TRUST BOARD
27 May 2020

ITEMS FOR APPROVAL

ITEMS FOR NOTING FOR ASSURANCE

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/05/53**			
SUBJECT:	**K25 Extension of Lease**			
DATE OF MEETING:	27 May 2020			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	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.			
	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. #134 Financial Sustainability a) Failure to sustain financial viability, #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.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust had an option to extend the current lease on K25 which was due to be decommissioned at the end of February 2020. There was an initial request to retain the ward to support additional capacity requirements from the operational planning guidance. There were however no funds available to support this and therefore support retention of the ward. Subsequently the COVID-19 pandemic meant that closing the ward was not an option available to the Trust. The Trust received a quote to retain K25 for 1 year – 3 years. If the ward was to be decommissioned it would needed to be done over a 12 week period. Decommisioning the ward would also have implications for winter planning. For expediency, the proposal was shared virtually with the Board and discussed in the Strategic Executive Oversight Group and the Covid NED Assurance Committee.			
PURPOSE: *(please select as appropriate)*	Information	**Ratification** √	To note	Decision
RECOMMENDATION:	The Board of Directors is asked to ratify the hire of K25 portacabin for up to 2 years from 6th April 2020 and the procurement of an alternative via capital during 2021/2022 which had previously been reviewed, discussed and approved at the Strategic Executive Oversight Group and NED Assurance Committee.			

PREVIOUSLY CONSIDERED BY:	**Strategic Oversight Executive Group, 14.04.2020 – Agenda Reference: C19SEOG/20/201** **NED Assurance Committee, 17.04.2020 – Agenda Reference: COVNED050**	
	Summary of Outcome	**Approved**
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**To be reviewed virtually**	
SUBJECT:	**K25 Extension of Lease**	
DATE OF MEETING:		
AUTHOR(S):	Chris Evans, Chief Operating Officer	
EXECUTIVE DIRECTOR SPONSOR:	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. 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):	#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 an option to extend the current lease on K25 which was due to be decommissioned at the end of February 2020. There was an initial request to retain the ward to support additional capacity requirements from the operational planning guidance. There were however no funds available to support this and therefore support retention of the ward. Subsequently the COVID-19 pandemic has meant that closing the ward is not an option available to the Trust at present. The Trust has received a quote to retain K25 for 1 year – 3 years. The ward needs to be decommissioned over a 12 week period, so for example if 1 year was to be the chosen option, the decommissioning would start in January 2021. This has implications for winter planning.	

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

RECOMMENDATION:	The Board of Directors is asked to approve the hire of K25 portacabin for up to 2 years from 6th April 2020 and the procurement of an alternative via capital during 2021/2022.	
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	K25 Lease Extension	AGENDA REF:	To be reviewed virtually

1. BACKGROUND/CONTEXT

The Trust has an option to extend the current lease on K25 which was due to be decommissioned at the end of February 2020. There was an initial request to retain the ward to support the additional capacity requirements set out within the 2020/21 operational planning guidance. There were however no funds available to support this and therefore support retention of the ward.

Subsequently the COVID- 19 pandemic has meant that closing the ward is not an option available to the Trust at present. In the Trust Board meeting on 26 February 2020, the Board supported the retention of K25. This paper presents the options relating to the time period for this retention.

The Trust has received a quote to retain K25 for 1 year – 3 years. The ward needs to be decommissioned over a 12 week period, so for example if 1 year was to be the chosen option, the decommissioning would need to commence in January 2021. This therefore presents significant risk given the current situation and beyond in terms of winter contingency, however costings have been provided for the 1 year option.

2. FINANCIAL APPRAISAL

The financial appraisal on page 3 sets out costings for the hire of the K25 portacabin for 1 – 3 years and staffing costs. Year 1 staffing is a combination of 6 months temporary staffing (NHSP) and 6 months substantive, and from Year 2 the staffing model is substantive.

Comparing a 3 year hire of K25 portacabin to a 1 year hire of K25 portacabin there would be an annual saving of £239,526. The reduction between 1 and 2 years hire is £83,835.

Given the operational requirement from the operational planning guidance and current performance of the wider system it is likely that the Trust will have a requirement to retain current capacity.

The revenue costs of leasing and staffing the ward are set out on page 3 (showing the costs of leasing for 1, 2 or 3 years). The leasing costs reduce depending upon the length of the lease. The staffing costs are higher in year one due to a combination of agency and substantive staffing. Agency costs are replaced by susbstantive costs after 1 year.

Annual Financial Summary (Assuming 1 Year commitment for K25 portakabin)

Plan	Total Cost Year 1 £	Total Cost Year 2 onwards £
K25 – 18 beds 1 year contract hire from 6th April 2020 – 5th April 2021 (includes VAT)	£958,104	£958,104
One off equipment purchase	£40,215	£40,215
Staffing (Ward and support staffing for 18 beds on K25)	£1,533,603	£1,379,892
Non Pay, Facilities and Other Costs (for 18 beds on K25)	£220,096	£220,086
Total	**£2,752,017**	**£2,598,297**

Annual Financial Summary (Assuming 2 Year commitment for K25 portakabin)

Plan	Total Cost Year 1 £	Total Cost Year 2 onwards £
K25 – 18 beds 2 year contract hire from 6th April 2020 – 5th April 2022 (includes VAT)	£874,269	£874,269
Staffing (Ward and support staffing for 18 beds on K25)	£1,533,603	£1,379,892
Non Pay, Facilities and Other Costs (for 18 beds on K25)	£220,096	£220,086
Total	**£2,627,967**	**£2,474,247**

Annual Financial Summary (Assuming 3 Year commitment for K25 portakabin)

Plan	Total Cost Year 1 £	Total Cost Year 2 onwards £
K25 – 18 beds 3 year contract hire from 6th April 2020 – 5th April 2023 (includes VAT)	£718,578	£718,578
Staffing (Ward and support staffing for 18 beds on K25)	£1,533,603	£1,379,892
Non Pay, Facilities and Other Costs (for 18 beds on K25)	£220,096	£220,086
Total	**£2,472,276**	**£2,318,556**

The Trust has also explored the option to purchase K25 as a one off capital payment. Portakabin has confirmed that at this current time there is no option for the Trust to purchase.

A high level costing has been obtained relating to the purchase of an alternative portacabin and then making fit for use. The estimated cost of this including design and installation is c£3m. It must be noted that this would impact upon the Trust's finite capital resources. The annual revenue costs (depreciation and interest) would be c£300k assuming a 15 year life. This is a significant reduction in the annual revenue costs.

A 3 year lease would cost £2.2m over the 3 year period. A 2 year lease followed by a capital purchase would incur revenue costs of £2.0m over the 3 year period. The Trust would then own the asset and incur £0.3m revenue charges per annum, a significant reduction from the lease charge.

3. TIMELINES

K25 original hire agreement with Portacabin expired on 21st February 2020. Portakabin have agreed with the Trust to a 4 weeks free hire period due to the length of time it was out of action during the water treatment works.

Further to this, Portakabin have agreed to extend by a further 2.5 weeks free of charge due to the estates costs expended in trying to assist in eradicating the water safety issue. The revised dates are therefore as follows:

Original hire expiry – 21st February 2020
4 week free hire – expires 20th March 2020
2.5 week free hire – expires 6th April 2020

Portacabin will start to officially charge the Trust from 6th April 2020.

It would be challenging to decommission the ward within the next 12 months, however given the difference in cost it would be financially prudent to decommission the ward within the next 24 months and purchase an alternative if still required at the time (contingent upon the oepraational performance of the wider system). There is a risk however to the availability of capital, although the Trust would be able to make a strong operational and financial case for capital support for this purchase.

4. RECOMMENDATIONS

The recommendation is for the Board of Directors to approve the hire of K25 portacabin for up to 2 years from 6th April 2020 – 5th April 2022 and the procurement of an alternative via capital during 2021/2022, if still required at the time.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/05/54**	
SUBJECT:	**Amendment to the Scheme of Reservation & Delegation (SoRD)**	
DATE OF MEETING:	27 May 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)***	#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. #134 Financial Sustainability a) Failure to sustain financial viability, #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.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Executive and Non-Executive Directors of the Board reviewed and approved an amendment to the SoRD in relation to COVID-19 Capital Expediture in the Strategic Executive Oversight Groups and COVID NED Assurance Committee respectively. The approved proposal allows the Director of Finance & Deputy Chief Executive and Chief Executive Officer to approve Covid related capital and report this to the Finance and Sustainability Committee and the Board in the usual way. The paper is included for reference.	

PURPOSE: *(please select as appropriate)*	Information	**Ratification** √	To note	Decision

RECOMMENDATION:	The Board of Directors is asked to ratify the amendment to the SoRD to allow the Director of Finance & Deputy Chief Executive and Chief Executive Officer to approve Covid related capital
PREVIOUSLY CONSIDERED BY:	**Strategic Oversight Executive Group, 14.04.2020 – Agenda Reference: C19SEOG/20/201** **NED Assurance Committee, 17.04.2020 – Agenda Reference: COVNED050**

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

REPORT TO EXECUTIVE TEAM

AGENDA REFERENCE:	**BM/20/xx/xx**			
SUBJECT:	**Covid19 Capital**			
DATE OF MEETING:	7 May 2020			
AUTHOR(S):	Jane Hurst, Deputy DoF + Commercial Development			
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance + 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)***	#134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #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. #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.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The purpose of this paper is to suggest an amendment to the Scheme of Reservation and Delegation (SORD) to enable prompt approval of capital expenditure relating to COVID19. In additional to being able to approve emergency capex, it is recommended that the Director of Finance & Deputy Chief Executive and Chief Executive Officer are able to approve Covid related capital and report this to the Finance and Sustainability Committee and the Board in the usual way.			
PURPOSE: *(please select as appropriate)*	Information	Approval x	To note	Decision
RECOMMENDATION:	The Trust Board is asked to support the proposal to update the SORD to reflect that the Director of Finance & Deputy Chief Executive and Chief Executive Officer can approve Covid19 capital expenditure. This will then be taken to the Non Executive Directors for their support.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.			

REPORT TO EXECUTIVE TEAM

SUBJECT	Covid19 Capital	AGENDA REF:	

1. BACKGROUND/CONTEXT

The purpose of this paper is to suggest an amendment to the Scheme of Reservation and Delegation (SORD) to enable prompt approval of capital expenditure relating to COVID19.

2. BACKGROUND/CONTEXT

The SORD states how powers are reserved to the Board of Directors whilst at the same time delegating powers to the appropriate level detailed in the application of the Trust's policies and procedures. A full comprehensive review of the SORD was approved by the Board of Directors in January 2019 with further updates in March 2019.

The SFIs detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the SoRD adopted by the Foundation Trust.

The Board currently approves the capital expenditure of the Trust as part of budget setting process and any changes durng the year are approved by the Board with the exception of emergency capital which the Director of Finance & Deputy Chief Executive and the Chief Executive Officer can approve.

The recent Covid19 capital expenditure has been treated as emergency capital with a process of Chief Nurse and Chief Operating Officer supporting the request and the Director of Finance approving the spend before submitting to NHSI. As we move into the recovery phase the Covid19 capital requests whilst still urgent are not emergency. Therefore for the Director of Finance to continue to approve the Covid19 capital spend it is suggested that the SORD should be amended from:-

"Approval of emergency requests necessary to meet legislative, regulatory, health and service requirements"

to

"Approval of emergency requests necessary to meet legislative, regulatory, health and service requirements and Covid19 Capital".

The Executive Team will continue to receive weekly updates on the revenue and capital expenditure for Covid19 and the Finance and Sustainability Committee and Board will continue to be sighted on the capital spend on a monthly basis.

If the Executive Team are in support of the suggested change the paper will be discussed with the Non Executives and with their approval will go to the May Board for ratification.

3. RECOMMENDATION

It is recommended that the SORD is updated to reflect that the Director of Finance & Deputy Chief Executive and Chief Executive Officer can approve Covid19 capital expenditure.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/05/55**			
SUBJECT:	**Compliance with Licence – Condition G6 and Condition CoS7**			
DATE OF MEETING:	27 May 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):*	NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.			
PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Self-Certification for the items is attached and the Board is asked to approve compliance with NHS Conditions G6 and CoS7			
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)*	Choose an item.			

Self-Certification Template - Conditions G6 and CoS7

Warrington & Halton Teaching Hospitals NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7" | **Financial Year to which self-certification relates** | 2019/2020

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust recorded a £0.2m surplus for the year, which included £17.9m for Provider Sustainability Funding (PSF), Financial Recovery Funding (FRF) and Marginal Rate Emergency Rule (MRET). This surplus was £0.2m better than the break even control total set by NHSI.
The Financial Resources Group and the Finance and Sustainability Committee review and scrutinise the financial position and performance of the Trust closely throughout the year and escalate any relevant items to the Board in the Chair's exception report. Furthermore, the Board review the position, seek assurance and challenge forecast outturns and mitigations in each Board meeting.
The Trust has monthly review meetings with NHSI and the financial position, forecast and associated mitigations were rigorously tested as part of these review meetings.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Steve McGuirk	**Name**	Simon Constable
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/05/56**
SUBJECT:	**Guardian of Safe Working for Junior Doctors** **Q4 Report - 1st Jan 2020 – 31st March 2020**
DATE OF MEETING:	27th May 2020
AUTHOR(S):	Mark Tighe, Guardian of Safe Working
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Acting Executive Medical Director
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#241 Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The 2016 Junior Doctor Contract is fully established at WHH for all of our Foundation Doctors, and the majority of the CT and ST grades. Monitoring of the safe implementation of the contract is now under the auspices of the Medical Education Department, overseen by Lesley Sala. Issues regarding safe working hours, rota problems, educational reasons or patient safety issues are recorded by Junior Doctors in the form of Exception Reporting via the Allocate System, which are then escalated to their responsible Educational Supervisors, and then to myself as Guardian of Safe Working Hours for the Trust. I regularly attend the Regional Guardian of Safe Working Forums, to ensure we are working in line with other Trusts in the region. Since the last report, we can confirm our rotas remain compliant, and the vast majority of our Junior Doctors are happy with their allocations. Our Junior Doctors (Trainee) Forum is supported by the Medical Director, HR and the Guardian of Safe Working into a single meeting on a bi-monthly basis, in order to identify and correct persistent ongoing concerns from the Trainee Workforce. As at the 9th April 2020, we have received Total of 19 Exception Reports (ERs) for Q4, which is nearly a three-fold

	decrease from **92** in Q3. This almost certainly relates to the change in practice related to the Covid-19 crisis Most ERs relate to doctors working in excess of their allocated hours, although unusually these were mainly within General Surgery and ENT. It is reassuring that only 1 report related to missed educational opportunities; however, this was in relation to finding time for completion of e-learning, was also noted in 3 other Exception Reports. There were no immediate patient safety concerns. The pressing issue that we have had with Exception Reporting is the failure of the Junior Doctors and their Educational Supervisors (ES) to achieve sign-off in a timely manner. This can lead to delays in our Junior Doctors being able to put in claims for time-off in lieu (TOIL) and/or compensatory payment. Medical Education has taken the task on to expedite quick and robust sign-off meetings, and we have seen improvements and progression here from Q3 with the newly designed ***"4 Point Action Plan"*** *as follows:-* 1. *Exception Reports should be completed ASAP but no later than 14 days of the Exception being submitted through ALLOCATE.* 2. *Where the Trainee is seeking payment as compensation, the report should be submitted within 7 days.* 3. *For EVERY Exception Report submitted, ether for payment or TOIL; it is the Educational Supervisor who is required to respond to the Exception Report within 7 days.* 4. *The Trainees need to indicate "acceptance" or "escalate" to the next stage, IT IS ONLY WHEN acceptance is confirmed the EXCEPTION REPORT can be closed.* ****As at the 9th April there were a Total of 44 ER's outside of the 40 day window**** The Guardian's aim is to encourage TOIL rather than compensatory payment, in an attempt to ensure our Juniors are not exceeding their maximum weekly hours for safe working (we will be able to mandate this once e-rostering is available for our rotas)

PURPOSE: ***(please select as appropriate)***	Information ✓	Approval	To note ✓	Decision Not required

RECOMMENDATION:	The Committee are requested to note the report findings and progress made with implementing the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health, and wellbeing and the safety of patients. Any concerns that the Committee have should be reported back to the Guardian of Safe Working for his attention, consideration and actions accordingly.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee
	Agenda Ref.	SPC/20/05/42
	Date of meeting	20th May 2020
	Summary of Outcome	Assurance is given that the Junior Doctors are working safely for their own health, and wellbeing and the safety of patients.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Guardian of Safe Working for Junior Doctors Q4 Report - 1st Jan 2020 – 31st March 2020	AGENDA REF:	BM/20/05/56

1. BACKGROUND/CONTEXT

The 2016 Junior Doctor Contract is now well established at WHH. Rotas for our doctors are fully compliant, although work schedule reviews can be undertaken if there are persistent problems with individual rotas. Most juniors are on board to engage with their Consultants, Educational Supervisors (ESs) and Guardian of Safe Working, if any new issues develop. We have a Junior Doctors Forum, held bi-monthly, which is attended by the Director of Medical Education – Dr Alison Coackley, Dr Alex Crowe – Executive Medical Director (Acting), HR Colleagues and Mr Mark Tighe - the Guardian of Safe Working.

As GSW for the trust, I continue to attend the Regional Guardian Forum, and am satisfied that we are in line with other Trusts. Once again, I am pleased to be able to confirm that there has been only one ER at a Level 2 Review. The Trust has cumulatively received one fine for the ED rota from the previous Quarter, for a contractual problem, which has now been resolved.

In the 4th Quarter of this financial year, we have a **total of 19 Exception Reports recorded**. This is the lowest number we have had in a Quarter since 2017. This almost certainly relates to the ongoing national crisis, but will require close monitoring going forward. We strive to improve the engagement process for sign-off and completion.

Rather than being seen as a concern for the Trust, ERs are useful to identify any problem areas within the Trust for our junior doctors.

I will continue to reiterate the message to Junior Doctors and their Educational Supervisors that time-off in lieu (TOIL) is the preferred option for compensation following ERs.

The majority of the ERs still relate to our Foundation Doctors working past their allocated time, usually on an ad hoc basis. Interestingly, these have occurred primarily in General Surgery (15), followed by Medicine (4) during this quarter. It is also to be acknowledged that there have been extensive efforts to enable safe staffing levels on the surgical wards, to give our juniors the support they need.

Importantly, I can confirm that all **72** Foundation Programme Doctors employed during this period were well on track to progress through their current year of training.

Concerns remain that there is a significant delay in the review meetings between the ES and Junior Doctor, once an ER has been submitted. Lesley Sala is tackling this issue currently, aiming to clear all ERs within 4 weeks of submission. This is also being reiterated at the Junior Doctors Forum and the Trust Induction for our junior doctors.

Any difficulties with the sign-off process will be escalated to the Medical Education Service and/or the Guardian of Safe Working for Action.

Junior Doctors on the 2002 Contract

It is important to remember that the vast majority of the Junior Doctors (employed by the Lead Employer) have now transitioned onto the new 2016 Contracts. However, some will retain the 2002 pay protection until the end of their Training Contract. We remain cognisant of a recent Case Law (Hallett vs Derby)

which effects Trust's using ALLOCATE for monitoring exercises; a further update will be provided in due course.

2. KEY ELEMENTS

In reviewing the data the current trends have been identified as follows:

- ER "Sign off" remains a concern regarding the Q4 position, but is on an improving trajectory
- 16 ERs recorded a "breach type" as Overtime through Allocate.
- 13 ERs reported by FY1 doctors
- 4 ERs were submitted from FY2 Trainees.
- 2 ERs were related to completion of e-learning, which are a requirement as a Trainee for HEENW
- Our report submitted to Lead Employer identified a total of 6 ER's in Q4. (data provided within this report)
- The required **NHSI Data** submission for the reporting period **Junior Doctors Rotations** was also achieved for Q4 on the 15th April 2020. This provides assurance that the we are within the time frame for our contractual requirement to obtain a work schedule **8 weeks prior** to rotation – this information was submitted on due date with a narrative based on the original work schedules and a caveat that Trainees have been redeployed due to COVID-19 -and there was not the time to get the work schedules out – waiting National Guidance.

Also, as part of the 2016 Contract for Junior Doctors; WHH's Guardian of Safe Working Hours – Mr. Mark Tighe is also required to submit data for the Lead Employer/Mr. Michael Chadwick, who is responsible for presenting a quarterly report to the St Helens and Knowsley Trust Board, this report will relate to the number of trainees hosted by WHH on the 2016 contract.

This report has been provided the following data sets:

- The number of exception reports raised split by grade. **= 11**
- The number of work schedule reviews that have taken place split by grade. **= 0**
- Any fines that were levied by the host's trust's Guardian **= NIL**

This is information has also been presented to our Trust Board.

Quarter	Reporting Period	Deadline for Data Provided by the Host
Q4 Report	**1st Jan 2020 – 31st March 2020**	**15th April 2020**

Quarterly Report on Safe Working Hours Data		
Reporting Time Period:		1st Jan - 31st March 2020
Trust Name:		Warrington & Halton Teaching Hospitals NHS Foundation Trust
Guardian of Safe Working Hours Name:		Mr Mark Tighe
GOSW Email Address:		mark.tighe@nhs.net
No.of doctors/dentists in training (total)		233
No.of doctors/dentists in training on the 2016 contract TCS (total)		204
No. of lead employer trainees on the 2016 contract at your Trust		132
Amount of time available in job plan for Guardian to do the role		2 PA's
Admin support provided to the Guardian (if any)		Under review
Amount of job-planned time for educational supervisors		0.25 PA's per trainee

	Exception reports								Work Schedule Reviews								Fines by department	
Specialities	No.at CT1/2 Level		No.at ST3+ Level		No. given TOIL or payment			No. that are on-going	No.at CT1/2 Level		No.at ST3+ Level		No. given TOIL or payment				No.of fines levied	Values of fines levied
	Raised	Closed	Raised	Closed	TOIL	Payment	Other - Please Specify		Raised	Closed	Raised	Closed	TOIL	Payment	Other- Please Specify			
General Surgery (Inc HPB/OG/CR)																		
Urology																		
Gynaecology & obstretrics																		
Orthopaedics																		
Vascular																		
ENT/ Head & Neck			6	6		6												
Plastics (Inc. Burns)																		
Neuro																		
Cardiothoracic																		
Maxillofacial																		
Transplant																		
Anaesthetics																		
ITU																		
Paediatrics																		
Aemergency medicine (A&E)																		
General medicine (AMU)																		
Cardiology																		
Respiratory			5	5	4		Missed teaching due to on call	0										
Gastroenterology																		
Nephrology																		
Endocrinology (Inc. Diabetes)																		
Neurology																		
Stroke Medicine																		
Elderly care																		
Ophthalmology																		
Dermatology																		
Oncology																		
Haematology																		
Chemical / Histopathology																		
Microbiology																		
Radiology																		
Other (e.g. Psychiatry)																		

*If you have any additional comments, issues arising or concerns then please fully detail in the section below

The Trust is also required to complete a Digital Submission to **NHSI Data Collection** to *"Monitor when Junior Doctors Receive Notification of their Rotas*" – although the deadline for submission was achieved to NHSI we further placed a caveat around the delays in work schedules (> 8 weeks) as a consequence of the re-deployment of the Medical Trainee Workforce in relation to COVID-19

Furthermore, the GSW has also noted a marked reduction in the submission of Exception Reports being presented through ALLOCATE during the overall Q4 period and noticeably within the months of February and March and below are the key comments from the GoSW with regards to the reduction:-

1. There is little doubt there is good morale and feeling amongst the trainees despite the clinical issues, and everyone is keen to chip in and help out as much as they can.
2. The sickness rates at WHH for our trainees have been low (so far!), so there are plenty of doctors around, especially with the added help of final year medical students and PAs.
3. There is very little elective surgical work going on (GS, orthopaedics, gynaecology etc.), so routine work is lighter.
4. The rotas for senior staff and consultants have been altered to help with the departmental rotas.
5. Obviously, trainees may have been putting on their claims in other ways e.g. locum claim forms and this has been queried with Medical Staffing Colleagues.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

As the GoSW, I am satisfied that our junior doctors are happy with their compliant rotas, accepting the fact that it is the nature of their job that they will have to stay beyond their hours at times, if they have unwell patients or a higher volume of work. Our main issue with the exception reporting at WHTH is the

delay in getting sign-off for the reports. Some supervisors are slow to respond to receipt of ERs, but the junior doctor can also be at fault for not signing the report off, once the exception meeting has taken place. Lesley Sala is tackling this problem currently, as we would like all our ERs signed off **within 4 weeks of receipt.**

We have addressed the issue of juniors getting time off for mandatory training and this has been evidenced in the ERs submitted, as well as compliance rates for completion. On discussions with the Regional Guardian and other HR departments, we should be facilitating time off at work for juniors to complete the trust requirement for their Mandatory Training/e-learning via the HEENW STEP System. As a consequence of ensuring the completion of all Mandatory Training, we are now starting to see ERs being submitted and they will continue to be encouraged to exception report in the future.

There have been no work schedule reviews in Q4, which reflects the introduction of new doctors into established rotas in the F1 and F2 posts

Discussions have been undertaken with some of our F2s, who were unhappy with their rotas, in particular the number of weekends they are allocated to work. Evidence has been presented to support a robust rota review in **Emergency Medicine,** and that the service is required to work towards solutions to support Trainees both to attend their Wednesday Afternoon Foundation Training Programme and to address the heavy rota pattern. There have also been problems with juniors in ED getting their allocated rest breaks. Any shift over 9 hours must be factored in for x2 30 minute rest breaks, or a total of one hour during the shift. Because of a failure in enforcing these rest breaks, a fine was submitted by the GSW to the ED Department in **Q3.**

4. IMPACT ON QPS?

None are noted.

5. MEASUREMENTS/EVALUATIONS

High level data essential for National Data Collection:

Key Indicators	Figures/Dates
Number of WHH doctors in training: Total Number of Doctors/Dentists in Training:	 **233**
Number of WHH doctors in training on 2016 TCS: Number of Lead Employer Trainees on 2016 TCS:	**204** **132**
Number of Doctors in Training on the 2002 TCS (inclusive of all Trainees & Lead Employer Trainees)	
Reference period of report	**Q4 Report - 1st Jan 2020 – 31st March 2020**
Total number of exception reports	**19**
Number relating to immediate patient safety issues	**4 – *but reviewed with GoSW and downgraded***
Number relating to working hours/pattern	**18**
Number relating to educational opportunities	**1**
Number of Exception Reports that remain Pending	**19**
Number relating to service support available to the doctor	**18**
Total hours of TOIL granted	**ALL remain Pending/Unresolved**
Total incidences of overtime payments issued	**ALL remain Pending/Unresolved**

Total number of work schedule reviews	**0**
Total number of reports resulting in no action	**0**
Total value of fines levied	**0**
Amount of time available in job plan for guardian to do the role:	**2.0 PAs / 8 hours per week**
Admin support provided to the Guardian (if any):	**0**
Amount of job-planned time for educational supervisors:	**0.25PA's per trainee**

Exception Reports

Type of Exception	**Still open**
Working hours ***(inc. Overtime & Natural Breaks)***	18
F1	13
F2	4
CT1-2 / ST1-2	0
ST3-8	**2**
Missed training ***(inc. Service Support)***	
F1	0
F2	0
CT1-2 / ST1-2	0
ST3-8	**0**
Safety	
F1	0
F2	4 (downgraded by the GSW)
CT1-2 / ST1-2	0
ST3-8	0
Total	**19**

Fines

There has been NO reported fine with reference to Exception Reporting in relation to the Q4 Reporting period.

Fines by department		
Department	Breach reason	Value of fines levied (£)
Emergency Department	*only received 1 x 30min break where the BMA stipulates 2x 30min breaks when worked over 9 or more hours*	**£1,834.38**
Total		

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter and previous quarter
£0	**none**	**none**	£1,834.38

6. TRAJECTORIES/OBJECTIVES AGREED

The Medical Education Service will continue to run month-end Exception Reports to identify Exception Reports that have not been signed-off to improve our the turnaround times, in accordance with the NHS Employers time lines as follows:

ALL Exception Reports for Review - ***As at the 9th April 2020 (16:21 pm)***

- 57 = Live
- 9 = Exceptions last 30 days
- 0 = Exceptions last 7 days
- 0 = ISCs last 30 days
- 0 = ISCs last 7 days
- 57 = Overdue
- 57 = Action required

1. **Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.**
2. **Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.**
3. **For EVERY Exception Report submitted, ether for payment or TOIL; it is the Educational Supervisor who is required to respond to the Exception Report within 7 days.**
4. **The Trainees need to indicate "acceptance" or "escalate" to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the Exception Report can be closed.**

The GoSW will be provided with timely data reports to support his role in the coming year, with particular reference to improvement in response times for ERs.

7. MONITORING/REPORTING ROUTES

Copies of the Guardian of Safe Working Hours' Reports, both the Quarterly and Annual Reports should also be provided to the LNC – Local Negotiating Committee. The Annual Report is also required to be included in the Trust's Annual Quality Account and signed off by the Chief Executive; the contents of both reports may be included or referenced in Annual Reports provided by the Employer to HEE, Care Quality Commission (CQC) and/or the General Medical Council (GMC)

It is also normal practice for the Trust's Executive Committee (Strategic People Committee) to have sight of the Reports before they are submitted to the Board as the Executive Committee may be able to describe to corporate responses to the issued raised by the Guardian of Safe Working and to provide relevant advice.

It might also be good practice to share a copy of the report with the Junior Doctors Forum of the employing/host Organisation. Guardians of Safe Working may also wish to share the data across regional networks to allow for aggregated regional and/or national analysis.

8. TIMELINES

Following the end of each Quarter of the financial year, the report will be one month in arrears to ensure follow-up on OPEN Exception Reports. The Annual Report will be submitted concurrently with the Report for the 4th Quarter, and will go to the following Months' Board Meeting.

SPC – Strategic People Committee
Guardian of Safe Working - Quarterly Reports, Safe Working Hours Jnr Doctors in Training:-

- (Q4 – end of March 2020) –*submitted for 20th May 2020 Meeting*
    - **Q4 – Report to Board of Directors – submitted for the 27th May 2020**

9. ASSURANCE COMMITTEE

Submitted to the Strategic People Committee – for the 20th May Meeting

10. RECOMMENDATIONS

In summary, this has been a quarter that has seen a demonstrable reduction in exception reporting by our trainees. This is mainly attributable to the COVID-19 Pandemic, but does reflect the increased volume of direct clinical support we have provided for our training grades during this difficult period. The attendance to the FY Formal Foundation Programme has not been compromised, and we continue to offer the teaching (using both social distancing measures and/or remote functionality). To support FY2 attendance, Medical Education continues to send the attendance registers to A&E following the weekly Wednesday afternoon sessions. Most ERs were submitted from surgical specialties, but these generally reflect our juniors staying late to complete jobs/service support. There were **4** immediate safety concerns in Q4 in WHTH, which have been promptly reviewed and downgraded by the GoSW, after discussion with the trainee. There have been no work schedule reviews to address any non-compliant rotas. Only 1 ER related to missed educational opportunities - this is reassuring considering the workload of our juniors, and reflected completion of Mandatory Training rather than protected teaching. We are pleased to note ERs are being raised as a consequence of completion of their **mandatory training** and would hope that this reflects an improvement in their Compliance Rates as noted in the Trainee Doctor Forums and acknowledged as a constructive approach with the BMA.

I am pleased that the Medical Education Department has taken ownership of the monitoring process, and Lesley Sala in particular is very motivated to sort the perennial problem of closing off ERs quickly and efficiently. This will ensure that our juniors can receive the compensation they deserve, and for us to be able to highlight and act on ongoing concerns with rotas and working hours. At the end of the day, our remit is that our junior doctors are able to work safely and effectively, for their benefit and our patients in the trust.

There are no new significant areas of concern arising from the data in Q4. However, we will need to be aware of potential problems going forward, especially in areas of under-reporting, as documented in AED in the last quarter. Further noting that when reporting is encouraged there is a significant increase in identifying the specialties that need to review and look to solutions to foster long-term improvements in the trainee's experiences in the coming quarter.

To conclude, I am currently satisfied with the overall safety of working hours in our organisation. I would ask the Board to note the Report, and consider the assurances made accordingly. I remain happy to attend the Board meeting if any queries or concerns are raised.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/05/57**			
SUBJECT:	**Finance + Sustainability Committee Terms of Reference and 2020-2021 Cycle of Business**			
DATE OF MEETING:	27 May 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)*	#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. #115 Failure to provide adequate staffing levels in some specialities and wards. #134 Financial Sustainability a) Failure to sustain financial viability,			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. The Terms of Referance and Cycle of Business were reviewed and approved by the Finance and Sustainbility Committee			
PURPOSE: *(please select as appropriate)*	Information	Approval X	To note	Decision
RECOMMENDATION:	The Trust Board is required to ratify the Terms of Reference and 2020-2021 Cycles of Business of the Finance and Sustainability Committee			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee		
	Agenda Ref.	FSC/FSC/20/03/41		
	Date of meeting	18 March 2020		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

FINANCE & SUSTAINABILITY COMMITTEE
TERMS OF REFERENCE

1. PURPOSE

The Finance and Sustainability Committee ("the Committee") is accountable to the Board of Directors (the Board) and will operate under the broad aims of reviewing financial and operational planning, performance and strategic & business development.

2. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain external assurance; legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it, or require executive action.

The Chair of the Committee will report to the Board annually on its work and performance in the preceding year. The Trust's Standing Orders of Reservation and Delegation and Standing Financial Instructions apply to the operation of the Committee.

4. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following two areas:

Finance and performance

- To provide overview and scrutiny in areas of financial performance referred to the Committee by the Trust Board particularly with regard to any regulatory breaches of the Monitor Provider Licence (under the auspices of NHS Improvement).
- Receive and consider the financial and operational plans and make recommendations as appropriate to the Board.
- To monitor the effectiveness of the Trust's financial performance reporting systems ensuring that the Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Trust's performance against its annual financial plan and budgets.
- Review the service line reports for the Trust and seek assurance that service improvements are being implemented.
- To review the Trust's operational performance against its annual plan and to monitor any necessary corrective planning and action.
- To provide overview and scrutiny to the development of the medium and long term financial models (MTFM and LTFM).
- To ensure the MTFM and LTFM is designed, developed, delivered, managed and monitored appropriately.

- To ensure that appropriate clinical advice and involvement in the MTFM and LTFM is provided.
- To review and monitor the in-year delivery of annual efficiency savings programmes.
- To review the performance indicators relevant to the remit of the Committee.
- Consider any relevant risks within the Board Assurance Framework and corporate level Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate via the Key Issues Report.
- To monitor compliance with NHSI requirements relating to pay policies
- To review and monitor the Trust's overall pay bill
- To monitor all elements of the Board Assurance Framework that relate to the work of this Committee

Strategy, planning and development

- Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management.
- Advise the Board and maintain an oversight on all major investments and business developments.
- Advise the Board on all proposals for major capital expenditure over £500k or such capital expenditure of lower levels that have a material impact on the Trust's operation.
- Oversee the development of the Trust's Commercial Strategy for approval by the Board and oversee implementation of that strategy.

5. MEMBERSHIP

The Committee shall be composed of not less than two (2) independent Non-Executive Directors, at least one of whom shall have recent and relevant financial experience.

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee. Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval from all the members of the Committee, such written approval may be by email from the members Trust email account.

6. CORE ATTENDEES

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Director of Finance & Commercial Development
- Chief Operating Officer
- Chief Nurse
- ~~Executive Medical Director and Deputy Chief Executive~~
- Medical Director
- Director of HR and Organisational Development
- Deputy Director of Finance & Commercial Development S~~trategy~~

- Director of Strategy (when required)
- Trust Secretary ~~Head of Corporate Affairs~~

Other Directors including the Chief Executive or staff members may also be invited/expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

7. QUORUM

A quorum shall be two (2) members. In the event that two Non-Executive Directors cannot attend a meeting of the Committee, one of the Non Executives Directors not normally members of the Committee may attend in substitution and be counted in the quorum.

8. FREQUENCY OF MEETINGS

Meetings shall be held on a monthly basis.

9. REPORTING GROUPS

The groups listed in the next paragraph are required to submit the following information to the Committee:

- the formally recorded minutes of their meeting;
- separate reports to support the working of the Committee or addressing areas of concern these Reporting Groups may have;
- an Annual Report setting out the progress they have made and future developments.

The following groups will report directly to the Committee:

- Capital Planning Group
- Finance and Resources Group
- Pay Spend and Review Committee, including reports on premium pay spend

10. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reach with the Chair of the Committee, Agenda and Papers will be sent 3 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

11. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed at least annually by the Committee.

Date: March 2020 ~~March 2019~~

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Finance and Sustainability Committee
Version:	**V6**
Implementation Date:	March 2020
Review Date:	March 2021
Approved by:	Finance + Sustainability Committee
Approval Date:	18 March 2020

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
22 March 2017	**3 – Reporting arrangements**	- There is no requirement to circulate Committee minutes unless specifically requested to the Trust Board, rather the Chair's key issues report will highlight points of note in the public forum.	
22nd March 2017	**4. Duties and Responsibilities**	- To recognise NHS Improvement as an umbrella organisation with oversight of Monitor-imposed regulation or enforcement	
22 March 2017	**6 - Attendance**	- Change of Core Membership to Core Attendees to distinguish between membership (non-executive – required for quoracy) and those invited to attend – not included in quoracy. - Changes to core attendees to include, Chief Nurse, Medical Director, Director of HR&OD, Deputy Director of Finance	
22 March 2017	**9. Reporting Groups**	Two groups removed: - The Business Planning sub Committee (strategic). - Strategic & Annual Planning Steering Group. One Group added: - Pay Spend and Review Committee minutes to reporting groups.	
22 March 2017	**10 Administrative Arrangements**	- Due to change in administrative support to the Committee - Agreement with the Chair and Director of Finance to amend the timescale for circulating papers	
18th October 2017	**4. Duties and responsibilities** **6. Core attendees** **9. Reporting Groups**	- Delete items relating to Estates and IM&T - Delete Director of IM&T Remove IM&T Steering Cttee, Lorenzo	

		Project Group, IM Governance and Records	
22nd November 2017	**Section 4 Duties and Responsibilities** **Section 9 Reporting Groups**	- To monitor compliance with NHSI requirements relating to pay policies - To review and monitor the Trust's overall pay bill - To monitor all elements of the Board Assurance Framework that relate to the work of this Committee To include: reports on premium pay spend	
21st March 2018	**Core Attendees**	Addition of Medical Director	Trust Board 29.5.2019
19th September 2018	**Core Attendees**	Remove Director of Transformation	Trust Board 29.5.2019
20 March 2019	**Section 6: Core Attendees**	Remove Medical Director Add Head of Corporate Affairs	Trust Board 29.5.2019
20 March 2019	**Section 9: Reporting**	Add Financial Resources Group Remove Out Patient Turnaround Remove ICIC	Trust Board 29.5.2019
18 March 2020	**Section 6: Core Attendees**	ADD Medical Director Amend Title of Head of Corporate Affairs to read Trust Secretary Amend title of Deputy director of Finance Strategy to read Deputy Director of Finance & Commercial Development ADD Director of Strategy (when required)	FSC 18.03.2020
18 March 2019	**Section 9: Reporting**	Remove Urgent & Emergency Care Improvement Committee	FSC 18.03.2020

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
20 March 2020	**V5 to be replaced by V6**	FSC 18.03.2020

Finance and Sustainability Cycle of Business 2020-2021

		2019									2021		
	Exec Lead	**19.4.20**	**20.5.20**	**17.6.20**	**22.7.20**	**19.8.20**	**23.9.20**	**21.10.20**	**18.11.20**	**23.12.20**	**20.1.21**	**17.2.21**	**24.3.21**
INTRODUCTION & ADMINISTRATION													
Apologies for Absence	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Declarations of Interest	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Minutes of the Last Meeting	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Matters Arising + Action Log	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Rolling attendance log + cycle of business	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
GOVERNANCE & COMPLIANCE													
Committee Terms of Reference	**Trust Sec**												X
Committee Cycle of Business	**Trust Sec**												X
Committee Chair's Annual Report to Board	**Chair**	X											X (rep April)
Pay Assurance Dashboard + Harmonisation Rep - Pay Spend and Review Group Mins	**Dir HR+OD**	X	X	X	X	X	X	X	X	X	X	X	X
Pay assurance checklist quarterly report	**Dir HR+OD**	X			X			X			X		
Risk Register	**Trust Sec**	X	X	X	X	X	X	X	X	X	X	X	X
PAF Review and Refresh of Trust KPIs	**DoF**											X	
Committee Effectiveness Review – 6 month	**Chair/T Sec**						XrepOct	X					
Committee Effectiveness Review – annual	**Chair/T Sec**	X											X repApr
System Governance Report	**DoF**	X	X	X	X	X	X	X	X	X	X	XX	X
PERFORMANCE													
Corporate Performance Report (incl efficiency, productivity, utilisation, LOS, DNAs)	**COO**	X	X	X	X	X	X	X	X	X	X	X	X
FINANCIAL ASSURANCE													
Monthly Finance report, + - Capital Planning Group Minutes - Finance + Resources Group Minutes and escalation log - Commissioner Contract minutes	**DoF&CD**	X	X	X	X	X	X	X	X	X	X	X	X
Combined Financial Position	**DoF+CD**				X			X			X		
Monthly Cost Pressure + CIP Report	**Dof+CD**	X	X	X	X	X	X	X	X	X	X	X	X
Indicative Financial cost of harm annual report	**DoF**		X										
INVESTMENT													
Annual Capital Programme	**DoF&CD**											X	
PLANNING													

Finance and Sustainability Cycle of Business 2020-2021

Operational Plan & Budgets	**DoF&CD**												X
Service Line Reporting Quarterly Report	**DoF&CD**			Xfullyr 19/20						XQ2 (20/21)			
Reference Cost Report	**DoF&CD**					X					X		
6 month priority review	**All**	~~X def Mrc 2021~~											X
CLOSING													
Key issues to the Board	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Any Other Business	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Next Meeting Date & Time	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/05/58**			
SUBJECT:	**Staff Survey**			
DATE OF MEETING:	27 May 2020			
AUTHOR(S):	Deborah Smith, Deputy Director of HR and OD			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director of HR and OD			
LINK TO STRATEGIC OBJECTIVE: (***Please select as appropriate)***	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.			
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. #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. #145 a. Failure to deliver our strategic vision. #241 Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an overview of the 2019 staff survey results which were published on the 18th February 2020. The paper highlights the organisation's response rate of 53% which was 6% better than the national acute trust score. The thematic results demonstrate how the organisation has improved from the 2018 results in 9 areas, remained the same as the 2018 results in 1 area which related to bullying and harassment and has decreased in 1 area relating to violence. The paper also provides a detailed analysis in relation to the 11 national staff survey themes and against the national Workforce Race Equality standard (WRES) and Workforce Disability Equality Standard (WDES). Following reports to both Operational People Committee (February 2020) and Strategic People Committee (March 2020), agreement was made around next steps in terms of both a Trust-wide and a CBU/Department level. Any further action has since been suspended due to COVID-19 and will be reviewed as part of workforce recovery planning.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note	Decision
RECOMMENDATION:	The Trust Board are asked to note the staff survey results and proposed approach for dissemination and defining priority workstreams on an organisational and CBU / Department basis.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/20/03/32		
	Date of meeting	18/03/2020		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Staff Survey	AGENDA REF:	BM/20/05/58

1. BACKGROUND/CONTEXT

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

The 2019 staff survey took place between September and November 2019 via Quality Health, who are an approved NHS staff survey provider. The organisation undertook a mixed mode approach to the survey providing paper copies as well as an online option for all members of staff.

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

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

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

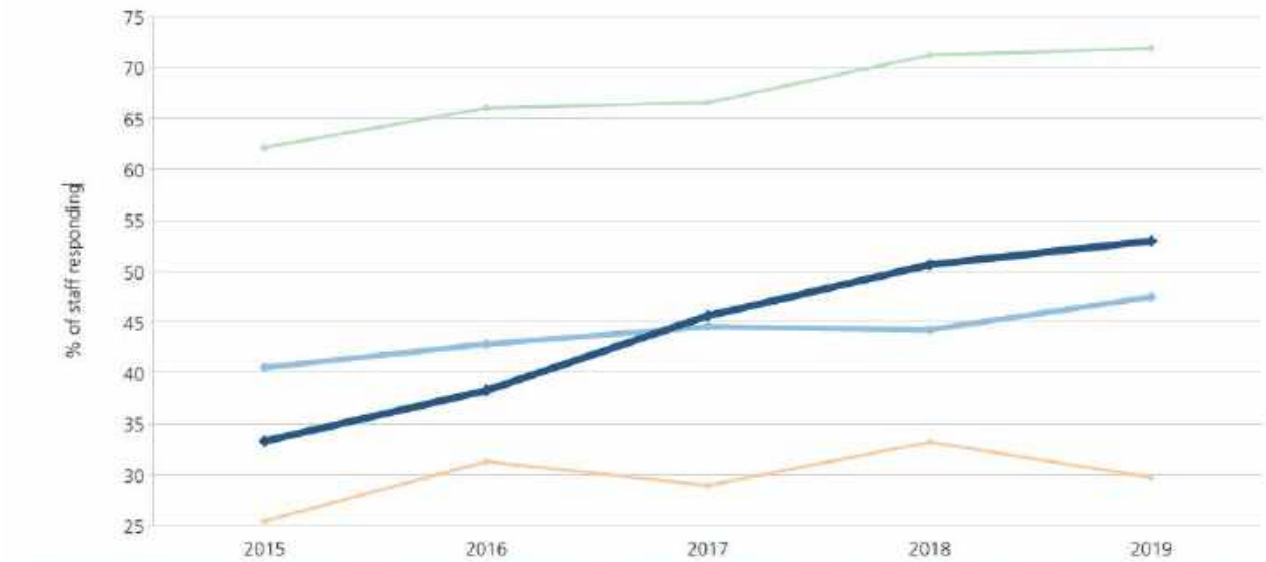
In addition to the publication of results, organisations are required to develop local priority workstreams to address the results from both an organisation and directorate (Clinical Business Unit) perspective to demonstrate to staff how the organisation is responding to staff feedback.

2. KEY ELEMENTS

2.1. THEMEATIC RESULTS

In the 2019 staff survey, the organisation's response rate was 53% which is an increase of 2.4% from the 2018 staff survey figures, **diagram one** identifies our organisational

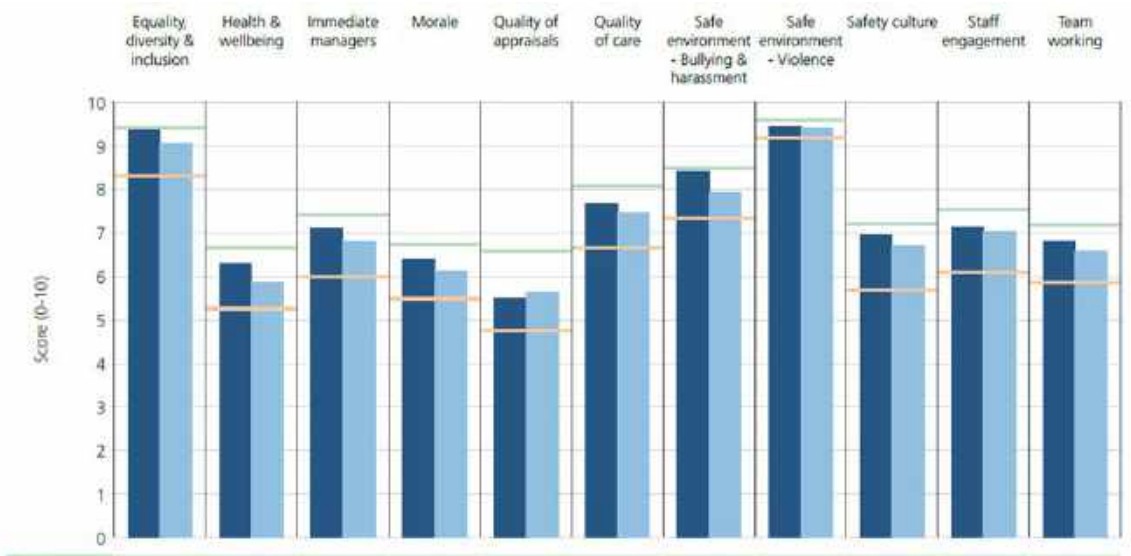
position in comparison with the best, average and worse acute trust scores. 2,136 member of staff completed their survey and the organisation's response rate was 6% above the national score when compared with other acute trusts nationally. The thematic results demonstrate how the organisation have made great strides in increasing participation in the survey and most importantly how there have been initiatives and interventions throughout the year which have contributed to a cycle of continuous improvement from our staff and the services that we provide.



	2015	2016	2017	2018	2019
Best	62.2%	66.0%	66.6%	71.3%	71.9%
Your org	33.3%	38.3%	45.6%	50.6%	53.0%
Median	40.5%	42.8%	44.5%	44.2%	47.5%
Worst	25.4%	31.3%	28.9%	33.2%	29.7%

Table one highlights the thematic results from the 2019 staff survey including best and average scores. The results illustrated that the organisation is better than the average score in 9 areas, the same as the average score in one area in relation to a safe environment from violence and slightly below average in the quality of appraisals. Although the quality of appraisals thematic score is lower than the national average for acute specialist trusts, the organisation has improved on last year's score which demonstrates the impact of some of the initial work undertaken in relation to refreshing and developing the PDR and appraisal process for the organisation.

Table one: Staff Survey Thematic Results



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	9.4	6.3	7.1	6.4	5.5	7.7	8.4	9.4	6.9	7.1	6.8
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	2,103	2,108	2,121	2,090	1,801	1,758	2,099	2,100	2,101	2,127	2,104

In comparison with the 2018 data, which is shown in **table two**, the organisation has improved in nine thematic areas, remained the same in one area which focuses on bullying and harassment and has decreased in providing a safe environment in relation to violence.

Table two: Comparison of thematic results

Theme	2018 score	2019 score	Comparison between years	Comparison with national acute trust average score
Equality, Diversity and Inclusion	9.3	9.4	↑	↑
Health and Wellbeing	6.2	6.3	↑	↑
Immediate Managers	7.0	7.1	↑	↑
Morale	6.2	6.4	↑*	↑
Quality of Appraisals	5.3	5.5	↑*	↓
Quality of Care	7.5	7.7	↑	
Safe Environment – Bullying and Harassment	8.4	8.4	–	↑
Safe Environment – Violence	9.5	9.4	↓	–
Safety Culture	6.7	6.9	↑*	↑
Staff Engagement	7.0	7.1	↑*	↑
Team Working	6.6	6.8	↑*	↑

* Refers to scores that are statistically significant according to Quality Health's significance testing. Quality Health are the organisation's NHS staff survey provider.

The thematic results demonstrate that the organisation is doing well in comparison with other acute trusts nationally, and there is demonstrably improvements in most areas as identified in table two. The thematic results identify the areas for improvement as quality of appraisals, bullying and harassment and violence.

2.2. DETAILED THEMATIC ANALYSIS

Overall, the organisation fares very well in terms of its thematic results and individual question breakdowns, a summary of the full results can be found in **appendix one.**

The staff survey contains 104 questions in total and 85 of these questions scored better than last year from an organisational perspective with two remaining the same and seventeen scoring lower than last year. In comparison with the average scores for acute trusts nationally, the organisation has fared better than the average score in 89 questions and slightly worse than the average score in 15 questions.

2.2.1. Equality, Diversity and Inclusion

- 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% 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.

2.2.2. Health and Wellbeing

- Staff feel that the organisation takes positive action on health and wellbeing with an increase of 2.9% from 2018
- There has been a decrease of staff feeling unwell as a result of work related stress
- Staff experiencing musculoskeletal issues as a result of work activities has declined by 2%
- Whilst the trust results are overall positive, MSK interventions will be an area to focus on over the next year.

2.2.3. Immediate Managers

- 5% increase in the numbers of staff feeling that senior managers act on staff feedback and involve staff in important decisions
- Increase by 2.3% in the workforce feeling that their immediate managers are supportive in terms of helping with difficult tasks
- There are slight improvements to be made in relation to staff feeling that clear feedback is given on their work as the score has decreased by 0.2%.

2.2.4. Staff Morale

- All questions relating to staff morale show a positive improvement above the national average for acute trusts

- There has been a 3.2% increase in individuals feeling that they have a choice in deciding how to do their work
- The workforce's intentions to leave the organisation have dropped by 2.4% which is positive news.

2.2.5. Quality of Appraisals

- The workforce feel that the appraisal process has helped to agree clear objectives which has increased by 2.3% since 2018
- There has been a 5% increase in staff feeling that the organisation's values were discussed as part of the appraisal
- The number of people having an annual appraisal has dropped by 3.3% but the organisation score is better than the national average for acute trusts
- An area identified for improvement is how the appraisal has helped individuals to improve how they do their job as the organisational score is 1.10% lower than the national acute trust average

2.2.6. Quality of Care

- Staff feel satisfied with the quality of care that they give which has increased by 2.5% from 2018
- Staff also feel able to deliver the care they aspire to which has increased by 4.6%
- However, there are issues with some of the workforce feeling that their role makes a difference to patients which has decreased by 1.2% and is less than the national average score for acute trusts.

2.2.7. Safe Environment – Bullying and Harassment

- In the last 12 months, there has been a decrease in harassment, bullying or abuse at work from patients, service users and managers
- In the last 12 months there has been an increase of 0.3% in staff experiencing bullying, harassment or abuse from other colleagues.

2.2.8. Safe Environment – Violence

- The organisation has a better score than the national average for acute trusts in the questions relating to experiences of violence
- In the last 12 months, there has been a reduction in staff experiencing physical violence from managers or work colleagues
- In the last 12 months, there has been an increase of 1% of the workforce experiencing physical violence from patients, carers or relatives at work.

2.2.9. Safety Culture

- All questions that fall under the safety culture theme have improved results since 2018
- The organisation has scored higher than the national average score for acute trusts
- 6% increase in staff feeling that they are given feedback about the changes made as a result of an error, near miss or incident
- 6% increase in staff feeling that the organisation responds to concerns raised by patients.

2.2.10. Staff Engagement

- All questions that fall under the staff engagement theme have improved since the 2018
- The organisation has scored higher than the national average score for acute trusts
- Staff look forward to coming to work and are enthusiastic about their job which has increased by 2% since 2018
- Staff engagement questions around coming to work are bucking the national trend
- 6% increase in staff recommending the organisation as a place to work

2.2.11. Team working

- All questions that fall under the team working theme have improved since the 2018 survey
- The organisation has scored higher than the national average score for acute trusts
- There has been a 1.6% increase in staff feeling part of an effective team with shared objectives
- Increase of 2% for our staff feeling that there are opportunities to meet regularly as a team.

2.2.12. Protected Characteristics Analysis

In addition to the detailed thematic results, **table three** illustrates some of the results that are used for the national Workforce Race Equality Standard (WRES) and **table four** illustrates the national Workforce Disability Equality Standard (WDES).

To provide some context to these results, 18.5% of respondents to the staff survey declared that they have physical or mental health conditions which are expected to last 12 months or more. In relation to ethnicity, 91.8% of respondents declared themselves to be white with other ethnicities declaring as follows:

- Mixed 0.9%
- Asian / Asian British – 5.5%
- Black / Black British – 0.7%
- Chinese – 0.4%
- Other – 0.7%

Although the organisation has the best score in relation to equality, diversity and inclusion, in comparison with other acute trusts there is still work to be undertaken in relation to tackling bullying and harassment and also the perception of our BAME and disabled members of staff who feel that the organisation does not provide equal opportunities for career progression or promotion.

Table three: Protected Characteristic Analysis – Workforce Race Equality Standard

Question	BAME members of Staff	White Members of Staff	Narrative
Percentage of staff experiencing harassment,	25.0%	21.6%	BAME members of staff are experiencing more harassment,

bullying or abuse from patients, relatives of the public in last 12 months			bullying or abuse from the public in the last 12 months than white staff.
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	26.0%	19.0%	BAME members of staff are experience more harassment or bullying from other members of staff than white staff.
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	82.3%	91.4%	More white members of staff than BAME members of staff believe that there are equal opportunities for career progression or promotion.
Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	10.7%	4.5%	More BAME members of staff than white members of staff have experienced discrimination at work from a manager, team leader or other colleague in the last 12 months.

Table Four: Protected Characteristic Analysis – Workforce Disability Equality Standard

Question	Disabled members of Staff	Non-disabled members of staff	Narrative
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	25.7%	20.7%	Disabled staff have reported experiencing slightly more harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months	13.1%	8.4%	More disabled staff than non-disabled staff have reported experiencing harassment, bullying or abuse from manager in last 12 months.
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	21.1%	13.2%	More disabled staff than non-disabled staff have reported experiencing harassment, bullying or abuse from other staff in the last 12 months.
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	48.0%	51.1%	Non-disabled staff are more likely to report their experiences of harassment, bullying or abuse than disabled members of staff.
Percentage of staff who	85.8%	91.5%	Non-disabled staff believe that the

believe that their organisation provides equal opportunities for career progression or promotion			organisation provides equal opportunities for career progression or promotion than disabled staff.
Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	27.9%	19.3%	More disabled staff have felt pressure to come to work despite not feeling well enough to perform their duties than non-disabled staff.
Question	**Disabled members of Staff**	**Non-disabled members of staff**	**Narrative**
Percentage of staff satisfied with the extent to which their organisation values their work	39.2%	54.6%	Disabled staff do not feel as satisfied as non-disabled staff that the organisation values their work
Percentage of disabled staff saying their employer has made adequate adjustment (s) to enable them to carry out their work	75.0%	N/A	In comparison with the average score for national acute trusts, our organisational score is 1.7% higher.
Staff engagement score	6.7	7.2	Non-disabled staff have scored the organisation higher than disabled members of staff in relation to intentions to stay and involvement in the organisation.

2.3. NEXT STEPS: TRUST WIDE

Following reports to both Operational People Committee (February 2020) and Strategic People Committee (March 2020), agreement was made around next steps in terms of both a Trust-wide and a CBU/Department level. Any further action has since been suspended due to COVID-19 and will be reviewed as part of workforce recovery planning.

3. RECOMMENDATIONS

The Trust Board are asked to note the staff survey results and proposed approach for dissemination and defining priority workstreams on an organisational and CBU / Department basis.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/05/60**	
SUBJECT:	**Personal Protective Equipment and Covid-19**	
DATE OF MEETING:	27 May 2020	
AUTHOR(S):	Lesley McKay, Associate Chief Nurse Infection Prevention and Control Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy CEO	
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)***	#145 (a) Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	To update the Board of Directors on the Trust requirements for personal protective equipment (PPE) including all recommended items of PPE required to protect healthcare workers when providing care and stock maintenance at a time of high demand during the global Covid-19 pandemic. National PPE guidance has been implemented and ongoing monitoring is in place. An audit tool has been devised to monitor standards in practice and will commence on 15 May 2020.	

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	Personal Protective Equipment and Covid-19	AGENDA REF:	BM/20/05/60

1. BACKGROUND/CONTEXT

On 31 December 2019, Chinese authorities alerted the World Health Organisation (WHO) to cases of pneumonia in Wuhan City. Transmission of this infection to other countries followed, resulting in the WHO declaring a public health emergency of international concern on 30 January 2020 and subsequently a global pandemic on 12 March 2020.

The Virus responsible for the pandemic has been named SARS-CoV-2 and the disease it causes Covid-19. Initially, this infection was classified as a High Consequence Infectious Disease (HCID). Personal Protective Equipment (PPE), required to protect healthcare workers providing care in the UK, was specified by Public Health England (PHE).

Since 19 March 2020, COVID-19 is no longer considered to be a HCID in the UK. National guidance has been frequently updated and recommendations for PPE are currently based on aerosol/non-aerosol generating procedures. There is high global demand for all recommended items of PPE which has the potential to impact on current and future availability.

2. KEY ELEMENTS

Infection Control: Standard Precautions/Transmission Based Precautions

All healthcare workers are trained in the principle of standard precautions. These are basic practices that should be used by all healthcare workers, at all times, for all patients, regardless of any suspected or known infection risks.

Transmission Based Precautions are additional actions taken alongside standard precautions to reduce the risk of transmitting infections. Transmission based precautions are categorised by the route in which infectious agent transfer from one person to another. SARS-CoV-2 is mainly transmitted by respiratory droplets and contact (direct and indirect). Where patients are undergoing clinical procedures with the potential to generate aerosols, transmission can be airborne. This information has informed national guidance on PPE.

Use of PPE is one element of standard infection control precautions that should be used alongside other measures including but not limited to: patient placement, environmental and hand hygiene.

Guidance for PPE

PHE has regularly updated guidance on PPE and this is currently split into two categories: aerosol and non-aerosol generating procedures. The highest risk of transmission of SARS-CoV-2 is during aerosol generating procedures relating to the respiratory tract. Items of PPE for each type of procedure are:-

Non-Aerosol Generating Procedures	Aerosol Generating Procedures
Disposable plastic apron	Fluid resistant Gown
Fluid resistant surgical face mask	FFP3/FFP2 Respirator
Eye-protection (according to risk assessment)	Visor/goggles or safety spectacles

Gloves Gloves

Disposable plastic apron

In most circumstances plastic aprons provide suitable protection from blood, body fluids, excreta and secretions where there is a risk of contamination of clothing. Plastic aprons should be put on immediately before an episode of direct patient contact/treatment and removed immediately after.

Plastic aprons must be changed between caring for different patients and between different care activities for the same patient. Plastic aprons are also worn over gowns (during sessional use) to reduce the risk of transmitting other pathogens e.g. MRSA.

Gowns/Coveralls

Disposable long sleeved fluid repellent gowns are worn to protect staff uniform when a plastic apron does not provide adequate cover e.g. when there is a risk of extensive splashing of bodily fluids (typically during aerosol generating procedures).

During April 2020, national gown shortages were reported in the media. Additional guidance was produced on using gowns for sessional activity and use of coveralls was introduced into the national guidance.

A single session refers to a period of time where a health and social care worker is undertaking duties in a specific clinical care setting or exposure environment. For example, a session might comprise a ward round or taking observations of several patients in a cohort bay or ward.

Fluid Repellent Surgical Face Masks

Fluid repellent surgical face masks (FRSM), Type IIR provide barrier protection against respiratory droplets reaching the mucosa of the mouth and nose. These items are advised for single or sessional use and should then be discarded.

The protective effect of masks against severe acute respiratory syndrome (SARS) and other respiratory viral infections has been well established. FRSM must be worn correctly to provide protection.

Fit Testing

The Trust has a legal responsibility to control substances hazardous to health in the workplace. This includes viral pathogens such as SARS-CoV-2. Facepiece fit testing is a method of checking that a tight-fitting facepiece matches the wearer's facial features and seals adequately to their face. It also helps to identify unsuitable facepieces that should not be used for that individual.

As people's faces come in all sorts of shapes and sizes, one particular type or size of FFP respirator will not fit everyone. Fit testing is required to ensure the equipment selected is suitable for the wearer. FFP respirators are allocated following fit testing which ensure a close fit is achieved. There are a number of different disposable FFP3 respirators in use in the Trust as shown in the images below.

Training to conduct Fit Testing was carried out by an accredited Fit2Fit company in October 2019 and over 60 members of Trust staff were training how to carry out this procedure. A Qualitative (relies on taste) Fit Testing programme was in place prior to the pandemic. Some of the FFP3 respirators

supplied from the national pandemic stock differed from the ones in use in the Trust and further action was required. A programme of Fit Testing was established and led by the Chief Nurse/DIPC, to increase capacity to Fit Test staff and re-Fit Test where FFP3 respirator makes/models had changed.

A spreadsheet has been developed to track the Fit Testing programme. This includes information on staff that have not passed fit testing on disposable FFP3 respirators. Staff have been rated as red, amber or green according to clinical duties helping to understand the risk to individual staff. Staff whose clinical duties involve performing aerosol generating procedures are considered to be at higher risk of exposure, rated as 'red or amber' and prioritised for further assessment.

Where staff did not pass Fit Testing on a disposable respirator, a reusable respirator has been offered following successful Fit Testing. Decontamination of these items is essential to prevent self-contamination and a Standard Operating Procedure (SOP) has been developed and circulated to staff using re-usable equipment.

A specialist PPE office, for staff to be allocated appropriate equipment was established on 10 April 2020. This process was established to ensure that appropriate governance measures were in place to guarantee the provision of suitable and appropriate equipment. Where equipment has been supplied a proforma is completed by the Head of Clinical Effectiveness following appropriate review by Infection Prevention and Control and Health and Safety as necessary. The proforma is completed to confirm that the equipment has been issued appropriately. The decision to progress with specific equipment is documented on the proforma and a record is kept. This also details equipment that has been rejected.

To date, 2465 staff have been fit tested and 196 items of reusable respiratory protective equipment has been issued to healthcare workers during the pandemic. The Fit Testing programme will be continued as supplies of disposable FFP respirators may change based on product availability.

Disposable/Reusable Respirators (FFP3/ FFP2)

PHE has recommended the use of disposable FFP3 or FFP2 respirators whilst undertaking aerosol generating procedures during the Covid-19 pandemic. Both these type of respirator are close fitting and filter out fine airborne particles. FFP stands for 'Filtering Face Piece. The number relates to filtration efficiency:

- FFP2 respirators have a filter efficiency of 95%
- FFP3 respirators have a filter efficiency of 99%

Both FFP2 and FFP3 are suitable for filtering out microorganisms.

Figure 1 Disposable FFP3 Respirators

Disposable PPE is the preferred standard as this removes the risk of exposure associated with decontamination of reusable items.

The Health and Safety Executive has stated that FFP2 offer protection against COVID-19 and may be used if FFP3 respirators are not available. Currently FFP2 respirators are not in use in the Trust. The Trust holds a stock of FFP2 masks and these form part of a contingency plan in the event that there is a shortage of FRSMs.

Sessional use of FRSM and FFP3 respirators is currently recommended in the UK Infection Prevention and Control guidance. Guidance is in place to advise the item should be disposed of if it becomes moist, damaged or visibly soiled. Healthcare workers are advised not to touch the item once it has been put on and to remove in a safe zone and dispose of into clinical waste when taking a break.

Figure 2 Reusable Half/Full Face Respirators

Fit Testing for the full face reusable respirator requires use of the Quantitative (particle counting) technique. The Trust has purchased the necessary equipment and trained staff in this process.

Where staff have not pass fit testing by either quantitative/qualitative techniques, powered hoods are offered as an alternative. These devices are not suitable for all staff.

Figure 3 Powered Hoods

All respiratory protective equipment in use been assessed and is compliant with CE marking.

Eye Protection

Eye protection is used where there is a risk of contamination of the eyes by splashes and/or droplets e.g. blood, body fluids, secretions, and excretions generated through patient care. Eye protection can be achieved by the use of any one of the following:-

- polycarbonate safety spectacles/goggles or equivalent
- full face visors

Reusable eye protective equipment e.g. polycarbonate safety spectacles pose a potential cross-infection risk. It is important that any such re-usable items are decontaminated safely after soiling, using agents recommended by the manufacture. There is a SOP in place for decontamination of re-usable eye protection.

Eye protection in use must fit snuggly over and around the eyes or personal prescription glasses, be indirectly-vented (to prevent penetration of splashes or sprays) and have an anti-fog coating to help maintain clarity of vision.

Visors provide staff with barrier protection to the facial area and related mucous membranes (eyes, nose, and lips). Staff members who work in areas that require PPE for aerosol generating procedures should wear face visors rather than safety spectacles/goggles as these provide additional protection to the FFP3 respirator.

Visors should be used if aerosol-generating procedures are performed. They should cover the forehead, extend below the chin, and wrap around the side of the face. Visors are available in both disposable and reusable options (reusable following strict guidelines for cleaning and decontamination).

Eye protection should be CE marked and is required to meet essential safety standards. However, the Office of Product Safety and Supply have recently issued new guidance (March 2020) on derogation of PPE requirements subject to meeting the essential safety requirements. This has allowed the use of donated visors.

All donated visors are checked by the Infection Prevention and Control Team and Health & Safety Team to ensure they meet the requirements as specified above and no additional Health and Safety risks are incurred. This check provides a comparative assessment against national technical specifications e.g. British Standards and European Standards. All products are reviewed and only used if appropriate. Some items have been rejected for use as they do not meet the required standard e.g. products containing latex or unprotected sharp edges. All items rejected are recorded.

Gloves

Examination gloves used for clinical care of COVID-19 patients are available in a variety of materials, are single use and must be disposed of after each use. Non-powdered, nitrile gloves are the most commonly recommended for healthcare.

Latex gloves should only be used where there is no alternative and following risk assessment. Control measures must be in place to restrict access to the users identified by a separate risk assessment.

Scrub Suits

Scrub suits are not considered part of PPE. Scrub suits are preferred workwear items as they are laundered by the Trust laundry contractor. This reduces the risks associated with home laundering of uniforms. The Trust has provided this service to all staff. Scrub Suits are not in shortage at WHH.

Supply/Procurement of Personal Protective Equipment

Availability of PPE has been discussed a great deal in the media creating anxiety for staff in health and social care settings. The Infection Control Sub-Committee, Associate Chief Nurse for IPC and Chief Nurse/DIPC ensured a nominal amount of PPE was held in preparation for an influenza pandemic. The items (gowns, aprons, fluid repellent surgical face masks, FFP3 respirators and gloves) were all compatible with PHE recommendations for Covid-19 and were distributed rapidly to support staff in high risk areas.

The vast quantity of PPE required by all health and social care providers put a huge strain on the NHS supply chain. Responsibility of managing PPE was delegated to a distribution organisation (Clipper), who is supported by the Ministry of Defence (MoD). National distribution of PPE is on a push out/ just in time basis.

Within WHH, a Tactical Group was established on 30 January 2020 and close liaison was established with the Procurement Department to monitor and manage PPE stock. Stock counts are undertaken daily and reported to the Tactical Group. The Chief Nurse/DIPC and Associate Chief Nurse for IPC work very closely with the Head and Deputy Head of Procurement throughout each day.

PPE usage rates are calculated to support requests to Clipper for next day deliveries. As the UK moves into the Recovery Stage, usage estimates will be increased to ensure sufficient quantities of PPE are available to meet the amount required. This is led by the Associate Chief Nurse for IPC with the Head of Procurement and will involve close liaison with all Clinical Business Unit (CBU) managers to estimate the right and required amounts of PPE for services being reinstated. This will be included on the governance service recovery proformas. This information will be shared with the Procurement Team.

Deliveries of PPE can occur at short notice and a system has been implemented to ensure stock can be received at short notice. The Procurement Department have extended daily working hours and currently provide a 7 day service. Internal distribution schedules have been set up and a protocol is in place for staff to access PPE out of hours.

The Chief Nurse/DIPC has ensured compliance with PPE throughout the pandemic working closely with the Associate Chief Nurse for IPC and Consultant Medial Microbiologists. Practices have been altered in accordance with PHE guidance. The Trust has ensured compliance with PPE throughout the pandemic and has altered practices in accordance with PHE guidance. Incidents are reviewed by both the Governance and Health and Safety Team daily. Investigations will be undertaken accordingly.

All organisations' Procurement Departments are provided with information on PPE stock deliveries across the local Health Economy. This has supported the mutual aid agreement, which is in place to share stocks of PPE. The Trust's Finance Director chairs the Cheshire and Merseyside Group and the Trust has received and provided support by sharing PPE. All PPE shortages are escalated via the National Supplies Disruption Response (NSDR) Team email address.

Plans were drawn up with local partners in Cheshire and Merseyside for bulk purchase of PPE, and alternative suppliers were actively being sourced. Some of these orders started to arrive and content was distributed equitably. One local supplier has been central to the supply of re-usable respirators for staff who have failed Fit Testing on all available disposable FFP3 respirators. All Trusts were informed they must not attempt to source their own stock and as such plans for bulk purchase with other Trusts locally ceased.

During April the Secretary of State for Health advised the risk of shortages of fluid resistant gowns. Guidance on sessional use of gowns was published on 02 April 2020. Alternative choices including reusable fluid repellent theatre gowns and coveralls were put in place by the Chief Nurse/DIPC and Associate Chief Nurse for IPC on 3 April 2020 as per the contingency plan for gown shortage.

Donated items

There has been a generous response from local schools and businesses and a number of items of PPE have been donated. All donated items of PPE are checked against the published technical specifications and have been risk assessed to ensure they are of an appropriate standard before being distributed for use. These are further supported by a wider PPE SOP. Whilst such PPE has been issued with the use of the devised proforma, staff in the PPE room has also kept a log of items that have not been accepted.

Contingency Plan for Extreme PPE Shortage

The Infection Prevention and Control Team have reviewed available alternative options for PPE if stocks of the preferred PPE are unavailable. PPE stock levels are examined daily at the Tactical meetings and low stock levels are escalated to the NSDR. In addition mutual aid is accessed from partnering Trusts.

A robust contingency plan is in place including:

- maximising the preferred PPE items through national and local supply
- mutual aid from Cheshire and Merseyside partners
- assessment of the use of alternative PPE

The contingency plan is designed to support the significant risk to national supply routes and to ensure staff and patient safety is maintained.

The volumes required by all NHS organisations has put a significant strain on the supply chain meaning that security and visibility of future deliveries of PPE stock is only on a 24 hour basis. This makes planning for surges in activity and for recovery of services extremely challenging. The reliability on national supply routes remains a significant risk.

The Infection Prevention and Control Team has reviewed alternative options for PPE. These options will only be implemented if the recommended PPE is unavailable. Each contingency option has been risk assessed based on scientific suitability, training needs/ability to deliver, and ease of procurement as well as reviewed against national and international guidance. The following list summarises the PPE type and contingency plan.

Aprons:

- single patient use

Gowns:

- Reserve fluid repellent gowns for high risk aerosol generating procedures
- Sterile Gowns for surgical procedures to be managed separately
- Education on appropriate use of gowns and monitoring use
- Introduced sessional use of gowns
- Introduced reusable fluid repellent gowns in hot zones (laundered by the Trust laundry contractor)
- Introduction of coveralls in place of gowns in ED
- Introduce non-fluid repellent gowns with additional use of a disposable plastic apron alongside information on arm washing once the gown is removed (only if fluid repellent gowns are unavailable or gowns have low levels of fluid repellence)

Mask/Respirator:

FRSM

- single use
- sessional use

FFP3

- Disposable FFP3 (single or sessional use)
- Re-useable FFP3 with decontamination guidance followed
- Powered hoods with decontamination guidance followed
- FFP2 (single or session use – not yet deployed)

Eyewear (visors/goggles/safety spectacles):

- single sessional use disposable
- reusable with decontamination guidance followed

Gloves:

- Single patient use/ single care activity use

Inventory control

The Procurement Team have centralised stocks of PPE and distribute items to ED, A7, ICU and other identified inpatient areas that are caring for patients with Covid 19. There remains ongoing fragility in the PPE supply chain. The Procurement Team escalate supply shortages to the NSDR, Clipper and the MoD.

Monitoring of stock levels supports planning how long stock will last and how recovery of services can proceed. CBU Managers have been asked to forecast the level of PPE they will require going forward.

Risk assessments (overarching risk assessment included at appendix 1) have been undertaken with the acknowledgement this is a live and ever-changing situation and may be subject to re-review at any time.

On 10 May 2020 the Government announced innovative collaborations with a number of organisations and establishment of a British manufacturing base for PPE to support future requirements.

Education and Training

One of the challenges to staff wellbeing relates to a number of Royal and Chartered Societies publishing guidance on aerosol generating procedures which differs from that of PHE. This has generated staff uncertainty and in addition, news reports are highlighting healthcare workers have lost their lives to Covid-19 leading to high anxiety.

The Infection Prevention and Control Team, including Consultant Medical Microbiologists, have attended a range of meetings (since early March) to inform and support staff around the availability and use of PPE. Educational materials including posters on donning and doffing, staff information leaflets and links to PHE training videos have been circulated.

All staff have been advised that, if they consider they have not been provided with the standard of equipment they need to be able to work safely, then they should not attempt to do so.

Consultation with Employees and Safety Representatives

The subject of PPE has been discussed twice weekly by the Director Human Resources & Organisational Development with our staff side colleagues to ensure any concerns raised can be addressed swiftly. On rare occasions, concerns have been raised about the availability of PPE and ensuring that staff have appropriate PPE available, these have all been addressed. There is a strong Freedom to Speak Up culture which supports staff to raise concerns.

Formal plans were put in place to address the CAS Alert (CEM/CMO/2020/018) relating to acute supply shortages of PPE published on 17 04 2020. This plan was approved by the Covid-19 Tactical Group and subsequently shared with our local Staff Side Chair (Unite), Deputy Staff Side Chair (Unison) and the Local Negotiating Committee Chair (BMA). The CEO has written to the Royal College of Nursing, Unite and Unison regional officers to provide assurance that the health and safety of the workforce is taken seriously and outlined measures in place.

Staff side colleagues have been advised of who the PPE Champions are. Copies of the Covid-19 PPE staff information leaflet and posters on donning and doffing have been provided. The Branch Health and Safety Officer from Unison has completed a number of ward visits to speak to staff and has advised no concerns or outstanding issues were raised.

Governance

The use of PPE has been adhered to in accordance with PHE guidance. This practice has altered as necessary in a timely manner with education for staff being provided. This has been delivered by the Infection Prevention and Control Team and via the implementation of PPE Champions introduced by DIPC in March 2020. There are fifty six PPE Champions in place.

PPE Champions visit areas across the hospital on a daily basis to ensure compliance and support staff queries. Dr Farag, Cardiology Clinical Lead /Innovation Lead has participated in ward/department visits with the PPE Champions and selection of specialist respiratory protective equipment for staff.

CInitially a PPE helpline was established but a limited number of calls were received. A PPE email address was introduced which is monitored and responded to by the Patient Safety Team. A small number of enquiries have been received. A frequently Asked Questions document has also been developed.

There has been clear instruction form the Chief Executive Officer and Chief Nurse/DIPC that staff must not undertake clinical duties without the correct PPE. All PPE in use has a risk assessment and an overarching PPE SOP with oversight provided at the Tactical meeting. This is held daily at 8am and the amount of PPE stock is discussed with any issues escalated to the Strategic Oversight Group.

Staff are well informed with regard to the use of PPE and when restarting recovery work a proforma has been devised. This also prompts further consideration for PPE ‘burnout’ supporting work around adequate provision of PPE. This is shared with the Procurement Team as the intention to recover services is in the planning phase of restarting.

Incident Reporting

Incidents are triangulate between the Governance Team and the Health and Safety Team to ensure clear oversight of PPE incidents. These are reported to the Strategic Oversight Group by the Chief Nurse/DIPC accordingly. Where necessary the Chief Nurse/DIPC will appraise the Strategic Oversight Group of cases for both patients and staff that require reporting to the Health and Safety Executive (HSE) under RIDDOR. These are reviewed on a case by case basis.

To date there have been nineteen incidents reported relating to PPE. Ten of these relate to clinical incidents and nine to non-clinical incidents. There are no incidents that relate to PPE provision. The main theme relates to education and training which has been provided throughout the pandemic by the Infection Prevention and Control Team and PPE champions. PPE incidents are monitored daily by the Senior Governance Manager and Health and Safety Team. There have been no harm incidents.

3 PPE incidents are currently being reviewed which relate to the following:

- Monitoring of PPE stock at local level in Critical Care
- Distribution of non-fluid repellent gowns to Critical Care 02 April 2020
- National product recall of Tiger Eye Protector Product on 9 May 2020

Following the incidents reported the Associate Chief Nurse for IPC and the Infection Control Team have reviewed the process for the distribution of equipment including gowns to ensure that all areas are allocated sufficient and appropriate equipment. Gowns are now rated as gold, silver or bronze which reflects the level of fluid repellence. This dictates the clinical distribution of gowns, those with higher fluid repellence will be distributed to areas where there are higher numbers of aerosol generating procedures. Daily stock reviews are undertaken by procurement and there is a clear labelling system in place to ensure that all areas are provided with the correct equipment and sufficient quantity.

The Tiger Eye Protector Products were immediately recalled at the time of the CMO alert (CEM/CMO/2020/021) on 9 May 2020. These products were added to the national pandemic preparedness programme stock in 2009 and testing by the HSE identified the product does not meet the current British or European safety standard for protective eyewear.

The Trust are further supported by a North West PPE meeting where clear actions are identified involving future modelling to identify how PPE is considered, the direction of procurement and the PPE national inventory. The last meeting was held on 11 May 2020, actions identified are detailed in appendix 2. The meeting also discussed a ‘Northwest PPE Battle Rhythm’ (appendix 3) which details the regional process to support PPE provision.

Trust’s are required to enter stock levels and burn rate for each item onto the new national procurement system every day 7 days a week. This system is reviewed daily to inform decisions regarding push stock. We escalate any issues regarding stock levels and quality of PPE via a daily NW PPE meeting. Each day any issues are then escalated on our behalf to the national Gold Commander at NHSE, Emily Lawson.

The CM Chief Executives and Finance Directors have supported a mutual aid scheme to provide support across all organisations. This scheme has been operating successfully and was in place very quickly as a contingency to support staff across the healthcare system. The NSDR emergency route

for stock that will run out within 24 hours, and the daily review of the national system also considers stocks across local healthcare systems. It is therefore essential that all providers keep the system updated every day, with accurate burn rates.

There have been a number of communications regarding Trust's ability to purchase PPE. Providers are still able to purchase PPE provided they don't purchase substantial levels. There has not been any further clarification regarding what amount 'substantial' is. Therefore we do continue to source stock locally.

A system has gone live developed with the NW Innovation Agency and Alder Hey Innovation Team that enables potential suppliers to submit their proposals / offer of PPE. A robust process is undertaken on behalf of all Cheshire Mersey Trusts to ensure the certification of the PPE and the financial viability of the supplier. Local procurement teams are then able to see which suppliers are available to provide PPE. In addition we are exploring a number of opportunities to establish new 'make' partners which could support the local health economy and provide a sustainable local production of PPE.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Continue:

- daily monitoring of PPE stock levels with escalation to the NSDR email address where outage is predicted
- NW PPE daily battle rhythm
- forward planning of PPE requirements for re-establishing elective activity

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

6. TRAJECTORIES/OBJECTIVES AGREED

Objective to ensure there are sufficient and appropriate stocks of PPE to meet all service requirements.

7. MONITORING/REPORTING ROUTES

Covid-19 Tactical Group

Covid-19 Strategic Group

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.

Appendix 1 PPE Risk Assessment/ PPE Shortage Plan

RISK ASSESSMENT

Division	Trust-wide	Assessment Reference Number	
Manager	Helen Wynn, Head of Safety and Risk	Date Of This Assessment	6th April 2020
Ward/Department	Trust-wide	Review Date	Weekly
Area/Process/ Activity To Be Assessed	Personal Protective Equipment during COVID-19 pandemic.		

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
1	Viral hazard (SARS-CoV-2) • Unknown hazard from asymptomatic patients/staff	Staff Patients Visitors	• Personal protective equipment (PPE) as per national guidance for COVID-19 pandemic • Visiting restrictions	4	3	12
2	Viral hazard (SARS-CoV-2)	Staff	• Visiting restrictions • PPE as per national guidance	4	3	12

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
	• Risk from suspected/confirmed cases (non-aerosol generating procedures)	Patients Visitors	- (2a) Fluid resistant surgical face mask (Type IIR) – to be worn at all times in clinical areas - (2b) disposable plastic apron and (2c) disposable non-latex gloves for close contact <2 meters with patients and risk of contact with patients' blood/body fluids/dealing with spillages - (2d) Eye protection (if risk of splash)			
2a)	Respiratory droplets reaching the mucosa of the mouth and nose	Staff	Fluid resistant surgical masks (FRSM) • FRSM can be used for a session of work rather than single patient where patients are cohorted in one area and multiple patients are visited in rapid sequence • Not to be worn in corridors or public areas unless transferring patients • To be worn in all clinical areas to provide a physical barrier and minimize contamination of the nose and mouth by droplets • Change masks when they become moist or damaged (leave the immediate clinical care are to change the surgical face mask) • Not be tied to lanyards pre-use	4	3	12

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
			• Cover both the nose and mouth • Not be touched once put on • Be worn once and discarded in an appropriate clinical waste bin (after leaving the clinical area) • not be allowed to dangle around the neck after use			
2b	Contamination of uniforms with respiratory droplets	Staff	Disposable plastic apron In most circumstances plastic aprons: • provide suitable protection from blood, body fluids, excreta and secretions where there is a risk of contamination of clothing. • should be put on immediately before an episode of direct patient contact/treatment and where there is a likelihood of blood/body fluid exposure • **should be removed immediately after an episode of patient contact/treatment or after decontamination of equipment used by that patient**	4	3	12

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
			• **should be donned prior to and immediately before entering the patient care area e.g. side room** • should be changed between caring for different patients and between different care activities for the same patient • Following removal must be discarded into a clinical or hazardous waste receptacle.			
2c	Contamination of hands and or forearms		Disposable non-latex gloves should be: • put on immediately before an episode of patient contact or treatment and must be removed immediately after completion of that episode of care • worn as a single use item. After each procedure, used gloves must be discarded into a clinical or hazardous waste receptacle • should be changed between caring for different	4	3	12

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
			patients and between different care activities for the same patient • Change if torn or contaminated • **Gloved hands must not be washed or decontaminated with the hygienic hand rub** • **Powdered gloves must not be used in the healthcare setting** Wash hands after glove removal as gloves may be punctured or torn during use and hands are easily contaminated as gloves are removed. Forearms should be washed if they are contaminated. The type of glove should be selected based on the task to be undertaken. Vinyl/PVC or nitrile gloves should be the first choice. • **Vinyl/PVC** gloves may be worn for tasks with a risk of			

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
			contact with blood/body fluids, urine, faeces and vomit • **Nitrile/synthetic latex alternatives** are suitable for tasks with a risk of prolonged contact with blood/body fluids, urine, faeces and vomit and where there is latex allergy • **Nitrile** gloves are also suitable for contact with hazardous chemicals following Control of Substances Hazardous to Health risk assessment • **Sterile PVC/Nitrile/Latex*** gloves must be used for invasive procedures into sterile tissues or body cavities • **Polythene** gloves are not recommended for use in the clinical setting ***Latex gloves should only be used where there is no alternative and following risk assessment. Control measures must be in place to restrict access to the users identified by a separate risk assessment.**			

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
2d	Respiratory droplets reaching the mucosa of the eyes		**Eye Protection** Eye protection must be used when there is a risk of contamination of the eyes by splashes and/or droplets e.g. blood, body fluids, secretions, and excretions generated through patient care. **Eye protection must always be worn during aerosol-generating procedures.** Eye protection can be achieved by the use of any one of the following:- • polycarbonate safety spectacles or equivalent • full face visors • surgical mask with integrated visor Non-disposable eye protective equipment e.g. polycarbonate safety spectacles pose a potential cross-infection risk. It is important that any such re-usable items are decontaminated	4	3	12

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
			safely after soiling, using agents recommended by the manufacturer. Wash hands after removing items of personal protective equipment including eye protection. Regular corrective spectacles/prescription glasses are not considered as protective eye protection.			
3	Viral hazard (SARS-CoV-2) Increased risk of transmission when performing aerosol generating procedures (AGPs) on any patient. AGPs include: • Intubation • Extubation • Manual ventilation • Tracheotomy/Tracheostomy • Bronchoscopy • Upper airway ENT procedures that	Staff	PPE as per national guidance for COVID-19 pandemic (3a) Long sleeved disposable fluid repellent gown (covering arms and body) (3b) An FFP3 respirator (model fit tested against) (2c) Gloves (2d) Eye protection • Use single use/ disposable PPE where available	4	3	12

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
	involve suctioning • Surgery/Post Mortem procedures involving high-speed devices • High flow nasal oxygen • Manual ventilation • Open suctioning of the respiratory tract • Induction of sputum (cough)* • Non-invasive ventilation • Bi-level positive airway pressure • Continuous positive airway pressure • High frequency oscillatory ventilation • Upper GI endoscopy where there is suctioning of the upper respiratory tract • Some dental procedures (for example high speed drilling) *PHE is currently updating the list of AGPs and this list will be revised once updated guidance is received.					

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
3a	Risk of extensive soiling of clothing with aerosols/respiratory droplets or blood/body fluids and a risk assessment indicates a plastic apron will not provide sufficient protection	Staff	Long sleeved fluid repellent gown • Use a disposable gown if available • Gowns can be worn for a session of work in high risk areas (e.g. ICU) • Gowns must be used during invasive procedures into sterile tissues or body cavities and for aerosol generating procedures where patients are suspected or known to have certain infections e.g. Covid-19 • Gowns should: fully cover the area to be protected, be worn only once and following removal placed in a clinical or hazardous waste receptacle or laundry receptacle as appropriate • If a non-fluid repellent gown is used, a plastic apron should be worn underneath • wash hands after all items of personal protective equipment including the gown have been removed	4	3	12
3b	Respiratory droplets reaching the mucosa of the mouth and nose when performing AGPS	Staff	Filtering face piece class 3 (FFP3 masks) • Trust employed Fit testers have been trained by an External accredited Fit2Fit company • FFP3 Fit testing carried out for all front line staff	4	3	12

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
	Risk of self-contamination from: • Touching once in use • Placed around the neck when not in use • Not sealing around face • Masks too big • Incompatible with other protective equipment (e.g. eye protection)		• Staff should only use the make and model of FFP3 respirator they have been successfully fit tested to use • Not be tied to lanyards pre-use • A Fit check is carried out each time an FFP3 respirator is put on before use • Cover both the nose and mouth • Not to be touched once put on • Various sizes available • Staff are advised to remove facial hair to ensure adequate seal • Change masks when they become moist or damaged (leave the immediate clinical care are to change the surgical face mask) • FFP3 respirators to be removed outside the patients room/isolation area in a safe zone • FFP3 respirator can be used for sessional activity (does not need to be changed in between each patient) • not be allowed to dangle around the neck after use			

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
			• Be worn once and discarded in an appropriate clinical waste bin (after leaving the clinical area) • Not to be worn in corridors or public areas unless transferring patients			
4	Risk of staff self-contamination due to using unfamiliar items of PPE	Staff	Training PHE training videos covering: • Donning • Doffing https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures • Covid-19 PPE Training booklet • Staff have been trained as PPE Champions • Staff have been trained in the use of donning and doffing of PPE /demonstration • Staff to be hydrated and used the toilet before donning equipment • Staff know what PPE they should be wearing and the order it must be put on and taken off to minimise the potential for cross contamination • All items of equipment adjusted to fit the wearer	4	3	12

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
			• A buddy system in place with other staff to ensure correct PPE is worn, adjusted and safely removed • Policy in place			
5	Lack of availability of PPE	Staff	• NHS Supply Chain delivering PPE to the Trusts on a push out basis • Daily PPE requirements to be emailed to the MOD • PPE supply shortages are escalated via the National Supplies Disruption Response Team email address • Alternative choices to national recommendations including reusable fluid repellent theatre gowns	4	5	20
6	Stress • Anxiety • Lack of confidence • Protection • Re-assurance • Uncertainty • Breaks	Staff	• Staff have been trained of what PPE they should wear and ensure hands are kept away from their faces • Specific training has been provided for Fit testing • PPE is ready available • Communications sent daily • Occupational Health help line available • Staff to take regular breaks/rest periods	4	3	12

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
7	Inadequate numbers of staff passing FFP3 Fit Testing or lack of alternative respiratory protection (e.g. powered hoods): including: • Inadequate FFP3 fit • Lack of training • Availability of staff • Availability of smaller size masks • Availability of alternative respiratory protection • Facial hair and markings e.g. mole	Staff	• A number of Fit Testers have been trained • Daily sessions being undertaken through the Trust • Equipment and sensitivity/test solutions available • Fit testing sessions are advertised through Communication • Supplies are actively sourcing alternatives to FFP3 respirators • Staff are asked to be clean shaven to ensure a secure fit/face seal • Use alternative face masks	4	3	12
8	Risk of contamination to hands and inadequate decontamination due to:- • Rings • Watches • Sleeves	Staff	• Uniform/Workwear Policy • Hand Hygiene Policy • Hand Hygiene to include exposed forearms • Use of alcohol hand rub/soap and water • To be completed after removing/ disposing of any/ all elements of PPE • Essential before and after all patient contact • Staff to be bare below the elbows when not performing AGPs • Hand hygiene as per WHO 5 moments	4	3	12

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
9	Waste disposal	Staff	• Use orange clinical waste bins inside rooms for waste disposal (including items of PPE and domestic waste) • Waste to be handled as per local policy • All PPE disposed of as clinical waste • Orange clinical waste bin outside the room for disposal of respirator	4	3	12
10	Patient Transfer	Staff Patients	• Staff to wear Aprons, FRSM and gloves for transferring possible or confirmed COVID 19 cases not on respiratory support that would be considered aerosol generating • If within 2 metres, eye protection is recommended • Patients to wear a surgical mask if this can be tolerated • PPE as per AGP (3) including FFP3 respirator and fluid repellent gown where patients are on respiratory support that would be considered aerosol generating	4	3	12
11	Room cleaning • Contamination	Staff	• The rooms of patients to be cleaned at least daily and enhanced cleaning of frequent hand touch surfaces • Domestic staff to wear PPE - PPE as per AGP (3) including FFP3 respirator and fluid repellent gown where patients are on respiratory support that would be considered aerosol generating	4	3	12

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
			- PPE as per non-aerosol generating procedures for possible or confirmed COVID 19 cases • The rooms appropriately decontaminated before being used again • Cleaning equipment must be decontaminated after use • Clinical staff may be asked to clean rooms • Rooms to be cleaned with the appropriate cleaning products i.e. Actichlor plus			
12	Risk associated with home laundering of uniforms	Staff	• Scrub suits to be provided for staff working in hot zones (e.g. ICU, theatres, A7) and scrub suits to be laundered by the Trust laundry contractor • Advice provided to: • change into uniforms at work and out of uniform before travelling home. Place used uniform in a plastic disposable bag. This bag should be disposed of into the household waste stream • wash uniforms separate to all other household items • do not overload the washing machine	4	3	12

No	Hazards Identified	Persons Affected	Existing Control Measures	Consequence x Likelihood		Initial Risk Grading
			• wash heavily soiled items separately • wash uniforms at the hottest temperature the material will allow ensuring a detergent is used (powder or liquid) then iron or tumbled-dry			
13	Risk to contracted service providers – pressure relieving mattresses	Contractor staff	• Mattress to be managed as per SOP from contractor - Exterior cover to be wiped with a solution of 1, 000ppm chlorine - Mattresses to be double bagged (red bags) - Decontamination certificate to be attached	4	3	12
14	Risk to contracted service providers – waste including sharps	Contractor staff	• Policy in place • All waste to be disposed of in orange bags • Sharps waste to be disposed of as per policy	4	3	12
15	Risk to contracted service providers – Linen	Contractor staff	• Policy in place • Used linen including scrub suits and launderable – reusable gowns to be placed in red bags and then a white outer bag	4	3	12
16	Risk associated with donations of PPE from external organisations and or newly developed items that do not meet EN standards or are not CE marked	Staff	• Review by end users, Infection Control and Health and Safety review and risk assessment, standard operating procedure, clear guidance on monitoring and Executive Team approval	4	3	12

ACTION PLAN

HAZARD NUMBER	ACTION REQUIRED	TARGET DATE FOR COMPLETION	PERSON RESPONSIBLE FOR ACTION	COMPLETED BY (Name and Date)	STRATEGIC AIM
All	Ensure a fit testing training programme is in place for all relevant staff This will include qualitative fit testing and quantitative fit testing	April 2020	Infection Control	Lesley McKay	
All	Ensure alternative respiratory protection (e.g. powered hood) is available if staff do not pass FFP3 respirator fit testing.	April 2020	Supplies	Alison Parker	
All	Where re-usable respiratory protection is provided staff receive instruction on care of the equipment including decontamination	April 2020	All Ward Managers	All Ward Managers	
All	Exclude staff from providing aerosol generating procedures where appropriate respiratory protection is not available	April 2020	All Ward Managers	All Ward Managers	
All	Ensure all relevant staff have suitable and sufficient training for the use of PPE	April 2020	All Ward Managers	All Ward Managers	
All	Ensure all relevant PPE is worn at all times when dealing with a confirmed or potential COVID-19 patient based on care activity i.e. aerosol/non-aerosol generating procedures	April 2020	All Ward Managers	All Ward Managers	
All	Ensure there is stock of all relevant PPE that is required for treating patients	April 2020	Supplies	Alison Parker	
All	Ensure all stock is kept in a locked designated area	April 2020	Supplies	Alison Parker	
All	Ensure PPE is in good working order, with no faults, damage or holes etc.	April 2020	All Staff	All Staff	
All	Ensure all relevant staff understand and trained in donning and doffing	April 2020	All Ward Managers	All Ward Managers	
All	Ensure all staff received training booklet	April 2020	All Ward Managers	All Ward Managers	
All	Ensure all staff have watched PHE donning and doffing training videos	April 2020	All Ward Managers	All Ward Managers	
All	Ensure mattresses are double bagged and decontamination certificate is attached.	April 2020	All Ward Managers	All Ward Managers	
All	Ensure all waste disposal of in orange bags	April 2020	All Ward Managers	All Ward Managers	
All	Ensure reusable gowns are placed in red bags and then a white outer bag.	April 2020	All Ward Managers	All Ward Managers	

COMPLETED BY (Please print name /Designation)	Debbie Weeks Health and Safety Advisor	**SIGNATURE** **DATE**	D Weeks 6th April 2020
APPROVED BY (Senior Manager – Please print name)	Helen Wynn Head of Safety and Risk	**SIGNATURE** **DATE**	H Wynn 6th April 2020

Appendix 2 North West 11 May 2020 meeting actions

Area	Description
NW Regional COVID 19 Governance Structure	Current NW Regional COVID 19 Governance Structure will be circulated to the Group (note PPE currently sits in the ICC).
Future Modelling	NW future modelling being submitted to Regional Incident Director on Fri 15 May 20. Suzanne will engage with team developing the model to identify how PPE is being considered.
Procurement Direction	Preeya Bailie to be invited to NW Lead meeting to discuss procurement model.
Non COVID19 PPE	Discussion around when non COVID19 PPE requirements will be identified. Agreed to take question to National Team.
LA PPE	Action to investigate if LA had same guidance as NHS Trusts regarding direct procurement of PPE.
Battle Rhythm	NW PPE Structure battle rhythm discussed. Slide to be sent to STP Area leads.
Push and Emergency Delivery Spreadsheets	All spreadsheets ref push and emergency deliveries to be sent to STP Area Leads.
PPE National Inventory	Request to National Team to release National PPE inventory figures as a 72hr RAG assessment.
NW PPE Meeting Invitees	The STP Area leads to identify and invite supporting personnel.
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Appendix 3 North West Battle Rhythm

NW PPE Daily Battle Rhythm

- 1030hrs – NW Daily PPE meeting – Regional PPE Lead and STP Cell leads
  - NW Region PPE Lead briefed on all issues and requirements by System Leads to take to the 15:00 Regional PPE meeting and 1800 National meeting
- 1100hrs – Area Cells daily Pick List requirements submitted to Supply leads.
- 1130hrs – EPRR/Supply leads daily Pick List meeting.
- 1200hrs – Trusts input to National COP complete.
- 1500hrs – Daily Pick List complete.
- 1500hrs – All Region PPE meeting.

  -NW Region PPE Lead attends with all Regions

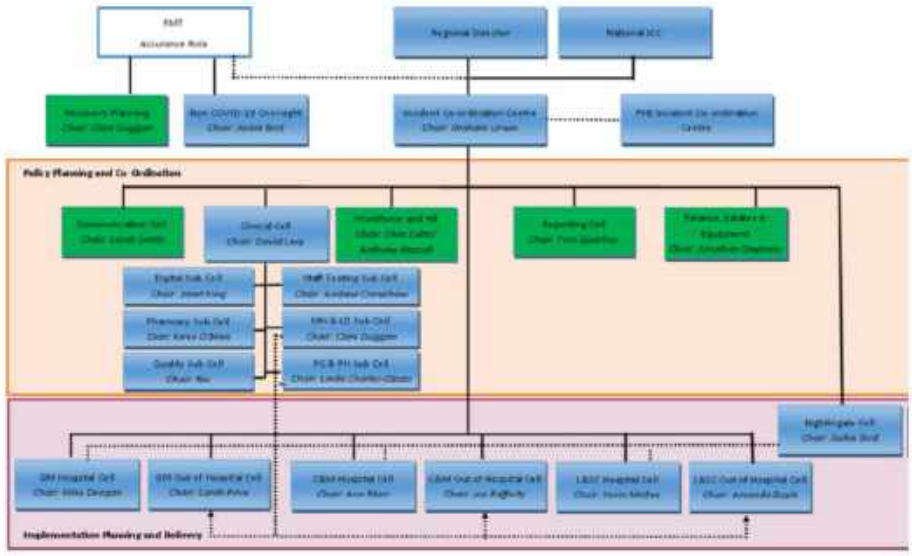
  -NW Region PPE Lead will feedback to STP Cell Leads (email or call)
- 1800hrs – National Supply Chain daily Pick List decision meeting.

  - NW Region PPE Lead attends with other Regional Leads plus the National PPE Leads

  - NW Region PPE Lead will feedback to Area Cell Leads (email)

1

North West COVID 19 Governance



2

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/05/61**	
SUBJECT:	**2019/20 SIRO (Senior Information Risk Owner) Report**	
DATE OF MEETING:	27th May 2020	
AUTHOR(S):	Phillip James, Chief Information Officer	
EXECUTIVE DIRECTOR SPONSOR:	Phillip James, Chief Information Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1114** Failure to provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, caused by increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, resulting in poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#145 a.** Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The report provides assurance that Information Risk is being managed robustly. Attention is drawn to the following key issues: • 11 Cyber Essentials+ actions remain outstanding due to their relationship with national actions. All possible local actions have been completed and the residual risk is tolerable; • 48% of server operating systems remain to be migrated to a supported operating system. Support for Windows 2008 has been extended whilst the trajectory is resolved and then regularly tracked by Digital risk reviews; • 1 DSPT requirement to train 95% of staff in-year remains unmet. The Trust is engaged in national work to resolve this; • 2 high Service Continuity and Resilience Actions remain outstanding. Plans are in place for December 2020 completion and are regularly tracked by Digital audit reviews; • Trust executive officers remain to receive the Board Cyber Security Training. Date for completion will be arranged with the Board Secretary.	

PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Board is asked to: • Note and approve the contents of the report; • Receive assurance that SIRO responsibilities are being fulfilled effectively.			

PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of	

	Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 31-Law Enforcement	

REPORT TO BOARD OF DIRECTORS

SUBJECT	SIRO Report	AGENDA REF:	BM/20/05/61

1. BACKGROUND/CONTEXT

This report relates to the period 1st May 2019 to end April 2020. It contains a quantitative and qualitative analysis (using information obtained from the Datix risk and incident system, CareCERT dashboard, Data Security And Protection Toolkit, audit reports, Microsoft windows management tools and the minutes of the Information Governance And Corporate Records Sub-Committee).

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

The purpose of the report is to ensure the Board understands how the strategic business goals of the organisation may be impacted by any information risks and the steps being taken to mitigate those risks. The Trust Senior Information Risk Owner is the Chief Information Officer whom holds responsibility for assuring the Board that Information Risks are indeed adequately managed.

2. KEY ELEMENTS

Summary Of Assurances

- IG Framework
  - The Board is sighted on Information Risks via a robust Information Governance Framework.
- Information Risk Analysis
  - Digital risks are regularly reviewed and allocated against CBU, Corporate or BAF;
  - A single Digital BAF entry exists;
  - A recent rise in risk volumes reflects our consideration of COVID-19.
- Data Security And Protection Toolkit
  - The Trust submitted its DSPT submission by the original deadline of 31st March 2020.
  - 1 requirement remains unmet – 95% of staff trained in-year. The Trust is engaged in national work to resolve this;
  - Internal Audit have recorded “substantial assurance” against their review of our DSPT 19/20 submission.
- Cyber Security
  - All CareCERT Alerts have been actioned;
  - The Windows 10 desktop programme is almost complete;
  - 52% of Server 2016 upgrades complete with trajectory for outstanding to be agreed;
  - 34 MIAA Service Continuity And Resilience Review actions have completed with 1 high/2 medium outstanding; plans are in place to compete these actions by 31st July 2020.
  - Cyber and Specialist Training has been implemented with outstanding Deputy SIRO Training and Executive Board Cyber Training planned.
- Information Governance Incidents Reported To The ICO
  - No Information Governance Incidents were reportable to the ICO.
- The Role Of The Trust Caldicott Guardian

- The Trust Caldicott Guardian is fulfilling their responsibilities via the Information Governance Framework.

IG Framework

The Trust's IG framework describes the approach taken to meeting its statutory duties in relation to information governance, cyber security, data protection and confidentiality.

The Trust's Information Governance and Corporate Records Sub-Committee (IGCRSC) meets bi-monthly to support and monitor the implementation of the standards contained within the NHS Digital Data Security and Protection Toolkit. The IGCRSC is chaired by the SIRO (Chief Information Officer) and is attended by the Caldicott Guardian (Acting Medical Director/Chief Clinical Information Officer). Both the SIRO and the Caldicott Guardian take a lead role at the IGCRSC and champion information governance requirements at the highest levels within the Trust.

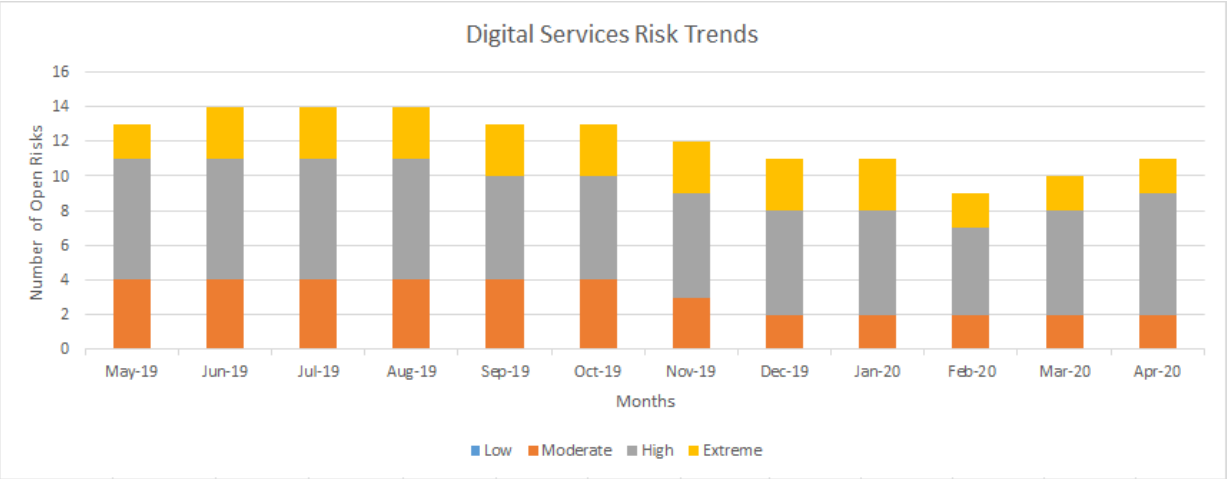
The IGCRSC reports to the Quality Assurance Committee.

Information Risk Analysis

The Digital Services department has identified a single point of contact to manage risks. The IT Manager is responsible for maintaining the department's risks in the Datix system. The departments' risk management discipline ensures all risks are structured according to Trust policy and regularly reviewed at the Digital Services Risk Review meeting.

Risks and mitigating actions are also scrutinised by the Trust's Risk Review Group and information risks are also included as a standing agenda item at the Information Governance and Corporate Records Sub-Committee which reports to the Quality Assurance Committee.

The below graph indicates Digital Services Risk trends over the previous 12 month period with risk numbers reducing over time as actions have completed. The recent rise in numbers reflects COVID-19 considerations.



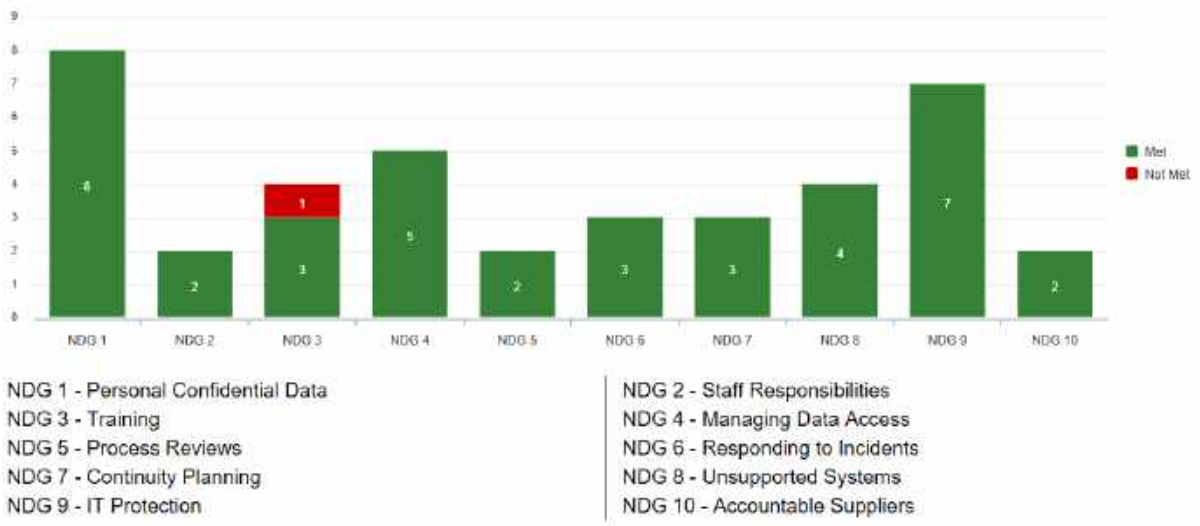
Appendix 1 contains details of current Digital Services open risks. These risks were last reviewed on 12th May 2020 by the Digital Services Risk Review Group.

Data Security and Protection Toolkit Assessment 2019/20

Organisations that have access to NHS patient information must provide assurances that best practice data security and protection mechanisms are in place. The Trust is contractually obliged to undertake assessments against the NHS Digital Data Security and Protection Toolkit on an annual basis.

In light of the current Covid-19 emergency NHSX took the decision to extend the deadline for the mandatory March 2020 DSPT submission. The deadline for submission was extended to 30th September 2020. Despite the extension the Trust's DSPT submission was made on time by 31st March 2020.

The Trust's 2019/20 Data Security and Protection Toolkit assessment was reviewed by Mersey Internal Audit Agency in March 2020 as part of the Trust's annual audit programme. The Governance assurance statement provided in the published review stated that *"Warrington and Halton Teaching Hospitals NHS Foundation Trust has demonstrated that it has implemented a robust, active framework to progress its information governance agenda".* The overall assurance level awarded for the Trust's 2019/20 Data Security and Protection Toolkit submission is Substantial Assurance.



NDG 1 - Personal Confidential Data
NDG 2 - Staff Responsibilities
NDG 3 - Training
NDG 4 - Managing Data Access
NDG 5 - Process Reviews
NDG 6 - Responding to Incidents
NDG 7 - Continuity Planning
NDG 8 - Unsupported Systems
NDG 9 - IT Protection
NDG 10 - Accountable Suppliers

The area highlighted in red in National Data Guardian standard 3 relates to the mandatory Data Security and Protection training of the Trust's staff. It is a requirement of the DSP Toolkit that 95% of staff must complete the DSP training in-year. This standard has been difficult to achieve and work is underway nationally to expedite a solution to the issue of training such a high volume of staff in-year. Difficulty in complying with this DSP Toolkit standard has been reported by a number of organisations across the Cheshire and Mersey region.

Cyber Security

The Lessons learned review of the WannaCry Ransomware Cyber Attack from February 2018 recommended that all NHS organisations move towards Cyber Essentials PLUS, as recommended by the National Cyber Security Centre (NCSC). Equivalent requirements were incorporated into the DSPT in 2019-20 for Large NHS organisations. Many of these requirements were "non-mandatory" to support organisations to work towards achieving Cyber Essentials PLUS equivalence. In 2020-21 these non-mandatory requirements are mandatory.

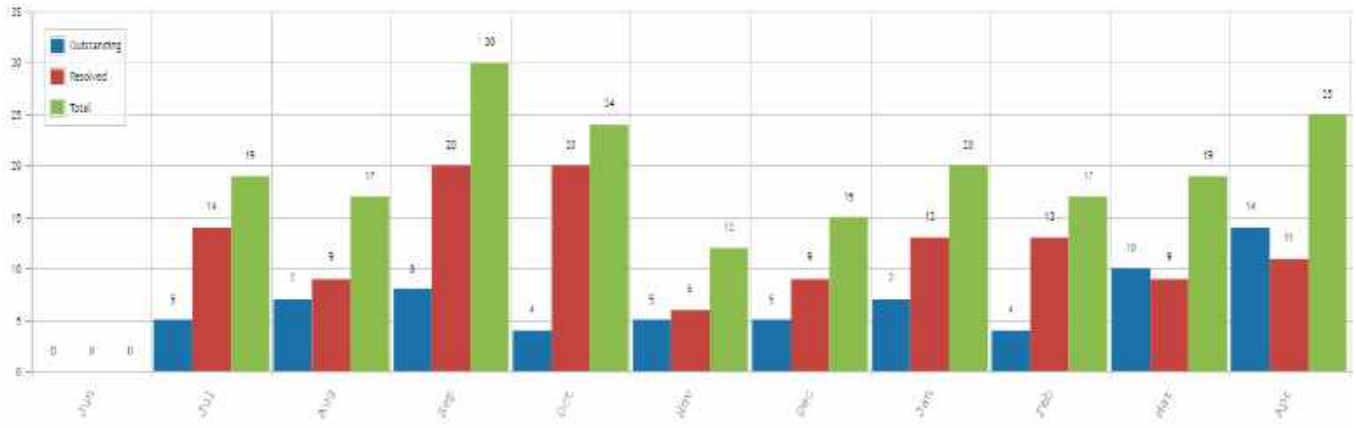
There are 51 standards within the Cyber Essentials Plus standard. The below tracker details the outstanding standards since May 2019. 11 of 51 standards are currently outstanding. Although a number of these standards have been completed locally there are national issues which prevent full compliance.

➢ CareCERT Alerts

All Trust's required to receive and act upon any critical and high security alerts from NHS Digital's CareCERT Cyber Security Bulletins, and to confirm that they have taken the required action, or have sought support from NHS Digital. Any issues are raised with the SIRO.

The Trust procured an IT Assurance Dashboard Solution which consolidates all areas of WHH cyber security into a single, real-time view including our status in respect of the regular CareCERT alerts. This gives complete visibility of what's happening within the Trust network. It significantly increases our understanding of the risks we face and levels of compliance at both a local and national NHS Digital level. Most importantly it provides the IT Team with confidence in the assurance provided to the Board on the security of our IT infrastructure and any risks identified.

The below tracker details the CareCERTS issued, what have been completed and what is outstanding since June 2019. Numbers of outstanding actions do fluctuate dependent upon cyber threat levels but all actions are closed, ensuring the green total does not trend upwards overtime.



➢ Desktop and Server Operating System Patching

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

➢ Migration from Unsupported Operating Systems and Applications

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

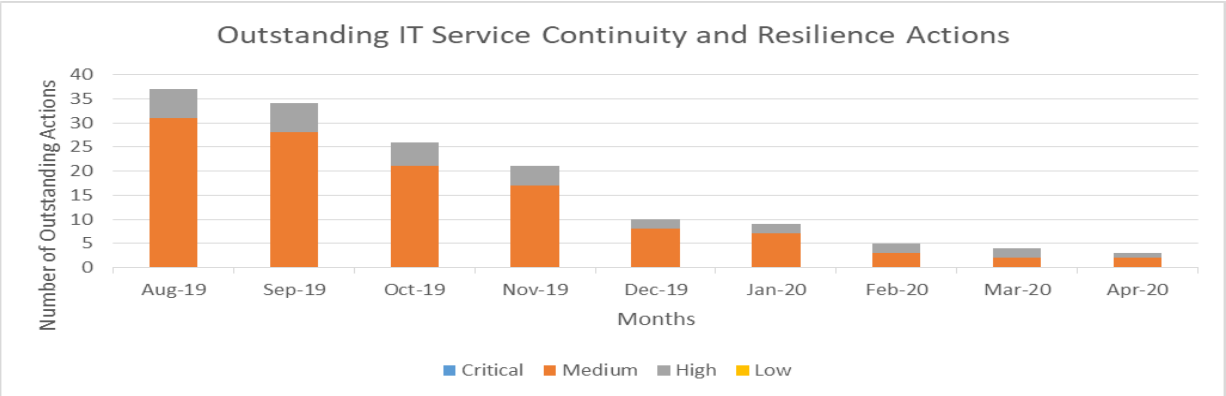
- Software will no longer receive security updates from its developers, increasing the likelihood that exploitable vulnerabilities will become known by attackers.
- Latest security mitigations are not present in older software, increasing the impact of vulnerabilities, making exploitation more likely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

The Trust have migrated 99% of desktop machines from unsupported Windows 7 to the latest Windows 10 operating system. The Trust have migrated 52% of the unsupported Windows Servers to Windows Server 2016 and extended support for Windows 2008 whilst the migration trajectory is resolved. The Trust has registered an interest with NHS Digital to migrate Office 2010 to Office 365, with the projected migration of September 2020.

➢ MIAA IT Service Continuity and Resilience Review

The IT infrastructure and services within the Trust are critical in delivering business and care enabling technology, systems and data to the organisation. Disruption to these will have a significant adverse impact on operational effectiveness and efficiency of the organisation. Incidents and events do, however, occur and it is important that the Trust, have in place robust, tested and business aligned IT service continuity and recovery arrangements in order to minimise these impacts.

There were 37 recommendations from the review. The tracker below details the number of outstanding actions since August 2019.



➢ Cyber and Specialist Training

During 2019/20 bespoke Cyber Security training has been provided to key staff including Non-Executive Directors with some Executive Directors outstanding. The remaining directors will be briefed on a date to be arranged with the Board Secretary. In addition to this the SIRO training has been undertaken by the SIRO and the Deputy SIRO has been provided with the NHS Digital approved training materials.

Specialist training undertaken is included in the table below.

Training	Attendees	Provider	Date
GCHQ Certified SIRO Training	• Chief Information Officer	Templar Executives (on behalf of NHS Digital)	13/03/20
GCHQ Certified Board Cyber Security Training	• SIRO • Caldicott Guardian • IT Manager • IG Manager • Senior Digital Services Technical Staff	Templar Executives (on behalf of NHS Digital)	16/01/20
Cyber Security Training	• Chairman • Non-Executive Directors • IT Manager • IG Manager	SIRO	07/05/20
Introduction to Cyber Security course	• IT Manager	Open University (on-line)	2020
Cyber Security Skills	• IT Manager	Immersive Labs Cyber Skills Platform (GCHQ recognised)	2020

The Trust IT Manager and Information Governance Manager are active members of STP cyber forums through which additional personal development is gained, alignment of approaches is agreed and lessons are shared.

Information Governance Incidents Reported to the ICO

In the 2019/20 financial year the Trust reported 5 data loss incidents via the Data Security and Protection Toolkit reporting tool which were escalated to the Information Commissioner's Office (ICO). After investigating the circumstances surrounding each of the 5 reported incidents the ICO ruled that further action against the Trust was not necessary. Under the Network and Information Systems (NIS) Regulations 2018 the Trust is required to have adequate data and cyber security measures in place to protect against the increasing cyber threat. As an operator of essential services we are required to report network and information systems incidents which have significantly affected the continuity of services. The Trust has recorded no such incidents in the 2019/20 financial year.

ICO Reportable Incidents 2019/20		
Incident Ref & Date	**Detail**	**Outcome**
13121-26/04/19	A Friends and Family automated SMS message was sent to the biological mother of a child treated at the Trust's A&E department	ICO required no further action
14543-15/08/19	Casenotes released to relative of data subject without consent of data subject. Data subject is known to have safeguarding issues with the relative that has obtained the casenotes	ICO required no further action
15919-17/09/19	A complaints letter for complainant was posted to an incorrect recipient (another complainant)	ICO required no further action
17505-29/10/19	A clinic letter was sent to the incorrect patient	ICO required no further action
18045-09/12/19	A data subject with a very similar name to a second data subject received a referral letter for an Ophthalmic appointment.	ICO required no further action

The Role of the Trust's Caldicott Guardian

A Caldicott Guardian is a senior person within a health or social care organisation who makes sure that the personal information about those who use its services is used legally, ethically and appropriately, and that confidentiality is maintained. The Caldicott Guardian works closely with the SIRO to ensure they are appropriately consulted when information risk reviews are conducted for assets which are or that contain personal information.

The Trust's Caldicott Guardian role is held by the acting Executive Medical Director/Chief Clinical Information Officer.

The table below contains information relating to how the work of the Trust's Caldicott Guardian supports the wider Information Governance agenda.

Data Protection Impact Assessments are completed for new / amended processing use cases of Personal Information and signed off	• 11 Data Protection Impact Assessments were approved at the IGCRSC during 2019/20.
IG skills and knowledge are kept up-to-date	• CG has attended meetings of the UK Caldicott Guardian Council. • CG attended GCHQ Certified Board Cyber Security Training in January 2020. This was provided as part of NHS Digital's Cyber Security Support Model (CSSM) .
The Board is informed of confidentiality concerns	• CG attends the IGCRSC and scrutinises reports provided to the QAC. Confidentiality incidents report is a standing agenda item at IGCRSC. • CG routinely informed of incidents escalated via the DSP Toolkit incident reporting system and of incidents escalated to ICO.
Arrangements for confidentiality and data protection are monitored	• Confidentiality audits conducted provided to IGCRSC attended by CG. • Confidentiality audits performed in clinical areas to support CQC KLoE 6 evidence provision provided to CG. • Approval of Information Sharing agreements entered into is sought from CG and records kept of approved ISAs.
Staff are provided with clear guidelines and procedures	• Alerts, guidance and policies issued are approved by CG as a core member of the IGCRSC.
Identified improvements to confidentiality processes are implemented	• Lessons learned from IG incidents scrutinised by CG and SIRO at IGCRS and escalated to Quality Assurance Committee. • Actions identified to improve confidentiality processes in audits undertaken approved by CG. • CG approved the 'You Didn't Think Privacy' initiative used to audit IG practices in clinical areas.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The key issues outlines within this report will continually be managed by the named responsible officers through the stated SIRO framework.

4. IMPACT ON QPS?

Our Digital Strategy states *"Well executed digital services are a key care quality enabler, avoiding security risks and interpretation errors associated with paper processes and enhancing the information available in the right place, time and manner."*

Robust information governance processes are essential to the safe delivery of our Digital Strategy.

5. MEASUREMENTS/EVALUATIONS

The 2020/21 SIRO report will report upon these same trends and outcomes to assure the continued effectiveness of the information governance framework.

6. TRAJECTORIES/OBJECTIVES AGREED

The objectives of the SIRO framework are to ensure:

- the board understands how the strategic business goals of the organisation may be impacted by any information risks and
- steps are being taken to mitigate those risks.

7. MONITORING/REPORTING ROUTES

The Information Governance and Corporate Records Sub-Committee has been established to support the Information Governance and corporate records agenda and to provide the Quality Assurance Committee with the assurance that effective Information Governance best practice mechanisms are in place within the organisation.

8. TIMELINES

All timelines are stated in the report.

9. ASSURANCE COMMITTEE

Quality Assurance Committee.

10. RECOMMENDATIONS

The Board is asked to note the assurance provided.

APPENDIX 1 – Current Digital (CBU) Risk Register

Risk	Action	Due Date
ID-135 **FAILURE TO** provide adequate and timely IMT system implementations & systems optimisation **CAUSED BY** either increasing demands or enhanced system functionality **RESULTING IN** additional effort required by staff manifesting as poor data quality, reduced patient access to services, inferior quality of care provided, potential patient harm and missed financial & performance targets.	• Publish revised Digital Strategy with associated 7 year investment profile and delivery plan	**30/06/20**
ID-138 **FAILURE TO** provide timely information **CAUSED BY** increasing demand for accessible Business Intelligence, Insight reports and automated Integrated Dashboards based on data captured within Trust key systems **RESULTING IN** poor decision making, financial impact and external scrutiny and reputational damage.	• Fully develop Interactive Business Intelligence system	**30/09/20**
ID-143 **FAILURE TO** deliver essential Digital services, **CAUSED BY** a successfully executed Cyber Attack, resulting in loss of access to data and vital IT systems, **RESULTING IN** potential patient harm, loss in productivity, damage to the Trust reputation and possible income losses and regulatory fines of up to 4% of the Trusts annual turnover.	• Upgrade Windows 7 to Windows 10	**29/05/20**
ID-202 **FAILURE TO** prevent unauthorised access to electronic person identifiable data **CAUSED BY** smartcard and password sharing **RESULTING IN** invalidation of electronic clinical systems audit trail data	• Recommence ward audits post to maintain improved standards • Review the potential use of virtual smartcards to mitigate the bad practice of leaving smartcards in smartcard readers	**31/12/20** **30/09/20**
ID-208 **FAILURE TO** secure paper medical records in clinical areas **CAUSED BY** poor housekeeping **RESULTING IN** potential breaches of confidentiality	• Recommence ward audits to maintain improved standards	**31/12/20**
ID-211 **FAILURE TO** purchase additional hardware **CAUSED BY** lack of funding **RESULTING IN** Risk of unavailability of IT backend infrastructure (Server & Network hardware).	• Bidding for funding 19/20	**29/05/20**
ID-220 **FAILURE TO** implement the requisite NIS Directive (Networks and Information Systems) policies, procedures and processes **CAUSED BY** lack of resources and monies **RESULTING IN** potential unplanned downtime for systems without resilience,	• MIAA IT Service Continuity & Resilience Review	**29/05/20**

possible income losses and regulatory fines of up to 4% of the Trusts annual turnover.		
ID-221 **FAILURE TO** prepare effectively for the unavailability of telephone systems due to a total network failure **CAUSED BY** reliance on a single digital platform for WHH telephony requirements **RESULTING IN** an inability to communicate internally or externally via telephone	• Red phone availability in ED has been strengthened (Virgin Media Number Added)	**30/06/20**
ID-414 **FAILURE TO** implement best practice information governance and information security policies and procedures **CAUSED BY** increased competing priorities due to an outdated IM&T workforce plan **RESULTING IN** ineffective information governance advice and guidance to reduce information breaches.	• IT Dept restructure to increase resources targeted at Information Governance	**29/05/20**
ID 1114 **FAILURE TO** provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, **CAUSED BY** increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, **RESULTING IN** poor data quality and its effects upon clinical and operational decisions/returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	• To upgrade all windows 7 to Windows 10	**29/05/20**
ID 1127 **FAILURE TO** provide support to Digital services **CAUSED BY** the threat of large numbers of staff unavailable to report to work due to epidemic/pandemic illness or death, enforced isolation, caring responsibilities and other general / related sickness conditions **RESULTING IN** an potential lack of specialist knowledge in specialist areas and adequate number of staff causing an increased time in downtime of systems / hardware or request for change.	• Strengthen Digital Services Business Continuity Plan	**29/05/20**