We are WHH & We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WHH Board of Directors Meeting Part 1

Wednesday 27 May 2020
10.00am-12.00pm
Via MS Teams video conference
Trust Conference Room

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

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

Wednesday 27 May 2020 time 10.00am -12.00pm

Via MS Teams Video Conference, Trust Conference Room, Warrington Hospital

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REF BM/20/05	ITEM	PRESENTER	PURPOSE		
BM/20/05/43	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	10.00	Verb
BM/20/05/44/PAGE 7	Minutes of the previous meeting held on 25 March 2020	Steve McGuirk, Chairman	Decision	10:02	Encl
BM/20/05/45PAGE 17	Actions & Matters Arising	Steve McGuirk, Chairman	To note assurance	10:05	Encl
BM/20/05/46PAGE 19	Chief Executive's Report	Simon Constable Chief Executive	To note for assurance	10:10	Encl
BM/20/05/47	Chairman's Report	Steve McGuirk, Chairman	Information	10:15	Verb

Quality People Sustainability

BM/20/05/48	(a) COVID-19 Situation Report PAGE 24 (b) COVID-19 Performance Summary PAGE 40	Simon Constable Chief Executive	Assurance	10.25	PPT + Enc
BM/20/05/49ai PAGE 62	Integrated Performance Dashboard M1 and Assurance Committee Reports	Kimberley Salmon-Jamieson, Chief Nurse+ Deputy Chief Executive	To note for assurance	10.55	Enc
49 a (ii) PAGE 111	IPR Key Issues – - Quality	Alex Crowe, Acting Exec Medical Director			Enc
49 a (iii)	- Access and Performance	Chris Evans, Chief Operating Officer			Enc
49 a (iv)	- People	Michelle Cloney Director of HR + OD			Enc
49 a (v)	- Sustainability	Andrea McGee Director of Finance + Deputy Chief Executive			Enc
(b) PAGE 116	- Committee Assurance Report Quality Assurance Committee (5.05.2020)				Enc
(c) PAGE 119	- Committee Assurance Report Strategic People Committee (20.05.2020)				Enc
(d) PAGE 122	- Committee Assurance Report Finance and Sustainability Committee (22.04.2020 + 20.05.2020)				Enc
(e) PAGE 126	- Committee Assurance Report Audit Committee (30.04.2020)				Enc

BM/20/05/ 50 PAGE 128	Operational plan 2020/21 including capital plan	Andrea McGee Director of Finance + Deputy Chief Executive	Approval	11.25	PPT

GOVERNANCE

BM/20/05/ 51 PAGE 141	Strategic Risk Register + BAF	John Culshaw Trust Secretary	For approval	11.50	Enc
BM/20/05/ 52 PAGE 166	Infection Control Board Assurance Framework (BAF)	Kimberley Salmon-Jamieson, Chief Nurse+ Deputy Chief Executive	To note for assurance	11.55	Enc
	Any Other Business	Steve McGuirk, Chairman	N/A		Ver
	Schedule of dates attached for information Date of next meeting: Wednesday 29 JULY 2020 Trust Conference Room				

MATTERS FOR APPROVAL

	ITEM	Lead (s)				
BM/20/05/ 53	Extension of Ward K25 – for Ratification	Chris Evans Chief Operating Officer	Committee Agenda Ref. Date of meeting Summary of Outcome	SEOG + COVNED C19SEOG/20/201 + COVNED050 14.04.2020 + 17.04.2020 Approved		Enc
BM/20/05/ 54	Amendment to the Scheme of Reservation & Delegation (SoRD) – For ratification	Simon Constable Chief Executive	Committee Agenda Ref. Date of meeting Summary of Outcome	Executive Team C19SEOG/20/338 07.05.2020 Approved		Enc
BM/20/05/ 55	Compliance with Licence Annual Return - Condition G6 and Condition CoS7	John Culshaw Trust Secretary	Committee Agenda Ref. Date of meeting Summary of Outcome	Not applicable		Enc

MATTERS FOR NOTING FOR ASSURANCE

	ITEM	Lead (s)				
BM/20/05/ 56	Guardian of Safe Working Q4 report	Alex Crowe Acting Executive Medical Director	Committee Agenda Ref. Date of meeting Summary of Outcome	Strategic People SPC/20/05/42 20 May 2020 Noted		Enc
BM/20/05/ 57	Finance + Sustainability Committee - Terms of Reference + Cycle of Business 2020-21	John Culshaw Trust Secretary	Committee Agenda Ref. Date of meeting Summary of Outcome	Finance + Sustainability FSC/20/03/41 18 March 2020 Approved		Enc
BM/20/05/ 58	Key Elements of NHS Staff Opinion Survey	Michelle Cloney Director of HR & OD	Committee Agenda Ref. Date of meeting Summary of Outcome	Strategic People SPC/20/03/32 18/03/2020 Noted		Enc
BM/20/05/ 60	PPE Update	Kimberley Salmon-Jamieson, Chief Nurse+ Deputy Chief Executive	Committee Agenda Ref. Date of meeting Summary of Outcome	Not applicable		Enc

BM/20/05/ 61	**Annual Senior Information Risk Owner) SIRO Report**	**Phill James Chief Information Officer**	**Committee**	Not applicable		**Enc**
			Agenda Ref.			
			Date of meeting			
			Summary of Outcome			

Conflicts of Interest

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

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

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

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

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

Interests fall into the following categories:

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

GLOSSARY OF TERMS

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

DRAFT

Warrington and Halton Teaching Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 25 March 2020
Trust Conference Room, Warrington Hospital

Present	
Steve McGuirk (SMcG)	Chairman, via Teleconference
Simon Constable (SC)	Chief Executive (to Chair meeting at the request of the Chairman)
Terry Atherton (TA)	Deputy Chair, Non-Executive Director, via Teleconference
Margaret Bamforth (MB)	Non-Executive Director, via Teleconference
Alex Crowe (AC)	Acting Medical Director + Chief Clinical Information Officer WHH/Acting Exec Medical Director Bridgewater CHT
Chris Evans (CE)	Chief Operating Officer
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director, via Teleconference
Andrea McGee (AMcG)	Director of Finance and Commercial Development
Cliff Richards (CR)	Non-Executive Director, via Teleconference
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse + Director of Infection Prevention and Control
Anita Wainwright (AW)	Non-Executive Director, via Teleconference
In Attendance	
Michelle Cloney (MC)	Director of HR + Organisational Development WHH + Bridgewater CHFT
Lucy Gardner (LG)	Director of Strategy
Phillip James (PJ)	Chief Information Officer
Pat McLaren (PMcL)	Director of Community Engagement + Fundraising
John Culshaw (JC)	Trust Secretary
Paula Gunner	Senior Executive Assistant (Minutes)
Observing	Norman Holding, Public Governor, via Teleconference
Apologies	None received

BM/20/03/18	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting and welcomed colleagues, and explained that due to COVID-19 and social distancing guidance by the Government in place he and the rest of the Non-Executive and Public Governor would be attending the meeting via Teleconferencing and this was a closed session to the public. All papers and subsequent minutes would be made available on the Trust website as usual. The Chair suggested with the agreement of the rest of the Board that the Chief Executive Chaired the meeting on his behalf in the circumstances all agreed. The CEO detailed how the agenda would flow with the majority of time being spent on updating in the Board on the COVID-19 preparedness Major Incident. The IPR would be taken by exception, ED Nursing Establishment paper to be reviewed for decision and Corporate Governance paper for discussion on how the Board manages Corporate Governance changes going forward in these unprecedented times. Apologies noted above. Previously declared standing declarations were noted from Director HR+OD and Acting Executive Medical Director. CR declared that his partner has taken a position as a casual care worker with the Halton Borough Council. No other declarations in relation to the

	agenda were noted.
BM/20/03/19	**Minutes of the meeting held 29 January 2020** The word (Chair) to be deleted from TA role. With these amendments, the Minutes of 29 January 2020 were agreed as an accurate record.
BM/20/03/20	**Actions and Matters Arising. Action log and rolling actions were noted.**
BM/20/03/21	**COVID-19 Major Incident WHH responses and situation report** The CEO provided an overview of the report as follow: • Up-to-date Situation Report • Incident Management arrangements • Summary of each Executive Portfolio • Key Issue • Questions and Challenge The CEO explained that COVID-19 is a level 4 major incident and the NHS was in a command and control situation. To date the Trust has had 6 patient test positive for COVID-19 and highlighted the following: • 4x In-patients • 1 Community case managed in the POD • 1x death • 60 beds available across the Trust at this time • Significant reduction in stranded and super stranded patients • Low attendances at ED • Leadership slide, showing daily meeting and daily / twice daily Chair & CEO calls • Weekly / twice-weekly NED & CEO calls • Links to national regional and W&H system • CEO and 'technical' communications on a daily basis. • Coronavirus Management Board Structure The CEO explained the clinical features and that supportive treatment is required as there is no cure for COVID-19 the treatment is supportive the initial pressures will be on ED/respiratory/ITU & Anaesthetics. Single organ failure to the lungs and some people will require a length of stay in ITU. Most people will have mild symptoms and all with probable immunity upon recovery. CE presented the Operational / Estates & Facilities slide following: • **Escalation plans** are in place to increase capacity in line with business continuity planning for: • ED – Paediatrics - Inpatients- Critical Care • **Elective** activity reduced to only Cancer Fast Track (CFT's) and clinically urgent cases, to date 158/299 elective theatre sessions cancelled • **Halton / CMTC** – site rationalisation plan in line with elective activity reductions, no further electives at CMTC from 24.03.20 • **Out-patient** activity prioritising CFT's and clinically urgent, patient cancellations increased to 24%, DNA rate 8%, approximately 50% converted to virtual clinics • **Diagnostics / Screening** maintaining appropriate level of provision, reviewed daily. Breast screening reducing in line with other North West screening services. Routine surveillance for endoscopy cancelled in line with BSG guidance. CE stated that the rest of the country is 10 – 14 days behind London but the Trust is well

prepared.

MC presented the workforce overview slide as follows:

- OH Service Update – extended hours, weekend cover with partners
- Workforce Hub:
    - To oversee and administrate the safe and effective redeployment of Corporate Services staff into front line services – to be demand led.
    - To oversee and administrate the safe and effective redeployment of 'social distancing' staff.
    - To relieve professional / clinical leads of the administrative burden of staffing redeployment.
    - To have organisational overview of staffing , Workforce hub live
    - Developed a Dashboard to report staff calling in and with COVID-19
    - COVID-19 Bill will allow DBS checks to be retuned in 24 hours with a more enhanced report to follow at a later date.
- Processes changed to support the workforce including retire & return, special leave, a/l carry over, a/l over Easter, fast track recruitment, key workers letters, medical students, C+M MOU.

TA asked if the huge numbers of people who have signed up to Volunteer with the NHS are able to access the 24 hour DBS process. MC replied that the National Team is working on this.

MC confirmed that 33 5th Year Medical Students will arrive at the Trust on Monday 30th March.

Agency Arrangements NHSE/I are ensuring that these recruitment agencies do not take advantage of the situation and adhere to the National Guidelines, there is an escalation process if this does not happen.

KSJ presented the Nursing & Midwifery Workforce slide as follows:

- Some PPE ran out last night but 56 boxes masks and gowns have arrived this morning (Solway small masks and gowns)
- Central staffing command centre initiated along with Redeployment Hub
- Non ward based staff identified = 193
    - 70 to fulfil RN role – training needs identified and commenced
    - 94 identified to fulfil HCA role
    - 29 identified to fulfil ODP role
- Redeployment plan for AHPs in place
- Rapid recruitment process in place for NHSP - 24hours
- 7 day rota in place for Senior Nurses
- Helping Hands training
- Agency staff utilised x2 per shift for Critical Care
- Reviewing national plan on return to register for RNs (previous 3 year)
- Review student nurse availability following changes in NMC / University position
- Note all above fluid during to changing staffing position

- ITU Nurses 19 are currently absent with suspected COVID-19 symptoms and 15 that will not return due to underlying conditions and in ED 29 nurses off and 20 may not

return.
- ITU normally 1:1 nursing now moving to 4:1 nursing across department new National Guidance requirements.
- Staffing is fluid moving people around the organisation and skilling up staff.

AC updated on Medical Staffing
- COVID-19 Consultant on daily
- Additional tier of on-call with Respiratory Consultant on call
- Medics no boundaries cross covering and up skilling on respiratory with oversight from Consultants with respiratory expertise
- Critical Care Consultants working as outreach Consultants during escalation looking at clinical performance and frailty gatekeeping exercise reporting through the COVID-19 Tactical Group.
- Theatre Pods 18 max and Critical Care 47
- PPE Microbiology road shows with the infection control team

LG has undertaken the portfolio for Staff Welfare at this time and updated the Board as follows:
- **In place:**
  - Free accommodation
  - Free childcare
  - Free car parking
  - Extended mental health and emotional wellbeing offer
  - Free healthy snacks in key areas
  - Regular welfare visits
  - Single point of contact for suggestions, advice and support
- **In progress:**
  - Extended provision of nutritious food
  - Working from home support packs
  - Quiet areas for staff to access
  - Specific advice and support

AMcG raised caution with regards to anything free may be having an impact down the line with HMRC and this has been raised with the Regional Director of Finance to be raised nationally to bring HMRC on board.

KSJ updated on the Clinical Governance slide as follows:
- COVID-19 Management Board Structure developed
- Virtual process in place for ratification of policies
- Service / process proforma in place to evidence changes with Executive sign off and on-going review
- Alternative process for Weekly Meeting of Harm. Virtual review and sign off if necessary
- Harm Dashboard developed reporting to Executive Team weekly
- Risk assessment of Clinical Governance systems in place
- Medical Team support identified to support on-going Governance Team
- Liaising with CCG on timeframe submission and service alterations
- SLA for introduction of childcare facility reviewed and approved by legal team and governance

- Monitoring of Safeguarding referrals

KSJ to share Harm dashboard with MB and CR.

PJ updated on the Digital slide as follows:

- Covid-19 data capture / reporting / ad-hoc reports
- ICO IG advice / NHSX comms tools advice
- Membership of STP CIO Network response
- Working From Home technology being supported
- Microsoft Teams configured for all
- Applied for National Virtual Clinics App for Out Patients
- STP Patient/Staff Portal being opened up for wellbeing advice

AMcG updated on the Finance slide as follows:

- Operational Planning suspended
- Block payments based on 2019/20 income plus inflation (excl. tariff efficiency factor)and CQUIN for first four months
- Financial Recovery Fund and associated rules are suspended
- CIP not expected to be delivered in first four months
- COVID related costs recoverable – revenue and capital
- Required to have strong financial governance for expenditure including agency controls
- Two months income from Commissioners to be received in April 2020
- Expectation of prompt payment to suppliers and reduced administration time
- Audited accounts moved from 29th May 2020 to 25th June 2020.

PMcL updated on the Communications slide as follows:

- Operating under strict 'Command and Control' from NHSE/I Comms - Daily system calls, Weekly national/regional call
- Media lockdown – no exceptions (v-difficult with +cases/RIPs)
- PHE resource hub – for print/social media use – changes frequently
- Patient Information re service change/suspension
- Public health messaging
- Staff Comms – streamlining (Safety brief, CEO msg, Staff Bulletin daily)
- V large demand for design and film to support staff training
- FOIs suspended
- Community Hub now open – led by WHH Charity and WHH Volunteers – huge response so far
- Warrington Guardian Fundraising Campaign for Staff Health and Wellbeing currently at £1,145 in 48hrs
- Business continuity plan already activated, staff sickness

The CEO took the Board through the last slide which detailed the following key risks

- PPE – supply and confidence
- Staffing levels (with sickness)
- ITU capacity
- Communication challenges
- Public/personal/professional interface.

The CEO opened the meeting to questions from the Chairman and Non-Executive Directors.

	AW asked PJ about Digital E-Rostering? PJ replied that the Trust is reviewing an offer from Rotamap and also an updated offer from Allocate and looking to implement in the next week or two. MB asked about training on cross specialist cover to get clinicians out of there speciality teams? AC explained that surgery is working in ED and are supporting rotation training to enable them to support medical colleagues and working closely with FY Doctors. CR asked how secure is the supply chain for the equipment the Trust requires to have in place? KSJ commented that PPE the supply chain is delivering to Trusts on the number of cases shown and is an issue and is being escalated to Regional Teams constantly. There has been a National call for ventilators, oxygen concentrate and incubation tubes. NW predictions show that the main peak of the pandemic will hit 11th April 2020 and this may require the Trust to four times the amount of Critical Care beds that it has now. IJ asked about how 70k volunteers and how they plan to use these people if given a significant allocation? KSJ explained that 95% of the volunteers who work in the hospital have stood back which is the right thing for them to do. PMcL and KSJ they will be deployed around the Trust but in areas that keep everyone safe. MB said that the governance around COVID-19 would be the answer to any challenge in the future on this in the future. SC explained that the Mortality Review Group would continue chaired by Dr Phil Cantrell. TAW said that she was grateful that the Trust had such a talented Executive Team at this time and thanked them for an incredible effort on the preparedness for what is to come with COVID-19 and added that if there is anything the Non-Executives can do to help and support the Team at this time. The Chairman and the rest of the Non-Executives echoed this.
BM/20/03/22	**Chief Executive's report** The CEO referred to his report and highlighted the following: – From 21st March 2020 free car parking for staff and visitors. • **The Board noted the report.**
BM/20/03/23	**Chairman's Report** The Chair raised one point in his report which was that created a blog linked in Crisis leadership and he has had 13k views which commented what a great job we doing in Warrington Hospital and shows the support that is out there including external stakeholders. David Parr, CEO Halton Borough Council and Steve Broomhead, CEO Warrington Borough Council and the Local MP's have also expressed their support. • **The Board noted the report.**
BM/20/03/24	**IPR Dashboard**

	SC suggested that the IPR Dashboard is taken as read if no comments. – Chairman asked about the CQC unannounced visits? SC explained that the CQC has confirmed that all visits to Trust have stopped for the foreseeable future due to COVID-19. – TA asked about who Maternity Services were doing? KSJ commented that antenatal where possible is being undertaken by telephone calls. The specific issue relating to Maternity will be updated in Part 2 of the Board of Directors meeting. – AW asked about agencies taking advantage of the situation at the moment? MC replied that this will be escalated and appropriate action taken at a National level. – Gender Pay Gap report was approved at Strategic People Committee, however the Trust had received national notification that the Gender Pay Gap reporting annual requirement was to be suspended for 2020 due to Covid19. • **The Board reviewed and discussed the report.**
BM/20/03/27	**2020-21 Financial Plan and Budget Book** AMcG highlighted key points for the Board to note within in the report which provided progress to date on the following: – Draft Operational Plan –delivery for 29th April 2020 – Budget books including Income Statement, CBU & Corporate I&E budgets, CIP position, Cost Pressures, Loans & Cash and Activity and performance. – No CIP going forward for 4 months – Covid-19 submission adding lost income to the return although no National decision on this whether this will be refunded. There has been guidance from the Centre which states that all Trusts should pay their supplier as soon as possible within 30 days payment terms. AMcG raised the fact that this would mean the Trust would have to take out a loan to be able to do this and had escalated this to NHSE/I. The Board supported this approach. Ward K25 was discussed with regards to either keeping which provides extra capacity or removing it. TA explained that Ward K25 has been discussed at the Finance & Sustainability Committee and it is virtually full most of the time. TA commented that it would be madness to seek to remove it and then due to pressures have to re-instate it. SC stated that with the Operational Plan it states that Trusts should have 92% occupancy rate and keeping Ward K25 will help the Trust achieve this. • **The Board approved keeping Ward K25.** AMcG informed the Board that the Trust had agreed to offer to pay staff for leave not taken in March. There was also a discussion around the offer to staff to buy back leave not taken in April which was supported by the Board. • **The Board supported the approval of the Operational Plan and Budget setting for 2020-21**
BM/20/03/28	**Annual Capital Programme 2020-21** AMcG highlighted key points for the Board to note within in the report which provided capital budget estimated at £8.4n (based on internally generated depreciation of £7.3m, and PDC funding of £1.1m for MRI Scanner).

	The Capital Programme has been presented to the Executive Team meeting and Finance & Sustainability Committee. COVID-19 capital expenditure will be dealt with through NHSE/I. Urgent capital will be dealt with as quickly as possible so as not to slow down the process. The Board noted the report. • **The Board supported the approval of the Annual Capital Programme 2020-21.**
BM/20/03/29	**ED Nursing Staffing Establishment** TA commented that there had been a good discussion at the Finance & Sustainability Committee on 18th March 2020. KSJ confirmed that the business case would allow some flexibility with staffing and also confirmed that there would be no issue with recruitment of staff as the Trust has 10WTE ready who wish to work at the Trust. AMcG commented that all business cases of this nature would tracked to see the impact on the cost pressure reduction and not purely additional staff over and above and the business case is very transparent about that. • **The Board supported the approved of option 2 of the ED Nursing Staffing Establishment business case.**
BM/20/03/30	**Strategic Risk Register and Board Assurance Framework (BAF)** JC asked the Board to note that COVID-19 has been added to the Strategic Risk Register at 5x5=25. Chairman commented that as per usual operating standards mitigations would be put in place. CR suggested that the COVID-19 should be more specific e.g. Equipment, Cash flow, overload by demand. AMcG suggested that the more granular mitigation should be linked to portfolio mitigation. JC to keep overarching review of BAF. • **The Board reviewed and noted the BAF and Strategic Risk Register.**
BM/20/03/30a	**Corporate Governance Arrangement** JC presented a paper to the Board which detailed the governance arrangements around the Trust Board, Committees and Governors' Council in regards to the current and worsening circumstances arising from COVID-19. The measures which have been set out in this paper seek to maintain effective corporate governance arrangement whilst adhering to the national guidelines about social distancing and also recognising the operational pressures. These measures are planned to be in place for the foreseeable future. Meeting to be held by video conferencing. The Board discussed the paper MB commented that the Quality Assurance Committee moving from bi-monthly for 3½ hours to 1 hour that this was not sufficient the Quality Assurance Committee would need to take place on a monthly basis for 1 hour to provide assurance paper to be amended.

	Governors' Council meeting will be suspended but Governors' will be kept informed of the situation and to this end up to 10 Governors would be selected to by the Lead Governor to attend each Governor Council meeting remotely via MS Teams. The Chairman suggested that the 10 Governors should be selected by himself in conjunction with the Lead Governor paper to be amended. The Board and the Governors' Council will be invited to approve any amendments to the Trust's Constitution and Standing Orders that will be required these to be drafted by the Trust Secretary in consultation with the Chairman and CEO. In the meantime, the Trust Board will be invited to suspend it's 'Standing Orders' where necessary and appropriate. All Governor and NED ward visits have been cancelled. Due COVID-19 and social distancing the public are not being allowed to attend Board meetings. CR commented that when he was Chair at the PCT the public could write in or email questions to the Board after some debate is was agreed that this would not be appropriate under the present circumstances as the Trust is in a command and control situation. • **The Board approved the report to include the two items for amendments as discussed.**
	MATTERS FOR APPROVAL
BM/20/03/32	**Performance Assurance Framework (PAF) and Integrated Performance Report (IPR) review 2020-21** • **The Board approved the Charity Annual Report and Accounts.**
BM/20/03/33	**Terms of Reference and Cycle of Business – Audit Committee** • **The Board approved the Terms of Reference and Cycle of Business which had been approved at the Audit Committee on 20 February 2020.**
BM/20/03/34	**Terms of Reference and Cycle of Business – Strategic People Committee** • **The Board approved the Terms of Reference and Cycle of Business which had been approved at the Strategic People Committee on 18 March 2020.**
BM/20/03/35	**Trust Board Cycle of Business 2020-21** • **The Board approved the Cycle of Business for the Trust Board 2020-21.**

	MATTERS FOR NOTING FOR ASSURANCE
BM/20/03/36	**Freedom to Speak Up Bi-Annual Report.** This report had been reviewed and discussed at the Strategic People Committee on 18 March 2020. • **The Board noted the report.**
BM/20/03/37	**Mortality Review Q3 report** This report had been reviewed and discussed at the Quality Assurance Committee on 3 March 2020. **The Board noted the report.**
BM/20/03/38	**Director of Infection Prevention and Control Q3 report** This report had been reviewed and discussed at the Quality Assurance Committee on 3 March 2020.

	The Board noted the report.
BM/20/03/39	**Learning from Experience Q3 report** This report had been reviewed and discussed at the Quality Assurance Committee on 3 March 2020. **The Board noted the report.**
BM/20/03/40	**Nurse Staffing Bi-Annual report** This report had been reviewed and discussed at the Quality Assurance Committee on 3 March 2020. **The Board noted the report.**
BM/20/04/41	**CPD Allocation for Nursing, Midwifery and AHP** **The Board noted the report.**
BM/20/04/42	**Staff Opinion Survey** The survey was presented to the Strategic People Committee on 18th March 2020. **Strategic People Committee Chairs Annual Report** This report was presented on Strategic People Committee on 18th March 2020 and was supported and approved. **The Board noted the report.**
	Any Other Business None discussed.
	Next meeting to be held: Wednesday 27 May 2020

Signed …… Date …….

Chairman ……..

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE	BM/20/05/45	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	27 May 2020

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/07/57	26.05.2020	Junior Doctor/Trainee Engagement update Trello)	6 mth update presentation.	**Acting Executive Medical Director + CCIO**	**May 25.05.2020**		14.01.2019. Deferred to March 27.03.2019. Referred to future BTO 29.05.2019. Update to September Board to include results from GMC survey results. 06.09.2019. Deferred to November Board due to deferred HEE visit. 18.11.2019. Deferred to January Board due to HEE visit. 13.01.2020 Date of HEE visit still to be confirmed. **9.03.2020 HEE visits cancelled on 3 occasions. HEE visit confirmed for 22.5.2020. Verbal update to May Board**	

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/20/01/07	29.01.2020	IPR Dashboard – Quality indicators	Board to be updated on Ecoli benchmark findings via QAC Key Issues Report	**Chief Nurse + Deputy CEO**	**25.03.2020**		Action on hold due to COVID-19 Pandemic.	
BM/20/01/07	29.01.2020	IPR Dashboard – Quality indicators	IPR to be amended to show trend line for WHH for CDiff cases and unavoidable cases signed off by the CCG.	**Chief Nurse + Deputy CEO DoF + Deputy CEO**	**25.03.2020**		Action on hold due to COVID-19 Pandemic.	

BM/20/01/10	29.01.2020	Digital Strategy	Medical Electronic Handover presentation to future QAC and reported to Board through Key Issues	**Acting Executive Medical Director + CCIO / Chief Nurse + Deputy CEO**	**DATE TBC**		Date for presentation to QAC to be confirmed, action on hold due to COVID-19 Pandemic.	
EBM/20/04/14	29.04.2020	COVID-19 Update - Service Change Forms	Service Change Report to July QAC	**Chief Nurse + Deputy CEO**	**Board 29.07.2020**		To be reported through QAC Committee Assurance Report to July Board	

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

RAG Key

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

We are WHH & we are PROUD to make a difference

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/05/46**				
SUBJECT:	**Chief Executive's Briefing**				
DATE OF MEETING:	27th May 2020				
AUTHOR(S):	Simon Constable, Chief Executive				
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive				
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will…Always put our patients first through high quality, safe care and an excellent patient experience.	✓			
	SO2 We will…Be the best place to work with a diverse, engaged workforce that is fit for the future.	✓			
	SO3 We will...Work in partnership to design and provide high quality, financially sustainable services.	✓			
LINK TO BAF RISK:	All				
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.				
PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note	Decision	
RECOMMENDATION:	The Board is asked to note the content of this report.				
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable			
	Agenda Ref.				
	Date of meeting				
	Summary of Outcome				
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full				
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None				

SUBJECT	Chief Executive's Briefing	AGENDA REF:	BM/20/05/46

1) BACKGROUND/CONTEXT

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

2) KEY ELEMENTS

2.1 Briefings shared with the Board since the last meeting

- Stakeholder briefing advising of the arrangements for NHS Nightingale Hospital North West.
- Letter from Alan Yates, Chair of Cheshire & Merseyside Health and Care Partnership describing arrangements during the COVID-19 pandemic.
- NHSE/I Capital Planning regime guidance.
- Cheshire & Merseyside Partnership Briefing – April 2020.
- Second Phase of the NHS Response to COVID19 – Sir Simon Stevens and Amanda Pritchard.
- Letter to all Chief Executives and Chairs of NHS Organisations across the North West from Bill McCarthy, NHSE/I Regional Director.

2.2 Key issues

2.2.1 COVID-19 Pandemic and WHH Trust Response

This will be covered as a specific item on the Trust Board agenda, through an up-to-date performance report, current situation report and summary of key issues by executive portfolio. However, an overview summary will be provided here.

We remain in a level 4 major incident and national emergency with a command and control structure in place through NHSE/I and the NW Regional Team. We have been operating with a Tactical Operational Group Meeting at 0800 daily, followed by a Strategic Executive Oversight Group at Midday. Twice weekly, minuted, Non-Executive Director Assurance calls have been occurring between myself, the Chairman and all Non-Executive Directors. Whilst many meeting schedules have been suspended, Trust assurance committees have continued to operate, albeit with an abbreveiated agenda and remotely via use of MS Teams.

Visible senior leadership and transparent communication with all has been a signififcant feature of the Trust response alongside making sure that the entire workforce is safe and well-looked after. We have followed the national guidance through the NHS Emergency Preparedness Resilience and Response (EPRR) route, through the Single Point of Contact, and our Incident Control Room, ensuring that everything is logged and actioned through the appropriate mechanism. The clinical evidence and protocols have been continually updated.

WHH has been operating within safe limits over the past few weeks. We have not suffered from any stock-outs of any Personal Protective Equipment (PPE), although there was a single incident fully mitigated in March 2020 (this was DATIX reported and managed accordingly). There have not been any bed capacity constraints, and no patients have been cared for in anything other than appropriate clinical areas. Our peak of COVID-19 cases was 124 on 12th April 2020. Critical care capacity (including ventilator capacity) has not been rate-limiting (a peak of 24 patients with COVID-19 in critical care occurred on 8th April 2020) and no clinicians have been working outside of their professional capabilities; however staff have been redeployed. There have been no critically unsafe staffing levels; total staff sickness absence (including shielding, self-isolation and non-COVID-19 related absence) peaked at just over 17%.

The amount of PPE has been managed tightly, 7 days a week, and a successful scheme of mutual aid across trusts in Cheshire and Merseyside and the North West has been deployed with good effect. Whilst ventilator capacity has not been rate-limiting, oxygen supply and flow rates have also had to be closely monitored; the peak delivery requirement was 42% of maximum capacity.

We are now preparing for the next phase of the management of the COVID-19 pandemic (phase 2) with a realignment of our usual activity alongside the burden of continuing to work and live with COVID-19. There will be a gradual restart of non-urgent elective work in a structured way that incorporates the appropriate infection prevention and control guidance alongside rapid, point of care testing for clinical and operational decision-making. Understanding our outcomes and the broader health impacts of COVID-19 will be crucially important as will be maintaining staff wellbeing resilience in what will likely be many more months of working in a challenging environment.

Much innovation and new ways of working have been successfully delivered at pace over the last few weeks. We will ensure that the recovery and restoration phase of our management takes all of this into account and builds on what has worked-well.

2.2.2 Joselito (Jo) Habab RN, Trauma Nurse Coordinator

It was with great sadness that on 21st May 2020 I had to advise WHH of the loss of our own Jo Habab. Following many weeks on Whiston Hospital's ICU, where he was being treated for COVID-19, Jo passed away in the early hours of the morning of 20th May 2020, his wife Michelle by his side.

Jo (Joselito) joined the Trust nearly 18 years ago having trained as a nurse in his native Manila, Philippines. Jo achieved his NMC registration in 2003 and was a staff nurse in Trauma & Orthopaedics until 2011. He became a clinical nurse educator in 2011 during which time he was awarded Employee of the Month in May 2016, his nomination reflecting the views of many saying "Jo is an excellent clinical educator with excellent clinical skills. He has a friendly and approachable presence which has helped to improve the educational support that is provided to staff. This in turn, assists staff to integrate well into the workforce and provide a much more safer and smoother journey for our patients."

Just this year Jo moved to become Orthopaedic Trauma Nurse Co-ordinator where he noted upon his application form that he was very proud to have received both a *Role Model* and *Working Together* values badge. All those who know Jo will smile at this as he was indeed an exemplary role model and fiercely proud of being both a nurse and a member of our WHH Family.

Before becoming ill, Jo was back in a key clinical education and training role keeping others safe by doing PPE training and FIT testing.

Jo leaves behind his wife Michelle, also a nurse in A&E at Whiston and his teenage son Dylan.

A minute's silience to honour Jo's memory was held similtaneously at both Warrington and Halton Hospitals at 11am on 22nd May 2020. This was a fitting tribute and mark of respect from all of us. As a Trust, and in conjunction with the Habab family and Jo's colleagues, we will ensure there will be an appropriate and lasting legacy in his memory, almost certainly in recognition of his role in clinical education.

2.2.3 Employee Recognition

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

Chief Executive Award (April 2020): Integrated Hospital Discharge Team

This is a team that has been working exceptionally well as a team to enable safe patient discharge from hospital and has been very successful over the last few months. The number of patients with long length of stay, so-called stranded (over 7 days) and super-stranded (over 21 days) has been steadily falling since before Christmas 2019 and this hass helped significantly over the winter period and in our preparation for the COVID-19 pandemic.

Chief Executive Awards (May 2020): Rachael Browning, Associate Chief Nurse; Wendy Johnson, Head of Education & Wellbeing; Judith Burgess, Lead Nurse

These three senior nurses with many decades of nursing and clinical education experience behind them have deferred their retirement in order to support the Trust during the COVID-19 pandemic. Their nursing leadership has been extremely welcome at this time.

3) MEETINGS ATTENDED/ATTENDING

The following is a summary of key external stakeholder meetings I have attended since the last Trust Board Meeting. It is not intended to be an exhaustive list.

April / May 2020 – Meeting taking place via conference call or MS Teams
– NHSE/I COVID-19 Telephone calls (Weekly)
– Warrington & Halton COVID-19 System Assurance Meeting (Weekly)
– NTLS COVID-19 Planning Warrington Residential & Care Home call (ad-hoc)
– C&M CEO Provider Group Calls (Biweekly)
– Nightingale NW C&M CEO/COO session (ad-hoc)

– Second Phase of NHS response to COVID-19 with Simon Stevens
– Update calls with our local MPs: Andy Carter MP, Charlotte Nichols MP, Derek Twigg MP, Mike Amesbury MP
– David Parr, Chief Executive, Halton Borough Council
– Bed Capacity Planning NHSE/I (ad-hoc)
– NW Mortality Cell (weekly)
– Restoration Plan, Ann Marr, Hospital Cell
– Steve Broomhead, Chief Executive, Halton Borough Council
– Andy Davies, Clinical Chief Officer, NHS Warrington and Halton CCG

4) RECOMMENDATIONS

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

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

COVID-19 MAJOR INCIDENT

WHH Response & Situation Report

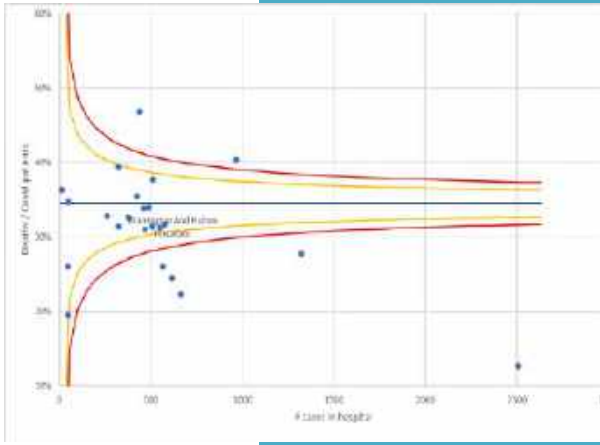
Trust Board 27 May 2020

Situation Report as of Midday 26/05/20

- 49 COVID-19 positive cases (peak of 124 on 12/04)
- 5 COVID-19 patients in critical care (peak of 24 on 08/04)
- 117 COVID-19 deaths; 291 discharges
- Utilising 18% of oxygen delivery capacity (peak of 42%)
- Bed capacity in critical care and general bed-base
- Super-stranded patients at 74 (nadir <50)
- Staff sickness absence: 11.3% (peak >17%)
- Staff tested (swab numbers): 1134; Positive: 346

Clinical update

- SOP for endoscopy/laparoscopy to support **Recovery Diagnostic/Treatment** and for **Cancer** activity
- **Simulation** prior to 'go live' for endoscopy services
- **Clinical Education event** to Primary Care: Cancer Update
- **Rotamap** e-rostering roll out for General Surgery
- Advancing Quality Alliance **Innovation report**; positive for clinicians
- **Positive feedback** from trainees and undergraduates
- **Early identification** of palliative patients during COVID
- **Mortality Review Group** monthly reviews; SJR's including patients with COVID diagnosis
- ICE streamline referrals for **clinical reviews**
- Anticipated 'Drive Through' **ambulatory ECG monitor** service



Operational/Estates & Facilities

- **Escalation:** plans in place to increase capacity in line with business continuity planning eg, Critical Care. Dedicated Covid bed base across A7, A8 and A5. Wards A2 and A4 stood down and re-provided as core medical bed base. Bed base continually reviewed.
- **Elective:** activity reduced to only Cancer Fast Track (CFT's) and clinically urgent cases. Full use of 3 theatres at Spire Warrington until 24/6 under national contract. Covid 'Green Lane' commenced in Theatre 4 at Warrington and Ward B18 to support Colorectal, Urology, Breast, ENT and Gynae pathways. All urgent and cancer patients on the elective waiting list to be re-catergorised in line with national waiting time guidance by WC 25/05 to support Phase 2 planning.
- **Halton / CMTC:** site rationalisation plan in line with elective activity reductions, no further electives at CMTC from 24.03.20. Plans for Halton and CMTC re-start being drawn up in line with Phase 2 and recovery plans. Proposals being worked up to restart some services from end of June.
- **Out-patient:** activity prioritising CFT's and clinically urgent, patient cancellations increased to 13%, DNA rate 8%, approximately 50% converted to virtual clinics. To support recovery, Speciality by specialty reviews are underway to support the introduction of video consultation software and reconfiguration plans to support face to face appointments eg, for shielding / vulnerable patients.
- **Diagnostics / Screening:** maintaining appropriate level of provision, reviewed daily. Routine surveillance for endoscopy cancelled in line with BSG guidance. Endoscopy recommenced at Halton (Colonoscopy) and Spire (OGD) at 50% of usual list capacity on 14/5 to support urgent and cancer pathways. Use of Spire Warrington imaging facilities commenced in May to support the waiting list.

Patient Safety & Experience

- Escalation wards triggered in line with Trust plan which includes supportive care wards for patients with ceilings of treatment plans in place Add in detail
- End of Life: increase in patient deaths monitored weekly via Palliative Care dashboard. Ongoing training with 450 staff to date trained
- Family Liaison Officers (FLO) – 50% overall relative telephone contact with an average of 25 messages from families to patients (FLOgrams) delivered daily
- Hospital visiting paper reviewed at Strategic Covid-19 meeting in line with national guidance
- Oxygen usage : Daily sitrep returns to ensure within maximum flow per min
- Safety Response Brief; oversight and action of daily safety issues raised includes daily infection prevention and control update
- Continued oversight of Sepsis, VTE, Falls and Tissue Viability – PU theme noted due to COVID patient positioning, proning and masks
- Senior nurse oversight of available clinical equipment
- CNST Safety Action - Digital Maternity Record Standard - Current DXC target is Lorenzo version 2.19 due to be deployed 23rd October 2020
- Cheshire and Mersey review of stillbirth's and born before arrival (BBA's) during COVID underway – WHH position: no reported cases of stillbirth. 2 reported cases of BBA's (Bridgewater women)

Maternity

- CNST Safety Action - Digital Maternity Record Standard - Current DXC target is Lorenzo version 2.19 due to be deployed 23rd October 2020
- In response to COVID, the plan must now be recorded by the Trust Board and confirmed to NHS Resolution by Wednesday 30 September 2020 for deployment of DCB3066 Digital Maternity Record Standard by Sunday 28 February 2021
- The Trust requires a DXC EPR Lorenzo upgrade to enable this requirement
- Cheshire and Mersey review of stillbirth's and born before arrival (BBA's) during COVID underway – WHH position: no reported cases of stillbirth. 2 reported cases of BBA's (Bridgewater women)
- MLU on plan to open end of June / early July 2020
- Restart Home Birth Service from 25th May 2020

Workforce

- Redeployment hub (Nursing/Midwifery/AHP/Corporate)
- 109 corporate and 270 non-ward based clinical staff identified and allocated to support clinical areas
- Expansion of the workforce:
- National call to arms: 15 registered nursing staff
- WHH recent leavers : 21 registered nursing staff
- Local Recruitment : 44 health care assistants recruited and allocated to wards since Feb 2020, 32 vacancies remaining
- NHSP/Patchwork rapid response recruitment – 98 RN's, 38 HCA's
- 140 Nursing, Midwifery Students in paid placements
- Expanded critical care workforce mapped against current critical care footprint
- Change in the profile of high level care beds with the introduction of level 2 beds on AMU and the development of a PACU
- Upskilling/flexibility across disciplines adaptation of different roles
- Senior nurse rota evenings and weekends continues
- Utilisation of shielding staff; home working continues
- Business as usual recruitment campaigns with adapted recruitment processes

Clinical Governance

- Service restart: recovery proforma + PPE burn rate interlinked . SOPs and simulations in place
- Service changes: 248: all risk rated moderate, 41 high, 6 very high: 4 x Ophthalmology, 1 x diabetes , 1 x Cardio – Respiratory outpatients
- RIDDOR : COVID-19 is now a reportable disease. There is a process in place to ensure compliance. 0 staff , 1 patient report. Daily review underway.
- Harm Dashboard: Reports to Strategic Executive Team
- Weekly meeting of harm continues via Microsoft Teams
- COVID19 risk register: 13 risks. Overarching risk (25) describes global pandemic (BAF)
- 4 new risks on BAF: PPE, elective/ emergency healthcare service, staffing, oxygen supply
- 59 high risk complaints: not COVID related
- Monthly CCG meeting in place with Deputy Chief Nurse and Quality Lead
- CQC: 3 weekly meetings, review of M20 action plan underway. New inspection manager in place.
- Learning Framework supported by recovery work stream
- Monitoring the increase of Safeguarding referrals
- Vulnerable (Shielded patient) process in place reported daily via tactical:
  - 3753 letters sent from NHSE/I
  - 3058 identified independently letters being provided
  - 2726 being validated from new list NHSE/I
  - 717 letters sent incorrectly. Patients being contacted

Corporate Governance

Trust Board – continues to convene bi-monthly through videoconference facilities.

- All Governors invited to observe the meeting
- Members of the Public will not be admitted to the Board meeting, process for posting papers/agenda on the website prior to the meeting remains unchanged

Board Committees –

- All Board Committees have continued to take place via videoconference albeit in a focussed and streamlined format.
- Since the last Board meeting, the Finance & Sustainability Committee has taken place on two occasions, and the Quality Assurance Committee, Audit Committee and Strategic People Committee have also taken place

Council of Governors

- COG meeting took place on 14th May

Recovery Structure

- Recovery Structure established for an initial 3- 6 month period

Other meetings

- The Strategic Executive Oversight Group continues to meet most weekdays
- COVID NED Assurance Committee established on 31st March 2020 and usually meets twice per week

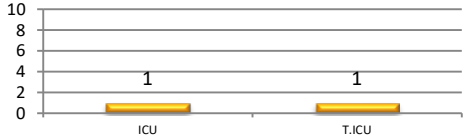
Infection Prevention & Control – Covid-19

- Oversight and contingency plan for PPE shortage.
- Recovery plan incorporates PPE estimates.
- PPE sessional use and mutual aid continues.
- PPE walkabouts Dr Farag/PPE Champions.
- Fit testing/Respiratory Protective Equipment programme - compliance with regulatory requirement to fit test/one size does not fit all.
- Covid-19 testing - (18/05/20) 3952 tests/ 945 positive.
- Rapid - 1 hour on site testing turn around time (capacity 15 tests/day)
- On site testing to commence mid June - 4 hour turn around time (capacity 240 tests/day)
- 2041 staff fit test trained for FFP3 masks

- Other HCAIs
- 2020 – in year position.
- Clostridium difficile – 5 - annual threshold TBC.
- E Coli bacteraemia – 2 - annual threshold TBC.
- MRSA bacteraemia – Nil return.
- Contractual HCAI targets for 2020/21 not yet published/received.

C. difficile - year to date position

Hospital onset E. coli bacteraemia



HR and OD Overview

1. **Occupational Health Services:**
   - Testing of asymptomatic staff
   - COVID-19 absence 'hot spots'
   - Workforce Risk Assessments

2. **Wellbeing Services:**
   - Drop in sessions, management referrals, one to one sessions and group sessions with teams
   - Staff counselling capacity increase
   - Care First
   - Wellbeing Hubs
   - Project Wingman

3. **Resourcing:**
   - Workforce redeployment
   - Retaining the temporary workforce

4. **Recovery Planning:**
   - Shielding staff
   - Agile working
   - Physical and mental health
   - Supporting managers, leaders and teams
   - Working in partnership with staff side colleagues

Staff welfare

Key services update:

- Free accommodation – 56 requests accommodated, 28 members of staff currently accessing free accommodation via Trust
- Free childcare – 567 childcare sessions utilised as of 14th May
- Regular welfare visits – 1,779 visits as of 13th May
- 32,809 donated items, including meals and toiletries, delivered to staff between 23rd March and 11th May
- Single point of contact for suggestions, advice and support – 495 email queries responded to as of 14th May
- Improvements to 23 department specific and 5 communal staff rest areas approved and being implemented

Phase 2 and future planning:

- All services reviewed
- All continue in phase 2
- Initial plan for longer term agreed at SEOG

Finance

- Financial position of breakeven at the end of April
- Position includes Covid19 expenditure of £3.4m and a retrospective top up of £2.5m
- CIP not expected to be delivered in first four months
- Two months cash was received in April 2020
- Working towards prompt payment to suppliers at 30 April 65% achieved (34% 31 March)
- Covid19 capital of £1.4m approved in April, received capital items of £0.5m which NHSI have been asked to reimburse
- All Covid19 capital now requires NHSE/I approval
- Revised capital plans have been requested for submission 29 May
- Covid19 related capital is separate to the Cheshire and Mersey envelope
- Accounts submitted ahead of plan to auditors
- Audit Committee planned for 17 June to sign off the accounts

Digital – IT And Integration / Data

- Modern Telephony Trunks upgrade ordered.
- Additional work done to enable Trust IT services in Spire Healthcare.
- Service Desk / Device deployment:
  - Logged Jobs since 1st April: 2614 calls, 1371 Emails;
  - First Time Fixes For Callers: 1924 (74%);
  - 40 laptops / 50 iPads / 30 Android Tablets.
- Trust internet pipe Upgrade (Home Workers):
  - An average 24 hour period:
    - Peak Received 65%;
    - Peak Transmit 54 %;
    - Continues to demonstrate Value For Money.

- FIT mask testing booking system ready for launch.
- Extensive support provided for letters to vulnerable patients.

Digital – Intelligence, Programmes & Governance

- Cancer FIT Test Tracker dashboard successfully launched.
- STP Population Health Track and Trace solution development being monitored.

- Trust access to Primary Care Records / End Of Life Records resolved - planning for launch.
- Video OP consultation pilot complete – CBUs planning deployment.
- E-Rostering for Digestive Diseases CBU consultants successful live at pace. Now planning for Medical Care CBU.

- National COVID-19 cyber threats continue to be addressed.
- Cyber Training delivered to Non-Executive Directors.

Communications

MEDIA:

- **Sky News:** Coronavirus on the Home Front documentary : 2.01m viewers, 18K viewers on YouTube, 3.9K shares on FB
- **Good Morning Britain:** Recovered patient thanks WHH nurses 'live' from WHH 1.23m viewers
- **Positive media strategy in place** (CT Scanner, Sikh community support, virtual OPD clinics, Cancer services resume, 'black box' feature, contact a patient service)
- **Weekly Covid-19 Status** issued by WHH for balance (tests/discharges/C-19+ and RIPs) – high interest and uptake

COMMUNICATIONS

- **Resumed 'normal' communications** (Daily Safety Brief, Tues bulletin, The Week – Team Brief by MS Teams next week)

COMMUNITY HUB

- To date has sourced donations of food, drinks and entertainment items for patients and staff worth £220K
- Financial donations through WHH Charity at 30th April 2020 £175K (verified)

COMMUNITY ENGAGEMENT

- **Project Wingman** – first class service for NHS Staff launched at Warrington – a voluntary programme of 'tea and sympathy' provided by the airline industry

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/20/05/48		
SUBJECT:	**COVID-19 Performance Summary**		
DATE OF MEETING:	27th May 2020		
AUTHOR(S):	Dan Birtwistle, Senior Business & Performance Manager		
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive		
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x x x	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	1126 – Failure to provide the required levels of oxygen for ventilators caused by system constraints, resulting in a lack of adequate oxygen flow at outlets. 1134 – Failure to provide adequate staffing caused by absence relating to COVID-19, resulting in resource challenges and an increase within the temporary staffing domain.		
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily COVID-19 Executive Summary which outlines key information pertinent to the command and control of the situation. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where possible. This is the second iteration of this report which is part of the continuing development of understanding of demand, capacity and outcomes that will determine future strategic planning. Data up to 23rd May 2020 is included.		
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

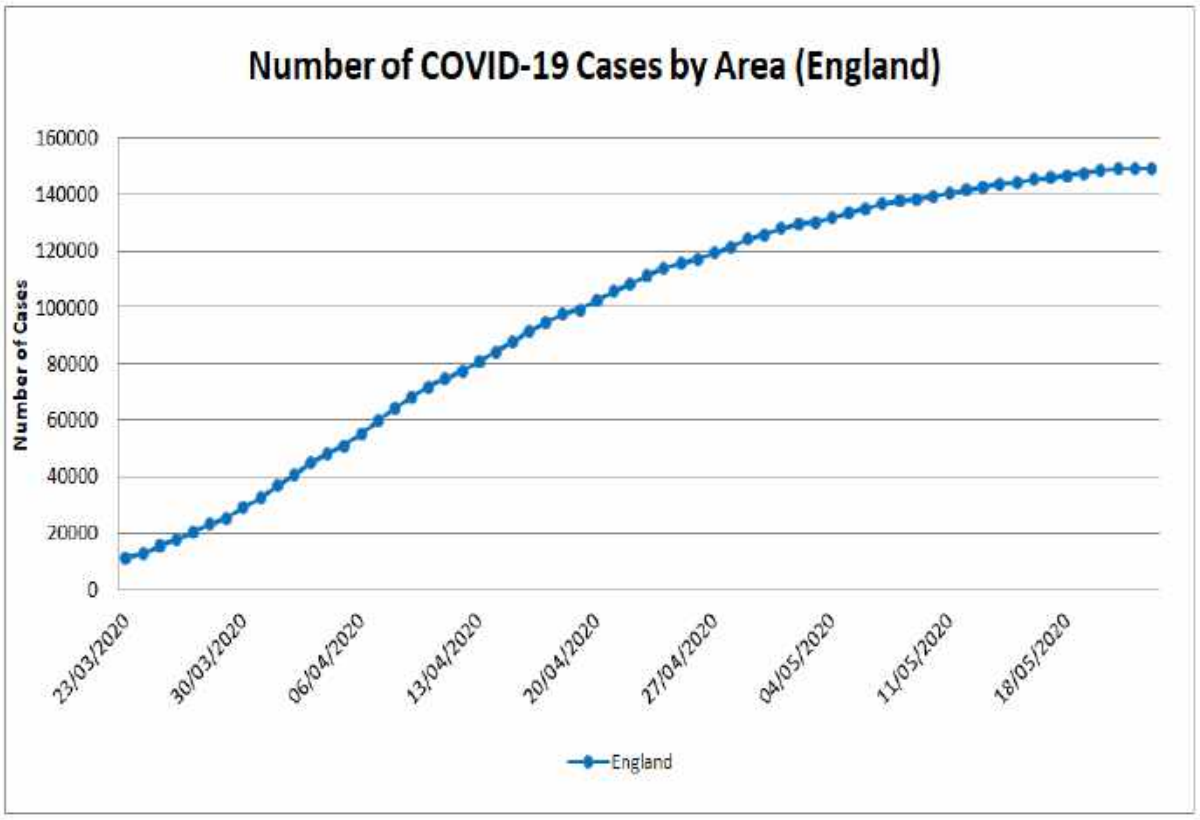
SUBJECT	COVID-19 Performance Summary	AGENDA REF:	BM/20/05/48

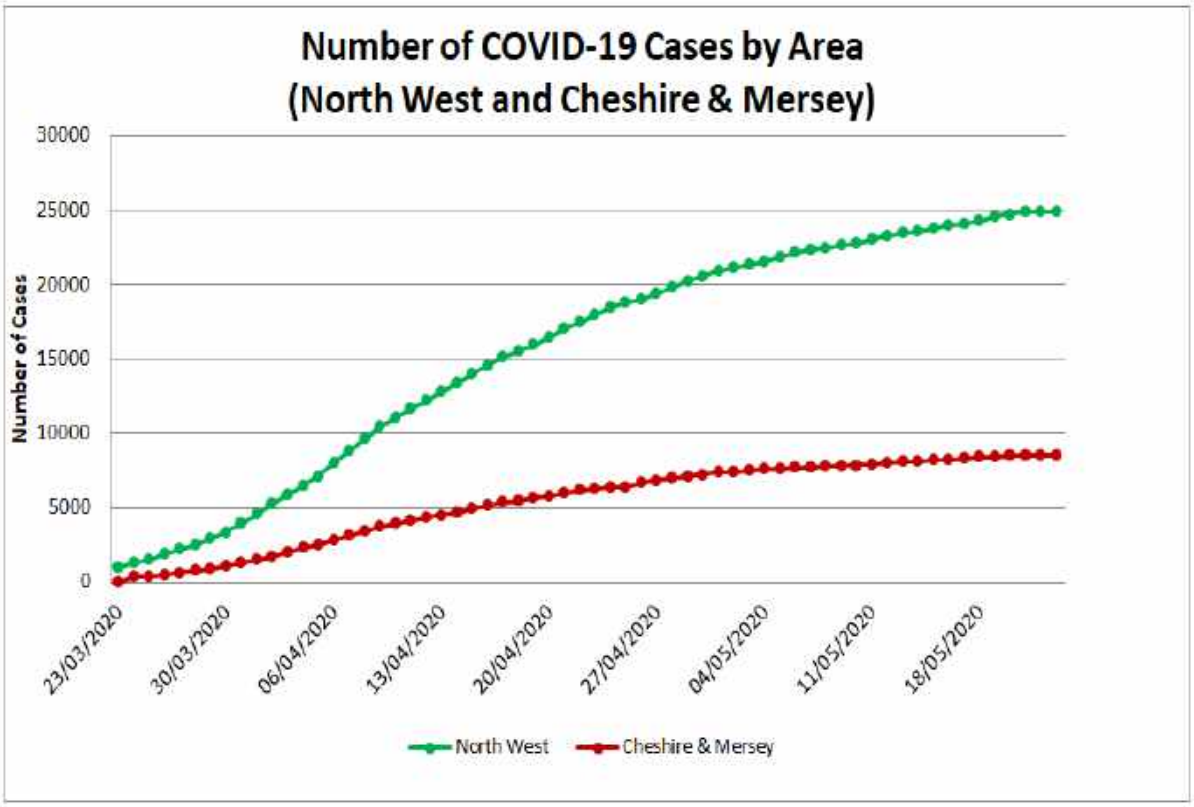
1. BACKGROUND/CONTEXT

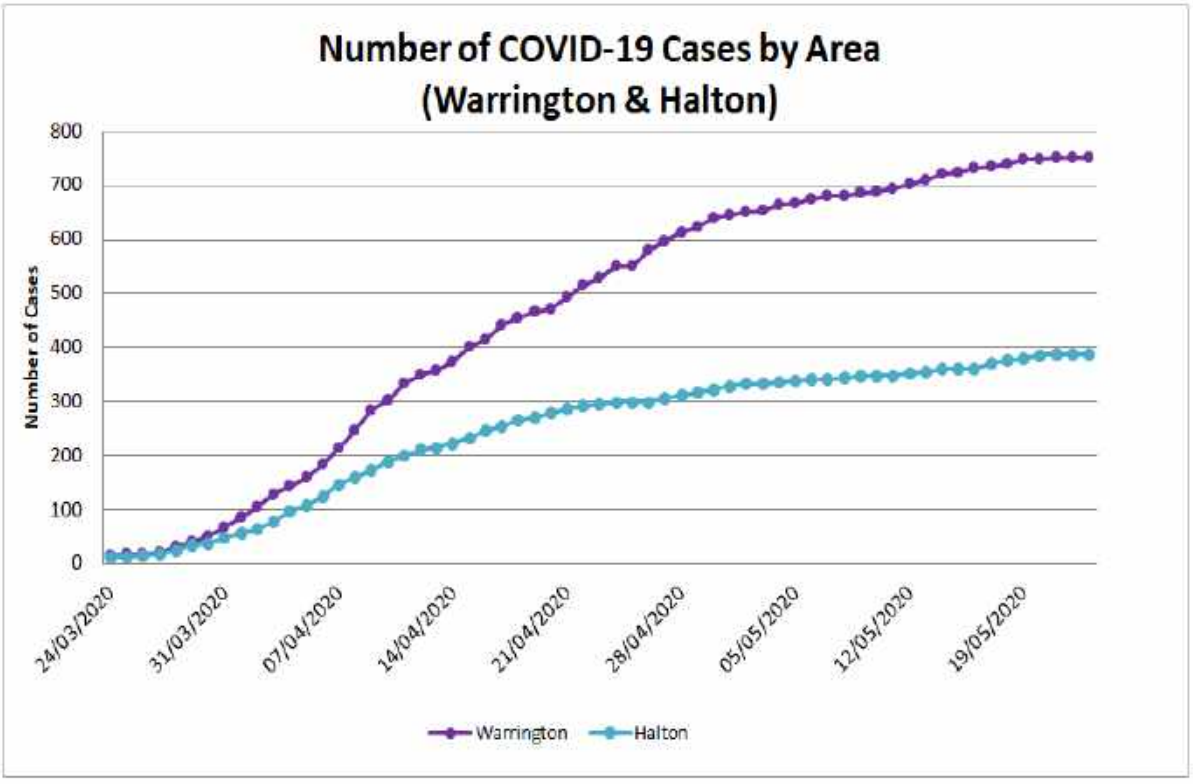
The Trust has robust operational and reporting procedures in place to respond to the COVID-19 pandemic. The Trust Executive Team receives a daily COVID-19 Executive Summary which outlines key information pertinent to the command and control of the situation. This paper provides an overview of this summary since the start of the pandemic, showing trends and benchmarking data where possible. This is the second iteration of this report which is part of the continuing development of understanding of demand, capacity and outcomes that will determine future strategic planning. Data up to 23rd May 2020 is included.

2. KEY ELEMENTS

Number of Reported Cases



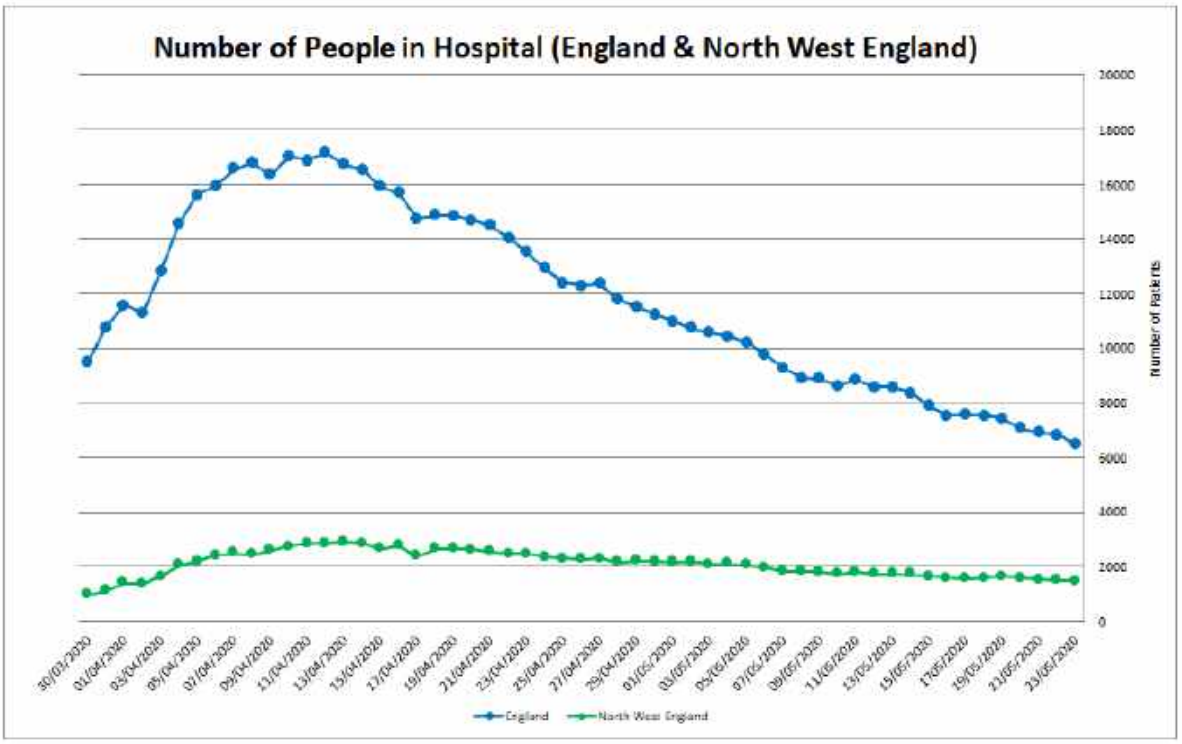


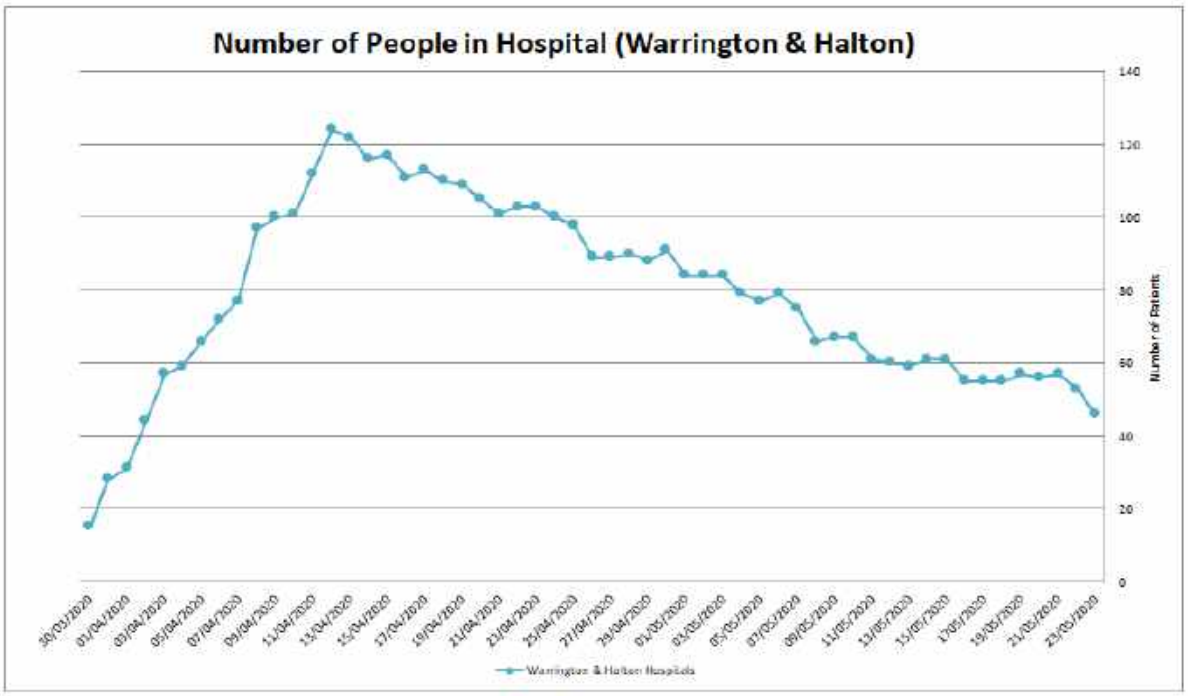


Narrative: As of 23/05/2020, there were 751 cases of confirmed COVID-19 reported in Warrington and 387 cases reported in Halton. The trend is in line with the National, North West and Cheshire & Merseyside position.

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

Number of People in Hospital

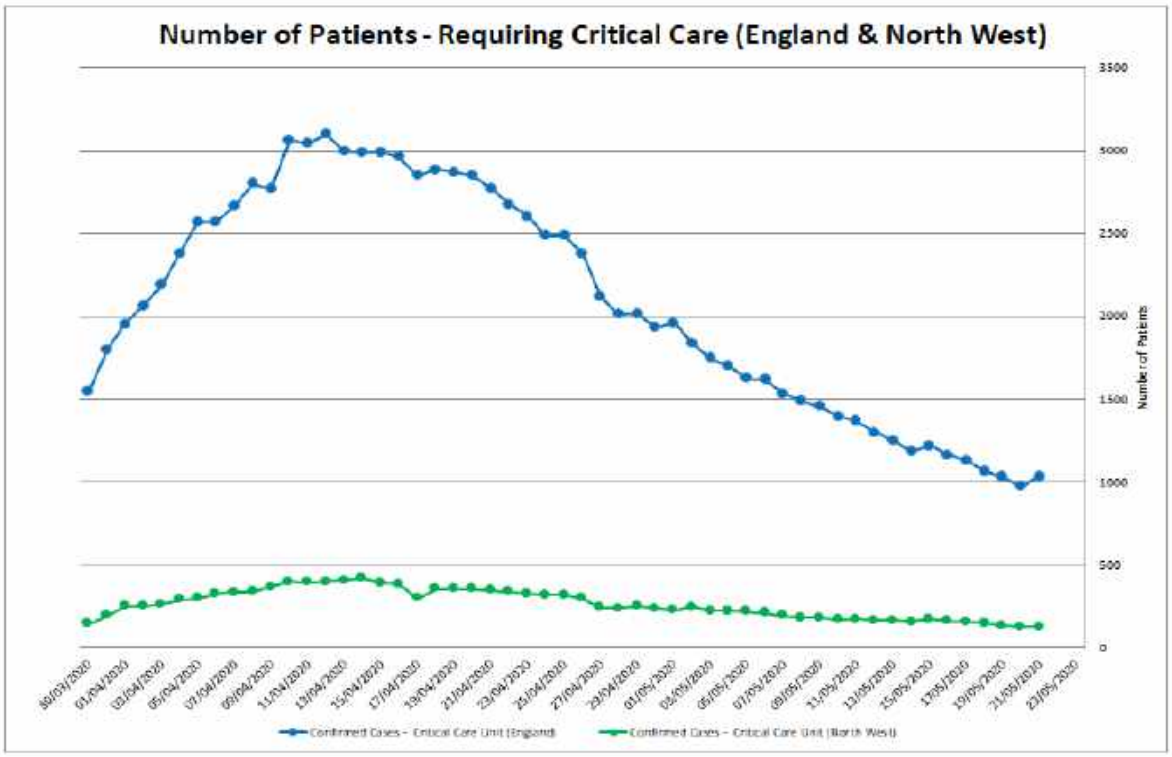


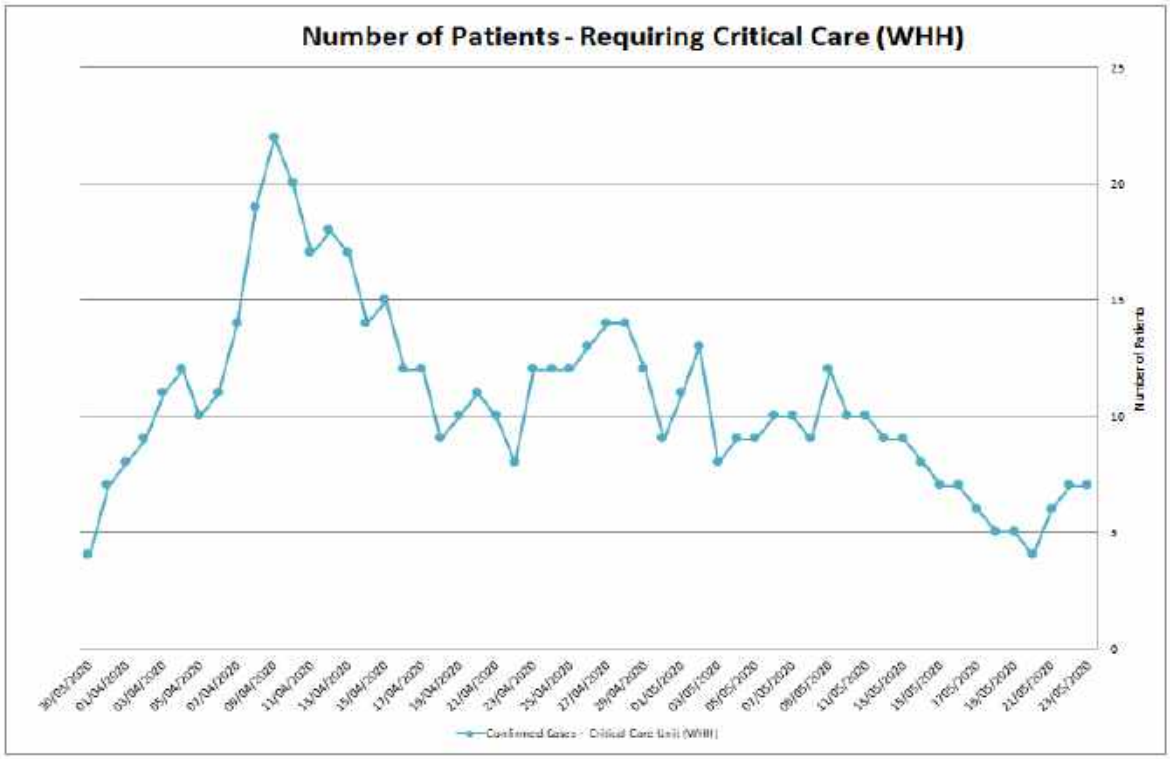


Narrative: As of 23/05/2020, there were 46 inpatients being treated by the Trust with confirmed COVID-19. The peak came on 12/04/2020 with 124 inpatients. The trend in reduction is in line with the National and North West positions.

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

Number of Patients Requiring Critical Care

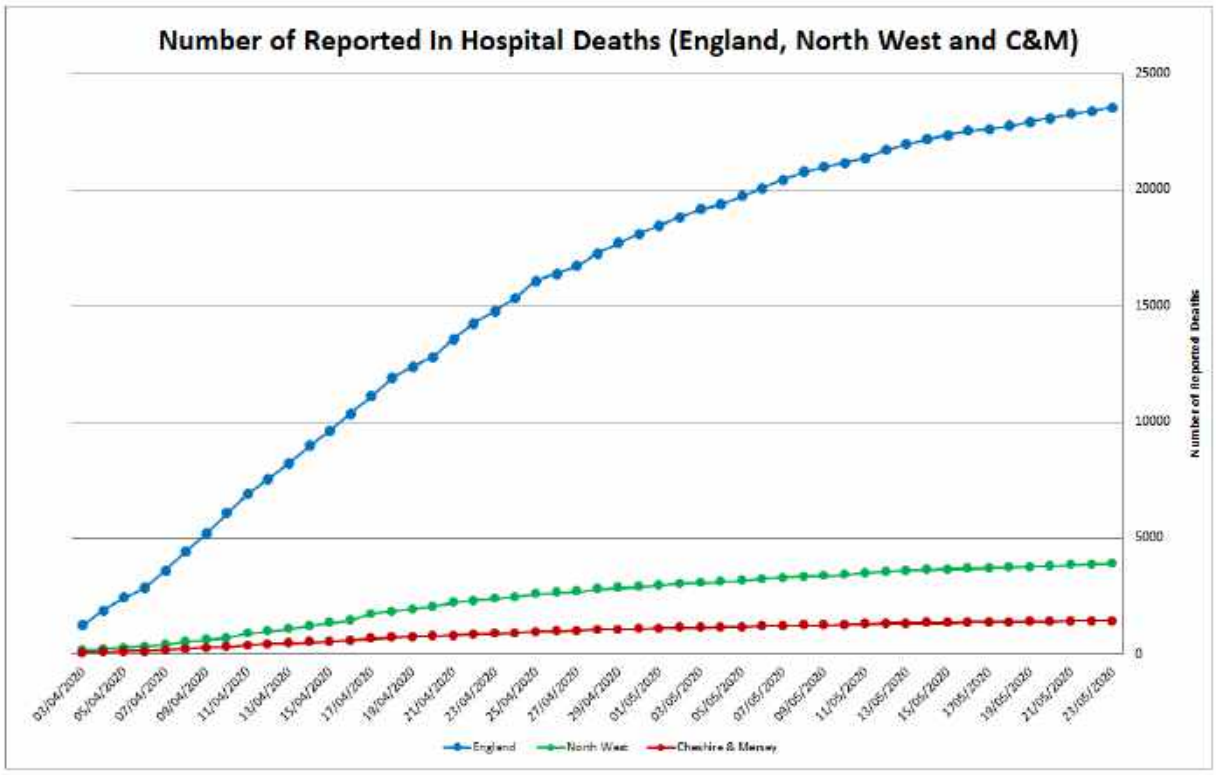


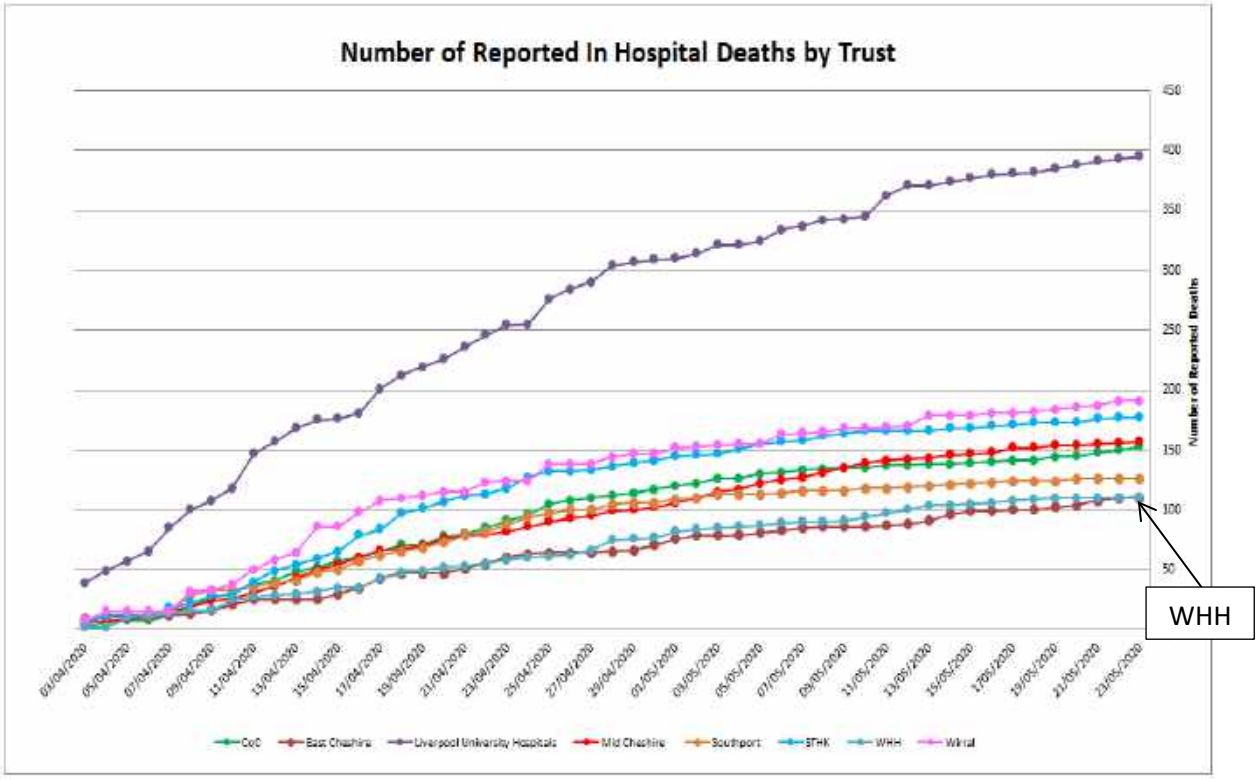


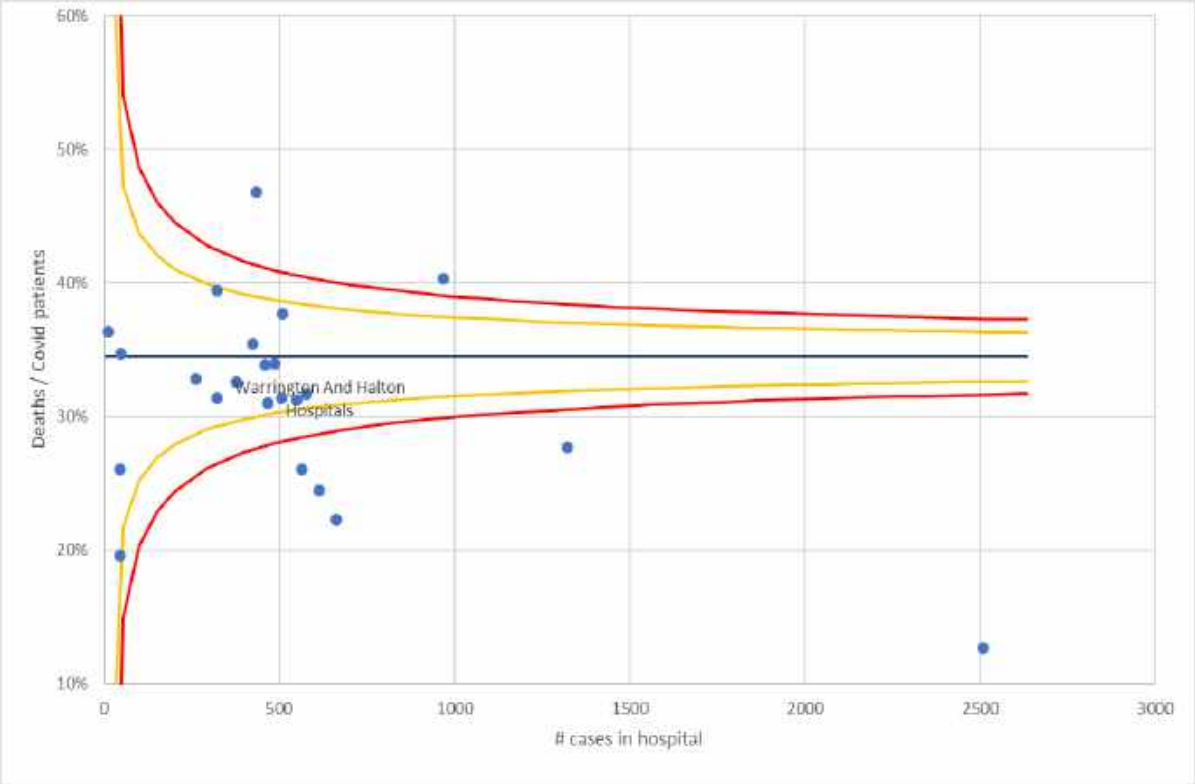
Narrative: As of 23/05/2020, there were 7 inpatients with confirmed COVID-19 and 0 inpatients with suspected COVID-19 in critical care. The Trust saw a peak of 22 patients on 09/04/2020. The number of inpatients requiring critical care has reduced with a slight increase in the last few days in line with the National and North West positions.

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

Number of In-Hospital Deaths





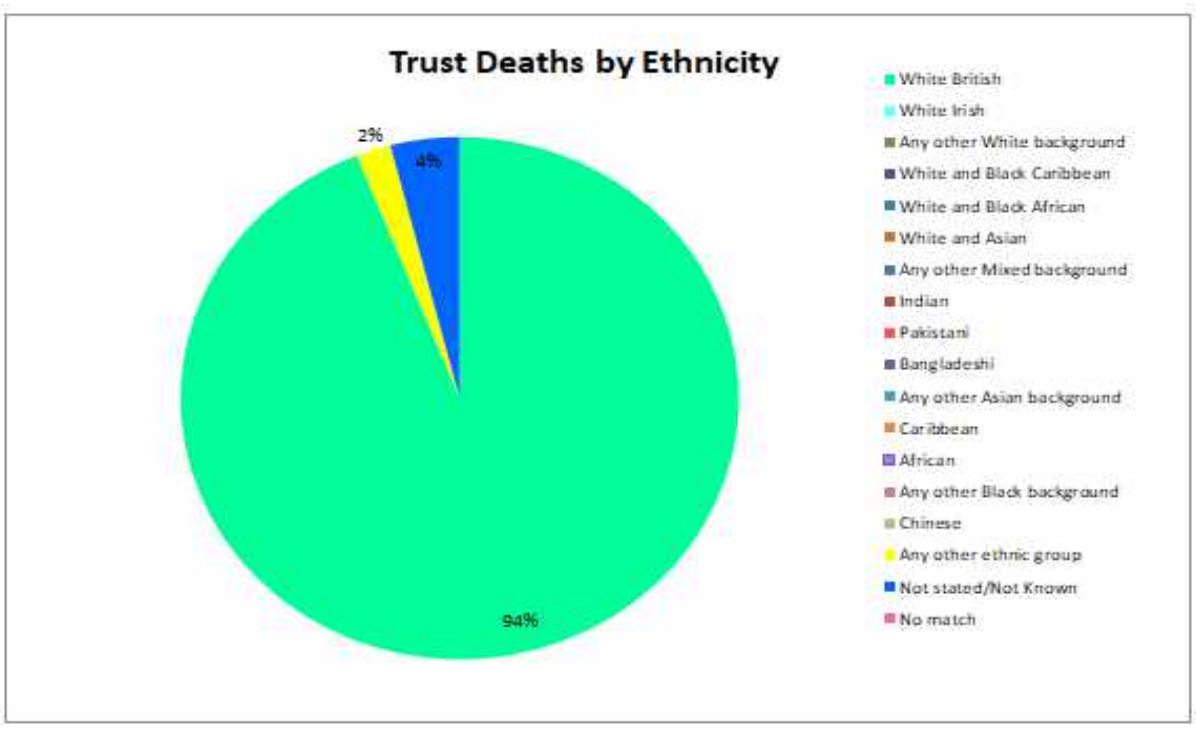


Narrative: As of 23/05/2020, the Trust had reported 116 deaths of inpatients with confirmed COVID-19. The trend is in line with the North West and Cheshire & Mersey positions. From 02/03/2020 – 23/05/2020, the Trust recorded 307 inpatient deaths in total (all causes). Between March – May 2019, the Trust recorded a total of 280 deaths (all causes).

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

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

Number of In Hospital Deaths (Ethnicity)

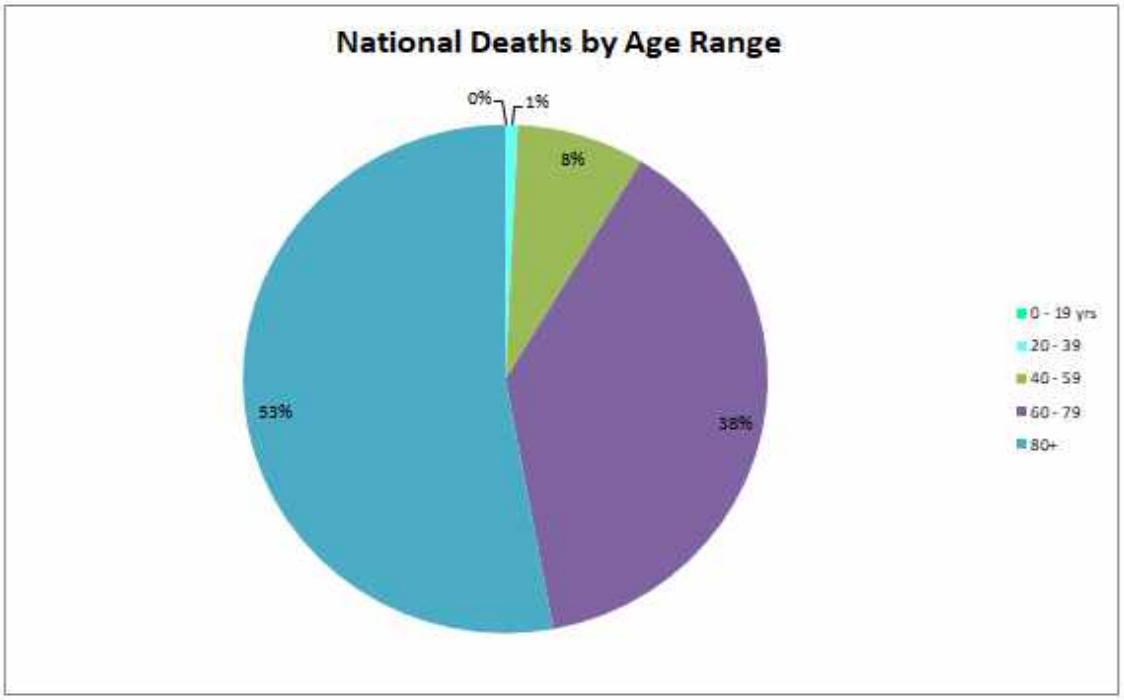


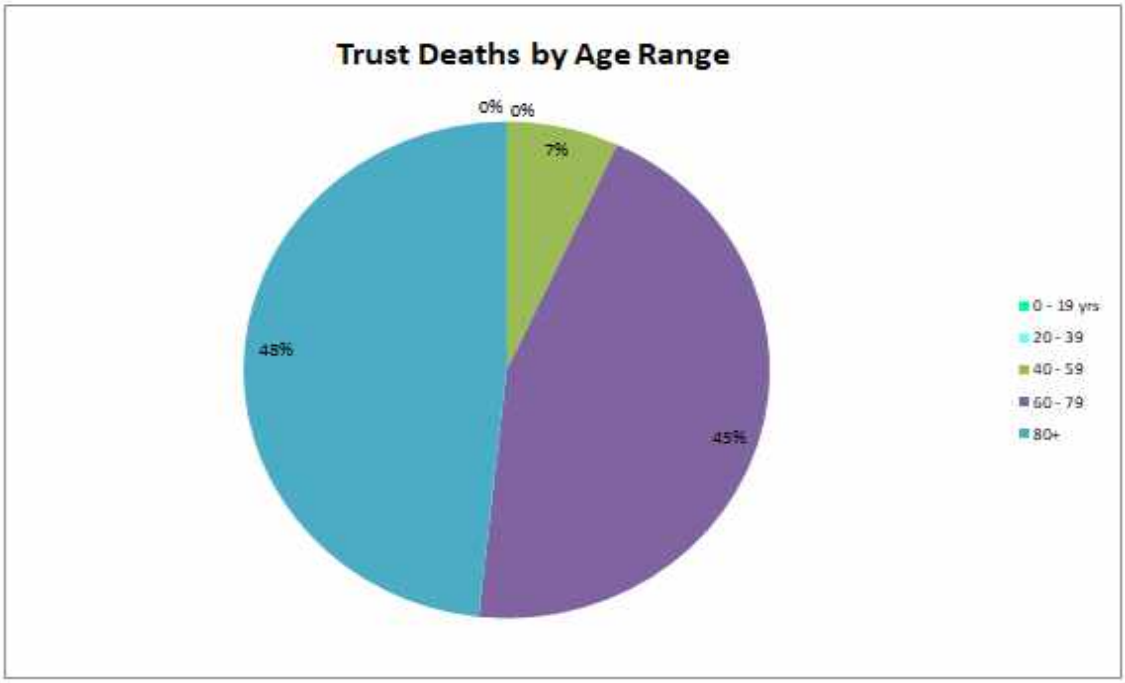
Narrative: As of 23/05/2020, 109 of the 116 reported deaths were patients who identified as "White British", with 5 patient's ethnicity "Not Stated" and 2 patient's ethnicity stated as "Any Other Mixed Background". The proportion of White British patient deaths is significantly greater than the national position, however this is as expected when comparing the population of Warrington (96% White) & Halton (98% White).

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

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

Number of In Hospital Deaths (Age Range)



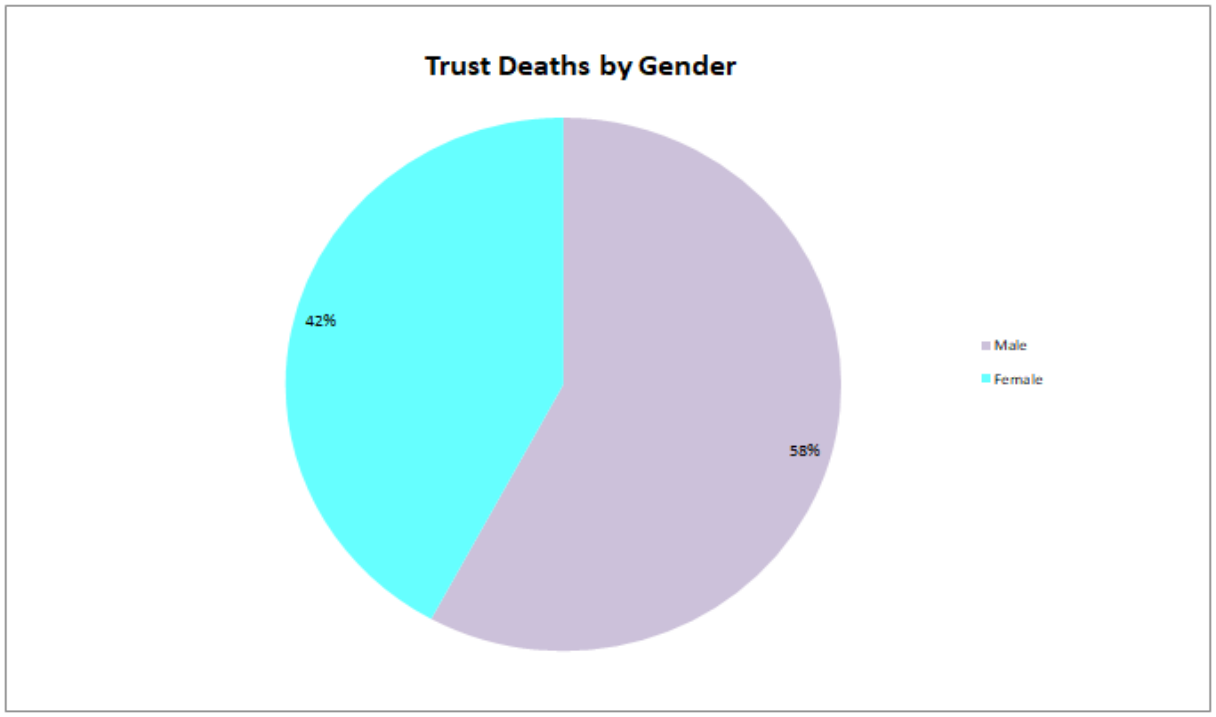


Narrative: As at 23/05/2020, 93% of COVID-19 related deaths were inpatients over the age of 60, which is line with the national position. The average age of death was 72 years.

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

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

Number of In Hospital Deaths (Gender)

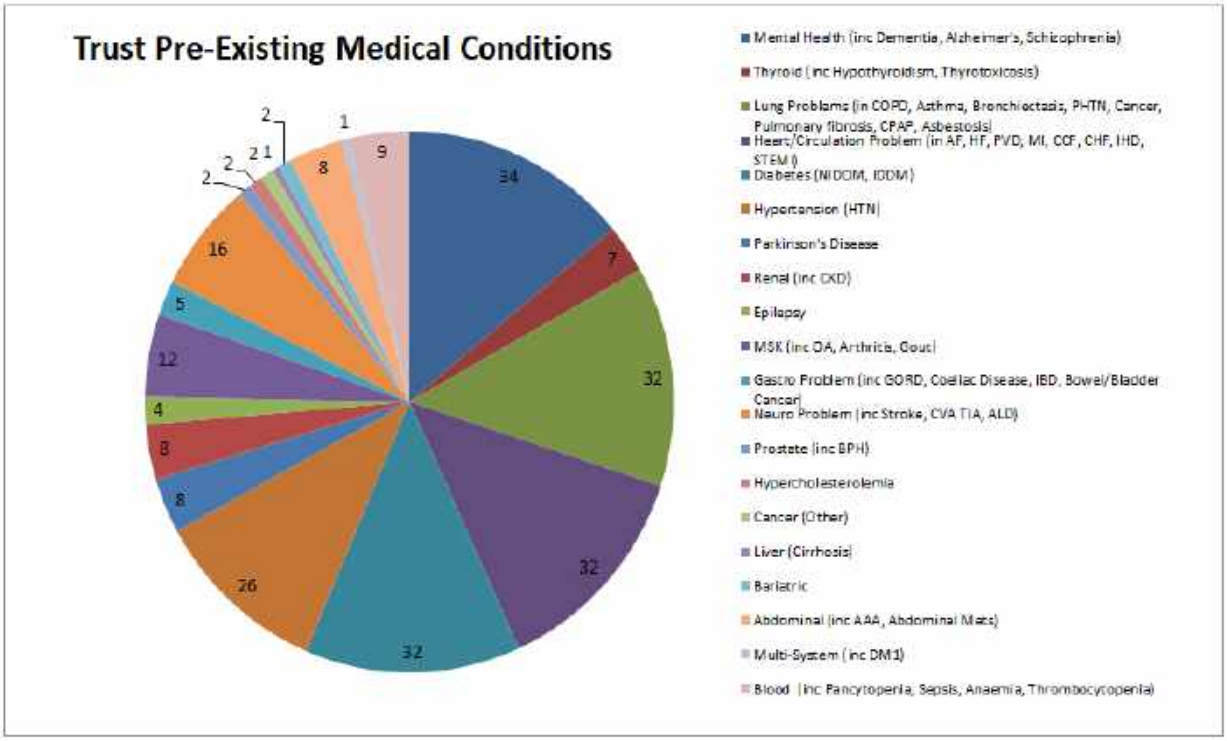


Narrative: As at 23/05/2020, there were 67 (58%) male inpatient deaths and 49 (42%) female inpatient deaths.

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

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

In Hospital Deaths - Pre-Existing Medical Conditions



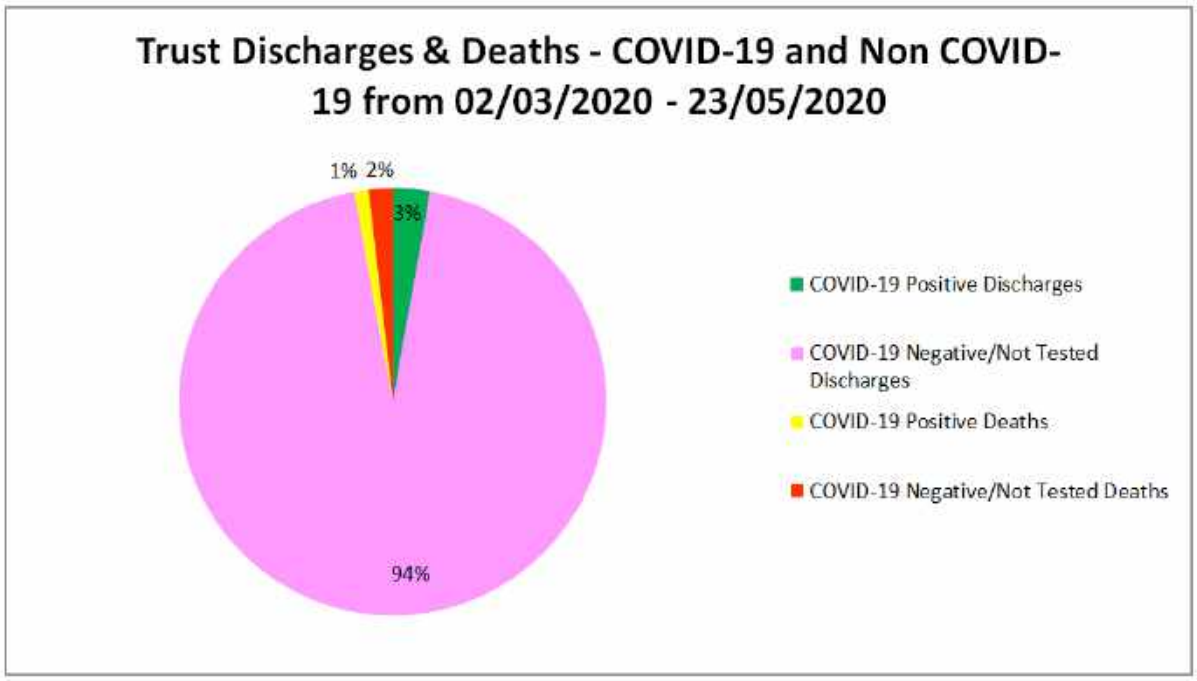
Narrative: As at 23/05/2020, 87% of Trust inpatients who have died as a result of COVID-19 had a pre-existing medical condition. The most common of these were Heart and Lung conditions in additional to organic mental health conditions such as Dementia and Alzheimer's.

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

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

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

Trust Outcomes

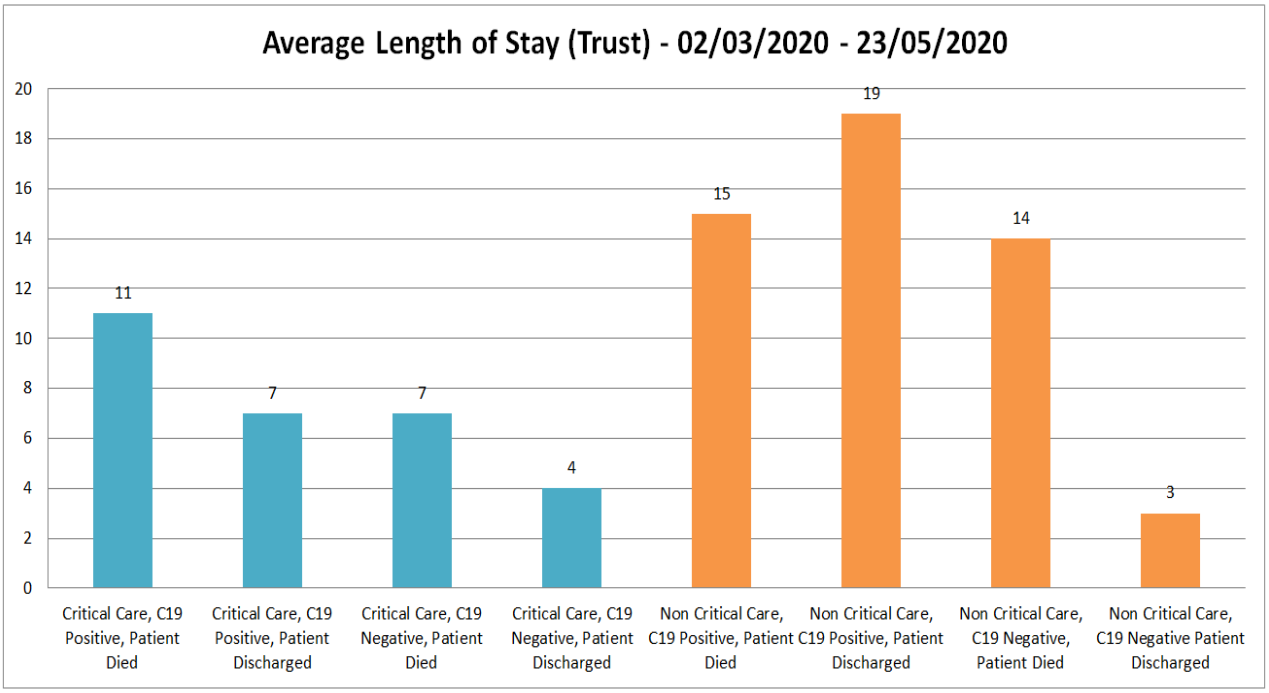


Narrative:

- Between 02/03/2020 – 23/05/2020, the Trust treated 10577 inpatients. 415 (3.92%) of inpatients had tested positive for COVID-19.
- 97.1% of all patients were discharged from hospital.
- There were a total of 307 patients (all causes) who have died, this represents 2.90% of all inpatients.
- 116 of inpatient deaths were related to COVID-19 which represented 1.1% of all inpatients, 37.8% of all inpatient deaths and 27.9% of all patients who had tested positive for COVID-19.
- 68 patients who have died and who had tested positive for COVID-19 were admitted from a care home (16.38% of all COVID-19 positive inpatients).

Source: Trust Data

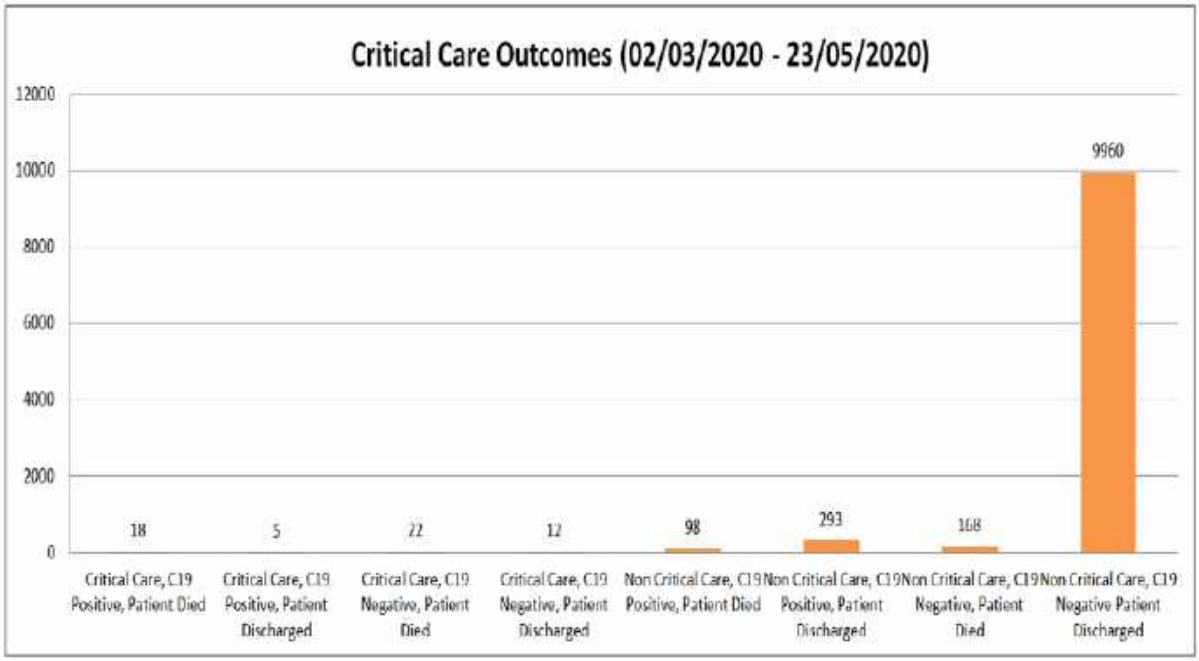
Average Length of Stay



Narrative: From 02/03/2020 - 23/05/2020, the average length of stay for patients who had tested positive for COVID-19 was 14 days.

Source: Trust Data

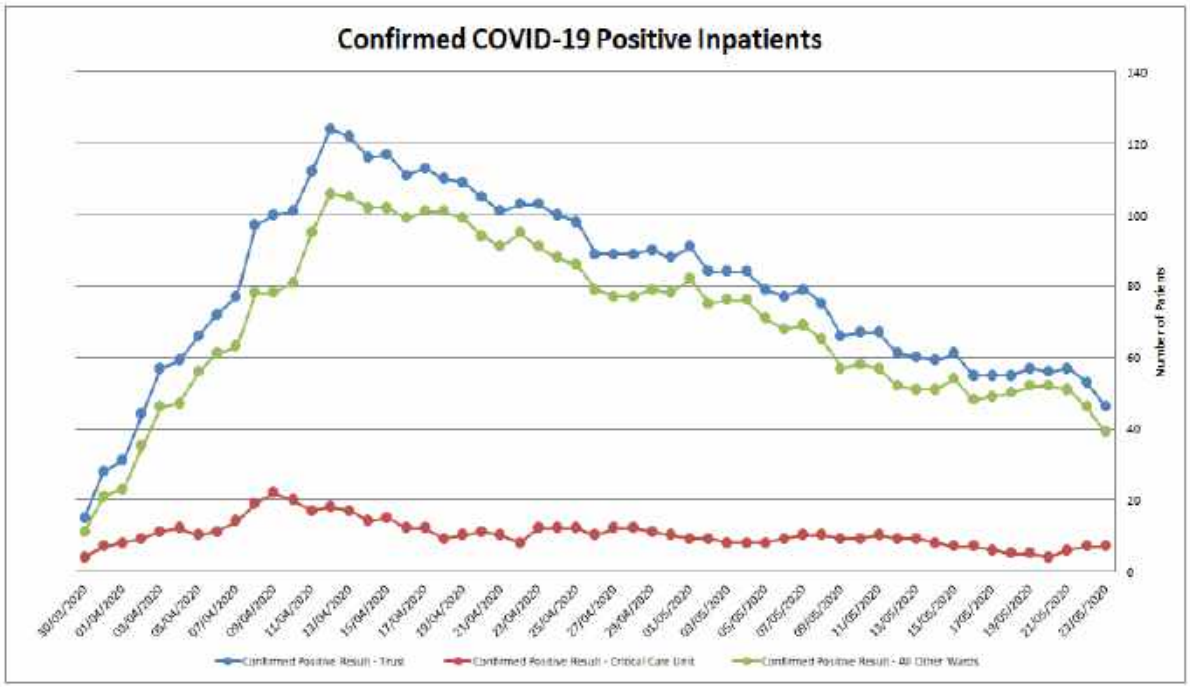
Critical Care Outcomes



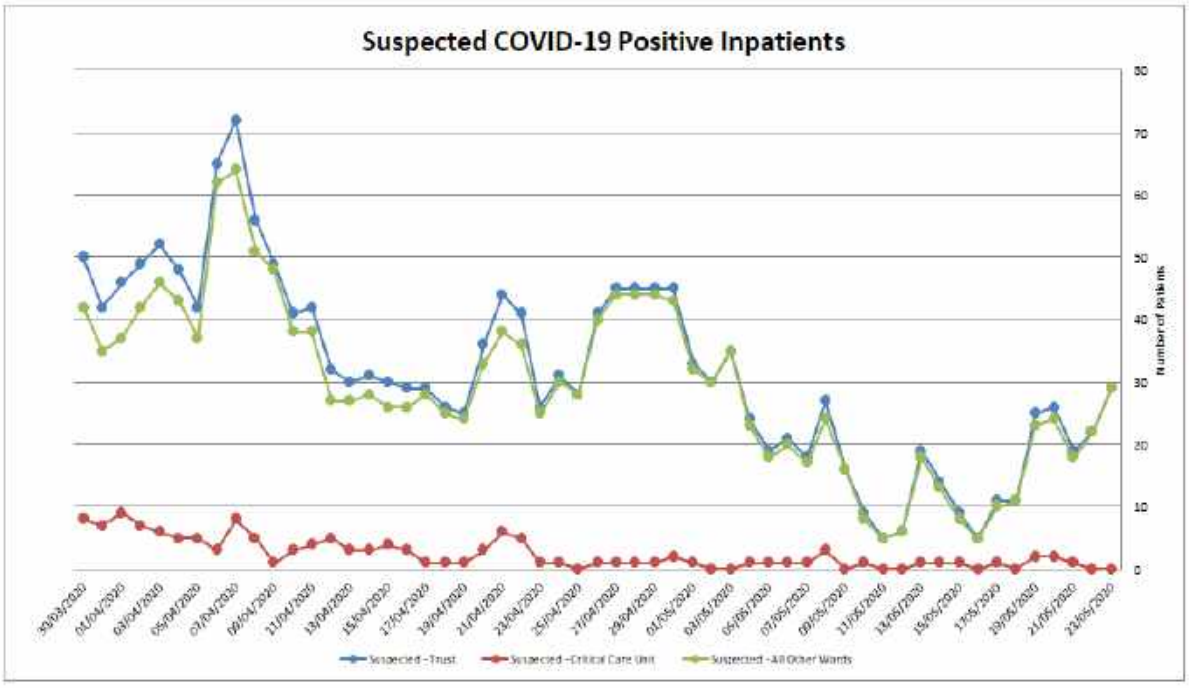
Narrative: From 02/03/2020 – 23/05/2020, there were 40 inpatient deaths and 17 inpatient discharges from critical care in total. This included 22 patients who had tested positive for COVID-19 (18 deaths, 5 discharges).

Source: Trust Data

Confirmed Positive & Suspected Positive COVID-19 Patients



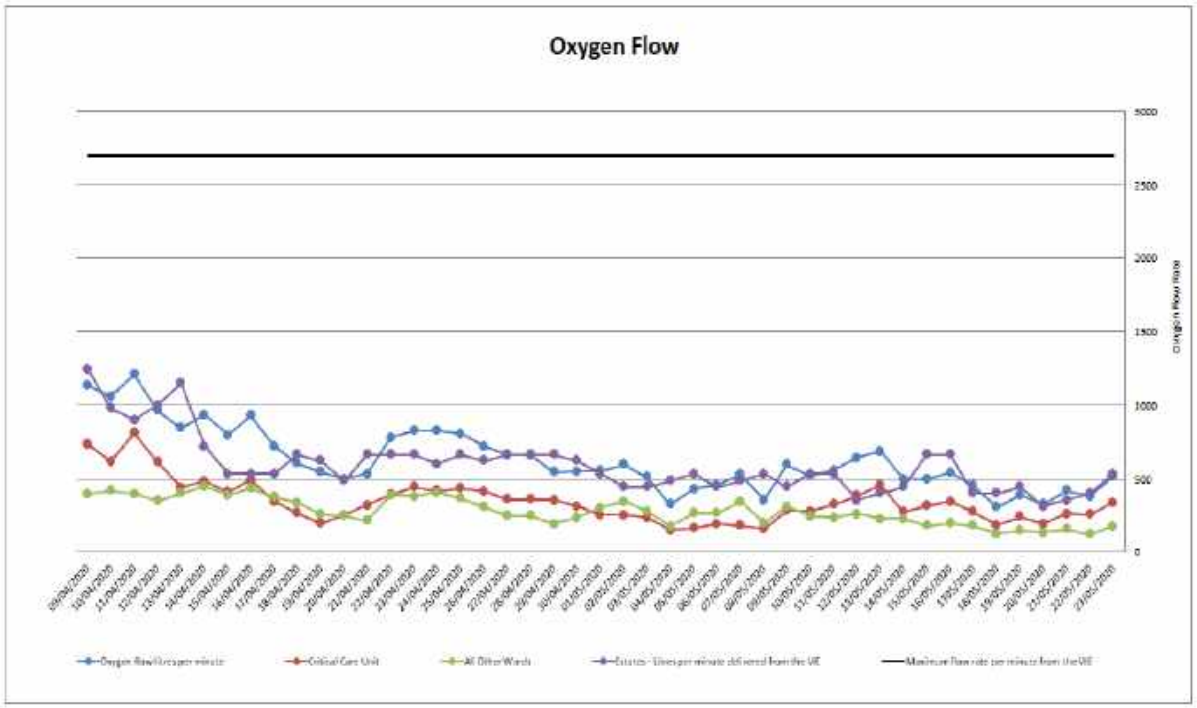
Narrative: As of 23/05/2020, there were 46 confirmed positive current inpatients with COVID-19, this was the lowest number since 02/04/2020. There are 7 inpatients in the critical care unit.



Narrative: As of 23/05/2020, there were 29 current inpatients with suspected COVID-19 (0 in critical care), with a peak of suspected cases on 07/04/2020 at 72 cases. There has been an increase over the last 7 days.

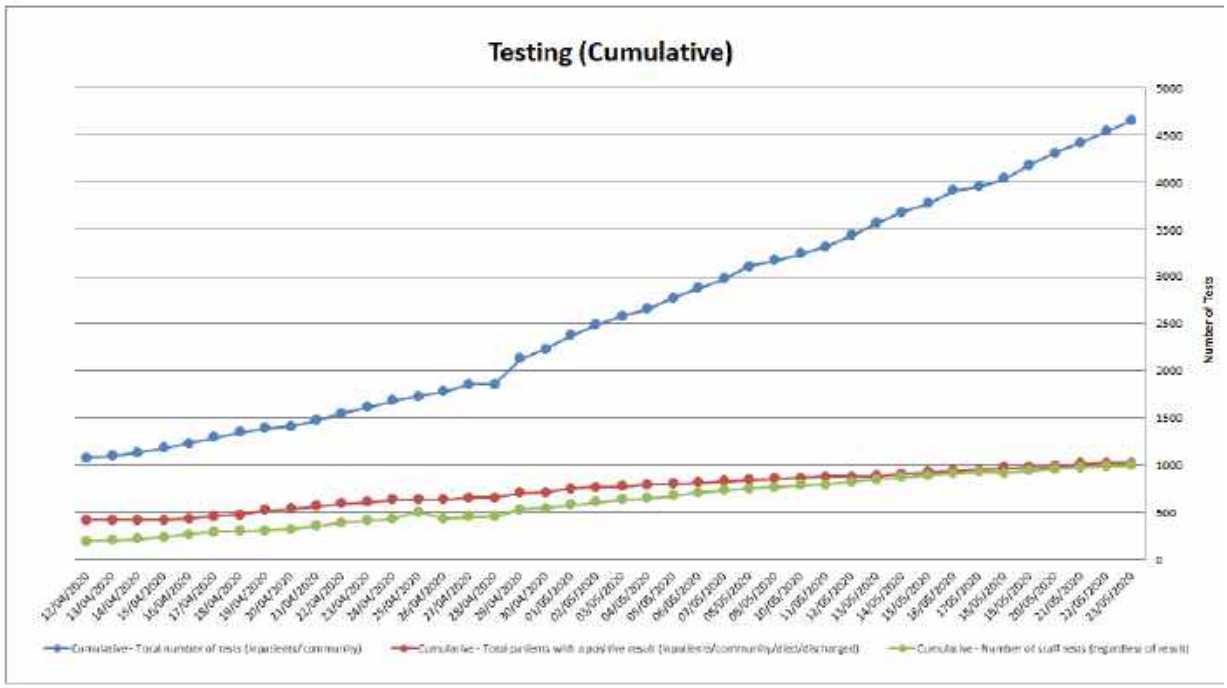
Source: Trust Data

Oxygen Flow



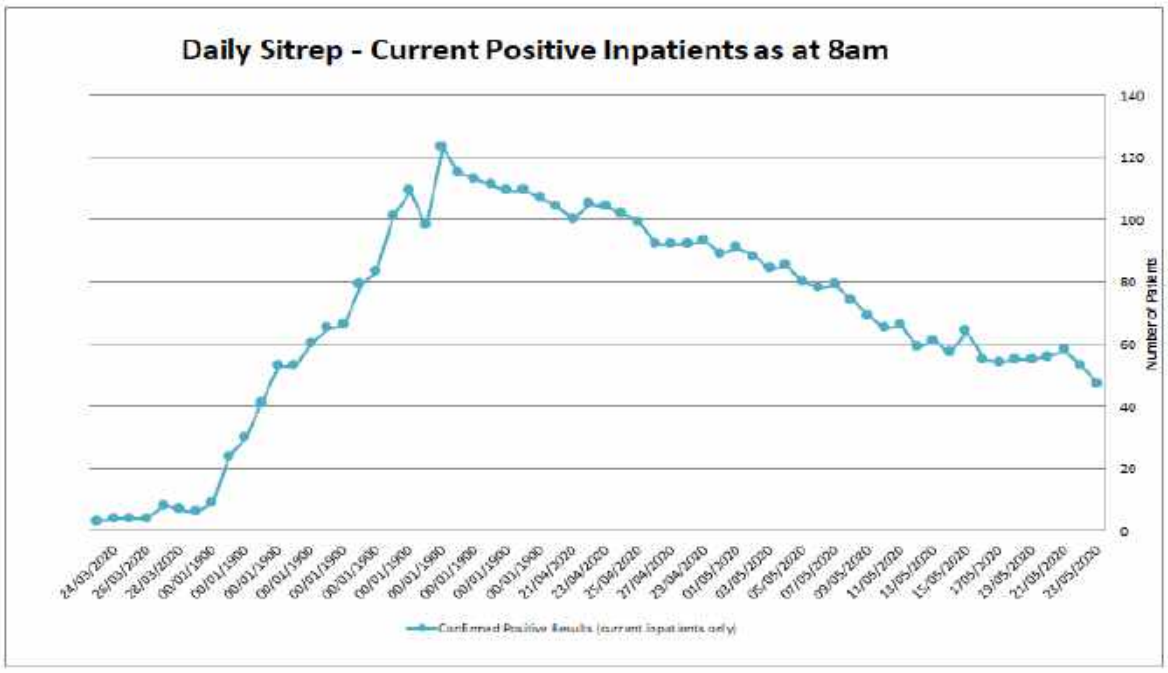
Narrative: The Trust has not experienced any capacity issues with the oxygen flow rate. The maximum amount of oxygen used was on 09/04/2020 at 1244 litres per minute which was 46% of capacity.
Source: Trust Data

COVID-19 Testing



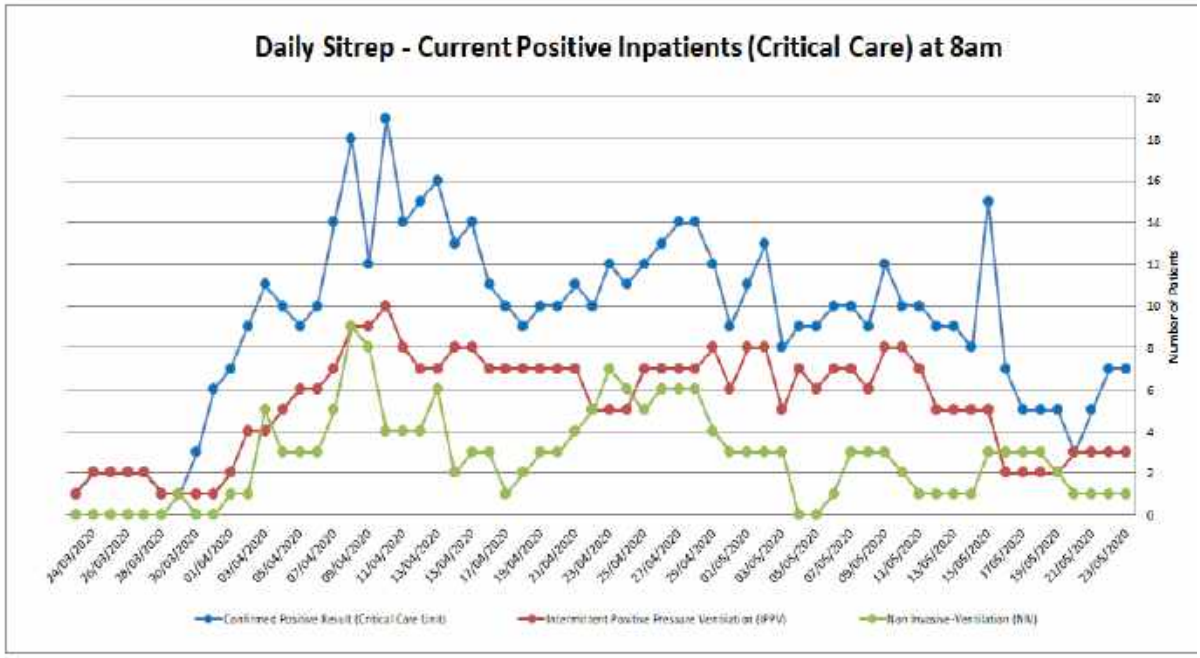
Narrative: As of 23/05/2020, 4657 patients (inpatients & community) have been tested and 998 staff tests have been carried out. Of the 4657 patients tested, 1019 patients tested positive.
Source: Trust Data

Daily Sitreps



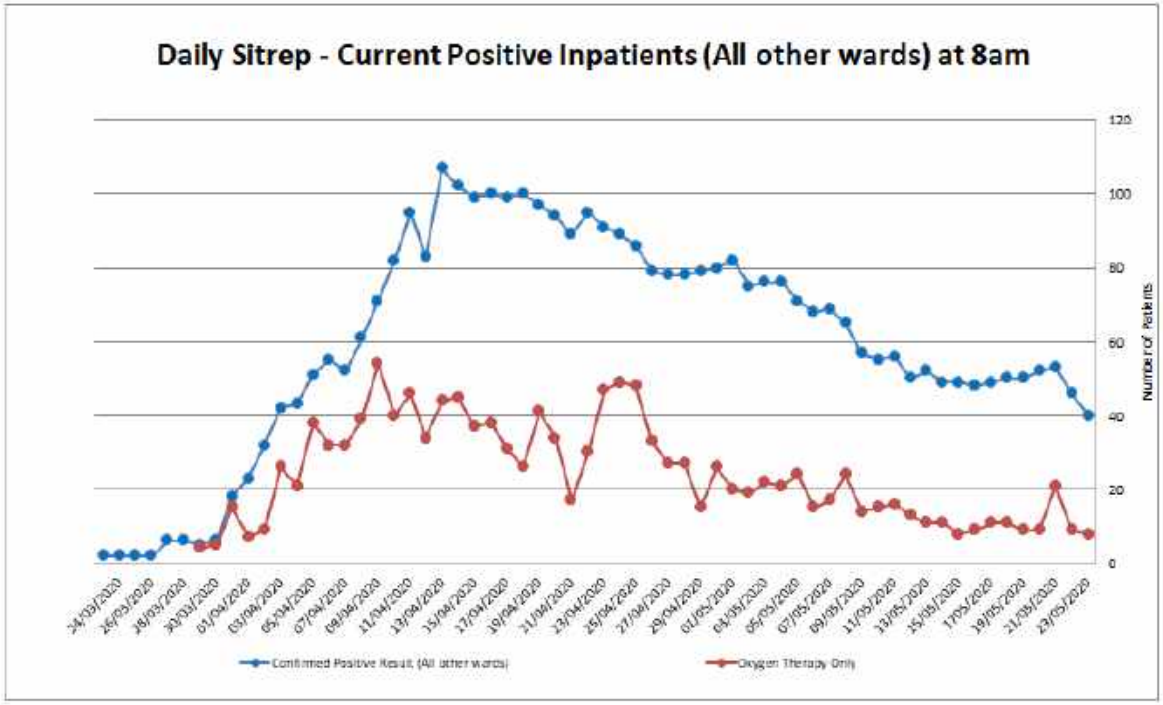
Narrative: From 30/03/2020 – 13/04/2020, the Trust saw a steady increase in COVID-19 positive inpatients, this has since reduced from a peak of 124 inpatients on 13/04/2020 to 47 inpatients on 23/05/2020.

Source: Trust Data

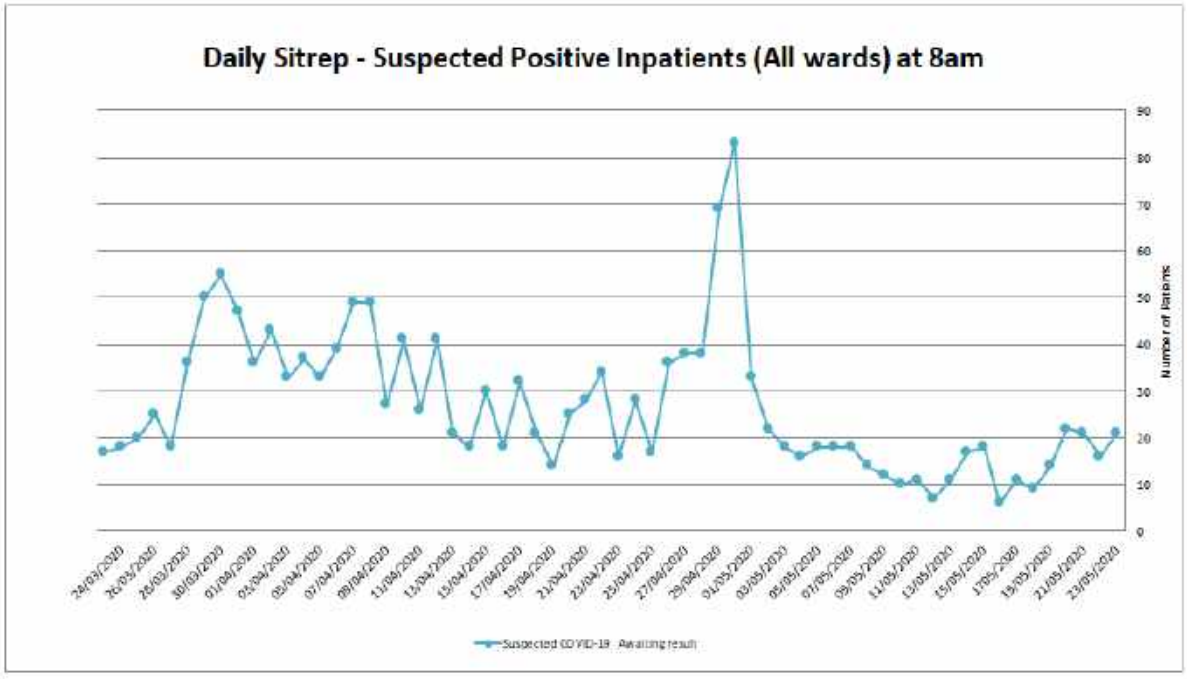


Narrative: As of 23/05/2020, there were 7 inpatients in critical care with confirmed COVID-19 and 0 patients with suspected COVID-19. 3 patients were on Intermittent Positive Pressure Ventilation (IPPV) and 1 patient on Non-Invasive-Ventilation (NIV).

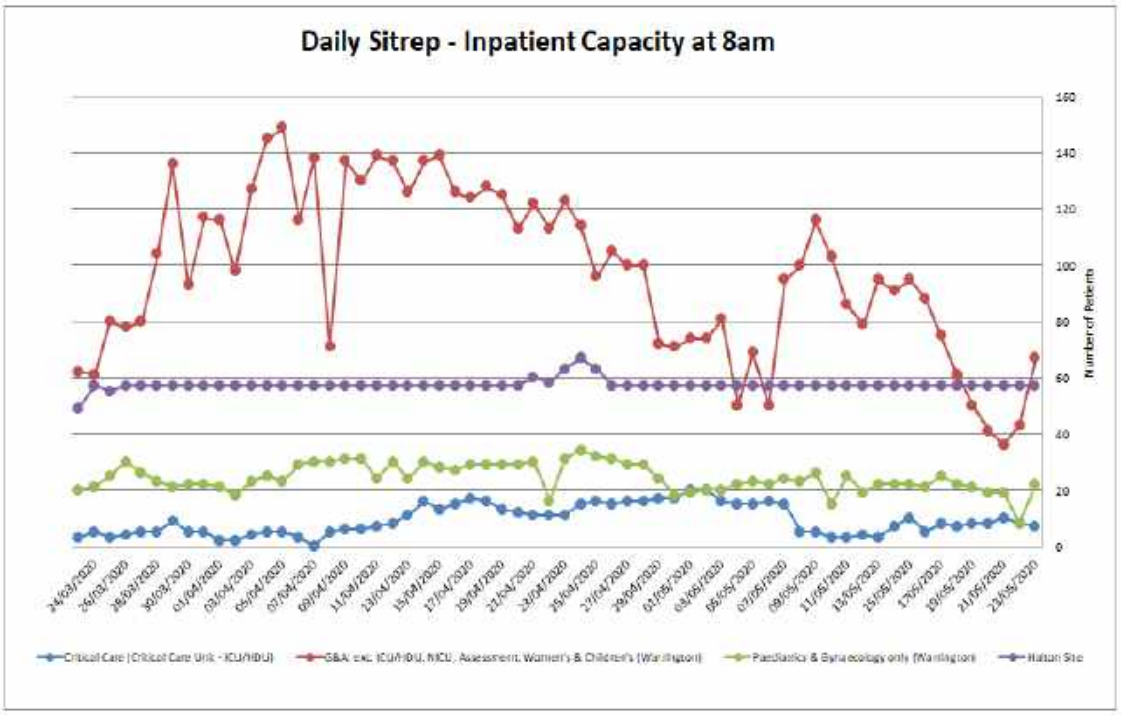
Source: Trust Data



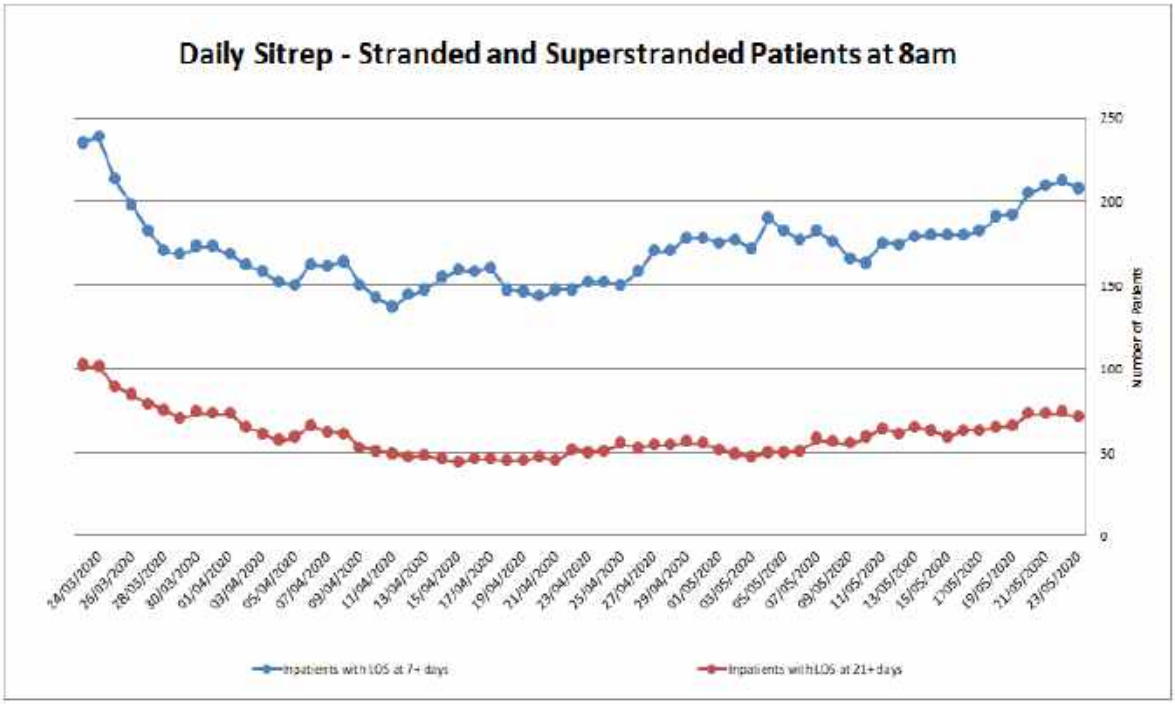
Narrative: As of 23/05/2020, there were 40 patients on all other wards with a confirmed COVID-19. This is the lowest number since 02/04/2020 (32 patients). Of the 40 patients, 8 patients are receiving oxygen therapy.
Source: Trust Data



Narrative: As from 23/05/2020, there were 21 patients with suspected COVID-19, this has fluctuated over the last 2 weeks.
Source: Trust Data

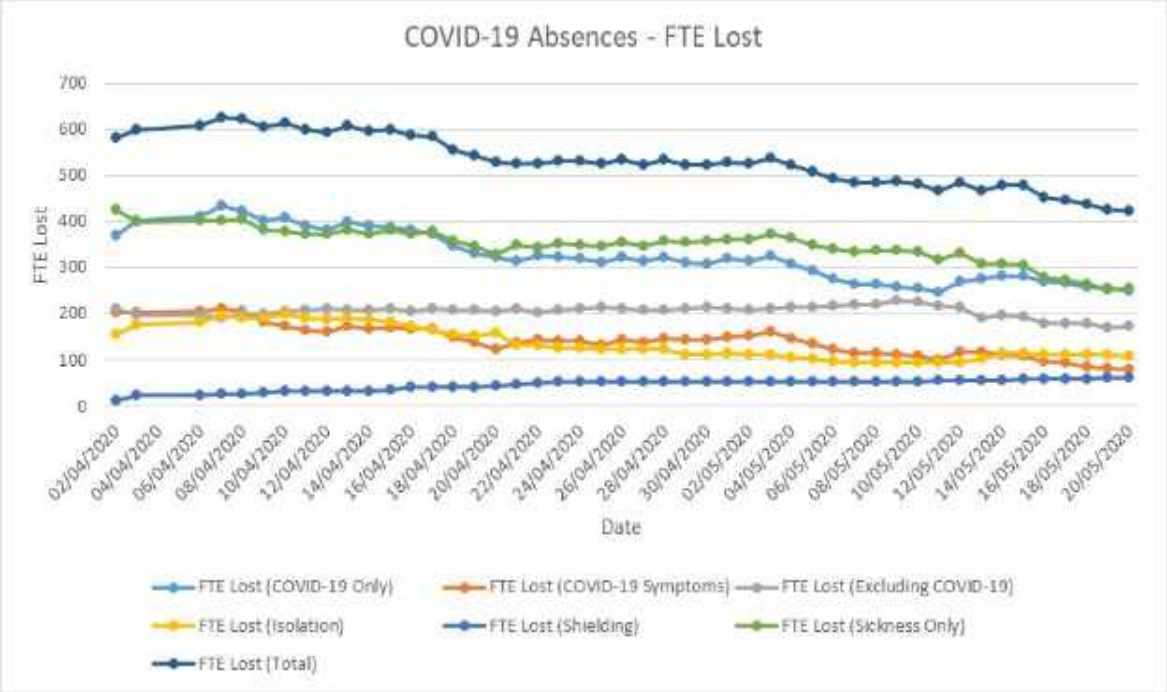


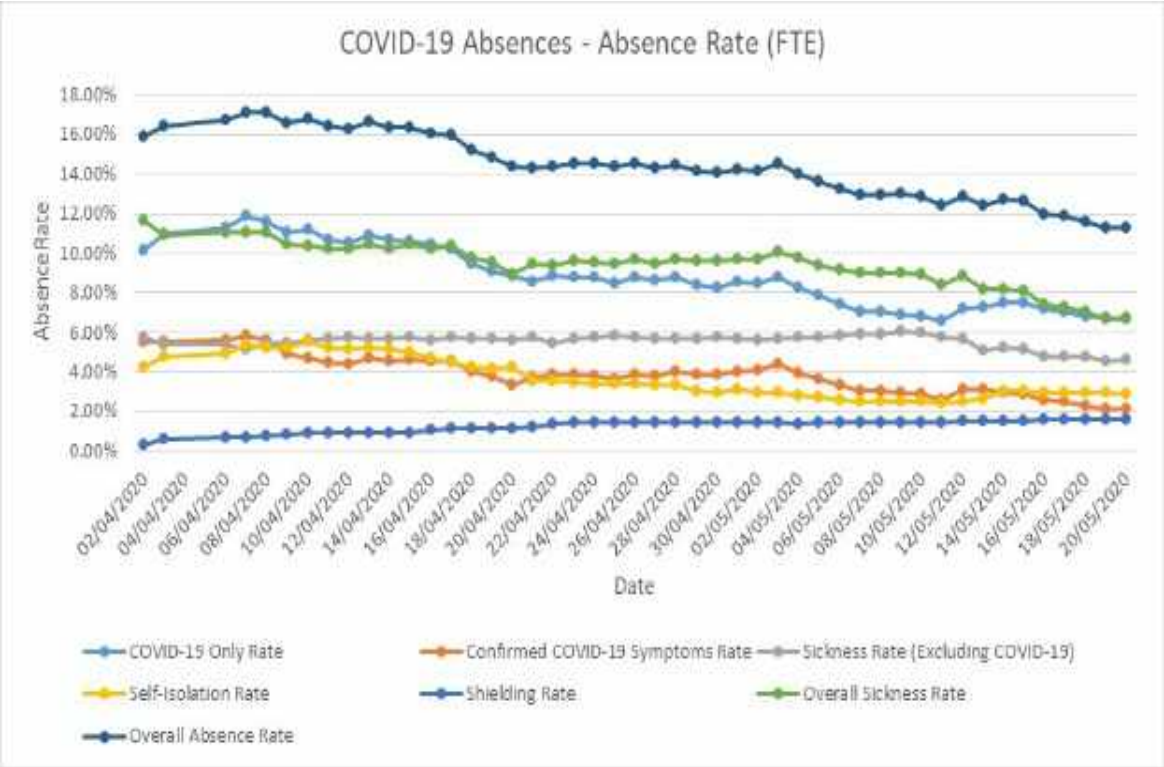
Narrative: Since 23/03/2020, the minium number of critical care beds available was 2, this was on 01/04/2020 – 02/04/2020. Capacity in other areas has remained stable.
Source: Trust Data



Narrative: On 23/03/2020, there were 235 Stranded and 102 Super Stranded patients. The lowest number of super stranded patients was on 15/04/2020 with 44. This has since increased and as of 23/05/2020, there were 71 super stranded patients.
Source: Trust Data

Staff Sickness

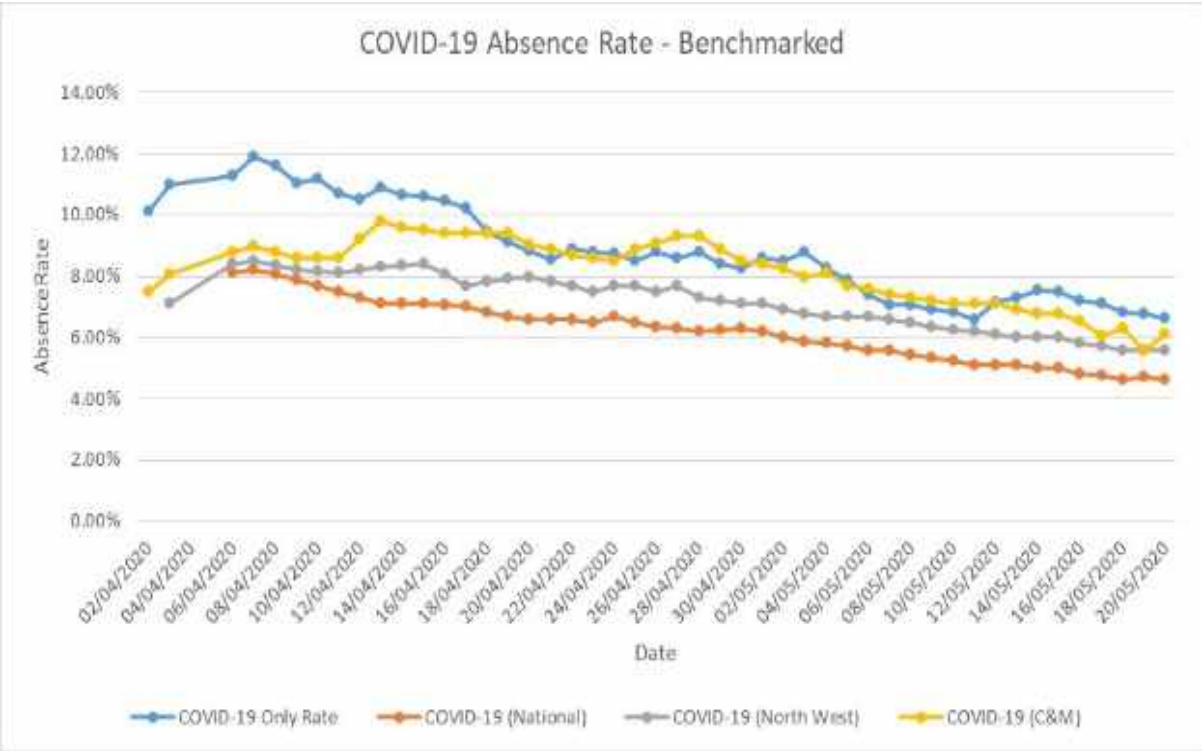


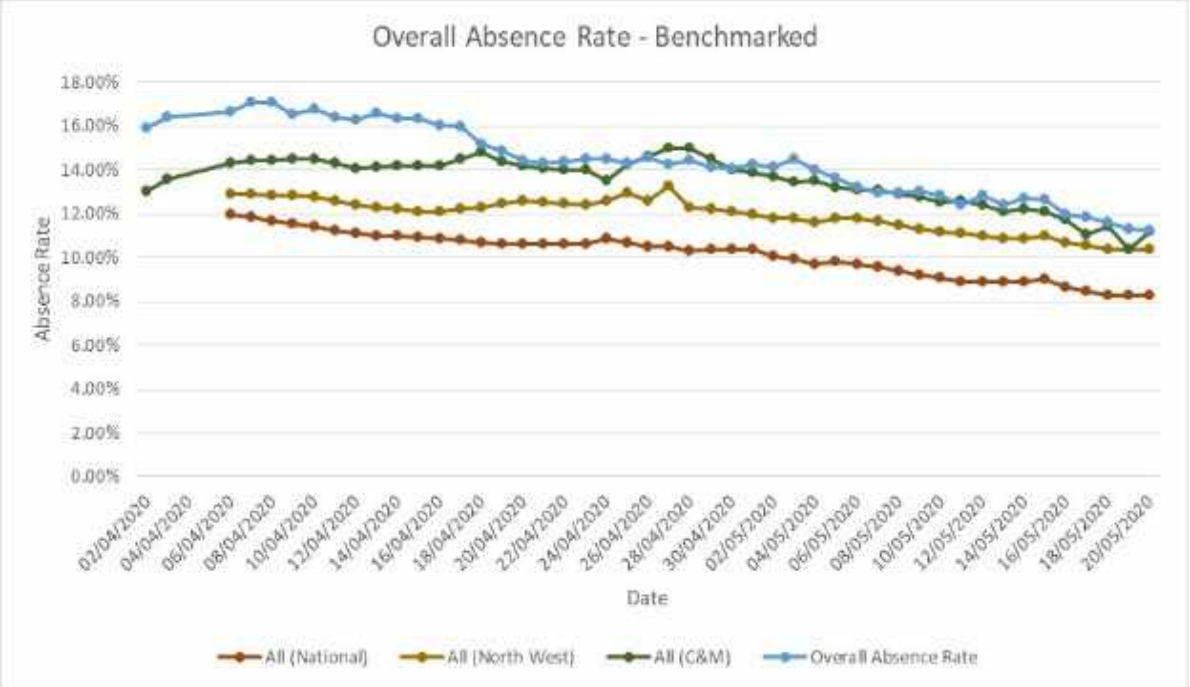


Narrative: Non COVID-19 related sickness absence has reduced by 1.2% since 02/04/2020 and is now being reported as 4.61%. COVID-19 related sickness absence continues to reduce from 5.56% (02/04/2020) to 2.14% (20/05/2020) and is consistent with previous reporting.

There has been a reduction in number of staff isolating for 7 days from 203 FTE on 02/04/2020 to 99 FTE on 20/05/2020. This is also reflected in the number of staff self-isolating for 14 days from 155 FTE to 130 FTE. There continues to be an increase in the number of staff shielding for 12 weeks from 11 FTE to 75 FTE.

Source: Trust Data





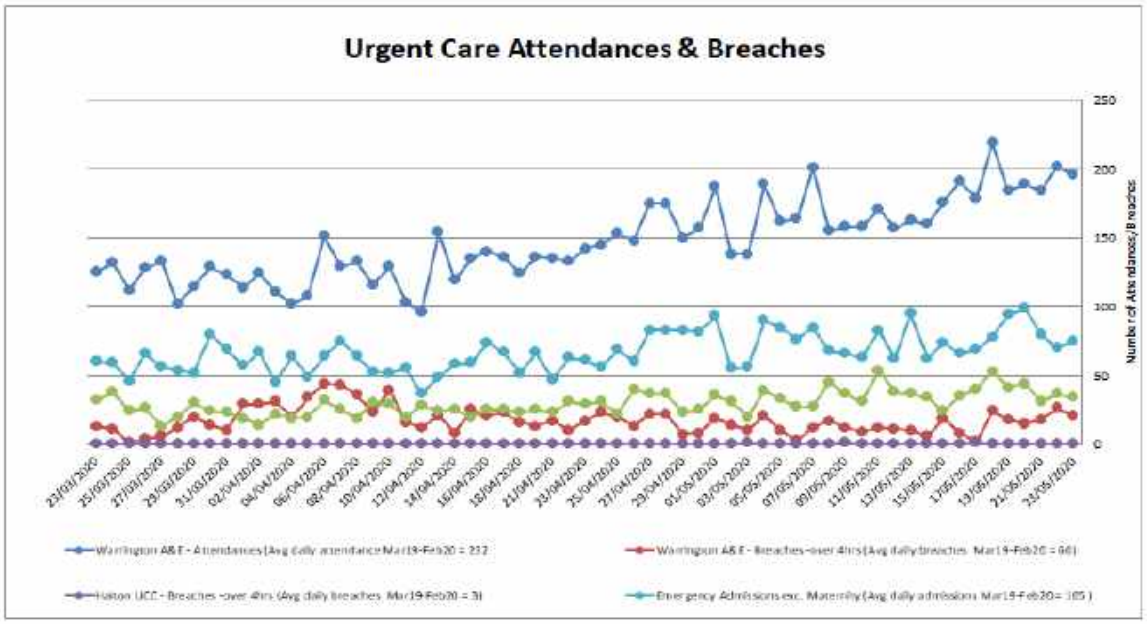
Narrative: The NorthWest has the highest overall absence rate (COVID-19 and Non COVID-19) nationally at 10.4%. Cheshire & Mersey has the highest absence rate in the North West reporting 11.2%.

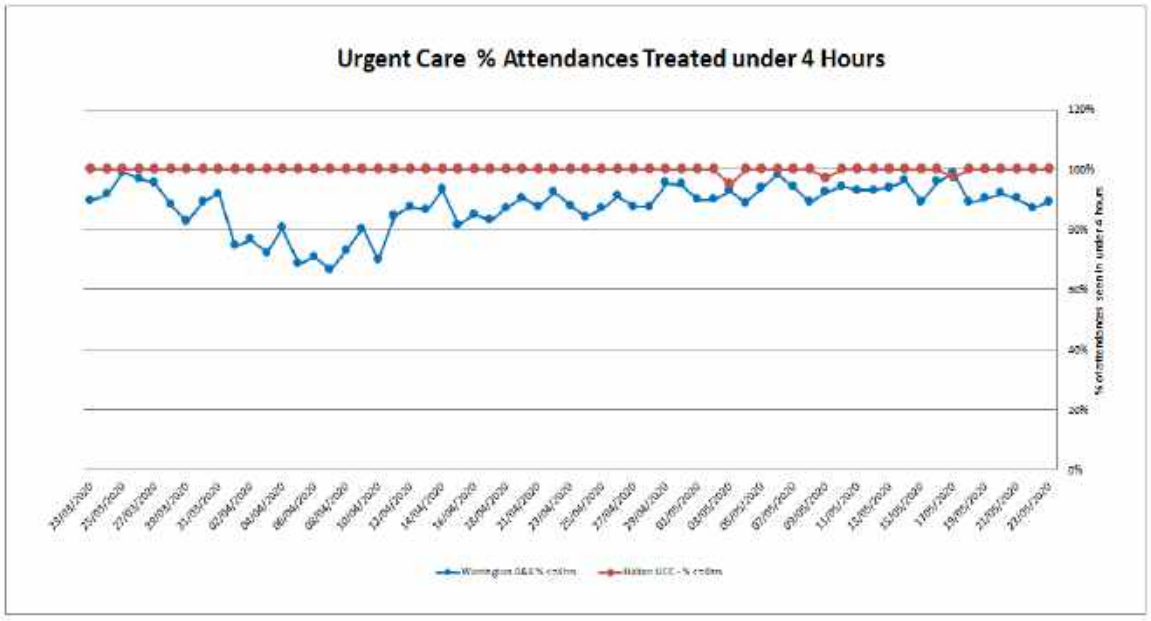
In comparison, the Trust's overall absence is 11.26%, and COVID-19 absence rate is 6.65% compared to a 6.1% average in Cheshire & Mersey.

Note: Where data isn't available for Benchmarking, an average between dates has been used.

Source: Trust Data

Urgent Care Attendances





Narrative: The Trust has seen the number of A&E attendances begin to increase since the start of the pandemic. Performance against the 4 hour A&E standard has continued to be positive at just under the 95% target in Warrington. The Trust has continued to maintain 100% in Halton at the Urgent Care Centre.

Source: Trust Data

3. CONCLUSION

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

4. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/20/05/49	
SUBJECT:	**Integrated Performance Report Dashboard**	
DATE OF MEETING:	27th May 2020	
AUTHOR(S):	Dan Birtwistle, Senior Business & Performance Manager	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Acting Medical Director Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Director of Human Resources & Organisational Development Andrea McGee - Director of Finance and Deputy Chief Executive Chris Evans - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #224 Failure to meet the emergency access standard.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has 68* IPR indicators which have been RAG rated in April as follows: **Red: 18 (from 24 in March)** **Amber: 4 (from 10 in March)** **Green: 33 (from 25 in March)** **Not RAG Rated: 13 (from 4 in March)** *The number of indicators has increased from 63 to 68 as approved by the Trust Board in March 2020. There are a number of indicators which cannot be RAG rated in month due to the impact of COVID-19. The Trust has ensured that processes remain in place to monitor and improve quality during the COVID-19 pandemic. Open Incidents are monitored, with progress tracked weekly via the Trust Meeting of Harm. CBUs continue to be supported to ensure the timely closure of incidents and governance meetings continue to take place via Microsoft teams. There has been a significant improvement in Medicines Reconciliation within 24 hours, which has been achieved through a combination of staffing skill mix and the	

<table>
<tr><td></td><td colspan="4">implementation of ePMA. Falls, Pressure Ulcers and Healthcare Acquired Infections continue to be monitored and action is taken to address any concerns as they arise.

The new financial system of top ups has moved the Trust to a breakeven position. Capital costs relating to COVID-19 were £1.4m and revenue costs were £3.2m. Controls are in place to ensure only those costs necessary are incurred in supporting the COVID-19 response and the recovery phase. The Trust continues to monitor the changing guidance relating to the financial regime and COVID-19 expenditure. The cash balance is £15.4m.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval</td><td>To note
X</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to:
1. Note the contents of this report.
2. Note the COVID-19 capital approved as an emergency by the Director of Finance & Deputy Chief Executive.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3">Choose an item.</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="3"></td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="3"></td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="3"></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">Choose an item.</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report Dashboard	**AGENDA REF:**	BM/20/05/49

1. BACKGROUND/CONTEXT

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

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

In March 2020, the Trust Board approved the recommended amendments to the KPIs as part of the annual refresh. Therefore the total number of indicators has increased from 63 to 68 for 2020/21.

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

Table 1: RAG Rating Movement

	March	April
Red	24	18
Amber	10	4
Green	25	33
Not RAG Rated	4	13
Total:	63	68

Due to validation and review timescales for Cancer, the RAG rating on the dashboard for these indicators is based on March's validated position. VTE is a quarterly position and is therefore not RAG rated in month.

Due to the impact of COVID-19, 12 indicators cannot be RAG rated in month, as the data is not available or not reportable. These are:

Quality

- Friends & Family Test (Inpatients & Daycases) – the FFT has been suspended nationally.
- Friends and Family Test (ED & UCC) – the FFT has been suspended nationally.
- Staffing Average Fill Rate – Staffing Average Fill Rate reporting has been suspended nationally.
- Care Hours Per Patient Day (CHPPD) – CHPPD reporting has been suspended nationally.
- CQC Insight Report – the CQC Insight Report has not been published for March/April.

Access & Performance

- Ambulance Handover – 30-60 minutes – data has not been published by the North West Ambulance Service.
- Ambulance Handover 60 minutes plus – data has not been published by the North West Ambulance Service.

Finance

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

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

Quality

Quality KPIs

There is 1 Quality indicator rated Red in April. This is a reduction from 7 in March, mainly due to a number of KPIs being reset for 2020/21.

The 1 indicator rated Red in March, which has remained Red in April is as follows:

- Incidents: There were 31 open incidents over 40 days old at the end of April. A reduction from 39 in March. This is against a target of 0. Performance has been impacted by the COVID-19 pandemic, as clinical areas have been required to focus upon providing direct care. All areas continue to be supported by the Governance Department and virtual meetings continue.

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

- Mixed Sex Accommodation Breaches (MSA) – There were 0 Mixed Sex Accommodation Breaches reported in April, a reduction from 4 reported in March, against a target of 0.
- Healthcare Acquired Infections (MRSA) – The RAG rating for this indicator is based on any cases being reported during the financial year, of which there were 2 in 2019/20. The RAG rating for this indicator has been reset for 2020/21. There were no MRSA cases reported in April (under review).
- Healthcare Acquired Infections (CDI) – The threshold for this indicator has been reset for 2020/21. There were 5 cases of CDI reported in April.
- Healthcare Acquired Infections (Gram Negative) – The threshold for this indicator has been reset for 2020/21. There were 2 cases of E.coli, 0 cases of Pseudomonas aeruginosa and 0 cases of Klebsillea reported in April.

- Pressure Ulcers – The Trust exceeded the threshold of 57 pressure ulcers in 2019/20, with a total of 65 reported. The RAG rating for this indicator has been reset for 2020/21. There were 3 category 2 pressure ulcers reported in April.

There is 1 indicator which was rated Red in March and has not been RAG rated in April as follows:

- VTE Assessments – VTE assessments are reported as a quarterly position and will be reported for Q1 in July's Board report.

Access and Performance

Access and Performance KPIs

There are 8 Access and Performance indicators rated Red in April, the same number March. Performance against these indicators has been significantly impacted by the COVID-19 pandemic.

The 5 indicators which were rated Red in March and remain Red in April are as follows:

- Diagnostic 6 Week Target – the Trust achieved 26.27% in April, a reduction from 97.32% in March, against a target of 99.00%.
- Referral to Treatment Open Pathways – the Trust achieved 81.62% in April, a reduction from 90.04% in March, against a target of 92.00%.
- A&E Waiting Times 4 hour national target – the Trust achieved 92.54% (excluding Widnes Walk ins) in April, an improvement from March's position of 81.89%, against a target of 95.00%.
- Discharge Summaries % sent within 24 hours – the Trust achieved 75.80% in April, a reduction from 83.72% in March, against a target of 95.00%.
- Discharge Summaries not sent within 7 days – there were 9 discharge summaries not sent within 7 days in order to meet the 95.00% threshold in April, increased from 3 in March against a target of 0.

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

- Cancelled Operations on the Day (non clinical reasons) – the Trust performance was 3.37% in April, increased from 1.67% in March, against a target of less than 2.00%.
- Cancelled Operations on the Day (non clinical reasons, not rebooked within 28 days) – there were 25 patients who's operations was cancelled on the day and not rebooked within 28 days in April, increased from 1 in March against a target of 0.

There is 1 indicator which was not RAG rated in March, and has been rated as Red in April as follows:

- Breast Symptoms 14 days – the Trust achieved 89.66% in March, a reduction from 98.77% in February against a target of 93.00%.

There are 2 indicators which were rated Red in March but have not been RAG rated in April as follows:

- Ambulance Handovers (30 – 60 minutes).
- Ambulance Handovers (60 minutes plus).

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

- Cancer 62 days urgent – the Trust achieved 86.41% in March, an improvement from 71.76% in February, against a target of 85.00%.

PEOPLE

Workforce KPIs

There are 6 Workforce indicators rated Red in April, increased from 5 in March.

The 5 indicators which were Red in March and remain Red in April are as follows:

- Sickness Absence – The Trust's sickness absence was 9.70% in April, increased from 7.02% in March, against a target of less than 4.20%. Non COVID-19 related sickness absence was 5.36% and COVID-19 related sickness absence was 4.34%.
- Return to work – Trust compliance was 57.79% in April, decreased from 59.08% in March, against a target of 85.00%.
- Bank/Agency Reliance – The Trust's reliance was 18.63% in April, increased from 14.23% in March, against a target of less than 9.00%.
- Monthly Pay Spend – Pay spend was £18.0m in April, against a budget of £17.0m. COVID-19 related pay spend was £2.3m in April.
- Agency Shifts Compliant with the Cap – 32.5% of agency shifts were compliant with the cap in April, a decrease from 42.09% in March, against a target of over 49.00%.

There is 1 indicator which was not RAG rated in March and has been rated Red in April as follows:

- % Use of Apprenticeship Levy – Use of the Levy was 45.00% in April, against a target of 85.00%.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 3 Finance & Sustainability indicators rated Red in April, reduced from 4 in March.

The 3 indicators which were Red in March and remain Red in April are as follows:

- Capital Programme – The actual spend is £0.5m (£0.1m is related to COVID-19) which is £0.4m below the planned spend of £0.9m.
- Better Payment Practice Code (BPPC) – The Trust received additional income in April to facilitate the new guidelines to pay creditors within 7 days. As a result performance of 65.00% has been achieved, which was an improvement from 31.00% in March. There is a focus to ensure compliance of 95.00% by the end of June 2020.
- Agency Spending – The actual spend in April was £1.2m which is £0.2m above the £1.0m plan.

There is 1 indicator which was RAG rated as Red in March but has not been RAG rated in April as follows:

- CIP Plans in Progress (Recurrent)

The Income and Activity Statement for month 1 is attached in **Appendix 5**.

The Trust has received income based upon the run rate across months 8-10 2019/20. The Trust has required a top up of £2.5m to achieve breakeven. The key movements are:

- Loss of income from car parking and accommodation - £0.2m
- Improvements for the reduction in elective activity - (£0.9m)
- Costs of COVID-19 - £3.2m

Capital Programme

In April, COVID-19 capital spend was approved and is outlined in **Table 1**.

Table 1: Covid-19 Capital approved in April 2020

Reference	Description	Price incl VAT £
COV19-000046	Additional Works in Minors (UEC)	5,227
COV19-000056	Ventilators Drager	120,011
COV19-000064	Paxton Net 2 System Door Access Control	33,121
COV19-000024	Carescape B650 Monitors	33,187
COV19-000065	Blood Gas Analysers	64,007
COV19-000066	Inflatable Zapp Shelter for Bed Storage	28,232
COV19-000023	Incubators	27,979
COV19-000080	Tranfser Vapotherm	7,570
COV19-000088	V60 Non invasive ventilators x 6	66,150
COV19-000083	Lucas Compression Machines for ED – Resus (UEC)	20,611
COV19-000101	Interfacing costs to the CGM MOLIS system	12,800
COV19-000092	Blood Gas trolleys	2,400
COV19-000097	Echo machine	121,000
COV19-000098	Cerebral Function Analyser Monitor (CFAM)	23,102
COV19-000102	Lucas machines	20,796
COV19-000110	Replacement of Echo Machine and Toe Probe	120,000
COV19-000111	Phlebotomy Module	86,818
COV19-000113	Replacement of Electrocardiogram (ECG) Machines 2	14,000
COV19-000116	Ward A7 Disabled Toilet/Shower Access for Males	15,000
COV19-000122	Oxygen Points B10 & B11	16,020
COV19-000129	Session Initiation Protocal ((SIP) Trunking	42,727
COV19-000131	25 x Qube monitors (Spacelabs)	209,437
COV19-000140	ECG Machine (UEC)	6,847
COV19-000106	Facial Nerve Stimulators	36,000
COV19-000107	Diathermy Systems	72,000
COV19-000108	ENT Microscope	90,000
COV19-000109	Fluid Warming Cabinets	38,000

COV19-000115	Surgical Head Lights	35,000
COV19-000141	Mini C Arm for Fracture Clinic	60,444
Total		**1,428,486**

The Trust has a clear process for approval of capital and revenue expenditure and for reporting on a regular basis.

From mid-May, the Trust has been informed by NHSE/I that all future COVID-19 capital must be approved nationally before committing to expenditure. The Trust's internal process has been amended to meet this requirement.

In addition, all Trusts have been asked to review their 2020/21 capital plans, with a target for Cheshire and Merseyside Health and Care Partnership to reduce the overall spend by 14.00%. Capital to support the COVID-19 response and recovery is anticipated, however further guidance is awaited. The revised operational plan agenda item details the suggested changes supported by the Executive Team.

The Board is requested to note the COVID-19 capital approved as an emergency by the Director of Finance & Deputy Chief Executive.

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

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

- Finance and Sustainability Committee
- Audit Committee
- Quality & Assurance Committee
- Trust Operational Board
- Strategic People Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

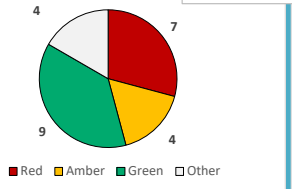
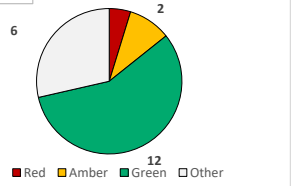
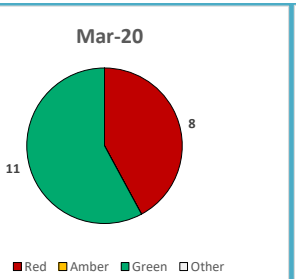
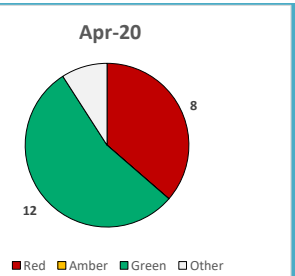
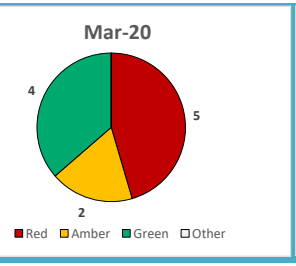
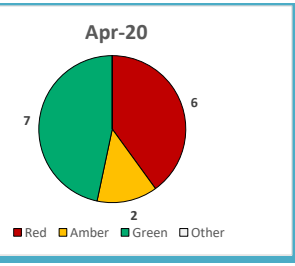
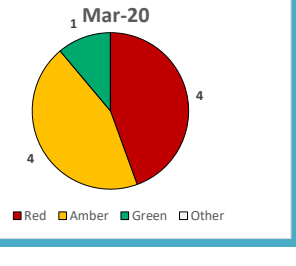
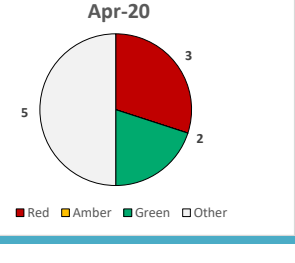
1. Note the contents of this report.
2. Note the Covid-19 capital approved as an emergency by the Director of Finance & Deputy Chief Executive.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Integrated Dashboard - April 2020

Appendix 2

The Total Number of KPIs has been increased from 63 to 68 for 2020/21.

	Mar-20	Apr-20	Key Points/Actions
Quality Improvement			There are 104 open incidents that require review and sign off, of which 31 have been open over 40 days. Compliance in relation to Duty of Candour remains 100% in month. Healthcare Acquired Infection objectives have not been published nationally. CDI reviews with the CCG are delayed due to COVID-19; there has been 5 CDI (under review), 1 MSSA and 2 E.coli cases reported. There has been 3 category 2 pressure ulcers reported with no category 3 or 4 pressure ulcers in month. There were 53 falls, of which 43 were inpatient falls. Medication reconciliation within 24 hours has increased to 79.00% and overall reconciliation is at 94.00%. NICE compliance was at 87.57%. There were 0 mixed sex accommodation breaches in month. Continuity of Carer compliance has increased to 55.00%.
Access & Performance			In April, 12 out of the 22 indicators were RAG rated Green, performance against these indicators has been significantly impacted by COVID-19. The Trust did not achieve the RTT or the 6 week diagnostic standards in month. The Trust did not meet the 4 hour A&E standard, however performance has improved. The Trust did not meet the Breast Symptomatic standard, however the Trust did achieve all other Cancer standards (based on March's validated position). Discharge summaries sent within 24 hours continues to be challenging and the Trust did not meet the 7 day standard, work continues to improve this position. The Trust has exceeded the 2.00% threshold for the number of cancelled operations on the day for non-clinical reasons and 25 of these operations could not be rebooked within 28 days. The number of super stranded patients has reduced to 55 as at the end of April.
Workforce			Trust sickness absence has increased 9.70% in month as expected due to COVID-19. Return to work compliance was 57.79%. Average recruitment timeframes over the 12 month rolling period are on target at 57 days. Turnover is at 10.94% and Retention is at 88.90% which remains positive. Vacancy rates were 8.99%. Bank and Agency reliance increased to 18.63%. Core Skills Training compliance continues to be positive at 85.59% with Role Specific Training at 90.87%. PDR compliance in month was 99.28%. Agency shift compliance against the pay cap is at 32.50%. Pay spend was £18.0m against a budget of £17.0m.
Finance			In April, the Trust recorded a breakeven position which included £3.2m COVID-19 expenditure and £2.5m retrospective top up. The cash balance at the end of the month was £15.4m. Capital spend was £0.5m which is £0.4m below the planned capital spend of £0.9m. Agency spend is £1.2m which is £0.3m above the planned spend of £0.9m, April 2019 agency spend was £1m. Better Practice Payment Code was 65.00% which is 30.00% below the target of 95.00%. This is a significant improvement on March's position due to the early receipt of block income, enabling the Trust to work towards paying all creditors within 7 days of receipt of goods and services.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

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

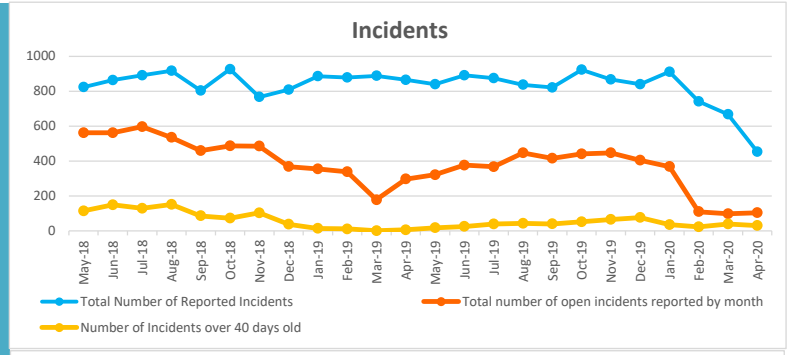
Patient Safety

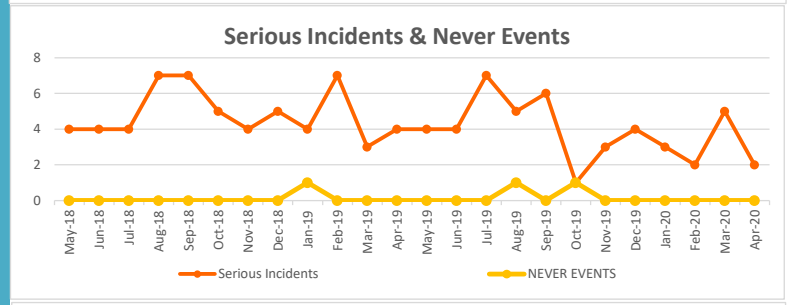
SOF CQC

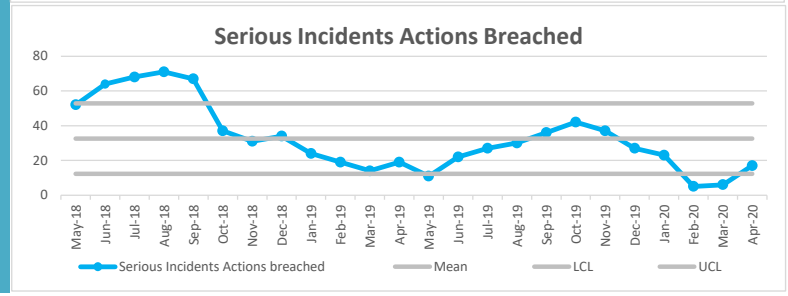
Incidents

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

There were 31 incidents over 40 days old, open in April 2020 across the CBUs. This is a reduction compared to the previous month and will be continuously reviewed to ensure incidents are closed in a timely manner during the COVID-19 response.







There were 2 Serious Incidents reported in month. Incidents and actions continue to be a focus to achieve timely review and completion. This is monitored at the Patient Safety and Clinical Effectiveness Sub-Committee and weekly Meeting of Harm.

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework (SOF) | Risk Register (RR116)
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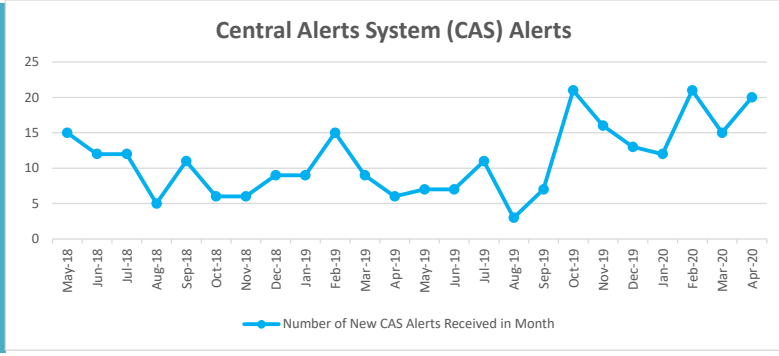
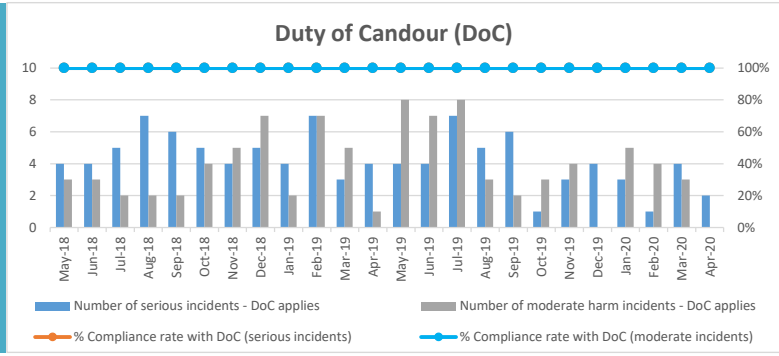
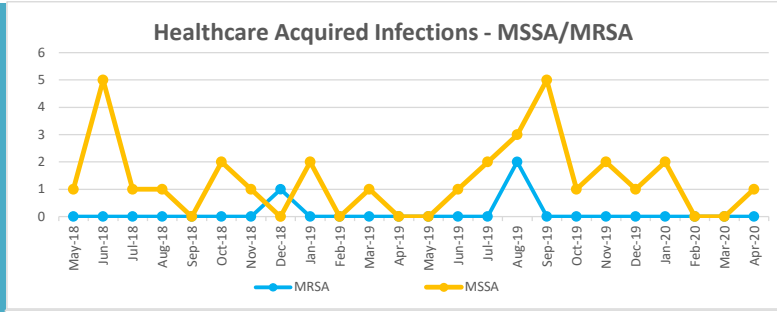
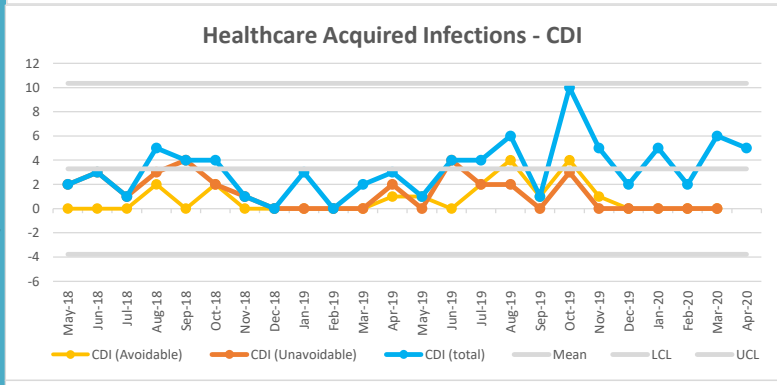
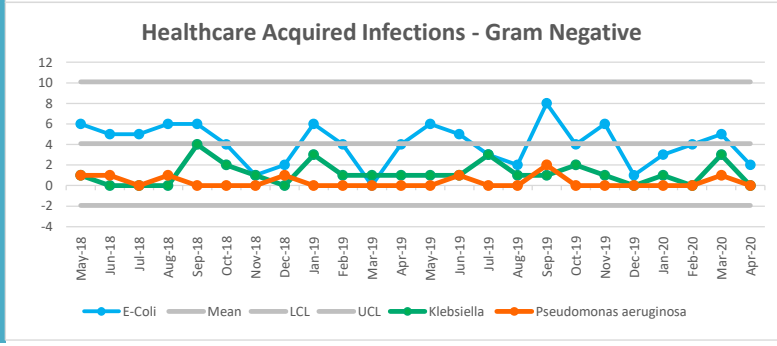
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
CAS Alerts - Green - All relevant CAS Alerts actioned within timescales Red - Applicable CAS Alert not actioned within the timescale.	CQC There were 20 new CAS Alerts received in month. There were no CAS alert actions which have breached the timescale in month.		The Trust received 20 CAS alerts in month with no breaches.	There is ongoing monitoring and oversight at the Health and Safety and Patient Safety and Effectiveness Sub-Committees in place to ensure the current position is sustained.
Duty of Candour Red: <100% Green: 100%	CQC The Trust achieved 100% for Duty of Candour in month.		Compliance with Duty of Candour remains in line with Trust policy and continues to be supported through monitoring via the Datix system with oversight by the clinical governance department. The Trust remains 100% compliant.	Duty of Candour is monitored at the weekly Governance Oversight meeting by the Deputy Director of Governance to ensure that performance is sustained. Daily monitoring is provided by the Patient Safety Manager.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Healthcare Acquired Infections MRSA Red: 1 or more Green: 0 Healthcare Acquired Infections C-Difficile Red: 44+ per annum Green: Less than 44 per annum Healthcare Acquired Infections - Gram Negative E-Coli Red: 47+ per annum Green: Less than 47 per annum Pseudomonas aeruginosa & Klebsillea - No Threshold Set	CQC SOF S HCAI objectives have not t been published nationally by NHSE/I for GNBSI or C. difficile, the RAG rating is based on 2019/20 thresholds. There were 5 cases of CDI (under review), 2 cases of E.coli and 1 case of MSSA reported in April 2020.	  	There may be an increase in pneumonia cases following viral infection with SARS-CoV-2 (Covid-19). There is a different inpatient profile due to the COVID-19 pandemic.	Action plans are in place for reduction of all HCAIs and will be applied throughout the recovery period from the COVID-19 pandemic. Plans will be reviewed and adapted in accordance with the results of Root Cause Analysis (RCA) report findings which highlight themes of patient and staff hand hygiene and hydration.

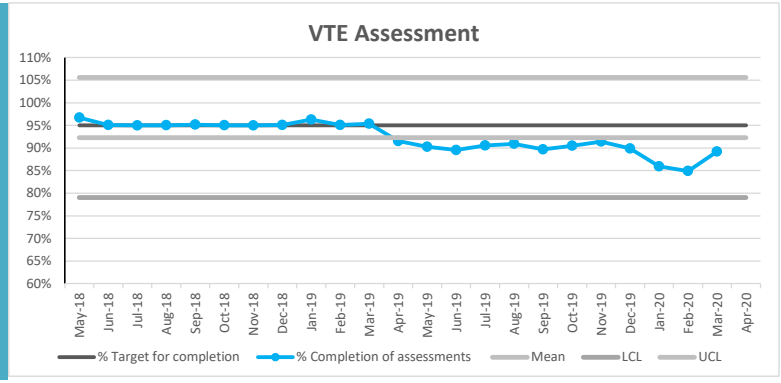
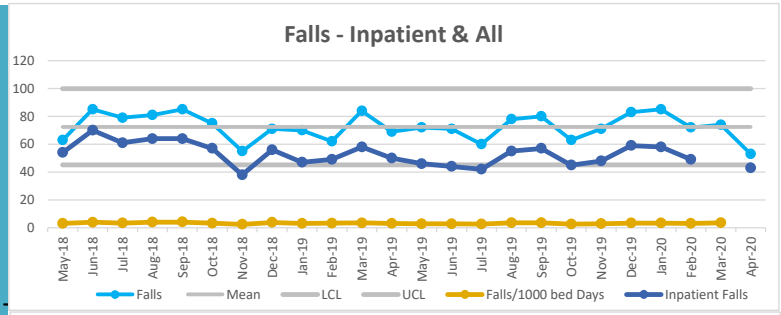
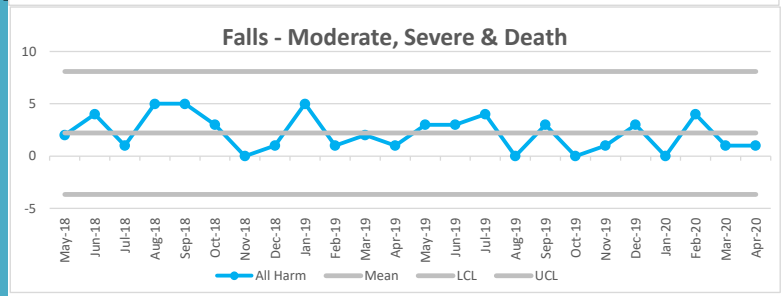
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:

Single Oversight Framework (SOF) | Risk Register (RR116)

Care Quality Commission (CQC) | Trust Strategy (S)

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
VTE Assessment **Red: <95%** **Green: 95% or above based on previous months' figures due to timescales for validation of data**	SOF S **The Trust achieved 89.00% for VTE assessments on average in Q4 2019/20.** **SPC - VTE Assessments are within common cause (expected) variation.** RR128		**The Trust achieved 89.00% for VTE assessments on average in Q4 2019/20. The VTE assessment data is reported quarterly, the next update will be in June's dashboard (reported in July).** **National Trajectory: The Trust is 6.00% below the 95.00% target for VTE. From October to March 2020, the Trust has aligned the VTE audit process with the GIRFT framework for further oversight on quality.**	**Focussed work with clinical teams to improve compliance with VTE electronic risk assessment processes are in operation. Daily progress updates are escalated to clinicians supported by the Associate Medical Director to ensure completion of risk assessments.**
Total number of Inpatient Falls & harm levels **Red: <10% decrease from 19/20** **Amber: 10-19% decrease from 19/20** **Green 20% or more decrease from 19/20**	CQC S **There were a total of 53 falls in the month; of which 43 were inpatient falls. SPC - Falls are within common cause (expected) variation.** RR120	 	**There were a total of 53 falls in the month; of which 43 were inpatient falls.** **Internal Variance Plan: Falls are within expected internal plan of 20% reduction.**	**The Trust continues to review Falls daily at the COVID-19 Safety Response Meeting (which has temporarily replaced the Safety Huddle). The weekly Meeting of Harm will be reinstated in May. The Trust action plan is now in place.**

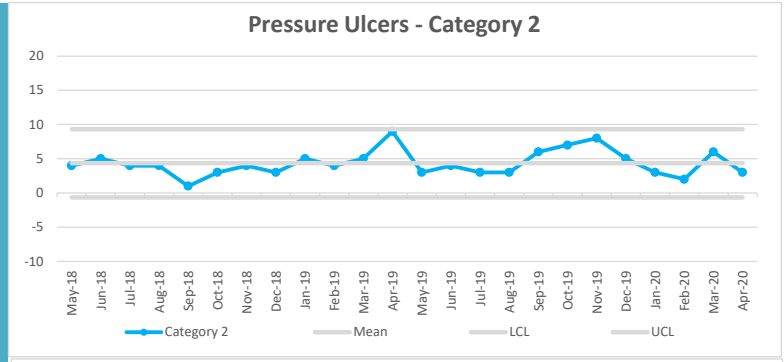
Warrington and Halton Teaching Hospitals NHS Foundation Trust

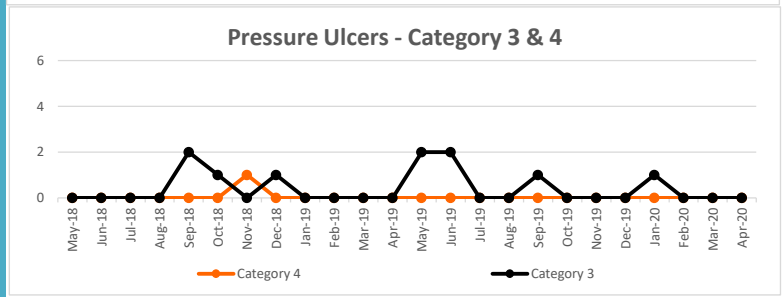
Key:

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

Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Pressure Ulcers Based on 65 in 2019/20 Red: 4% reduction or below Amber: 5%-9% reduction Green: 10% reduction or above.	CQC There were 0 hospital acquired Category 4 pressure ulcers, 0 Category 3 pressure ulcers and 3 Category 2 pressure ulcers reported in month. SPC - Pressure ulcers are within common cause (expected) variation.	Variation is noted in the accuracy of initial and subsequent risk assessments in relation to the change of the patients condition. Internal Variance Plan: The Trust has had a total of 3 category 2 pressure ulcers which is within target for reduction.	Themes noted from pressure ulcer review in April highlight links to proning positioning of patients during COVID-19. Lessons learned and support to prevent further harms immediately provided by the Tissue Viability Team within the areas where harm occurred. Root cause analysis (RCA) of each pressure ulcer is completed and reviewed with wider lessons learned shared across the organisation via Trust wide Safety Brief and newsletter during COVID-19.





Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Single Oversight Framework (SOF) | Risk Register (RR116)
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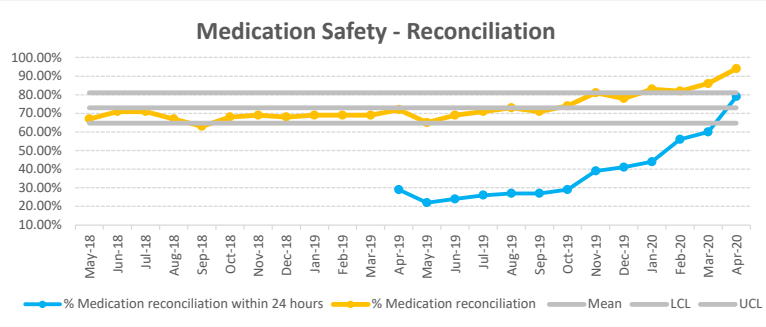
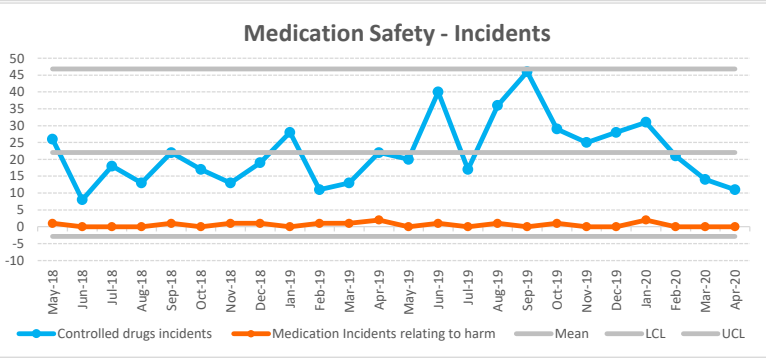
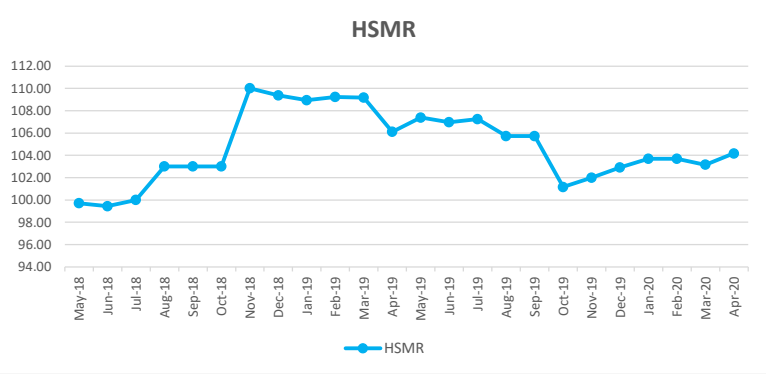
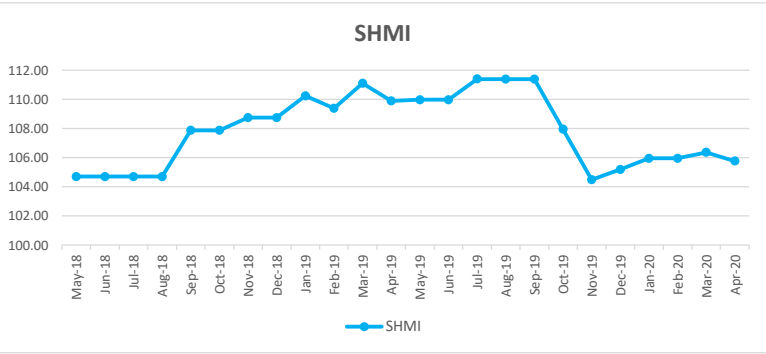
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Medication Safety Reconciliation within 24 hours Red: below 60% Amber: 60% - 79% Green: 80% or above	S RR415 Medication Reconciliation within 24hrs was 79.00% in April 2020. There were 0 incidents of harm relating to medication safety in month.	 	Performance against both medicines reconciliation targets has improved during the COVID-19 response. Factors influencing this: • The ability to direct additional staffing resource to ward-based clinical pharmacy has been facilitated. • The ability to allocate additional time to staff training directed at managing the COVID-19 response. • The use of modified daily rotas with time allocations that reflect workload at ward level and tight control of staffing resources. • Flexible use of the workforce.	Information obtained during the COVID-19 response will be used to review lessons learned and propose further changes as required. Notably, within the Womens and Childrens Health CBU, medicines reconciliation was lower. This reflects the fact that resources did not stretch to provide a bank holiday/weekend ward clinical pharmacy service to this CBUs wards. Staffing resources have continued to be allocated for controlled drugs and medication safety related activities during the COVID-19 response. A deep dive review is to be completed into medication incidents during COVID-19.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	RR115 **Staffing Average Fill Rates reporting has been suspended during the COVID-19 period.**			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Staffing - Care Hours Per Patient Day (CHPPD) Red: Below 6.0 Amber: 6.0 - 7.8 Green: 7.9 or More	RR115 **Care Hours Per Patient Day reporting has been suspended during the COVID-19 period. CHPPD is still recorded and displayed by ward locally and monitored three times per day via operational staffing meetings.**			
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	CQC **The HSMR ratio in month was 104.17 (compared to 99.97 peer).**		**The most recent HSMR/SHMI are within the expected range. Work continues at Mortality Review Group using the Structured Judgement Review tool.** **National Trajectory: The Trust is within the expected range for HSMR and is currently at 104.17.**	**Mortality reviews will continue to be undertaken alongside the governance incident process to ensure triangulation and learning. The process will continue to be overseen by the Head of Clinical Effectiveness with escalation to the Deputy Director of Governance.**
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	SOF CQC **The SHMI ratio in month was 105.77 (compared to 108 peer).**		**The most recent HSMR/SHMI are within the expected range. Work continues at Mortality Review Group using the Structured Judgement Review tool.** **National Trajectory: The Trust is within the expected range for SHMI and is currently at 105.77.**	**Mortality reviews will continue to be undertaken alongside the governance incident process to ensure triangulation and learning. The process will continue to be overseen by the Head of Clinical Effectiveness with escalation to the Deputy Director of Governance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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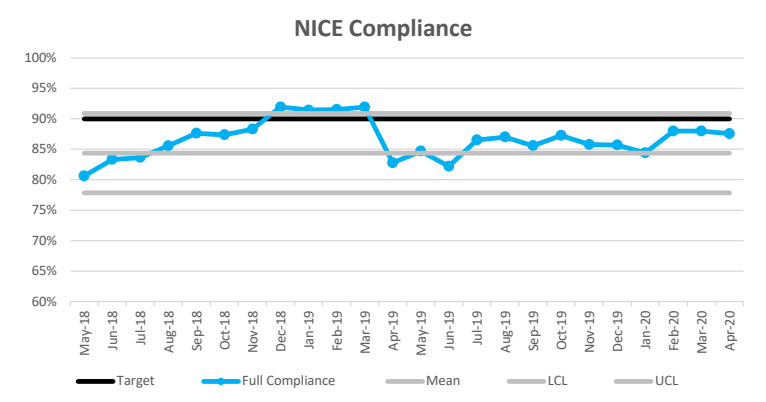
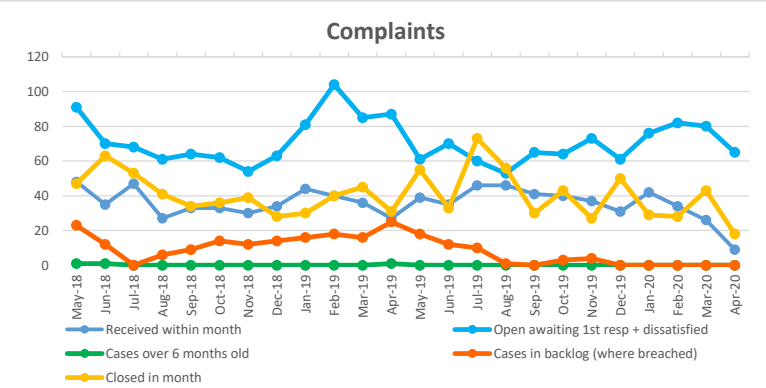
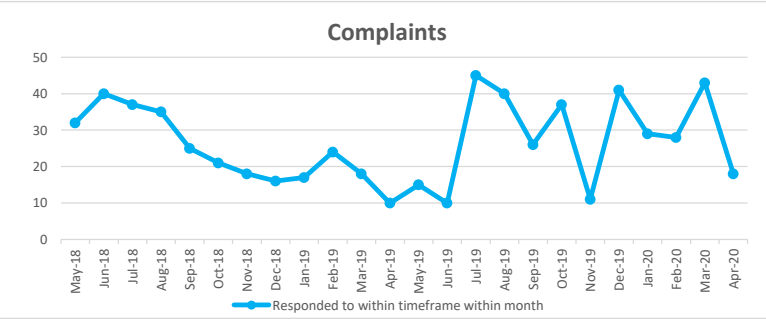
Quality Improvement - Trust Position

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

Patient Experience

Complaints Red: Complaints over 6 months old/69% or less responded to within the timeframe Amber: No complaints over 6 months old, 70% - 89% responded to within the timeframe Green: No backlog, 90% responded to within the timeframe.	S As per the directive from NHSE/I the complaints process has been placed on 'pause' due to the COVID-19 pandemic.	 	As per the NHSE/I directive, the complaints process has been placed on 'pause' due to COVID-19. As of 30 March 2020 complaints that are risk graded low/moderate, will not be responded to unless advised by the complainant. All high risk complaints are to be actioned. During April, 18 complaints were closed, 16 of which were graded low/moderate and did not relate to COVID-19. The remaining 2 complaints were closed and responded to.	During the COVID-19 pandemic, complaints will handled on a case by case basis. All high graded complaints will responded to. This will be monitored on a daily basis by the Deputy Director of Governance and reported at weekly meeting of harm by the Head of Complaints.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Quality Improvement - Trust Position

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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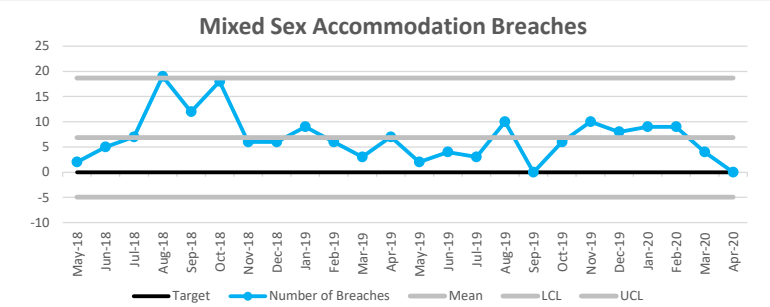
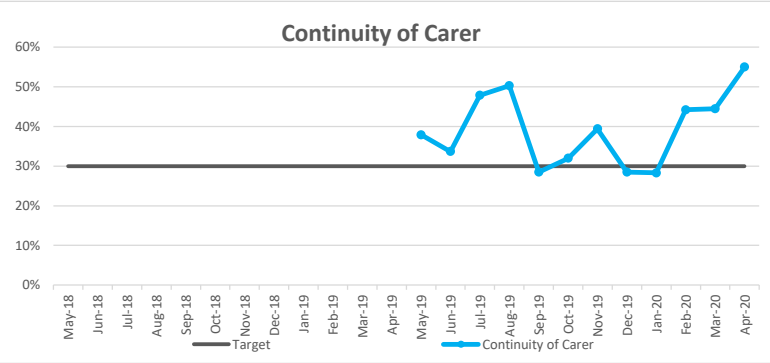
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	SOF There were 0 mixed sex accommodation breaches reported in month. SPC - Mixed Sex Accommodation Breaches are within common cause (expected) variation.		There were 0 MSA breaches in April. National Trajectory: The Trust has met the national target of 0.	Patients are cohorted to minimise breaches and step down is expedited as soon as is practicable. During COVID-19, additional bed capacity has facilitated the timely transfer of patients in line with the clinical pathway.
Continuity of Carer Green: 35% or Above Amber: 25% - 34% Red: below 25%	The target percentage for women being booked onto a continuity of carer pathway by March 2021 is over 51.00% (National). The Trust achieved 55.00% in April 2020.		The percentage of women booked onto a continuity of carer pathway in April was 55.00%. This is above current national target (51.00%) set for March 2021. Internal Variance Plan: The Trust is surpassing the current national target of 51.00% (by March 2021) and is already achieving over 55.00%.	All community midwives have received updated training to ensure they document on Lorenzo that women are on a continuity of carer pathway. A resolution plan to upgrade Lorenzo to facilitate the continuity of carer pathway is in place.

CQC

CQC Insight Composite Score

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

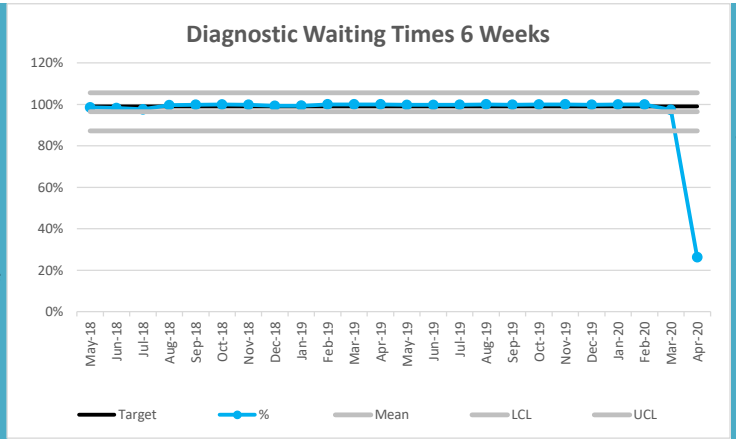
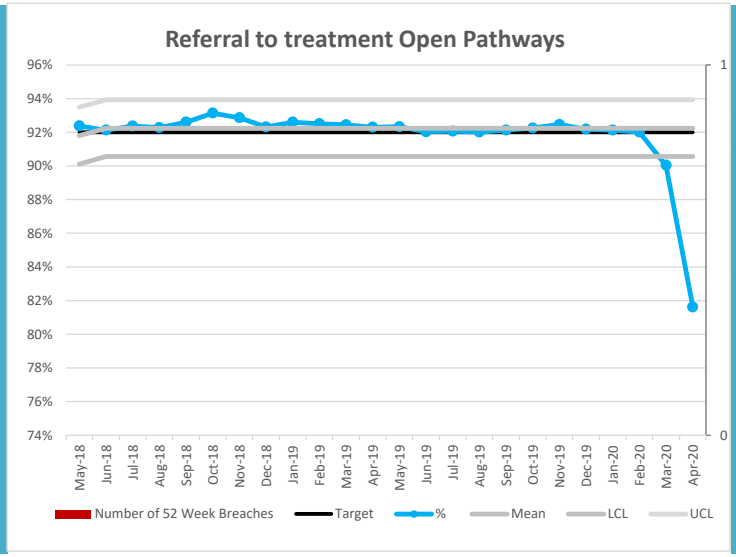
CQC RR115

CQC Insight reporting has been suspended.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

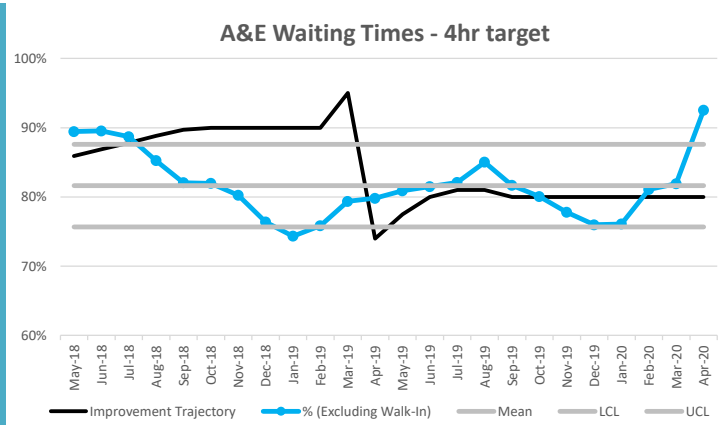
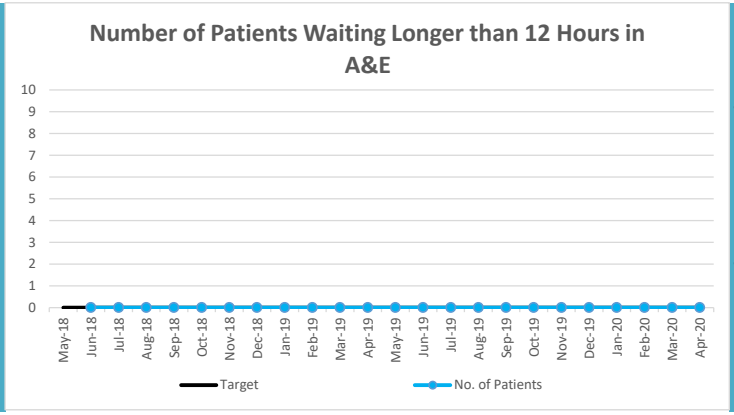
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	SOF CQC The Trust achieved 26.27% in month. SPC - There is evidence of special cause variation for Diagnostic Waiting Times, this relates to the impact of COVID-19 RR116		The Diagnostic target was not achieved in April 2020. This was due to the impact of the COVID-19 pandemic. The number of breaches significantly increased as services were suspended due to adherence to national guidance.	Recovery plans have commenced for diagnostic services including endoscopy and radiology. This is in line with national guidance which will continue to be reviewed. As part of the recovery, the Independent Sector is supporting additional capacity in this area.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or above RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red	SOF CQC The Trust achieved 81.62% in month. SPC - There is evidence of special cause variation in RTT pathways, this relates to the impact of COVID-19. RR116		The Trust missed the 18 week Referral to Treatment standard in April 2020 for the second successive month. This was associated with the cancellation of the elective programme due to COVID-19 and the preparation of the theatres as additional capacity to support ICU. The Trust was required to cease all routine work by the 15th April, following national guidance received to prepare capacity to manage anticipated demand from COVID-19.	All urgent cancer and elective activity is being progressed and monitored daily, with all patients being clinically reviewed in conjunction with guidance released for the management of vulnerable patients. The patients remain on our waiting list and their RTT pathways are still in place and being monitored.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

Key:
Risk Register
Single Oversight Framework
Care Quality Commission

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Four Hour Standard - National Target Red: Less than 95% Green: 95% or Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory	SOF CQC The Trust achieved 92.54% excluding walk ins in month. SPC - There is special cause variation present in the Four Hour A&E standard. RR224		The start of the new financial year saw improved performance compared with 2019/20 achieving 93.49% which is approximately 11% improvement on the same period in April 2019. The improvement in performance was supported by reduction in attendances as a consequence of the COVID-19 pandemic, however, this has still been reliant upon being able to manage segregated flows throughout the department which have been achieved.	A Respiratory Ambulatory Care Unit has been implemented from 1st April and supported by Warrington & Halton CCGs. This utilises the same footprint of the previous ED Ambulatory Care Unit and is based upon the SDEC methodology. Royal College of Emergency Medicine, Resetting Emergency Department Care guidance, was received on 06/05/20 and outlines 5 recommendations. An action plan has been developed and will be monitored via the COVID-19 Recovery Group.
The number of patients who has experienced a wait in A&E longer than 12 hours from the decision to admit. Green = 0 Red = > 0	SOF There were 0 patients waiting longer than 12 hours in A&E in month.		The Trust has achieved the standard of not having any patients waiting longer than 12 hours from the decision to admit in April 2020. This standard has been consistently achieved over time.	Maintain compliance against the 12 hour standard from the decision to admit.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Risk Register RR116
Single Oversight Framework SOF
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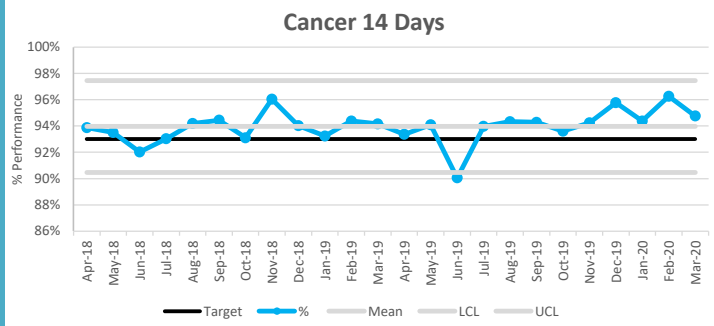
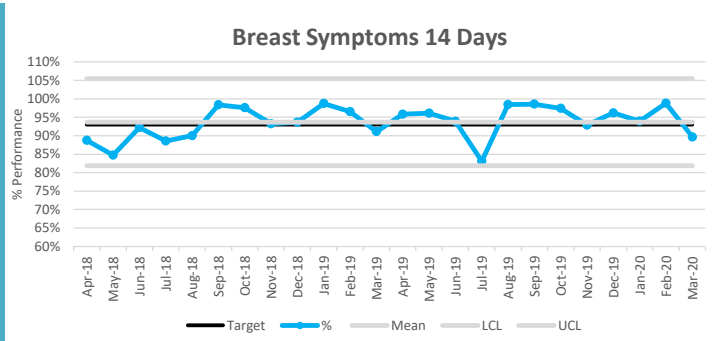
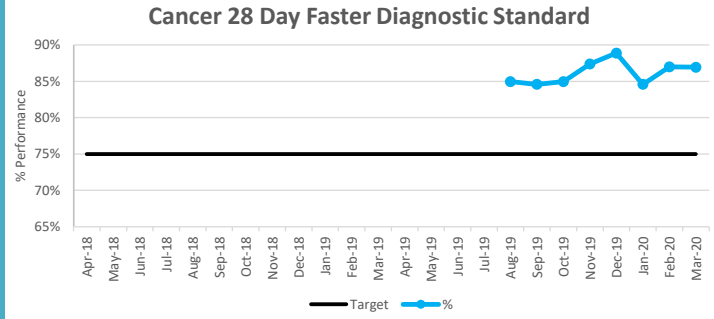
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 14 Days Red: Less than 93% Green: 93% or above	SOF CQC The Trust achieved 94.76% in March 2020. SPC - Cancer 14 days is within common cause (expected) variation. RR116		The Trust achieved the 2 week wait standard in March 2020.	Maintain compliance against the 2 week wait standard.
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	SOF CQC The Trust achieved 89.66% in March 2020. SPC - Breast Symptoms is within common cause (expected) variation. RR116		The Trust did not achieve the breast symptomatic standard in March 2020. This was due to a small patient cohort and a high proportion of patient cancellations in this time period.	This standard can fluctuate on a monthly basis due to the relatively small patient numbers. However, we continue to offer patient appointments within 7 days to maximise compliance against the breast symptomatic standard.
28 Day Faster Cancer Diagnosis Standard Red: Less than 75% Green: 75% or above	The Trust achieved 86.93% in March 2020.		The Trust achieved 86.93% in March 2020 against a target of 75.00%.	Continue to maintain improvement against the FDS clinical review of standards pilot.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

Key:
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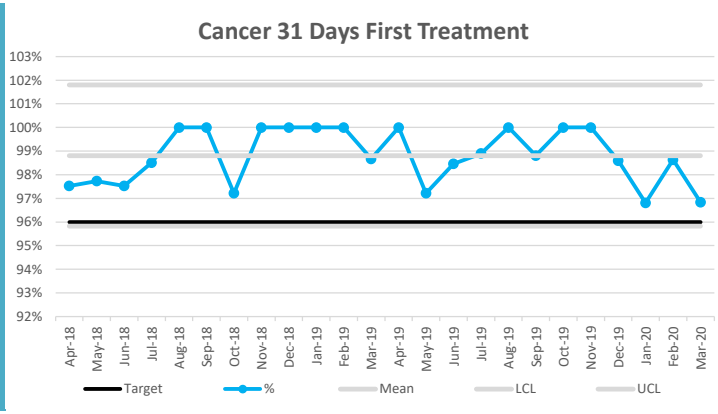
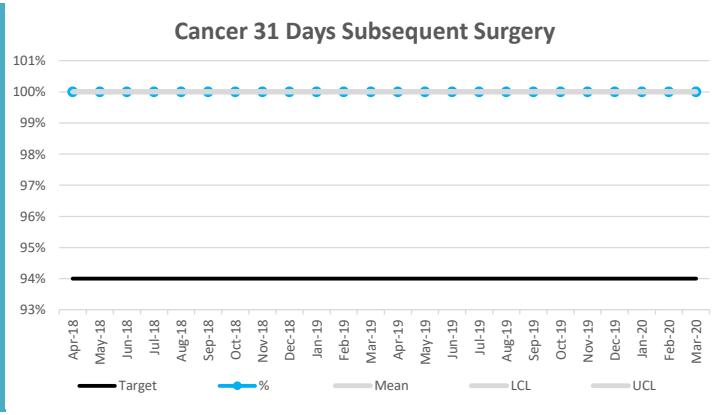
Care Quality Commission CQC

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	SOF CQC The Trust achieved 96.84% in March 2020. SPC - Cancer 31 days is within common cause (expected) variation. RR116		The Trust achieved 96.84% in March 2020.	Maintain compliance against the 31 day first treatment standard.
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	SOF CQC The Trust achieved 100% in March 2020. SPC - Cancer 31 days surgery is within common cause (expected) variation. RR116		The Trust achieved 100% in March 2020.	Maintain compliance against the 31 day subsequent treatment (surgery) standard.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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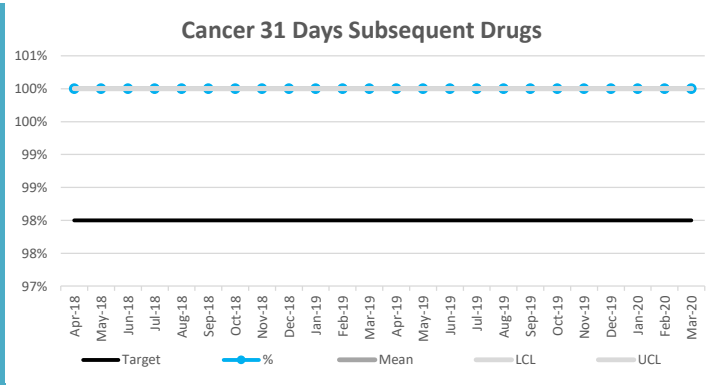
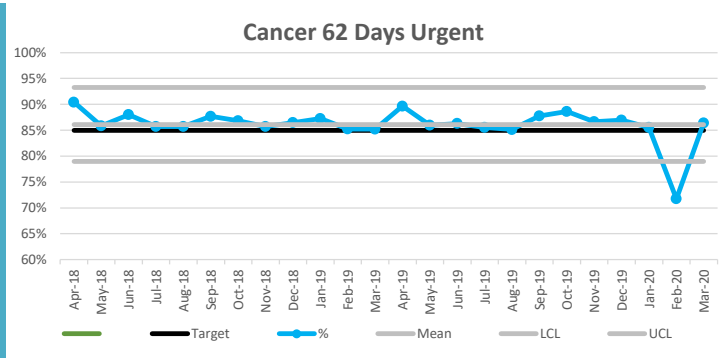
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	SOF CQC The Trust achieved 100% in March 2020. SPC - Cancer 31 days drug is within common cause (expected) variation. RR116		The Trust achieved 100% in March 2020.	Maintain compliance against the 31 day subsequent treatment (drug) standard.
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	SOF CQC The Trust achieved 86.41% in March 2020. SPC - Cancer 62 days urgent is within common cause (expected) variation. RR116		The Trust achieved 86.41% in March 2020.	Maintain active monitoring of all pathways to maintain compliance against the 62 day standard.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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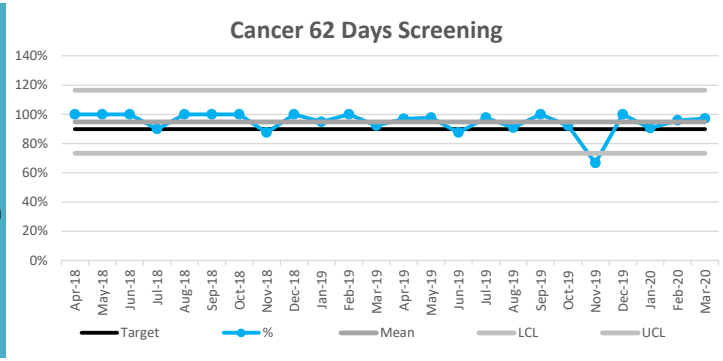
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	SOF CQC The Trust achieved 97.06% in March 2020. SPC - Cancer 62 days Screening is within common cause (expected) variation. RR116		The Trust achieved 97.06% in March 2020.	Maintain active monitoring of all pathways to maintain compliance against the 62 day screening standard.
Ambulance Handovers 30 to <60 minutes Red: More than 0 Green: 0	Data for Ambulance Handovers is not available this month.			
Ambulance Handovers at 60 minutes or more Red: More than 0 Green: 0				

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

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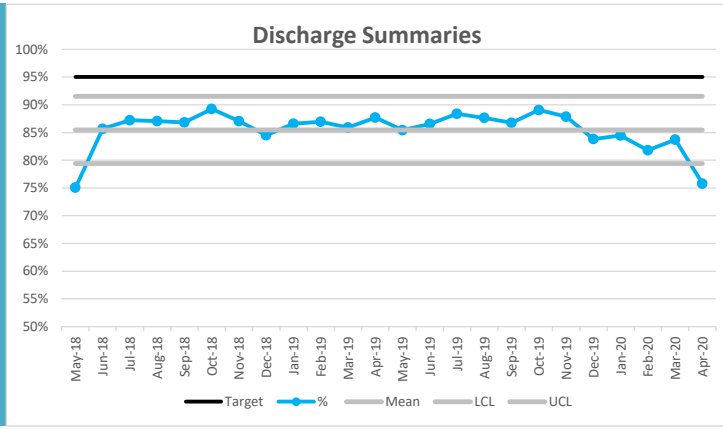
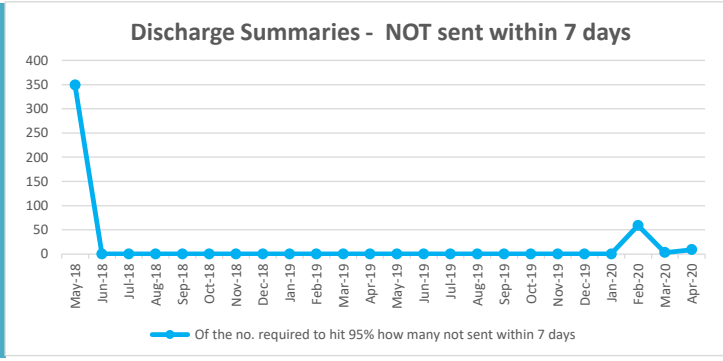
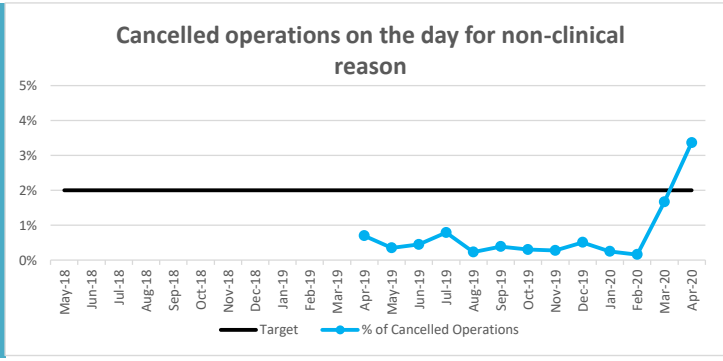
Discharge Summaries - % sent within 24hrs **Red: Less than 95%** **Green: 95% or above**	RR123 **The Trust achieved 75.80% in month.** **SPC - There is evidence of special cause variation in Discharge Summaries sent within 24 hours.**		**The Trust continues to monitor compliance across all CBUs. This is monitored via the weekly PRG and monthly KPI meetings.** **A Standard Operating Procedure has been in place to support compliance against this standard. In addition, all logic to support the reporting of this standard has been reviewed to ensure up-to-date and accurate reporting.**	**This standard remains challenging for the Trust with performance deteriorating in recent months.** **The Performance Review Group has been asked to undertake a deep dive in to sub-specialties to support improvement in future months.**
Discharge Summaries - Number NOT sent within 7 days **Red: Above 0** **Green: 0**	RR123 **There were 9 discharge summaries not sent within 7 days required to meet the 95.00% threshold.**		**The Trust did not achieve compliance against the 7 day discharge summary standard in April 2020.**	**A review is being undertaken to understand the key specialties where there has been a deterioration in performance. An associated action plan will be developed to return compliance against this standard.**
Cancelled Operations on the day for a non-clinical reason **Red: > 2%** **Green: < 2%**	CQC **3.37% operations were cancelled on the day for non clinical reasons in month.**		**In April 2020, there was an increase in the number of cancelled operations on the day to 17.** **The majority of the cancellations were as a result of more urgent cases taking priority with a reduced theatre capacity due to early phases of COVID-19.**	**Recovery of all activity as a consequence to the COVID-19 pandemic is being monitored via daily elective meetings, supported by Recovery Board and the Strategic Executive Oversight Group.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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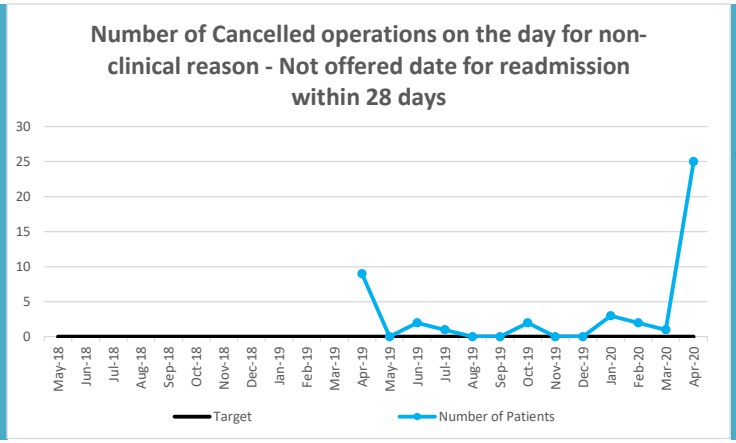
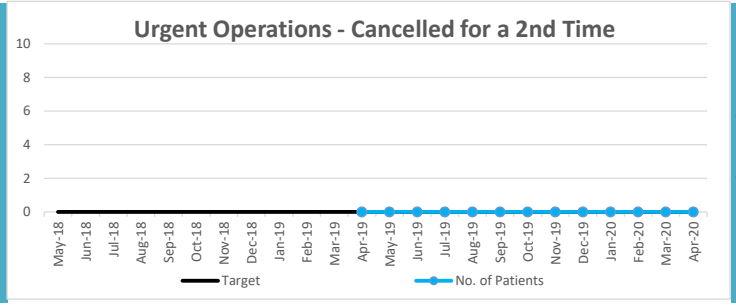
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	There were 25 cancelled operations on the day for non clinical reasons in month, where the patient was not booked in within 28 days.		There were 25 breaches of the 28 day rule in April 2020 as there was no capacity available as a consequence to the COVID-19 pandemic in which to relist the patients within this timeframe.	Recovery of all activity as a consequence to the COVID-19 pandemic is being monitored via daily elective meetings, supported by Recovery Board and the Strategic Executive Oversight Group.
Urgent Operations - Cancelled for a 2nd Time Green = 0 Red = > 0	There were 0 urgent operations cancelled for a second time in month.		This is an additional standard to enhance monitoring of cancelled operations. The Trust continues to maintain this standard.	Maintain the standard that no urgent operation are cancelled for a second time.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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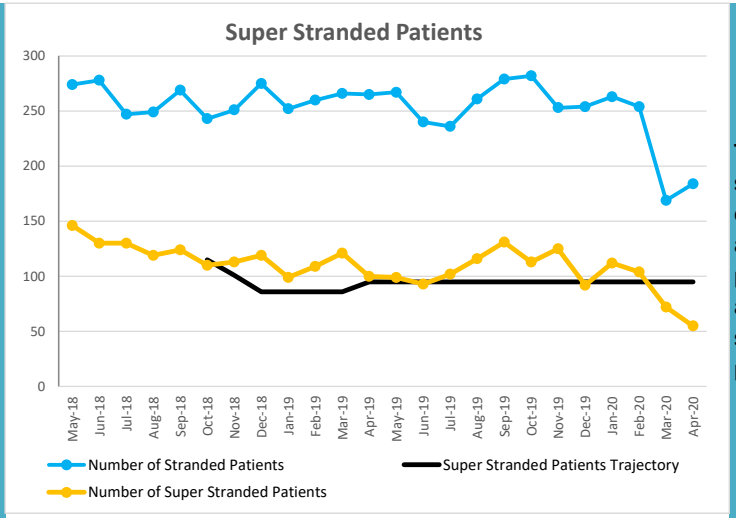
Access & Performance - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Super Stranded Patients Green: Meeting Trajectory Red: Missing Trajectory	There were 184 stranded and 55 super stranded patients at the end of the April 2020.	The numbers of patients categorised as super stranded improved in April 2020 overall, and compliance against the NHSI trajectory was achieved again in April 2020. The initiatives planned for the "Home for Easter" campaign and COVID-19, supported a further and sustained reduction in Super Stranded patients.	Corporate Patient Flow meetings are embedded and now take place daily with leadership from the Associate Director for Integrated Care. These are supported by daily follow up huddles between the Lead Social Worker and ward Matrons to escalate and address barriers to onward transfers from hospital. Chaired by the Integrated Hospital Discharge Team Manager, a daily check and challenge session on progress with the top 30 Super Stranded and DTOC patients has been implemented, to ensure senior oversight of complex patients and minimise delays in onward transfers.



Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance

Trend

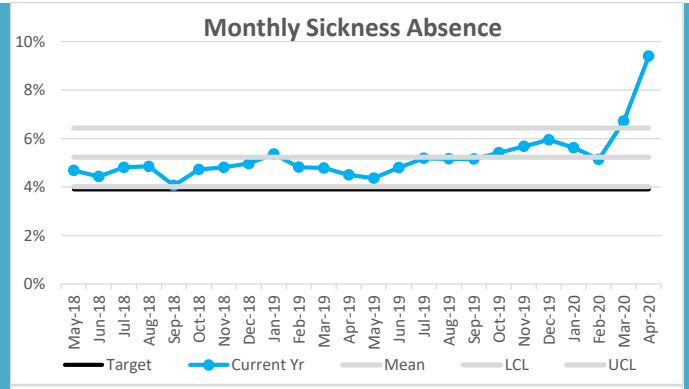
What are the reasons for the variation and what is the impact?

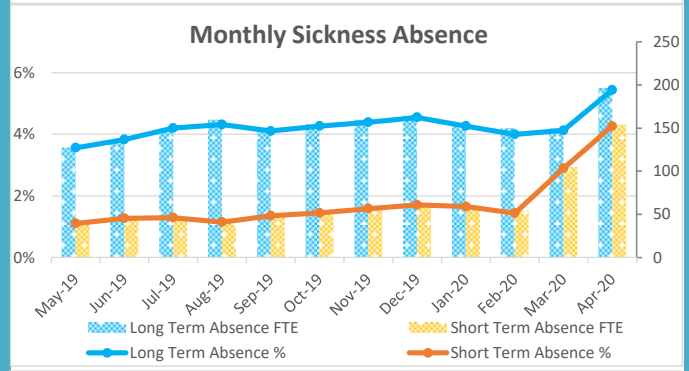
How are we going to improve the position (Short & Long Term)?

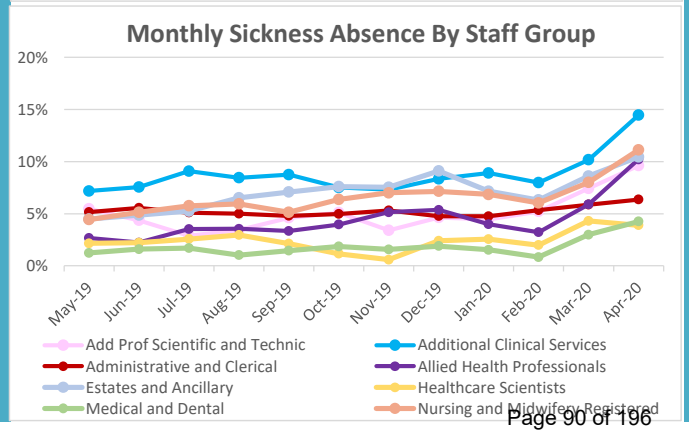
Sickness Absence

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

The Trust's sickness absence was 9.70% in month.
SPC - There is evidence of special cause variation for sickness absence.







Sickness absence has increased to 9.70% in April 2020. The increase in sickness absence is due to COVID-19 related absence across the workforce. Sickness absence relating to non-COVID-19 illness has remained stable.

As expected, there has been a significant increase in short term sickness absence however; there has also been an increase of 1.30% in long term absence. Trends relating to long term absence are currently being reviewed to understand this change.

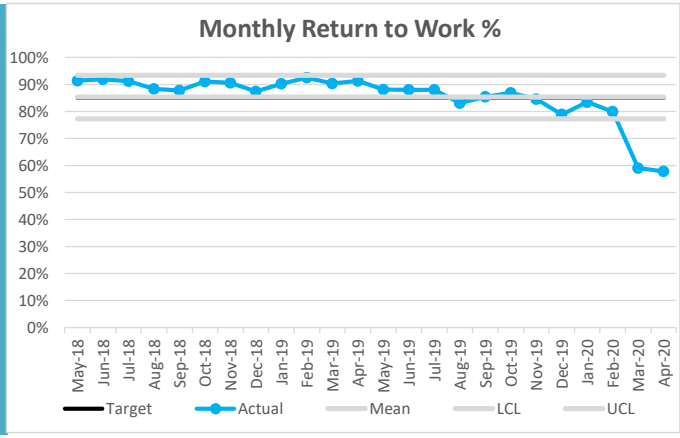
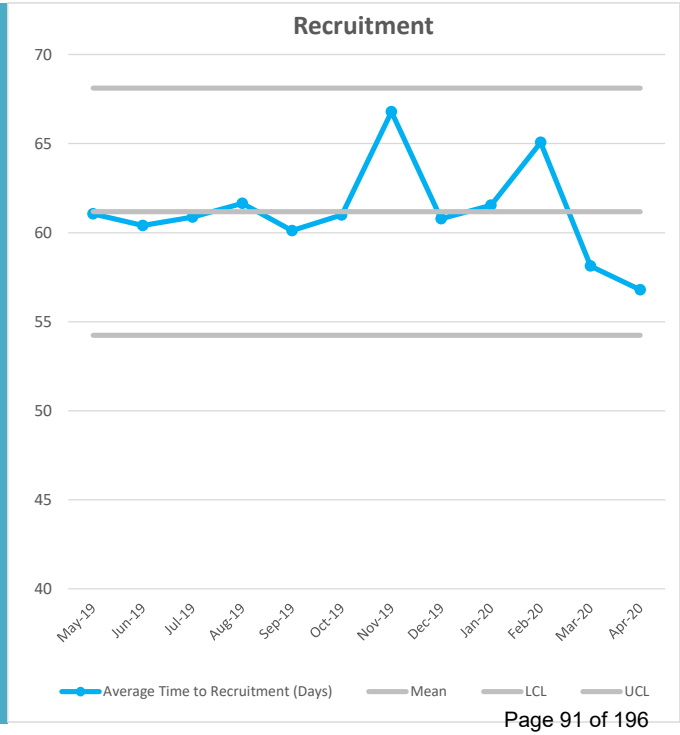
- **A COVID-19 nursing advice line has been created, to provide a range of advice and guidance to the workforce.**
- **An Occupational Health call centre has been created, which enables all calls to be answered and triaged by a team of administrators.**
- **The Occupational Health Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff).**
- **An enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical has been implemented.**
- **An enhanced wellbeing offer has been developed, linked to learning from Wuhan, Italy and the British Psychological Society.**
- **A specialist extranet page has been developed which includes all national wellbeing offers, and links to discounts for NHS staff during this period of time.**
- **Mental health wellbeing drop in sessions have been introduced across both Warrington and Halton sites, with a specific wellbeing email address created for any enquiries to the wellbeing hub.**
- **Facilitated conversations are available to staff.**
- **Face to face counselling is available on-site.**
- **Telephone counselling is available.**
- **Availability of alternative therapies such as relaxation therapy.**
- **A Workforce Welfare Hub has been established by the Director of Strategy to support the practical needs of our workforce.**
- **Additional support has been put in place for Black, Asian and Minority Ethnic staff including a specific risk assessment.**
- **Guidance on risk assessments for various groups of staff has been issued to managers with clear expectation on completion.**
- **Staff events have been stood down to support social distancing in work.**

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
Single Oversight Framework (SOF) | Care Quality Commission (CQC)
Use of Resources Assessment (UoR) | Trust Strategy (S)
Risk Register (RR3DG)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	**The Trust's return to work compliance was 57.79% in month.** **SPC - There is evidence of special cause variation for Return to Work compliance.**		**Return to work interview compliance has reduced significantly due to pressures relating to COVID-19.**	**Return to work interviews remain a vital part of the support in place for our workforce and a review of this process will form part of workforce recovery planning.**
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or below	**The average number of working days to recruit is 57, based on the last 12 months average.** **SPC - Recruitment time is within common cause (expected) variation.**		**Recruitment time to hire has reduced to 57 days in April 2020.** **Following national guidance, amendments have been made to the pre-employment check process to support speedier recruitment:** **• Verification of original documents - we are now able to accept scanned and emailed copies of original documentary evidence for urgent appointments.** **• Fast Track DBS Checks – urgent appointments related to COVID-19 can obtain a fast-track check against the children's and/or adults barred lists, which will be turned around within 24 hours of DBS receiving it.** **• References and Employment History – seeking at least one reference from the individual's current or previous employer (previously had to cover last 3 years). Where it has not been practically possible for a reference to be obtained, recruitment decisions are based on what information can reasonably be obtained about the individual such as latest payslips verifying their last/current employment and position.** **• Work Health Assessments – fast track Occupational Health clearance has been sought, with a 24 hour turnaround.** **• Inductions are now weekly providing much more flexibility with start dates.** **• The conditional offer letter is now sent via email and requests the candidate to supply all the information required via email (enabled because of the changes to the verification of original documents). Support is still given to those candidates unable to complete their checks via email.** **• Contractual change letters are now emailed using the information supplied on the contractual change form (ECF).**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

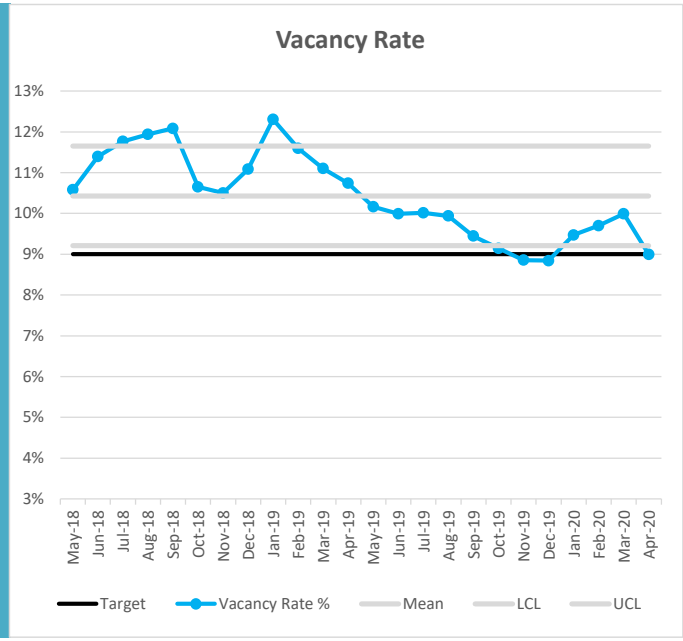
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Vacancy Rates

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

UoR

Trust vacancy rate was 8.99% in month.
SPC - there is evidence of special cause variation for Vacancy Rates.



Vacancy rates reduced in month to just below the 9% target, due to recruitment initiatives and a further reduction in turnover.

Recruitment has continued as per business as usual processes. An additional local campaign was instigated in April for Nursing, HCA, Domestic and Portering Staff.

Additional groups of staff have been brought into the organisation, including:
- **Medical Students**
- **Nursing Students**
- **AHP Students**
- **Medical 'Returners'**
- **Nursing 'Returners'**
- **AHP 'Returners'**

A temporary Workforce Redeployment Hub has been established to support staffing levels by identifying staff who are available for redeployment and match them with demand. In addition, partnership working is in place with Cheshire Fire and Rescue to utilise their staff members available for redeployment.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

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

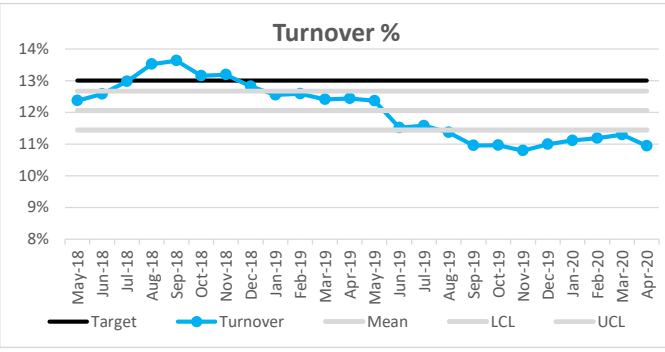
Turnover

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

CQC UoR

Trust turnover was 10.94% in month.
SPC - There is evidence of special cause variation for Turnover.

S SOF



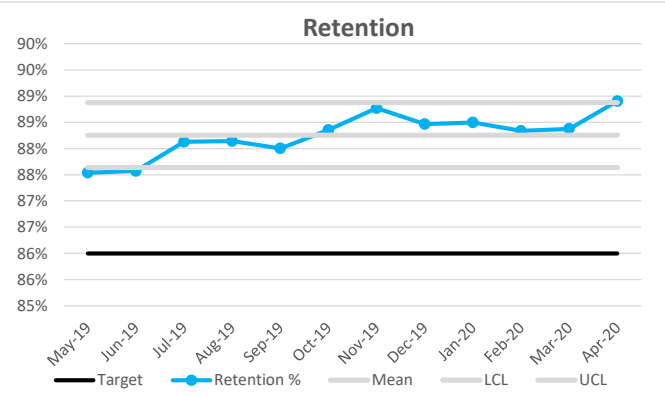
Turnover has remained below target (positive) and has further reduced to 10.94%. There is less movement of staff during the pandemic, however the sustained improvement in turnover is linked to improved employee engagement (as evidenced by the 2019 Staff Survey results) and to the work undertaken as part of the NHSI Retention Programme.

Retention

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

UoR

Trust Retention was 88.90% in month.
SPC - There is evidence of special cause variation for Retention.



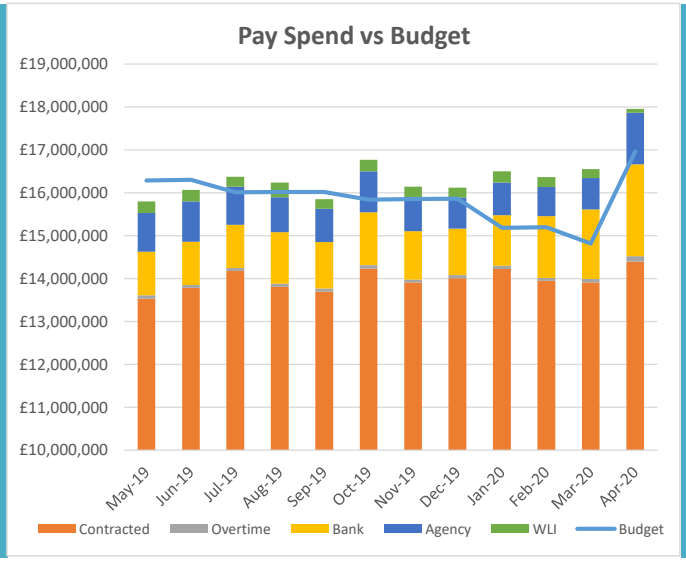
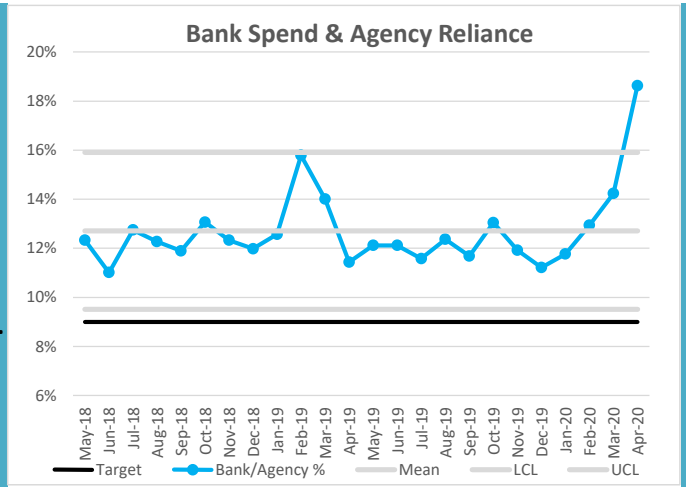
Retention has remained above target (positive) and has further increased to 88.90%. There is less movement of staff during the pandemic, however the sustained improvement in turnover is linked to improved employee engagement (as evidenced by the 2019 Staff Survey results) and to the work undertaken as part of the NHSI Retention Programme.

Workforce recovery planning is underway and includes consideration relating to:
- **Proposals to make permanent the temporary changes to the Retirement Policy relating to the break in service and permanent contract upon return.**
- **Supporting and retaining the temporary workforce who have joined the Trust during the pandemic.**
- **Keeping in touch with the student workforce who have joined the Trust during the pandemic.**
- **A range of health and wellbeing interventions, based on evidence following pandemics and serious incidents.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

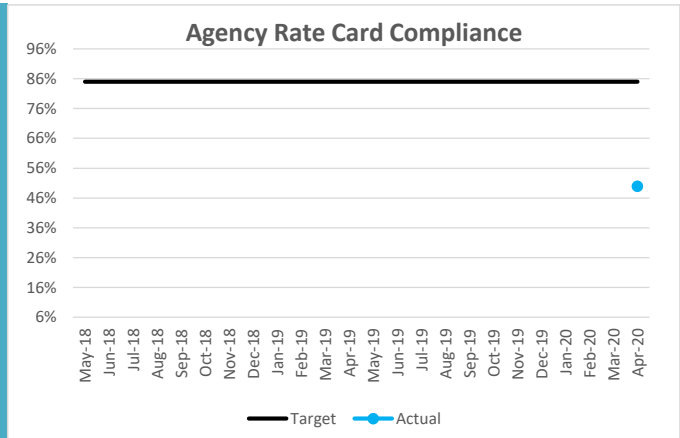
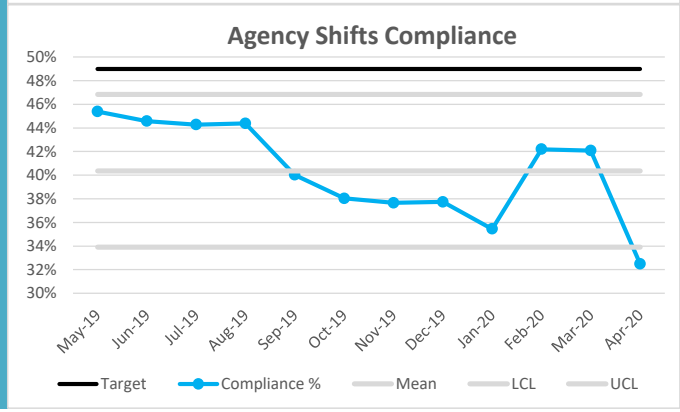
Key:
Single Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Pay Red: Greater than Budget Green: Less than Budget			
UoR SOF RR199 **Trust pay was £1.0m above budget in month.**		**Total pay spend in April 2020 was £17.96m against a budget of £16.96m.** **The total pay spend is broken down into the following elements:** **• £14.4m Contracted Pay (i.e. substantive staff)** **• £2.14m Bank Pay** **• £1.2m Agency Pay** **• £0.087m Waiting List Initiative (WLI) Pay** **• £0.126m Overtime Pay**	**Additional controls and challenge around pay spend have been identified, to support a reduction in premium pay:** **• Enhanced ECF process for non-clinical vacancies;** **• Expanded ECF process for some temporary staffing pay spend;** **• Implementation of Cheshire and Mersey Rate Cards;** **• Introduction of Patchwork Medical Bank system;**
Bank and Agency Reliance Red: 11% or Above Amber: 11% to 9% Green: 9% or Below			
UoR RR199 **Bank and Agency Reliance reduced to 18.63% in month.** **SPC - Bank/Agency reliance is within common cause (expected) variation.**		**Both bank and agency spend have increased in April due to COVID-19. Agency spend has been driven by an increase in usage within the Nursing and Midwifery staff group - £0.7m in month Bank spend has been driven by an increase in usage within Medical staff group - £1.2m in month.**	**The Bank and Agency Team continue business as usual. Processes are in place to ensure appropriate sign off of the need for temporary staffing, the on-going negotiation of rates, recruitment onto the bank, removing the requirement for an agency worker.** **In order to reduce agency spend through increased bank fill rate, the Patchwork system was implemented in February 2020.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Agency Rate Card Compliance Red: below 50% Amber: 50-59% Green: 60% or above		Compliance with the Cheshire & Mersey Agency Rate Card has been impacted by the COVID-10 pandemic. There has been a requirement to use additional agencies which charge higher rates to ensure sufficient staffing levels.	The central bank and agency team continue to negotiate rates down towards the Cheshire and Mersey Rate Card and the NHSI Price Cap compliance. Increasing medical bank usage will support improving the compliance.
Agency Shifts Compliant with the Cap Red: below 49% Green: above 49%		The majority of shifts that are not compliant with the NHSI Price Cap relate to Medical staff agency bookings, although there have also been some Nursing staff bookings which have breached the cap due to a need to utilise off-framework agencies.	

UoR

Agency Rate Card Compliance was 49.84% in month.

UoR

32.50% of shifts were compliant with the NHSI Price Cap.
SPC - There is evidence of special cause variation within Agency Shift Compliance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

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

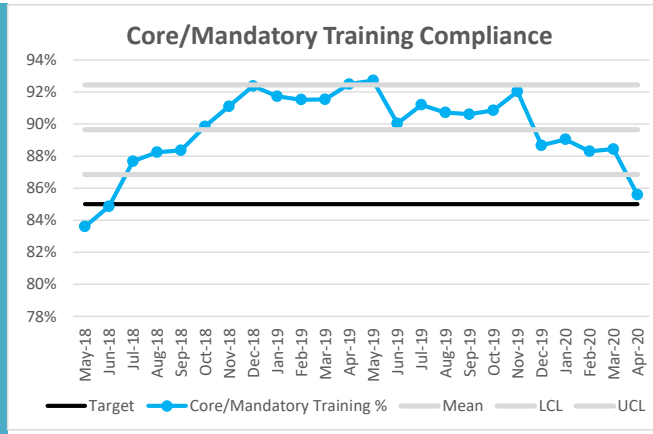
Core/Mandatory Training

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

CQC

Core/Mandatory training compliance was 85.59% in month.
SPC - there has previously been evidence of special cause variation which has now stabilised.

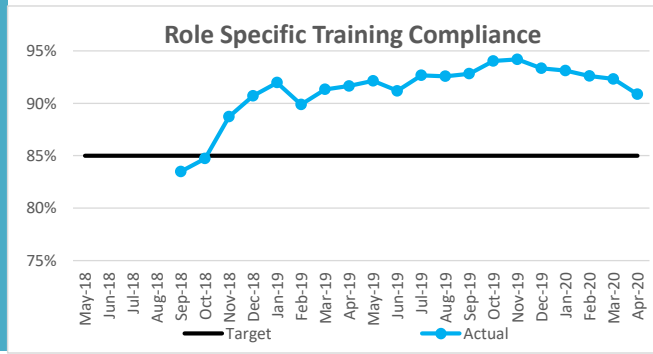
RR153



Role Specific Training

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

Role Specific Training compliance was 90.87% in month.



Role Specific and Mandatory Training has been paused for existing staff who have not changed role as per NHS Employers guidance, where staff are working in a frontline patient facing role and do not have capacity/opportunity to complete the training. For those who are able to continue to complete the training, this should continue via ESR.

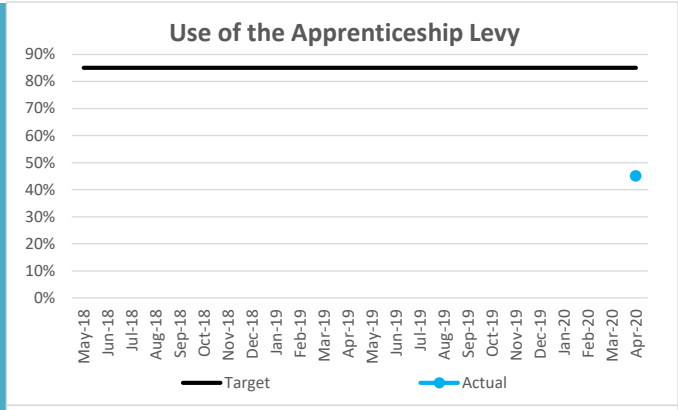
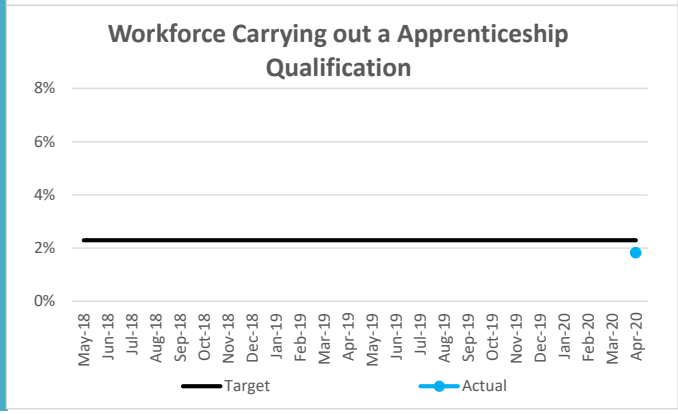
Local management decisions are made on training requirements for staff who have changed role. National guidance for specific areas such as critical care will continue to be monitored and implemented locally.

The current position regarding training is being reviewed in May 2020.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Use of Apprenticeship Levy Red: below 50% Amber: 50-84% Green: 85% or above		**Use of the apprenticeship levy was 45.00% in April 2020.**	**Utilisation of the apprenticeship levy remains a key enabler to workforce attraction, development and retention. All posts are reviewed for potential apprenticeship opportunities prior to advertisement and one to one support is provided to managers to explore all possible options. Currently, we have continued to sign staff up to apprenticeships that can be undertaken remotely.**
Use of the Apprenticeship Levy was 45.00% in month.			
Workforce carrying out an Apprenticeship Qualification Red: below 1.5% Amber: 1.5% - 2.2% Green: 2.3% or above		**% of the Trust workforce carrying out a Apprenticeship qualification was 1.82% in April 2020.**	
Percentage of the workforce carrying out a qualification was 1.82% in month.			

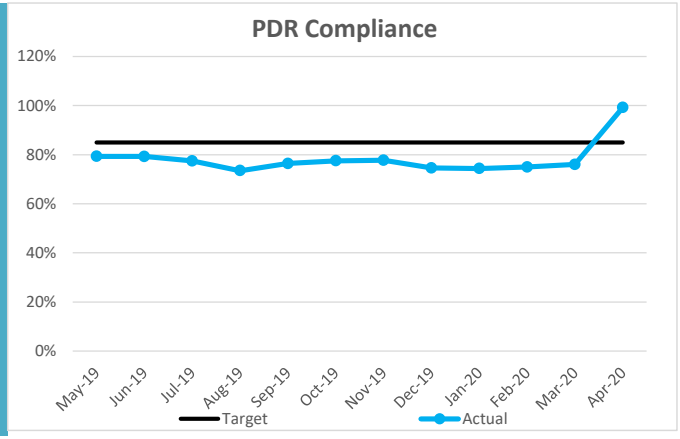
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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

PDR

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
PDR compliance was 99.28% in month.		PDRs form an important part of learning and development for our workforce, however at the moment there is limited time to prepare for and carry out PDRs. With this in mind the Executive Team have taken a decision to give a three month extension to those who are due a PDR between the 1st of March and the 1st of July 2020. For those whose PDR was due before the 1st of March a new completion date of the 1st July will be added onto ESR.	The current position regarding PDRs will be reviewed in July 2020. This review will also consider the role of the PDR in supporting workforce recovery.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

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

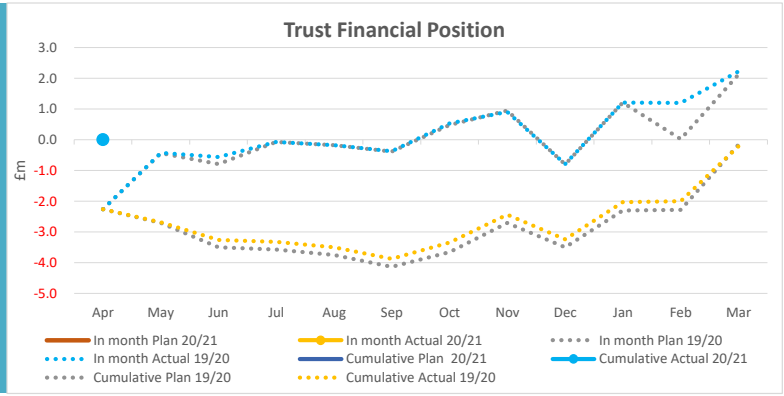
Trust Financial Position

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

UoR SOF S

The Trust has achieved a breakeven position as at 30 April.

RR134



The Trust has achieved a breakeven position as at 30 April, supported by the changes in the financial regime due to the national COVID-19 response and the introduction of a top up system.

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

System Financial Position

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

System reporting is currently on hold.

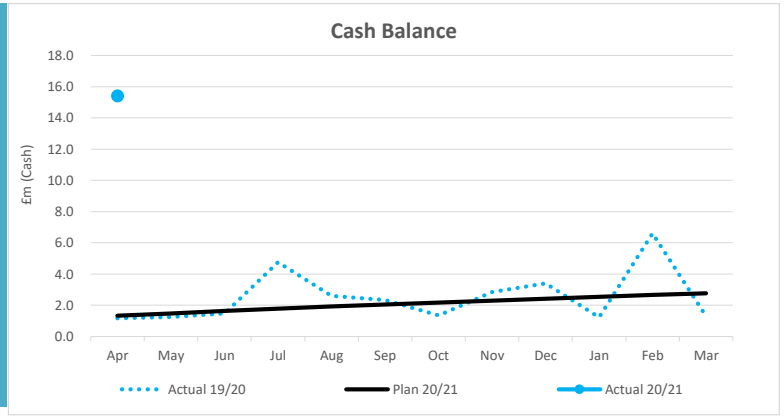
Cash Balance

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

UoR SOF

The current cash balance is £15.4m.

RR134



The current cash balance is £15.4m which is £14.1m better than plan. This is due to early receipt of block income and the top ups as part of the new financial regime. The cash is to be used to achieve the new target of paying suppliers within 7 days for the receipt of goods and services.

The cash flow forecast has been remodelled based on the current financial regime to 31 July and will need to be updated as further guidance emerges.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

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

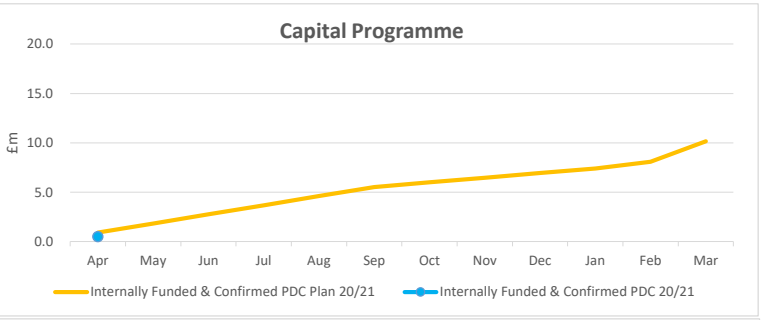
Capital Programme

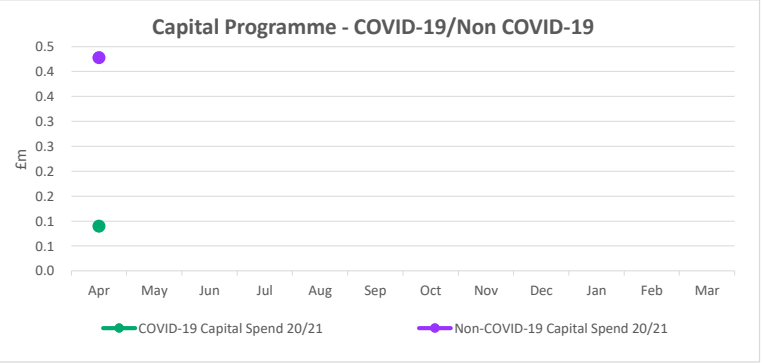
Red: Off plan <80% - >110%
Amber: Off plan 80-90% or 101 - 110%
Green: On plan 90%-100%

UoR SOF

The actual capital spend in the month is £0.5m of which £0.01m related to COVID-19.

RR669





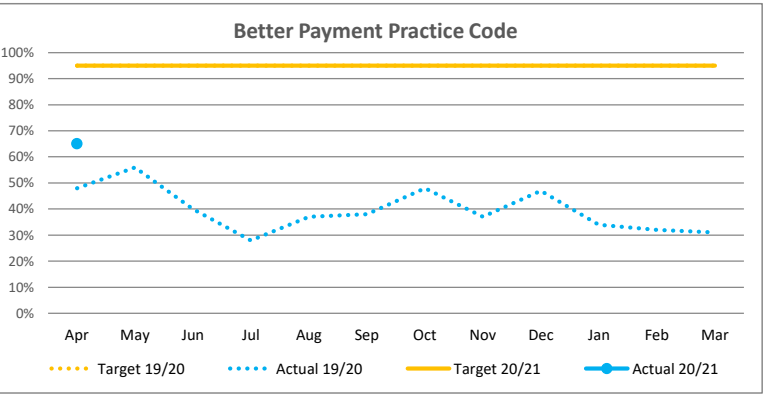
The Trust submitted a capital plan of £30.1m of which £10.1m is internally funded/confirmed PDC, with a loan of £20.0m required for the remainder. Until the loan is approved, the profile plan only represents the internally funded/confirmed PDC capital spend. The Cheshire & Mersey capital envelope required a further 14.00% reduction. The capital programme has been revised to support the recovery phase. It is currently anticipated that £23.4m will be required in 2020/21 of which £12.2m is COVID-19 related. This will require national approval for PDC of £12.2m.

Better Payment Practice Code

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

UoR SOF

In month, the Trust has paid 65.00% of suppliers within 30 days.



Performance of 65.00% is below the national standard of 95.00%, this is due to the backlog of invoices. However this is a improvement on previous performance due to the receipt of additional income in April.

As aged creditors are paid and therefore cleared, it is anticipated that the target will be achieved by the end of June 2020. Communications have gone out across the Trust to ensure the receipting of goods and services are recorded promptly.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

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

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

UoR SOF

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

Agency Spending

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

UoR SOF

The actual agency spend in month is £1.2m.

RR199

The spend of £1.2m is £0.3m above the plan of £0.9m. Of the total, £0.8m expenditure relates to COVID-19. The Trust continues to monitor this.

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR		**CIP has been suspended nationally with no requirement for delivery and reporting until at least 31st July 2020, the Trust is awaiting guidance on next steps.**	
UoR			
UoR			

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

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

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

Appendix 3 – Trust IPR Indicator Overview

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

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

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

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

Appendix 4 - Statistical Process Control

What is SPC?

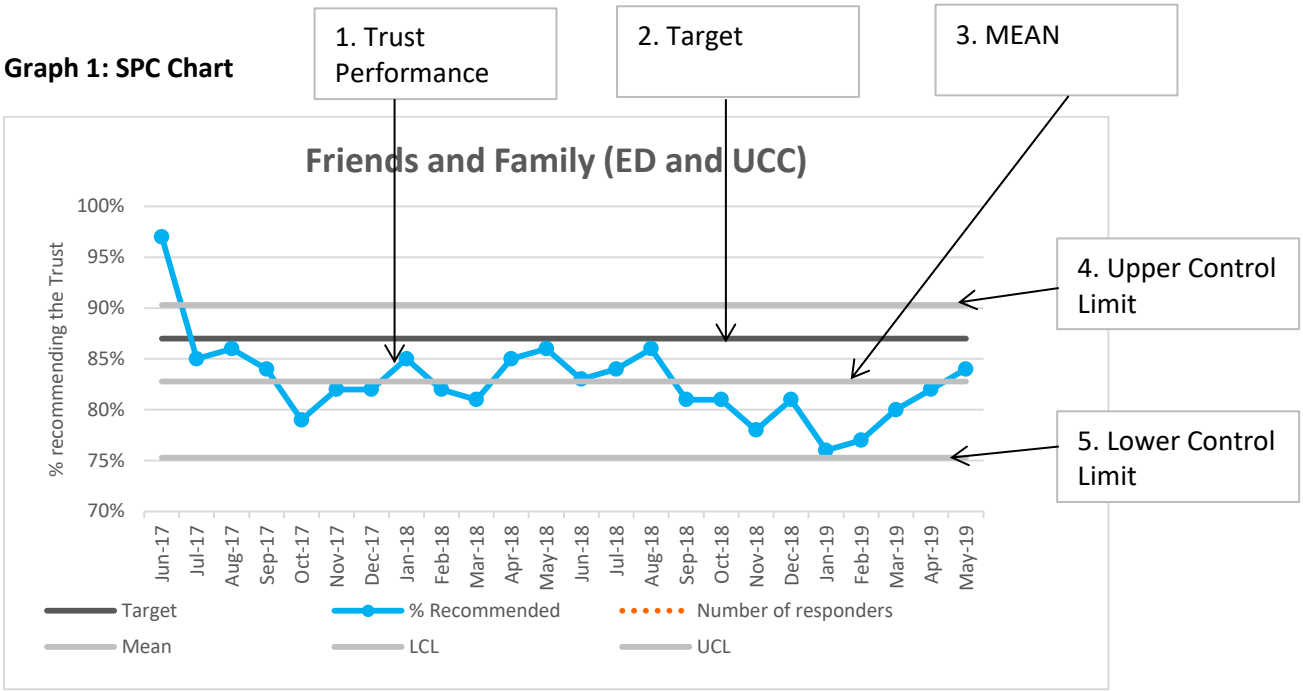
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

SPC Charts

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

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

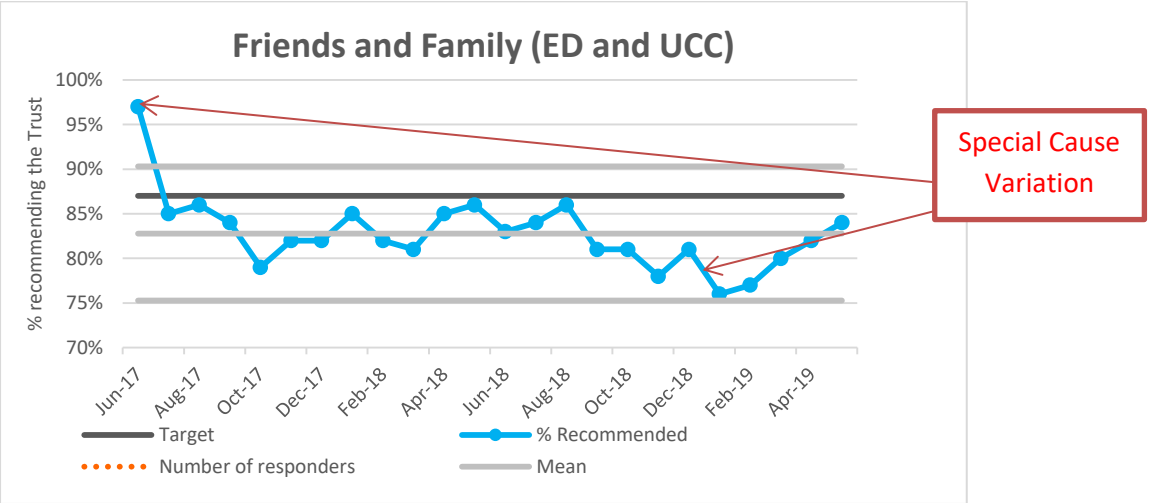
Graph 1: SPC Chart



Interpreting a SPC Chart

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

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



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

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

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

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

Appendix 5

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

Income Statement	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income						
NHS Clinical Income						
Elective Spells	2,417	397	-2,020	2,417	397	-2,020
Elective Excess Bed Days	18	0	-18	18	0	-18
Non Elective Spells	5,893	4,468	-1,425	5,893	4,468	-1,425
Non Elective Bed Days	166	84	-82	166	84	-82
Non Elective Excess Bed Days	105	35	-70	105	35	-70
Outpatient Attendances	2,854	1,565	-1,289	2,854	1,565	-1,289
Accident & Emergency Attendances	1,412	930	-482	1,412	930	-482
Other Activity	5,818	11,585	5,766	5,818	11,585	5,766
Sub total	**18,684**	**19,064**	**380**	**18,684**	**19,064**	**380**
Non NHS Clinical Income						
Private Patients	6	1	-6	6	1	-6
Non NHS Overseas Patients	22	0	-22	22	0	-22
Other non protected	82	78	-4	82	78	-4
Sub total	**110**	**79**	**-31**	**110**	**79**	**-31**
Other Operating Income						
Retrospective Income / NHSE Top U	0	4,333	4,333	0	4,333	4,333
Training & Education	640	640	0	640	640	0
Donations and Grants	0	0	0	0	0	0
Miscellaneous Income	713	744	31	713	744	31
Sub total	**1,353**	**5,717**	**4,364**	**1,353**	**5,717**	**4,364**
Total Operating Income	**20,147**	**24,860**	**4,713**	**20,147**	**24,860**	**4,713**
Operating Expenses						
Employee Benefit Expenses	-16,960	-17,959	-999	-16,960	-17,959	-999
Drugs	-1,197	-1,198	-1	-1,197	-1,198	-1
Clinical Supplies and Services	-1,505	-1,785	-280	-1,505	-1,785	-280
Non Clinical Supplies	-2,397	-2,984	-587	-2,397	-2,984	-587
Depreciation and Amortisation	-755	-657	98	-755	-657	98
Net Impairments (DEL)	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0
Total Operating Expenses	**-22,814**	**-24,584**	**-1,770**	**-22,814**	**-24,584**	**-1,770**
Operating Surplus / (Deficit)	**-2,667**	**276**	**2,943**	**-2,667**	**276**	**2,943**
Non Operating Income and Expenses						
Profit / (Loss) on disposal of assets	0	0	0	0	0	0
Interest Income	3	1	-2	3	1	-2
Interest Expenses	-60	0	60	-60	0	60
PDC Dividends	-276	-276	0	-276	-276	0
Total Non Operating Income and Expenses	**-333**	**-275**	**58**	**-333**	**-275**	**58**
Surplus / (Deficit)	**-3,000**	**0**	**3,001**	**-3,000**	**0**	**3,001**
Adjustments to Financial Performance						
Less Impact of I&E (Impairments)/Reversals DE	0	0	0	0	0	0
Less Donations & Grants Income	0	0	0	0	0	0
Add Depreciation on Donated & Granted Assets	17	16	-1	17	16	-1
Total Adjustments to Financial Performance	**17**	**16**	**-1**	**17**	**16**	**-1**
Adjusted Surplus / (Deficit)	**-2,983**	**16**	**2,999**	**-2,983**	**16**	**2,999**

Activity Summary	Planned	Actual	Variance	Planned	Actual	Variance
Elective Spells	2,658	651	-2,007	2,658	651	-2,007
Elective Excess Bed Days	68	0	-68	68	0	-68
Non Elective Spells	3,413	1,950	-1,463	3,413	1,950	-1,463
Non Elective Bed Days	466	472	6	466	472	6
Non Elective Excess Bed Days	392	139	-253	392	139	-253
Outpatient Attendances	24,120	14,329	-9,791	24,120	14,329	-9,791
Accident & Emergency Attendances	9,644	4,757	-4,887	9,644	4,757	-4,887

Revised Capital 2020/21 as at 14 May 2020

			Revised	Revised	Revised
	original plan	Funding	Non Covid19	Covid 19	Total
	£m		£m	£m	£m
Mandatated (Appendix 1 note 1)	2.13	Dep'n	2.13		2.13
Business Critical (Appendix 1 note 2)	1.82	Dep'n	1.82		1.82
Approved by exec (Appendix 1 note 3)	1.94	Dep'n	1.94		1.94
Brought Forward	1.52	Cash	1.52		1.52
Executive Team / Boardroom (was BW relocation)	0.15	Dep'n	0.15		0.15
EPMA Phase 1 & 2 (Additional areas)	0.06	Dep'n	0.06		0.06
EPMA Phase 3 & 4	0.21	Dep'n	0.21		0.21
Lorenzo Digital Examplar plus	0.29	Dep'n	0.29		0.29
Digital Restructure - Enhanced Structure	0.17	Dep'n	0.00		0.00
Falsified Medicines Directive	0.08	Dep'n	0.08		0.08
Ophthalmology Equipment (Halton)	0.21	Dep'n	0.00		0.00
Finance & Commercial Development - Refurbishment	0.40	Dep'n	0.40		0.40
Finance & Commercial Development - Office/Kitchen Equipment	0.05	Dep'n	0.05		0.05
Refurbishment of Warrington Education Centre	0.01	Dep'n	0.01		0.01
Ultrasound Machine (provision of in house vascular services)	0.08	Dep'n	0.00	0.08	0.08
Contingency	0.00		0.17		0.17
Subtotal	**9.10**		**8.82**	**0.08**	**8.90**
Internally Generated Funds (Dep'n)	7.30		7.30		7.30
Cash from carry forward underspend	1.16		1.16		1.16
Shortfall / (Surplus)	**0.65**		**0.37**	**0.08**	**0.45**
MRI	**1.06**	**PDC**	**1.06**		**1.06**
Loan					
Microsoft Office upgrade	1.72	loan	0.00	0.00	0.00
Dexa Scanner	0.25	loan	0.25	0.00	0.25
Labour Ward Screens and Licences	0.10	loan	0.10	0.00	0.10
Warrington Car Park (H)	10.00	loan	0.00	0.00	0.00
Halton Programme (Elective Centre) (Appendix 3)	2.50	loan	0.00	4.90	4.90
A&E Plaza	2.30	loan	0.00	4.00	4.00
Other schemes	3.10	loan	0.00		0.00
Supportive Care Hub	0.00	loan		1.00	1.00
Urology Investigations Unit and Paed OPD	0.00	loan		1.40	1.40
Pneumatic transport system	0.00	loan		0.30	0.30
Mortuary	0.00	loan	1.00	0.00	1.00
CT Ventilation	0.00	loan		0.01	
Subtotal Loan	**19.97**		**1.35**	**11.61**	**12.95**
Total	**30.13**		**11.23**	**11.69**	**22.92**

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board

IPR Key Issues

27th May 2020

IPR Quality Key Issues

- Incident reporting ↓, refocus on closing incidents commenced
- 0 mixed sex accommodation beaches
- Medication Reconcillation improvement 79% in April, CD incidents reduced
- 0 MRSA cases, 5 CDI cases & 5 E Coli (Gram Negative) cases - awaiting threshold reset for 2020/21
- 65 Pressure Ulcers against target of 57 – threshold reset for 2020/21. 3 Category 2 pressure ulcers reported in month
- Continuity of Carer 55% against national target of 51% for March 2021
- VTE – refocus with Acting Medical Director Lead in June
- FFT & CHPPD suspended – staffing acuity measurements to restart in June as appropriate

IPR Access & Performance

Emergency Department

- April 20 – 92.54% (*May 20 @ 20/05/20 – 93.83%*)
- RCEM Guidance; *Must not become crowded again – ED footprint review for segregated flows, ED Plaza*

RTT

- April 20 – 81.62%
- Clinical review & prioritisation of all elective activity in accordance with national guidance and categorisation. Complete.

Diagnostics

- April 20 – 73.73%
- Utilisation of the IS / CMTC

Cancer

- March 20 – all achieved with exception of 2WW breast symptomatic
- Urgent elective activity re-commenced 5th May 20. C&M SOP for Mutual Aid.

IPR People

- Sickness Absence:
  - Increases in short term sickness relate to COVID-19 absence.
  - Increases in long term sickness relate to an increase in mental health absence.
  - Full range of support for physical and mental health in place and continues to be enhanced.
  - Approach to Return to Work Interviews to be reviewed as part of workforce recovery planning.
- Bank and Agency Reliance:
  - Increase in temporary staffing reliance due to COVID-19.
  - Increase in agency spend for Nursing staff group and increase in bank spend for Medical staff group.
- Mandatory Training:
  - Remains above target but has reduced due to postponement of training in line with national guidance
  - Training to restart from May 2020
- Improvements across Time to Hire, Turnover and Retention KPIs

IPR – Sustainability

- Financial position of breakeven at the end of April
- Position includes Covid19 expenditure of £3.4m and a retrospective top up of £2.5m
- CIP not expected to be delivered in first four months
- Two months cash was received in April 2020
- Working towards prompt payment to suppliers at 30 April 65% achieved (34% 31 March)
- Covid19 capital of £1.4m approved in April, received capital items of £0.5m which NHSI have been asked to reimburse
- All Covid19 capital now requires NHSE/I approval
- Revised capital plans have been requested for submission 29 May
- Covid19 related capital is separate to the Cheshire and Mersey envelope
- Accounts submitted ahead of plan to auditors
- Audit Committee planned for 17 June to sign off the accounts

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM 20/05/49 b	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	27 May 2020

Date of Meeting	5 May 2020
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

Following consideration of the above, the Committee wishes to bring the following matters to the attention of the Board:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/20 /05/67	Matters arising	Lorenzo functionality – Maternity services • Strategic Outline case to be progressed to support moving Maternity out of Lorenzo. Specification to be agreed as part of SOC • Lorenzo upgrade anticipated Autumn 2020, approval required by Board 30.09.2020, Go Live 28.02.2021. • No requirement to submit PIR questionnaire as part of CNST submission.	Progress against action plan to be included in future Maternity Champion reports and reported to Board through QAC Key Issues Reports	**QAC 07.07.2020** **Trust Board 30.09.2020**
QAC/20 /05/68	COVID-19 Update	Specifically related to COVID-19, the Committee received updates on Clinical Care, Clinical Governance, Infection Prevention & Control, Workforce, PPE and safety. • Recovery - First elective cancer patient had commenced treatment in theatre that morning • PPE will be more challenging when other services re-start • Assurance provided that no service will be commenced without the appropriate PPE with no members of staff working without the correct PPE • Sepsis/VTE assurance provided, all areas continue to be reviewed and RCAs continue to be undertaken for hospital VTEs.	The Committee received and discussed updates related to monitoring during COVID-19 Pandemic, receiving high assurance in relation to the Trust's response. The situation in respect of PPE however to be escalated to Board	**Trust Board 27.05.2020** **QAC 07.07.2020**

QAC/20 /04/ 69	BAF/Risk Register - COVID-19 - BAF - Corporate Risk Register	• Proposal for the addition of three new COVID-19 related risks to the BAF Risk #1134 (staffing); Risk #1126 (Oxygen/ventilation); Risk #1124 (PPE) all at a rating of 20. • Agreed rating of 20 not sufficient for Risk #1124. Rating to be amended to 25. • Mitigation and gaps reviewed on a weekly basis. • 7 new risks had been added to the Corporate Risk Register, • Committee reviewed and received the COVID-19 Risk Register.	The Committee received and discussed and approved the proposed changes to the BAF and CRR, receiving high assurance	**Board 27.05.2020** **QAC 07.07.2020**
QAC/20 /05/70	Maternity Update	• One list Elective C-section cancelled, two maternity theatres kept open supported by anaesthetic and theatre teams. List resume 11 May 2020. • Home births service to be resumed 11 May 2020 with Continuity of Care Model. • Challenges remain to deploy an effective Maternity digital system for both WHH and the Community. Refer to Matters arising above. • CNST – 10 safety actions paused until 31 August 2020, 10% uplift to CNST for maternity incentive scheme will not be collected from April 2020 for 2020-21.	The Committee received and discussed the update receiving moderate assurance	**QAC 07.07.2020**
QAC/20 /05/72	Update on Complaints and Incident arrangements	Committee were informed of the process implemented following national guidance during the COVID-19 Pandemic: • Weekly update continues to be shared with NEDs during current meeting arrangements • Complaints processes 'paused' by the Trust in line with national directive, for 3 months in the first instance. • Compliant responses being supported by staff identified in the re-deployment hub and those who are shielded.	The Committee received and discussed the update on complaints and incident arrangements during the COVID-19 Pandemic, receiving moderate assurance	**QAC 07.07.2020**
QAC/20 /05/76	Mortality Review Report	The Committee particularly noted the following in the update received: • Trust not an outlier for SHMI + HMSR 103.16 and SHMI 106.36 • At 4 May 2020, 90 COVID-19 related deaths, only 1 other Acute Trust in C&M reported lower death rate than WHH. • 4 SJRs had been discussed during April, themes were reassessment, vascular pathway, gastroenterology referral pathways to other Trusts and DNACPR document. • Assurance that Exec Medical Director continues to receive monthly MRG reports and had no matters to escalate • No concerns relating to inappropriate referrals to Palliative Care.	The Committee noted the report high level of assurance.	**Board 27.05.2020** **QAC 07.07.2020**

QAC/20 /05/78	Hot Topics	The Committee received up to dates information relating to PPE - reusable fluid repellent gowns had been introduced in clinical areas as a temporary measure whilst there is a shortage of disposable gowns, these will be distributed as part of the daily supply deliveries to ICU/Theatres/Ward A7/Endoscopy. It is anticipated this will be a temporary measure and disposable gowns will be reintroduced as soon as production increases to meet the high global demand. Fit Testing - On-going programme in place, overseen by Specialist Office to look at Respiratory Kit and FFP equipment with risk assessment in place for any equipment purchased off supply. Constitutional Standards – C Evans - ED 4 Hour, improving standard, April position reported 92.35% subject to validation. - Recovery plans for RTT, Diagnostic and Cancer standards. - Trust reporting a higher level that neighbouring partners who had recorded a greater deterioration in standards for the same period of time. Palliative Care Dashboard - Monthly dashboard in place for monitoring End of Life (EoL) KPIs. - Committee received a summary of principles implemented where a family member is not present when a patient is nearing EoL.	The Committee noted the updates and received moderate assurance	**Board 27.05.2020** **QAC 07.07.2020**

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/20/05/49 c		TRUST BOARD OF DIRECTORS	DATE OF MEETING	27 May 2020

Date of Meeting	**20 May 2020**
Name of Meeting + Chair	**Strategic People Committee** **Anita Wainwright, Non-Executive Director**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
SPC/20/05/37	**Matters arising: Appraisee training – outcomes of evaluation process (Appraisal and Revalidation Report)**	Acting Executive Medical Director The Committee noted the following: • The GMC have deferred for 12 months any medical revalidation due between 17 March 2020 and 30 September 2020. • NHS England recommended that medical appraisal should be suspended from 20 March 2020 unless there is good reason to continue.	The Committee received assurance that: • Where possible, medical appraisal has continued and where this has not been possible, appropriate steps have been taken to suspend in line with the national position. • Medical appraisal training has been provisionally booked for September and October 2020.	
SPC/20/05/ 38	**Recommendation to Pause and /or Amend Business cycle 2020 to 2021 (attached)**	Chair of Committee / Director HR & OD / Chief Nurse & Deputy CEO and Acting Executive Medical Director The Committee received a recommendation to Pause and /or Amend Business cycle as follows:	The Committee approved the recommendation to Pause and /or Amend Business cycle.	SPC July 2020

		Recommendation from Director HR & OD • CQC – Moving to Outstanding (Staff) • Employee Relations Report • National Staff Opinion Survey Update • Equality Duty Assurance Report (EDAR) PSED Standard • Workforce Equality Assurance Report (WEAR) PSED Standard • Equality Delivery System 2 (EDS2) • Gender Pay Report • Workforce Race Equality Standard (WRES) • Workforce Disability Equality Standard (WDES) • Facilities Time Off Annual Report Recommendation from Chief Nurse & Deputy CEO • Trust Board Monthly Staffing Report – Key Issues Report • Hospital Volunteer Annual Report Recommendation from Acting Executive Medical Director • HENW Monitoring Visit (Annual Assessment Visit) Recommendation from Chair of Committee • Committee Effectiveness – Annual survey		
SPC/20/05/ 39	**Policies and Procedures Report:**	Director HRD + OD The Committee received the Media and Social Media Policy for approval.	The Committee approved the policy	
SPC/20/05/40	**Director of HR &**	Director HRD + OD	The Committee noted the report and requested	SPC July

	OD Report	The Committee received the report which set out the key workforce elements of the Trust response to the COVID-19 pandemic and included: • The HR and OD Directorate Response • Policy Updates • Partnership Working • Workforce Reporting • Workforce Recovery • Freedom to Speak Up	additional information to be submitted back to SPC in July relating to: • Workforce risk assessments • Uptake of wellbeing offers • Workforce baseline assessment	2020
SPC/20/05/ 41	**Guardian of Safe Working Hours Quarterly Report**	Acting Executive Medical Director The Committee received a report providing an update on exception reporting in Q4 2019/20. Of particular note: • Only 19 exceptions reported during the period • 44 exceptions outside of the 40 day window – actions are in place to address • Positive feedback from BMA regarding exception reporting in the Trust	The Committee noted the report	

BOARD OF DIRECTORS CHAIR'S ASSURANCE REPORT

AGENDA REFERENCE:	BM/20/05/49 d		TRUST BOARD OF DIRECTORS	DATE OF MEETING	27 May 2020

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	RECEIVING BODY (eg Board or Committee)	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
FSC/20/04/56	Corporate Performance Report	• March A&E performance is 81.89% • Diagnostics 97.32% against standard of 99%, Cancer will miss target in March • Anticipate 18 month plus for recovery of RTT • Super stranded 73 as at 31 March 2020 and has been as low as 44 • B18, C20, B3 and K25 closed	Committee	The Committee noted the report.	FSC May 2020
FSC/20/04/57	Pay Assurance Report	• Noted the report and change in activity linked to Covid19 • Patchwork continued to reduce costs • Will closely monitor bank and agency as expect an increase due to bank and agency	Committee	The Committee noted the report.	FSC May 2020
FSC/20/04/58	Monthly Finance Report	• Achieved control total with surplus of £0.2m including PSF, FRF and MRET	Committee	The Committee reviewed, discussed	FSC May 2020

		• Noted the income risk relating to B3 • Achieved £7m of £7.5m CIP target - for 2020/21 there will be a pause in CIP delivery for the first 4 months • Capital undershot by £1.1m linked to fire and estates. The plan to bring forward 2020/21 IM&T equipment failed due to Covid19 • Covid19 capital noted		and noted the report. The capital changes were approved.	
FSC/20/04/59	Cash & Capital Regime	• Noted the report • Discussed the contracting arrangements for 2020/21 with block for the first 4 months • The need to pay suppliers within 7 days • Changes to access emergency and additional capital via STP	Committee	The Committee noted the report.	
FSC/20/04/60	BAF/Risk Register	• Noted the report • Discussed the Covid19 BAF risk • Corporate risk register includes finance Covid19 risk and a fraud Covid19 risk	Committee	The Committee noted the report.	FSC May 2020
FSC/20/04/61	Key issues to the Board	• The financial position and risk of B3 income • Cancer and RTT situation • Pause in CIP for 4 months and new block contract arrangements • Further review of 2020/21 capital spend required	Committee		FSC May 2020

BOARD OF DIRECTORS CHAIR'S ASSURANCE REPORT

AGENDA REFERENCE:	BM/20/05/49		TRUST BOARD OF DIRECTORS	DATE OF MEETING	27 May 2020

Date of Meeting	20 May 2020
Name of Meeting + Chair	Finance & Sustainability Committee – Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	RECEIVING BODY (eg Board or Committee)	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
FSC/20/05/67	Corporate Performance Report	• April A&E performance is 92.54% May to date 93.85% • No ambulance handover data for April • RTT 81.62% against target of 92% • Recovery planning is underway and the first activity return will be submitted this week • The Trust is utilising the private sector under the national contract at no cost until 24/6/20	Committee	The Committee noted the report.	FSC June 2020
FSC/20/05/68	Pay Assurance Report	• Noted the use of bank and agency during the pandemic, where possible bank is used and patchwork has been key to this • The Pay Assurance Checklist quarterly report has been reviewed. Agreed that this has now served its` purpose and is no longer required. • The Trust has had to use some off framework agency Greenstaff and Thornbury process has been followed and a plan is in place to reduce the use of these premium rate	Committee	The Committee noted the report.	FSC June 2020

		staff. A monthly monitoring report is going to Executive Meeting and agreed will add to FSC agenda • Absence for both Covid and Non Covid has been between 14% - 16%			
FSC/20/05/69	Cost of harm	• Noted indicative figures	Committee	The Committee noted the report.	FSC May 2021
FSC/20/05/70	Monthly Finance Report	• Achieved breakeven position with retrospective top up of £2.5m • Noted the income risk relating to B3 and requested further escalation • Noted the improvement in BPPC and the efforts of the team • Noted there will be a pause in CIP delivery for the first 4 months • Covid19 capital noted	Committee	The Committee reviewed, discussed and noted the report.	FSC June 2020
FSC/20/05/71	Revised Operational Plan	• Discussed the contracting arrangements for 2020/21 with block for the first 4 months and top ups • Reviewed the cashflow • Discussed the review of capital and the potential changes to the loan request	Committee	The Committee noted the report and support the changes in principle	To be discussed at Board May 2020
FSC/20/05/72	BAF/Risk Register	• Noted the report • No new risks or amendments	Committee	The Committee noted the report.	FSC June 2020
FSC/20/05/73	Key issues to the Board	• Risk of B3 income and need to escalate • Cancer and RTT situation • Further monitoring of the use of off framework agency • Further review of 2020/21 capital plan required	Committee		Board May 2020

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/20/04/49 e	COMMITTEE/ GROUP	TRUST BOARD OF DIRECTORS	DATE OF MEETING	27 May 2020

Date of Meeting	30 April 2020
Name of Meeting + Chair	Audit Committee, Chaired by Ian Jones, Non-Executive Director
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
AC/20/04/24	Matters arising	• DNACPR training, formal training to re-commence as part of COVID-19 recovery phase. Risk to be considered for addition to the Risk Register. • It was agreed that oversight and monitoring of the DNACPR Audit Tool and compliance of training will be reported to Quality Assurance Committee in July. • MIAA confirmed recommendations for (1) Audit and (2) Compliance with training be closed	DNACPR Audit Tool and compliance of training will be reported to Quality Assurance Committee in July.	**Quality Assurance Committee July 2020**
AC/20/04/29	Response of Management on Key Areas affecting the Financial Statements	The Committee reviewed and accepted both responses from the Director of Finance and Commercial Development + Deputy CEO and the Chair of the Audit Committee for preparation of the final accounts	**The Committee accepted proposed responses for preparation of the final accounts**	**Audit Committee June 2020**
AC/20/04/34	Progress Report on Internal Audit Follow-Up Actions at 31 March 2020	The Committee particularly noted the following: • 7 audits that have 14 outstanding management actions recorded. • No critical recommendations that are overdue, however there was 1 high recommendation overdue in relation to Discharge Planning.	**The Committee discussed the report and received moderate assurance**	**Audit Committee August 2020.**

		Outstanding action to undertake further audit temporarily on hold and will be prioritised when recovery phase is in place. in the response		
AC/20/04/35	Internal Audit Progress Report	The Committee noted that the following reports had been issued; • Data Security and Protection Review – **Substantial Assurance** • Assurance Framework Review concluded that the organisation's Assurance Framework is structured to meet the NHS requirements, all elements rated Green. 1 report had been issued to Trust Officers, CQC Review awaiting sign off of final report which does not affect the Head of Internal Audit Opinion.	**The Committee noted and discussed the report and progress against actions will be reported at the next meeting.**	**Audit Committee August 2020**
AC/20/04/36	Head of Internal Audit Opinion	• Substantial Internal Audit Opinion issued	**The Committee noted the opinion of Substantial Assurance**	**Audit Committee April 2021**
AC/20/02/14	Review Losses and Special Payments Period 1 January 2020-31 March 2020	The Committee particularly noted: • The value of Losses and Special Payments for the year to 31 March 2020 after recovery of monies from NHS Resolution amounts to £275,199, compared to £165,915 for 2018-19. • Q4 Losses and Special Payments reported £100,722 (compared to £24,475 in Q4 2018-19)	**The Audit Committee reviewed and discusses the report noting and received moderate assurance**	**Audit Committee August 2020.**


We are WHH & We are
PROUD
to make a difference

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Revised Operational Plan 2020/21

Trust Board 27th May 2020

We are WHH & We are PROUD to make a difference

Andrea McGee - Director of Finance and Deputy Chief Executive

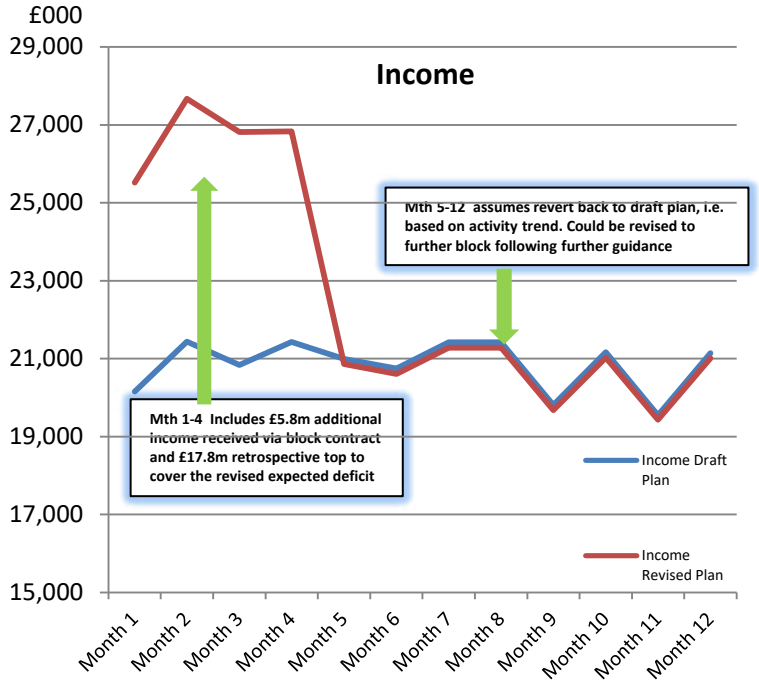
Overview

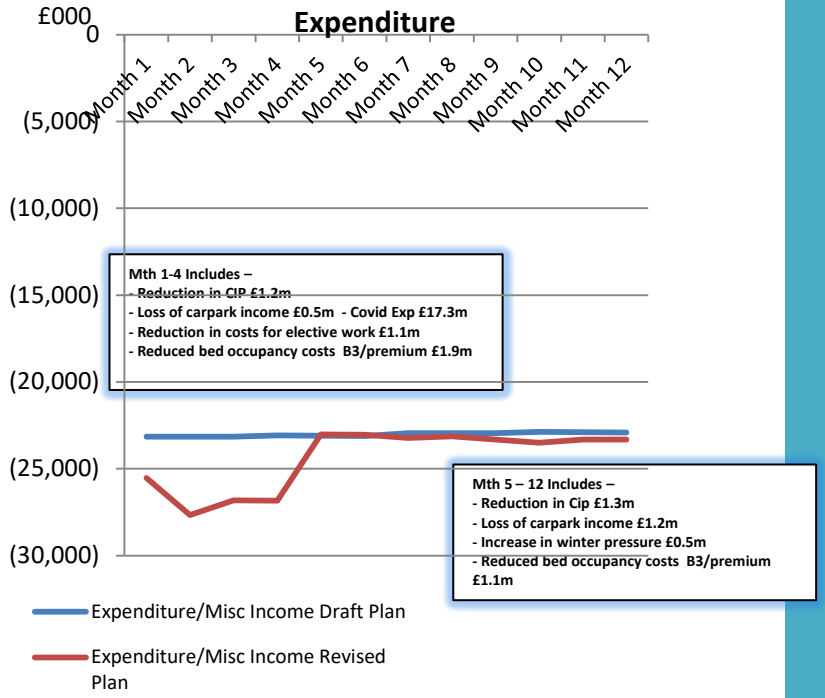
- Board signed off draft operational plan in February 2020 with a deficit plan of £26.1m (control total not agreed) and capital programme of £29.3m
- Submitted the draft operational plan on 5th March 2020
- Board signed off the financial plan and budget book in March 2020
- In March 2020 the Board was informed the operational planning round for 2020/21 was suspended, due to Covid-19
- NHSE/I are using a prepopulated plan that calculated the expected breakeven position. It is based on last year's run rate and not our detailed budget settings for 20/21

Overview – cont.

- A revised I&E plan has been prepared to account for the known changes from the draft plan and the changes related to COVID-19 (income & expenditure)
- Capital to be reviewed and resubmitted to Cheshire & Merseyside Health & Care Partnerships for central submission on 29th May 2020, C&M currently oversubscribed for C&M by £25.2m (£198.6m envelope)
- Further guidance is due for planning August – October 2020

Draft Plan v Revised Plan





I&E Movements to Revised Plan

Description	£000	Month
Draft Plan Deficit	**(26,138)**	
Forecast Covid Expenditure	(17,330)	1-4
CIP removed for April to July 2020 and then lifted programme to commence August 2020. Reduced from £5.6m to £3.1m	(2,547)	1-12
*Car-Parking income losses	(1,777)	1-12
Provision for Winter	(488)	10-12
Income Contract changes	(240)	1-12
Reduce pipeline Business cases April - July	68	1-12
Reduction in Elective work - WLIs	310	1-4
Reduction in Elective work - Non Pay	830	1-4
Revised 92% Bed Occupancy	1,871	1-4
Revised 92% Bed Occupancy August 2020 - March 2021	1,096	5-12
Additional Block Income	5,827	1-4
Retrospective top up	17,831	1-4
Revised Plan Deficit	**(20,686)**	

** Decision to remove income from August 2020 onwards required by the end of June 2020*

Cash flow

Narrative	Actual April £000	Forecast May £000	Forecast June £000	Forecast July £000	Forecast August £000	Forecast Sept £000	Forecast Oct £000	Forecast Nov £000	Forecast Dec £000	Forecast January £000	Forecast February £000	Forecast March £000	Annual Position £000
Operating Income	43,288	22,251	22,251	20,827	20,610	21,278	21,278	19,679	21,024	19,419	21,008	1,265	254,177
Operating Expenses	(25,201)	(27,351)	(26,494)	(26,511)	(22,698)	(22,723)	(22,896)	(22,817)	(22,998)	(23,172)	(23,002)	(23,003)	(288,866)
Operating Surplus/(Deficit)	**18,087**	**(5,100)**	**(4,243)**	**(5,684)**	**(2,088)**	**(1,445)**	**(1,618)**	**(3,138)**	**(1,974)**	**(3,753)**	**(1,994)**	**(21,738)**	**(34,689)**
Non Cash Items:													
Depreciation and Amortisation	609	609	609	609	609	609	609	609	609	609	609	608	7,307
NHS Trade Receivables												(276)	(276)
Other Related Part Receivables	5,287												5,287
Accrued Income (negative = deferred income)	1,070	1,070	1,070	1,070	(324)	(571)	96	103	(1,503)	(157)	(1,751)	(172)	0
NHS Trade Payables	(3,500)	(3,563)	27	(564)	(69)	1,772	(565)	(1,527)	544	(813)	867	1,149	(6,242)
Non NHS Trade payables	(7,369)	(5,000)											(12,369)
Cash Flows from investing activities:													
Interest income	3	3	3	3	3	3	3	3	3	3	3	3	36
Capex : Estates	(483)	(483)	(483)	(483)	(483)	(483)	(405)	(405)	(405)	(405)	(405)	(405)	(5,325)
Capex : IM&T	(206)	(206)	(206)	(206)	(206)	(206)	(203)	(203)	(203)	(203)	(203)	(203)	(2,455)
Capex : MRI	(177)	(177)	(177)	(177)	(177)	(177)	0	0	0	0	0	0	(1,061)
Capex : Medical Equipment	(63)	(63)	(63)	(63)	(63)	(63)	(63)	(63)	(63)	(63)	(63)	(63)	(760)
Movement from financing activities:													
20/21 Working Capital Loan (Received)		0	0	0	0	0	0	0	0	0	0	0	0
Dividends paid						(1,654)						(1,656)	(3,310)
PDC Received			1,061										1,061
NHSI 'True Top-Up'			**3,269**	**5,419**	**4,563**	**4,580**							**17,831**
Increase/decrease in cash equivalents	**13,258**	**(12,911)**	**866**	**(77)**	**1,765**	**2,364**	**(2,145)**	**(4,621)**	**(2,991)**	**(4,783)**	**(2,937)**	**(22,752)**	**(34,965)**
Opening Cash Balances	**2,125**	**15,383**	**2,472**	**3,338**	**3,260**	**5,026**	**7,390**	**5,244**	**623**	**(2,368)**	**(7,151)**	**(10,087)**	**2,125**
Closing cash and cash equivalents	**15,383**	**2,472**	**3,338**	**3,260**	**5,026**	**7,390**	**5,244**	**623**	**(2,368)**	**(7,151)**	**(10,087)**	**(32,840)**	**(32,840)**

The Trust will require cash PDC from November 2020. However this position only includes a retrospective top up to July 2020.

Assumptions:

- Retrospective top up only relates to deficit Apr-Jul and paid Jun - Sep
- No capital loan and associated Capex; base programme only of £7.4m, £1.1m carry forward plus £1m PDC funded MRI scheme (total £8.4m)
- April closing cash is actual

Capital

- See additional sheets

Next Steps

- Submit revised capital plan to NHSE/I 29 May 2020
- Amend budget book for sign off by budget holders

Recommendations

- The Board of Directors is asked approve the proposed amendments to the operational plan for 2020/21

Revised Capital Plan 2020/21 as at 14 May 2020

	Original plan	Funding	Revised Non Covid19	Revised Covid 19	Revised Total	
	£m		£m	£m	£m	
Mandatated (Appendix 1 note 1)	2.13	Dep'n	2.13		2.13	
Business Critical (Appendix 1 note 2)	1.82	Dep'n	1.82		1.82	
Approved by exec (Appendix 1 note 3)	1.94	Dep'n	1.94		1.94	
Executive Team / Boardroom (was BW relocation)	0.15	Dep'n	0.15		0.15	
EPMA Phase 1 & 2 (Additional areas)	0.06	Dep'n	0.06		0.06	
EPMA Phase 3 & 4	0.21	Dep'n	0.21		0.21	
Lorenzo Digital Examplar plus	0.29	Dep'n	0.29		0.29	
Digital Restructure - Enhanced Structure	0.17	Dep'n	0.00		0.00	Would make the Trust an c
Falsified Medicines Directive	0.08	Dep'n	0.08		0.08	
Ophthalmology Equipment (Halton)	0.21	Dep'n	0.00		0.00	Moved to Halton scheme
Finance & Commercial Development - Refurbishment	0.40	Dep'n	0.40		0.40	
Finance & Commercial Development - Office/Kitchen Equipment	0.05	Dep'n	0.05		0.05	
Refurbishment of Warrington Education Centre	0.01	Dep'n	0.01		0.01	
Ultrasound Machine (provision of in house vascular services)	0.08	Dep'n	0.00	0.08	0.08	
Contingency	0.00		0.17		0.17	
Subtotal	**7.58**		**7.30**	**0.08**	**7.38**	
Internally Generated Funds (Dep'n)	-7.38		-7.38		-7.38	
Shortfall / (Surplus)	**0.20**		**-0.08**	**0.08**	**0.00**	
Brought Forward	**1.52**	**Cash**	**1.52**		**1.52**	
MRI	**1.06**	**PDC**	**1.06**		**1.06**	
Cash from carry forward underspend	-1.52		-1.52		-1.52	
PDC for MRI	-1.06		-1.06		-1.06	
Shortfall / (Surplus)	**0.00**		**0.00**		**0.00**	
Loan						
Microsoft Office upgrade	1.72	loan	0.00	0.00	0.00	Move to revenue
Dexa Scanner	0.25	loan	0.25	0.00	0.25	Urgent loan
Labour Ward Screens and Licences	0.10	loan	0.10	0.00	0.10	Urgent loan
Warrington Car Park (H)	10.00	loan	0.00	0.00	0.00	
Halton Programme (Elective Centre) (Appendix 3)	2.50	loan	0.00	4.90	4.90	Breast Screening Relocatio
A&E Plaza	2.30	loan	0.00	4.50	4.50	
Other schemes	3.10	loan	0.00		0.00	Moved to Halton £1.4m ar
Supportive Care Hub	0.00	loan		1.00	1.00	
Urology Investigations Unit and Paed OPD	0.00	loan		1.40	1.40	
Pneumatic transport system	0.00	loan		0.30	0.30	
Mortuary	0.00	loan	1.00	0.00	1.00	Urgent loan
CT Ventilation	0.00	loan		0.01		
Subtotal Loan	**19.97**		**1.35**	**12.11**	**13.45**	
Total	**30.13**		**11.23**	**12.19**	**23.42**	**78%**

Notes			£m	£m	£m
Further Covid19 requests being reviewed (Appendix 2)				0.80	
Further Covid19 Recovery requests being reviewed				TBC	
Assumes IM&T can be managed through revenue reduced figure due to deal			1.20		
Assumes Car Park can be moved to 21/22			10.00		
Excludes shopping city as assume funding from exernal source			2.50		

Capital Bid Analysis 2020/21	**Appendix 1**
Scheme Name	**Value £000**
Mandated (Note 1)	
Fire - Replacement of Obsolete 5000 Series Fire Alarm Panels	600
Backlog - Electrical Infrastructure Upgrade	200
Fire - Halton 30 Minute Fire Compartmentation	150
Appleton Wing Circulation Areas 60 Minute Fire Doors	100
Warrington and Halton Gas Meter Replacement	100
Backlog - All Areas Fixed Installation Wiring Testing	100
Fire - Thelwall House Emergency Lighting Final Phase	100
Backlog - Kendrick Wing Works To Emergency Lighting	75
6 Facet Survey	55
Backlog - Water Safety Compliance	50
Backlog - HV Maintenance Annual	40
Pharmacy Fire Doors Sliding Type	30
Backlog - Annual Asbestos Management Survey & Remedials	30
Fire - Alarm System Monitoring	30
Halton Residential Blocks 2 & 3 Fire Doors	25
Estates Department Fire Doors	20
Thelwall House - Improvements to Fire Alarm System	20
Fire - Remove Final Stepped Exits from Kendrick Wing	20
Backlog - Kendrick Wing Fire Alarms to Portakabin Buildings	15
Cheshire House Fire Alarm	25
Cheshire House Emergency Lighting	20
Anaesthetic Machines (ASCA accreditation standards)	260
Call Alarms for all Anaesthetic Rooms (ASCA Accreditation standards)	60
Sub total	**2,125**
Business Critical (Note 2)	
MRI Turnkey/Enabling Work (Estimate)	200
Devices Replacement (Tech Refresh)	1,189
Electronic Patient Record Procurement (£70k for scoping / £180k for procurement)	250
E-Outcome Resilience	100
Additional Network Cabinets	30
Backup Storage	20
Replacement for Trackit	30
Sub total	**1,819**
Executive Team/Board Approved (Note 3)	
EPMA Phase 1 & 2	20
Balance of Midwifery Led Unit (Building Works)	289
Induction of Labour Ward (Building £22k, Equipment £56k)	78
Workplace Health & Wellbeing Service Development (Building works only)	52
MRI Estates Work	1,008
Estates Capitalisation of Staff Costs	177
IM&T (current structure) Capitalisation of Staff Costs	316
Sub total	**1,940**
Potential Schemes requiring Executive Team/Board Approval	
Bridgewater Executive Team Relocation	154
EPMA Phase 1 & 2 (Additional areas)	60
EPMA Phase 3 & 4	210
Lorenzo Digital Examplar plus	285
Falsified Medicines Directive	83
Finance & Commercial Development - Refurbishment	400
Finance & Commercial Development - Office/Kitchen Equipment	50
Refurbishment of Warrington Education Centre	5
Ultrasound Machine (provision of in house vascular services)	80
Contingency	170
Sub total	**1,497**
Schemes carried forward from 2019/20	**1,518**
MRI PDC Funded	**1,061**
Total for dep'n and externally funded MRI	**9,960**
Loan	
Radiology - Dexa Scanner	250
Labour Ward Bedside Touch Screens and Archiving Software/Licences	101
Breast Screening reloaction	4,900
A&E Plaza	4,000
Supportive Care Hub	1,000
Urology Investigations Unit and Paed OPD	1,400
Pneumatic transport system	300
Mortuary	1,000
Sub total	**12,951**
Total	**22,911**

Appendix 2 - Covid Capital being processed with need external approval

Reference	Type	Date Request Received	Date Forwarded to KSJ/CE	Description	Qty	Supplier	Order Number	Order Value (inc. VAT)	Annual Ongoing Revenue (Inc. VAT)	Capital / Revenue
COV19-00000	Equipment	25.03.20	25.03.20	TORCH2 Film Array System	1	Biomerieux	133495466	£67,200.00	£6,512.83	Capital
COV19-00011	Equipment	21.04.20	06.05.20	Ultrasound Machine for Vascular scanning	1			£70,800.00	£108,000.00	Capital
COV19-00011	Estates	21.04.20		Oxygen Points - Paediatrics B11/PAU						Capital
COV19-00016	Equipment	30.04.20		Funus Camera	1	Silverson		£145,000.00		Capital
COV19-00016	IT	30.04.20		Medisoft Module	1	Medisoft		£13,800.00		Capital
COV19-00016	Equipment	30.04.20		Visual Field Analyser	1	Zeiss		£35,677.00		Capital
COV19-00016	Equipment	30.04.20		Optical Coherence Tomographs	1	Topcon		£60,588.00		Capital
COV19-00016	Equipment	30.04.20		Digital Gonioscope	1	Birmingham Optical		£21,948.00		Capital
COV19-00018	Equipment	08.05.20	13.05.20	Incubators	7	Drager		£113,003.06		Capital
COV19-00019	Equipment	11.05.20	13.05.20	Ultrasound Transducer Probes	5	Sonsite		£21,846.00	£2,000.00	Capital
COV19-00019	Equipment	11.05.20	13.05.20	Plasma Tawer	1	Labcold		£7,500.00		Capital
COV19-00019	Equipment	11.05.20	13.05.20	Hoists	1	Arjo		£32,235.41		Capital
COV19-00019	Equipment	11.05.20	13.05.20	Fetal Monitors	3	Huntleigh		£32,235.41		Capital
COV19-00019	IT	12.05.20	13.05.20	Interface Connection of GeneXpert to MOLIS LIMS	1	CGM Molis		£6,228.00		Capital
COV19-00019	Equipment	12.05.20	13.05.20	Blood Bank Fridge	1	Labcold		£8,837.00		Capital
COV19-00020	Equipment	12.05.20	13.05.20	Panda Resus Units	12	GE Healthcare		£158,793.60		Capital
				Total				**£795,691.48**		

Appendix 3

	£m
Halton Elective Centre	
Original	2.50
Ophthalmology	0.2
Endo Ventilation	0.6
Halton CMTC+ design works	0.1
From Other schemes	1.4
Theatre 4 Halton Vent	0.03
Main OPD Phelobotomy	0.072
Total	**4.90**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/05/51**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	27th 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):***	It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Since the last meeting: • Three new risks have been added to the BAF; • There have been no amendments to the ratings of any risks since the last meeting. • There have been no amendments to the descriptions of any risks on the BA. • No risks have been de-escalated from the BAF since the last meeting. Also included in the report are notable updates to existing risks.	

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

RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC 20/05/69
	Date of meeting	5th May 2020
	Summary of Outcome	The Committee reviewed, discussed and approved the amendments
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework and Strategic Risk Register report	AGENDA REF:	BM/20/05/27

1. BACKGROUND/CONTEXT

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

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

2. KEY ELEMENTS

2.1 New Risks

In response to the COVID-19 global pandemic, the Trust has established a specific COVID-19 risk register. The COVID-19 risk register includes all those risks related to the pandemic including those on (or proposed to the added to) the BAF and Corporate risk register.

At the Quality Assurance Committee on 5th May2020, a further three risks relating to the COVID-19 pandemic were added to the BAF:

Risk 1124

Risk Description:	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff	**Initial:**	25 (5x5)
		Current:	25 (5x5)
		Target:	8 (4x2)

Risk 1134

Risk Description:	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	**Initial:**	20 (4x5)
		Current:	20 (4x5)
		Target:	8 (4x2)

Risk 1126

Risk Description:	Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.	**Initial:**	**15 (5x3)**
		Current:	**15 (5x3)**
		Target:	**5 (5x1)**

Full details of these risks are provided in Appendix 1

2.2 Removal of Risks

Since the last meeting, no risks have been de-escalated from the BAF

2.3 Amendments to risk ratings

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

2.4 Amendments to risk titles

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

2.5 Existing Risks - Updates

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

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
1135	Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision.	• Daily Tactical/Recovery Meetings taking place • Removed Clinical Staff from Senior Manager on Call (SMOC) rota • Enhanced SMOC rota established • Recovery Structure established • Approval process established for all service changes during COVID-19 Pandemic • The Trust is following national guidance in relation to all constitutional standards • Operating Framework for Urgent & Planned services during COVID-19 received • Adherence to constitutional standards adversely affected due to pandemic.	No impact on risk rating
134	Risk: Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future	<u>Assurance updates</u> • Block contract approach for all trusts for months 1 - 4 with income matched to expenditure and similar anticipated for the whole year due to the impact of Covid19 with additional controls and constraints • Monthly FRG meeting to be re-established from June 2020 • Capital Loan – Provided draft revised programme to Cheshire &	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	Merseyside Health & Care Partnership which is supported by the Executive Team and will be presented to Finance & Sustainability Committee and Trust Board for approval <u>COVID-19</u> • Weekly update to Strategic Executive Oversight Group in relation to the impact of COVID-19 • Receiving Charitable donations that will support sustainability of Trust Charity <u>Gaps updates</u> • Non-recurrent CIP presents a risk to in-year and future year financial position. – CIP is currently paused for the first 4 months of the financial year as per national guidance	
224	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to trust reputation, financial impact and below expected Patient experience	• Capital funding approved for additional 18 beds within the clinical environment to be completed by end of March 2020 • 2020/21 Operational Plan requesting that Trust work towards reducing its occupancy level to below 92%. Business case being developed to support the plan. • Respiratory Ambulatory Care Facility agreed by CCG • Development of new combined assessment unit (plaza) progressed and forms part of capital planning • Improved ED Performance – April 2020 92.52%, May 2020 month to date 93.91% <u>COVID-19 related</u> • ED Business Continuity Plan evoked • Super Stranded patients reduced to c50 • Reduced occupancy levels in all inpatient wards • Reduction in ED attendances • Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients • ED performance continues to improve despite COVID-19 related pressures • ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised.	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• Staffing pressure created as a direct result of COVID-19 Global pandemic • Royal College Emergency Medicine Resetting ED Care guidance received and initial action plan produced.	

3 RECOMMENDATIONS

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

Board Assurance Framework

Board Assurance Framework

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

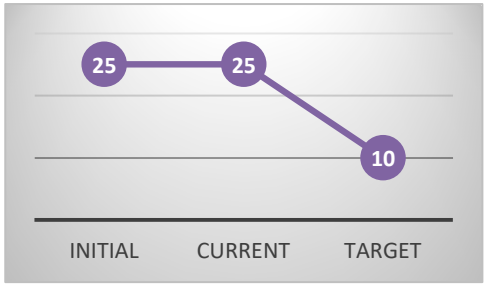
Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
1135	Chris Evans	Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision.	1	25 (5x5)	10 (5x2)	TBC	Quality Assurance Committee
1124	Kimberley Salmon-Jamieson	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff	2	25 (5x5)	8 (4x2)	TBC	Quality Assurance Committee
115	Kimberley Salmon-Jamieson	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	1	20 (5x4)	12 (4x3)	TBC	Trust Operations Board
134	Andrea McGee	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee
1134	Michelle Cloney	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee
1114	Phill James	Failure to provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, caused by increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, resulting in poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	1	16 (4x4)	8 (2x4)	TBC	Trust Operations Board
224	Chris Evans	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to the quality of care and patient	1	16 (4x4)	8 (4x2)	TBC	Trust Operations Board

Board Assurance Framework

		safety, risk to trust reputation, financial impact and below expected Patient experience.					
125	Chris Evans	Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	1	16 (4x4)	4 (4x1)	TBC	Trust Operations Board
145	Simon Constable	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	3	15 (5x3)	8 (4x2)	TBC	Trust Operations Board
1126	Chris Evans	Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.	1	15 (5x3)	5 (5x1)	TBC	Quality Assurance Committee
241	Alex Crowe	Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.	2	8 (4x2)	4 (4x1)	TBC	Trust Operations Board

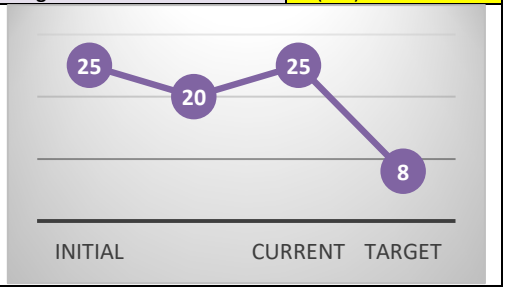
Strategic Objective 1: We will … always put our patients first through high quality, safe care and excellent patient experience.
Strategic Objective 2: We will … be the best place to work with a diverse, engaged workforce that is fit for the future.
Strategic Objective 3: We will … work in partnership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

Board Assurance Framework

Risk ID:	1135	**Executive Lead:**	Chris Evans	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision.			**Initial:**	25 (5x5)
				Current:	25 (5x5)
				Target:	10 (5x2)
Assurance Details:	• Daily Tactical/Recovery Meetings taking place • Daily Executive Strategic meeting • 4 x daily meeting with Senior Nursing Staff • Identified at risk staffing groups within each CBU • Sickness log maintained daily • ED and ITU removed from site rota • Removed Clinical Staff from Senior Manager on Call (SMOC) rota • Enhanced SMOC rota established • Created additional OOH rota • Set up of central staffing command centre • Fit testing training programme daily for all relevant staff • PPE training booklets now on all Wards • Enhanced Occupational Health service • Providing in house Mental Health service • Change of employee terms and conditions to allow more flexible working • Centralised Cheshire & Merseyside procurement in place led by the Trust's Director of Finance & CD • Regional mutual aid arrangements in place • Recovery Structure established • Approval process established for all service changes during COVID-19 Pandemic • The Trust is following national guidance in relation to all constitutional standards • Operating Framework for Urgent & Planned services during COVID-19 received				
Assurance Gaps:	• Staffing issues - staff sickness, staff self-isolating, staff at risk groups not permitted in clinical areas • Financial - unable to deliver financial position and increased threat of fraud • Operational issues - potential for insufficient levels of oxygen, shortage of PPE, limited capacity in the mortuary • Fit testing failure of some staff due to lack of appropriate PPE • Shortage of supply of certain pieces of PPE • Supply chain problem with PPE • Adherence to constitutional standards adversely affected due to pandemic.				

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

Board Assurance Framework

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

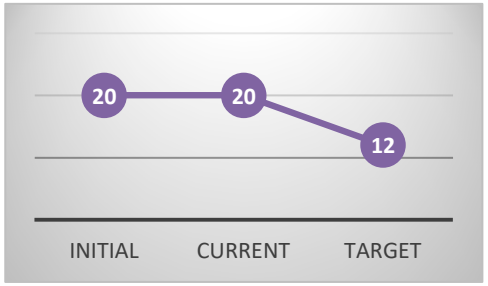
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Provide sufficient PPE for all staff.	PPE	Sourcing alternative suppliers, escalation into NSDR (National Supply Disruption Service), establish procurement networking, interhospital cel, looking at alternative PPE, etc	Wynn, Helen	13/04/2020	

Board Assurance Framework

Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	12 (4x3)

Assurance Details:

- Monthly workforce information produced via workforce dashboard. Information is reviewed and monitored at the Workforce Group Chaired by the Chief Nurse
- Robust staffing escalation process across WHH to manage staffing daily
- Lead Nurse identified daily to co-ordinate staffing
- 4 hourly update shared as part of Gold Command template
- Wards & Departments use E-Roster and Safecare data to support staffing ratios
- Maternity BirthRate + staffing review scheduled in March 2020 to reflect increase activity and changing models of care.
- Recruitment / media plan produced and recruitment campaign ongoing
- Following a successful recruitment day in January 2020 41 nurses accepted an offer of employment at WHH. We currently have a business case being developed for recruitment of international nurses which is due to be presented at the executive meeting in February.
- Staffing for the temporary winter ward managed via the daily staffing meeting
- We have just recruited 25 HCAs with another recruitment event the 24th April
- We have recruited 42 RNs with 50 in the system to start this year



Recruitment Assurances

- Rolling advert for B5 Nurses
- 12 month recruitment plan including open days, attendance at external events and 'keep in touch' events
- Developing WHH recruitment campaign with external marketing company
- Career advice events in local schools and colleges
- Production of monthly and bi-annual staffing reports received by the Trust Board

Retention Assurances

- Workforce Dashboard reporting monthly in relation to leavers
- Part of NHSI Cohort 4 Retention Collaborative
- WHH Nursing retention plan
- Improvement in nursing retention by 3.22% (Nov 2018 – Sept 2019)
- Burdett Nursing Trust award winners
- Highly commended for nursing retention data provision
- 'Transfer Window' implemented allowing staff to move to other specialties without having to apply for role

Assurance Gaps:

Increase staffing pressure due to ongoing use of temporary winter ward for which there is no funded establishment

Recruitment Gaps

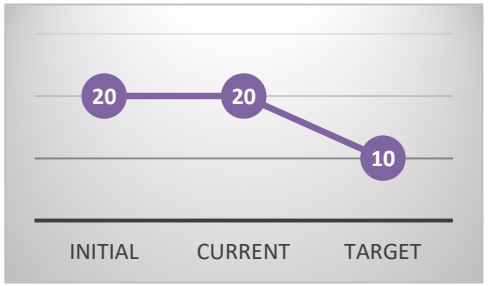
- 104 RN Vacancies
- 72 B5 Vacancies

Retention Gaps

- 17.06% B5 nursing turnover

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop business case for international nurse recruitment	Develop business case for international nurse recruitment	Present business case to Executive Team	Browning, Rachael	31/03/2020	

Board Assurance Framework

Risk ID:	134	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.			**Initial:** **Current:** **Target:**	20 (5x4) 20 (5x4) 10 (5x2)
Assurance Details:	•Core financial policies controls in place across the Trust •Revised governance structure within the Trust to enable strengthened accountability •Finance and Sustainability Committee (FSC) established overseeing financial planning •Regular financial monitoring with NHSI •Regular review at Executive team meeting and development sessions •Annual plan development process •Performance monitoring in QPS meeting •Block contract approach for all trusts for months 1 -4 with income matched to expenditure and similar anticipated for the whole year due to the impact of Covid19 with additional controls and constraints •Work with the Commissioners on QIPP and CIP schemes through the Collaborative and Sustainability Group to ensure the schemes have a positive impact on sustainability across the whole health economy •Monthly FRG meeting to be re-established from June 2020 •Corporate Trustee Charities Commission Checklist, reporting bi-annually through Board •Monitoring of charitable funds income, assessment of return on investment and controls on overhead ratios via quarterly financial reports •Regular updates to Executive Team, FSC and Trust Board - Financial Resources Group (FRG)that reports to FSC - Memorandum of understanding agreed with Bridgewater Community Trust • Workshop undertaken with - Exec, CBU, Corporate to review of 2020/21 cost pressures • Achieved 2019/20 Control Total subject to external audit of accounts • Capital Loan – Provided draft revised programme to Cheshire & Merseyside Health & Care Partnership which is supported by the Executive Team and will be presented to Finance & Sustainability Committee and Trust Board for approval <u>COVID-19</u> • Governance process in place to ensure all additional costs are being approved and monitored. • Reporting to NHSE/I • Regular attendance to regional and national conference calls • Attend Recovery Board to monitor financial impact of the changes relating to Covid19 Recovery plans – identifying revenue and capital expenditure • Review of latest guidance NHSE/I established block payments for the first 4 months of 2020/21 to ensure no impact of loss of elective activity • Accessed additional cash to pay outstanding creditors £16m paid in April 2020 • Circulate latest guidance from MIAA Fraud team • Ensure governance and processes in place including checks in place for all expenditure in particular procurement, contracts, payroll and HR. • Highlighted the different methods of fraud/ scam in operation to all staff and share it as widely through Trust • Weekly update to Strategic Executive Oversight Group in relation to the impact of COVID-19				

Board Assurance Framework

	• Receiving Charitable donations that will support sustainability of Trust Charity	
Assurance Gaps:	• Inability to develop a strategic plan to deliver a break even position over the next 5 to 10 years • Risk of under delivery of CIP due to impact of Covid19 and insufficient schemes identified to deliver the full program and the organisational ability to translate improvement work into financial improvement. • Non-recurrent CIP presents a risk to in-year and future year financial position. – CIP is currently paused for the first 4 months of the financial year as per national guidance • Failure to fully comply with emerging national employment litigation resulting in additional pay costs or the trust receiving potential claims. • Medical Staffing pressures identified at budget settings have not all been addressed putting pressure on the financial position. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Risk that capital needs exceed capital funding resources available. • Hospital Infrastructure Programme (HIP) announcement. WHH not included in with phase 1 or phase 2 funding allocation.. • Submitted 5 Year Plan on 2nd March, jointly with Warrington & Halton CCGs & Bridgewater Community Healthcare NHS FT with system gap of £26.5m <u>COVID-19</u> • Increased threat of fraud during COVID-19 global pandemic	

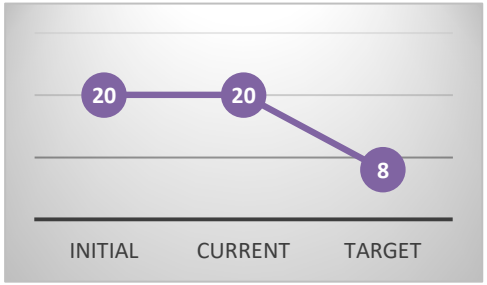
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Request Capital Loan	Loan application to be submitted for Business Critical Schemes	Submit capital loan request to NHSE/I	Andrea McGee	30/04/2020	Process has changed and new guidance has not yet been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

Board Assurance Framework

Risk ID:	1134	**Executive Lead:**	Cloney, Michelle	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain			**Initial:**	20 (4x5)
				Current:	20 (4x5)
				Target:	8 (4x2)

Assurance Details:

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



Board Assurance Framework

	• A plan is in place to support workforce recovery including health, wellbeing, leadership, teams, HR and resourcing. • All staff who are shielding are have individual reviews with line managers, supported by HR, to discuss impact on role and support to work from home. • Partnership working is in place with Cheshire Fire and Rescue to utilise their staff members available for redeployment.	
Assurance Gaps:	• Anti-body testing is currently unavailable nationally. • Central log for all sheilding staff. • Clarity around any local 'hot spots' of COVID-19 in teams due to redeployment not being logged via ESR. • Testing of asymptomatic staff – a pilot is underway	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Review of terms and conditions within contracts and policies to enable flexible working and enable staff to return from retirement.	Review of Terms and Conditions	Review terms and conditions of policies and staff contracts.	Smith, Deborah	30/04/2020	30/04/2020
Deploy workforce according to CBU / Department business continuity planning and recovery planning	Workforce planning to be included as part of service recovery planning	Workforce capacity plans to be developed and deployed at specialty / CBU level	Moore, Dan		
Line of sight on shielding staff is required to understand operational impact and ensure support is in place.	Create a central log of all shielding staff and the outcome up 1:1 discussions	HR Team to contact all managers to support conversations and hold central log	Smith, Deborah	30/06/2020	
Clarity needed around any local 'hot spots' of COVID-19 in teams due to redeployment not being logged via ESR.	Multi-disciplinary review	Infection Prevention and Control, Microbiology, HR and OH Teams to review available data and propose next steps	Mckay, Lesley	31/05/2020	
A deicsion is needed around the testing of asymptomatic staff	Pilot the testing of asymptomatic staff	Pilot due to complete 15/05/2020. Outcome to be reviewed and recommendation to Tactical Meeting on 20/05/2020.	Smith, Deborah	20/05/2020	

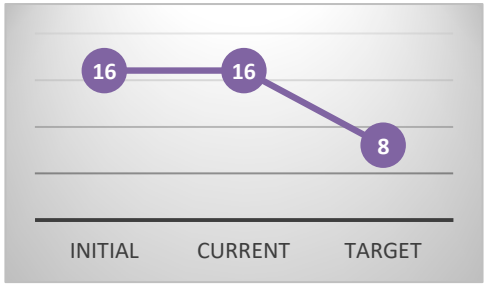
Board Assurance Framework

Risk ID:	1114	**Executive Lead:**	James, Phill	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	FAILURE TO provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, CAUSED BY increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber attack, RESULTING IN poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statatory obligations (e.g. Civil Contigency measures) and subsequent reputational damage.			**Initial:** **Current:** **Target:**	16 (4x4) 16 (4x4) 8 (2x4)

Assurance Details:

Assurance:

- **Digital Governance Structure** including weekly structured Senior Leadership Team meetings, Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Data Standards Group reporting to the Information Governance and Corporate Records Sub-Committee with escalations to the Quality Assurance Committee and onwards to the Digital Board, which itself submits highlights to the Trust Operations Board. The **Quality Assurance Committee report provides** assurance against all key security measures (i.e. Risks / GDPR / Data Security & Protection Toolkit / Cyber Essentials Plus).
- **Digital annual IT audit** plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with progress monitored at the Trust Audit Committee.
- **Trust benchmarking** activities including Use of Resources reviews (Model Hospital).
- Considered NHS Digitals Secure Boundary for the Internet connection.



Controls:

- **Digital Operations Governance** including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard.
- Active membership of the **Sustainability Transformation Partnership Cyber Group.**
- **Digital Change Management** regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions.
- **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training.
- **Cyber Training** for the Trust Board

Assurance Gaps:

Gaps In Assurance:

- Annual external penetration testing out of date (27/03/20). Due to Covid-19 pandemic the CIO confirms to delay testing until autumn, this is inline with other Trusts in the C&M Region. No significant changes top our infrastructure has been made since the last test, e.g. change of firewall. The DSPT will be updated with this decision.

Gaps In Controls:

- Approval of a **7 Year Capital Profiling** based upon asset replacement cycle and strategic roadmap (to deliver the approved Digital Strategy (January 2020)) plus the approval of the subsequent **Annual Prioritised Capital Investment Plan** as managed via the Trust Capital Management Committee.
- **Implementation of an effective workforce plan** via an approved structure investment business case that delivers fit for purpose levels of skills, resilience and capacity.
- **Implementation and normalising of cyber measures** for contributing to the mandated levels of compliance with DSPT, GDPR and Cyber Essentials Plus and the EU NIS directive.
- **Normalising of staff behaviours** to protect data evidenced via reduced IG incident report levels.
- **Top down approach to cyber leadership** via evidence of completion of accredited Board Level National Cyber Security training coupled with annual mandatory Data Security Training.
- Ability to mitigate cyber confiuration of **nationally provided systems** (e.g. ESR) and **non-Microsoft devices** (that meet a clinical need).

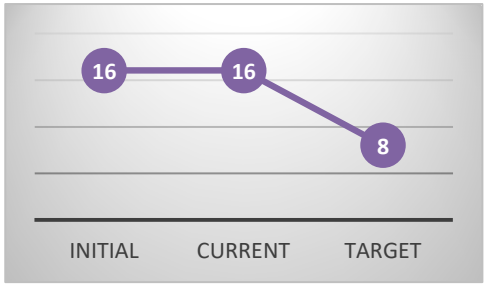
Board Assurance Framework

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Prioritise the immediate focus upon the overarching enablers of structure and capital resources. [Delivers: Optimisation / Timeliness / Best Practice]	By resolving the structure and capital investment gaps the range of gaps of assurance can be addressed.	• Conclude structure business case process. • Conclude pursuit of an approved fit for purpose annual capital plan. • Conclude Board Level Cyber training and flow new and robust awareness measures to all personnel.	Phill James	29/05/2020	
Draft Digital Strategy to be completed, approved and issued and multi-year investment profile to be supported by the Trust. [Delivers: Optimisation / Timeliness / Best Practice]	Publish revised Digital Strategy with associated 7 year investment profile and delivery plan.	• Publish approved Strategy. • Sign off agreed multi-year investment profile.	Phill James	29/05/2020	
Act on recommendations made in the Cyber essentials report to ensure improved cyber security. [Delivers: Best Practice]	Implement the recommendations made in the Cyber essentials report and DSPT to ensure improved cyber security. *NHS Digital have commented they are looking at whether to continue with Cyber Essentials+ revision (relies upon NHS Digital negotiations).*	• Enhanced Firewall controls on Trust network • Fully documented Firewall infrastructure (31/10/20 - Phil Smith) • • Enforced 90 Day System Password refresh (30/11/20 - Joe Garnett) • • Regular vulnerability scans of internal network via IT Health Assurance Dashboard (30/04/20 - Stephen Deacon) (COMPLETE)	Deacon, Stephen	31/11/2020	
Move medical devices into VLAN bubble. This will involve participation of multiple 3rd parties and internal WHH staff. [Delivers: Best Practice]	Add medical devices to the Medical VLAN bubble	• Network Manager create pre-work on the VLAN protective bubble • Network Manager to liaise with PACS Manager to arrange 3rd party support for migration over to VLAN	Deacon, Stephen	30/09/2020	
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust.	Migrate all 2003 and 2008 servers to 2016.	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to Windows Server 2016 • Extend Support for 2008 [52% migrated – March 2020]	Deacon, Stephen	29/05/2020	

Board Assurance Framework

We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system). [Delivers: Best Practice]					
To upgrade all windows 7 to Windows 10 before end of March 2020 [Delivers: Best Practice]	To upgrade all windows 7 to Windows 10 before end of March 2020	• Deployment and Desktop Team to go out and reimage the devices around the Trust. *[99% migrated – March 2020]*	Deacon, Stephen	29/05/2020	
As part of Cyber Essentials+ all unsupported software should be updated or isolated from internet based networks. Office 2010 will need upgrading to the latest version of Office for all endpoint devices on the WHHT network. [Delivers: Best Practice]	Migrate from Office 2010	• Secure funding nationally via NHSD (if available) or secure local funding via Capital to purchase the required licensing. • Migrate to the latest version of MS Office [£1.7 million investment currently identified within Trust capital plan for 20/21]	Deacon, Stephen	30/06/2020	
Deliver fit for purpose Lorenzo EPR Performance and agility of changes to deliver the paperless strategy. [Delivers: Optimisation / Timeliness]	Work with supplier to assure EPR performance whilst enhancing Digital capability (people and finance).	• Work with EPR supplier to safely migrate Lorenzo to the modern cloud solution. • Implement staffing structure enhancements within financial opportunities (i.e. capitalisation of roles).	Gardner, Matthew	30/06/2020	
To promote the risks of phishing, NHS digital will perform simulated phishing campaign targeted at the users of the Trust. The information will be collated and discussed at the Information Governance and Corporate Records Sub-committee	Perform simulated phishing campaign	NHS Digital to perform the simulated phishing campaign and report back to the Trust of the results.	Deacon, Stephen	30/06/2020	

Board Assurance Framework

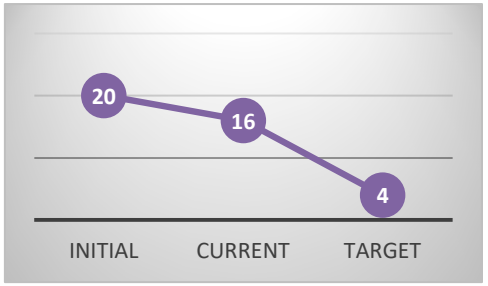
Risk ID:	224	**Executive Lead:**	Evans, Chris	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to trust reputation, financial impact and below expected Patient experience.			**Initial:**	16 (4x4)
				Current:	16 (4x4)
				Target:	8 (4x2)
Assurance Details:	Regular Trust Wide Capacity meetingsled by the Senior Site Manager for the day Systemwide relationships including social care, community, mental health and CCGs Discharge Lounge/Patient Flow Team Red to Green - Discharge Planning ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing Controller Chloe Care Transport to complement patient providers out of hours FAU/Hub operational from June 2018 - Now operating 5 days per week. Discharge Lounge opened 26th November 2018 Full ED business case approved from Q4 18/19 re: vision for ED Footprint creating assessment capacity. (approved substantively for Ambulatory Care Unit) System actions agreed supporting the Winter Plan Warrington Together Board have asked for focussed work to take forward outputs from the Venn Work 1. Further development of Rapid Response to avoid admission 2. Increase IMC 3. Increase IMC at home Regular monitored at the Mid Mersey A&E Board Long Length of Stay Collaborative in association with ECIST / NHSI. Bespoke approach for the Trust in embedding and sustaining LLoS review. To commence May 19 through until October 19. Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. Co-location of teams approved in April 19. This will support harmonisation of pathways and increase integrated working between health and social care. Co-location of teams to take place in June 2019 (Kendrick Wing) Urgent Care Improvement Committee to commence form May/June 2019 focussing on 5 priorities: 1. CQC Actions 2. Acute Medicine 3. Assessment Capacity/Environment 4. Decision to admit 5. Collective decision making The Committee will report to the Quality Assurance Committee and Exec Team New ED 'at a glance' dashboard gone live – supports organisational visibility and proactive response from specialties. Participated as a pilot site for recording of Same Day Emergency Care (SDEC) in association with NHSi & NHSE Urgent Care Improvement Committee High Level Briefing received at Quality Assurance Committee. Pilot of a co-located medical and surgical assessment unit taking place between 3 Sept – 10 Sept 2019. A review will then take place to inform the long term strategy for an Assessment Plaza. Co-located medical & surgical assessment unit to launch on 1st Dec 2019. Subject to consultation Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput – reports monitored via Patient Flow Sub-Committee and Trust Operations Board 8 IMC live from 27th September 2019 Integrated discharge Team now in place Urgent Care Improvement Committee – 2 regulatory breach complete and 33/35 actions complete. The Remaining action to be				

Board Assurance Framework

	completed by 31st December 2019 CAU Business Case approved by Executives on 31st October 2019 with a plan to implement from 9th December 2019 Winter plan developed with system support 10 additional beds on B3 supported by NHSE/I Funding received for K25 beds and to support protecting GPAU / CAU Combined Assessment Unit launched 16th December 2019 – 24/7 from 5th January 2020 U&EC Improvement Committee stepped down. All actions complete with 9 ongoing issues monitored at Moving to Outstanding Capital funding approved for additional 18 beds within the clinical environment to be completed by end of March 2020 2020/21 Operational Plan requesting that Trust work towards reducing its occupancy level to below 92%. Business case being developed to support the plan. The Trust's ambition to reduce super stranded by 40% is on track to be delivered by the end of March 2020 Respiratory Ambulatory Care Facility agreed by CCG Development of new combined assessment unit (plaza) progressed and forms part of capital planning Improved ED Performance – April 2020 92.52%, May 2020 month to date 93.91% <u>COVID-19 related Assurances</u> ED Business Continuity Plan evoked Super Stranded patients reduced to c50 Reduced occupancy levels in all inpatient wards Reduction in ED attendances Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients ED performance continues to improve despite COVID-19 related pressures ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised. Royal College Emergency Medicine Resetting ED Care guidance received and initial action plan produced.	
Assurance Gaps:	Fully embedding actions associated with system wide capacity & demand review undertaken by Venn Consulting – 3 key actions being progressed for Winter 2019 – 8 IMC Beds agreed via IBCF, Rapid Response Service and increased home reablement capacity (c 20 beds worth of capacity total) ED footprint with a view of right sizing for the future based on demand trends – review taking place in Sept 19 Staffing pressure created as a direct result of COVID-19 Global pandemic.	

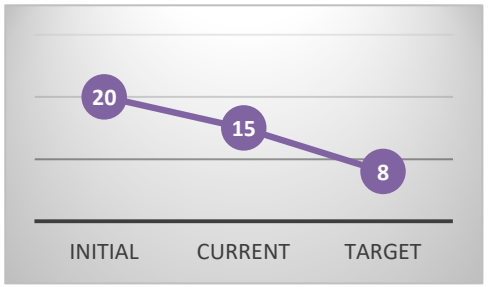
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Produce Action Plan for compliance against Royal College Emergency Medicine Resetting ED Care guidance	Undertake gap analysis and develop action plan	Complete Action plan	Chris Evans / Dan Moore	30/06/2020	
Finalise Assessment Plaza plan	Produce Estates plan for specifically designed plaza/assessment unit	Complete plan	Dan Moore	30/06/2020	

Board Assurance Framework

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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop and monitor action plan to address compliance	Action plan to address non compliance issues highlighted in report (Nov 2019)	Develop and monitor action plan to address compliance	Wardley, Darren	31/07/2020	

Board Assurance Framework

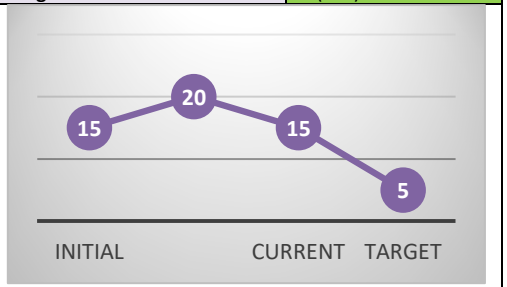
Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.			**Initial:** **Current:** **Target:**	20 (5x4) 15 (5x3) 8 (4x2)
Assurance Details:	The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. We are developing plans, with partners, to establish Accountable Care Organisations in both Halton and Warrington. We have developed an engagement strategy in partnership with our Governing Council We have established a community-wide newsletter Your Hospitals No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the STP. The Trust has developed effective clinical networking and integrated partnership arrangements: The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. 'What Matters to Me' conversation cafes held across both sites in partnership with patient experience committee and governors. Will also include WHH volunteers, WHH careers and WHH charity - Memorandum of Understanding and work plan with Bridgewater Community Healthcare NHS FT approved. - Working in partnership with GP Federation in Halton on relation to improving joint clinical pathways. - Council and CCG in both Warrington & Halton supportive of development of new hospitals. - Agreement of sustainability contract with Warrington CCG and subsequently Warringotn & HaltonSystem Finacial Recovery Plan - Work plan agreed with StHK - Shared a presentation demonstrating Halton Hospital's suitability to host the Eastern Sector Cancer Hub with Clatterbridge and other stakeholders. This forms part of the formal decision making process on the location of the hub - Regular GP engagement events held. - Regular Strategy updates are provided to the Council of Governors. - Clinical strategy engagement held with Trust Board - Submitted bid to provide UTCs in Runcorn & Widnes - Financial feasibility assessment for Halton Healthy New Town completed following unsuccessful bid to NHSE - Clinical Strategy approved by Trust Board - CBU specialty level strategies complete and incorporated in business plans - Successful in One Public Estate revenue funding bid for Halton - Initial talks held with Elective Care STP Lead in relation to the suitability of Halton as a potential Elective Care Hub Trust has met with Cheshire & Merseyside leads for Women's and Children's review to demonstrate strength of local Women's and Children's services and help inform outcomes of regional review. NHSE and local Commissioners supportive of draft strategy for breast screening. First Group Committee in Common held with BCH and Joint Sustainability plan developed. Revised process for evaluation of potential sites for the Eastern Sector Cancer Hub shared with the Trust, StHK, Clatterbridge and NHSE by Knowsley CCG. Submission due 24th July 2019. Decision expected January/February 2020.				

Board Assurance Framework

	UTC Procurement process abandoned Initial meeting for Cheshire & Merseyside respiratory review held. Trust presentation well received. No funding received in latest capital allocation. Additional £1b capital promised but allocation criteria yet tbc. DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. 27 Trusts have received funding with a further 13 TBC. The Trust has written to NHSP to seek support in raising the profile of our needs – NHSP have agreed to use the Trust as a case study in their national campaign Positive meeting the Medical Director and Director of Strategy at Alderhey confirming their intention to work with the Trust to repatriate WHH patients Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside. Currently options for further development do not include any option where WHH is a hub. All options proposed include an Essential Services Lab (ESL) at WHH. Currently providing detailed feedback on strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESL Pathology OBC received by the Trust Board and feedback provided has been included in the re-issued draft Pathology OBC supported by the Trust Board Eastern Sector Cancer Hub – Letter received providing feedback following submission. Letter has been sent from the Trust to the Lead for the Eastern Sector Cancer Hub process requesting details of the public consultation and formal procurement process as well as requests for further information in relation to our submission and the scoring under the evaluation process. Response received from Eastern Sector Cancer Hub SRO – Further clarification requested. Lead CCG Awaiting results from the NHSE stage 2 assurance process. Consultation now unlikely to take place before January 2020 at the earliest. A Decision is therefore not anticipated until mid 2020 Second Board to Board meeting held with Bridgewater with positive discussion on our shared intention to more formally collaborate. Confirmation received that there will be a new single lot open tender process to commence to determine the provider for both Runcorn and Widnes UTCs. Intention for the contract to commence 1 April 2020. Confirmation received from the CCG that the procurement process re: UTC is no longer being pursued. Requirement to deliver the UTC specification at Runcorn by January 2020 Detailed BCH/WHH Collaboration plan developed and received at the Joint Executive Meeting Funding being secured via Halton Borough Council and Liverpool City Region Town Centre Fund to potentially provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. Annual strategy refresh commenced with dedicated sessions for Execs, NEDs and members of the Strategic Development & Delivery Sub-Committee to influence revisions to objectives ahead of 2020/21 Director of Strategy invited to be a member and the health representative on Runcorn Town Deal Board tasked with planning for the investment of £25m to regenerate Runcorn Old Town Ability to influence Warrington Town Deal Board through health group WHH CEO met with the CEOs of Alderhey, StHK and Liverpool Heart & Chest to support further partnership working	
Assurance Gaps:	Organisational sovereignty and the need for individual Trusts, CCGs and others to meet performance targets at an organisational level have the potential to slow or block progress. Limitations of the size of the catchment area. Risk to Women's and Children's future provision due to Cheshire & Merseyside led review. Risk that the Trust will not secure the provision of the Eastern Sector Cancer Hub on site at Halton	

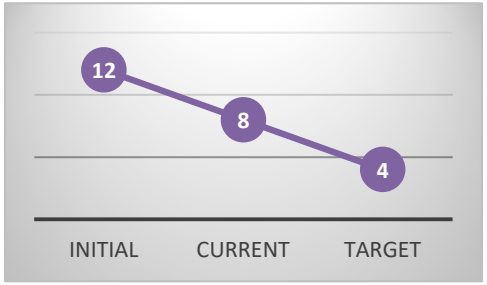
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Strengthen Women's & Children's Services	Establish Programme of Development	Develop & Complete Action Plan	Salmon-Jamieson, Kimberley	31/03/2020	

Board Assurance Framework

Risk ID:	1126	**Executive Lead:**	Evans, Chris	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.			**Initial:**	15 (5x3)
				Current:	15 (5x3)
				Target:	5 (5x1)
Assurance Details:	Estates to manage evaporators and VIE supplies. Estates to regularly monitor site consumption and pressure. It has been agreed by Command that clinical staff will complete a return with the amount of oxygen in use on each Ward. ICU and Theatres will complete a separate return. This will be sent out by the Incident Management Team. Estates will monitor oxygen usage via the BOC website and provide daily updates at the Tactical Meeting. Maximum capacity of 3,000l/min but maximum2,400 l/m safe flow to be maintained to allow for unexpected surge in demand to provide a wider safety marginf to deplpoy oxtgen concentrators id necessary Re-commissioned CPAP devices available Receipt of Oxygen Concentrators Oxygen Concentrators to be deployed when the oxygen capacity for the site pipeline system reaches 2400 litres per minute so that the maximum flow rate is not exceeded and patients can be supported with the concentrators to keep them off the main system and maintain the supplies to the ventilated patients.				
Assurance Gaps:	Maximum flow rate of 3,000l/min				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
To order oxygen concentrators.	Order Equipment	To order oxygen concentrator machines.	Wardley, Darren	31/08/2020	
Estates to receive a return from clinical staff daily and to monitor oxygen usage via the BOC website.	Monitoring	Collate data from return forms and monitor oxygen usage via the BOC website.	Wardley, Darren	31/07/2020	
Provide daily updates on the usage of oxygen.	Communication	Estates to attend the Tactical Meeting each day to provide updates on oxygen usage.	Wardley, Darren	31/07/2020	

Board Assurance Framework

Risk ID:	241	**Executive Lead:**	Crowe, Alex	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.			**Initial:**	12 (4x3)
				Current:	8 (4x2)
				Target:	4 (4x1)
Assurance Details:	Regular monthly meetings taking place with HENW involving The Deanery. An agreed action plan has commenced and is progressing. Regular weekly journal/ educational meetings on Mondays co-ordinated by a clinical fellow. Trust Locum Consultants have been approved as educational supervisors and are providing educational supervision to the ST3s in geriatric medicine. Appointment of a Chief Registrar; popular interest by doctors for future Chief Registrar appointments. Recruited to Medical Utilisation Manager Role. Trust wide work stream for rota management. An E-Rostering Bid has been made to NHSi Working on getting more bank doctors, rather than agency. Establishment of Medical Trainees Experience Improvement Group. Senior management presence at Medical handover to review any safety issues, escalated to Trust Wide Safety Brief. Weekly Medical Educational Huddle. Business Case currently being developed to support the recruitment of substantive consultant physicians. Clinic attendance for trainees to ensure they can be released from wards to attend – record log in place and escalation process if not occurring. Subsequent plans to improve training available clinics. 3 substantive consultant appointments in Acute Medicine, 1 consultant in Care of the Elderly who is also Clinical Director for Integrated Medical and Social Care CBU. Ward Round Accreditation quality improvement work stream. Access for trainees to Quality Academy and Quality Improvement work streams. Monthly Medical Education newsletter From August 2019, the Trust will have 3 additional International Training Fellows in Acute, Gastroenterology and Rheumatology. Completed HEENW Action Plan returned to HEENW GMC National Training Survey results received in July 2019, noting 6 Category 1 (minor) risks, no patient safety issues resulting in an overall Trust risk score of Category 1. This is a significant improvement compared to 2018, when the Trust was scored as Category 2. Key areas to note: Decreases in category 1 and 2 risks; significant improvement in GMC training feedback scoring; there is an action plan in place to resolve any concerns. Currently awaiting feedback in relation to enhanced monitoring. Enhanced monitoring position to be reviewed in Q4 2019/20 when HEE visit Medicine Additional FY lead recruited Increased recruitment of Physician Associates to facilitate better training experience for trainees Appointment of DME and deputy DME Established Junior Doctors forum with improving engagement Development of Medical Education Quality Committee Away Day for the Medical Education Faculty Ongoing annual Educator awards to acknowledge teaching contributions from trainees as well as substantive medical staff Educator of the month awards Review of appraisal process for educational supervisors underway Review of specialty action plans following 2019 survey results Development of project to improve FY experience and training				
Assurance Gaps:	Recruitment of substantive consultant physicians ongoing				

Board Assurance Framework

	Review of Digital Strategy on going Review of appraisal process for educational supervisors underway Review of specialty action plans following 2019 survey results Development of project to improve FY experience and training

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Identify lead to create a biweekly newsletter for trainees to provide vehicle for educational supervisors to deliver updates and good news.	improving experience for trainees	medical education business manager to co-ordinate across the Trust for all trainees	Coakley, Alison	30/03/2020	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/05/52**	
SUBJECT:	**Covid-19 IPC Board Assurance Framework**	
DATE OF MEETING:	27 May 2020	
AUTHOR(S):	Lesley McKay, Associate Chief Nurse Infection Prevention + Control	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1135 Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision. #1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #134 Financial Sustainability a) Failure to sustain financial viability, #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #224 Failure to meet the emergency access standard. #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. #145 a. Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	To provide the Board of Directors with assurance on actions in place to meet legislative requiremennts relating to the prevention and control of infection linked directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.	

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

RECOMMENDATION:	The Board of Directors are asked to note the report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Covid-19 IPC Board Assurance Framework	AGENDA REF:	BM/20/05/52

1. BACKGROUND/CONTEXT

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

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

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

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

This Assurance Framework will be reviewed monthly and an Action Plan developed to address areas of concern identified.

2. KEY ELEMENTS

Infection Prevention and Control Board Assurance Framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	• Electronic infection risk assessment tool in Lorenzo • Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab (to date 738 alerts added)	• Audit completion of Risk Assessments	• Request made to IT to update list of notifiable disease to include Covid-19 (15/05/20) – will be live on 21/05/20 
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status		
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• Discharge screening is in place prior to transfer to care homes		
• patients and staff are protected with PPE, as per the PHE national guidance	• PPE guidance included in the Covid 19 Policy and is line with PHE national Guidance. PPE champions support staff education		
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7). TWSB and Covid	• Further updates to the policy required	

• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework (BAF) where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	daily Bulletin used to communicate updates • Covid-19 Tactical Group Meetings in place and clear escalation route to Trust Board of risks and actions in place • A Covid-19 specific Risk Register has been created with risks escalated to the corporate Risk Register and BAF. 1 risk on the BAF linked to national shortage of PPE • Existing IPC policies in place. Isolation for other infections and pathogens is prioritised based on transmission route	• The C. difficile Cohort ward has been temporarily stepped down and is under review with recovery plans	• SOP is in place and all patients with a C. difficile toxin positive result are isolated
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• SOP for patient placement (agreed ward and critical care locations). Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status Respiratory Step Down Unit SOP		

• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance • increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance • linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken • single use items are used where possible and according to Single Use Policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	• Task Team and Domestic Assistant training for Covid-19 cohort ward areas has been carried out. Fit Testing for FFP3 masks undertaken for Domestic Assistants in areas where aerosol generating procedures are performed • Terminal cleaning and Decontamination polices in place. Decontamination included in the Covid-19 policy • Cleaning of frequently touched surfaces is included in cleaning policies • Process for managing linen is included in the COVID-19 policy. All linen is treated as infectious and placed in alginate bags • Decontamination Policy in place which includes single use/single patient use guidance • Decontamination Policy in place	• Cleaning audits have been halted for the initial stages of the pandemic • Occasional reporting of alginate bag shortage	• Cleaning audits being re-instated • Guidance received from the Laundry Contractor to double bag used linen in white bags

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting of HCAIs has continued. Data on HCAIs is included on the Quality Dashboard. The DIPC reports HCAI data at Trust Board • Antibiotic prescribing guidelines for COVID suspected patients have been published	• Reduction in antibiotic ward round activity	• Virtual Ward Round Critical Care. Ward based Pharmacist support • Prescribing advice available by telephone (in and out of hours) • Recovery plan for re-establishing ward rounds • Review as evidence/guidelines are updated
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with	• Restricted visiting implemented 17 March 2020; Visiting suspended from 26 March 2020; Compassionate visiting arrangements agreed 09 April 2020 • Coronavirus posters displayed outside areas where patients with suspected or confirmed COVID-19 are cared for		

appropriate signage and have restricted access • information and guidance on COVID-19 is available on all Trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• Information on COVID-19 is available on the Trust Web Site • Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab (to date 738 alerts added) • Covid-19 has been added to e-discharge summary template	• Confusion on the layout of the template	• Changes made to the standard template to clarify results
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection • patients with suspected COVID-19 are tested promptly • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	• Triage in ED and segregated areas for patient suspected to have COVID-19 • Admission screening has been updated in line with national guidance and currently includes all admissions • Repeat patient testing in place where there are on-going concerns about COVID-19 and initial swab was negative		

• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Rapid testing available 7 days/week • Routine appointments have been stepped down. Social distancing measures are in place in Outpatient Departments		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• PPE Champions, roving training on donning and doffing of PPE. Links to PHE videos have been distributed. Individual booklets on COVID-19 and PPE produced and distributed		
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• Links to PHE videos have been distributed. Posters are displayed in clinical areas on donning and doffing		
• a record of staff training is maintained	• Record of training requested	• Follow up of staff training records required	• Request for updated information from CBUs
• appropriate arrangements are in place that any reuse of PPE in line	• Reusable (laundered gowns) introduced as part of contingency		

with the CAS alert is properly monitored and managed • any incidents relating to the re-use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited • staff regularly undertake hand hygiene and observe standard infection control precautions • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	plan • To date 19 incidents reported relating to PPE • Observational audits completed and feedback received from PPE Champions. Electronic Audit Tool developed and launched 15/05/20 • Programme of hand hygiene audits in place • Guidance on home laundering is included in the COVID-19 PPE information leaflets • Staff shielding and screening for COVID-19 is undertaken in line with national guidance. Monitored by the Workforce and Organisational Development Team		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with suspected or	• SOP for patient placement. Patients	• Cohorting in place due	

confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	are assessed for location of care according to Clinical Frailty Score and WHO Performance Status • Additional work undertaken to provide hand washing facilities in anterooms on ward A7 • Isolation Policy in place • Elective surgery/Endoscopy including pre-operative assessment SOPs including (advice on self –isolation and Covid testing before surgery). Staff temperature/ symptoms screening in elective care areas to minimise transmission • Provision of seating with social distancing in out-patient areas and availability of face masks for patients In addition to staff	to limited number of single rooms for isolation • Limited number of side rooms further reduced by ward closures	• Isolation priority protocol in place based on transmission based precautions
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals	• Training on swabbing technique provided verbally and by video		

• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance • screening for other potential infections takes place	• Updates to guidance provided in light of swab availability changes to national guidance • Other routine admission screening (CPE,MRSA,VRE) in place		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	• PPE Champions in place. On-call service (and 7 day service) for IPC in place. Programme on clinical advice for management of patients with suspected infections continued		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7). TWSB and Covid daily Bulletin used to communicate updates		
• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• Guidance included in Covid-19 Policy. Early guidance adhered to when initial classification of a HCID. Waste was quarantined and disposed of by incineration		
• PPE stock is appropriately stored	• Stock control in place. In and out of		

and accessible to staff who require it	Hours access protocol in place		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• An integrated risk assessment has been produced for staff who are 'extremely vulnerable', at 'increased risk', pregnant and BAME staff • Individual letters have been sent to BAME members of staff, outlining support available • Named midwife contact within Maternity Department provided for pregnant staff • All staff requiring shielding are supported by robust workforce support and the Trust are in the process of having one to one discussions to agree support and adjustments • All staff working at home have been provided with a 'working from home pack', including access to mental health support		

• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • staff that test positive have adequate information and support to aid their recovery and return to work	• Fit testing programme, including quantitative and qualitative testing, in place. Records are added to a central database • Managers have been supported to record absence in 'real time'. Daily and weekly absence reporting is in place • A COVID-19 nursing advice line has been created, to provide a range of advice and guidance to the workforce • An OH call centre has been created, which enables all calls to be answered and triaged by a team of administrators • The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff) • Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical • Occupational Health and Wellbeing advise staff of test results and provide further wellbeing support as and		

	when required • Retesting is in place as appropriate and is set out in Staff Testing SOP		

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Develop an action plan to address gaps in assurance and monitor until completion.

4. IMPACT ON QPS?

Q: Visiting restrictions due to risk of infection may have a negative impact on patient experience. A number of communication mechanisms have been implemented.

P: Risk to staff health and wellbeing from anxiety associated with the unknown situation and risk of infection of self and family members. A number of staff are absent from work due to 'shielding' requirements.

S: Financial impact of a global pandemic and major interruption to business as usual.

5. MEASUREMENTS/EVALUATIONS

Incident reporting

Action plan monitoring

6. TRAJECTORIES/OBJECTIVES AGREED

To ensure compliance with the

7. MONITORING/REPORTING ROUTES

Infection Control Sub-Committee

Trust Board

8. TIMELINES

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

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

10. RECOMMENDATIONS

The Board of Directors are asked to note the report.

Publications approval reference: 001559

Infection prevention and control board assurance framework

4 May 2020, Version 1

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are

treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated appropriately.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission • compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients • patients and staff are protected with PPE, as per the PHE national guidance • national IPC PHE guidance is regularly checked for updates and any changes are			

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effectively communicated to staff in a timely way • changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens			
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • teams with appropriate training care for and treat patients in COVID-19 isolation or cohort areas • designated cleaning teams with appropriate training in required techniques and use			

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of PPE, are assigned to COVID-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance • increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance • linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken • single use items are used where possible and according to Single Use Policy • reusable equipment is appropriately decontaminated in line with local and PHE national policy			

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3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight			
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and			

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where appropriate with restricted access • information and guidance on COVID-19 is available on all Trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved			
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection • patients with suspected COVID-19 are tested promptly			

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• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately			
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it			

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• a record of staff training is maintained • appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed • any incidents relating to the re-use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited • staff regularly undertake hand hygiene and observe standard infection control precautions • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of their			

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household display any of the symptoms.			
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement			
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

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There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance • screening for other potential infections takes place			
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or suspected			

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COVID-19 cases is handled, stored and managed in accordance with current PHE national guidance • PPE stock is appropriately stored and accessible to staff who require it			
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing			

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• staff that test positive have adequate information and support to aid their recovery and return to work.			

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Trust Board

DATES 2019-2021

All meetings to be held in the Trust Conference Room

Date of Meeting	Agenda Settings	Deadline For Receipt of Papers	Papers Due Out
2019			
Wednesday 27 November	Thursday 7 Nov (EXECS)	Monday 18 November	**Wednesday 20 November**
2020			
Wednesday 29 January	Thursday 9 January (EXECS)	Monday 20 January	**Wednesday 22 January**
Wednesday 25 March	Thursday 5 March (EXECS)	Monday 16 March	**Wednesday 18 March**
Wednesday 27 May	Thursday 7 May (EXECS)	Monday 18 May	**Wednesday 20 May**
Wednesday 29 July	Thursday 9 July (EXECS)	Monday 20 July	**Wednesday 22 July**
Wednesday 30 September	Thursday 10 September (EXECS)	Monday 21 September	**Wednesday 23 September**
Wednesday 25 November	Thursday 5 November (EXECS)	Monday 16 November	**Wednesday 18 November**
2021			
Wednesday 27 January	Thursday 7 January (EXECS)	Monday 18 January	**Wednesday 20 January**
Wednesday 31 March	Thursday 10 March (EXECS)	Monday 22 March	**Wednesday 24 March**