	-3,498	207
Clinical Supplies and Services	-1,751	-2,145	-394	-6,750	-5,706	1,045
Non Clinical Supplies	-2,610	-2,883	-273	-8,241	-8,823	-582
Depreciation and Amortisation	-609	-674	-65	-1,827	-1,993	-166
Net Impairments (DEL)	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0
Total Operating Expenses	**-26,493**	**-25,515**	**978**	**-79,045**	**-74,996**	**4,050**
Operating Surplus / (Deficit)	**322**	**275**	**-47**	**960**	**830**	**-130**
Non Operating Income and Expenses						
Profit / (Loss) on disposal of assets	0	0	0	0	1	1
Interest Income	3	0	-3	9	-5	-14
Interest Expenses	-47	0	47	-141	0	141
PDC Dividends	-276	-275	1	-826	-826	0
Total Non Operating Income and Expenses	**-320**	**-275**	**45**	**-958**	**-830**	**128**
Surplus / (Deficit)	**2**	**0**	**-2**	**2**	**0**	**-2**
Adjustments to Financial Performance						
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0
Less Donations & Grants Income	17	16	-1	51	47	-4
Total Adjustments to Financial Performance	**17**	**16**	**-1**	**51**	**47**	**-4**
Adjusted Surplus / (Deficit)	**19**	**15**	**-3**	**53**	**47**	**-6**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	2,820	1,156	-1,664	8,278	2,680	-5,598
Elective Excess Bed Days	68	2	-66	205	3	-202
Non Elective Spells	3,502	2,517	-985	10,588	6,764	-3,824
Non Elective Bed Days	466	566	100	1,399	1,104	-295
Non Elective Excess Bed Days	392	265	-127	1,175	562	-613
Outpatient Attendances	25,862	18,019	-7,843	76,763	46,990	-29,773
Accident & Emergency Attendances	10,010	7,448	-2,562	29,936	18,920	-11,016

Appendix 6

Revised Capital (Core Programme) 2020/21 as at 30 June 20

	Revised Plan £m
Mandatated (Appendix 1 note 1)	2.125
Business Critical (Appendix 1 note 2)	1.819
Approved by exec (Appendix 1 note 3)	1.940
Brought Forward	1.518
Executive Team / Boardroom (was BW relocation)	0.154
EPMA Phase 1 & 2 (Additional areas)	0.060
EPMA Phase 3 & 4	0.210
Lorenzo Digital Examplar plus	0.285
Digital Restructure - Enhanced Structure	0.000
Falsified Medicines Directive	0.083
Ophthalmology Equipment (Halton)	0.000
Finance & Commercial Development - Refurbishment	0.400
Finance & Commercial Development - Office/Kitchen Equipment	0.050
Refurbishment of Warrington Education Centre	0.005
Ultrasound Machine (provision of in house vascular services)	0.080
Contingency	0.170
Subtotal	**8.899**
Internally Generated Funds (Dep'n)	7.380
Cash from carry forward underspend	1.518
Shortfall / (Surplus)	**0.001**
MRI	**1.061**
TOTAL M03	**9.96**

Note: Capital requests for Q1 relating to COVID-19 were £17.1m of which £2.8m was approved. Approval for the remaining £14.3m is anticipated from NHSE/I by the end of July. In addition, a bid for Seacole beds has been submitted to NHSE/I for £5.0m.

Appendix 7

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/20/07/**
SUBJECT:	**Quality Key Performance Indicator Addition – COVID-19**
DATE OF MEETING:	7th July 2020
AUTHOR(S):	Lesley McKay, Associate Chief Nurse and Associate Director of Infection Prevention & Control Dan Birtwistle, Senior Business & Performance Manager
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Andrea McGee, Chief Finance Officer and Deputy Chief Executive
EXECUTIVE SUMMARY:	This paper outlines a proposal for an additional Key Performance Indicator (KPI) to be included on the Trust Integrated Performance Report (IPR) dashboard. The new indicator will outline probable and confirmed Healthcare Acquired Infections (HCAIs) and any outbreaks of COVID-19.
PURPOSE: (please select as appropriate)	Information | Approval x | To note | Decision
RECOMMENDATION:	The Quality Assurance Committee (QAC) is asked to: 1. Support the addition of a COVID-19 probable/confirmed/outbreak Healthcare Acquired Infections (HCAI) KPI on the Trust IPR. This will be presented to Trust Board for approval on 29th July 2020.
PREVIOUSLY CONSIDERED BY:	**Committee**: Choose an item. **Agenda Ref.**: **Date of meeting**: **Summary of Outcome**:
NEXT STEPS: *State whether this report needs to be referred to at another meeting or requires additional monitoring*	**Submit to Trust Board**
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Section 22 – information intended for future publication

SUBJECT	Quality Key Performance Indicator Addition – COVID-19	AGENDA REF:	QAC/20/07/

1. BACKGROUND/CONTEXT

This paper outlines a proposal for an additional Key Performance Indicator (KPI) to be included on the Trust Integrated Performance Report (IPR) dashboard. The new indicator will outline probable and confirmed Healthcare Acquired Infections (HCAIs) and any outbreaks of COVID-19.

2. KEY ELEMENTS

To support the monitoring and management of Healthcare Acquired Infections for COVID-19, it is proposed the following indicator is added to the Trust IPR:

New Indicator

KPI	RAG Criteria	Rationale
Healthcare Acquired Infection – COVID-19	It is proposed this indicator is not RAG rated in the interim due to the ongoing and changing situation. The indicator will be for assurance only.	To support the Trust to monitor and manage COVID-19 Healthcare Acquired Infections as part of the national response.

This additional indicator will result in the total number of indicators on the Trust IPR increasing from 68 to 69. The 2020/21 Quality KPIs are outlined in **Appendix 1**.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

If supported by the Quality Assurance Committee, this new indicator will be reviewed by the Trust Board in July 2020. If approved by the Trust Board, the indicator will be added to the Trust IPR from the September 2020 Board report (August's data).

4. RECOMMENDATIONS

The Quality Assurance Committee (QAC) is asked to:

1. Support the addition of a COVID-19 probable/confirmed/outbreak Healthcare Acquired Infections (HCAI) KPI on the Trust IPR.

This will be presented to Trust Board for approval on 29th July 2020.

Appendix 1 – Quality IPR Indicators 2020/21

	2019/20 KPIs	**Target/Threshold/Tolerance**
	Quality Improvement	
1.	Incidents	Never Events – Zero Tolerance, No Incidents opened over 40 days
2.	CAS Alerts	All actions to be completed within timescales
3.	Duty of Candour	100%
4.	Health Care Acquired Infections – MRSA	Zero Tolerance
5.	Health Care Acquired Infections – CDIFF	Trajectory
6.	Health Care Acquired Infections – Gram Negative Blood Infections	Trajectory
7.	VTE Assessment	95%
8.	Total Fall & Harm Levels	20% reduction for 2018/19 using 2017/18 as a baseline
9.	Pressure Ulcers	Trajectory
10.	Medication Safety	Reconciliation within 24 hours
11.	Staffing Average Fill Rates	90%
12.	Care Hours Per Patient Day	N/A
13.	Mortality Ratio - HSMR	Within expected range.
14.	Mortality Ratio - SHMI	Within expected range.
15.	NICE Compliance	90%
16.	Complaints: • Received • Dissatisfied • Total cases open • Total cases over 6 months old	Improvement Trajectory
17.	Friends & Family Test – Inpatients	95%
18.	Friends & Family Test – A&E	87%
19.	Mixed Sex Accommodation	Zero Tolerance
20.	Continuity of Carer	30%
21.	CQC Insight Composite Score	1.5

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 20/07/69 a	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	29 July 2020

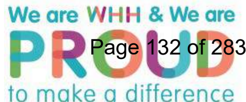
Date of Meeting	7 July 2020
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

In order to re-align the Committee's cycle of business as much as possible following the peak period of COVID-19, the Committee received a number of deferred papers. As a consequence, the agenda was unusually large. In the interests of efficiency, colleagues had the opportunity to raise any questions relating to any of the agenda items prior in order to facilitate a written response prior to the meeting. The questions and answers have been incorporated in the minutes of the meeting as part of the Committee Assurance

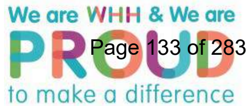
The Committee wishes to bring the following matters to the attention of the Board:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/20 /07/84	Moving to Outstanding Action Plan	The Committee received an update on the Moving to Outstanding Action plan and noted that Moving to Outstanding meetings had reconvened in June. - 63 actions, 14 remain - 50 issues on the CQC log, 4 remain Amber. - Regular CQC engagement meetings have continued during COVID Pandemic. CQC to review the Infection Prevention Control (IPC) Board Assurance Framework (BAF) at future engagement meetings. - A new CQC inspector had been assigned to WHH, Samantha Davies. - Trust had appointed a new Compliance Officer	The Committee received significant assurance on progress being made	**Trust Board 29.07.2020** **QAC 04.08.2020**
QAC/20 /07/89	Strategic Risk Register and BAF	The Committee considered and approved: - The addition of three new risks to the BAF (1) delayed appointments and treatment [rating 20]; (2) staff risk assessments for all staff [rating 16] and (3) failure to send accurate continuity of care information/Lorenzo ePR functionality	The Committee received and discussed and approved the proposed changes to the BAF and	**Trust Board 29.07.2020** **QAC**

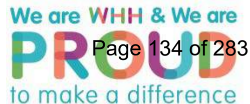
		[rating 15]. - De-escalation of two risks to the Corporate Risk Register, to reduce the risk rating of Risk #1126 from 15 to 12 Risk #241.	CRR, receiving high assurance	**04.08.2020**
QAC/20 /07/88	Hot Topics	The Committee received the following Hot Topic updates: **Lorenzo Discharge Summary Medication** Discharge medications documented in Lorenzo do not match those showing on the discharge summary – this results in some medications being duplicated, missing completely or being incorrectly cited into appropriate sections • 50 discharges has PAN related issues equivalent to 3.3% of encounters • Daily PAN reviews to be undertaken including continued liaison with DXC and their RCA progress; • Review procurement process for EPR/Digital Board; • Risk added to BAF **Emergency Services Framework (ESF**) regulatory approach during COVID-19 in 4 areas (1) Safe care and treatment; (2) Staffing arrangements; (3) Protection from abuse; (4) Assurance processes, monitoring, and risk management. - Draft document in preparation for use with the CQC, CQC focus on Infection Prevention Control Board Assurance Framework (BAF) and Management of Waiting Lists. ESF may replace the current PIR collection of data, each service may be asked to complete one of the documents on a regular basis, indicating if compliant or not, to inform CQC of areas of focus in the Trust.	The Committee noted the updates and received moderate assurance in relation to Lorenzo Discharge Summary Medication	**QAC 04.08.2020**
QAC/20 /07/94b	Care Home Discharge Process	The Committee received an update on the discharge process to Care Homes during the COVID-19 Pandemic. - Additional support provided by redeployment of Bridgewater Community Staff into therapy services. - Discussion regarding capacity to deal with second surge and winter, side room capacity circa 300 'Seacole' beds in C&M to support transfer from the Acute	Assurance provided of processes in place, all aligned to national, regional and local guidance and that measures were in place to ensure effective	**QAC 04.08.2020**



		sector to the Community with the capacity in Care Homes enabling the Trust to be in a positive positon to deal with surges in demand. - Trust had supported Infection Prevention and Control training in Care Home settings. - Discussed registration of deaths and multi-factorial deaths due to co-morbidities and other health reasons, taking into consideration incubation period of 14 days. All positive tests reported to the community in a timely manner; however this is not always reciprocated from the Community to the Trust. - Importance of availability of transitional beds and the mainstreaming of care home trusted assessors were stressed as important as we move in to winter.	communication with Care Homes	
QAC/20 /07	Maternity Update inc Maternity Safety Champion & Maternity Digital Improvement Committee	- WHH Perinatal deaths 1.01.2020-11.06.2020 – 5 reported still births, non COVID-19 related, none reported as Serious Incidents. Action plans continue to be monitored at Women's Health Governance Group. - Continuity of Carer – Trust achieved target of 35% of women booked onto a CoC pathway by March 2020, achieving 44% in March, 55% in April and 37% in May. Further national ambition to achieve 51% by March 2021. - Antenatal and Newborn Screening Action Plan 18 Green, 10 Amber, and 0 Red actions out of a total of 27, 3 of the highest risks relate to the digital system not being fit for purpose. - SCORE Survey – results presented at feedback session with maternity and neonatal staff, comments collated to form an Improvement Plan, developing the newly launched Good Day Collaborative Quality Improvement Programme. - On-going issues discussed relating to the suitability of Lorenzo as a maternity information system, particular concerns relating to CTG archiving, due for renewal November 2020 and CNST elements and (2) procurement and deployment of Maternity Digital System requiring dedicated project support. - Next steps agreed for PJ to present proposal/business case to Executives on 9 July and to QAC on 4 August 2020.	The Committee received and discussed the update receiving moderate assurance	**Executives 09.07.2020** **Trust Board 29.07.2020** **QAC 04.08.2020**
QAC/20 /07/8	Quality KPI – Addition of COVID-19	- Committee to supported and approved the addition of COVID-19 KPI to the Trust Integrated Performance Report (IPR) dashboard.	The Committee approved the addition of a COVID-19 related KPI to the IPR	**Trust Board 29.07.2020**



QAC/20 /07/92	Waiting List Oversight Report	The Committee received an update on the processes in place and those followed during COVID-19 Pandemic and to restart services as part of Recovery Plans, all aligned to national guidance. - Weekly Performance Review Group meetings and local improvement review meetings had recommenced. - Reassurance provided that Cancer 62 day waits not increasing and reduction anticipated now that some services have restarted. - Overall waits increased, some above 18 weeks and in excess of 52 weeks. Waiting lists re-categorised following national guidance, Colorectal Cancer services recommenced in May; Diagnostics and Out-Patient services recommenced. - Utilisation of Independent Private Sector continues with contract in place to August 2020. - Assurance provided of robust governance process is in place for any service changes during COVID-19 Pandemic and the restart of services, keeping CQC informed during this process. - Assurance provided of capacity in the system to manage a second surge, Winter planning to commence supported by capacity in Intermediate Care and the development of Halton Site	The Committee discussed the report and received moderate assurance Waiting List oversight report requested for August QAC.	**Trust Board 29.07.2020** **QAC 04.082020**
QAC/20 /07/109	Update on Complaints and Incident arrangements	The Committee were advised of the following: - Formal complaint response process had recommenced 1 July 2020, Complaints Quality Assurance Committee meetings had been re-introduced. - 80 complaints in the system, supportive work continues with CBUs for timely response/resolution of complaints.	The Committee noted the report and assurance provided of processes in place to monitor complaints	**QAC xx.xx.2020**
QAC/20 /07/110	MIAA – Quality Spot Check Review and Diagnostic Policy Progress report	- Quality Spot Check MIAA Review noted and reviewed - Diagnostic Policy Review – the Committee approved the revised deadlines prior to submission to the Audit Committee.	The Committee noted the report and received significant assurance of processes in place. Chair to report back to Audit Committee	**Board 29.07.2020** **QAC 04.08.2020** **Audit Cttee 06.08.2020**
QAC/20 /07/122 (a)	National Blood Inquiry	The Committee were advised that the Trust had been contacted in relation to the current National Blood Inquiry - One patient had raised concerns through the National Inquiry relating to treatment received during 1980. An action plan to investigate the concerns formulated to support completion of a statement from the Trust.	Further updates to QAC and Trust Board as appropriate	**QAC 04.08.2020**



		- Data records being reviewed by Deputy Director Governance, Exec Medical Director and Trust Solicitors in preparation of the Trust statement.		
QAC/20 /07/122 (b)	Patterson Inquiry	Committee received update on the process the National Patterson Inquiry will focus on during the Inquiry, including, review of all clinical practice of IP, how organisations were managed and inspected, if unnecessary clinical procedures had taken place, evidence of safe care and communication between Regulatory Boards and Trusts to provide assurance of monitoring processes.	Further updates to QAC and Trust Board as appropriate	**QAC 04.08.2020**
	Annual Reports for Approval/ Ratification	The Committee approved the following prior to ratification at Trust Board in July - Quality Priorities 2020-21 - Patient Experience Strategy - Safeguarding Annual Report - Clinical Audit Annual Report - Health and Safety Annual Report - Quality Strategy Annual Update Report - Risk Management Strategy Annual Update Report - Medicines Management/Controlled Drugs Annual Report - Committee Chairs Annual Report to Board - Dementia Strategy		**Trust Board 29.07.2020**

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/20/07/69 b		TRUST BOARD OF DIRECTORS	DATE OF MEETING	29 July 2020

Date of Meeting	**22 July 2020**
Name of Meeting + Chair	**Strategic People Committee** **Anita Wainwright, Non-Executive Director**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
SPC/20/07/49	**Action Log**	Local Induction for Temporary Medical Staff: • A paper on Medical Appraisal and Induction was presented. The paper included reference to work on-going to support a cultural shift from appraisals being compliance focused towards a more outcome focused process which adds value to practice and development.	**Further Action Required** The Committee noted the work on-going in relation to Medical Appraisal and requested an update in 6 months. The Committee were not assured in relation to the compliance with local induction requirements for temporary medical staff and requested a further update from the Medical Director to the next meeting.	September 2020

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

SPC/20/07/51	**People Strategy and EDI Strategy (workforce)**	The Committee received a proposal to refresh the strategic priorities relating to the objectives in these strategies.	**Decision** The proposed amendments were agreed with the following: • An addition of a reference to leadership recruitment in priority 9: *Introduce compassionate leadership development programmes and recruitment approaches* • Agreement that the refreshed priorities were would be additional priorities, rather than replace previous priorities, with the exception of number 9.	November 2020
SPC/20/07/52	**Committee Structure Review**	The Committee received a proposal to amend the reporting arrangements for Equality, Diversity and Inclusion Sub-Committee so that the workforce elements of this Sub-Committee would report to Strategic People Committee rather than Operational People Committee.	**Further Action Required** The Committee deferred a decision on this matter until further discussions had taken place at Executive and Board level relating to the EDI agenda.	September 2020
SPC/20/07/53	**Policies and Procedures**	The Committee received a paper providing an update on the temporary policy arrangements in place relating to COVID and a proposal to formally ratify the Agile Working Policy.	**Decision** The Agile Working Policy was ratified.	N/A
SPC/20/07/56	**Health, Wellbeing and Welfare Offers**	The Committee received a paper outlining the offers available to staff relating to health, wellbeing and welfare.	**Assurance and Action** The Committee noted the extensive work that has been undertaken and requested a one page visual summary submission to Trust Board and to be shared with the workforce.	September 2020

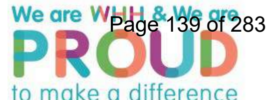
SPC/20/07/56	Employee Relations	The Committee received a paper updating on high risk employee relations activity, the National Social Partnership Forum agreement and a proposal to introduce measures to evaluate the impact of the Improving People Practices work.	**Decision** The Committee approved the proposal relating to the evaluation of the Improving People Practices work.	N/A

BOARD OF DIRECTORS CHAIR'S ASSURANCE REPORT

AGENDA REFERENCE:	BM/20/07/69 c ii		TRUST BOARD OF DIRECTORS	DATE OF MEETING	29 July 2020

Date of Meeting	17 June 2020
Name of Meeting + Chair	Finance & Sustainability Committee – Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	RECEIVING BODY (eg Board or Committee)	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
FSC/20/06/79	Corporate Performance Report	• May A&E performance is 93.38% • RTT 72.24% against target of 92% • Recovery planning is underway, CMTC launch T&O 22/6 and Breast 29/6 • The Trust is utilising the private sector under the national contract at no cost has been extended until 31/8/20	Committee	The Committee noted the report.	FSC July 2020
FSC/20/06/80	Pay Assurance Report	• May spend £18.4m • Medical agency has increased and Nursing decreased • Bank staff include student nurses and returns • Further work to triangulate vacancies and additional staff	Committee	The Committee noted the report.	FSC July 2020
FSC/20/06/81	Safe staffing Report	• The Trust has had to use some off framework agency Greenstaff and Thornbury due to specific skill set requirements which couldn't be filled by redeployment	Committee	The Committee reviewed, discussed and noted the report.	FSC July 2020



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NHS Foundation Trust

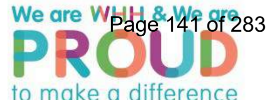
		• Sickness has been 11% for Nurses and 14% for HCAs • Vacancies of 107 Registered Nurses			
FSC/20/06/82	Service Line Reporting and National Costs Collection	• Noted progress • Highlighted top loss makers and most profitable • Update on National Cost Collection timescales • Highlighted need to establish Costing Steering Group	Committee	The Committee noted the report	FSC December 2020
FSC/20/06/84	Monthly Finance Report	• Achieved breakeven position with retrospective top up of £2.8m • Noted the income risk relating to B3 and await response from latest letter • Noted the improvement in BPPC to 95% • Noted there is a pause in CIP delivery for the first 4 months • Covid19 capital noted	Committee	The Committee reviewed, discussed and noted the report.	FSC July 2020
FSC/20/06/85	BAF/Risk Register	• Noted the report • No new risks or amendments to BAF • One new risk to Corporate Register in relation to 2020/21 Capital replacing old year Capital risk.	Committee	The Committee noted the report.	FSC July 2020
FSC/20/06/86	Key issues to the Board	• Risk of B3 income and need to escalate • Review of medical agency cover required	Committee		Board June 2020

BOARD OF DIRECTORS CHAIR'S ASSURANCE REPORT

AGENDA REFERENCE:	BM/20/07/69 c		TRUST BOARD OF DIRECTORS	DATE OF MEETING	29 July 2020

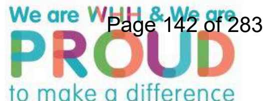
Date of Meeting	22 July 2020
Name of Meeting + Chair	Finance & Sustainability Committee – Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	RECEIVING BODY (eg Board or Committee)	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
FSC/20/07/92	Corporate Performance Report	• June A&E performance is 92.16%% July to date 92.28% • Increase in admissions 120 higher than May 2020 and 78% when compared to June 2019. No ambulance handover data for April. • RTT 61.78% against target of 92%, recovery is underway with increase in activity at CMTC. • Diagnostics did not achieve targets in month however we note a reduction of 836 patients waiting over 6 weeks compared to May 2020. • Increase in urgent and cancer cases being listed. These will be prioritised for treatment.	Committee	The Committee noted the report.	FSC August 2020
FSC/20/07/93	Pay Assurance Report	• Pay spend in June 2020 was £18.6m against a budget of £20.3m. • Further work to be completed on medic absences and	Committee	The Committee noted the report.	FSC August 2020



Warrington and Halton Teaching Hospitals
NHS Foundation Trust

		cost of locums.			
FSC/20/07/94	Covid Pay	• Highlighted spend to date and forecast along with the associated WTE.	Committee	The Committee noted the report.	
FSC/20/07/95	Premium Pay Spend Review Group	• Approved the closing of Premium Pay Spend and Review Group to allow members to refocus efforts on workforce planning and delivery. • Approved the proposed changes to the Pay Assurance Paper.	Committee	The Committee approved the changes in the report.	
FSC/20/07/96	Monthly Finance Report	• Q1 Achieved breakeven position with retrospective top up of £9m. • Covid expenditure and income loss £11.4m YTD. Required retrospective top up of £9m to achieve breakeven. • Agency £0.9m which is £0.3m higher than June last year and £0.7m related to Covid. • BPPC exceeded target of 95% achieving 97% in June. • Procurement Policy Note implemented for a supplier. • B1 and B3 risk highlighted. • Noted there is a pause in CIP delivery for the first 4 months of 2020/21. • Capital plan reviewed, noted emergency capital approval, number of requests for contingency funds can be funded with adjustment to the estates plan. This was supported to submit to Board for approval. • Recovery plans are being developed with potential c£11m additional cost which poses risk to sustainability. The Trust Board will consider finalised plans which will require scrutiny and prioritisation. • The Capital Planning Group Terms Of Reference were updated and approved.	Committee	The Committee reviewed, discussed and noted the report and support the Capital changes to go to Board.	FSC August 2020 Capital Changes to July Board for approval.



FSC/20/07/97	BAF/Risk Register	• Noted the report • No new BAF risks or amendments • Corporate no new risks	Committee	The Committee noted the report.	FSC August 2020
FSC/20/07/98	International Nursing Business Case	• Highlighted national and local nurse vacancies • Current overspend on agency • Initial financial investment to be taken to Board to discuss as part of prioritisation exercise.			
FSC/20/07/99	Key issues to the Board	• Returning activity for A&E, Cancer and RTT • Risk of B3 and B1 income / services and need to escalate • Review of potential recovery expenditure • Review of cost pressures for the international nursing business case • Further review of 2020/21 capital plan required	Committee		Board July 2020

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/20/07/69 d	COMMITTEE/ GROUP	TRUST BOARD OF DIRECTORS	DATE OF MEETING	29 July 2020

Date of Meeting	17 June 2020
Name of Meeting + Chair	Audit Committee, Chaired by Ian Jones, Non-Executive Director
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
AC/20/06/44	**External Auditors Findings Report on 2019-20 Accounts IAS 260 Memorandum**	The Audit Committee received and reviewed the External Auditors Report on the 2019-20 Accounts. Matters relating to Income and Expenditure and Plant and Equipment to be resolved outside of the Audit Committee relating to impairment figure in accounts. To be reviewed but no issue highlighted in accounts. Two areas highlighted relating to disclosures within the financial statements, Material Uncertainty relating to independent desktop valuation of land and buildings due to market uncertainty arising from COVID-19 and Going Concern disclosure. Not anticipated that this would affect the primary financial statements or report a different financial position. Financial Statements – reported anticipated **Unqualified Audit Opinion** to be issued ahead of deadline for submission on 25 June 2020.	**The Committee approved the Annual Accounts in principle, and supported delegated authority to the Chair of the Committee and Chief Finance Officer + Deputy CEO for final approval of the Annual Accounts.**	**Trust Board 29.07.2020**

		Other Findings– additional issues identified, not previously communicated in the Audit Plan, both are national issues and not Trust specific: NHS Shared Business Service Ltd – Finance and Accounting Services for period 6.03.2020-31.03.2020 – **Qualified Opinion**. NHS Shared Business Services Ltd – Employment Services – **Qualified Opinion** Value For Money (VFM). Trust had met its Control Total, Auditors satisfied with progress made and current arrangements in place in the challenging climate. No matters escalated. **Unqualified VFM conclusion.** Fees – revised report included a breakdown of the £60,000 audit fee, Main Audit fee £54,000 and Quality Account (QA) fee £6,000. Discussion had taken place at the previous Audit Committee to waive the £6,000 QA fee as the QA Audit had not been required. To be confirmed outside of the meeting Auditors had reviewed the Annual Report and Annual Governance Statement – no matters to escalate. The Committee **approved** the Annual Accounts in principle, and supported delegated authority to the Chair of the Committee and Chief Finance Officer + Deputy CEO for final approval of the Annual Accounts.		
AC/20/06/45 (a)	**Annual Report 2019-20**	The Committee received and reviewed the 2019-20 Annual Report. - The report did not include the Quality Account, the requirement to submit it as part of the Annual Report had been paused nationally due to COVID-19 Pandemic. - Audit Committee **approved** the Annual Report for CEO sign-off subject to minor amendments requested. **Post meeting note:** Annual Report submitted to Department of Health and Social Care for laying before Parliament on 2 July 2020.	**The Committee reviewed and approved the Annual Report, including the Annual Governance Statement for formal sign-off and approval**	**Trust Board 29.07.2020**

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

AC/20/06/45 (b)	**Final Audited Annual Accounts 2019-20**	The Committee received and reviewed the 2019-20 Final Audited Annual Accounts - No significant changes to the Annual Accounts presented at the Audit Committee on 30 April 2020. - Minor changes within financial statements (1.21/1.22) and prior year adjustments had been slightly amended. - The Audit Committee reviewed and **approved** the 2019-20 Final Audited Annual Accounts. **Post meeting note:** Audited Accounts submitted to NHSE/I 25 June 2020.	**The Committee reviewed and approved the Audited Annual Accounts for sign-off prior to submission to NHSE/I**	**Trust Board 29.07.2020**
AC/20/06/45 (c) & (d)	**2019-20 TAC Summarisation schedules/confirmation and certificate & Letter of Representation to Grant Thornton**	The Committee reviewed and approved: • 2019-20 TAC Summarisation schedules/confirmation and certificate. • Letter of Representation to Grant Thornton	**The Committee reviewed and approved the 2019-20 TAC Summarisation schedules and certificate, and approved the Letter of Representation to Grant Thornton.**	**Trust Board 29.07.2020**
AC/20/06/46	**Code of Governance Compliance**	**Code of Governance Compliance 2019-20** The report provided assurance of compliance with the Code. The Audit Committee reviewed and **approved** the report.		**Trust Board 29.07.2020**
AC/20/06/46	**Compliance with Licence Self Certification Annual Return**	**Compliance with Licence Self Certification Annual Return FT4** Continued compliance reported. Licence published on the Trust website. The Audit Committee reviewed and **approved** the report, noting continued full compliance with its Provider License conditions and Certificate of Compliance.	**The Audit Committee reviewed and approved the report, and assurance of continued compliance with its Provider License conditions and Certificate of Compliance.**	**Trust Board 29.07.2020**

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/70**			
SUBJECT:	**Covid-19 IPC Board Assurance Framework (v3)**			
DATE OF MEETING:	29 July 2020			
AUTHOR(S):	Lesley McKay, Associate Chief Nurse Infection Prevention + Control			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. ✓ SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. ✓ SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services. ✓			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	#1135 Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision. #1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #134 Financial Sustainability a) Failure to sustain financial viability, #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #224 Failure to meet the emergency access standard. #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. #145 a. Failure to deliver our strategic vision.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	To provide the Board of Directors with assurance on actions in place to meet legislative requirements relating to the prevention and control of infection linked directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note ✓	Decision
RECOMMENDATION:	The Board of Directors are asked to note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Covid-19 IPC Board Assurance Framework	AGENDA REF:	BM/20/07/70

1. BACKGROUND/CONTEXT

Over recent months understanding of COVID-19 has developed, and guidance on the required infection prevention and control measures has been published, updated and refined to reflect the learning.

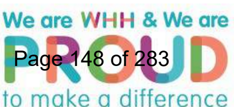
This assessment framework is linked to COVID-19 related infection prevention and control guidance and structured around the existing 10 criteria set out in the *Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and Related Guidance* (2015).

In the context of COVID-19, there is an inherent level of risk for NHS staff that are treating and caring for patients. Within the healthcare setting, transmission risks can arise from: patient to staff, staff to staff, staff to patient and patients to patient. Robust risk assessment processes are central to ensuring that these risks are identified, managed and mitigated effectively.

The risk assessment process will be continuous alongside review of emerging information to ensure that as an organisation the Trust can respond in an evidence-based way to maintain the safety of patients, services users and staff.

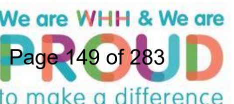
This Assurance Framework and Action Plan will be reviewed monthly by the Infection Control Sub-Committee and developed to address any emerging areas of concern identified.

Page 147 of 283



2. KEY ELEMENTS

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Infection risk is assessed at the front door and this is documented in patient notes	• Where patients are conveyed by the Ambulance Service with possible or confirmed infection risk for COVID-19 they are risk assessed pre-hospital by the Ambulance staff to inform destination decision. Government guidance for Ambulance Trusts is used for decision making https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts • ED are pre-alerted by the Ambulance Service of suspected Covid-19 cases	• Some COVID-19 positive individuals present at the hospital as asymptomatic patients	• Patient placement government guidance flow chart in place Mandatory surveillance\ncv2019\COVID-19 information\COVID-19 - Effective Patient Placement v2.1.docx • ED reorganized to have Hot and Cold respiratory assessment areas to segregate patients presenting with suspected Covid-19 from other attendees • All patients admitted via ED are screened for Covid-19, data reviewed daily
	• Electronic infection risk assessment tool in Lorenzo (Electronic Patient Record)	• Compliance with completion of infection risk assessments	• Audit of compliance with admission infection risk assessments planned for August
	• Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab and updated with additional swab results • 904 Covid-19 alerts added to individual patient records on Lorenzo • Covid-19 shielding Alerts added to Lorenzo		• IT surveillance system in place to track day of admissions and day 5 screening. Matrons and Lead Nurses review result daily and ensure Trust Covid-19 screening SOP is adhered to • Re-audit of compliance planned with admission screening for August
	• Alerting system in place for other healthcare associated infections: (MRSA; CDT; GRE; CPE; MDROs)		



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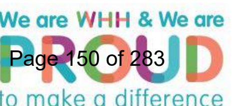
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status and clinical specialty need • The Trust is following PHE national guidance with admission screening and repeat swabbing undertaken 5 days post admission or sooner if initial test was negative and exhibits symptoms. Further repeat screening if symptoms • Screening data	• Potential incorrect or change in placement requirements identified	• SOP for patient placement in place which is in line with PHE national guidance • Operational Manager/Silver Command oversight of patient placement at Bed Meetings (4 times per day and frequency increased at times of increased activity/demand)
• Compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• In-house discharge screening is in place prior to transfer to care homes to facilitate timely and appropriate discharge of patients • The Trust is following PHE national guidance with repeat swab undertaken 48 hours prior to discharge/transfer • Included in Covid-19 screening SOP and Transfer to Care Home Pathway	• Assurance of full compliance with the Trust guidance for discharge screening	• Audit of compliance with discharge screening planned for August • Care Home process in place to request screening results prior to transfer • Care Homes request evidence of screening prior to accepting patients
• **All staff (clinical and non-clinical)** are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	• PPE guidance included in the Covid 19 Policy is line with PHE national Guidance • PPE Trust Board paper • Trust wide risk assessment • Local risk assessments in place for the use of PPE • Infection Prevention and Control Team support staff education for PPE • PPE training records • PPE Audit records • Face Masks distributed to all Non-clinical areas on Friday 12th June ahead of the change in guidance		• PPE champions (58) support staff education/face to face training • Updates on changes to guidance communicated as and when received • PPE audit tool developed for aerosol/non-aerosol generating procedures – weekly audit • Covid-19 PPE staff information booklet • PHE PPE training video website



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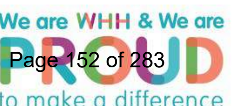
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	for PPE to be worn in non-clinical areas • Risk assessments include details on Covid-19 secure and when face masks are required • PPE training for visitors where compassionate visiting requirements are indicated		links shared and compliance monitored • Supplies including PPE is a standing agenda item at the Tactical Meetings and estimated usage rates have been added to all Recovery Plans • A protocol is in place for both in and out of hours access to PPE • Further PPE training scheduled with PPE champions for July and August
• National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7) shared at Trust Wide Safety Briefing (TWSB) and via Covid daily Bulletin • Control Room with dedicated email address receives national updates which are distributed as and when received for timely action • Compliance framework tracking compliance with national guidance under clearly defined work streams with nominated leads		• Coronavirus Assessment Pod decontamination SOP • Coronavirus Policy version 7. Updates were shown in different coloured font to support staff more easily identify latest changes/ updates • SOP for patient placement during Covid-19 pandemic • Quantitative Fit Testing SOP • Qualitative Fit Testing SOP • Reusable PPE Decontamination SOP • Covid-19 Screening SOP • Hospital onset Covid 19 and Outbreak Management SOP • Staff screening SOP • Review of compliance against national guidance

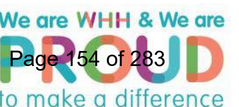
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
			• Policies, guidelines and SOPs and updates are distributed by Trust Wide Safety Brief
• Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Covid-19 Tactical Group Meetings and Recovery Board Meetings in place with clear escalation route to Trust Board • Tactical meetings (initially daily (weekdays) from 18/03/20 and stepped down to 3 times per week 01/05/20 and then to weekly from 06/07/20 and Recover Board Meetings twice per week starting on 05/05/20 feed in to Strategic Executive Oversight Group (SEOG) meeting and this feeds into Board. The Associate Director of IPC attend Tactical and Recovery meetings as do the DIPC and Deputy DIPC/Consultant Microbiologist Infection Control Doctor		
• Risks are reflected in risk registers and the Board Assurance Framework (BAF) where appropriate	• A Covid-19 specific Risk Register has been created with risks escalated to the corporate Risk Register and BAF as appropriate. Updates are discussed at the Quality Assurance Committee • Corporate Risks include impact on activity • Local risk assessments in place for the use of PPE • 2 risks on the BAF linked to: - national shortage of PPE - oxygen supply		• PPE is a standing agenda item for monitoring levels at the Tactical Meetings and estimated usage rates have been added to all Recovery Plans • Oxygen daily SitRep continued beyond national reporting requirements to provide local assurance
• Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Existing IPC policies in place: - Chickenpox - Clostridium difficile - Scabies - Shingles - Meningitis	• The C. difficile Cohort ward has been temporarily stepped down and will be reinstated with recovery plans	• Clostridium difficile Guidelines (2018) in place and all patients with a C. difficile toxin positive or PCR positive result are isolated • Ribotyping of all community onset healthcare associated and hospital



1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	- MRSA - Multi-drug resistant organisms - Influenza - TB/ MDR TB - Viral Gastroenteritis - Viral haemorrhagic fevers - Isolation of immunosuppressed patients • SOPs for rapid testing for CPE/ MRSA and enteric and respiratory pathogens • Isolation for other infections and pathogens is prioritised based on transmission route		onset healthcare associated cases • Root Cause Analysis investigation for all hospital apportioned cases • Compliance with Mandatory HCAI reporting requirements • Distribution of HCAI surveillance data weekly • Re-establishing the C. difficile Cohort Ward is included in Recovery Plans • GNBSI reduction Action Plan has been revised and work stream is being reinstated

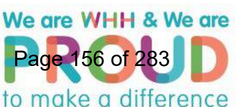
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• SOP for patient placement (agreed ward and critical care locations). Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status. Respiratory Step Down Unit SOP • Availability of rapid SARS-CoV2 testing in certain circumstances	• Revision to SOP required to agree placement of suspected Covid-19 cases according to clinical speciality as cases decrease with Recovery Team oversight • Response where unexpected sickness occurs	• Ongoing discussion at Nursing and Midwifery Forum, Medical Cabinet and Allied Health Professionals Forum as mitigation • Discussed at the Unplanned Care Group Meeting and action agreed to update guidance • The Matrons provide oversight of staffing levels to ensure all areas are appropriately and safely staffed
• Designated cleaning teams with appropriate training in	• Task Team and Domestic Assistant training for Covid-19 cohort ward areas has been carried out		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	• Fit Testing for FFP3 masks undertaken for Domestic Assistants in areas where aerosol generating procedures are performed • Task Team support areas where there are Domestic Assistant shortfalls		
• Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Terminal cleaning and Decontamination polices in place including guidance on environmental disinfectant required according to decontaminate the environment. Decontamination included in the Covid-19 policy • All policies are used in conjunction with any updates provided by COVID-19 national guidance • Terminal Cleaning Guidelines 2018 • Decontamination Policy 2019 • Novel Coronavirus Policy (version 7)		
• Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance • Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas • Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a	• Cleaning of frequently touched surfaces is included in cleaning policies • Toilets and bathroom cleaning carried out in all areas at least twice a day • Domestic staff document when areas have been cleaned • Frequencies detailed in Trust Cleaning standards policy • Staff training records	• Cleaning audits were halted for the initial stages of the pandemic with escalation in place from Wards and Departments in the event of any concerns regarding standards	• Cleaning audits have been re-instated and are carried out by staff in the Cleaning Monitoring Team • Ward/Department audits findings are emailed to the Ward/ Department Managers for action • Domestic Supervisory team ensure standards are adhered to



2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses • Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products • As per national guidance: - 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids • Electronic equipment, e.g. mobile phones, desk phones,	• Neutral detergent is the standard environmental cleaning agent. Chlorine based disinfectant diluted to 1,000ppm available chlorine is used for terminal cleaning, wards where C. difficile cases are cared for or Hydrogen Peroxide Vapour for cases of C. difficile • Consultant Microbiologists and IPCNs included in discussions on alternative products to ensure effective against coronaviruses • Information on contact time is included in the decontamination policy • Domestic staff record when they have cleaned areas • Information on cleaning of workstations is included in the Environmental Action Plan	• Compatibility issue with CT scanner	• CT Manufacturer contacted for alternative decontamination guidance

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
tablets, desktops and keyboards should be cleaned at least twice daily • Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Domestic staff time cleaning activity when areas are vacant		
• Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Process for managing linen is included in the COVID-19 policy. All linen from COVID-19 possible and confirmed positive patients is treated as infectious and placed in alginate bags which are tied and then placed in a white plastic bag • No DATIX reports on non-compliance with double bagging on used/infected linen	• Occasional reporting of alginate bag shortage (which are provided by the laundry contractor)	• Guidance received from the Laundry Contractor to double bag used linen in white bags
• Single use items are used where possible and according to Single Use Policy	• Decontamination Policy in place which includes single use/single patient use guidance used in conjunction with any updates provided by National Guidance in response to COVID-19 • Chlorine releasing agents are the nationally advised method of decontamination • Hydrogen Peroxide Vapour has been used for environmental decontamination as part of a deep clean programme for vacant wards		• An SOP for decontamination of reusable PPE is in place
• Reusable equipment is appropriately decontaminated in line with local and PHE and other	• Decontamination Policy in place used in conjunction with any updates provided by National Guidance in response to COVID-19	• Decontamination Meetings suspended	• Date scheduled to reconvene meetings from 17/08/20



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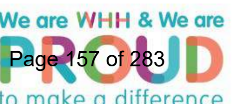
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
national policy			
• Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	• Windows within the waiting space are opened to ventilate the area and any space having forced ventilation is adequate to keep the area ventilated so windows can be kept closed • Signage on social distancing, hand hygiene and face coverings is displayed in ED waiting areas	• Not all areas will be provided with ventilation or have the ability to open windows	• These areas are ventilated by keeping doors open where possible

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Arrangements around antimicrobial stewardship are maintained	• Consultant Medical Microbiology Virtual Ward Round in Critical Care • Ward based Pharmacist support • Prescribing advice available by telephone (in and out of hours) • Antibiotic prescribing guidelines for COVID suspected patients have been published	• Reduction in antibiotic ward round activity • No C difficile MDT at present as there is no cohort ward and no single consultant covering C difficile patients	• Antibiotic ward rounds re-established (2 ward rounds / week) • Critical Care daily ward rounds recommenced • Infection Control Doctor presentations to Medical Cabinet • Review as evidence/guidelines are updated • Antimicrobial Management Steering Group Meetings will be reconvened from September • C diff outliers ward rounds recommenced in July
• Mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting of HCAIs has continued • Data on HCAIs is included on the Quality Dashboard • DIPC reports HCAI data at Trust Board • Information on Data Capture System • Distribution of HCAI surveillance data weekly	• RCA face to face meetings suspended due to COVID-19	• RCA now undertaken via Microsoft Teams • Review evidence/guidelines are updated



4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Implementation of national guidance on visiting patients in a care setting	• Restricted visiting implemented 17 March 2020; Visiting suspended from 26 March 2020; Compassionate visiting arrangements agreed 09 April 2020. Paper on visiting arrangements taken to SEOG • Visiting the dying guideline in place with training provided by the Palliative Care Team • Trust wide Communication via email on visiting restrictions then cessation	• Visitor arriving on site without knowledge of visiting arrangements	• Environmental Safety Plan includes site lock down to restrict access • Compassionate visiting arrangements agreed for the following patient groups where close family and friends visiting may be admitted: - Patients in critical care - Vulnerable young adults - Patients living with Dementia - Autism - Learning difficulties • Loved ones who are receiving end of life care • Signage at entrances
• Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• Coronavirus posters displayed outside areas where patients with suspected or confirmed COVID-19 are cared for		
• Information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Information on COVID-19 is available on the Trust Web Site and at entrances		
• Infection status is communicated to the	• Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab (to date 904	• Confusion on the layout of the template	• Changes made to the standard template to clarify results

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Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
receiving organisations or department when a possible or confirmed COVID-19 patient needs to be moved	alerts added) • Covid-19 has been added to e-discharge summary template		• Discussed at medical cabinet and Safety Alert distributed to all Consultants • Information added to medical staff induction training

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection	• Patients conveyed to hospital by Ambulance are pre-assessed to determine where they are taken to in ED • ED reorganised to have Hot and Cold respiratory assessment areas to segregate patients presenting with suspected Covid-19 • Triage in ED and segregated areas for patient suspected to have COVID-19 • Environmental Safety Action Plan with proposal to lockdown 25% of entrances • Manned mask stations at main entrance Warrington and mask available at other entrances with access to hand sanitisers	• Asymptomatic patients subsequently identified as COVID-19 positive	• Process in place to isolate and close the bay to admissions
• Mask usage is emphasized for suspected individuals	• Masks are offered to patients where O_2 therapy is not required and 2 metre distancing is not possible		
• Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	• Estate work has been carried out to install additional doors within ED • Where available, doors are closed on ward corridors to separate Covid and non-Covid areas • Perspex screens have been installed in a number of		

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Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	reception areas		
• For patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	• Symptomatic screening is advised after 48 hours if admission screen result was negative • Routine swabs for Covid have been added to the sepsis screening packs • Isolation facilities are prioritized for patients with suspected infections transmitted by the respiratory room • Contact tracing is including in the Covid-19 Hospital Onset and Outbreak Investigation SOP		
• Patients with suspected COVID-19 are tested promptly	• Admission screening has been updated in line with national guidance and currently includes all admissions • IT surveillance system in place to track day of admissions & day 5 screening. Matrons and Lead Nurses review result daily & ensure Trust Covid-19 screening SOP is adhered to • Rapid screening swabs are available, limited number (6 -7 per day). On site testing is in place with same day turnaround of results for routine specimens		
• Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	• Repeat patient testing in place where there are on-going concerns about COVID-19 and initial swab was negative • SOP on Covid-19 screening and isolation and PPE in place • Contact tracing is including in the Covid-19 Hospital Onset and Outbreak Investigation SOP		
• Patients that attend for routine appointments who display symptoms of COVID-	• Rapid testing available 7 days per week • Routine appointments have been stepped down. Social distancing measures are in place in	• Public compliance with social distancing measures	• Social distancing measures are in place in Outpatient Departments

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
19 are managed appropriately	Outpatient Departments • Recovery plan for Outpatients (28/05/2020) includes providing information not to attend if unwell with Covid-19 symptoms • Risk rated appointment schedule based on clinical priority • Virtual 'attend anywhere' clinics • Rooms identified for shielding patients		• Signage in place to keep left on corridors, walk in single file and socially distance • Seating arranged in Outpatient waiting areas to support social distancing

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• PPE Champions (58), roving training on donning and doffing of PPE • Links to PHE videos have been distributed. Individual booklets on COVID-19 and PPE produced and distributed • Training records from all CBUs that staff have read the Covid-19 policy, receive the PPE booklet, watched the PHE videos, received face to face training, read the Covid-19 swabbing SOP	• Staff returning to work, including after pregnancy, shielding or long term sick leave may not be fully informed with the latest guidance • PPE to be maintained on CBU Governance agendas	• Action plan in place with Unplanned and Planned Care Groups to ensure all staff return to work receive appropriate level of training • Action plans in place with CBUs where there are shortfalls in staff training • IPC Team provide ongoing training to PPE champions on donning and doffing of PPE • Links to PHE videos are available and distributed • Request addition via Governance Teams
• All staff providing patient care are trained in the	• Links to PHE videos have been distributed. Posters are displayed in clinical areas on donning and	• Posters not displayed in all areas	• Additional posters ordered and site survey to be completed by

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Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	doffing • Information recirculated to Planned and Unplanned Care Groups • Information circulated on Trust Wide Safety Brief	• Staff returning from absence may not be fully informed/updated with latest guidance • PPE to be maintained on CBU Governance agenda's	IPCNs with PPE champions for each area • IPC team provide ongoing training on donning and doffing of PPE. Links to PHE videos are available and distributed • Request addition via Governance Teams
• A record of staff training is maintained	• Record of training	• Follow up of staff training records required and identify shortfalls	• Action plan in place with Unplanned and Planned Care Groups to ensure all staff return to work receive appropriate level of training • Action plans in place with CBUs where there are shortfalls in staff training
• Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	• Reusable (laundered gowns) introduced as part of contingency as per national guidance as a temporary measure during national shortage of gowns • PPE paper submitted to Trust Board and Risk Assessment in place		
• Any incidents relating to the re-use of PPE are monitored and appropriate action taken	• To date 19 incidents reported relating to Covid-19 - Communication of suspected infection status - Distribution of non-fluid repellant gowns • Reusable FFP3 respirators labelled as latex free – however do have latex content		• Non-fluid repellent gowns withdrawn from use • Trust wide alert and email sent to users to complete Latex questionnaire and return to Occupational Health or return for alternative mask fit testing
• Adherence to PHE national	• Observational audits completed and feedback received from PPE Champions	• Trust wide over view of compliance	• Dashboard being set up

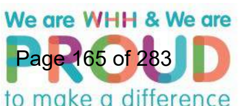
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
guidance on the use of PPE is regularly audited	• Electronic Audit Tool developed and launched 15/05/20 • Audits are carried out weekly and repeated in a shorter timescale where issues are identified		
• Staff regularly undertake hand hygiene and observe standard infection control precautions	• Programme of hand hygiene audits in place – carried out weekly in areas operational. Overall compliance • April =98%; May=98%; June=98%		
• Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• Removal of hand driers in public toilets (none in clinical areas) has taken place as part of the environmental action plan • Hand towel dispensers have been installed and waste collection schedule put in place	• Audit exact location of hand towel dispensers	• Review scheduled for July 2020
• Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• Signage on hand washing technique is displayed on all soap dispensers. • HM Government signage has been displayed detailing 20 second handwashing	• Audit signage is in all public toilet locations	• Review scheduled for July 2020
• Staff understand the requirements for uniform laundering where this is not provided for on site	• Guidance on home laundering is included in the COVID-19 PPE information leaflets • Scrub Suits have been offered as an alternative to uniforms and are laundered centrally		
• All staff understand the symptoms of COVID-19 and	• Staff shielding and screening for COVID-19 is undertaken in line with national guidance • Monitored by the Occupational Health Team and		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms	overseen by the Workforce and Organisational Development Team		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status	• Limited number of single rooms for isolation (65)	• Cohorting in place as advised by the Infection Prevention and Control Team • Operational Manager/Silver Command oversight at Bed Meetings (4 times per day and frequency increased at times of increased activity/demand)
• Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• Additional hand washing facilities in anterooms on ward A7 • Side rooms in use for non-clinical activity converted back for clinical inpatient use - 2 single rooms on A2 - 1 single room on A7 - Plans in place for 4 additional single rooms: 2 between A5 and A6; and 2 between A8 and A9 - 3 single room pods built in AMU		
• Patients with resistant/alert organisms are managed according to local IPC	• Isolation Policy in place • Elective surgery/Endoscopy including pre-operative assessment SOPs including (advice on self –isolation	• Limited number of side rooms further reduced by ward closures	• Isolation priority protocol in place based on transmission based precautions

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
guidance, including ensuring appropriate patient placement	and Covid testing before surgery). Staff temperature/ symptoms screening in elective care areas to minimise transmission • Provision of seating with social distancing in out-patient areas and availability of face masks for patients In addition to staff • All patients in waiting areas will wear a mask / face covering unless it compromises their breathing and for that there would be alternative arrangements (as per published FAQs)	• Potential non-compliance of patients with shielding pre-operatively	

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure:			
• Testing is undertaken by competent and trained individuals	• Training on swabbing technique provided verbally and by video	• Small number of samples rejected due to insufficient cellular material or incorrectly labelled	• Swabbing SOP and training provided
• Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Updates to guidance provided in light of swab availability changes to national guidance • Swabbing SOP in place covering: day of admission, day 5, symptomatic, pre-admission elective and discharge screening		
• Screening for other potential infections takes place	• Other routine admission screening (CPE,MRSA,VRE) in place		

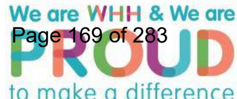


9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that:			
• Staff are supported in adhering to all IPC policies, including those for other alert organisms	• PPE Champions in place. On-call service (and 7 day service) for IPC in place. Clinical advice for management of patients with suspected infections continued • IPC 7 day and on call service		
• Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7). TWSB and Covid daily Bulletin used to communicate updates	• Potential for delay where changes released out of hours e.g. weekends	• Subscription and daily review of Gov. UK email updates • Control Room inbox is monitored 7 days per week and guidance issued over the weekend- out or of hours is escalated for action • Additional posters ordered Links to PHE videos are available on the Trust Hub and distributed
• All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• Guidance included in Covid-19 Policy. Early guidance adhered to when initial classification of a HCID. Waste was quarantined and disposed of by incineration • Guidance included in the Coronavirus Policy		
• PPE stock is appropriately stored and accessible to staff who require it	• Stock control in place • In and out of Hours access protocol in place • Specialist PPE equipment office with access available 7 days/week		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
• Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• An integrated risk assessment has been produced for staff who are 'extremely vulnerable', at 'increased risk', pregnant and Black, Asian and Minority Ethnic (BAME) staff. For BAME staff, based on the number of BAME staff recorded on ESR, there is 93.5% compliance. All BAME staff risk assessments will be quality checked and a sample audit will take place in July 2020 to ensure agreed actions have been undertaken. • Individual letters have been sent to BAME members of staff, outlining support available • Named midwife contact within Maternity Department provided for pregnant staff • All staff requiring shielding are supported by robust workforce support and the Trust are in the process of having one to one discussions to agree support and adjustments • All staff working at home have been provided with a 'working from home pack', including access to mental health support • Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical • An enhanced wellbeing offer has been developed, linked to learning from Wuhan, Italy and the British Psychological Society	• An electronic system is required to support the roll out of a new COVID-19 Workforce Risk Assessment Tool in line with Risk Reduction Framework • Feedback from BAME members of staff on accessing support • Access to face to face counselling is limited as only 1 FTE counsellor on site	• An electronic system is currently under development with IT and Workforce Information Teams. Planned launch date is 29/06/2020 • Chief People Officer and Chief Executive Officer attended the BAME Staff Network Group in June 2020 to receive feedback • An additional 2 FTE Counsellors employed - due to start 1 July 2020
• Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is	• Fit testing programme, including quantitative and qualitative testing, in place • Qualitative Fit testing SOP • Quantitative Fit testing SOP • Records are added to a central database		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
maintained	• Powered Hoods are offered as an alternative where it has not been possible to Fit close fitting face masks • Only EN 149:2001 compliant masks are accepted as fit for use		
• Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	• Staffing reviews undertaken for all COVID areas • Staff movements managed by the senior nursing team at daily meetings • Senior Nurse presence 7 days per week 8am-8pm to support staffing management • Planned elective areas have designated teams, who are not moved to any other area in the Trust • Where it is necessary to move staff between different areas to support patient safety, this is discussed with the Infection Control Team. This cross over has not occurred between Elective and Emergency Care pathways		
• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Signage in place along corridors to socially distance, keep left and walk in single file • Risk assessments of all areas to achieve Covid-19 Secure spaces • IPC Team and/or Health and Safety Team review where concerns have been raised		
• Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	• Requirement to stagger breaks is included in the Covid-19 Environmental Safety Plan		
• Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access	• Managers have been supported to record absence in 'real time'. Daily and weekly absence reporting is in place		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
testing			
• Staff that test positive have adequate information and support to aid their recovery and return to work	• A COVID-19 Occupatinal Health advice line has been created, to provide a range of advice and guidance to the workforce • The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff) • Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical • Occupational Health and Wellbeing advise staff of test results and provide further wellbeing support as and when required • Retesting is in place as appropriate and is set out in Staff Testing SOP	• Test and Trace Service hours of operation	• National guidance for 16 hour per day service (cover in place for 11.5 hours per day) • Notifications from Test and Trace are received in the Control Room and forwarded to the Occupational Health and Infection Control Teams for action



3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Include in cycle of business for Infection Control Sub-Committee monthly and keep under continuous review to identify any emerging information that would require addition to the action plan
- Monitor the action plan to address gaps in assurance until completion

4. IMPACT ON QPS?

Q: Visiting restrictions due to risk of infection may have a negative impact on patient experience. A number of communication mechanisms have been implemented.
P: Risk to staff health and wellbeing from anxiety associated with the unknown situation and risk of infection of self and family members. A number of staff are absent from work due to 'shielding' requirements.
S: Financial impact of a global pandemic and major interruption to business as usual.

5. MEASUREMENTS/EVALUATIONS

Incident reporting

Action plan monitoring

6. TRAJECTORIES/OBJECTIVES AGREED

- To ensure compliance with the Code of Practice on prevention of Healthcare Associated Infections

7. MONITORING/REPORTING ROUTES

- Infection Control Sub-Committee
- Quality Assurance Committee
- Trust Board

8. TIMELINES

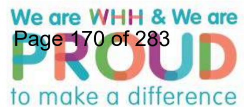
For the duration of the Covid-19 pandemic at all stages which is yet to be determined

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

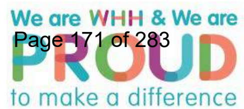
10. RECOMMENDATIONS

The Board of Directors are asked to note the report.



11. Appendix Action Plan for IPC BAF

Ref No	Action required	Target date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 1 Systems are in place to manage and monitor the prevention and control of infection								
1	Audit completion of admission infection risk assessments	Aug 20			ADIPC	Information Team		
2	Audit of compliance with discharge screening	Aug 20			ADIPC	Information Team		
3	Re-establish Clostridium difficile Cohort Facility	Aug 20			ADIPC	ACN Unplanned Care Group		
Criterion 2 Provide and maintain a clean and appropriate environment								
4	Revision to Patient Placement SOP	Jul 20			AMD Unplanned Care Group			
Criterion 3 Ensure appropriate antimicrobial use to optimise patient outcomes								
5	Re-establish C. difficile MDT	Aug 20			CMMs	AMD Unplanned Care Group		
6	Re-establish HCAI RCA Review meetings	Jul 20			ADIPC	CMMs		
Criterion 4 Provide suitable accurate information on infections to service users								
7	Safety Alert on completion of the E-discharge summary	Jul 20	Jul 20		AMD Unplanned & Planned Care Groups	ADIPC	Safety Alert Medical Cabinet Minutes Email audit trail	
Criterion 5 Ensure prompt identification **of people who have or are at risk of developing an infection – Nil action Required**								
Criterion 6 Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of								



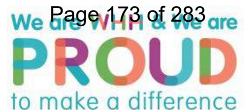
Ref No	Action required	Target date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
preventing and controlling infection								
8	Education on Covid-19 PPE for staff returning to work, including after pregnancy, shielding or long term sick leave	Sep 20			ADIPC	ACNs Unplanned & Planned Care Groups		
9	Availability of PPE to be maintained on CBU Governance agenda's	Jul 20			ADG	CBU Governance Managers		
10	Dashboard to be developed to provide a Trust wide overview of PPE training records	Jul 20			ADIPC	ACNs Unplanned & Planned Care Groups		
11	Dashboard to be developed to provide a Trust wide overview of PPE Audits	Jul 20			ADIPC	IPC Admin		
12	Site Survey to be completed of all clinical areas to ensure posters for donning and doffing are displayed on all bay/ side room doors	Sep 20			ADIPC	IPCNs		
13	Audit exact location of hand towel dispensers in public toilets	Aug 20			ADIPC	IPCNs		
14	Audit signage is in all public toilet locations	Aug 20			ADIPC	IPCNs		
Criterion 7 Provide or secure adequate isolation facilities								
15	Review of daily side room survey to optimise use of side rooms	Jul 20			DCOO	ADIPC		
Criterion 8 Secure adequate access to laboratory support as appropriate								
16	Dashboard to be developed to provide a Trust wide overview of compliance with Covid-19 swabbing	Jul 20			ADIPC	IPC Admin		

Ref No	Action required	Target date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
	training							
Criterion 9 Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections – Nil Concerns								
Criterion 10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection								
17	Guidance on risk assessments for staff who have been shielding returning to work in clinical areas	Jul 20			DD HR & OD	ADG; DCN; AMD; DCOO; CMM; ADIPC		
18	Review updated Guidance to ensure timely response to Test and Trace service referrals and develop SOP	Jul 20			DD HR & OD	OHWB Manager		

RAG Legend	
Action not commenced	
Action in progress	
Action completed	

Key Personnel

ACNs	**Associate Chief Nurses**
ADIPC	**Associate Director of Infection Prevention and Control**
ADG	**Associate Director of Governance**
AMD	**Associate Medical Director**
CBU	**Clinical Business Managers**
CMM	**Consultant Medical Microbiologists**
DCN	**Deputy Chief Nurse**
DCOO	**Deputy Chief Operating Officer**
DD HR	**Deputy Director of Human Resources and Organisational Development**
IPC Admin	**Infection Prevention and Control Administrator**



Infection Prevention and Control
Board Assurance Framework for Covid-19

Created 13 May 2020 v1
Updated 20 July 2020 v2
Updated 22 July 2020 v3

Introduction

Over recent months understanding of COVID-19 has developed, and guidance on the required infection prevention and control measures has been published, updated and refined to reflect the learning.

This assessment framework is linked to COVID-19 related infection prevention and control guidance and structured around the existing 10 criteria set out in the *Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and Related Guidance* (2015).

In the context of COVID-19, there is an inherent level of risk for NHS staff that are treating and caring for patients. Within the healthcare setting, transmission risks can arise from: patient to staff, staff to staff, staff to patient and patients to patient. Robust risk assessment processes are central to ensuring that these risks are identified, managed and mitigated effectively.

The risk assessment process will be continuous alongside review of emerging information to ensure that as an organisation the Trust can respond in an evidence-based way to maintain the safety of patients, services users and staff.

This Assurance Framework and Action Plan will be reviewed monthly by the Infection Control Sub-Committee and developed to address any emerging areas of concern identified.

Page 174 of 283

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Infection risk is assessed at the front door and this is documented in patient notes	• Where patients are conveyed by the Ambulance Service with possible or confirmed infection risk for COVID-19 they are risk assessed pre-hospital by the Ambulance staff to inform destination decision. Government guidance for Ambulance Trusts is used for decision making https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts • ED are pre-alerted by the Ambulance Service of suspected Covid-19 cases	• Some COVID-19 positive individuals present at the hospital as asymptomatic patients	• Patient placement government guidance flow chart in place Mandatory surveillance\ncv2019\COVID-19 information\COVID-19 - Effective Patient Placement v2.1.docx • ED reorganized to have Hot and Cold respiratory assessment areas to segregate patients presenting with suspected Covid-19 from other attendees • All patients admitted via ED are screened for Covid-19, data reviewed daily
	• Electronic infection risk assessment tool in Lorenzo (Electronic Patient Record)	• Compliance with completion of infection risk assessments	• Audit of compliance with admission infection risk assessments planned for August
	• Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab and updated with additional swab results • 904 Covid-19 alerts added to individual patient records on Lorenzo • Covid-19 shielding Alerts added to Lorenzo		• IT surveillance system in place to track day of admissions and day 5 screening. Matrons and Lead Nurses review result daily and ensure Trust Covid-19 screening SOP is adhered to • Re-audit of compliance planned with admission screening for August
	• Alerting system in place for other healthcare associated infections: (MRSA; CDT; GRE; CPE; MDROs)		

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status and clinical specialty need • The Trust is following PHE national guidance with admission screening and repeat swabbing undertaken 5 days post admission or sooner if initial test was negative and exhibits symptoms. Further repeat screening if symptoms • Screening data	• Potential incorrect or change in placement requirements identified	• SOP for patient placement in place which is in line with PHE national guidance • Operational Manager/Silver Command oversight of patient placement at Bed Meetings (4 times per day and frequency increased at times of increased activity/demand)
• Compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• In-house discharge screening is in place prior to transfer to care homes to facilitate timely and appropriate discharge of patients • The Trust is following PHE national guidance with repeat swab undertaken 48 hours prior to discharge/transfer • Included in Covid-19 screening SOP and Transfer to Care Home Pathway	• Assurance of full compliance with the Trust guidance for discharge screening	• Audit of compliance with discharge screening planned for August • Care Home process in place to request screening results prior to transfer • Care Homes request evidence of screening prior to accepting patients
• **All staff (clinical and non-clinical)** are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national	• PPE guidance included in the Covid 19 Policy is line with PHE national Guidance • PPE Trust Board paper • Trust wide risk assessment • Local risk assessments in place for the use of PPE • Infection Prevention and Control Team support staff education for PPE • PPE training records • PPE Audit records		• PPE champions (58) support staff education/face to face training • Updates on changes to guidance communicated as and when received • PPE audit tool developed for aerosol/non-aerosol generating procedures – weekly audit • Covid-19 PPE staff information

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
guidance	• Face Masks distributed to all Non-clinical areas on Friday 12th June ahead of the change in guidance for PPE to be worn in non-clinical areas • Risk assessments include details on Covid-19 secure and when face masks are required • PPE training for visitors where compassionate visiting requirements are indicated		booklet • PHE PPE training video website links shared and compliance monitored • Supplies including PPE is a standing agenda item at the Tactical Meetings and estimated usage rates have been added to all Recovery Plans • A protocol is in place for both in and out of hours access to PPE • Further PPE training scheduled with PPE champions for July and August
• National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7) shared at Trust Wide Safety Briefing (TWSB) and via Covid daily Bulletin • Control Room with dedicated email address receives national updates which are distributed as and when received for timely action • Compliance framework tracking compliance with national guidance under clearly defined work streams with nominated leads		• Coronavirus Assessment Pod decontamination SOP • Coronavirus Policy version 7. Updates were shown in different coloured font to support staff more easily identify latest changes/ updates • SOP for patient placement during Covid-19 pandemic • Quantitative Fit Testing SOP • Qualitative Fit Testing SOP • Reusable PPE Decontamination SOP • Covid-19 Screening SOP • Hospital onset Covid 19 and

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
			Outbreak Management SOP • Staff screening SOP • Review of compliance against national guidance • Policies, guidelines and SOPs and updates are distributed by Trust Wide Safety Brief
• Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Covid-19 Tactical Group Meetings and Recovery Board Meetings in place with clear escalation route to Trust Board • Tactical meetings (initially daily (weekdays) from 18/03/20 and stepped down to 3 times per week 01/05/20 and then to weekly from 06/07/20 and Recover Board Meetings twice per week starting on 05/05/20 feed in to Strategic Executive Oversight Group (SEOG) meeting and this feeds into Board. The Associate Director of IPC attend Tactical and Recovery meetings as do the DIPC and Deputy DIPC/Consultant Microbiologist Infection Control Doctor		
• Risks are reflected in risk registers and the Board Assurance Framework (BAF) where appropriate	• A Covid-19 specific Risk Register has been created with risks escalated to the corporate Risk Register and BAF as appropriate. Updates are discussed at the Quality Assurance Committee • Corporate Risks include impact on activity • Local risk assessments in place for the use of PPE • 2 risks on the BAF linked to: - national shortage of PPE - oxygen supply		• PPE is a standing agenda item for monitoring levels at the Tactical Meetings and estimated usage rates have been added to all Recovery Plans • Oxygen daily SitRep continued beyond national reporting requirements to provide local assurance

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Existing IPC policies in place: - Chickenpox - Clostridium difficile - Scabies - Shingles - Meningitis - MRSA - Multi-drug resistant organisms - Influenza - TB/ MDR TB - Viral Gastroenteritis - Viral haemorrhagic fevers - Isolation of immunosuppressed patients • SOPs for rapid testing for CPE/ MRSA and enteric and respiratory pathogens • Isolation for other infections and pathogens is prioritised based on transmission route	• The C. difficile Cohort ward has been temporarily stepped down and will be reinstated with recovery plans	• Clostridium difficile Guidelines (2018) in place and all patients with a C. difficile toxin positive or PCR positive result are isolated • Ribotyping of all community onset healthcare associated and hospital onset healthcare associated cases • Root Cause Analysis investigation for all hospital apportioned cases • Compliance with Mandatory HCAI reporting requirements • Distribution of HCAI surveillance data weekly • Re-establishing the C. difficile Cohort Ward is included in Recovery Plans • GNBSI reduction Action Plan has been revised and work stream is being reinstated

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• SOP for patient placement (agreed ward and critical care locations). Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status. Respiratory Step Down Unit SOP	• Revision to SOP required to agree placement of suspected Covid-19 cases according to clinical speciality as cases decrease with	• Ongoing discussion at Nursing and Midwifery Forum, Medical Cabinet and Allied Health Professionals Forum as mitigation • Discussed at the Unplanned Care Group Meeting and action agreed

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	• Availability of rapid SARS-CoV2 testing in certain circumstances	Recovery Team oversight • Response where unexpected sickness occurs	to update guidance • The Matrons provide oversight of staffing levels to ensure all areas are appropriately and safely staffed
• Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	• Task Team and Domestic Assistant training for Covid-19 cohort ward areas has been carried out • Fit Testing for FFP3 masks undertaken for Domestic Assistants in areas where aerosol generating procedures are performed • Task Team support areas where there are Domestic Assistant shortfalls		
• Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Terminal cleaning and Decontamination polices in place including guidance on environmental disinfectant required according to decontaminate the environment. Decontamination included in the Covid-19 policy • All policies are used in conjunction with any updates provided by COVID-19 national guidance • Terminal Cleaning Guidelines 2018 • Decontamination Policy 2019 • Novel Coronavirus Policy (version 7)		
• Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	• Cleaning of frequently touched surfaces is included in cleaning policies	• Cleaning audits were halted for the initial stages of the pandemic with escalation in place from Wards and Departments in the event of any concerns	• Cleaning audits have been re-instated and are carried out by staff in the Cleaning Monitoring Team • Ward/Department audits findings are emailed to the Ward/ Department Managers for action

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas • Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses • Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products • As per national guidance: - 'frequently touched'	• Toilets and bathroom cleaning carried out in all areas at least twice a day • Domestic staff document when areas have been cleaned • Frequencies detailed in Trust Cleaning standards policy • Staff training records • Neutral detergent is the standard environmental cleaning agent. Chlorine based disinfectant diluted to 1,000ppm available chlorine is used for terminal cleaning, wards where C. difficile cases are cared for or Hydrogen Peroxide Vapour for cases of C. difficile • Consultant Microbiologists and IPCNs included in discussions on alternative products to ensure effective against coronaviruses • Information on contact time is included in the decontamination policy	regarding standards • Compatibility issue with CT scanner	• Domestic Supervisory team ensure standards are adhered to • CT Manufacturer contacted for alternative decontamination guidance

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily • Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Domestic staff record when they have cleaned areas • Information on cleaning of workstations is included in the Environmental Action Plan • Domestic staff time cleaning activity when areas are vacant		
• Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Process for managing linen is included in the COVID-19 policy. All linen from COVID-19 possible and confirmed positive patients is treated as infectious and placed in alginate bags which are tied and then placed in a white plastic bag • No DATIX reports on non-compliance with double bagging on used/infected linen	• Occasional reporting of alginate bag shortage (which are provided by the laundry contractor)	• Guidance received from the Laundry Contractor to double bag used linen in white bags

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Single use items are used where possible and according to Single Use Policy	• Decontamination Policy in place which includes single use/single patient use guidance used in conjunction with any updates provided by National Guidance in response to COVID-19 • Chlorine releasing agents are the nationally advised method of decontamination • Hydrogen Peroxide Vapour has been used for environmental decontamination as part of a deep clean programme for vacant wards		• An SOP for decontamination of reusable PPE is in place
• Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	• Decontamination Policy in place used in conjunction with any updates provided by National Guidance in response to COVID-19	• Decontamination Meetings suspended	• Date scheduled to reconvene meetings from 17/08/20
• Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	• Windows within the waiting space are opened to ventilate the area and any space having forced ventilation is adequate to keep the area ventilated so windows can be kept closed • Signage on social distancing, hand hygiene and face coverings is displayed in ED waiting areas	• Not all areas will be provided with ventilation or have the ability to open windows	• These areas are ventilated by keeping doors open where possible

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Arrangements around antimicrobial stewardship are maintained	• Consultant Medical Microbiology Virtual Ward Round in Critical Care • Ward based Pharmacist support • Prescribing advice available by telephone (in and out of hours)	• Reduction in antibiotic ward round activity • No C difficile MDT at present as there is no cohort ward and no single consultant	• Antibiotic ward rounds re-established (2 ward rounds / week) • Critical Care daily ward rounds recommenced • Infection Control Doctor presentations to Medical Cabinet

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	• Antibiotic prescribing guidelines for COVID suspected patients have been published	covering C difficile patients	• Review as evidence/guidelines are updated • Antimicrobial Management Steering Group Meetings will be reconvened from September • C diff outliers ward rounds recommenced in July
• Mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting of HCAIs has continued • Data on HCAIs is included on the Quality Dashboard • DIPC reports HCAI data at Trust Board • Information on Data Capture System • Distribution of HCAI surveillance data weekly	• RCA face to face meetings suspended due to COVID-19	• RCA now undertaken via Microsoft Teams • Review evidence/guidelines are updated

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Implementation of national guidance on visiting patients in a care setting	• Restricted visiting implemented 17 March 2020; Visiting suspended from 26 March 2020; Compassionate visiting arrangements agreed 09 April 2020. Paper on visiting arrangements taken to SEOG • Visiting the dying guideline in place with training provided by the Palliative Care Team • Trust wide Communication via email on visiting restrictions then cessation	• Visitor arriving on site without knowledge of visiting arrangements	• Environmental Safety Plan includes site lock down to restrict access • Compassionate visiting arrangements agreed for the following patient groups where close family and friends visiting may be admitted: - Patients in critical care - Vulnerable young adults

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
			- Patients living with Dementia - Autism - Learning difficulties • Loved ones who are receiving end of life care • Signage at entrances
• Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• Coronavirus posters displayed outside areas where patients with suspected or confirmed COVID-19 are cared for		
• Information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Information on COVID-19 is available on the Trust Web Site and at entrances		
• Infection status is communicated to the receiving organisations or department when a possible or confirmed COVID-19 patient needs to be moved	• Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab (to date 904 alerts added) • Covid-19 has been added to e-discharge summary template	• Confusion on the layout of the template	• Changes made to the standard template to clarify results • Discussed at medical cabinet and Safety Alert distributed to all Consultants • Information added to medical staff induction training

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection	• Patients conveyed to hospital by Ambulance are pre-assessed to determine where they are taken to in ED • ED reorganised to have Hot and Cold respiratory assessment areas to segregate patients presenting with suspected Covid-19 • Triage in ED and segregated areas for patient suspected to have COVID-19 • Environmental Safety Action Plan with proposal to lockdown 25% of entrances • Manned mask stations at main entrance Warrington and mask available at other entrances with access to hand sanitisers	• Asymptomatic patients subsequently identified as COVID-19 positive	• Process in place to isolate and close the bay to admissions
• Mask usage is emphasized for suspected individuals	• Masks are offered to patients where O_2 therapy is not required and 2 metre distancing is not possible		
• Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	• Estate work has been carried out to install additional doors within ED • Where available, doors are closed on ward corridors to separate Covid and non-Covid areas • Perspex screens have been installed in a number of reception areas		
• For patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	• Symptomatic screening is advised after 48 hours if admission screen result was negative • Routine swabs for Covid have been added to the sepsis screening packs • Isolation facilities are prioritized for patients with suspected infections transmitted by the respiratory room • Contact tracing is including in the Covid-19 Hospital		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	Onset and Outbreak Investigation SOP		
• Patients with suspected COVID-19 are tested promptly	• Admission screening has been updated in line with national guidance and currently includes all admissions • IT surveillance system in place to track day of admissions & day 5 screening. Matrons and Lead Nurses review result daily & ensure Trust Covid-19 screening SOP is adhered to • Rapid screening swabs are available, limited number (6 -7 per day). On site testing is in place with same day turnaround of results for routine specimens		
• Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	• Repeat patient testing in place where there are on-going concerns about COVID-19 and initial swab was negative • SOP on Covid-19 screening and isolation and PPE in place • Contact tracing is including in the Covid-19 Hospital Onset and Outbreak Investigation SOP		
• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Rapid testing available 7 days per week • Routine appointments have been stepped down. Social distancing measures are in place in Outpatient Departments • Recovery plan for Outpatients (28/05/2020) includes providing information not to attend if unwell with Covid-19 symptoms • Risk rated appointment schedule based on clinical priority • Virtual 'attend anywhere' clinics	• Public compliance with social distancing measures	• Social distancing measures are in place in Outpatient Departments • Signage in place to keep left on corridors, walk in single file and socially distance • Seating arranged in Outpatient waiting areas to support social distancing

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	• Rooms identified for shielding patients		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• PPE Champions (58), roving training on donning and doffing of PPE • Links to PHE videos have been distributed. Individual booklets on COVID-19 and PPE produced and distributed • Training records from all CBUs that staff have read the Covid-19 policy, receive the PPE booklet, watched the PHE videos, received face to face training, read the Covid-19 swabbing SOP	• Staff returning to work, including after pregnancy, shielding or long term sick leave may not be fully informed with the latest guidance • PPE to be maintained on CBU Governance agendas	• Action plan in place with Unplanned and Planned Care Groups to ensure all staff return to work receive appropriate level of training • Action plans in place with CBUs where there are shortfalls in staff training • IPC Team provide ongoing training to PPE champions on donning and doffing of PPE • Links to PHE videos are available and distributed • Request addition via Governance Teams
• All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• Links to PHE videos have been distributed. Posters are displayed in clinical areas on donning and doffing • Information recirculated to Planned and Unplanned Care Groups • Information circulated on Trust Wide Safety Brief	• Posters not displayed in all areas • Staff returning from absence may not be fully informed/updated with latest guidance	• Additional posters ordered and site survey to be completed by IPCNs with PPE champions for each area • IPC team provide ongoing training on donning and doffing of PPE. Links to PHE videos are

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
		• PPE to be maintained on CBU Governance agenda's	available and distributed • Request addition via Governance Teams
• A record of staff training is maintained	• Record of training	• Follow up of staff training records required and identify shortfalls	• Action plan in place with Unplanned and Planned Care Groups to ensure all staff return to work receive appropriate level of training • Action plans in place with CBUs where there are shortfalls in staff training
• Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	• Reusable (laundered gowns) introduced as part of contingency as per national guidance as a temporary measure during national shortage of gowns • PPE paper submitted to Trust Board and Risk Assessment in place		
• Any incidents relating to the re-use of PPE are monitored and appropriate action taken	• To date 19 incidents reported relating to Covid-19 - Communication of suspected infection status - Distribution of non-fluid repellant gowns • Reusable FFP3 respirators labelled as latex free – however do have latex content		• Non-fluid repellent gowns withdrawn from use • Trust wide alert and email sent to users to complete Latex questionnaire and return to Occupational Health or return for alternative mask fit testing
• Adherence to PHE national guidance on the use of PPE is regularly audited	• Observational audits completed and feedback received from PPE Champions • Electronic Audit Tool developed and launched 15/05/20 • Audits are carried out weekly and repeated in a	• Trust wide over view of compliance	• Dashboard being set up

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	shorter timescale where issues are identified		
• Staff regularly undertake hand hygiene and observe standard infection control precautions	• Programme of hand hygiene audits in place – carried out weekly in areas operational. Overall compliance • April =98%; May=98%; June=98%		
• Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• Removal of hand driers in public toilets (none in clinical areas) has taken place as part of the environmental action plan • Hand towel dispensers have been installed and waste collection schedule put in place	• Audit exact location of hand towel dispensers	• Review scheduled for July 2020
• Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• Signage on hand washing technique is displayed on all soap dispensers. • HM Government signage has been displayed detailing 20 second handwashing	• Audit signage is in all public toilet locations	• Review scheduled for July 2020
• Staff understand the requirements for uniform laundering where this is not provided for on site	• Guidance on home laundering is included in the COVID-19 PPE information leaflets • Scrub Suits have been offered as an alternative to uniforms and are laundered centrally		
• All staff understand the symptoms of COVID-19 and take appropriate action in	• Staff shielding and screening for COVID-19 is undertaken in line with national guidance • Monitored by the Occupational Health Team and overseen by the Workforce and Organisational		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
line with PHE and other national guidance if they or a member of their household display any of the symptoms	Development Team		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status	• Limited number of single rooms for isolation (65)	• Cohorting in place as advised by the Infection Prevention and Control Team • Operational Manager/Silver Command oversight at Bed Meetings (4 times per day and frequency increased at times of increased activity/demand)
• Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• Additional hand washing facilities in anterooms on ward A7 • Side rooms in use for non-clinical activity converted back for clinical inpatient use - 2 single rooms on A2 - 1 single room on A7 - Plans in place for 4 additional single rooms: 2 between A5 and A6; and 2 between A8 and A9 - 3 single room pods built in AMU		
• Patients with resistant/alert organisms are managed according to local IPC	• Isolation Policy in place • Elective surgery/Endoscopy including pre-operative assessment SOPs including (advice on self –isolation	• Limited number of side rooms further reduced by ward closures	• Isolation priority protocol in place based on transmission based precautions

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
guidance, including ensuring appropriate patient placement	and Covid testing before surgery). Staff temperature/ symptoms screening in elective care areas to minimise transmission • Provision of seating with social distancing in out-patient areas and availability of face masks for patients In addition to staff • All patients in waiting areas will wear a mask / face covering unless it compromises their breathing and for that there would be alternative arrangements (as per published FAQs)	• Potential non-compliance of patients with shielding pre-operatively	

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure:			
• Testing is undertaken by competent and trained individuals	• Training on swabbing technique provided verbally and by video	• Small number of samples rejected due to insufficient cellular material or incorrectly labelled	• Swabbing SOP and training provided
• Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Updates to guidance provided in light of swab availability changes to national guidance • Swabbing SOP in place covering: day of admission, day 5, symptomatic, pre-admission elective and discharge screening		
• Screening for other potential infections takes place	• Other routine admission screening (CPE,MRSA,VRE) in place		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that:			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that:			
• Staff are supported in adhering to all IPC policies, including those for other alert organisms	• PPE Champions in place. On-call service (and 7 day service) for IPC in place. Clinical advice for management of patients with suspected infections continued • IPC 7 day and on call service		
• Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7). TWSB and Covid daily Bulletin used to communicate updates	• Potential for delay where changes released out of hours e.g. weekends	• Subscription and daily review of Gov. UK email updates • Control Room inbox is monitored 7 days per week and guidance issued over the weekend- out or of hours is escalated for action • Additional posters ordered Links to PHE videos are available on the Trust Hub and distributed
• All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• Guidance included in Covid-19 Policy. Early guidance adhered to when initial classification of a HCID. Waste was quarantined and disposed of by incineration • Guidance included in the Coronavirus Policy		
• PPE stock is appropriately stored and accessible to staff who require it	• Stock control in place • In and out of Hours access protocol in place • Specialist PPE equipment office with access available 7 days/week		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
• Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• An integrated risk assessment has been produced for staff who are 'extremely vulnerable', at 'increased risk', pregnant and Black, Asian and Minority Ethnic (BAME) staff. For BAME staff, based on the number of BAME staff recorded on ESR, there is 93.5% compliance. All BAME staff risk assessments will be quality checked and a sample audit will take place in July 2020 to ensure agreed actions have been undertaken. • Individual letters have been sent to BAME members of staff, outlining support available • Named midwife contact within Maternity Department provided for pregnant staff • All staff requiring shielding are supported by robust workforce support and the Trust are in the process of having one to one discussions to agree support and adjustments • All staff working at home have been provided with a 'working from home pack', including access to mental health support • Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical • An enhanced wellbeing offer has been developed, linked to learning from Wuhan, Italy and the British Psychological Society	• An electronic system is required to support the roll out of a new COVID-19 Workforce Risk Assessment Tool in line with Risk Reduction Framework • Feedback from BAME members of staff on accessing support • Access to face to face counselling is limited as only 1 FTE counsellor on site	• An electronic system is currently under development with IT and Workforce Information Teams. Planned launch date is 29/06/2020 • Chief People Officer and Chief Executive Officer attended the BAME Staff Network Group in June 2020 to receive feedback • An additional 2 FTE Counsellors employed - due to start 1 July 2020
• Staff required to wear FFP reusable respirators undergo training that is compliant	• Fit testing programme, including quantitative and qualitative testing, in place • Qualitative Fit testing SOP		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
with PHE national guidance and a record of this training is maintained	• Quantitative Fit testing SOP • Records are added to a central database • Powered Hoods are offered as an alternative where it has not been possible to Fit close fitting face masks • Only EN 149:2001 compliant masks are accepted as fit for use		
• Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	• Staffing reviews undertaken for all COVID areas • Staff movements managed by the senior nursing team at daily meetings • Senior Nurse presence 7 days per week 8am-8pm to support staffing management • Planned elective areas have designated teams, who are not moved to any other area in the Trust • Where it is necessary to move staff between different areas to support patient safety, this is discussed with the Infection Control Team. This cross over has not occurred between Elective and Emergency Care pathways		
• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Signage in place along corridors to socially distance, keep left and walk in single file • Risk assessments of all areas to achieve Covid-19 Secure spaces • IPC Team and/or Health and Safety Team review where concerns have been raised		
• Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	• Requirement to stagger breaks is included in the Covid-19 Environmental Safety Plan		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
• Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Managers have been supported to record absence in 'real time'. Daily and weekly absence reporting is in place		
• Staff that test positive have adequate information and support to aid their recovery and return to work	• A COVID-19 Occupatinal Health advice line has been created, to provide a range of advice and guidance to the workforce • The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff) • Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical • Occupational Health and Wellbeing advise staff of test results and provide further wellbeing support as and when required • Retesting is in place as appropriate and is set out in Staff Testing SOP	• Test and Trace Service hours of operation	• National guidance for 16 hour per day service (cover in place for 11.5 hours per day) • Notifications from Test and Trace are received in the Control Room and forwarded to the Occupational Health and Infection Control Teams for action

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/71**	
SUBJECT:	**Moving to Outstanding Action Plan Update**	
DATE OF MEETING:	29 July 2020	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate*)**	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	x
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF)	#115 Failure to provide adequate staffing levels in some specialities and wards. #145 a. Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The following are key issues to highlight within the report: • Of the original 60 actions in the CQC action plan there are 7 actions remaining. These will be completed by August 2020 (6 Should, 1 However). • All actions and timeframes have been agreed by Executive leads and core service leads • The Trust action plan following receipt of the CQC report from the 2019 inspection is shown in **Appendix 1.**	

PURPOSE: *(please select as appropriate)*	Information	Approval	To note x	Decision
RECOMMENDATION:	The Trust Board are asked to note the contents of this report.			

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/20/07/84
	Date of meeting	7 July 2020
	Summary of Outcome	The Quality Committee were asked to receive the report.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.	

BOARD OF DIRECTORS

SUBJECT	CQC Update Report	AGENDA REF:	BM/20/07/71

1. Background

The Trust received the CQC Report in June 2019, following the inspection in April and May 2019.

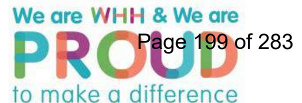
A 60 point action plan was developed in response to the CQC report, seven actions remain outstanding. These are detailed in Appendix 1. This action plan and actions are approved by Executive and core service leads and is monitored by the Moving to Outstanding Steering Group, which is chaired by the Chief Nurse/ Deputy Chief Nurse.

2. CQC action plan

The following are key points relating to the CQC action plan:

- There were originally 60 actions across 35 recommendations made by CQC.
- There were no ‘Must Do’ actions or regulatory breaches.
- There were 53 actions relating to ‘Should Do’ recommendations.
- There are 7 actions remaining which will be completed by August 2020. Full details of the outstanding actions can be seen in Appendix 1. In summary they are:
    - 6 Should do actions.
    - 1 However action.
    - 3 actions for Medical Care.
    - 2 actions for Critical Care
    - 2 actions are Trustwide.
    - All outstanding actions are due to be closed by 31st August 2020 and updates provided to the Moving to the Outstanding Steering Group
- Current compliance of the CQC action plan is as follows.

	Report completed - Compliant	Report completed - further evidence requested	On Track	Amended date agreed	No report provided	Action closed- merged with another	Action moved - being reported and monitored at other forum	Grand Total
HOWEVER	5	1				2		8
SHOULD	37			6		5	7	55
Grand Total	42	1		6		7	7	63



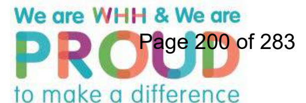
This can be further shown broken down by core service.

Row Labels	HOWEVER	SHOULD	Grand Total
Surgery	**2**	**15**	**17**
Report completed - Compliant	1	8	9
Action closed-merged with another	1	3	4
Action moved - being reported and monitored at other forum		4	4
Trustwide		**12**	**12**
Amended date agreed		2	2
Report completed - Compliant		7	7
Action moved - being reported and monitored at other forum		3	3
Critical Care	**4**	**5**	**9**
Amended date agreed		1	1
Report completed - Compliant	2	4	6
Report completed - further evidence requested	1		1
Action closed-merged with another	1		1
Maternity	**1**	**2**	**3**
Report completed - Compliant	1	2	3
Medical Care	**1**	**20**	**21**
Amended date agreed		3	3
Report completed - Compliant	1	15	16
Action closed-merged with another		2	2
Outpatients		**1**	**1**
Report completed - Compliant		1	1
(blank)			
(blank)			
Grand Total	**8**	**55**	**63**

3. Recovery

During the Covid19 pandemic a pause was placed on the Moving to Outstanding meetings and completion of the action plan. This has now resumed. This is supported by a number of task and finish groups including:

- Child Health Improvement (Paediatrics) and Medicines. This has now restarted.
- The 'Well Led' Executive led group which is due to restart in August 2020.
- The Executive led group for Use of Resources . We are awaiting a further update from NHSE/I regarding plans to restart.
- Executive led groups for Urgent and Emergency Care and End of Life Care. This has now restarted.



4. CQC Requests for Information since 16th June 2020

Since the previous Moving to Outstanding Meeting on 16th June 2020 we have received 3 enquiries from the CQC. These relate to the delivery of neurophysiology services, a query regarding discharge to a care home and a request for our meeting structure which has been provided.

Two pieces of positive feedback have also been provided by the CQC as below:

Compliment for Warrington Phlebotomy Service

Had blood test today . Everything was well organised and efficient. The staff were delightful as usual and it was nice to see their smiling faces . I am 70+ and was a bit concerned to leave my home but I needn't have worried . I had blood samples taken to enable me to have an urgent online consultation on Friday . If Warrington hospital had not been so safe and efficient I would have had to cancel it . Don't forget to take care . We need you.

Compliment for Halton Urgent Care Centre

I had two visits to the Urgent Care Centre during the recent lockdown…..In each case they dealt with me promptly and gave appropriate treatment which solved the problem.
The first visit took place shortly after the lockdown started. I was the only patient in Urgent Care.

5. Assurance During Covid19 Pandemic

Further instruction is awaited from the CQC with regard to the implementation of the Emergency Service Framework. This is currently being piloted across three acute Trusts. The Governance Department has drafted a proforma in preparation to respond to the questions that will be raised. These will focus upon four key areas:

- Safe care and treatment
- Staffing arrangements
- Protection from abuse
- Assurance processes, monitoring, and risk management

The information gathered will provide the CQC with the intelligence to identify and monitor potential risk and respond to emerging issues to ensure the delivery of safe care.

During the pandemic three weekly meetings have been undertaken and these will continue. At each meeting the Trust will be expected to produce the Infection Prevention Board Assurance Framework and provide assurance around waiting list management. Updates are also provided at these meetings from the CQC to the Trust.

6. Recommendations

The Board of Directors is asked to discuss and receive the CQC action plan progress and update.

APPENDIX 1 – MOVING TO OUTSTANDING OUTSTANDING ACTIONS

Ref	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completio
MC01d	Medical Care	Safe	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Review escalation processes for medical staff and develop a Standard Operating procedure	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Mark Forrest	31/08/20
CC01a	Critical Care	Effective	The trust should consider increasing the number of isolation rooms with negative and positive ventilation, in accordance with Department of Health guidelines. The unit only had two isolation rooms with negative and positive ventilation. This was below the recommended number in national guidance.	Ensure capital bid is developed and timeframe agreed Provide an option paper to enable decision on what can be done 19/20 or 20/21 to share with CQC with risk appraisal	SHOULD	Chris Evans	Mark Carmichael	31/08/20
MC01c	Medical Care	Safe	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Implementation of electronic rostering for Medical Staff	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Anne Robinson	31/08/20
MC04i	Medical Care	Responsive	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Development of the Trust Frailty pathway	SHOULD	Chris Evans	Fraser Gordon	31/08/20
CC05b	Critical Care	Safe	Not all prescriptions had review of stop dates documented; the indication for the antibiotic was not always recorded. A medicines reconciliation had been completed for most of the records reviewed.	standardise where information will be documented audit in 3 months for effectiveness	HOWEVER	Alex Crowe	Jerome McCann	31/08/20
TW03c	Trustwide	Well Led	The trust should review the progress of the implementation of strategies for patients living with dementia and with a learning disability and consider the implementation of a strategy for patients with mental health needs. The trust did not currently have strategies to support patients living with dementia, learning disabilities or mental health illness. Some of the enabling strategies lacked clear delivery plans.	Ensure there is a strategy and implementation plan for patients living with Mental Health needs	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	31/08/20
TW03b	Trustwide	Well Led	The trust should review the progress of the implementation of strategies for patients living with dementia and with a learning disability and consider the implementation of a strategy for patients with mental health needs. The trust did not currently have strategies to support patients living with dementia, learning disabilities or mental health illness. Some of the enabling strategies lacked clear delivery plans.	Ensure there is a strategy and implementation plan for patients living with Learning Disabilities	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	31/08/20

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/72**			
SUBJECT:	**Progress on Lord Carter Report Recommendations & Use of Resource Assessment (UoRA) - Q4 2019/20 and Q1 2020/21**			
DATE OF MEETING:	29th July 2020			
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance			
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer and Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.			x
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.			x
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #135 Failure to provide adequate and timely IMT system. #125 Failure to maintain an old estate. #145 (a) Failure to deliver our strategic vision. #145 (b) Failure to fund two new hospitals. #241 Failure to retain medical trainee doctors.			
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. The Lord Carter recommendations are 5 years old in 2020 and the Trust has implemented the majority of the recommendations. It is therefore proposed that this report is streamlined to focus on the Use of Resource Assessment (UoRA). However any outstanding actions around Lord Carter Recommendations will be aligned to a UoRA Key Line of Enquiry (KLOE) and will continue to form part of this report.			
PURPOSE: ***(please select as appropriate)***	Information	Approval x	To note x	Decision
RECOMMENDATION:	The Board of Directors is asked to: 1. Note the contents of this report. 2. Approve the proposal to streamline this report to focus on UoRA as set out in Appendix 3 .			
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.	

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Progress on Lord Carter Report Recommendations & Use of Resource Assessment (UoRA) - Q4 2019/20 and Q1 2020/21	AGENDA REF:	BM/20/07/72

1. BACKGROUND/CONTEXT

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

Where appropriate, Lord Carter Recommendations have been aligned with the UoRA indicators for the purposes of this report. UoRA indicators are denoted by the UoR stamp:

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 2019/20 and Quarter 1 2020/21. 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 and progress against the Lord Carter Recommendations can be found in **Appendix 2**.

UoRA National Status

In line with CQC inspections, UoRA inspections have been suspended nationally in response to COVID-19. In addition, much of the Model hospital reporting has also been suspended and therefore the dashboard is currently showing older data. At this time, there are no timescales when the inspections will resume or the format future inspections will take given the potential impact of additional costs and resources that have been required. It is anticipated the Trust will resume the internal UoRA group meetings in Quarter 3.

Future Reporting

The Trust Board has received Lord Carter updates since 2016 and UoRA updates since 2018. The majority of the actions around the Lord Carter Recommendations have now been completed, however there is still some residual work which will continue as part of UoRA. It is therefore proposed that this report is streamlined to focus on UoRA. Any outstanding Lord Carter Recommendation actions will be aligned to a UoRA Key Line of Enquiry (KLOE)

and will continue to be reported on. This will avoid repetition and the need to provide the Board with information that has already been received.

The report in **Appendix 2** has been amended to indicate which actions have been or will be closed and which actions which will be taken forward and included in future reports. This is outlined in the "Future Assurance" column on the right hand side of the report.

The layout of the new proposed streamlined format is available in **Appendix 3**.

3. RECOMMENDATIONS

The Board of Directors is asked to:

1. Note the contents of this report.
2. Approve the proposal to streamline this report to focus on UoRA as set out in Appendix 3.

Andrea McGee
Chief Finance Officer and Deputy Chief Executive
22nd July 2020

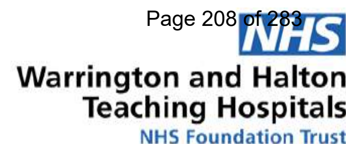
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Appendix 1 – Benchmarking Performance against the National Median

KLOE Indicator	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21
KLOE 1 - Clinical									
Pre Procedure Elective Bed Days	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Pre Procedure Non Elective Bed Days	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Emergency Readmission (30 Days)	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Did Not Attend (DNA) Rate	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
KLOE 2 - People									
Staff Retention Rate	March 2018	June 2018	September 2018	December 2018	December 2018	December 2018	December 2018	March 2020	March 2020
Sickness Absence Rate	February 2018	May 2018	August 2018	November 2018	November 2018	June 2019	October 2019	March 2020	March 2020
Pay Costs per Weighted Activity Unit	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	This indicator has been moved to a "Legacy" area of the model hospital and is no longer being updated.	
Medical Costs per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19
Nurses Cost Per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19
AHP Cost per WAU (community adjusted)	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19
KLOE 3 – Clinical Support Services									
Top 10 Medicines - Percentage Delivery of Savings	March 2018	March 2018	March 2018	March 2018	March 2018	September 2019	November 2019	March 2020	March 2020
Pathology - Overall Costs Per Test	Q2 2017/18	Q4 2017/18	Q4 2017/18	Q2 2018/19	Q2 2018/19	Q4 2018/19	Q2 2019/20	Q3 2019/20	Q3 2019/20
KLOE 4 – Corporate Services									
Non Pay Costs per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	This indicator has been moved to a "Legacy" area of the model hospital and is no longer being updated.	
Finance Costs per £100m Turnover	2016/17	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19
Human Resource Costs per £100m Turnover	2016/17	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19
Procurement Process Efficiency and Price Performance Score Clinics	Q4 2016/17	Q4 2016/17	Q4 2017/18	Q3 2018/19	Q3 2018/19	Q4 2018/19	Q4 2018/19	Q4 2018/19	Q4 2018/19
Estates Costs Per Square Meter	2016/17	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19

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

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



Use of Resource Graph Key

Label	Colour
Trust Position	(blue)
National Median	(black)
Peer Median	(grey)

Key

Colour	Meaning
(green)	Complete/Green on Model Hospital (against National median)
(yellow)	On track for completion
(amber)	Progress off track - plans in place to get back on track/Amber on the Model Hospital
(red)	Progress significantly off track/Red on Model Hospital
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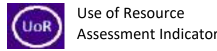


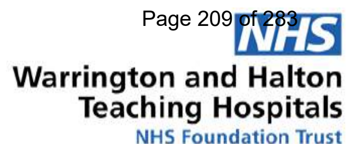
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

Recommendation 1 - NHS Improvement (NHSI) should develop a national people strategy and implementation plan by October 2016 that sets a timetable for simplifying system structures, raising people management capacity, building greater engagement and creates an engaged and inclusive environment for all colleagues by significantly improving leadership capability from "ward to board", so that transformational change can be planned more effectively, managed and sustained in all Trusts.

Lead Director: Chief People Officer

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Development and Approval of People Strategy and Dashboard	• The refreshed People Strategy was signed off by the Trust board in Q2 2018/19. Quarterly reports are presented to the Strategic People Committee.	• The Trust continues to monitor and manage the strategy and dashboard.	Strategic People Committee	Complete	Close on report - complete. Future oversight by the Strategic People Committee as required.
Restructure of HR Directorate	• The HR department restructure is complete and key posts in the Senior Management Team have been recruited to.		Strategic People Committee, Trust Board	Complete	Close on report - complete.
HR Polices reviewed to ensure they are clear, simple and transparent	• The Human Resources & Organisational Development (HR&OD) Directorate has a policies and procedures group with management and staff side representation. All HR policies are taken through this group and then progressed to JNCC. • Policies reviewed and ratified to date include; the Disciplinary, Relationships at Work, Special Leave, Secondment, Annual Leave, Equality in Employment, Temporary Staffing, Professional Clinical Registration, Recovery of Employee Overpayments and the Outstanding Debt Policy. • In Q1 (2020/21), the Trust agreed an Agile Working Policy, in response to the COVID-19 pandemic.	• The Trust is undertaking a rolling programme to review, and where required, simplify HR policies. This is monitored by the Strategic People Committee. • In Q3, the Trust's commenced a review of the Attendance Management policy with staffside, this was due to be completed during Q4, however this review was paused due to COVID-19 and will be picked up as part of the recovery process. • In Q4, the Trust was due to review the Associate Specialist job planning policy and was developing a new Covering for Colleagues policy around the Medical Workforce, this was also placed on hold due to the COVID-19 pandemic and will be picked up as part of recovery.	Strategic People Committee	Rolling Programme	Close on report - rolling programme. Oversight by the Strategic People Committee.
"Fit to Care" Heath & Wellbeing Programme	• The Trust has a wide range of wellbeing approaches aimed at supporting staff back into work which include; a Weight management clinic, Healthy Topics, Drop in sessions for healthy hearts, Wellbeing clinics and Mental Health First Aid. • The rollout of the refreshed fit to care programme was completed during Q1 2019/20. The Trust is building on the previous approach of educational and information campaigns to adopt an impact based approach e.g. Know Your Heart Age event. The programme is reviewed annually.	• Wellbeing initiatives will continue to be offered and monitored for effectiveness. • In Q1 (2020/21), the Trust produced a suite of wellbeing and organisation development offers to support workforce recovery during COVID-19. These are based on evidence and learning e.g. from WUHAN, Italy and the Armed Forces. These being launched between May and August 2020.	Strategic People Committee	Complete	Close on report - complete. Future oversight by the Strategic People Committee as required.



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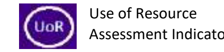
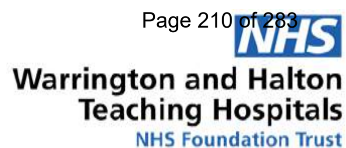


Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Development of Workforce Streaming Programme across the North West	• The Trust has worked with colleagues across the North West to agree unified ways of working and to reduce bureaucracy. • Key actions included: o Implementation of factual references. o Streamlining of notice periods for new starters. o Agreed the honorary contract process and streamlining of mandatory training across the region. o Values based recruitment. • Region wide TUPE guidelines have been implemented. • The streamlining programme is now complete with benefits realisation signed off.		Strategic People Committee	Complete	Close on report - complete.
Staff Opinion Survey	• Themes from the staff survey were used to develop the refreshed People Strategy. • The 2019 SoS closed at the end of November, the Trust response rate was 53%, the average Acute Trust (for those using Quality Health) was 47%. The Trust had campaign in place throughout the survey period which included regular reporting across the workforce, a communications plan, incentives and a emphasis on ownership by local managers. This resulted in the best response rate for the Trust to date.	• CBUs and corporate departments were asked to identify a local lead to commence operationalising results once received. The final national response rate and results was published in March 2020. The final national response rates was shared with SPC, no further action has taken place due to COVID-19, however this will be picked up as part of recovery and will be monitored via SPC.	Strategic People Committee, Trust Board	Annual Rolling Programme	Close on report - annual rolling programme. Oversight by the Strategic People Committee and reported to the Trust Board.
Reduction in the high rates of bullying and harassment with a sustained campaign led personally by each trust Chief Executive	• The Freedom to Speak Up Guardian has a network of champions to support staff to raise concerns. • The Trust performed in the upper quartile in the 2017, 2018 & 2019 staff surveys in relation to bullying and harassment in comparison with other Acute Trusts. • The Trust has reviewed the SoS results against other employee relations metrics around bullying and harassment and has analysed the areas where we are doing well to look how learning can be shared across other areas. This was focused specifically around; managers training, standards, policy implementation and reward. • Work was undertaken with the Trust's communications team to ensure staff know who to raise concerns with and how they would go about this. • An Equality, Diversity and Inclusion Strategy has been developed and implemented.	• The Trust has the culture and infrastructure to address bullying and harassment and this is supported by the latest staff survey results. • This also links in the with EDI strategy which is reported through the SPC.	Strategic People Committee	Complete	Close on report - complete. Future oversight by the Strategic People Committee as required.



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National Median	Black
Peer Median	Grey

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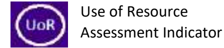
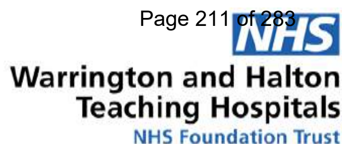


Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Ensure Staff have regular performance reviews	• The number of staff with a valid PDR is 93.94% (May 2020) against a target of 85%.	• A new appraisal tool was drafted with engagement from staff across the workforce, the focus is on little paperwork, big conversation. This was piloted in November 2019 using a Plan Do Study Act (PDSA) test of change cycle. The final PDR tool was signed off during Q4, however this was not launched due to COVID-19. As part of the workforce recovery plans during Q1, the Trust has introduced a "check in" conversation which will take place between line managers and members of staff. This will include a look back on experiences over the past 4 months, discussions around health and wellbeing and a look forward around objectives and development. Managers and staff therefore have the option of using this in place of a full PDR, which has been approved by the Executive Team.	Strategic People Committee, Trust Board	Ongoing Monitoring	Close on report - ongoing monitoring. Oversight by the Strategic People Committee, reported to the Trust Board.
Improving Sickness Absence	• Sickness absence was 7.33% in May 2020 (including COVID-19 related sickness, excluding shielding/isolation). • Over the past 2 years, the Trust has implemented a series of measures in order to improve sickness absence, these include; Mental Health First Aid, Heath Promotion, Clinical Supervision Framework, An Employee Assistance Programme, Investment in Occupational Health and Heath & Wellbeing Initiatives. • The HR&OD team have used the NHSE/I endorsed Health & Wellbeing Partnership framework to undertake a high level gap analysis in order to identify actions to improve attendance.	• In order to improve sickness absence and also in response to COVID-19 related sickness absence, the Trust has implemented or is in the process of implementing a number of initiatives including: COVID-19 Nursing Advice Line, Occupation Health Call Centre & Enhanced 7 Day Service, Enhanced Health & Wellbeing Options, Mental Health Wellbeing Drop In Sessions, Facilitated Conversations within Impacted Clinical Areas, Face to Face On Site Counselling, Alternative Therapies, Workforce Welfare Hub, Additional Support for BAME Staff, Additional Staff Groups (inc Returners, Students), Real-time Workforce Information Hub, Support for Shielding Staff, Partnerships with Cheshire & Mersey Fire & Rescue for Staff Redeployment and Processes around Antigen and Antibody Testing.	Strategic People Committee, Trust Board	Ongoing Monitoring	Continue on report - ongoing monitoring. Oversight by the Strategic People Committee, reported to the Trust Board. Include in future UoRA report.



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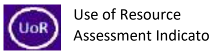


Use of Resource Assessment Indicator

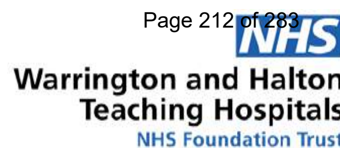
Appendix 2

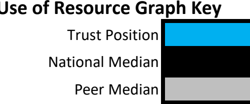
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

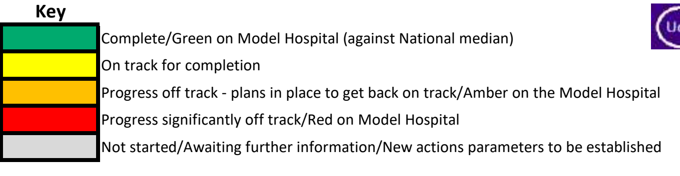
	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance

KLOE 2 - People

Indicator	Description	Progress/Performance		Assurance	Future Assurance
Sickness Absence Rate	UoR Percentage of staff FTE sick days.	**National Median = 5.27%** **Peer Median = 5.45%** **1. Sunderland 2.80%** **2. Chester 4.34%** **3. Gateshead 5.07%** **4. N Lincolnshire 5.15%** **5. Mid Cheshire 5.34%** **6. North Tees 5.57%** **Current Quartile:** **Best Quartile Target:** **Source: HSCIC - NHS Digital iView Stability Index** **Monitoring - Trust Board, TOB, SPC**	**March 2020** **7. S'port 5.82%** **8. B'mouth 5.88%** **9. Wirral 6.34%** **10. WHH 6.82%** **11. STHK 7.33%** **4 (Worst)** **4.63%**	The latest data (pre-COVID-19) places the Trust above the national and peer median for sickness absence in the latest reporting period. Significant strategic and operational work has been undertaken to improve the position.	• In order to improve sickness absence and also in response to COVID-19 related sickness absence, the Trust has implemented or is in the process of implementing a number of initiatives including: COVID-19 Nursing Advice Line, Occupation Health Call Centre & Enhanced 7 Day Service, Enhanced Health & Wellbeing Options, Mental Health Wellbeing Drop In Sessions, Facilitated Conversations within Impacted Clinical Areas, Face to Face On Site Counselling, Alternative Therapies, Workforce Welfare Hub, Additional Support for BAME Staff, Additional Staff Groups (inc Returners, Students), Real-time Workforce Information Hub, Support for Shielding Staff, Partnerships with Cheshire & Mersey Fire & Rescue for Staff Redeployment and Processes around Antigen and Antibody Testing.
Staff Retention Rate	UoR The percentage of staff that remained stable over 12 months period.	**National Median = 86.7%** **Peer Median = 88.4%** **1. Mid Cheshire 90.9%** **2. Bournemouth 89.8%** **3. STHK 88.7%** **4. Chester 88.7%** **5. Wirral 88.4%** **7. North Tees 87.8%** **Current Quartile:** **Best Quartile Target:** **Source: HSCIC - NHS Digital iView Stability Index** **Monitoring - SPC**	**March 2020** **8. N L'shire 87.7%** **9. WHH 87.7%** **10. S'port 87.4%** **11. G'head 86.6%** **3 (2nd Best)** **88.70%**	As at March 2020, the Trust Retention rate remains positive and better than the national median at 87.7% (Trust data as at May 2020 places the Trust at 88.20%). Turnover also remains positive at 11.84% (May 2020), demonstrating the success of the programme of work implemented in line with the NHSI nursing retention programme.	Workforce recovery planning is underway and includes: • Proposals to make permanent the temporary changes to the Retirement Policy relating to the break in service and permanent contract upon return. • Supporting and retaining the temporary workforce who have joined the Trust during the pandemic. • Keeping in touch with the student workforce who have joined the Trust during the pandemic. • A range of health and wellbeing interventions, based on evidence following pandemics and serious incidents.







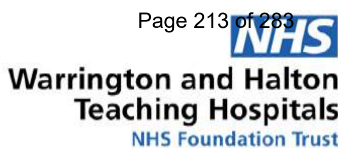
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Pay Costs per Weighted Activity Unit	UoR Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a Trust to produce one Weighted Activity Unit (WAU) of clinical output. This metric shows the amount the trust spends on pay per WAU across all areas of NHS clinical activity. **Please note: This indicator is no longer being updated on the Model Hospital and has been moved to a legacy area.**	**National Median = £2180** **2017/18** **Peer Median = £2312** **1. Sunderland £1904** **2. STHK £1995** **3. Bournemouth £2010** **4. Gateshead £2151** **5. Wirral £2219** **6. North Tees £2242** **7. Chester £2336** **8. Mid Cheshire £2442** **9. WHH £2455** **10. N L'shire £2482** **11. Southport £2577** **Current Quartile: 4 (Worse)** **Best Quartile Target: £2,014** **Source: Trust consolidated annual accounts and reference cost data.** **Monitoring - Trust Board, SPC (From March 2019), FSC, TOB.**		Pay Costs per WAU exceeds the Peer and National Medians. The below shows the WAU Staff Costs per staff group and the percentage difference compared to our peers: (see table below) When removing AHP costs associated with external SLA, this impacts positively on the overall position.		Additional controls and challenge around pay spend have been identified, to support a reduction in premium pay: • Enhanced ECF process for non-clinical vacancies. • Expanded ECF process for some temporary staffing pay spend. • Implementation of Cheshire and Mersey Rate Cards. • Introduction of Patchwork Medical Bank system.

Staff Group	**Trust**	**Peer %**
Medical	**£465**	**-4.5%**
Nursing	**£764**	**-6.2%**
AHP	**£188**	**19.1%**
Scientists	**£192**	**9.4%**
Corp Supp	**£413**	**-3.1%**
Agency	**£169**	**32.0%**
Non-Sub	**£183**	**8.2%**



Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Use of Resource Graph Key

Trust Position	(blue)
National Median	(black)
Peer Median	(grey)

Key

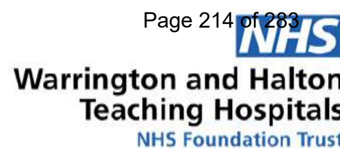
(green)	Complete/Green on Model Hospital (against National median)
(yellow)	On track for completion
(amber)	Progress off track - plans in place to get back on track/Amber on the Model Hospital
(red)	Progress significantly off track/Red on Model Hospital
(grey)	Not started/Awaiting further information/New actions parameters to be established

UoR — Use of Resource Assessment Indicator

Appendix 2

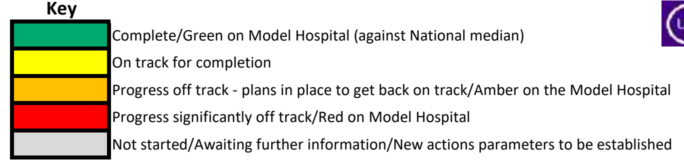
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Medical Costs per WAU	Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a trust to produce one Weighted Activity Unit (WAU) of clinical output. This metric shows the amount the trust spend on pay for medical staff per WAU across all areas of NHS clinical activity. UoR	**National Median = £763** **2018/19** **Peer Median = £697** **1. Sunderland £591** **2. North Tees £592** **3.Wirral £635** **4. WHH £642** **5. Southport £725** **6. Bournemouth £757** **7. MC'hire £794** **8. N L'shire £1008** **9. Chester £1019** **Current Quartile: 1 (Best)** **Best Quartile Target: £675** **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC**	Medical staff cost per WAU, National Distribution (chart)	The Trust is below the national and peer median (positive), however the large number of vacancies within this workforce will have contributed to this. As we seek to recruit to these vacant posts, we could see costs per WAU increase, however this may lead to the reduction in other areas such as agency.		The key actions relate to the Medical Establishment Review include: > Analyse the established medical model and the proposed effective establishment, within the context of RCP Safe Medical Staffing Guide. > Identify the gaps within the Medical Workforce based on the analysis, developing innovative solutions to fill the gaps. > Working with WWL to recruit Doctors Internationally.
Nursing Cost Per WAU	UoR Total pay costs for nursing staff, adjusted for the % of Trust expenditure reported in reference costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median = £892** **2018/19** **Peer Median = £897** **1. Southport £704** **2. Bournemouth £710** **3. Sunderland £790** **4. WHH £817** **5. Wirral £849** **6. STHK £866** **7. North Tees £907** **8. Gateshead £933** **9. Chester £1029** **10. N L'Shire £1077** **11. MCheshire £1490** **Current Quartile: 1 (Best)** **Best Quartile Target: £821** **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC**	Nursing staff cost per WAU, National Distribution (chart)	The Trust is below the national peer medians for Nursing Costs per WAU which is positive, however again the large number of vacancies will have contributed to this. The Trust seeks to reduce reliance on temporary staffing by offering alternative retention and recruitment solutions with the expansion of the nursing workforce, advanced practice and specialist interest roles.		The key actions are: > Working alongside the WHH Recruitment and Retention group, develop retention strategy and NHSI. > Continue the successful Staff Nurse recruitment open days. The Trust has been in contact with NHSI to look at conflicting data points, which has been escalated to national level within NHSI. The Trust has also been in contact with other Trusts who have the same data issue. The Trust has queried this indicator with NHSI as the data on the model hospital indicators does not triangulate with Trust data.



Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	



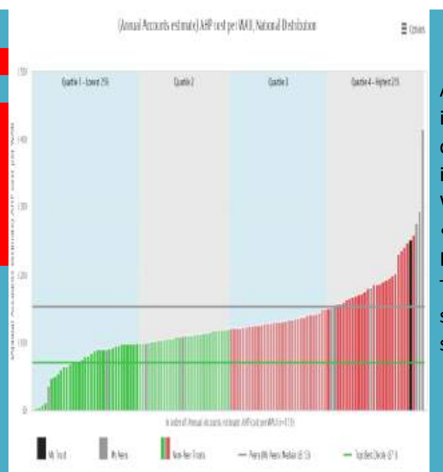
Key

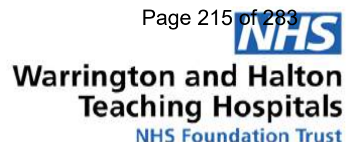
	Complete/Green on Model Hospital (against National median)
	On track for completion
	Progress off track - plans in place to get back on track/Amber on the Model Hospital
	Progress significantly off track/Red on Model Hospital
	Not started/Awaiting further information/New actions parameters to be established

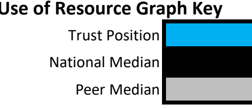
Use of Resource Assessment Indicator

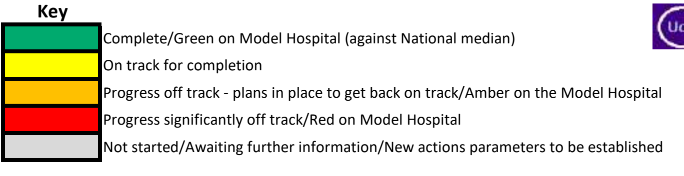
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Substantive AHP Cost per WAU	UoR Total pay costs for Allied Health Professionals, adjusted for the % of trust expenditure reported in Reference Costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median = £121** **2018/19** **Peer Median = £153** **1. Chester £37** **2. STHK £91** **3. Wirral £100** **4. Gateshead £110** **5. N Lincolnshire £152** **6. Sunderland £154** **7. North Tees £183** **8. WHH £251** **9. M Cheshire £276** **10. Southport £295** **11. B'Mouth £416** **Current Quartile:** **4 (Worse)** **Best Quartile Target:** **£107** **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC**		Across the therapy element of AHP, pay costs for community/other work has been included in the cost per WAU calculation on Model Hospital. This indicator includes costs for staffing who are outsourced via SLA to other Trusts. This activity is not included in the WAU, if these costs were removed, the revised estimated costs per WAU would be £123 which brings the Trust in line with the national median. • For example, we have Therapists working as 'first point of contact practitioners'. Rather than seeing a GP first, patients with musculoskeletal issues are triaged by a Therapist and either discharged, treated or referred to secondary care. Also Therapy staff within RARS form part of Halton integrated community teams and the activity sits with the borough council.		







UoR Use of Resource Assessment Indicator

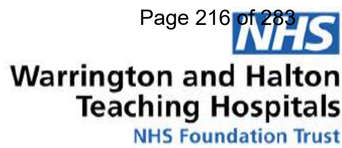
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

Recommendation 2 - NHS Improvement should develop and implement measures for analysing staff deployment during 2016, including metrics such as Care Hours Per Patient Day (CHPPD) and consultant job planning analysis, so that the right teams are in the right place at the right time collaborating to deliver high quality, efficient patient care.

Lead Director(s): Medical Director & Chief Nurse

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Care hours per patient day	• The Trust continues to systematically collect and submit Care Hours per Patient Day (CHPPD) data since the national changes in April 2016. • The data is included in the monthly safe staffing and assurance report presented by the Chief Nurse at the Trust Board as well as the Trust Board IPR. • Data is submitted monthly to NHSI via the Trust Information team.	• Care Hours are reviewed each month as part of the Integrated Performance Report (IPR). In 2018/19 this went from 6.2 to 7.6 CHPPD. • Care Hours per Patient Day for the Trust in June 2020 was 7.7 hours.	Quality Assurance Committee, Trust Board	Ongoing Monitoring	Close on report - ongoing monitoring. Oversight by the Quality Assurance Committee and reported to the Trust Board.
Electronic roster and safe care module – six week rosters submitted to NHSI, process for improvement, cultural change and communications	• Implementation of Electronic Roster & Safe Care – all core wards is now live. • The corporate nursing team has taken over management of the e-roster team. • The E-Rostering team is co-located with the operational management team in a centralised location. • Capacity and demand meetings are held after the bed meetings and the staffing template updated in real time. • The interface between e-roster and NHS(P) is now in place and temporary staff must now be booked via e-roster. • Safe Care acuity is now embedded and the information is used for 6 monthly safe staffing review. • The Trust has shared its achievements with Safe Care and Health Roster products with 4 Trusts in the region and continues to be seen as an exemplar by Allocate for Nurse Rostering & SafeCare.	• Continue to support the Matron daily safe staffing meetings which allows for early identification of hotspots/issues. • Future rollouts for Outpatient Nursing, Administration Staff, Medical Staff and Corporate Function.	Quality Assurance Committee	Complete	Close on report - complete.



Use of Resource Graph Key

Label	
Trust Position	
National Median	
Peer Median	

Key

- Complete/Green on Model Hospital (against National median)
- On track for completion
- Progress off track - plans in place to get back on track/Amber on the Model Hospital
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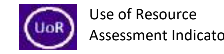


Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

Consultant job planning - improving analysis of consultant job plans and better collaboration within and between specialist teams

Progress/Performance

• The Trust uses Allocate Software for e-Job planning.
• The Trust is in the middle of the 2020/21 Job Planning Round with the current status of Consultant job plans being as follows:

Job Plan Year	Number of job plans progressing
2018/19	1
2019/20	35
2020/21	134
Total	**170**

• The project involving Programmed Activity (PA) corporate budgets for Medical Leadership, Education & Training, Quality & Governance and Appraisal & Revalidation has been completed. The Trust has provided a SOP to detail the revised process for the financial management of PAs.
• The renewed Job planning policy for Consultants was agreed with Staff Side via JLNC and was implemented on 19th June 2018.
• A proposal for reducing sign off levels from 3 to 2 was accepted.
• The language used within the e-Job planning software has been improved to allow more effective reporting and easier inputting.
• Newly structured monthly Job Planning meetings were established in September 2019 for each CBU. This structure saw improvements in job plan progress and sign off; however progress has been hampered due to the COVID-19 pandemic when all non-essential meetings, including routine job planning meetings were cancelled from March 2020.

Actions to Improve Position/Actions for Next Quarter

• Job planning progress has continued to be monitored in a virtual manner.
• In-depth reviews of Corporate Job Planning budgets have been undertaken recently and papers presented to the Executive Management Team for Medical Leadership, Quality & Governance and Appraisal & Revalidation in January 2020 and Medical Education & Training in June 2020.
• Additional scrutiny will be placed on non-core SPA activities with regular meetings with budget holders and a planned benchmarking exercise to compare WHH with a Trust of a similar size. The job planning policy will also be reviewed in light of the reviews undertaken and lessons learned from the new meeting structures and the 2019/20 job planning round.
• Updates are provided regarding progress to the Trust Joint Local Negotiating Committee.
• Mediation meetings will continue to be scheduled for outstanding job plans.

Assurance

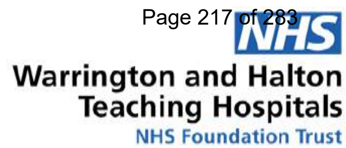
Strategic People Committee

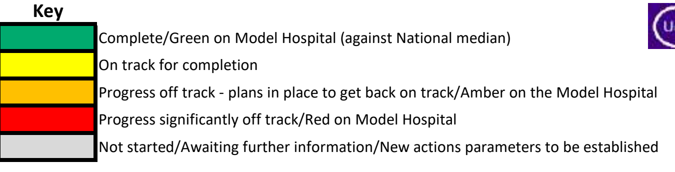
Status

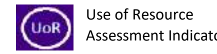
Daily Monitoring

Future Assurance

Close on report - ongoing monitoring. Oversight by the Strategic People Committee.







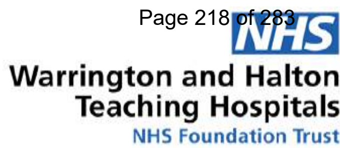
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

Recommendation 3 - Trusts should, through a Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost, coding of medicines and consolidating stockholding by April 2020, in agreement with NHS Improvement and NHS England so that their pharmacists and clinical pharmacy technicians spend more time on patient facing medicines optimisation activities.

Lead Director(s): Chief Operating Officer

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Hospital Pharmacy Transformation Programme - developing HPTP plans at a local level	• Developed and approved HPTP Plan, nominated Directors, Board sign off and submission of final plan to NHS Improvement. • The HPTP was completed in May 2017.	• Model hospital metrics are monitored at the Trust's Medicines Governance Committee.	Quality Assurance Committee	Complete	Close on report - monitoring of the plan will via the Medicines Governance Committee reported to the Quality Assurance Committee.
Moving prescribing and administration from traditional drug cards to Electronic Prescribing and Medicines Administration systems (EPMA)	• The electronic prescribing and medicines administration (ePMA) business case and PID signed off by Trust Board and NHS Digital. Implementation commenced in March 2018 on CAU, followed by UCC and surgical pathways (in Halton) in December 2018 and the CMTC in March 2019. Implementation in Warrington took place in November/December 2019.	• Rollout of ePMA on the Warrington site was completed in December 2019 for all wards/services with the exception of Maternity, Paediatrics and ITU which was due to be completed during Q4, however this was placed on hold due to the COVID-19 pandemic. This will be picked up as part of recovery planning.	Digital Operational Group, Trust Operational Board.	Project Implementation	Continue on report - Oversight by the Digital Operational Group, reported to the Trust Operational Board. Include in future UoRA report.
Ensuring that coding of medicines are accurately recorded	• The Trust continues to work on improving data quality with workshops held to identify gaps, issues and areas for improvement with plans to address. • PHE SACT data has been reviewed, based on this, the Trust is achieving current data quality targets.	• The Trust continues to monitor and address any data quality issues around medicines. • Blueteq has been rolled out in all areas with the exception of Ophthalmology. The rollout of Blueteq within Ophthalmology will be picked up during the recovery phase.	Medicines Governance Committee	Ongoing Work Programme	Close on report - ongoing work programme monitored by the Medicines Governance Committee.



Use of Resource Graph Key

Trust Position	(blue)
National Median	(black)
Peer Median	(grey)

Key

(green)	Complete/Green on Model Hospital (against National median)
(yellow)	On track for completion
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Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
80% of Trusts' pharmacist resource utilised for direct medicines optimisation activities, medicines governance and safety remits	• The Trust is achieving the recommendation for pharmacists. • All Pharmacy technicians have now been upskilled to carry out medicines reconciliation with new starters being trained as they commence in post. • The ward medicines management technician role has been reviewed with the Associate Directors of Nursing. • Midwifes are screening for regular medication so that pharmacy resources can be focused on those specific patients, this has resulted in an increase in medicines reconciliation within the Women's & Children's CBU. • The Trust implemented weekend on ward pharmacy services in December 2019 and has increased dispensary hours. In addition, there is now a pharmacist based in ED to complete medicine reconciliation before a patient is admitted which will have a positive impact on a number of areas.	• The ongoing training program continues to upskill pharmacy technicians on medicines optimisation and administration. • The Trust is providing training to new pharmacists for non-medical prescribing on a rolling programme.	Medicines Governance Committee	Complete	Close on report - complete
Reduce stockholding days from 20 to 15, deliveries to less than 5 per day and ensure 90% orders and invoices are sent and processed electronically	• The Trust's current stockholding days are 18, which is below the national and peer median. • Average number of deliveries to the Trust per day is 14 which is below the national median. • 97% orders are carried out electronically.	• Reducing stockholding days or number of deliveries to the Trust per day any further would carry an unacceptable level of risk. The Trust continues to monitor performance against our peers.	Medicines Governance Committee	Complete	Close on report - complete.

KLOE 3 - Clinical Support Services

Top 10 Medicines - Percentage Delivery of Savings

This indicator identifies the year to date total % achievement toward the cumulative target saving opportunity.

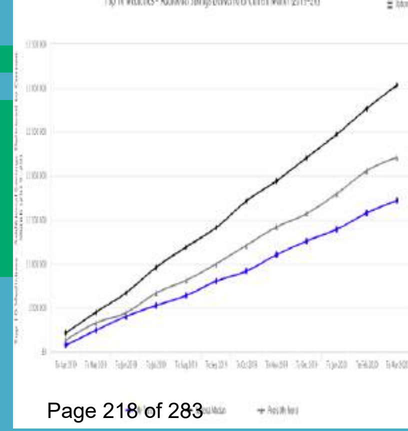
Benchmark = £1.37m **March 2020**
Peer Median = £2.21m

1. N Lincolnshire £3.3m	**6. STHK £2.2m**
2. Bournemouth £2.9m	**7. Wirral £2.2m**
3. Gateshead £2.4m	**8. WHH £1.7m**
4. North Tees £2.3m	**9. Mid Cheshire £1.6m**
5. Chester £2.2m	**10. Sunderland £1.2m**
	11. Southport £1.2m

Current Quartile: **N/A**
Best Quartile Target: **N/A**

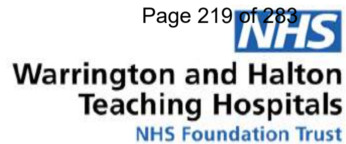
Source: Rx-Info Define© (processed by Model Hospital)

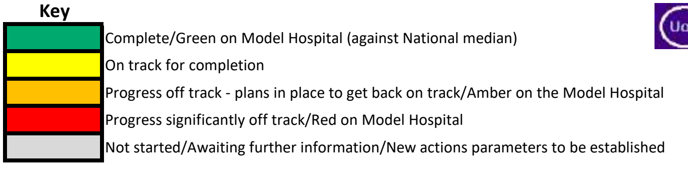
Monitoring - Medicines Governance Committee



As of March 2020, the Trust has achieved £1.7m which is positive and is better than the national benchmark.

The Trust continues to engage with the Top 10 savings schemes and will work with system partners to identify opportunities for further savings. NHSI has not published targets for 2020/21, however the Trust will continue to identify potential savings working with Warrington & Halton CCGs.





UoR Use of Resource Assessment Indicator

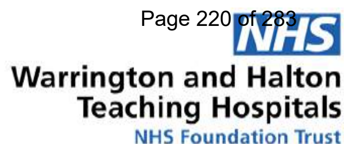
Appendix 2

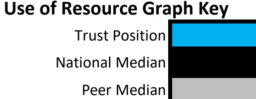
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

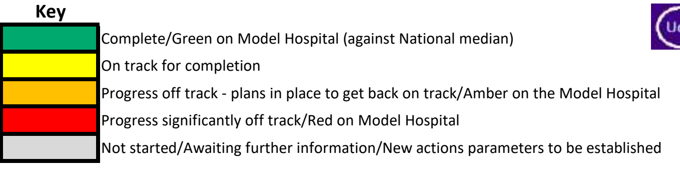
Recommendation 4 - Trusts should ensure their pathology and imaging departments achieve their benchmarks as agreed with NHS Improvement by April 2017, so that there is a consistent approach to the quality and cost of diagnostic services across the NHS. If benchmarks for pathology are unlikely to be achieved, trusts should have agreed plans for consolidation with, or outsourcing to, other providers by January 2017.

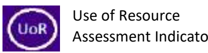
Lead Director(s): Chief Operating Officer & Director of Strategy

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Establishment of a shared pathology across the local economy	• NHSI proposed 29 Pathology Networks across the country, with WHH being part of the Cheshire & Mersey network. A Cheshire & Mersey Pathology board was established with the development of several work streams. An overarching business case was approved in December 2018 with a Clinical Director and a Director of Operations appointed. • As part of COVID-19 response, in Q1 (2020/21), the Trust has received funding to implement NPEX which supports joint working across the Cheshire & Mersey Pathology Network with electronic requests, removing the requirements for manual intervention.	• NHSE/I have reviewed the options put forward by the network around the future of pathology services across the Cheshire and Mersey Network. NHSE/I have asked Trusts to devise a local business case for working with the identified cohorts (the Trust will be working with St Helens and Knowsley Teaching Hospitals NHS Trust). This was due to take place during Q4, however this has been placed on hold due to the COVID-19 pandemic and will be picked up during recovery. • As part of the benchmarking work undertaken by the network, Keele has identified a number of tests where the Trust is a outlier in terms of over and undertesting. These results are being analysed and will be presented internally followed by external discussions with the CCG to understand what the impact and potential benefits, this was due to take place in Q4/Q1 and will be picked up as part of recovery.	Strategic Executive Oversight Group (pending a governance review). Trust Board	Project Implementation	Continue on report - project oversight by the Strategic Executive Oversight Group (pending a governance review), sign off by the Trust Board. Include in future UoRA report.
Development of pathology service specification	• The original plan called for a new specification to be developed, however this has now been superseded by the STP wide pathology board.	N/A	N/A	N/A	N/A
Introduce the Pathology Quality Assurance Dashboard (PQAD) by July 2016	• A Pathology Quality Assurance Dashboard (PQAD) has been developed. • PQAD implemented from November 2016. • Monthly data indicators continue to be submitted. • PQAD data is reviewed monthly at the KPI sub-committee. • A new PQAD has been developed, feedback has been provided from the Cheshire & Mersey Network.		KPI Sub-Committee	Ongoing Monitoring	Close on report - ongoing monitoring. Oversight by the KPI Sub-Committee.







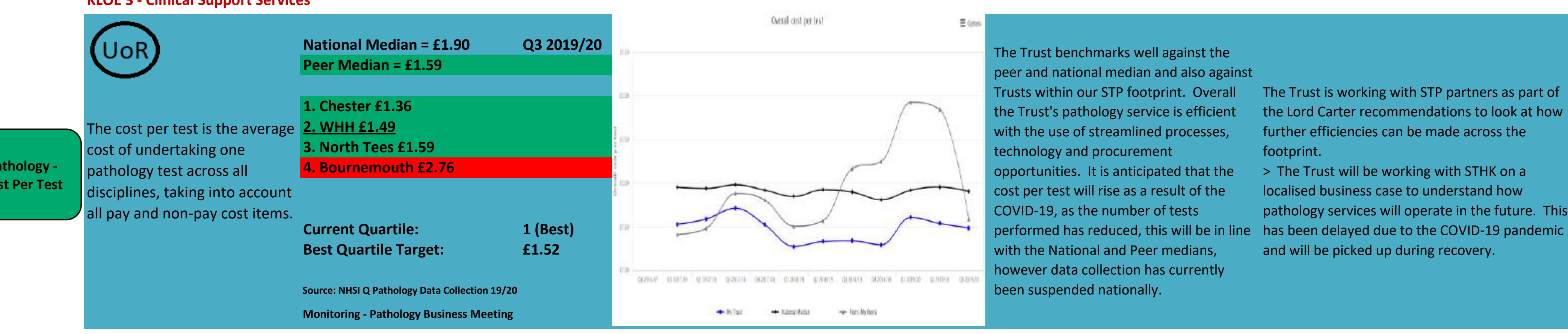


Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance

KLOE 3 - Clinical Support Services



Pathology - Cost Per Test

UoR

The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items.

National Median = £1.90 **Q3 2019/20**
Peer Median = £1.59

1. Chester £1.36
2. WHH £1.49
3. North Tees £1.59
4. Bournemouth £2.76

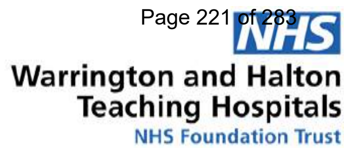
Current Quartile: **1 (Best)**
Best Quartile Target: **£1.52**

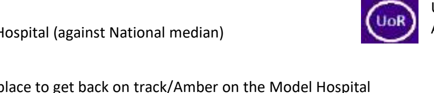
Source: NHSI Q Pathology Data Collection 19/20

Monitoring - Pathology Business Meeting

The Trust benchmarks well against the peer and national median and also against Trusts within our STP footprint. Overall the Trust's pathology service is efficient with the use of streamlined processes, technology and procurement opportunities. It is anticipated that the cost per test will rise as a result of the COVID-19, as the number of tests performed has reduced, this will be in line with the National and Peer medians, however data collection has currently been suspended nationally.

The Trust is working with STP partners as part of the Lord Carter recommendations to look at how further efficiencies can be made across the footprint.
> The Trust will be working with STHK on a localised business case to understand how pathology services will operate in the future. This has been delayed due to the COVID-19 pandemic and will be picked up during recovery.





Key
- Complete/Green on Model Hospital (against National median)
- On track for completion
- Progress off track - plans in place to get back on track/Amber on the Model Hospital
- Progress significantly off track/Red on Model Hospital
- Not started/Awaiting further information/New actions parameters to be established

UoR — Use of Resource Assessment Indicator

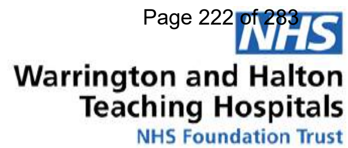
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

Recommendation 5 - All trusts should report their procurement information monthly to NHS Improvement to create an NHS Purchasing Price Index commencing April 2016, collaborate with other trusts and NHS Supply Chain with immediate effect, and commit to the Department of Health's NHS Procurement Transformation Programme (PTP), so that there is an increase in transparency and a reduction of at least 10% in non-pay costs is delivered across the NHS by April 2018.

Lead Director(s): Chief Finance Officer

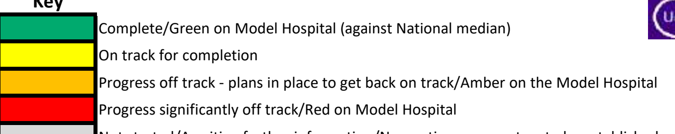
	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Provide data to NHSi for the NHS Spend Comparison Service (SCS)	• In August 2019, PPIB was replaced with the NHS Spend Comparison Service (SCS). and the Trust continues to provide data on a monthly basis. • The Trust is submitting Accounts Payable data to the SCS. • During COVID-19, the Trust has been submitted data weekly including COVID-19 spend to SCS. M > TB > last year > 11 > FSC > FSC Finance Appendix (appex)	• The Trust is carrying out analysis to look at data of the top quartile performing Trusts who are paying lower prices using the SCS. A report has been run against the top 500 by price variance comparing our data C&M, NHSI Peer and Acute Trusts in Top 25% of the Procurement League Table based on price. This will be run every six months. This will serve two purposes; support the delivery of savings and support work required in line with model hospital requirements. • Catalogue Benchmarking is to be undertaken annually. This will review how our catalogue prices benchmark against other Trusts. • SCCL monthly tracking commencing 01.04.19 and tracked on a monthly basis. This will review any increases/decreases in NHS SC prices and where prices have increased enable an informed decision to be made on source of supply along with informed discussions with SCCL. • The Purchasing Team is to benchmark all non-stock requisitions. The activity above was placed on hold during the COVID-19 pandemic and it is anticipated this will be revisited during Q3.	Finance & Sustainability Committee	Rolling Programme	Continue on report - rolling programme Oversight by the Finance & Sustainability Committee. Include in future UoRA report.
Developing PTP plans at a local level with each trust board nominating a director to work with their procurement lead to implement changes	• The Procurement Transformation Plan was submitted to NHSI. To support this, a procurement dashboard was established to measure Trust performance against the Carter metrics. The PTP was refreshed using the new NHSI format. • The Director of Finance & Commercial development is the responsible board member and will work with the Associate Director of Procurement to implemented changes around the PTP plan. • A review has been completed for all direct spend (i.e. that not with NHS SC) to determine which products can be transferred to NHS SC to further support the operating model. • All savings identified by Supply Chain Coordination Ltd (SCCL) will be incorporated in the Trust's 2019/20 CIP Plans. Based on 2018/19, 375 lines were transferred into the operating model representing a saving of £0.08m.	• The Trust continues to measure progress against the PTP. • The Trust continues to work with the network, SCCL account manager and the category towers to understand how savings can be achieved. • The Trust continues to develop working methodologies to streamline processes.	Finance Resource Group	Project Implementation	Close on report - any future changes will be reported to the Finance & Resource Group

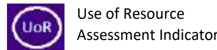


Use of Resource Graph Key

Trust Position	(blue)
National Median	(black)
Peer Median	(grey)

Key

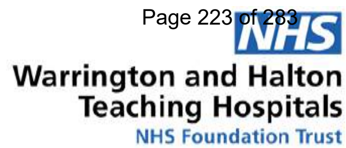




Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Adoption plan for Scan4Safety	• The Trust's adoption plan for Scan4Safety (formally the Global Standard: GS1) and pan European Public Procurement Online (PEPPOL) standards was drafted, the procurement lead for the project is the Deputy Head of Procurement. • Scan4Safety was presented to a number of forums throughout the Trust. • A draft PID was developed. The Trust has made progress in a number of areas: • Been allocated our 10,000 GLN's by GS1 as a way to assign a GLN to all of the locations within the Trust. • Agreed in principle that the issue relating to GSRN will be dealt with by replacing all staff ID Badges with a badge which as well as a photograph, will contain a barcode linked to the member of staffs payroll number. • The inventory management systems offered by the main providers in this area have been evaluated. This area along with the associated hardware and software represents the biggest cost to the Trust, so care is required to ensure that the solution selected meets the requirements into the future. • It has been agreed that Trust's lead executive for Scan 4 Safety is the Chief Information Officer. Scan 4 Safety is incorporated in the Trust's Digital Strategy.	• Estimated costs have been obtained for a trust inventory management system and visits to demonstrator sites are being set up. The Trust is positioning itself as leading the STP Scan4Safety on the Digital Collaboration @ Scale tracker. • Discussions have been held with GS1 to determine the best approach to implementation and liaise with STP partners for a potential collaboration. The STP Digital Design Authority supported the principles of a collaborative project but the two target collaborators cannot currently prioritise the work. • The STP Collaboration At Scale team is providing project management resource to aid WHH's Scan4Safety aspirations as a first of type. This will be planned around potential STP funding for a WHH GS1 gap analysis to map the current position and revisit the scope. A scope proposal will then be taken to WHH Executive Team for approval. Resourcing and Finance are key risks to progressing this scheme.	Digital Operational Group, Trust Operational Board	Project Implementation	Continue on report-project implementation oversight by the Digital Operational Group and Trust Operational Board. Include in future UoRA report.
NHS Standards of Procurement - to achieve level 1 by October 2016, develop improvement plan to meet target by March 2017	• The Trust has achieved NHS Standards of Procurement Level 1 accreditation. • The Trust has successfully achieved Level 2 for the Procurement Skills Development Network which was signed off in August 2019.	• The Trust will undertake a gap analysis during Q3/4 2020/21 to understand what is required to achieve Level 3.	Finance Resource Group	Project Implementation	Close on report - future oversight by the Finance Resource Group



Use of Resource Graph Key

Trust Position	(blue)
National Median	(black)
Peer Median	(grey)

Key

(green)	Complete/Green on Model Hospital (against National median)
(yellow)	On track for completion
(amber)	Progress off track - plans in place to get back on track/Amber on the Model Hospital
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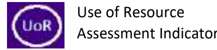
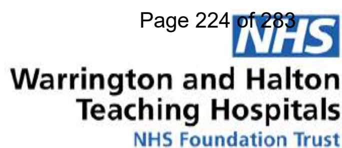


Use of Resource Assessment Indicator

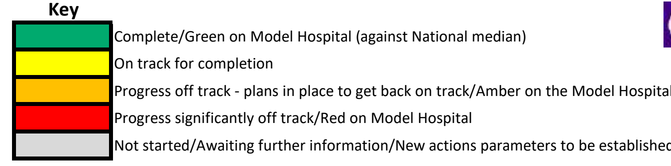
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Benchmarking – Model Hospital Procurement	• The Trust is currently ranked 71/133 Trusts – placing the Trust in the 2nd upper quartile (2nd best). • A review has taken place for each of the model hospital procurement metrics which looks at how far the Trust is from reaching with upper quartile. • The procurement team has produced a strategy to look at the feasibility of the Trust reaching the upper quartile for each metric and actions needed to get there. • The procurement team has developed a tracker to review progress against the key metrics. • The main metrics are included on the Trust Procurement Dashboard.	• The Trust continues to work through actions to improve its position against the Model Hospital metrics as part of a rolling programme, the focus is on the new Spend Comparison Service.	Finance & Sustainability Committee	Ongoing Monitoring	Continue on report - ongoing monitoring. Oversight by the Finance & Sustainability Committee. Include in future UoRA report.
Key Procurement Metrics	• Target of 80% addressable spend transaction volume on catalogue - Trust currently is at 92% (Q3 2019/20). • Target of 90% addressable spend transaction volume with a purchase order - Trust currently at 98% (Q3 2019/20). • 90% addressable spend by value under contract - Trust currently at 77% (Q3 2019/20). As of June 2020, this is the most up to date data available on the model hospital. • The procurement team produce monthly reports on all orders raised to ensure the contract register is up to date. The contract register is reviewed monthly by the Senior Contract Managers with oversight from procurement management meetings.	• During COVID-19, the procurement team has carried out a 7 day service on a split shift basis within existing resources in order to support the Trust during the pandemic, ensuring equipment and PPE is readily available.	Finance & Sustainability Committee	Ongoing Monitoring	Continue on report - ongoing monitoring. Oversight by the Finance & Sustainability Committee. Include in future UoRA report.



Warrington and Halton Teaching Hospitals
NHS Foundation Trust



Use of Resource Graph Key

Trust Position	(blue)
National Median	(black)
Peer Median	(grey)

Key

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(yellow)	On track for completion
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UoR — Use of Resource Assessment Indicator

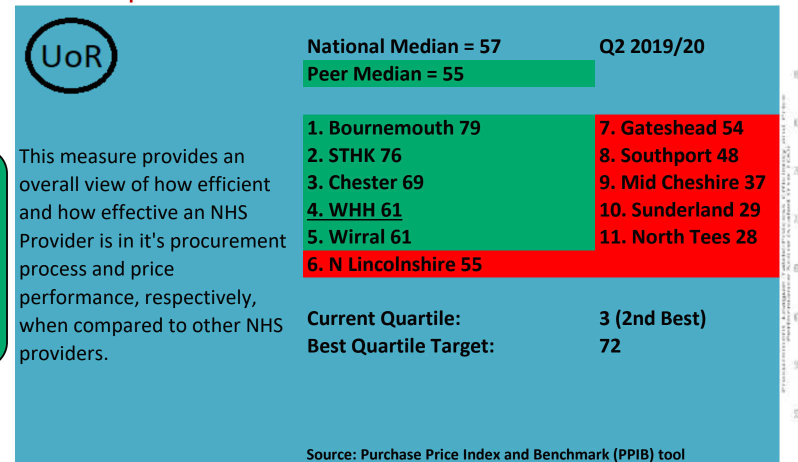
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance

KLOE 4 - Corporate Services

Procurement Process Efficiency and Price Performance Score Clinics



UoR

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.

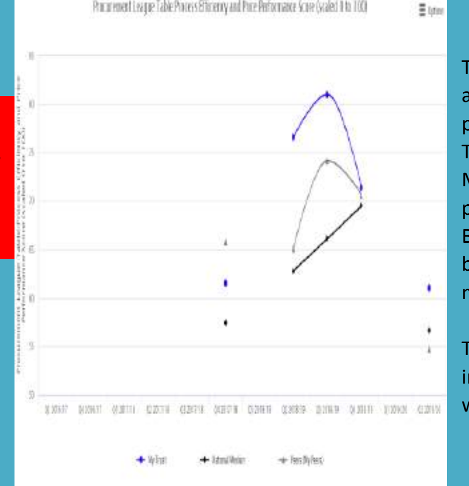
National Median = 57 **Q2 2019/20**
Peer Median = 55

1. Bournemouth 79	**7. Gateshead 54**
2. STHK 76	**8. Southport 48**
3. Chester 69	**9. Mid Cheshire 37**
4. WHH 61	**10. Sunderland 29**
5. Wirral 61	**11. North Tees 28**
6. N Lincolnshire 55	

Current Quartile:	**3 (2nd Best)**
Best Quartile Target:	**72**

Source: Purchase Price Index and Benchmark (PPIB) tool

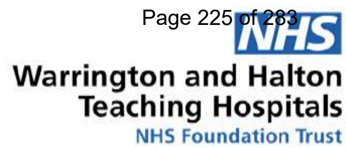
Monitoring: Senior Procurement Meeting



The Trust is above the National Median and peer median (Positive). The latest procurement league table has the Trust at a weighted score of 71 (Peer Median 71 National Median 69) which puts the Trust in the 3rd quartile (2nd Best). The Trust is ranked 58 which is better than both the peer and national median.

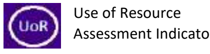
The Procurement Team has a strategy in place for improving performance which is reviewed on a monthly basis.

The Trust has undertaken a review of all procurement metrics and track this on a monthly basis. The Trust is carrying out analysis to look at data of the top quartile performing Trusts who are paying lower prices using the SCS. The Top 500 products are being review to understand the reasons for the price variance and to see if this can be replicated by the Trust.



Use of Resource Graph Key	
Trust Position	
National Median	
Peer Median	

Key	
	Complete/Green on Model Hospital (against National median)
	On track for completion
	Progress off track - plans in place to get back on track/Amber on the Model Hospital
	Progress significantly off track/Red on Model Hospital
	Not started/Awaiting further information/New actions parameters to be established



Use of Resource Assessment Indicator

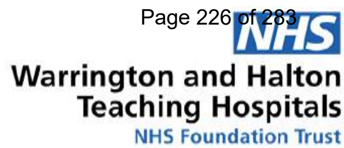
Appendix 2

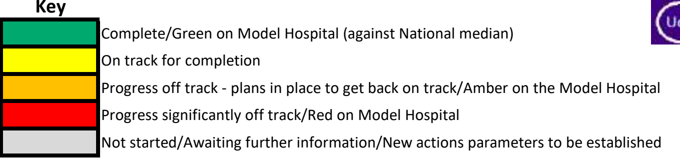
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

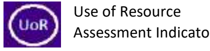
Recommendation 6 - All trusts estates and facilities departments should operate at or above the benchmarks for the operational management of their estates and facilities functions by April 2017 (as set by NHS Improvement by April 2016); with all trusts (where appropriate) having a plan to operate with a maximum of 35% of nonclinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner.

Lead Director: Chief Operating Officer

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Strategic estates strategy inc cost reduction based on benchmarks and in the longer term plan for investment/re configuration	• The Trust has an estates strategy in place to meet the overall Trust strategy. The strategy is phased 1, 2, and 3. Phase 1 is to explore immediate options for delivering savings by rationalising part of the estate. Phase 2 is to explore the potential for external and/or better utilised 'on site' accommodation for current service provision and phase 3 is to explore opportunities for wider STP collaborative initiatives. • Phase 1 is being delivered and monitored through Strategic Development and Delivery Committee. The strategy has been refreshed to reflect local clinical strategy and the STP estates strategy. • The Associate Director of Estates and Facilities has been nominated as co-chair for the One Halton estates enabler sub-group. • The Trust estates and facilities strategy was approved during Q2 2020/21.	• The Trust continues to explore internal and partnership collaboration opportunities for relocation of back office and clinical support functions. Previous work with Bridgewater has been suspended during the COVID-19 pandemic. • The Cheshire and Mersey Partnership is reviewing facilities management contracts across the patch and has identified four initial areas for collaboration opportunities, these include; Energy, Linen, Post and Decontamination, the Trust is fully engaged in all four work streams. • A draft Cheshire & Mersey estates strategy has been developed and will be reviewed by the Cheshire & Mersey estates Board.	Estates and Facilities sub-Committee, Trust Operational Board	Ongoing management and monitoring of the plan	Continue on report - ongoing monitoring. Oversight by the Estates and Facilities sub-committee and reported to the Trust Operational Board. Include in future UoRA report.
Investing in energy saving schemes such as LED lighting, combined heat and power units, and smart energy management systems	• The Trust has procured an energy infrastructure upgrade (CHP) which will save carbon, energy, money and future investment, upgrading their facilities using private sector capital repaid through guaranteed savings. • Estates have accessed funding from Carbon Energy Fund (CEF) replacing 4000 halogen bulbs with more cost effective LED. • The Trust has realised saving of £140k from the CHP contract which has been used for the departments CIP target.	• The Trust is progressing an internal replacement programme for emergency lighting as and when the lighting needs to be replaced. • The Trust is seeking to recruit a Sustainability Manager in 2020/21, a proposal is being developed for the Executive Team. • The Trust will put forward a cost neutral proposal for charging points for electric vehicles.	Estates and Facilities Sub-Committee, Trust Operational Board	Ongoing	Continue on report - rolling programme. Oversight by the Estates and Facilities sub-Committee and reported to the Trust Operational Board. Include in future UoRA report.



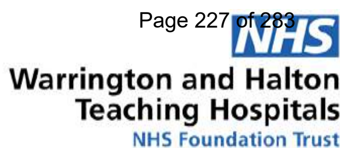




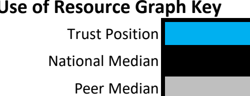
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Estates and facilities costs embedded into trusts' patient costing and service line reporting systems.	• Estates and Facilities costs are incorporated into the PLICS system. Quarterly service line reports are provided to CBUs by the financial planning team. The costing teams use the estates system, MICAD, to export floor area and can allocate energy/facilities costs based on m2.		Estates and Facilities Sub-Committee	Complete	Close on report - complete
Model Hospital & Effectiveness of Estates	• The Trust continues to review the effectiveness of its estate and monitors cost efficiency metrics to ensure it provides value for money and take actions for any deviation from the benchmark values. • Results of the Trust PLACE assessment have been developed into an action plan which is monitored by the estates and facilities operational board and the Quality Assurance Committee.	• The model hospital data shows the Trust favourable when benchmarking against peer and national medians. Nationally, ERIC returns in 2020 have been delayed, it is anticipated these will be submitted in August for reporting in December 2020.	Estates and Facilities Sub-Committee, Trust Operational Board	Ongoing Monitoring	Continue on report - ongoing monitoring. Oversight by the Estates and Facilities sub-committee and reported to the Trust Operational Board. Include in future UoRA report.
All Trusts (where appropriate) have a plan to operate with a maximum of 35% of non-clinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities	• Model hospital data reports the Trust utilises 38.7% of its estate for non-clinical use and has 2.3% of empty space. Whilst every effort to minimise the use of trust accommodation for non-clinical purposes has been made, it is difficult given the complexities of the numerous corporate functions and the estate footprint. • The current estate strategy addresses under-utilised space which has seen a reduction to under 2.5%. • An agile working pilot has taken place in several teams within the Finance Directorate; this has demonstrated a potential opportunity to reduce desk space by up to 20%. The pilot will be extended to the wider Finance Directorate in Q4.	• The Trust is working in collaboration with Bridgewater, its possible that the non clinical area floor space will increase, however this can be considered warranted variation. The Trust is constantly reviewing available floor space to maximise opportunities. • In response to COVID-19 the Trust has agreed agile working policy, the pandemic has highlighted the possibilities of agile working, learning from which will be taken forward in future estates planning.	Estates and Facilities Sub-Committee, Trust Operational Board	Ongoing Monitoring	Continue on report - ongoing monitoring. Oversight by the Estates and Facilities Sub-Committee reported to the Trust Operational Board. Include in future UoRA report.



Use of Resource Graph Key



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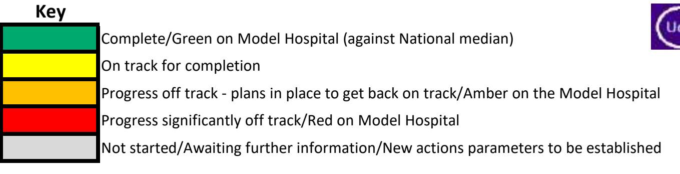
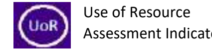




Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance

KLOE 4 - Corporate Services

Estates & Facilities Costs (£ per m2)

UoR

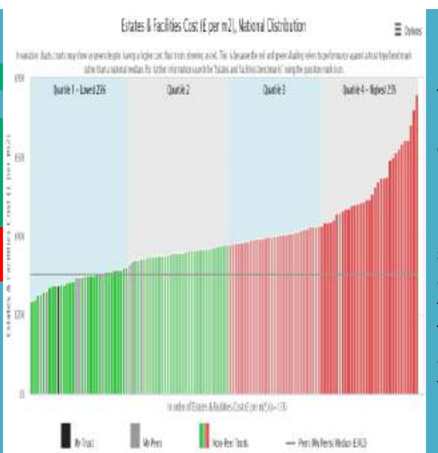
The total estates and facilities running costs is the total cost of running the estate in an NHS trust including, staff and overhead costs. In-house and out-sourced costs, including PFI costs, will be included.

National Median = £377	2018/19
Peer Median = £302	
1. Sunderland £253	7. North Tees £305
2. N Lincolnshire £263	8. Chester £322
3. WHH £275	9. Gateshead £335
4. Southport £296	10. B'mouth £342
5. Wirral £297	11. STHK £461
6. Mid Cheshire £299	

Current Quartile:	1 (Best)
Best Quartile Target:	£322

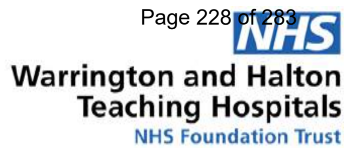
Source: ERIC 2018-19 Total Estates and Facilities Running Costs

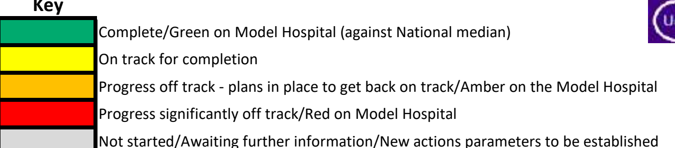
Monitoring - Estates and Facilities Operational Group



The Trust benchmarks well against national and peer median for hard facilities costs even with the challenges of maintaining an aging estate. We have invested year on year to reduce backlog maintenance, however without a significant increase in investment, the amount of backlog to bring the estate up to appropriate standards will always rise. This in turn has and will continue to have an adverse effect on overall estates and facilities costs.

Estates and facilities costs are continually monitored. Where efficiencies can be made, proposals/business cases are produced for consideration by the Trusts Executive Team. It is anticipated that the COVID-19 pandemic will have a service line impact on estates and facilities costs with costs in some areas e.g. cleaning, portering and security rising and costs in other areas such as maintenance reducing.





UoR Use of Resource Assessment Indicator

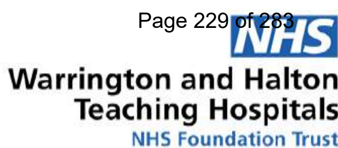
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

Recommendation 7 - All trusts corporate and administration functions should rationalise to ensure their costs do not exceed 7% of their income by April 2018 and 6% of their income by 2020 (or have plans in place for shared service consolidation with, or outsourcing to, other providers by January 2017), so that resources are used in a cost effective manner.

Lead Director(s): Chief People Officer, Chief Finance Officer and Chief Information Officer

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Rationalisation of corporate and administration functions	• The Trust's corporate and administration functions current costs are 6.0% of income based on actual income as of Q1 2020/21. This includes Finance, HR, IM&T, Communications, Research, Transformational and Executive costs (excluding Governance). • The Trust will collaborate with other organisations where appropriate to provide services in a more streamlined way maximizing opportunities to procure and work at scale, reduce waste and support the delivery of clinical services, facilitating change where required. • The NHSI operational productivity team visited the Trust in August 2018 to look at the whole of the model hospital and identify opportunities. • As a follow up to the NHSI productivity session, a specific corporate service session took place in October 2018 which focused on IM&T, Finance and HR. • Corporate Services are utilising NHSI Corporate Service Productivity Programme to review opportunities around Chart of Accounts, Journal Policy, Budget Holder Support, Accounts Payable Automation, Sharing Ledger Costs, Policies and Procedures and Financial Reporting. The Trust had worked with Mid-Cheshire Hospitals NHS Trust to review structures as part of a wider benchmarking exercise. • Improving the consistency of Benchmarking returns was discussed at the Collaboration @ Scale workshop. NHSi is to support work to assess returns and advise on amendments. • The IM&T SLT have reviewed the IM&T Model Hospital metrics and apportioned the costs so that they accurately reflect the work areas for pay and non-pay. Looking at the pure IT areas the department is within national levels however further work is underway to see where tangible improvements can be made.	• Due to the COVID-19 pandemic this work has been placed on hold. The Trust will continue to work collaboratively and participate in Carter @ Scale once these groups resume. As part of the system wider recovery plan the Trust will be looking to make c£2m of corporate savings over the next two years.	Strategic Executive Oversight Group (pending a governance review).	Rolling Programme	Continue on report - ongoing review. Oversight by the Strategic Executive Oversight Group (pending a governance review). Include in future UoRA report.
Corporate CIP Targets	• CIP has been suspended nationally due to COVID-19 with no requirement for delivery and reporting until at least 31st July 2020, the Trust is awaiting guidance on next steps.	• Corporate CIP performance for 2019/20 was an over performance of £0.1m, with £1.3m achieved against the target of £1.2m. Of this £0.4m was recurrent and £0.9m was non-recurrent. • Collaboration at Scale activity is seen as key to future improvements and aims to identify future procurement opportunities.	Finance & Sustainability Committee	Rolling Programme	Closed - Oversight by the Finance & Sustainability Committee.



Use of Resource Graph Key

Trust Position	(blue)
National Median	(black)
Peer Median	(grey)

Key

(green)	Complete/Green on Model Hospital (against National median)
(yellow)	On track for completion
(amber)	Progress off track - plans in place to get back on track/Amber on the Model Hospital
(red)	Progress significantly off track/Red on Model Hospital
(grey)	Not started/Awaiting further information/New actions parameters to be established

UoR — Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance

KLOE 4 - Corporate Services

Non Pay Costs per WAU

Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a trust to produce one Weighted Activity Unit (WAU) of clinical output.

This metric show the amount the trust spends on non-pay per WAU across all areas of NHS clinical activity.

Please note: This indicator is no longer being updated on the Model Hospital and has been moved to a legacy area.

National Median = £1307 — **2017/18**

Peer Median = £1200

1. Chester £898	**7. N L'nshire £1187**
2. Mid Cheshire £954	**8. B'mouth £1213**
3. WHH £1027	**9. STHK £1218**
4. Gateshead £1058	**10. North Tees £1280**
5. Wirral £1078	**11. Sunderland £1518**
6. Southport £1172	

Current Quartile: **1 (Best)**

Best Quartile Target: **£1172**

Source: HSCIC - NHS Digital iView Stability Index

UoR

The Trust is performing in the upper quartile (best) nationally. The Trust continues to review opportunities to reduce non-pay costs whilst maintaining quality.

All departments across the Trust are continuously looking at ways to reduce costs as part of day to day business as well as via CIP.

UoR

Finance Costs per £100m Turnover

Total finance cost divided by trust turnover multiplied by a £100m

National Median = £653k — **2018/19**

Peer Median = £673k

1. Bournemouth £560k	**7. North Tees £694k**
2. Sunderland £572k	**8. N L'shire £701k**
3. STHK £649k	**9. Gateshead £745k**
4. Chester £656k	**10. WHH £839k**
5. Wirral £665k	**11. Southport £1.1m**
6. Mid Cheshire £682k	

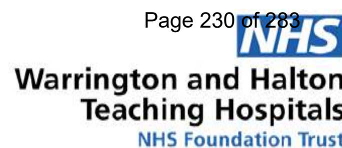
Current Quartile: **4 (Worst)**

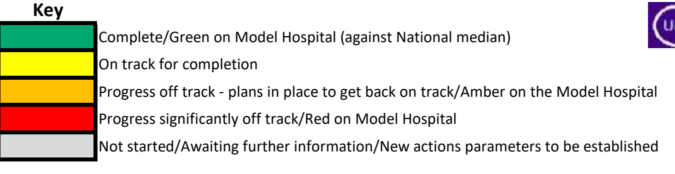
Best Quartile Target: **£541k**

Source: Trust consolidated annual accounts and NHSI improvement 18/19 data collection template.

The Trust is above the national and peer median when compared to costs per £100m income, however based on absolute costs, the Finance function is lower than the national and peer median. There remains an issue with the way the SBS costs are treated and this has skewed the position, if these costs were removed, it would bring the Trust to below the national median.

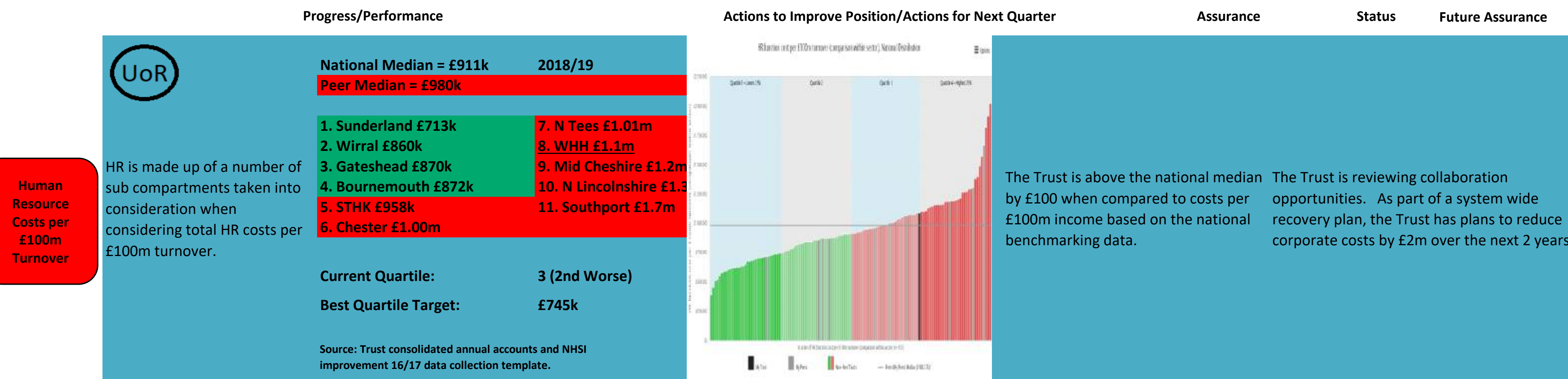
The Trust is reviewing collaboration opportunities. As part of a system wide recovery plan, the Trust has plans to reduce corporate costs by £2m over the next 2 years.





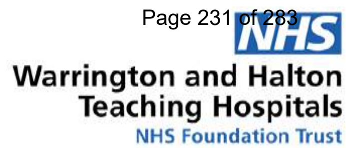
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21



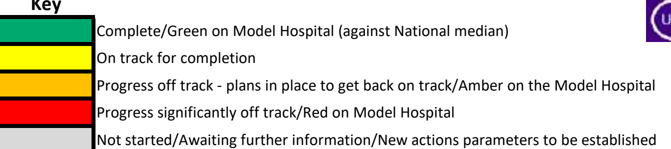
	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Human Resource Costs per £100m Turnover	UoR HR is made up of a number of sub compartments taken into consideration when considering total HR costs per £100m turnover.	**National Median = £911k** **Peer Median = £980k** **1. Sunderland £713k** **2. Wirral £860k** **3. Gateshead £870k** **4. Bournemouth £872k** **5. STHK £958k** **6. Chester £1.00m** **Current Quartile:** **Best Quartile Target:**	**2018/19** **7. N Tees £1.01m** **8. WHH £1.1m** **9. Mid Cheshire £1.2m** **10. N Lincolnshire £1.3** **11. Southport £1.7m** **3 (2nd Worse)** **£745k**		The Trust is above the national median by £100 when compared to costs per £100m income based on the national benchmarking data.	The Trust is reviewing collaboration opportunities. As part of a system wide recovery plan, the Trust has plans to reduce corporate costs by £2m over the next 2 years.	

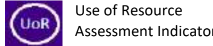
Source: Trust consolidated annual accounts and NHSI improvement 16/17 data collection template.



Use of Resource Graph Key

Trust Position
National Median
Peer Median





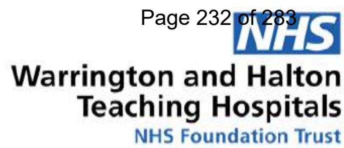
Appendix 2

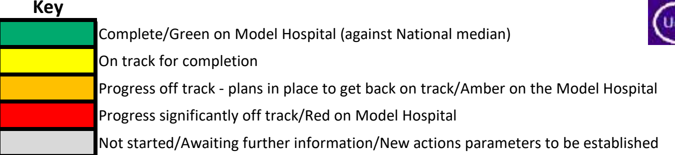
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

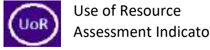
Recommendation 8 - NHS Improvement and NHS England should establish joint clinical governance by April 2016 to set standards of best practice for all specialties, which will analyse and produce assessments of clinical variation, so that unwarranted variation is reduced, quality outcomes improve, the performance of specialist medical teams is assessed according to how well they meet the needs of patients and efficiency and productivity increase along the entire care pathway.

Lead Director(s): Chief Operating Officer

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Variation in Theatres and Outpatients	• A theatre scheduling process was launched and is designed to provide improved visibility and forward planning around utilising theatre and anaesthetic capacity. • Theatre listing meetings immediately and '6-4-2' were established. • A list planning process was launched with the aim of formally introducing expected list timings into the discussion to ensure all scheduled lists are planned to run at or close to maximum operating time available. • Demand and Capacity work is complete and the model is now fully functional. • A Theatre Transformation Board chaired by the CBU Manager for Digestive Diseases has been established. • A programme of work around improving Theatre Utilisation and Late Starts was undertaken. • The Theatre productivity group has been established with a sub-group focusing specifically on cancellations with a view to address the number of cancelled sessions. • The Trust has implemented new dashboards allowing live reporting of theatre productivity.	• As part of the national COVID-19 response, the Trust is operating in a level 4 command and control national framework and is locally participating in a In/Out of Hospital Cells across Cheshire & Mersey. • Outpatients - The use of virtual clinics has been accelerated (using a combination of telephone consultations and "attend anywhere" software). This has taken place as part of the Trust's response to the COVID-19 pandemic, with face to face appointments only taking place where necessary. This process will continue to be adopted long term. • All non-urgent elective activity was suspended in line with national guidance; the Trust is in the process of restarting these services which is being overseen by the Recovery Board. As part of this restart, the Trust has developed a programme to deliver elective Breast, ENT and Urology at Halton.	Trust Operational Board, Finance & Sustainability Committee	Rolling Programme	Close on report - rolling programme. Oversight by Trust Operational Board, Finance & Sustainability Committee. Future efficiencies reported as part of UoRA.



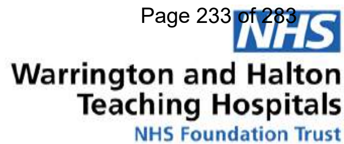




Appendix 2

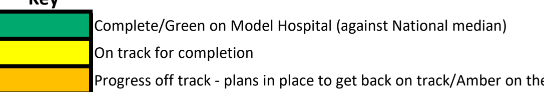
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Emergency Care Improvement Programme	• An improvement programme for patient flow agreed a number of key work streams across mid Mersey following a system review, these work streams feed into the Mid-Mersey A&E delivery board. • The Trust has its own internal flow board which focuses on 9 key work streams to support improvements in flow. • Red 2 Green patient data is collected on all wards through daily board rounds and a process to share the data around patient delays with partner organisations is in place with partner organisations expected to respond with actions in place to reduce the delays. • The Emergency Care Improvement Programme visited the Trust. There was an NWAS challenge for all conveyances and a walk through of the urgent/emergency care system. • As a result of the system-wide capacity and demand review carried out by the Venn Group, the Trust has agreed with partners to approve capacity and flow in the short term. • ED Ambulatory Care opened January 2019. This has resulted in increased assessment through put and a reduction in direct admissions from ED. • The Trusts dedicated discharge lounge opened in March 2019. • The Integrated Care team is now co-located from June 2019. • A new ward round accreditation process is being developed. • CAU (Combined Assessment Unit) test of change took place in September 2019 bringing together GPAU and SAU, significant positive impact was demonstrated. • The Trust took part with NHSI in a SAFER/LLOS Collaboration which was completed in November 2019. • An Urgent & Emergency improvement committee is now in place with an action plan to support improvement and address breaches. All actions are complete with continual audits to be carried out. • The CAU (Combined Assessment Unit) business case was approved and went live in December 2019 with a full 24/7 rota in place by 5th January 2020.	• Royal College of Emergency Medicine (RCEM) guidance around COVID-19 has been issued and the Trust has developed an action plan in response. The ED environment has been segregated in COVID & Non-COVID. • The Trust has been appointed as the Cheshire & Mersey pilot site for 111 first, this is a national programme to support streamline of attendance in ED to maximise direction to other appropriate resources. • A full staffing review has been undertaken. A business case has been approved to support the removal of non-contracted expenditure.	Recovery Board, Trust Operational Board	Rolling Programme	Close on report - rolling programme. Oversight via the Recovery Board and Trust Operational Board.



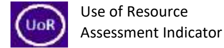
Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	



Key

	Complete/Green on Model Hospital (against National median)
	On track for completion
	Progress off track - plans in place to get back on track/Amber on the Model Hospital
	Progress significantly off track/Red on Model Hospital
	Not started/Awaiting further information/New actions parameters to be established

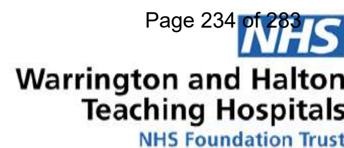


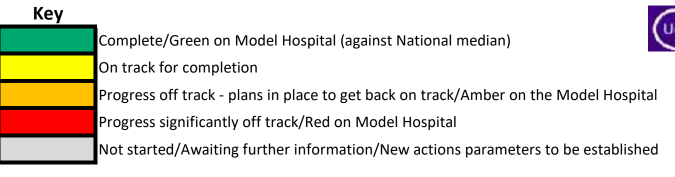
Use of Resource Assessment Indicator

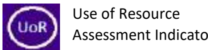
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Specialty level reviews across local delivery system	• The Trust is participating in a series of specialty level reviews across the Local Delivery System (LDS). • Implementation of plans to reduce variation within pathways across the LDS. • Specialty reviews have now been held in urology, trauma & orthopaedics and ophthalmology. • A programme of workshops across priority specialties has been agreed, led by the LDS Director of Service Redesign. • A new clinical strategy was developed and launched. • Work to re-invigorate the DTOC process to include daily validation with weekly reviews and a weekly corporate flow meeting has been completed. • The Trust is working with Cheshire and Mersey Cancer Alliance to develop optimal pathways beginning with Colorectal, the Trust is supported by Aqua. A one stop shop has been launched. Colorectal Straight to Test has been implemented. • A new clinical model around the Stroke Pathway has been agreed, implementation took place in April 2019. • An Integrated Discharge Manager has been recruited who will manage both Health & Social Care Teams. • All 33 clinical services now have 3-5 year clinical strategies agreed and prioritised. The Clinical strategies seek to address variation and target improvement.	• GIRFT reviews continue to take place within a number of specialities across the Cheshire & Mersey footprint, with each speciality developing an action plan. • The Trust is working in collaboration with Bridgewater Community Healthcare NHS Foundation Trust to look at the integration of clinical pathways, this will continue as part of the recovery phase.	Strategic Executive Oversight Group (pending a governance review).	Rolling Programme	Close on report - rolling programme. Collaboration and system activity Oversight by Strategic Executive Oversight Group (pending a governance review).



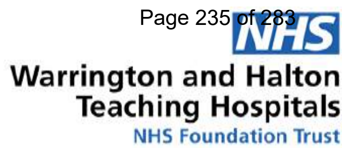




Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
KLOE 1 - Clinical						
Pre Procedure Elective Bed	UoR The number of bed days between the elective admission date and the date that the procedure taken place.	**National Median = 0.05** **Q4 2019/20** **Peer Median = 0.15** **1. North Tees 0.01** **2. Mid Cheshire 0.03** **3. WHH 0.05** **4. Bournemouth 0.09** **5. Chester 0.12** **6. Southport 0.15** **7. STHK 0.17** **8. Wirral 0.20** **9. N L'shire 0.23** **10. Gateshead 0.27** **Current Quartile:** **1 (Best)** **Best Quartile Target:** **0.05 days** **Monitoring : KPI Sub-Committee** **Source: Hospital Episode Statistics**	The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency.	Performance against this metric is further monitored via the Theatre Performance Dashboard.		
Pre Procedure Non Elective Bed Days	UoR The number of bed days between an emergency admission date and the date the procedure taken place.	**National Median = 0.63** **Q42019/20** **Peer Median = 0.85** **1. Bournemouth 0.32** **2. WHH 0.45** **3. N Tees 0.54** **4. Wirral 0.64** **5. Mid Cheshire 0.82** **6. Gateshead 0.85** **7. STHK 0.87** **8. Chester 0.93** **9. Southport 1.09** **10. N L'shire 1.13** **Current Quartile:** **1 (Best)** **Best Quartile Target:** **0.49 days** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	The Trust continually reviews opportunities to improve efficiency around emergency and non elective procedures. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency.	Performance against this metric is further monitored via the Theatre Performance Dashboard.		

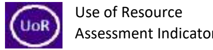


Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

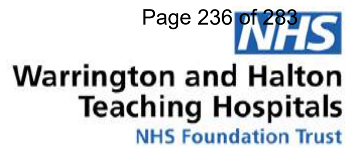
	Complete/Green on Model Hospital (against National median)
	On track for completion
	Progress off track - plans in place to get back on track/Amber on the Model Hospital
	Progress significantly off track/Red on Model Hospital
	Not started/Awaiting further information/New actions parameters to be established



Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Did Not Attend (DNA) Rate	UoR Rate of patients not attending their outpatient appointment.	**National Median = 6.91%** **Q4 2019/20** **Peer Median = 7.86%** **1. Mid Cheshire 5.46%** **2. Chester 5.80%** **3. N Lincolnshire 6.68%** **4. Southport 6.70%** **5. WHH 7.37%** **6. North Tees 7.86%** **7. STHK 8.08%** **8. G'head 8.17%** **9. B'mouth 8.34%** **10. Wirral 8.59%** **Current Quartile: 3 (2nd Worst)** **Best Quartile Target: 6.05%** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		The Trust reintroduced a text reminder service which has resulted in a significant improvement in the DNA rate. The Trust is slightly above the national median, however we perform better than our peers.		The Trust has continued to implement improvements in the interface with patients. Further improvements in the interface are being implemented via the Outpatient Steering group, which is intended to improve the position further. It is anticipated that the wider use of virtual clinics which was implemented as part of the COVID-19 pandemic, will improve the DNA rate.
Emergency Readmission (30 Days)	UoR 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 = 7.09%** **Q4 2019/20** **Peer Median = 7.16%** **1. Chester 5.61%** **2. N Lincolnshire 5.97%** **3. Bournemouth 6.75%** **4. Wirral 7.10%** **5. STHK 7.16%** **6. Mid Cheshire 7.78%** **7. WHH 7.82%** **8. G'head 7.95%** **9. S'port 8.11%** **10. N Tees 8.12%** **Current Quartile: 3 (2nd Worse)** **Best Quartile Target: 4.75%** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		Every effort is made when discharging patients to ensure that the discharge is appropriate. Readmissions are reviewed by the clinical directors to review any inappropriate discharges and ensure lessons are learned.		The Trust will continue to review the improvement through the Trust clinical governance processes to ascertain if there is a need to review discharge procedures.



Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

	Complete/Green on Model Hospital (against National median)
	On track for completion
	Progress off track - plans in place to get back on track/Amber on the Model Hospital
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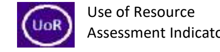


Use of Resource Assessment Indicator

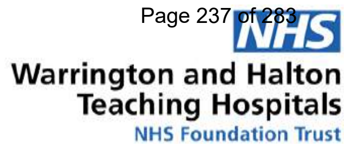
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

Recommendation 9 - All trusts should have the key digital information systems in place, fully integrated and utilised by October 2018, and NHS Improvement should ensure this happens through the use of 'meaningful use' standards and incentives.

Lead Director: Chief Information Officer

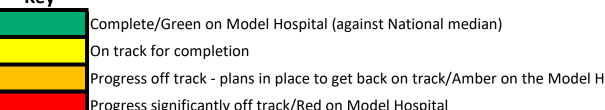
	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Electronic Patient Record & Structured Clinical Notes	• The Trust implemented Lorenzo EPR in December 2015. • The Trust continues to optimise Lorenzo functionality to ensure that it meets with developing business and clinical needs. This project is monitored by the Digital Board. • The Trust continues to upgrade Lorenzo in line with the development roadmap. • The Trust has been selected as a Digital Exemplar for work relating to the use of the Electronic Patient Record. This project is making excellent progress. The team is pulling together conceptual designs to support future state for the selected pathways 'Head Trauma and Diabetes'. • Electronic Maternity Nursing Observations (MEWS) went live during Q4 2018/19. • The Trust was successful in their bid to HLSI (Health System Led Investment Programme) to support implementation of Inpatient nursing observations. • Lorenzo ePMA Phases 1 & 2 successfully deployed in December 2019.	• Lorenzo Digital Exemplar – LDE workstreams put on hold due to COVID 19 priorities. ePMA rollout successfully completed November 2019. Remaining services being planned ITU, Paediatrics and Maternity Q3 and Q4 2020/21. • Warrington Care Record - Despite COVID 19 pressures. Good progress is being made to make available GP discharge letters in Shared2Care solution. Go live being planned for Q3 2020/21. • The GP viewer went live June 2020 giving Trust clinicians access to Warrington GP records via Lorenzo. • The GP Connect data sharing agreement remains in progress with all GPs signed up. Testing has commend using live interface with TPP Warrington GP. Target go live Q2 2020/21. • The HLSI (Health System Led Investment Programme) Funding Agreement to support implementation of ED and Inpatient Nursing Observations and clinical decision support implementation has re started following COVID-19. Inpatient nursing observation pilot target go live Q2 2019/20. Clinical Decision Support development restarted following COVID-19.	Digital Operational Board, Trust Operational Board, Trust Board	Project Implementation	Close on report - project implementation. Oversight by Digital Operational Board and Trust Operational Board. Future IM&T projects which will impact on efficiencies to be reported in UoRA.
Electronic Document Management System	• A review of requirements now Lorenzo has been live for 3 years has been undertaken to ensure any investment required is for the right solution.	• The Trust Digital Strategy has been refreshed and was published January 2020. • Estimated timescales are recognised in the Digital Strategy programme of work as "Ongoing EPR Forms Development".	Digital Operational Group, Trust Operational Board	Project Implementation	Close on report - project implementation. Oversight by Digital Operational Group reported to the Trust Operational Board.



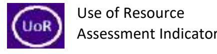
Use of Resource Graph Key

Trust Position
National Median
Peer Median

Key



Complete/Green on Model Hospital (against National median)
On track for completion
Progress off track - plans in place to get back on track/Amber on the Model Hospital
Progress significantly off track/Red on Model Hospital
Not started/Awaiting further information/New actions parameters to be established

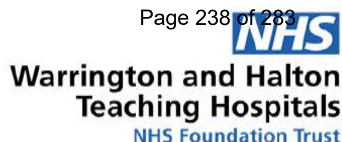


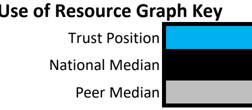
Use of Resource Assessment Indicator

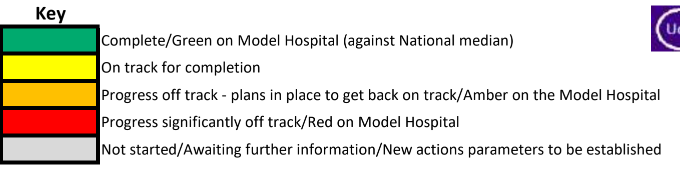
Appendix 2

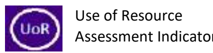
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
	• Electronic prescribing and medicines administration (ePMA) business case and PID signed off by Trust Board and NHS Digital – the outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017. • The ePMA rollout plan was signed off by the Digital Operational Group and the IM&T Committee. • The ePMA pilot commenced on CDU on 5th March 2018. Positive feedback from staff/system users was received. 2nd ePMA pilot at Halton UCC – the pilot was a success and operation of the system has continued post pilot. • ePMA was successfully implemented on the surgical pathway on Ward B4 in December 2018 and within Ward and Theatre orthopaedic pathways at the CMTC in March 2019.	• ePMA Phases 1 & 2 deployment successfully completed early December 2019. Residual issues now being resolved via Steering Group. • Business cases are being developed to deliver parts 3 (dose range checking) and 4 (to develop interface with JAC Pharmacy to support closed loop prescribing) approved and project planning underway. Sequencing prioritised ITU, Paediatrics and Maternity. Target go live ITU Q3 2020/21.	Digital Operational Group, Trust Operational Board	Project Implementation	Continue on report - project implementation Oversight by Digital Operational Group, reported to the Trust Operational Board. Include in future UoRA report.









Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance

Recommendation 10 - DH, NHS England and NHS Improvement, working with local government representatives, to provide a strategy for trusts to ensure that patient care is focussed equally upon their recovery and how they can leave acute hospitals beds, or transfer to a suitable step down facility as soon as their clinical needs allow so they are cared for in the appropriate setting for themselves, their families and their carers.

Lead Director: Not Applicable

Recommendation 11 - Trust boards to work with NHS Improvement and NHS England to identify where there are quality and efficiency opportunities for better collaboration and coordination of their clinical services across their local health economies, so that they can better meet the clinical needs of the local community.

Lead Director: Not Applicable

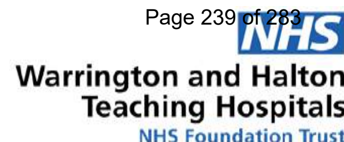
Collaborative working across the healthcare

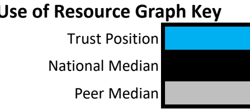
• The Trust continues to work in collaboration with external providers and commissioners within the STP and LDS to seek to address clinical and financial constraints through service, productivity and rationalisation opportunities.

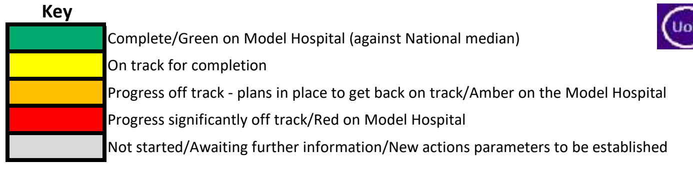
Recommendation 12 - NHS Improvement should develop the Model Hospital and the underlying metrics, to identify what good looks like, so that there is one source of data, benchmarks and good practice.

Lead Director: Not Applicable

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Development of a Model Hospital	• NHS Improvement has now published the model hospital data and the Trust is focussing on the use of the information to drive forward clinical and corporate practices so that outputs and financial performances can be improved.	• A report that extracts all key metrics from the Model Hospital portal that enables our individual services to review and analyse has been produced. • The key metrics include Clinical Service Lines (Emergency, General Surgery, Urology and Paediatrics) Operational (Theatres, Procurement, Pathology, Estates) and People (Nursing, AHP, Medical, Workforce Analysis). https://model.nhs.uk		Ongoing Monitoring	







UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance

Recommendation 13 - NHS Improvement should, in partnership with NHS England by July 2016, develop an integrated performance framework to ensure there is one set of metrics and approach to reporting, so that the focus of the NHS is on improvement and the reporting burden is reduced to allow trusts to focus on quality and efficiency. .

Lead Director: Not Applicable

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Implementation of Single Oversight Framework	• NHS Improvement published the document Single Oversight Framework (SOF) effective from 1st October 2016, updated in October 2017 and September 2019 (renamed NHSI Oversight Framework. • New SOF reviewed and indicators have been incorporated into IPR and other performance monitoring tools.		Trust Board	Ongoing Monitoring	
Segmentation	• The Trust received written confirmation on 7th December 2017 that it has been moved from Segment 3 to Segment 2.		Trust Board	Ongoing Monitoring	

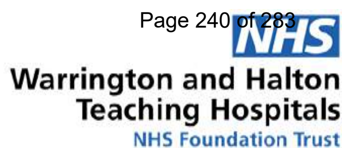
Recommendation 14 - All acute trusts should make preparations to implement the recommendations of this report by the dates indicated, so that productivity and efficiency improvement plans for each year until 2020/21 can be expeditiously achieved.

Lead Director: Not Applicable

See individual recommendations.

Recommendation 15 - National bodies should engage with trusts to develop their timetable of efficiency and productivity improvements up until 2020/21, and overlay a benefits realisation system to track the delivery of savings, so that there is a shared understanding of what needs to be achieved.

Lead Director: Not Applicable



Use of Resource Graph Key

- Trust Position
- National Median
- Peer Median

Key

- Complete/Green on Model Hospital (against National median)
- On track for completion
- Progress off track - plans in place to get back on track/Amber on the Model Hospital
- Progress significantly off track/Red on Model Hospital
- Not started/Awaiting further information/New actions parameters to be established

UoR — Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance

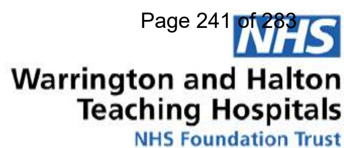
KLOE 5 - Finance

Indicator	Progress/Performance		Actions to Improve Position/Actions for Next Quarter / Assurance
Capital Services Capacity	UoR The degree to which the provider's generated income covers its financial obligations	**WHH Model = 1.99 (Feb 2020)** **Source: Provider returns** **Monitoring: FSC/Trust Board**	The Trust is currently working under an alternative financial regime (01/04/2020 - 31/07/2020) which has been implemented nationally in response to the COVID-19 pandemic. These indicators are not currently being reported. However once it becomes clear as to the future structure of financial arrangements, the Trust will recommence reporting.
Liquidity (Days)	UoR Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.	**WHH Model = -60.53 days (Feb 2020)** **Monitoring: FSC/Trust Board** **Source: Provider returns**	
Income & Expenditure Margin	UoR The income and expenditure surplus or deficit, divided by total revenue.	**WHH Model = -0.85% (Feb 2020)** **Monitoring: FSC/Trust Board** **Source: Provider returns**	

Capital service capacity - value

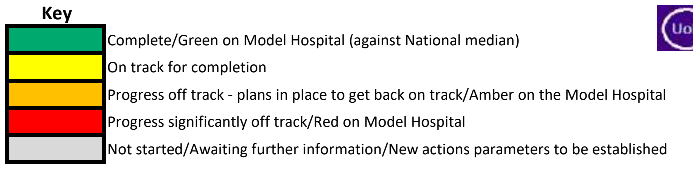
Liquidity (days) - value

Income and expenditure (I&E) margin - value



Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	



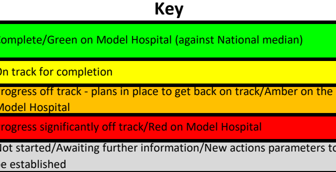
UoR Use of Resource Assessment Indicator

Appendix 2

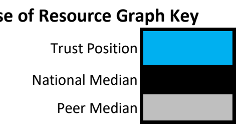
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2019/20 & Quarter 1 2020/21

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status	Future Assurance
Distance from Financial Plan	UoR 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. **WHH Model = -0.85% (Feb 2020)** **Monitoring: FSC/Trust Board** **Source: Provider returns**	Distance from financial plan – value			
Agency Spend - Cap Value	UoR The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year. **WHH Model = 13.0% (Feb 2020)** **Monitoring: FSC/Trust Board** **Source: Provider returns**	Distance from agency spend cap – value			

Key



Use of Resource Graph Key



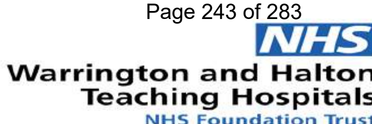
Use of Resources Assessment Dashboard - EXAMPLE DASHBOARD

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

KLOE 1: NAME OF UORA KLOE

KLOE Operational Lead: KLOE LEAD

UoRA Indicator & RAG Rating	**Model Hospital Benchmarking**	**Graph**	**Narrative**
UoRA Indicator & RAG Rating	**Model Hospital Benchmarking**	**Graph**	**Narrative**
UoRA Indicator & RAG Rating	**Model Hospital Benchmarking**	**Graph**	**Narrative**



Use of Resources Assessment - Action Plan Q2 2020/21 EXAMPLE ACTION PLAN

KLOE/Area	Action Lead(s)	Actions undertaken in last 12-18 Months	Actions to be undertaken in next quarter (Q3)	Future Actions
Name of KLOE	Action Lead	Detail of actions that have been taken in the last 12 months to improve Trust Use of Resources	Actions to be undertaken in the next quarter.	Future Actions
Name of KLOE	Action Lead	Detail of actions that have been taken in the last 12 months to improve Trust Use of Resources	Actions to be undertaken in the next quarter.	Future Actions
Name of KLOE	Action Lead	Detail of actions that have been taken in the last 12 months to improve Trust Use of Resources	Actions to be undertaken in the next quarter.	Future Actions

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/74**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	29th July 2020	
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: • Three new risks have been added to the BAF; • It is proposed that the ratings of two risks are reduced. • There have been no amendments to the descriptions of any risks on the BAF. • Two risks have been de-escalated from the BAF since the last meeting and a further two risks are proposed for de-escalation Also included in the report are notable updates to existing risks.	

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

RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC 20/07/86
	Date of meeting	7th July 2020
	Summary of Outcome	The Committee reviewed, discussed and approved the amendments
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework and Strategic Risk Register report	AGENDA REF:	BM/20/07/74

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 and following approval at the Quality Assurance Committee on 7th July 2020, it was agreed that three risks should be added to the BAF

Risk 1215

Risk Description:	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	Initial:	25 (5x5)
		Current:	25 (5x5)
		Target:	6 (3x2)

Risk 1207

Risk Description:	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	Initial:	16 (4 x 4)
		Current:	16 (4 x 4)
		Target:	8 (2 x 4)

Risk 1205

Risk Description:	FAILURE TO send accurate continuity of care information medication and / or allergies information from the Lorenzo EPR to external stakeholder. E.g. GPs CAUSED BY errors within the Lorenzo EPR electronic discharge summary code and/or configuration, i.e. the DXC PAN summarises the issue as: *"Discharge medications documented in Lorenzo do not match those showing on the discharge summary – this results in some medications being duplicated, missing completely or being incorrectly cited into appropriate sections." The medications section of the Discharge summary is split into the four heading of "Continued", "Stopped", "Changed" and "UnChanged" but the Trust response has deduced that medications are also appearing in the allergies section of the discharge summary.* RESULTING IN patient harm due to errors and/or omissions within the medications and allergies information that is transmitted from the WHH FT Lorenzo EPR to its external stakeholders for approximately 4% of all patient discharges for the affected period. *** There is currently no evidence of patient harm but there is evidence of potential for harm to result ***	**Initial:** **Current:**	20 (4x5) 15 (3x5)

Full details of these risks are provided in Appendix 1

2.2 De-escalation of Risks

Since the last meeting, and following approval at the Quality Assurance Committee on 7th July 2020, two risks have been de-escalated to the corporate risk register.

Risk ID:	1126	**Executive Lead:**	Evans, Chris	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.			**Initial:**	15 (5x3)
				Current:	15 (5x3)
				Target:	5 (5x1)

Oxygen usage has reduced significantly from its peak and all current actions have been completed.

Risk ID:	241	**Executive Lead:**	Crowe, Alex	**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 retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.			**Initial:**	12 (4x3)
				Current:	8 (4x2)
				Target:	4 (4x1)

As a result of the COVID-19 pandemic, the visit by HENW has been delayed until further notice. As significant progress has been made since the last visit, it is proposed that the risk is de-escalated for monitoring via the Corporate Risk Register.

A further two risks are proposed for de-escalation to the Corporate Risk Register. Details of these risks and the rationale for reducing the risk ratings are included in section 2.3 overleaf.

2.3 Amendments to risk ratings

Risk 1135 relates to delivery of performance during the peak periods of COVID-19. An additional risk has been added to the BAF (#1215 as described in section 2.1) to monitor the Trust's ability to deliver the capacity required during the recovery period. Therefore, following the inclusion of the additional risk and due to the restoration of services and the re-opening of the CMTC; and completion of associated actions, it is recommended that the following risk rating is reduced from 25 to 15 and de-escalted to to the Corporate Risk Register for continued monitoring.

Risk #1135
Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision.

The Emergency Department has returned to 85-90% of normal activity and recorded a consistent performance of in excess of 90%. Due to the consistent over the last quarter it is proposed that the risk rating is reduced from 16 to 12 and and de-escalted to to the Corporate Risk Register for continued monitoring.

Risk #224
Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to trust reputation, financial impact and below expected Patient experience.

The Board are asked to approve the proposal for the de-escalation of risks #1135 and #224 to the Corporate Risk Register.

2.4 Amendments to risk titles

Since the last meeting, there have been no amendments to the titles of any of the risks on the BAF

2.5 Existing Risks - Updates

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

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
1135	Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision.	• Review of all urgent activity on Trust Waiting Lists undertaken in accordance with national guidance and clinical review • Emergency and Trauma theatres maintained throughout pandemic • Cancer Theatre re-established on 5th May 2020 • Action plan in place for delivery of Emergency Care following guidance issued by RCHEM. This is	Recommend to reduce rating from 25 to 15 and de-escalate to the Corporate Risk Register

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		managed by the Recovery Board • Recovery Operational Group meet daily – managing planned and unplanned care • CMTC re-opened 29th June 2020	
1124	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff	• 8833 respirators are no longer available • Supplies are seeking alternative supplies of PPE with a safety check that essential standards are met before purchasing any items.	No impact on risk rating
115	Failure to provide adequate staffing levels in some specialities and wards, caused by inability to fill vacancies, sickness, resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	• National staffing guidance has been utilised to inform new staffing models • New models of care currently being implemented in Maternity in line with BR+. Business case being developed as there will be a requirement for a staffing uplift • Rolling advert for RN's continue with 12 nurses accepted an offer of employment at WHH in July 2020. Students who were redeployed to the Trust during the COVID 19 pandemic have been offered substantive posts • A business case has been developed for recruitment of international nurses which is due to be presented at the executive meeting in July 2020. • We have recruited 73 HCAs since February 2020 with rolling HCA recruitment programme in place <u>Recruitment Assurances</u> • 73 HCAs recruited from February 2020 to July 2020 currently undergoing pre-employment checks. • 12 month recruitment plan in place taking into consideration social distancing restrictions <u>Retention Assurances</u> • Workforce Dashboard reporting monthly in relation to leavers • WHH Nursing retention plan to be refreshed for 2020 • Improvement in nursing retention by 2.44% (Nov 2018 – Nov 2019) • Burdett Nursing Trust award winners • Highly commended for nursing retention data provision • 'Transfer Window' implemented allowing staff to move to other	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		specialties without having to apply for role Recruitment Gaps • 104 RN Vacancies • 84 B2 Vacancies Retention Gaps • 13.59% nursing turnover	
134	Risk: Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	Assurance updates • Trust Board approval of Capital Plan including the requirement for PDC as part of the final programme • On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust. • Re-instatement of Financial Resources Group (FRG) meeting from June 2020 • Positive Value for Money conclusion & unqualified audit opinion • Head of Internal Audit Opinion of Significant Assurance COVID-19 • Submitted COVID-19 capital bids to NHSE/I & Hospital Cell to support Business as Usual & Recovery plans • Achieved 95% BPPC June 2020 • Monthly Report to F&SC on COVID Pay Costs Gaps updates • Unclear on financial envelope to support COVID-19 capital needs – awaiting further notification ahead of Cheshire & Merseyside prioritisation process • Awaiting further information re: Financial regime post July 2020	No impact on risk rating
1134	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	• All additional hours and bank shifts worked by medical staff between 7th April 2020 and 31st May 2020, will be paid at the enhanced rates. This arrangement was extended until 9 June 2020 to review the scheme	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		and consider whether this should continue – decision taken by Strategic Oversight Group to revert back to Pre-Covid Enhanced and Standard rates of pay. • A plan is in place to support workforce recovery including health, wellbeing, leadership, teams, HR and resourcing. • All staff who are shielding are have individual reviews with line managers, supported by HR, to discuss impact on role and support to work from home. • Partnership working is in place with Cheshire Fire and Rescue to utilise their staff members available for redeployment. • Antibody testing for staff is now in place. Approximately 3440 have been tested as at 15.06.2020. • Pilot of testing for asymptomatic staff complete. SOP signed off via Tactical Meeting. • Process in place for escalation of any potential local 'hot spots' of COVID-19 in teams on a weekly basis to Infection, Prevention and Control and Microbiology Teams • Central log in HR Department to capture all sheilding staff – process in place for on-going updates • Electronic system is in place to support the roll out of a new COVID-19 Workforce Risk Assessment Tool in line with Risk Reduction Framework • Regular reporting on compliance with risk assessment requirements is in place • Regular training on COVID-19 Workforce Risk Assessment is in place	
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	• Secured annual capital investment to increase Digital skills and capacity. • Approval of a 7 Year Capital Profiling based upon asset replacement cycle and strategic roadmap (to deliver the approved Digital Strategy (January 2020)) plus the approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee.	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	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 Contigency measures) and subsequent reputational damage.		
224	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to trust reputation, financial impact and below expected Patient experience	• ED Performance – April 2020 92.52%, May 2020 93.36%, June Month to date month to date 92.34% • Development of new combined assessment unit (plaza) progressed and forms part of capital planning with plans submitted to Hospital Cell and NHSE/I • Collaborative working with Orthopaedics in management ok MSK Minor injuries via Minor's Stream • Reinstated CAU 24/7 • ED Ambulatory Care operating out of CAU • Upgrade to Minor's resulting in Oxygen points in all cubicles • Business case to increase staffing in Radiology approved	Recommend reducing rating from 16 to 12 and de-escalate to the Corporate Risk Register

3 RECOMMENDATIONS

Discuss and approve the changes and updates to the Board Assurance Framework.

Appendix 1

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
1135	Chris Evans	Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision.	1	25 (5x5)	10 (5x2)	TBC	Quality Assurance Committee
1124	Kimberley Salmon-Jamieson	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff	2	25 (5x5)	8 (4x2)	TBC	Quality Assurance Committee
TBC	Chris Evans	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
115	Kimberley Salmon-Jamieson	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	1	20 (5x4)	12 (4x3)	TBC	Trust Operations Board
134	Andrea McGee	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee
1134	Michelle Cloney	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee
1114	Phill James	Failure to provide essential, 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	1	16 (4x4)	8 (2x4)	TBC	Trust Operations Board

Board Assurance Framework

		(e.g. Civil Contingency measures) and subsequent reputational damage.					
224	Chris Evans	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to trust reputation, financial impact and below expected Patient experience.	1	16 (4x4)	8 (4x2)	TBC	Trust Operations Board
1207	Michelle Cloney	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	2	16 (4x4)	8 (2x4)	TBC	Strategic People Committee
125	Chris Evans	Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	1	16 (4x4)	4 (4x1)	TBC	Trust Operations Board
145	Simon Constable	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	3	15 (5x3)	8 (4x2)	TBC	Trust Operations Board
1205	Phill James	FAILURE TO send accurate continuity of care information medication and / or allergies information from the Lorenzo EPR to external stakeholder. E.g. GPs CAUSED BY errors within the Lorenzo EPR electronic discharge summary code and/or configuration, i.e. the DXC PAN summarises the issue as: *"Discharge medications documented in Lorenzo do not match those showing on the discharge summary – this results in some medications being duplicated, missing completely or being incorrectly cited into appropriate sections." The medications section of the Discharge summary is split into the four heading of "Continued", "Stopped", "Changed" and "UnChanged" but the Trust response has deduced that medications are also appearing in*	1	15 (4x5)	5 (1x5)	TBC	Quality Assurance Committee

Board Assurance Framework

		the allergies section of the discharge summary. RESULTING IN patient harm due to errors and/or omissions within the medications and allergies information that is transmitted from the WHH FT Lorenzo EPR to its external stakeholders for approximately 4% of all patient discharges for the affected period. *** There is currently no evidence of patient harm but there is evidence of potential for harm to result ***					

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

Board Assurance Framework

Risk ID:	1135	Executive Lead:	Chris Evans	Rating	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision.			Initial:	25 (5x5)
				Current:	25 (5x5)
				Target:	10 (5x2)

Assurance Details:

- Daily Tactical/Recovery Meetings taking place – Moved to weekly
- Daily Executive Strategic meeting – Twice Weekly
- 4 x daily meeting with Senior Nursing Staff
- Identified at risk staffing groups within each CBU
- Sickness log maintained daily
- ED and ITU removed from site rota
- Removed Clinical Staff from Senior Manager on Call (SMOC) rota
- Enhanced SMOC rota established
- Created additional OOH rota
- Set up of central staffing command centre
- Fit testing training programme daily for all relevant staff
- PPE training booklets now on all Wards
- Enhanced Occupational Health service
- Providing in house Mental Health service
- Change of employee terms and conditions to allow more flexible working
- Centralised Cheshire & Merseyside procurement in place led by the Trust's Director of Finance & CD
- Regional mutual aid arrangements in place
- Recovery Structure established
- Approval process established for all service changes during COVID-19 Pandemic
- The Trust is following national guidance in relation to all constitutional standards
- Operating Framework for Urgent & Planned services during COVID-19 received
- Review of all urgent activity on Trust Waiting Lists undertaken in accordance with national guidance and clinical review
- Emergency and Trauma theatres maintained throughout pandemic
- Cancer Theatre re-established on 5th May 2020
- Action plan in place for delivery of Emergency Care following guidance issued by RCHEM. This is managed by the Recovery Board
- Recovery Operational Group meet daily – managing planned and unplanned care
- CMTC re-opened 29th June 2020

	Initial	Current	Target
Rating	25	25	10

Assurance Gaps:

- Staffing issues - staff sickness, staff self-isolating, staff at risk groups not permitted in clinical areas
- Financial - unable to deliver financial position and increased threat of fraud
- Operational issues - potential for insufficient levels of oxygen, shortage of PPE, limited capacity in the mortuary
- Fit testing failure of some staff due to lack of appropriate PPE
- Shortage of supply of certain pieces of PPE
- Supply chain problem with PPE
- Adherence to constitutional standards adversely affected due to pandemic.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Produce Action Plan for compliance against Operating Framework for Urgent & Planned services during COVID-19	Undertake gap analysis and develop action plan	Complete Action plan	Chris Evans / Dan Moore	30/06/2020	01/06/2020

Board Assurance Framework

Risk ID:	1124	Executive Lead:	Salmon-Jamieson, Kimberley	Rating	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff			Initial:	25 (5x5)
				Current:	25 (5x5)
				Target:	8 (4x2)
Assurance Details:	Centralised PPE store in place , giving out in accordance with the Control Centre approval (number of stock), supplies are controlling, in and out of hours process in place, daily monitoring process and escalation to the NSDR, extended opening hours in procurement and 7 day service, issuing PPE material management services i.e topping up areas, etc Centralised Cheshire & Merseyside mutual aid plan in place led by the Trust's Director of Finance & Deputy CEO Regional mutual aid arrangements in place Training and education of staff, Fit Testing programme in place for FFP3/FFP2 respirators, risk assessment and contingency plan in place if recommended PPE stock is not available. Where services are re-started, recovery forms and PPE burn rate to be documented on appropriate proformas with monitoring via the Elective Planning Meeting, with escalation to the Recovery, Tactical and Strategic Groups. No staff member to work without appropriate PPE. Supplies are seeking alternative supplies of PPE with a safety check that essential standards are met before purchasing any items.			25 · 20 · 25 · 8 INITIAL · CURRENT · TARGET	
Assurance Gaps:	Current shortage of specific PPE equipment e.g. small Solway FFP3 respirators and expected shortage of 8833 respirators, Repeated Fit Testing will be required as different makes/models of FFP3 respirators are supplied – with potential to disrupt service provision. Increased demand for PPE as recovery plans will increase demand, service provision may be affected if PPE is not available. Balance of usage required to ensure recovery plans do not impact on PPE for care of patients with Covid-19. Supply of gowns with adequate fluid repellency level Availability of fluid resistant surgical masks and visors Current shortage in gowns which may lead to inadequate protection Fragile and uncertainty of future PPE availability 8833 respirators are no longer available				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Provide sufficient PPE for all staff.	PPE	Sourcing alternative suppliers, escalation into NSDR (National Supply Disruption Service), establish procurement networking, interhospital cel, looking at alternative PPE, etc	McKay, Lesley	30/08/2020	

Board Assurance Framework

Risk ID:	115	Executive Lead:	Salmon-Jamieson, Kimberley	Rating	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.			Initial:	20 (5x4)
				Current:	20 (5x4)
				Target:	12 (4x3)
Assurance Details:	• Monthly workforce information produced via workforce dashboard. Information is reviewed and monitored at the Workforce Group Chaired by the Chief Nurse • Robust staffing escalation process across WHH to manage staffing daily – This has become the forum for responsive staff management during the COVID 19 pandemic • Lead Nurse identified daily to co-ordinate staffing supported by a senior nurse rota 7 days a week 8am – 8pm which commenced in April 2020 • 4 hourly update shared as part of Gold Command template • Wards & Departments use E-Roster and Safecare data to support staffing ratios • New models of care currently being implemented in Maternity in line with BR+. Business case being developed as there will be a requirement for a staffing uplift • Recruitment / media plan produced and recruitment campaign ongoing • Rolling advert for RN's continue with 12 nurses accepted an offer of employment at WHH in July 2020. Students who were redeployed to the Trust during the COVID 19 pandemic have been offered substantive posts • A business case has been developed for recruitment of international nurses which is due to be presented at the executive meeting in July 2020. • We have recruited 73 HCAs since February 2020 with rolling HCA recruitment programme in place • National staffing guidance has been utilised to inform new staffing models <u>Recruitment Assurances</u> • Rolling advert for B5 Nurses • 12 month recruitment plan in place taking into consideration social distancing restrictions • Developing WHH recruitment campaign • Career advice events in local schools and colleges • Production of monthly and bi-annual staffing reports received by the Trust Board • 73 HCAs recruited from February 2020 to July 2020 currently undergoing pre-employment checks. • Students who have re deployed to the Trust have been offered substantive posts <u>Retention Assurances</u> • Workforce Dashboard reporting monthly in relation to leavers • WHH Nursing retention plan to be refreshed for 2020 • Improvement in nursing retention by 2.44% (Nov 2018 – Nov 2019) • Burdett Nursing Trust award winners • Highly commended for nursing retention data provision • 'Transfer Window' implemented allowing staff to move to other specialties without having to apply for role <u>COVID-19 Assurances</u> • Implemented a graduated and planned nurse staffing response to the COVID-19 Pandemic. • Revised staffing models for the expansion of critical care capacity, acute and supportive respiratory wards • Strengthened daily staffing meetings chaired by the Associate Chief Nurse for senior oversight • Workforce expansion initiative in place, including the development of a redeployment Hub, local and national call to arms and student deployment • Increased use of temporary staffing through NHSP and off framework agencies – close monitoring arrangements in place				Chart: INITIAL 20, CURRENT 20, TARGET 12	

Board Assurance Framework

Assurance Gaps:	Increase staffing pressure due to ongoing use of temporary winter ward for which there is no funded establishment Recruitment Gaps • 104 RN Vacancies • 84 B2 Vacancies Retention Gaps • 13.59% nursing turnover				
Recommendation	**Action Description**	**Actions Required**	**Responsible Officer**	**Deadline Date**	**Completion Date**
Business case for international nurse recruitment in place	Business case for international nurse recruitment	Present business case to Executive Team	Browning, Rachael	23/07/2020	

Board Assurance Framework

Risk ID:	TBC	Executive Lead:	Chris Evans	Rating	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to deliver the capacity required caused by the ongoing 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:	Radiology • Capacity is reduced across Radiology by 30-40%. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Department has been supported by the Trust through £380K recurrent funding to recruit additional staff. Advert out 11th June 2020. Recruiting 4 Radiographers, 2 Sonographers, 2 Healthcare Assistants. • Additional staff will support additional capacity through extended working days across all scanners – currently unable to achieve this due to Covid-19 demands. • Additional capacity for CT and MRI (70 exams per week total) has been secured at Spire Cheshire under National Contract – due to finish end Aug 2020. • Additional CT capacity (15 exams per week) will be provided mid-July 2020 via use of mobile CT scanner supported by the National Imaging Team Covid-19 Response initiative. This is sited at Whiston Hospital – WHH patient will have to travel to this site. • All outstanding requests are clinically reviewed by Senior Consultant Radiologists as per local SOP. Exams are deferred in line with clinical priority. Cancer and Urgent patients are being imaged as per pre-Covid-19 as per national guidance. • Those deferred patients are sent a letter informing of delay, and to contact their Doctor if any concern. The referrer of delayed patients are also sent a letter informing of delay, but this referrer letter includes a direct telephone number to the Senior Radiology Consultants, and also an email address should there be a concern with delaying. Any exams that are highlighted from referrers as not suitable for delay are appointed on the next available appointment. • This delay process has been discussed via Medical Cabinet and agreed as most appropriate process. • This clinical review and delay process is ongoing daily. • Current building works to increase the footprint of the CT department will bring increased patient areas. This will allow addition Outpatients to be imaged at Warrington where currently due to lack of waiting areas, the service is almost 100% Inpatient based. This completion if works will increase capacity and flexibility for CT. Unplanned care • The emergency department has been reconfigured to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics • Minor injuries is provided in an area in close proximity but separate to the main emergency department • 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. • NHS 111 First pilot to start by the end of August2020 to reduce attendances to the emergency department and to				

Board Assurance Framework

<table>
<tr><td></td><td>support the planning of activity in a more streamlined way to reduce overcrowding and risk of nosocomial infection.
Planned Care
• All elective patients have been clinically reviewed and categorised in line with national guidance.
• Suspected cancer, cancer and clinically urgent patients are treated as a priority.
• Theatre capacity has been reviewed and additional capacity is now available with the de-escalation of the theatre PODs
• The Halton site is being developed as a covid light site and will be run as an Elective Centre.
• Two theatre PODs have been retained in the event they are required and plans are in place to utilise if required.
• Elective Surgery Standard Operating Procedure (SOP) in place
• Capacity identified and being utilised at spire Healthcare
• An elective meeting takes place three times a week to plan the recovery of individual services
• Clean/green pathways have been developed and category 2 patients are being treated on B18 and at Halton Elective Centre
• 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</td><td></td></tr>
<tr><td>Assurance Gaps:</td><td colspan="2">Radiology
1. Harm may be caused due to the incompleteness of clinical information on a referral. This may also be compounded by the referrer incorrectly entering the wrong priority code on the referral.
• It is thought that the letter to the referrer will highlight the exam has been delayed and that the provision of a direct link to the Radiology Consultant team by phone/email will allow these cases to be expedited where appropriate.
2. Harm may be caused by the delay of a routine examination where there is an unlikley serious pathological finding present.
• This risk is present in all routine exmas as the waiting time for routine diagnostic imaging is up to 6 weeks as per national targets. This risk is hightened due to Covid-19 and the reduced capacity at present. It is thought the letter to the patient advising to contact their Doctor with any concern will reduce this risk.
Unplanned care
1. Estates work is required to complete the segregation of paediatric patients in the emergency department.
• This is being progressed with the support of the estates and capital planning team.
2. Expansion of the emergency department is required to ensure any increase in demand can be accomodated in line with RCEM guidance
• Bid submitted to support capital works for ED plaza.
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
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</td></tr>
</table>

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
CT Department building works	Completion of building works increase CT Footprint	Complete Building work	Hilary Stennings	30/09/2020	
Paediatric patient segregation in ED	Review options to segregate paediatric patients in ED	Assess scope of work required	Sharon Kilkenny	31/08/2020	

Board Assurance Framework

Ward Reconfiguration	Trust-wide ward configuration	Implement trust-wide reconfiguration plan	Sharon Kilkenny	31/08/2020	
PACU Business Case	Develop business case for a Post Anaesthetic Care Unti	Develop business case	Val Doyle	31/08/2020	

Board Assurance Framework

Risk ID:	134	Executive Lead:	McGee, Andrea
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.		
Risk Description:	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.		
Assurance Details:	•Core financial policies controls in place across the Trust •Revised governance structure within the Trust to enable strengthened accountability •Finance and Sustainability Committee (FSC) established overseeing financial planning •Regular financial monitoring with NHSI •Regular review at Executive team meeting and development sessions •Annual plan development process •Performance monitoring in QPS meeting •Block contract approach for all trusts for months 1 -4 with income matched to expenditure and similar anticipated for the whole year due to the impact of Covid19 with additional controls and constraints •Work with the Commissioners on QIPP and CIP schemes through the Collaborative and Sustainability Group to ensure the schemes have a positive impact on sustainability across the whole health economy •Corporate Trustee Charities Commission Checklist, reporting bi-annually through Board •Monitoring of charitable funds income, assessment of return on investment and controls on overhead ratios via quarterly financial reports •Regular updates to Executive Team, FSC and Trust Board - Financial Resources Group (FRG)that reports to FSC • Workshop undertaken with - Exec, CBU, Corporate to review of 2020/21 cost pressures • Achieved 2019/20 Control Total. •Trust Board approval of Capital Plan including the requirement for PDC as part of the final programme •On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust. •Positive Value for Money conclusion & unqualified audit opinion •Head of Internal Audit Opinion of Significant Assurance COVID-19 • Governance process in place to ensure all additional costs are being approved and monitored. • Reporting to NHSE/I • Regular attendance to regional and national conference calls • Attend Recovery Board to monitor financial impact of the changes relating to Covid19 Recovery plans – identifying revenue and capital expenditure • Review of latest guidance NHSE/I established block payments for the first 4 months of 2020/21 to ensure no impact of loss of elective activity • Accessed additional cash to pay outstanding creditors £16m paid in April 2020 • Achieved 95% BPPC June 2020 • Circulate latest guidance from MIAA Counter Fraud team • Ensure governance and processes in place including checks in place for all expenditure in particular procurement, contracts,		

Rating	
Initial:	20 (5x4)
Current:	20 (5x4)
Target:	10 (5x2)

Board Assurance Framework

	payroll and HR. • Highlighted the different methods of fraud/ scam in operation to all staff and share it as widely through Trust • Weekly update to Strategic Executive Oversight Group in relation to the cost impact of COVID-19 – Monthly from June 2020 • Receiving Charitable donations that will support sustainability of Trust Charity • Submitted COVID-19 capital bids to NHSE/I & Hospital Cell to support Business as Usual & Recovery plans • Monthly Report to F&SC on COVID Pay Costs	
Assurance Gaps:	• Inability to develop a strategic plan to deliver a break even position over the next 5 to 10 years • Risk of under delivery of CIP due to impact of Covid19 and insufficient schemes identified to deliver the full program and the organisational ability to translate improvement work into financial improvement. • Non-recurrent CIP presents a risk to in-year and future year financial position. – CIP is currently paused for the first 4 months of the financial year as per national guidance • Failure to fully comply with emerging national employment litigation resulting in additional pay costs or the trust receiving potential claims. • Medical Staffing pressures identified at budget settings have not all been addressed putting pressure on the 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. • Hospital Infrastructure Programme (HIP) announcement. WHH not included in with phase 1 or phase 2 funding allocation.. • Submitted 5 Year Plan on 2nd March, jointly with Warrington & Halton CCGs & Bridgewater Community Healthcare NHS FT with system gap of £26.5m COVID-19 • Increased threat of fraud during COVID-19 global pandemic • Unclear on financial envelope to support COVID-19 capital needs – awaiting further notification ahead of Cheshire & Merseyside prioritisation process • Awaiting further information re: Financial regime post July 2020	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Request Capital Loan	Loan application to be submitted for Business Critical Schemes	Submit capital loan request to NHSE/I	Andrea McGee	30/04/2020	Process has changed and new guidance has not yet been released
Submit requested Workforce & CIP information to NW Intensive Support Director	Cheshire and Merseyside Health & Care Partnership in receipt of Tier 1 Intensive Support – Information requested by NHSE/I on workforce & CIP	Submit requested Workforce & CIP information to NW Intensive Support Director	Andrea McGee	30/03/2020	Paused
Submit prioritised COVID-19 Capital schemes to NHSE/I & Hospital Cell for approval	Prepare proposal for COVID-19 Capital Schemes	Submit proposal to NHSE/I	Andrea McGee	30/06/2020	30/06/2020

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:	• A COVID-19 nursing advice line has been created, to provide a range of advice and guidance to the workforce. • An OH call centre has been created, which enables all calls to be answered and triaged by a team of administrators. • The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff) • Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical. • An enhanced wellbeing offer has been developed, linked to learning from Wuhan, Italy and the British Psychological Society. • A specialist extranet page has been developed which includes all national wellbeing offers, and links to discounts for our NHS staff during this period of time. • Mental health wellbeing drop in sessions have been introduced across both Warrington and Halton sites, with a specific wellbeing email address created for any enquiries to the wellbeing hub. • Facilitated conversations are available to staff working on COVID-19 wards. • Face to face counselling on-site. • Telephone counselling. • Alternative therapies such as relaxation therapy. • A Workforce Welfare Hub has been established by the Director of Strategy to support the practical needs of our workforce. • Additional support put in place for Black, Asian and Minority Ethnic staff including a specific risk assessment • Guidance on risk assessments for various groups of staff has been issued to managers with clear expectation on completion. • Staff events have been stood down to support socially distancing in work. • Additional groups of staff have been brought into the organisation, including: Medical Students Nursing Students AHP Students Medical 'Returners' Nursing 'Returners' AHP 'Returners' • Following national guidance, amendments have been made to the pre-employment check process to support speedier recruitment • The Workforce Information Hub has supported the 'real time' reporting of absence, to enable a clear picture of current staffing. • A Temporary Workforce Redeployment Hub has been established to support staffing levels by identifying staff who are available for redeployment and match them with demand. • Retirement Policy has been updated to allow a shorter break (24 hours) in service. • National annual leave changes mean that staff can carry forward any untaken annual leave above 20 days into the next leave year. In addition, a local scheme has been introduced to allow substantive staff to sell annual leave back to the Trust during the period 26th March 2020 to 30th June 2020. • Flat rate overtime has been introduced for staff in band 8A and above. • All additional hours and bank shifts worked by medical staff between 7th April 2020 and 31st May 2020, will be paid at the enhanced rates. This arrangement was extended until 9 June 2020 to review the scheme and consider whether this should			INITIAL 20 — CURRENT 20 — TARGET 8	

Board Assurance Framework

	continue – decision taken by Strategic Oversight Group to revert back to Pre-Covid Enhanced and Standard rates of pay. • A plan is in place to support workforce recovery including health, wellbeing, leadership, teams, HR and resourcing. • All staff who are shielding are have individual reviews with line managers, supported by HR, to discuss impact on role and support to work from home. • Partnership working is in place with Cheshire Fire and Rescue to utilise their staff members available for redeployment. • Antibody testing for staff is now in place. Approximately 3440 have been tested as at 15.06.2020. • Pilot of testing for asymptomatic staff complete. SOP signed off via Tactical Meeting. • Process in place for escalation of any potential local 'hot spots' of COVID-19 in teams on a weekly basis to Infection, Prevention and Control and Microbiology Teams • Central log in HR Department to capture all sheilding staff – process in place for on-going updates • Electronic system is in place to support the roll out of a new COVID-19 Workforce Risk Assessment Tool in line with Risk Reduction Framework • Regular reporting on compliance with risk assessment requirements is in place • Regular training on COVID-19 Workforce Risk Assessment is in place	
Assurance Gaps:		

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

<table>
<tr><td>Risk ID:</td><td>1114</td><td>Executive Lead:</td><td>James, Phill</td><td colspan="2" rowspan="2">Rating</td></tr>
<tr><td>Strategic Objective:</td><td colspan="3">Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.</td></tr>
<tr><td rowspan="3">Risk Description:</td><td colspan="3" rowspan="3">FAILURE TO provide essential, optimised digital services in a timely manner in line with best practice governance and security policies,
CAUSED BY increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber attack,
RESULTING IN poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statatory obligations (e.g. Civil Contigency measures) and subsequent reputational damage.</td><td>Initial:</td><td>20 (5x4)</td></tr>
<tr><td>Current:</td><td>16 (4x4)</td></tr>
<tr><td>Target:</td><td>8 (2x4)</td></tr>
<tr><td>Assurance Details:</td><td colspan="3">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 Trust Operations Board. The Quality Assurance Committee report provides assurance against all key security measures (i.e. Risks / GDPR / Data Security & Protection Toolkit / Cyber Essentials Plus).
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).
The Information Governance And Corporate Records Sub-Committee records assurances regarding Digital risks and incident management data.
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 Board
Secured annual capital investment to increase Digital skills and capacity.
Approval of a 7 Year Capital Profiling based upon asset replacement cycle and strategic roadmap (to deliver the approved Digital Strategy (January 2020)) plus the approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee.</td><td colspan="2">20 16 8
INITIAL CURRENT TARGET</td></tr>
<tr><td>Assurance Gaps:</td><td colspan="5">Gaps In Assurance:
Annual external penetration testing out of date (27/03/20). Due to Covid-19 pandemic the CIO confirms to delay testing until autumn, this is inline with other Trusts in the C&M Region. No significant changes top our infrastructure has been made since the last test, e.g. change of firewall. The DSPT will be updated with this decision.
Gaps In Controls:
Approval of a 7 Year Capital Profiling based upon asset replacement cycle and strategic roadmap (to deliver the approved Digital Strategy (January 2020)) plus the approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee.
Implementation of an effective workforce plan via an approved structure investment business case that delivers fit for purpose levels of skills, resilience and capacity.</td></tr>
</table>

Board Assurance Framework

	• **Implementation and normalising of cyber measures** for contributing to the mandated levels of compliance with DSPT, GDPR and Cyber Essentials Plus and the EU NIS directive. • **Normalising of staff behaviours** to protect data evidenced via reduced IG incident report levels. • **Top down approach to cyber leadership** via evidence of completion of accredited Board Level National Cyber Security training coupled with annual mandatory Data Security Training. • Ability to mitigate cyber confiuration of **nationally provided systems** (e.g. ESR) and **non-Microsoft devices** (that meet a clinical need). • Deployment of NHS Digital Secure Boundary for the Internet connection

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Standardised policies and procedures across the C&M STP using the core documentation from standard of ISO 27001 and the DSPT	Standardise policies and procedures across the C&M STP	• MIAA to map the basic standards to form the minimum and gold standard of documentation for Cyber. MIAA and WHHT to create the documentation templates from the mapping: • ISO 27001 (ISMS) • Data Security & Protection Toolkit (DSPT) • Information Security Standard (ISF) • Center for Internet Security (CIS) • Information Systems Audit and Control Association (ISACA) • National Institute of Standards and Technology (NIST) • Cyber Security Body Of Knowledge (CyBOK) MIAA current completing the basic mapping.	Deacon, Stephen	31/10/2020	
Act on recommendations made in the Cyber essentials report to ensure improved cyber security. [Delivers: Best Practice]	Implement the recommendations made in the Cyber essentials report and DSPT to ensure improved cyber security. *NHS Digital have commented they are looking at whether to continue with Cyber Essentials+ revision (relies upon NHS Digital negotiations).*	• Enhanced Firewall controls on Trust network • Fully documented Firewall infrastructure (31/10/20 - Phil Smith) • • Enforced 90 Day System Password refresh (30/11/20 - Joe Garnett) • • Regular vulnerability scans of internal network via IT Health Assurance Dashboard (30/04/20 - Stephen Deacon) (COMPLETE)	Deacon, Stephen	31/11/2020	
Move medical devices into VLAN bubble. This will involve participation of multiple 3rd parties and internal WHH staff. [Delivers: Best Practice]	Add medical devices to the Medical VLAN bubble	• A better solution to isolate the medical devices have been devised. It's the same as the "VLAN bubble" in that it's a firewalled VLAN, its more secure as devices within a VLAN are not	Deacon, Stephen	29/01/2021	

Board Assurance Framework

		limited in communicating with each other, keeping all PACs devices separate is better than isolating them all together with other medical devices.			
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system). [Delivers: Best Practice]	Migrate all 2003 and 2008 servers to 2016.	Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to Windows Server 2016 • Extend Support for 2008 (a part of the N365 offer) [Status May 20] Total Completed %Complete 2003 Servers 21 11 52.4% 2008 Servers 56 25 44.6% All simple migrations have been completed by IT Services. The remaining servers are complex migrations and require more analysis to look at licenses, resources and impact on other systems. A business case may be needed for any associated costs.	Deacon, Stephen	30/06/2020	
To upgrade all windows 7 to Windows 10 before end of March 2020 [Delivers: Best Practice]	To upgrade all windows 7 to Windows 10 before end of March 2020	Deployment and Desktop Team to go out and reimage the devices around the Trust. [99% migrated – June 2020] 15 outstanding devices to be migrated: Department: Outstanding Pathology 2 (Issues with the software – a mitigation plan will be needed by IT Seniors) Audiology 5 (Covid-19 staff shielding) Catering 1 (Waiting on MenuMark system upgrade) Ophthalmology 4 (Waiting on 3rd party post Covid-19) Theatres 2 (Covid-19 hotspot, unable to access)	Deacon, Stephen	31/10/2020	

Board Assurance Framework

		ED 1 (Covid-19 hotspot, unable to access) IT Services have completed the migration as far as they can until the issues above can be resolved. CIO/SIRO has been made aware and is happy with the current risk. The Virtual Desktops (VDI) Windows 7 image migration to the Windows 10 image is set to be complete by the end of June 20			
As part of Cyber Essentials+ all unsupported software should be updated or isolated from internet based networks. Office 2010 will need upgrading to the latest version of Office for all endpoint devices on the WHHT network. [Delivers: Best Practice]	Migrate from Office 2010	• •Secure funding and take advantage of the NHS Digital's N365 discount licensing offer (May 20) • Submit the Trust's licensing requirement (June 20) • Migrate to N365 using remote installing software SCCM (Sept 20) [£1.7 million investment currently identified within Trust capital plan for 20/21]	Deacon, Stephen	30/09/2020	
Deliver fit for purpose Lorenzo EPR Performance and agility of changes to deliver the paperless strategy. [Delivers: Optimisation / Timeliness]	Work with supplier to assure EPR performance whilst enhancing Digital capability (people and finance).	• Work with EPR supplier to safely migrate Lorenzo to the modern cloud solution. • Implement staffing structure enhancements within financial opportunities (i.e. capitalisation of roles).	Gardner, Matthew	30/09/2020	
To promote the risks of phishing, NHS digital will perform simulated phishing campaign targeted at the users of the Trust. The information will be collated and discussed at the Information Governance and Corporate Records Sub-committee	Perform simulated phishing campaign	NHS Digital to perform the simulated phishing campaign and report back to the Trust of the results. [NHS Digital have delayed the simulated phishing exercises to all Trusts due to deployment of staff due to increased COVID-19 phishing activity. NHS Digital will be in touch once ready to progress. MA to chases NHS Digital for an update]	Deacon, Stephen	31/07/2020	

Board Assurance Framework

Risk ID:	224	Executive Lead:	Evans, Chris	Rating	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to trust reputation, financial impact and below expected Patient experience.			Initial:	16 (4x4)
				Current:	16 (4x4)
				Target:	8 (4x2)
Assurance Details:	Regular Trust Wide Capacity meetingsled by the Senior Site Manager for the day Systemwide relationships including social care, community, mental health and CCGs Discharge Lounge/Patient Flow Team Red to Green - Discharge Planning ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing Controller Chloe Care 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 Full ED business case approved from Q4 18/19 re: vision for ED Footprint creating assessment capacity. (approved substantively for Ambulatory Care Unit) System actions agreed supporting the Winter Plan Warrington Together Board have asked for focussed work to take forward outputs from the Venn Work 1. Further development of Rapid Response to avoid admission 2. Increase IMC 3. Increase IMC at home Regular monitored at the Mid Mersey A&E Board Long Length of Stay Collaborative in association with ECIST / NHSI. Bespoke approach for the Trust in embedding and sustaining LLoS review. To commence May 19 through until October 19. Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. Co-location of teams approved in April 19. This will support harmonisation of pathways and increase integrated working between health and social care. Co-location of teams to take place in June 2019 (Kendrick Wing) Urgent Care Improvement Committee to commence form May/June 2019 focussing on 5 priorities: 1. CQC Actions 2. Acute Medicine 3. Assessment Capacity/Environment 4. Decision to admit 5. Collective decision making The Committee will report to the Quality Assurance Committee and Exec Team New ED 'at a glance' dashboard gone live – supports organisational visibility and proactive response from specialties. Participated as a pilot site for recording of Same Day Emergency Care (SDEC) in association with NHSi & NHSE Urgent Care Improvement Committee High Level Briefing received at Quality Assurance Committee. Pilot of a co-located medical and surgical assessment unit taking place between 3 Sept – 10 Sept 2019. A review will then take place to inform the long term strategy for an Assessment Plaza. Co-located medical & surgical assessment unit to launch on 1st Dec 2019. Subject to consultation Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput – reports monitored via Patient Flow Sub-Committee and Trust Operations Board 8 IMC live from 27th September 2019 Integrated discharge Team now in place Urgent Care Improvement Committee – 2 regulatory breach complete and 33/35 actions complete. The Remaining action to be			INITIAL: 16, CURRENT: 16, TARGET: 8	

Board Assurance Framework

	completed by 31st December 2019 CAU Business Case approved by Executives on 31st October 2019 with a plan to implement from 9th December 2019 Winter plan developed with system support 10 additional beds on B3 supported by NHSE/I Funding received for K25 beds and to support protecting GPAU / CAU Combined Assessment Unit launched 16th December 2019 – 24/7 from 5th January 2020 U&EC Improvement Committee stepped down. All actions complete with 9 ongoing issues monitored at Moving to Outstanding Capital funding approved for additional 18 beds within the clinical environment to be completed by end of March 2020 2020/21 Operational Plan requesting that Trust work towards reducing its occupancy level to below 92%. Business case being developed to support the plan. The Trust's ambition to reduce super stranded by 40% is on track to be delivered by the end of March 2020 COVID-19 related Assurances ED Business Continuity Plan evoked Super Stranded patients reduced to c50 Reduced occupancy levels in all inpatient wards Reduction in ED attendances Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients ED performance continues to improve despite COVID-19 related pressures ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised. Respiratory Ambulatory Care Facility agreed by CCG ED Performance – April 2020 92.52%, May 2020 93.36%, June 92.16% Royal College Emergency Medicine Resetting ED Care guidance received and initial action plan produced. Development of new combined assessment unit (plaza) progressed and forms part of capital planning with plans submitted to Hospital Cell and NHSE/I Collaborative working with Orthopaedics in management ok MSK Minor injuries via Minor's Stream Reinstated CAU 24/7 ED Ambulatory Care operating out of CAU Upgrade to Minor's resulting in Oxygen points in all cubicles Business case to increase staffing in Radiology approved Non-Elective flow c80% of normal attendances Bed reconfiguration plan to support appropriate capacity for current type of activity attending the Trust post peak Covid-19 levels Capital Bid submitted to the region for Assessment plaza	
Assurance Gaps:	Fully embedding actions associated with system wide capacity & demand review undertaken by Venn Consulting – 3 key actions being progressed for Winter 2019 – 8 IMC Beds agreed via IBCF, Rapid Response Service and increased home reablement capacity (c 20 beds worth of capacity total) ED footprint with a view of right sizing for the future based on demand trends – review taking place in Sept 19 Staffing pressure created as a direct result of COVID-19 Global pandemic.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Risk ID:	1207	Executive Lead:	Michelle Cloney, Chief People Officer	Rating	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.			Initial: Current: Target:	16 (4 x 4) 16 (4 x 4) 8 (2 x 4)
Assurance Details:	The development of a Workplace Risk Assessment form (NHSI/E state, using online risk assessments to achieve better adoption) and accompanying database will enable the Trust to quickly and smartly deploy the workplace risk assessments and monitor completion and quality. Trust Board and NHSI/E will seek assurance from the completion of the following metrics: • Number of staff risk-assessed and percentage of whole workplace • Number of black, Asian and minority ethnic (BAME) staff risk assessments completed, and percentage of total risk assessments completed and of whole workplace • Percentage of staff risk-assessed by staff group • Additional mitigation over and above the individual risk assessments in settings where infection rates are highest Having already deployed a Workplace Risk Assessment for BAME staff, both managers and co-ordinators have gained experience in the process to enable improvements to be made. Nominated accountable managers will take the lead for the completion of the Workplace Risk Assessments in their area, and will start ensuring their line managers are booked on the available training to ensure the Trust take a competent and consistent approach to completing the Workplace Risk Assessments. As recommended by NHSI/E the Trust has a clear direction that this is an organisational priority by the leadership team, including CEO ownership and making it a standing item at board meetings.			INITIAL 16, CURRENT 16, TARGET 8	
Assurance Gaps:	The required quick turnaround requires enagement at all levels of the organisation. The Trust requires all staff to recongnise the imprortance of the Workplace Risk Assessment and therefore make accessing the training and support available a priotiy. To ensure the Workforce Risk Assessments are completed in a timely manner and to a high standard. Due to the nature of COVID-19 our knowledge of it is changing constantly; therefore it is a challenge to keep up-to-date with the guidance and then react appropriately through changes in our processes				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop a communication plan that reaches all levels of the organisation.	A communication plan must ensure the following message is clear, that it is our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	• Develop a communication plan	Rebecca Patel, Head of Employee Engagement and Wellbeing	31/07/2020	
Develop and promote training and support available to managers	Develop a training package for managers to book on and promote the support that	• Training sessions to be developed and tested	Ruth Heggie, Interim Head of Learning and	31/07/2020	

Board Assurance Framework

completing Workplace Risk Assessments	is available thereafter.	• Training dates to be published • Ongoing support that is available to be published	Organisational Development		
Contact all accountable managers outlining their responsibilities	Send a letter informing the accountable managers of their responsibilities. Ensure they are aware both their managers are required to be trained to complete the Workplace Risk Assessments and their staff are aware the self-declaration process	• Issue a letter to the accountable managers of their responsibilities. • Follow up the letter to ensure their line managers have been booked on the training course. • Develop further communications outlining the process for all staff to self-declare, promoting the link to the online Workplace Risk Assessment	Rebecca Patel, Head of Employee Engagement and Wellbeing	31/07/2020	
Develop metrics to enable both Trust Board and NHSI/E to have assurance on the completion on the Workplace Risk Assessments	Ensure the Trust can report on the following metrics : • Number of staff risk-assessed and percentage of whole workplace • Number of black, Asian and minority ethnic (BAME) staff risk assessments completed, and percentage of total risk assessments completed and of whole workplace • Percentage of staff risk-assessed by staff group • Additional mitigation over and above the individual risk assessments in settings where infection rates are highest Ensure the Trust are assured on the metrics through a robust governance process reporting the metrics too: Board, Staff Council, Staff Networks, JNCC, JLNCC, SPC, SEOG	• Develop the Workplace Risk Assessment tool to ensure the Trust are able to report on the content of the Workplace Risk Assessments, linking it to staff lists to develop compliance percentages.	Carl Roberts, Head of Workplace Systems and Intelligence	31/07/2020	

Board Assurance Framework

Risk ID:	125	Executive Lead:	Evans, Chris	Rating	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide a safe, secure, fit for purpose hospitals and environment caused by the age and condition of the WHH estate and limited availble resource resulting in a risk to meeting compliance targets, staff and patient safety, increased backlog costs, increased critical infrastructure risk and increased revenue and capital spend.			Initial:	20 (5x4)
				Current:	16 (4x4)
				Target:	4 (4x1)
Assurance Details:	Controls: 2018 C&M H&CP Estates strategy – updated annually Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out Capital Planning Group and associated capital funding allocation process Planned Maintenance Program Reactive maintenance regime Annual asbestos survey - asbestos management survey makes an assessment of the condition of any materials present and determine the likelihood of any fibres being released. Annual PLACE assessments Assurance: External estates compliance audit carried out in November 2019 which has in formed a number of remedial actions to improve compliance across the estate Monthly Estates compliance audit Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers Fire Safety Group – monitors fire safety issues across the trust and provides assurance to Cheshire fire and rescue service on Fire Safety Management PLACE assessment action plan and monitoring - Capital Planning Group – determine how the trust capital is spent Trust Ops Board Use of resources group – monitors how cost effective and value for money estates and facilities are in relation to a number of national and regional benchmarks New hospitals for Warrington and Halton groups – providing a platform to address the critical infrastructure and backlog risk 20-21 capital programme approved which includes £2.27m to address backlog maintenance			20 / 16 / 4 INITIAL CURRENT TARGET	
Assurance Gaps:	Capital funding 19-20 (£ of requested schemes : £ of actual funding) Estates staffing - reduced staffing numbers since 2011 has impacted on ability to carry out elements of essential maintenance Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome Cost pressures – unfunded elements of maintenance in I&E budget Use of Resources - benchmarking against backlog maintenance and critical infrastructure risk are below national medium Reduced estates compliance				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop and monitor action plan to address compliance	Action plan to address non compliance issues highlighted in report (Nov 2019)	Develop and monitor action plan to address compliance	Wardley, Darren	31/12/2020	

Board Assurance Framework

Risk ID:	145	Executive Lead:	Constable, Simon	Rating	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.			Initial: Current: Target:	20 (5x4) 15 (5x3) 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. We have developed an engagement strategy in partnership with our Governing Council We have established a community-wide newsletter Your Hospitals No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the C&M Health and Care Partnership plans. The Trust has developed effective clinical networking and integrated partnership arrangements. Some examples include: - The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. - Collaboration with Bridgewater - Council and CCG in both Warrington & Halton supportive of development of new hospitals. - Agreement of sustainability contract with Warrington CCG and subsequently Warringotn & HaltonSystem Finacial Recovery Plan - Collaboration with STHK - Regular GP engagement events held - Regular Strategy updates are provided to the Council of Governors - Clinical strategy wide engagement - Clinical Strategy approved by Trust Board - CBU specialty level strategies complete and incorporated in business plans. Currently being refreshed to account for impact of Covid - Successful in One Public Estate revenue funding bid for Halton - Initial talks held with Elective Care C&M Lead in relation to the suitability of Halton as a potential Elective Care Hub. Opportunity to accelerate elective hub as part of Covid recovery - Trust has met with Cheshire & Merseyside leads for Women's and Children's review to demonstrate strength of local Women's and Children's services and help inform outcomes of regional review. - NHSE and local Commissioners supportive of draft strategy for breast screening - Initial meeting for Cheshire & Merseyside respiratory review held. Trust presentation well received. - DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. The Trust has written to NHSP to seek support in raising the profile of our needs – NHSP have agreed to use the Trust as a case study in their national campaign - Positive meeting the Medical Director and Director of Strategy at Alderhey confirming their intention to work with the Trust to repatriate WHH patients - Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside. Currently options for further development do not include any option where WHH is a hub. All options proposed include an Essential Services Lab (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESL.			20 / 15 / 8 INITIAL CURRENT TARGET	

Board Assurance Framework

	Pathology OBC supported by the Trust Board - Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. - Director of Strategy invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington	
Assurance Gaps:	Organisational sovereignty and the need for individual Trusts, CCGs and others to meet performance targets at an organisational level have the potential to slow or block progress. Limitations of the size of the catchment area. Risk to Women's and Children's future provision due to Cheshire & Merseyside led review. Risk to securing capital funding to progress new hospitals	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Strengthen Women's & Children's Services	Establish Programme of Development	Develop & Complete Action Plan	Salmon-Jamieson, Kimberley	30/10/2020	
Progress plans for new hospitals to be best placed to secure funding when available	Develop SOCs and OBCs	Develop SOCs and OBCs	Lucy Gardner	SOCs – April 2020 OBCs - TBC	SOCs – March 2020

Board Assurance Framework

<table>
<tr><td>Risk ID:</td><td>1205 Executive Lead: Phill James, Chief Information Officer</td><td colspan="2" rowspan="2">Rating</td></tr>
<tr><td>Strategic Objective:</td><td>Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.</td></tr>
<tr><td rowspan="3">Risk Description:</td><td rowspan="3">FAILURE TO send accurate continuity of care information medication and / or allergies information from the Lorenzo EPR to external stakeholder. E.g. GPs

CAUSED BY errors within the Lorenzo EPR electronic discharge summary code and/or configuration, i.e. the DXC PAN summarises the issue as:
“Discharge medications documented in Lorenzo do not match those showing on the discharge summary – this results in some medications being duplicated, missing completely or being incorrectly cited into appropriate sections.” The medications section of the Discharge summary is split into the four heading of “Continued”, “Stopped”, “Changed” and “UnChanged” but the Trust response has deduced that medications are also appearing in the allergies section of the discharge summary.

RESULTING IN patient harm due to errors and/or omissions within the medications and allergies information that is transmitted from the WHH FT Lorenzo EPR to its external stakeholders for approximately 4% of all patient discharges for the affected period.

** There is currently no evidence of patient harm but there is evidence of potential for harm to result **</td><td>Initial:</td><td>20 (4x5)</td></tr>
<tr><td>Current:</td><td>15 (3x5)</td></tr>
<tr><td>Target:</td><td>5 (1x5)</td></tr>
<tr><td>Assurance Details:</td><td>Assurance:
• Receipt and review of updates to the DXC Product Alert Notice (in response to new data as their investigation progresses and intelligence improves);
• WHH FT has spoken with other Lorenzo Trusts to compare known information to inform the WHHFT response plan;
• Registration of a BAF risk for this issue, to ensure the Trust Board are sighted on the salient and able to provide constructive challenge.
Controls:
• Immediate removal of affected discharge summary sections;
• Manual review of all June 2020 and 1/3 of May 2020 discharge summary records;
• Issue of an urgent communication to the CCG to inform the GPs of the issue, our actions and our plan;
• Issuing of lists of all affected patients to GPs with a copy of the discharge prescription;
• Safe re-introduction of known good headers in medications section of discharge summary.</td><td colspan="2">20
15
5
INITIAL CURRENT TARGET</td></tr>
<tr><td>Assurance Gaps:</td><td colspan="3">Gaps In Assurance:
• Receipt of confirmation of harm / no harm from GPs of affected patients and follow on actions where necessary;
• Creation of a Datix incident to manage the clinical investigation of the impact of the fault;
• Identification and correction of root cause within the Lorenzo EPR;
• Proven identification of first date that the fault affected WHH Lorenzo ERP and subsequent manual review of all discharge summaries back to and including that date;
• Presence of affected discharge summaries within the EPR (inpatients and discharged patients)
• Confirmation that GPs have acted upon the alert and amended their records as required.

Gaps In Controls:
• Creation of a Datix incident to manage the clinical investigation of the impact of the fault;
• Manual review of 2/3 of May 2020 discharge summary records;
• Provision of copies of the discharge prescriptions to the GPs for the period during which no medication information is provided on the discharge summary plus corrected medication information where discharge summaries have been identified as incorrect.
• Issue, test and deployment of a proven resolution;
• De-risking of Lorenzo EPR releases via thorough WHHFT discharge summary tests;</td></tr>
</table>

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
		• Robust WHHFT PAN receipt, review and act process for all PANs.			
Investigate Ensure a thorough clinical impact assessment is undertaken and due process is applied.	Register a Datix incident and progress the resulting actions. *(also refer to PAN process recommendation below)*	• Register the clinical impact of the PAN details within a new Datix record; • Insert actions against team members.	Ellis Clarke Ellis Clarke	3rd July 2020 6th July 2020	
Investigate Ensure all affected records are identified. Communicate a list of encounters with CCG Medications Management Team for liaison with necessary GP Practice Pharmacists.	Manual review of discharge summaries (search / print / check / record) for June, July and back through to beginning of May until either instances are no longer found or DXC positively confirms the root cause and its introduction date.	• Print all discharge records; • Review all discharge records; • Record all affected discharge summaries; • Confirm CCGs with which the identified patients are associated with out of area and contact. • Daily communication of additionally identified affected encounters to CCG Medications Management Team by email – for up to 3rd July@8 PM.	Emma O'Brien / Diane Matthew Diane Matthew Diane Matthew Diane Matthew Diane Matthew	8th July 2020 8th July 2020 8th July 2020 8th July 2020 8th July 2020	
Investigate Seek urgent clarification of the start date of the issue via database reports from DXC.	Maintain daily contact with DXC in pursuit of database report. Formal root cause analysis required	• Maintain daily contact and action list with DXC. • DXC's target date for RCA to be confirmed.	Sue Caisley Carl Ward (DXC)	6th July 2020	
Protect Ensure affected records are brought up to date swiftly that all potential harm and actual harm is identified and acted upon without delay.	Communicate all affected records to CCG / GPs.	• Production of daily report for inpatients (to identify where an existing inpatient has no Discharge Medications in their Discharge Summary Medications sections but	Louise Ainsworth / Emma O'Brien	Daily until Issue Start Date Is Formally Notified By DXC PAN Update DM: Emma and Diane to	

Board Assurance Framework

(GPS communications and liaison process agreed with CCG 6th July 2020@16:30 via Teams call between Phill James, Diane Matthews, Pam Broadhead, Sangeetha Steevart, Michelle Creed, Maria Austin)		the patient needs a prescription) • Production of report (LA) and subsequent communication of discharge prescriptions (EO) as PDF document to the CCG medications management team for the period during which no medication information is provided on the discharge summary, i.e. 3rd July 2020@8PM onwards. • Production of report (LA) and subsequent creation and posting of covering letters to be posted (EO) to GPs with copies of each discharge prescription from 3rd July 2020@8 PM (as it's the most straightforward and follow), backed up by an emailed list to the generic CCG meds email (DM). (approximately 60 records) This action includes agreeing with CCGs the method of providing assured Discharge Summaries to GPs in a manual method, i.e. • Agree Trust process and resource for creation of discharge prescription lists to ensure GPs know	Louise Ainsworth / Emma O'Brien Louise Ainsworth / Emma O'Brien / Diane Matthew	continue dealing with this today. EO: new discharge summary with no meds on but advises prescription will follow – to agree covering letter format 080720. Aim to start posting today. GPs have been told to contact Pharmacy for any missing info – in original comms from CCG to GPs. 8th July 2020 8th July 2020 onwards 10th July 2020	

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		they've received everything they should have. • Print and post to GP Practices on daily basis (excluding weekends) • Communicate discharge prescriptions as PDF document to the CCG medications management team for all encounters identified as suffering the error up to 3rd July 2020@8 PM through the review process – continue to provide daily updates as review continues; (55 records as of 070720) Must use final version of the same Discharge prescription • CCGs Medication Management Team to compare information against Primary Care Records and communicate with GP Practices as deemed necessary (Report available 070720 and process requires agreement with CCG) • CCG to issue daily position updates to GP Practices; • Update to be provided at Practice Learning Time Meeting 9th July 2020. • Review of spreadsheet of	Diane Matthew/ Emma O'Brien Trust ePR Team Emma O'Brien Emma O'Brien / Diane Matthew / CCG Medications	SE to confirm this process is underway 090720. No initial feedback from GPs. CCG Feedback due to Trust from CCG via DM – then to Governance.	

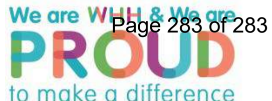
Board Assurance Framework

		problematic discharge summaries updated and searched for encounters occurring after issue arose, i.e. re-admissions / multiple encounters. This spreadsheet is to help the CCG Team track how changes are taking place in the Discharge Summary.	Management Lead CCG Comms - Pam Broadhead CCG Comms - Pam Broadhead Diane Matthew	8th July 2020 8th July 2020	
<u>Recover</u> <u>(added 100720)</u> Trust to put in place a temporary electronic discharge summary on DXC workaround advice based upon a simple medication list, to limit ongoing impact upon Trust workforce until the eDS is returned to its normal state.	Discharge prescriptions within the record are known to be good and remain important to GP and Patient *(the Patient is always provided with a correct discharge medications list so the issue is restricted to the GP records).*	• Apply and Test 'getmedication' functions in Lorenzo configuration; • Agree with Pharmacy what information to include e.g. ONLY active Discharge Medications; • Apply new configuration to LIVE production eDischarge Summary;	Emma O'Brien/ Kelly Halliwell Diane Matthew/ Emma O'Brien Emma O'Brien/ Kelly Halliwell	8th July 2020 8th July 2020 8th July 2020	
<u>Investigate</u> All gathered intelligence must be shared to the supplier to contribute to a timely and safe resolution.	Ensure all identified affected records are communicated to DXC to aid the technical investigation.	Communicated summary of all affected records to DXC.	Sue Caisley	Daily until Issue Start Date Is Formally Notified By DXC PAN Update	.

Board Assurance Framework

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Recover DXC must provide a thorough root cause analysis report that sets out the facts leading to the issue, actions taken to resolve the issue, lessons learnt and subsequent corrective actions to prevent a reoccurrence.	Seek DXC's estimated date for an investigation RCA report.	Maintain daily contact and action list with DXC.	Sue Caisley	Daily until root cause and resolution are declared by DXC. No new DXC info available 7th July 2020.	
Recover As this is a third similar event in the past 12 months the Trust should now de-risk the lack of assurance demonstrated by DXC and implement more robust and comprehensive site testing.	Ensure a range of test patients records are exercised in all Lorenzo acceptance tests to incorporate a range of patient complexities and history permutations.	Document and implement strengthened Trust discharge summary acceptance test process for all Lorenzo EPR releases	Emma O'Brien	Prior to next Lorenzo EPR release.	
Recover Ensure PAN notices are processed robustly and without delay and dovetail into clinical risk processes.	Document and implement more robust PAN receipt, confirmation, triage and management process.	• Review existing PAN management process • Consider automation of Datix for all PANs • Ensure Email is not a weakness • Ensue DXC seek formal response of receipt and action • Review PAN format for aiding Trust triage and prioritisation in response to potential threat to patient care, i.e. understand why the DXC assessment of this risk was "Medium".	Sue Caisley David Kelly Sue Caisley Sue Caisley Sue Caisley	10th July 2020 10th July 2020 10th July 2020 10th July 2020 17th July 2020	



Trust Board

DATES 2019-2021

All meetings to be held in the Trust Conference Room

Date of Meeting	Agenda Settings	Deadline For Receipt of Papers	Papers Due Out
2020			
Wednesday 29 January	Thursday 9 January (EXECS)	Monday 20 January	**Wednesday 22 January**
Wednesday 25 March	Thursday 5 March (EXECS)	Monday 16 March	**Wednesday 18 March**
Wednesday 27 May	Thursday 7 May (EXECS)	Monday 18 May	**Wednesday 20 May**
Wednesday 29 July	Thursday 9 July (EXECS)	Monday 20 July	**Wednesday 22 July**
Wednesday 30 September	Thursday 10 September (EXECS)	Monday 21 September	**Wednesday 23 September**
Wednesday 25 November	Thursday 5 November (EXECS)	Monday 16 November	**Wednesday 18 November**
2021			
Wednesday 27 January	Thursday 7 January (EXECS)	Monday 18 January	**Wednesday 20 January**
Wednesday 31 March	Thursday 10 March (EXECS)	Monday 22 March	**Wednesday 24 March**