Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

27 January 2021

together we will

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NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Meeting of the Board of Directors
12.30pm - Wednesday 27 January 2021
via Microsoft Teams

AGENDA

Item	Item Description	Presenter	Verbal or Paper	Page Number
20/21-214	**Apologies for Absence**	Chair	Verbal	N/A
20/21-215	**Declaration of Interests**	Chair	Verbal	N/A
20/21-216	**Patient Story**	Chief Nurse	Video	N/A
20/21-217	**Minutes** of Previous Meeting – 2 December 2020	Chair	Paper	1
20/21-218	**Board Action Log**	Interim Director of Corporate Affairs	Paper	11
20/21-219	**Chair's Business**	Chair	Verbal	N/A
20/21-220	**Key Strategic Issues**	Chair	Verbal	N/A
20/21-221	**Chief Executive's Report**	Chief Executive	Paper	13
Performance & Improvement				
20/21-222	**Quality and Performance Dashboards & Exception Reports**	Chief Operating Officer, Medical Director, Director of Workforce & OD and Chief Nurse	Paper	17
20/21-223	**Financial Report including CIP**	Chief Finance Officer	Paper to Follow	26
Governance				
20/21-224	**Infection Prevention Update and Assurance, including IPC BAF V1.4**	Chief Nurse	Paper	41
20/21-225	**Mortality Report** *Mike Ellard, Deputy Medical Director to attend*	Medical Director	Presentation	90
20/21-226	**Monthly Safe Staffing Report**	Chief Nurse	Paper	108
20/21-227	**Change Programme Summary, Delivery & Assurance**	Director of Strategy and Partnerships	Paper	113

20/21-228	**EU Exit Transition Period**	Chief Operating Officer	Paper	129
20/21-229	**Progress Against Enforcement Undertakings**	Interim Director of Corporate Affairs	Paper to Follow	131
20/21-230	**Charitable Funds Annual Report and Accounts / Receipt of Audit Opinion**	Chief Finance Officer	Paper	134
20/21-231	**Chair's Report – Audit Committee**	Committee Chair	Paper	138
20/21-232	**Communications and Engagement Report**	Director of Communications and Engagement	Paper	141
20/21-233	**Introduction of new NED / Appointment to Board Committees**	Chair	Paper	146
20/21-234	**Any Other Business**	Chair	Verbal	N/A
20/21-235	**Date of Next Meeting – 3 March 2021, 12.30 via MS Teams**	Chair	Verbal	N/A
20/21-236	**Exclusion of the Press and Public** To resolve that under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960, the public and press be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.			

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING HELD IN PUBLIC

2 DECEMBER 2020

VIRTUAL MEETING VIA MICROSOFT TEAMS

Commencing at 12.30 and Concluding at 14.45

Present

Sir David Henshaw	Chair
Steve Igoe	Non-Executive Director
John Sullivan	Non-Executive Director
Chris Clarkson	Non-Executive Director
Mrs Sue Lorimer	Non-Executive Director
John Coakley	Non-Executive Director
Mrs Jayne Coulson	Non-Executive Director
Janelle Holmes	Chief Executive
Nicola Stevenson	Medical Director
Claire Wilson	Chief Finance Officer
Hazel Richards	Chief Nurse
Anthony Middleton	Chief Operating Officer
Matthew Swanborough	Director of Strategy and Partnerships
Jacqui Grice	Director of Workforce

In attendance

Joe Gibson*	External Programme Assurance
Jill Hall	Interim Director of Corporate Affairs
Sharon Landrum*	Diversity and Inclusion Lead
Jonathan Lund	Associate Medical Director
Chris Mason	Chief Information Officer
Oyetona Raheem	Interim Deputy Trust Secretary (Minutes)
Sally Sykes	Director of Communications & Engagement
Eileen Hume	Public Governor
Allen Peters*	Public Governor
Ann Taylor	Staff Governor
Sharon Bamber	Staff Observer

Apologies
None
*Denotes attendance for part of the meeting

Reference	Minute	Action
20/21 184	**Apologies for Absence**	
	No apologies were reported as all Directors were present. The Board noted that the tenure of Dr John Coakley as a Non-Executive Director was due to expire on 31 December 20. The Chairman and Dr Stevenson expressed the appreciation of the Board for the immense contribution and support that had been received from Dr Coakley during his tenure. The Chairman recognised the presence of three governors and Sharon Bamber who were observing.	
20/21 185	**Declarations of Interest**	
	There were no Declarations of Interests.	

Reference	Minute	Action
20/21 186	**Patient Story**	
	The Board viewed a video from Denise Dempsey, who talked about her experience of being treated at WUTH. Denise described the treatment she received from the A&E department right to the ward as first class. She had been particularly impressed with the level of empathy and reassurance she had received from the nurses and the medical staff. Denise also expressed satisfaction for the speed at which her X-ray had been undertaken and the amount of cleaning being done by staff members which really made her to feel safe. She therefore requested that her appreciation be passed on to the staff members whom she believed had gone above and beyond their normal call of duties.	
20/21 202	**Change Programme Summary, Delivery & Assurance**	
	Mr. Joe Gibson talked the meeting through the change programme report and highlighted that there had been slight improvement in the overall ratings for governance. The delivery ratings had also seen a modest improvement. Further action needed to be taken to continue that trend. The Chief Operating Officer (COO) agreed with the assessments and highlighted some of the on-going work in conjunction with the Service Improvement Team, particularly on patient flow which had led to the positive trajectories. Sue Lorimer was pleased that the flow project had been broken into manageable units and that the progress was becoming obvious. The Chair recognized that it was Joe Gibson's last meeting and conveyed the Board's appreciation for the good job he had done. At the request of the Board, Mr. Gibson gave some final reflections on the need to have the right scope and clarity on what needed to be achieved. Mr. Gibson acknowledged that the Change Programme was complex and he was pleased to have played a part in the positive transformation that was developing. **RESOLVED:** **That the Board NOTED the report.**	
20/21 201	**Diversity and Inclusion Annual Report**	
	Sharon Landrum, the Diversity and Inclusion Lead talked the Board through some of the key features in the Annual Report. She highlighted aspects of the Equality Act 2010 where the Trust had been fully compliant and areas that were still developing as detailed in the report. The Chairman thanked Sharon and her team for the report and for leading the Trust to a much better position in its equality duties. **RESOLVED:** **That the Board NOTED the report.**	
20/21 187	**Chair's Business**	
	The Chair had attended the Chair/NEDs/Executives Time Out that was held on 01 December 2020.	
20-21/188	**Key Strategic Issues**	

Reference	Minute	Action
	There were no additional strategic issues to report.	
20/21 189	**Minutes**	
	The minutes of the meeting held on 4 November 2020 were approved as an accurate record.	
20/21 190	**Board Action Log** The Board reviewed the actions log noting that items had either been actioned or were on the agenda.	
20/21 191	**Chief Executive's Report**	
	The Chief Executive talked the Board through her report and highlighted that despite the second wave of COVID-19, there had been significant improvement in the delivery of the planned care objectives. The Chief Executive highlighted that the asymptomatic staff testing pilot had shown a COVID-19 positivity rate of 1.4% which was the lowest rate amongst the pilot group. Updates would be provided on the due to commence, routine asymptomatic swabbing (lateral flow) of staff in line with the national directive. The government had recently approved the Pfizer vaccines which meant that COVID-19 vaccination programme through the Hospital Hub based at Clatterbridge would start imminently. A local recruitment campaign had been undertaken to recruit additional vaccinators and administrators to run the programme. It was noted that the Trust Strategy 2021/26 had been discussed at the Time Out for Chair/NEDs/Executives the previous day. Clinical and operational teams would be requested to present their operational and clinical service plans to the Board in the new year. The Chief Executive advised that an external review of statutory estates compliance had been commissioned to help identify any gaps in the current processes as well as areas for further development. Sue Lorimer queried why another estate review was needed since the six facet survey had been undertaken recently. The Chief Finance Officer described that the six facet survey was a review of the structure, maintenance and general condition of the Trust buildings. The newly commissioned review was specifically around compliance with mandatory standards, such as having the right policies and procedures, fire safety, alarm testing, lighting and other H&S checks. The review would establish if there was appropriate management structure to provide the right level of assurance that the Trust was compliant with its regulatory responsibilities. **RESOLVED:** **That the Board RECEIVED and NOTED the report.**	**MS**
20/21 192	**Quality and Performance Dashboard and Exception Reports**	
	The Executive Directors briefed the Board on the content of the Quality & Performance Dashboard for their respective areas. The Chief Operating Officer (COO) highlighted the drop in A&E performance in the month of October. The second wave of COVID-19 had begun in October and contrary to the first wave, there had been no corresponding drop	

Reference	Minute	Action
	in non-COVID-19 demand. On the elective side, there had been some level of recovery but not yet where it needed to be. 18 week RTT had also begun to pick up. The COO drew attention to the modest achievement on the 52 weeks RTT during the month of October. Diagnostic waiters had achieved 90.5% and the number would have been higher but for the shortfall in endoscopy. Cancer was on track to achieving the performance target. John Sullivan asked if there was a set target of what elective was expected to achieve across the winter. The Chief Operating Officer replied that a paper presented around September 20 on Phase 3 reset and recovery plans had set out what was expected for Q3 and Q4. That had been set across the backdrop of not having a second wave of COVID-19. It was agreed that a phase 4 submission would be presented to the board when and if that requirement came from NHSE. Following further questioning by the Chairman, the COO advised that a target of 87% had been set for the elective day cases and 100% for outpatients for Q4, which had already been achieved in November. In terms of the revised expectations, it was anticipated that there would be a push to improve the figures further. The COO added that performance levels varied from service to service as some specialties were in excess of 100% but endoscopy had been the biggest challenge at 85%. The Medical Director briefed the Board about on-going trials including COVID-19 and non-COVID-19 related trials. Safe Pathway had been discussed at the Away Day and work had commenced in conjunction with the Patients Flow Steering Group on how to improve on the discharges. The Director of Workforce advised that appraisals had remained behind trajectory due to the negative impact of COVID-19. Long-term sickness had gone down for the first time since COVID-19 and the current figure of sickness was less than those of the previous year before COVID-19. There had been a lot of staff engagement work by the HR partners and the communications team which had proved to be effective. The Chief Nurse highlighted that there had been a planned trajectory of 6 infections per month for Gram negative bacteraemia. In October, 7 cases had been reported. She added that there had been no mixed accommodation breaches for October. Safeguarding training had seen some improvements but was yet to reach the required level. **RESOLVED:** **The Board of Directors received and noted the Quality and Performance Dashboard, together with associated Exception Reports, for the period to 30 October 2020.**	
20/21 193	**Month 7 Finance Report 2020/21**	
	The Chief Finance Officer (CFO) presented the month 7 financial report and highlighted that the overall performance position was a surplus of £0.8m, representing a favourable variance of £0.4m from the plan submitted to NHSI for the second half of the year. The CFO advised that month 7 was the first month of the new financial regime. The Trust no longer received "additional top-up" funding to ensure	

Reference	Minute	Action
	break-even. Instead, there had been a system funds for top up, COVID-19 and growth from Cheshire and Merseyside Health & Care Partnership which were on a fair share basis calculated using each Trust's turnover. There had been a slight underperformance in the elective programme as well as COVID-19 costs not reaching the level that had been budgeted for. It was forecasted however that within the remaining months of the financial year, a balanced financial position would be delivered. The CFO also talked the meeting through the Capital budget and the list of projects that were on course to be completed during the financial year. Sue Lorimer referred to external consultancy services and queried if they had been provided for in the budget. The CFO replied that the cost of estates review of about £24K had been included in the budget. Explanations were given on other consultancy services that had been reported to the Capital Committee which would be partly funded by the local partners. Mrs Lorimer sought further assurance that none of the consultancy fees would take the budget over the original forecasts to which the CFO replied in the affirmative. John Sullivan sought assurance that the procurement process for the capital projects would be in line with the agreed protocol. The CFO assured the Board that the procurement team would follow guidelines in the Trust's Standing Financial Instructions (SFIs). **RESOLVED:** **That the Board NOTED the report.**	
20/21 194	**CQC Compliance and Action Plan Quarterly Update**	
	The Chief Nurse presented the report and highlighted that it had been reviewed by the Quality Committee. She added that some of the overdue actions have now been closed. Risks remained on patient flow actions and the inter professional standards. The Chief Nurse expressed that steady progress had been made given the negative impact of the COVID-19 pandemic. The Chief Nurse advised that Jacqui Robinson had left the Trust and an interim Deputy Director of Patient Safety & Governance had been engaged who had started to review the CQC Action Plans. She added that highlight report would continue to be presented to the PSQB on monthly basis. John Sullivan wanted to know the efforts that had been made to fill the Governance Director positon on a permanent basis. The Chief Nurse replied that the recruitment process had been completed following which an experienced candidate had been offered the position, and will start in post in March 2021. **RESOLVED:** **That the Board NOTED the report.**	
20/21 195	**Winter Plan**	
	The COO presented the Winter Plan which would serve as a single source of reference for the winter and surge plans for 2020/21.	

Reference	Minute	Action
	Detailed discussion was held on what appeared to be a disproportionate effect on the entire service of COVID-19 patients which accounted for about 20%. Improvement to ward configurations was considered as one of the solutions to maximise bed space for COVID-19 or other respiratory diseases in the future. The Medical Director advised that it had been recognised that the estate needed further work to comply with some specialist guidelines. There had been situations where beds had been available but could not be used because they were in the wrong clinical stream. The CFO talked the meeting through the financial provisions in support of the Winter Plan. She advised that a funding of £12m was available for COVID-19 related programmes this year and that had formed part of the Winter Plan. She advised that it could sometimes be difficult to differentiate between spending for COVID-19 and those specifically for the Winter. Mechanisms would need to be developed to monitor the investments with the most positive impact in the future. **RESOLVED:** **That the Board NOTED the report.**	
20/21 196	**Annual Quality Account**	
	The Chief Nurse presented the Annual Quality Account and pointed out that comments received from HealthWatch and Wirral CCG had been added to the final version. It was noted that the Quality Account had been reviewed by the Quality Committee which had recommended it to the Board for approval. **RESOLVED: To APPROVE the Annual Quality Account.**	
20/21 197	**Safe Staffing Report**	
	The Chief Nurse presented the safe staffing report and highlighted that a dashboard format had been added. John Sullivan queried if there was assurance that professional judgement was being applied consistently. The Chief Nurse replied that professional judgement had been quality assured by the Deputy Chief Nurse on a weekly basis. She gave further explanations on how incident data had been reviewed to ensure that professional judgements were consistently applied. The Chairman expressed that it was encouraging to see the slight improvement in staffing level but noted that safe staffing remained one of the biggest risks on the Risk Register. Steve Igoe advised that there had been some improvements in the number of student nurses enrolling in the universities. He also noted that payment of bursaries by the government had a direct impact on the number of those enrolling for the course. John Sullivan suggested that efforts be made to reach out to the local communities to promote volunteering opportunities. John Sullivan wanted to know if there were explanations as to why the rate of sickness by the Care Support Workers had been significantly higher compared to the Registered Nurses. The Chief Nurse replied that it was difficult to attribute this to one particular factor and would be happy to explore	**HR**

Reference	Minute	Action
	all possible reasons and report back to the Workforce Committee as part of managing sickness. **RESOLVED:** **That the Board NOTED the report.**	
20/21 198	**6 Monthly Acuity and Dependency Nurse Staffing Report**	
	The Chief Nurse presented the report which provided oversight on how the Trust had met effective governance requirements and provide assurance to the Board that workforce decisions promote patient safety and complied with the Care Quality Commission (CQC) fundamental standards. The Chief Nurse recommended to the Board that no changes should currently be made to nursing establishments as the reliability of the data could not be assured, due to the changing nature of the wards during July when the study was undertaken. The next data set will be collected in Spring 2021. **RESOLVED:** **That the Board NOTED the report.**	
20/21 199	**Infection Prevention and Control – COVID 19 Update**	
	The Chief Nurse presented the report including details of actions taken to minimise the risk of transmission of COVID-19, the learning that had taken place and other data relevant to managing the pandemic. Since writing the report, new guidelines had been received which required that swabbing should now be done on Days 0, 3 and 6. There were ongoing education and assessments to ensure that staff were compliant with all the guidelines. Visiting restrictions had continued with additional security on visitor and patient entrance. Progress reports would be coming to the next Board on the ten actions highlighted in the report. John Coakley commented on the risks associated with non-compliance with hand hygiene and requested to know the steps being taken to reduce incidences of hospital acquired infections. The Chief Nurse gave explanations on how hand hygiene was being enforced including provision of gel and sanitisers at key locations. The Medical Director explained that ward configuration was reviewed regularly by CAG to ensure that infected patients were properly separated but there had been instances of 'green patients' who were later discovered to have the virus few days later because they had been asymptomatic. **RESOLVED** **That the Board NOTED the report.**	
20/21 200	**Sickness Absence Report**	
	The Board received the sickness absence report which provided details of the current work and initiatives in place to improve performance by addressing Short Term Sickness absence. The report also featured broader interventions that were intended to improve Short Term Sickness. **RESOLVED:** **That the Board NOTED the report.**	

Reference	Minute	Action
20/21 203	**Chair's Report – Audit Committee**	
	The Committee Chair highlighted the key issues discussed at the Committee held on 24 November including the need to strengthen the control environment and for the responsibility to flow through the Board down to the Committees and the Executives. That would be a focus of the Committee going forward. The Committee had also discussed the challenging market for the audit profession and how that could impact on the external audit tender process for which bids were due to close on Friday 4 December 20. **RESOLVED:** **That the Board NOTED the report.**	
20/21 204	**Chair's Report – Quality Committee**	
	The Committee Chair highlighted some of the key issues discussed at the Committee held on 25 November including a review of the CQC action plan, updates from Learning from Deaths and the Annual Quality Account which had been recommended to the Trust Board for approval. The Committee had noted that three serious incidents had been declared for the previous month and that assurance had been given about the Duty of Candour. **RESOLVED:** **That the Board NOTED the report.**	
20/21 205	**Chair's Report – Fin. Business Performance and Assurance (FBPAC)**	
	The Committee Chair highlighted some of the issues that had been discussed at the Committee held on 25 November including a review of month 7 finance report which had shown an overall position of £0.8m surplus; a review of the financial planning approach for 2021/22 and the plan for CIP; and a presentation on the outline business case for the Urgent Emergency Care (UEC) Centre Options. **RESOLVED** **That the Board NOTED the report.**	
20/21 206	**Chair's Report – Charitable Funds**	
	The Committee Chair presented the report of the Committee held on 10 November and acknowledged the tremendous support that had been received from the staff members as well as corporate sponsors. The Committee had received the report of the head of fundraising and reviewed the month 6 financial position. The Committee had also reviewed some charity policies. The Annual Report and Accounts as well as the Charitable Funds Plan had been reviewed and recommended for approval at the Trustees meeting in January 2021. **RESOLVED** **That the Board NOTED the report.**	
20/21 207	**Chair's Report – Workforce Assurance Committee**	
	The Committee Chair highlighted some of the key issues discussed at the	

Reference	Minute	Action
	meeting including a very inspiring staff story from Ward 25 Manager; detailed performance report which provided additional workforce assurance; sickness absence report which had shown improvements in the COVID-19 and non-COVID-19 absence rates. Amongst other issues discussed were updates on the staff flu jab, COVID-19 vaccine; asymptomatic staff testing; and nursing workforce recruitment. **RESOLVED** **That the Board NOTED the report.**	
20-21/208	**Report of the Trust Management Board (TMB)**	
	The Board received the report which contained some of the business conducted during the TMB held on 26 November 2020. The Chief Executive advised that in order to strengthen the operations monitoring and management of the organisation, a new Operations and Performance Committee had been established to ensure there was full oversight of operations across the whole organisation. The Chief Executive also advised that work had progressed on the Planned Care Control Centre (PCCC) which would provide full feasibility of the capacity for elective care across the organisation starting with consulting job plans through to theatre sessions, outpatients, etc. Nicola Cundle-Carr's team would be asked to make a presentation to the Board in the new year. The Chair commented on the significance of the PCCC and requested that the presentation by the team should be made to the January 21 Board if possible. **RESOLVED** **That the Board NOTED the report.**	**NCC**
20-21 209	**Communications and Engagement Monthly Report**	
	The Board received the report of activity in the areas of staff engagement and communications, the NHS Staff Survey, media and social media, charitable fundraising and stakeholder relations. The Director of Communications and Engagement gave explanations on the media campaign ahead of the COVID-19 vaccinations which was due to commence soon. **RESOLVED:** **That the Board NOTED the report.**	
20/21 210	**Calendar of Meetings 2021/22**	
	The Board received the proposal for calendar of meetings for the Board and its Committees for the 2021/22 year. **RESOLVED** **That the Board APPROVED the meetings schedule.**	
20/21 211	**Any other business**	
	a. It was noted that a member of staff had been present to observe the meeting to gain experience of Board meetings as part of a training	

Reference	Minute	Action
	programme. The Chairman suggested that a rolling programme should be devised to expose some other colleagues to what the Board does in the future. b. Jonathan Lund, Associate Medical Director, who had regularly attended the meetings, said he had found the experience to be helpful and suggested that Divisions should be encouraged to send representatives to observe the Board from time to time.	
20/21 212	**Date of Next Meeting** Wednesday 27 January 2021, via MS Teams	
20/21 213	**Exclusion of the Press and Public**	
	RESOLVED: That under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960, the public and press be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.	

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Chair

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Date

Board of Directors Action Log
Updated – 2 December 2020
Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 02.12.20						
1	BM20-21/191	Clinical and operational teams to present their plans to the Board in the new year	**MS**			
2	BM20-21/197	Identify the factors for the big gap in the rate of sickness by CSWs and RNs.	**HR**	This would be reported to the Workforce Committee as part of sickness management		
3	BM20-21/199	Presentation to the January 21 Board on progress with the Planned Care Control Centre	**NCC**			
Date of Meeting 04.11.20						
2	BM20-21/168	Present a Mortality Report at Board's Request	**NS**	Detailed work has been undertaken regarding the SHIMI including consultation with colleagues throughout the UK. The issues around SHIMI are multi-factorial and work is being undertaken to triangulate with other mortality indices including HSMR, and national audits such as ICNARC, SSNAP and MiNAP to ensure patient safety is assured. Clinical reviews are being undertaken into diagnostic areas which show higher SHIMI indicators. Work is also being undertaken to ensure data quality. In view of the complexity of the work required, a detailed report will be provided to January Board	January 2021	On the agenda

3	BM20-21.174	Update the Board on progress regarding work on the new strategy on Culture and Leadership	**JG/MS**		April 2021	Not Due
4	BM20-21.175	Seek clarification on the status of the additional license condition that was imposed by NHSI in 2018.	**JH**			Not Due
Date of Meeting 04.03.20						
1	BM 19-20/237	Discussion at future Board meeting regarding internal productivity to support financial sustainability	**CW**		July 2020	April '20 – agreed to defer until Q2 following stabilisation of COVID activities.

Board of Directors	
Agenda Item	20-21/221
Title of Report	Chief Executive's Report
Date of Meeting	27 January 2021
Author	Janelle Holmes, Chief Executive
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

This report provides an overview of work undertaken and any important announcements in January 2021.

1. Covid-19 Update

The number of people testing positive for COVID-19 on the Wirral is currently extremely high. There is widespread community transmission with new positive COVID-19 cases being seen each day across Wirral and in all age groups.
This has translated into increased hospital admissions throughout January with over 35% of General & Acute beds currently occupied by patients with COVID-19.
We have enacted our surge & business continuity plans and released capacity to cope with the influx of COVID-19 cases, which includes conversion of theatre recovery into a COVID-19 level 3 Critical Care facility.
We continue to work with our health & social care partners across Wirral & into the Cheshire & Mersey region. Emergency Preparedness, Resilience and Response **(EPRR)** Level 4 national command systems & structures remain in place to deal with the pandemic.

2. LAMP Testing

The programme of WUTH employee Covid-19 asymptomatic self-testing continues and is set to switch from using Lateral Flow Device (LFD) tests to LAMP from March, 2021. LAMP offers benefits in ease of application, the accuracy of test results and in arrangements for capturing / reporting / utilising test result information.

3. Reset and Recovery

Planned care activities have been restarted in line with phase 3 national plans, and are being delivered with the optimum focus of COVID safety measures.

The Phase 3 national expectation was that plans should deliver the following %'s of activity in comparison with the same period last year:

Outpatient Activity – 100% from September
Daycase Activity – 80% in September, 90% from October to February
Elective Activity – 80% in September, 90% from October to February

Activity	Trajectory	Actual	Variance
Outpatients	90%	103%	+3%
Daycase	85%	90%	+5%
Inpatients	85%	98%	+13%

We have had to suspend all non-urgent elective activities as we did in the first wave of the pandemic. We continue to treat cancer patients and those patients that require urgent procedures within 4 weeks, as well as other essential services such as ophthalmology. We are also using the independent sector in line with national guidance to treat as many people as possible, as well as being supported by colleagues in Wirral Community Trust.

4. Vaccination Programme

The Covid-19 vaccination programme – the biggest in NHS history – is off to a strong start nationally, at the time of writing this report five million doses have been given, and 4.6 million people have now had their first dose, with teams across the country now delivering around 140 doses every minute.

At WUTH, our main vaccination site is based at Clatterbridge with a satellite hub at Arrowe Park. Clatterbridge was among the first 50 hospital hubs nationally to begin vaccinating and at all times WUTH has rigorously applied the Joint Committee on Vaccinations and Immunisations Guidance on priority order for the vaccine, including rebooking second appointments for patients in the over 80s age group and a small number of staff, when the follow up interval was revised to 12 weeks, in order to enable more people to have their first dose of the vaccine.
I am very proud of the way staff have responded to the challenges of setting up and staffing the hubs, whilst also dealing with significant patient numbers with COVID-19 in the hospital and Critical Care.

5. Trust Strategy 2021/26

Following the launch of the 2021-26 Trust Strategy officially commenced in January 2021, with the document published on the Trust website and circulated to internal and external stakeholders.

The Trust is finalising the specialty level Clinical Service Strategies, with 29 of the 31 specialty strategies drafted. These are in the process of being reviewed and approved by Divisional Leadership Teams and Trust Management Board. In addition, the Strategy Team are producing a Clinical Service Strategy summary, bringing together the key objectives across the 31 clinical service strategies drawing the alignment to the 21-26 Trust Strategy.

The Divisions have also commenced the development of key strategic priorities for the 21/22 financial year, aligning to the Trust Strategy and support the development of Divisional level operational plans for 21/22.

In addition, the Trust has tendered for support in the review and production of an outline business case (OBC) for the integration of pathology services with the Countess of Chester Hospital NHS Foundation Trust. This follows the national review of pathology services in 2018 and development of the Cheshire and Merseyside HCP business case for the consolidation of pathology services. This project is being supported by Cheshire and Merseyside HCP.

It is anticipated that the selected bidder will commence at the Trust in March 2021 and produce an OBC and integration plan for Board approval by July 2021.

6. Capital and Campus Master Planning

The Trust has made significant progress with the delivery of capital projects, across December 2020 and January 2021, including the opening of the upgraded Emergency Department majors area, with new eight side rooms, and installation of major ventilation system installations in the ground floor of Arrowe Park Hospital.

In February 2021, the Trust will commence a number of capital projects including the upgrade of critical care services at Arrowe Park Hospital, the refurbishment of operating theatres at Clatterbridge General Hospital and the refurbishment of the Renal Unit on the Arrowe Park Hospital campus.

The Trust is finalising the procurement process for an external architectural consultancy to support the Trust in developing a capital master plan for the Clatterbridge General Hospital campus. This process will examine current building use and develop options for the future delivery of health and care services on the campus, with the aim of redeveloping the campus over the coming years, in conjunction with partners. It is expected that the architectural consultancy will commence in February 2021 and complete the master planning by August 2021.

7. WUTH among top Trusts for hip fracture care

The Trust has been recognised among the top nine performing organisations for hip fracture care. The National Hip Fracture Database (NHFD) for 2019, which is the most recent report. The report covers 174 organisations in England, Wales and Northern Ireland. We were listed in the top nine. The NHFD uses six key indicators to judge overall performance and determine which hospitals are providing care well.

8. Serious Incidents

In November 2020 two serious incidents were declared; one related to a medicine management incident where the patient suffered an anaphylactic reaction to prescribed medication and one related to difficulties siting a tracheostomy tube replacement during procedure.
Both incidents are being investigated under the Serious Incident Framework to identify opportunities for learning and actions to drive improvement and reduce future risk.
In both cases Duty of Candour has been undertaken.

9. RIDDOR Update

There were 2 RIDDOR reports to the HSE in November; both related to the manual handling of objects.

10. Positive Feedback

It's always important, and helps to boost staff morale, when we receive compliments and positive feedback from our patients and their families, particularly at this time when the NHS and our hospital are under such pressure. I wanted to share a couple of the compliments staff and the Trust have received recently:

Received from a patient via NHS England website: *"Absolute favourite – over 25 years of so, I have been taken in to 4 different hospitals in the UK and yesterday's 2nd experience at Clatterbridge confirmed my opinion of this unit being the best – in every respect….."*

"My wife and I have just returned from having our COVID-19 vaccinations at Clatterbridge Hospital. What a superbly organised event…."

Janelle Holmes
Chief Executive

Board of Directors	
Agenda Item	20-21/222
Title of Report	Quality Performance Dashboard
Date of Meeting	27th January 2021
Author	WUTH Information Team, Corporate Nursing and Governance Support Unit
Accountable Executive	COO, MD, CN, DQG, HRD, DoF
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	Quality and Safety of Care Patient flow management during periods of high demand
Level of Assurance **Positive** **Gap(s)**	Gaps in Assurance
Purpose of the Paper **Discussion** **Approval** **To Note**	Provided for assurance to the Board
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	TBC
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

1. Executive Summary

This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note performance to the end of December 2020.

2. Background

The Quality Performance Dashboard is designed to provide accessible oversight of the Trust's performance against key indicators, grouped under the CQC five key question headings.

The Quality Performance Dashboard is work-in-progress and will develop further iterations over time. This will include development of targets and thresholds where these are not currently established and the sourcing of data where new indicators are under development.

3. Key Issues

Of the 46 indicators that are reported for December (excluding Use of Resources):

- 21 are currently off-target or failing to meet performance thresholds
- 25 of the indicators are on-target

Please note during the current Covid-19 pandemic a number of metrics have been suspended from national reporting, and departments within the Trust have been focused on operational priorities over some internal reporting. Where the information is still available and reported within the Trust it has been included.

The metrics included are under continual review with the Directors to consider the appropriateness and value of inclusion, and also the performance thresholds being applied. Amendments to previous metrics and/or thresholds are detailed below the dashboard.

4. Next Steps

WUTH remains committed to attaining standards through 2020-21.

5. Conclusion

Actions to improve are noted in the exception reports on the qualifying metrics to provide monitoring and assurance on progress *(exception reports have been suspended for the current phase of the Covid-19 pandemic)*.

6. Recommendation

The Board of Directors is asked to note the Trust's performance against the indicators to the end of December 2020.

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

December 2020
Upated 23-12-20

	Indicator	Objective	Director	Threshold	Set by	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	2020/21	Trend
Safe	Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	Safe, high quality care	CN	≤0.24 per 1000 Bed Days	WUTH	0.13	0.13	0.32	0.31	0.25	0.14	0.29	0.13	0.18	0.21	0.00	0.11	0.21	0.17	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit	Safe, high quality care	MD	≥95%	WUTH	95.3%	95.8%	96.2%	95.8%	96.2%	96.4%	95.8%	95.1%	95.3%	95.4%	95.1%	95.3%	94.7%	95.5%	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital (all patients)	Safe, high quality care	MD	≥95%	SOF	97.3%	97.8%	97.7%	97.5%	97.8%	97.8%	97.6%	97.2%	97.2%	97.4%	96.8%	96.9%	96.9%	97.3%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	CN	≥95%	National	95.1%	95.2%	97.0%	96.9%	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased		
	Serious Incidents declared	Safe, high quality care	DQ&G	≤48 per annum (max 4 per month)	WUTH	5	5	4	4	3	4	1	4	4	2	3	2	4	27	
	Never Events	Safe, high quality care	DQ&G	0	SOF	0	0	2	0	0	0	0	0	0	0	0	0	0	0	
	CAS Alerts not completed by deadline	Safe, high quality care	CN	0	SOF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Clostridium difficile (healthcare associated)	Safe, high quality care	CN	≤88 WUTH maximum from 2019-20 retained, with a varying trajectory of a max 6 to 8 cases per month	SOF	7	4	4	3	6	5	5	1	4	1	5	10	8	45	
	Gram negative bacteraemia	Safe, high quality care	CN	Maximum 77 for financial year 2020-21, with a varying trajectory of a max 6 or 7 cases per month	WUTH	6	8	9	1	7	4	6	8	5	3	7	3	1	44	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	1	0	0	0	0	1	0	1	0	0	0	0	0	2	
	Hand Hygiene Compliance	Safe, high quality care	CN	≥95%	WUTH	99.0%	100.0%	100.0%	100.0%	100.0%	99.1%	99.0%	99.5%	99.0%	99.6%	100.0%	100.0%	100.0%	99.6%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	1	0	0	2	0	2	0	4	0	0	1	0	9	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	99%	96%	96%	96%	96%	91%	95%	95%	98%	96%	94%	91%	93%	94%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	CN	≥90%	WUTH	91.2%	92.2%	92.3%	90.2%	90.4%	88.7%	71.6%	79.3%	75.9%	72.9%	73.2%	75.1%	76.6%	78.2%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	CN	≥90%	WUTH	84.9%	84.4%	85.0%	82.8%	80.6%	71.4%	71.8%	73.5%	72.1%	73.9%	74.5%	77.6%	81.3%	75.2%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	CN	≥90%	WUTH	89.7%	89.5%	86.7%	79.9%	51.5%	19.7%	19.0%	42.0%	48.3%	53.2%	54.7%	60.9%	77.8%	77.8%	
	Attendance % (12-month rolling average)	Safe, high quality care	DHR	≥95%	SOF	94.10%	94.11%	94.15%	94.05%	94.14%	94.20%	94.25%	94.35%	94.41%	94.40%	93.58%	93.61%	93.66%	93.66%	
	Attendance % (in-month rate)	Safe, high quality care	DHR	≥95%	SOF	93.87%	94.40%	94.85%	94.90%	94.78%	95.04%	95.01%	94.92%	94.63%	94.41%	93.81%	94.04%	94.14%	94.53%	
	Staff turnover % (in-month rate)	Safe, high quality care	DHR	Annual ≤10% (equates to monthly ≤0.83%)	WUTH	0.86%	0.62%	0.54%	0.90%	0.42%	0.43%	1.17%	1.17%	1.79%	0.97%	0.64%	0.97%	0.82%	0.93%	
	Staff turnover (rolling 12 month rate)	Safe, high quality care	DHR	≤10%	WUTH	11.3%	11.5%	11.3%	11.1%	10.9%	10.7%	11.1%	11.7%	11.1%	12.7%	12.6%	13.2%	13.3%	13.3%	
	Care hours per patient day (CHPPD)	Safe, high quality care	CN	Between 6 and 10	WUTH	7.55	7.9	7.7	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	9.9	8.0	8.5	10.1	9.5	9.5	

Quality Performance Dashboard

December 2020
Upated 23-12-20

	Indicator	Objective	Director	Threshold	Set by	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	2020/21	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	97.5%	98.3%	99.1%	98.7%	93.6%	96.5%	96.4%	99.1%	99.0%	96.8%	97.4%	97.5%	96.2%	96.9%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH		96%	94%	95%	93%	98%	97%	98%	98%	96%	96%	98%	97%	96.7%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	19.3%	18.8%	19.3%	19.8%	20.7%	19.6%	19.5%	18.8%	18.6%	17.8%	17.7%	18.5%	17.9%	18.8%	
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	Safe, high quality care	MD / COO	≤156 (WUTH Total)	WUTH	444	446	448	383	174	209	210	202	239	309	305	279	319	319	
	Long length of stay - number of patients in hospital for 21 or more days	Safe, high quality care	MD / COO	Maintain at a maximum 52 (revised Sept 2020)	WUTH	207	200	198	108	35	54	48	53	59	92	95	86	112	112	
	Length of stay - elective (actual in month - Patient Flow wards only) **	Safe, high quality care	COO	≤5.3 days average	WUTH	8.5	4.5	5.9	4.9	6.8	5.5	6.2	3.6	3.8	4.8	3.9	4.1	3.4	4.7	
	Length of stay - non elective (actual in month - Patient Flow wards only) **	Safe, high quality care	COO	≤7.3 days average	WUTH	7.9	7.8	7.8	9.9	6.9	4.7	4.7	4.2	4.5	5.4	5.8	5.4	4.3	5.1	
	Emergency readmissions within 28 days **	Safe, high quality care	COO	≤1,110 per month	WUTH	1080	1115	1006	827	667	870	941	1016	1012	1014	1007	992	1020	949	
	Delayed Transfers of Care **	Safe, high quality care	COO	Maximum 3.5% of beds occupied by DTOCs	WUTH	1.8%	2.1%	2.1%	3.3%	2.3%	3.3%	2.3%	2.1%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended		
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	77.3%	78.3%	83.0%	82.0%	71.4%	69.7%	65.4%	70.9%	75.6%	79.3%	79.2%	81.3%	77.7%	76.6%	

Quality Performance Dashboard

December 2020
Upated 23-12-20

	Indicator	Objective	Director	Threshold	Set by	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	2020/21	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	10	10	14	4	2	0	2	3	5	1	0	0	3	16	
	FFT Recommend Rate: ED	Outstanding Patient Experience	CN	≥95%	SOF	87%	85%	80%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting to recommence		
	FFT Overall Response Rate: ED	Outstanding Patient Experience	CN	≥12%	WUTH	11%	10%	11%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting to recommence		
	FFT Recommend Rate: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	97%	97%	97%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting to recommence		
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	CN	≥25%	WUTH	27%	27%	27%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting to recommence		
	FFT Recommend Rate: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	94.5%	94.1%	95.0%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting to recommence		
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	99%	97%	98%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting to recommence		
	FFT Overall response rate: Maternity (point 2)	Outstanding Patient Experience	CN	≥25%	WUTH	33%	22%	20%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting to recommence		

Quality Performance Dashboard

December 2020
Upated 23-12-20

	Indicator	Objective	Director	Threshold	Set by	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	2020/21	Trend
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	NHSI Trajectory for 2020-21	SOF	72.1%	70.5%	67.6%	72.7%	85.5%	93.7%	90.0%	90.4%	85.0%	76.9%	71.6%	76.2%	71.8%	71.8%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	95	40	24	21	0	0	0	0	0	0	0	0	0	0	
	Ambulance Handovers: > 30 minute delays **	Safe, high quality care	COO	<5%	WUTH					7.8%	3.8%	3.5%	3.2%	4.2%	8.3%	13.8%	9.2%	13.2%	7.4%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% for WUTH through 2020-21	SOF	78.10%	78.26%	78.51%	75.01%	64.88%	54.05%	43.29%	41.67%	51.30%	59.76%	65.66%	69.16%	69.81%	69.81%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 22,750 for WUTH by March 2021	National	23,233	22,988	23,207	22,350	21,284	21,288	21,383	23,034	24,486	24,212	22,945	21,633	21,792	21,792	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2020-21	National	0	0	0	15	56	200	413	616	733	806	777	704	666	666	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	99.1%	98.8%	99.5%	96.8%	45.2%	46.5%	74.9%	78.8%	83.5%	88.8%	90.5%	93.7%	94.9%	77.4%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	94.4%	90.5%	92.7%	96.9%	70.6%	97.2%	98.3%	95.5%	89.3%	92.6%	94.9%	90.5%	97.2%	91.8%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	94.4%	–	–	93.4%	–	–	90.2%	–	–	92.48	-	-			
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	97.1%	97.2%	96.9%	98.5%	100.0%	98.3%	97.1%	90.7%	94.8%	92.1%	98.0%	97.4%	96.9%	96.2%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	96.9%	–	–	97.6%	–	–	98.6%	–	–	92.44	-	-			
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	85.9%	85.9%	85.9%	86.0%	87.4%	86.2%	82.1%	80.7%	78.6%	82.6%	82.9%	85.3%	82.7%	83.2%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	86.1%	–	–	85.9%	–	–	85.3%	–	–	80.68	–	–			
	Patient Experience: Number of concerns received in month - Level 1 (informal) **	Outstanding Patient Experience	CN	≤173 per month	WUTH	148	186	160	125	74	99	119	143	124	183	178	161	150	137	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal) **	Outstanding Patient Experience	CN	≤3.1	WUTH	1.92	1.50	3.10	2.70	1.30	1.50	2.80	2.10	3.40	4.20	3.80	3.20	1.32	2.62	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	100%	100%	100%	100%	86%	88%	100%	100%	100%	100%	100%	94%	100%	96.4%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	0	3	0	1	0	1	5	1	0	2	1	4	2	2	

Quality Performance Dashboard

December 2020
Upated 23-12-20

	Indicator	Objective	Director	Threshold	Set by	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	2020/21	Trend
Well-led	Duty of Candour compliance (for all moderate and above incidents)	Outstanding Patient Experience	DQ&G	100%	National	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review		
	Number of patients recruited to NIHR studies	Outstanding Patient Experience	MD	700 for FY 20/21 (ave min 59 per month until year total achieved) - target retained from 19/20)	National	41	55	49	117	326	181	151	87	31	126	328	215	166	1611	
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	80.9%	81.9%	84.9%	83.0%	82.9%	85.1%	77.9%	81.3%	84.3%	76.3%	73.0%	74.1%	76.2%	76.2%	

	Indicator	Objective	Director	Threshold	Set by	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	2020/21	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	-9.543	-0.668	-2.929	2.377	0.00	0.00	0.00	0.00	0.00	0.00	0.78	0.74	0.51	2.035	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	-8.755	-1.818	-2.445	-0.589	0.00	0.00	0.00	0.00	0.00	0.00	0.39	0.53	0.34	1.260	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	3	4	4	4	2	2	2	2	2	2	2	2	2	2	
	CIP Performance	Effective use of Resources	CFO	On Plan	WUTH	-11.4%	-18.1%	-18.1%	-17.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
	NHSI Agency Performance (monthly % variance)	Effective use of Resources	CFO	On Plan	NHSI	-8.4%	-14.4%	4.3%	53.3%	9.8%	25.9%	27.4%	25.0%	34.5%	22.3%	12.1%	0.5%	10.2%	21.6%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-14.1	-28.0	-32.3	-30.4	-97.4	-98.4	-98.2	-98.0	-97.9	-16.3	-15.0	-15.6	-17.4	-17.4	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	54.4%	53.8%	50.7%	74.8%	101.0%	100.4%	61.1%	53.0%	44.6%	42.1%	41.8%	46.2%	66.3%	66.3%	

(*) Updated Metrics

Metric Change

(**) Updated Thresholds

Threshold Change

Workforce Dashboard – December 2020

Wirral University Teaching Hospital NHS Foundation Trust

Indicator	Target		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Trend
Total Staff WTE		20/21	5279.45	5346.52	5379.59	5321.75	5307.45	5263.97	5271.40	5234.68	5284.58				
		19/20	5152.61	5162.54	5145.80	5141.02	5163.25	5164.40	5198.32	5208.23	5196.40	5194.07	5209.94	5211.29	
Sickness rate - in month	5.00%	20/21	9.11%	7.13%	6.51%	5.67%	5.73%	6.19%	6.25%	5.96%	5.86%				
		19/20	5.16%	5.09%	5.51%	5.93%	6.04%	5.75%	6.01%	6.18%	6.13%	5.60%	5.15%	6.08%	
Sickness rate - rolling 12 months	5.00%	20/21	6.29%	6.42%	6.47%	6.40%	6.37%	6.42%	6.42%	6.39%	6.34%				
		19/20	5.19%	5.26%	5.37%	5.49%	5.60%	5.62%	5.67%	5.86%	5.90%	5.89%	5.85%	5.95%	
Sickness - over 28 days		20/21	250	269	251	223	235	221	204	217	219				
		19/20	185	181	202	246	226	211	214	204	223	162	156	167	
Sickness rate - MSK		20/21	3.77%	5.15%	3.20%	5.79%	5.94%	6.18%	7.08%	7.52%	7.37%				
		19/20	11.42%	10.91%	10.87%	10.57%	10.86%	11.17%	9.75%	8.80%	8.28%	9.77%	8.97%	6.62%	
Sickness rate - Anxiety/mental health		20/21	21.75%	29.38%	29.97%	35.37%	38.71%	34.74%	31.12%	30.44%	30.47%				
		19/20	24.61%	31.51%	27.65%	28.69%	29.33%	27.49%	27.37%	27.46%	25.81%	25.91%	30.71%	27.54%	
RTW	100.00%	20/21	42.90%	45.44%	52.30%	45.96%	45.57%	60.98%	66.67%	73.55%	69.15%				
		19/20	61.06%	62.13%	65.77%	66.98%	66.24%	66.85%	71.75%	70.56%	69.53%	81.03%	73.06%	57.27%	
Turnover Rate - in month	0.83%	20/21	0.42%	0.43%	1.17%	1.17%	1.79%	0.97%	0.64%	0.97%	0.82%				
		19/20	0.86%	0.83%	0.85%	0.68%	2.03%	1.21%	0.86%	0.77%	0.86%	0.62%	0.54%	0.90%	
Turnover Rate - rolling 12 months	10.00%	20/21	10.89%	10.65%	11.08%	11.67%	11.82%	12.74%	12.59%	13.23%	13.30%				
		19/20	9.99%	10.18%	10.51%	9.49%	10.61%	10.92%	11.01%	11.25%	11.31%	11.47%	11.33%	11.11%	
Vacancy rate - Trust all	6.50%	20/21	7.32%	6.09%	5.55%	6.61%	6.84%	7.61%	7.75%	8.54%	8.52%				
		19/20	9.71%	9.67%	10.22%	10.06%	9.74%	9.21%	8.70%	8.53%	8.67%	9.17%	8.55%	8.55%	
Vacancy rate - Qualified Nurses.	6.50%	20/21	9.68%	9.65%	9.48%	9.81%	9.90%	9.40%	8.67%	9.79%	9.57%				
		19/20	9.01%	8.90%	8.94%	8.90%	9.57%	8.88%	8.52%	8.53%	8.59%	9.50%	9.65%	10.05%	
Vacancy rate - Clinical Nursing Support Workers	6.50%	20/21	5.07%	5.15%	5.78%	5.89%	5.86%	7.86%	7.77%	8.81%	6.28%				
		19/20	3.94%	4.57%	5.87%	5.18%	6.45%	6.52%	5.90%	5.03%	4.60%	5.39%	5.35%	6.14%	
Appraisal rate	88.00%	20/21	82.92%	85.11%	80.14%	81.25%	84.28%	76.26%	73.00%	74.07%	76.21%				
		19/20	77.63%	81.06%	82.08%	83.58%	83.36%	82.67%	83.75%	81.35%	80.92%	81.90%	84.85%	83.00%	
Mandatory training - core modules	90.00%	20/21	88.64%	85.70%	84.46%	86.71%	86.02%	86.91%	86.52%	87.24%	87.98%				
		19/20	86.47%	88.15%	89.85%	90.42%	90.05%	89.98%	89.48%	89.76%	89.25%	89.75%	90.41%	89.50%	
Agency Spend as % of spend		20/21	2.18%	1.69%	1.60%	2.19%	1.64%	1.98%	2.62%	3.36%	3.10%				
		19/20	3.50%	3.82%	3.42%	4.12%	3.02%	3.46%	3.41%	2.75%	3.14%	3.18%	2.63%	3.12%	
Agency Shifts over cap rate	0	20/21	474	321	380	471	344	430	528	588	602				
		19/20	692	786	728	799	580	674	647	547	459	508	484	577	
Risk Assessments - All	100.00%	20/21			49.96%	79.26%	81.18%	90.80%	89.14%	91.89%	92.24%				
		19/20													
Risk Assessments - BAME	100.00%	20/21			57.80%	94.48%	89.29%	93.47%	90.85%	91.52%	89.82%				
		19/20													
Risk Assessments - At Risk	100.00%	20/21			52.09%	79.26%	88.49%	93.97%	95.71%	91.89%	92.24%				
		19/20													
Recruitment - Time to Recruit	56.00	20/21	49.22	88.19	48.38	88.21	62.36	67.03	57.86	63.10	63.65				
		19/20	69.83	69.06	62.62	68.66	72.40	87.03	73.02	61.32	52.82	74.65	80.27	78.36	
Recruitment - Number Roles Outstanding over 90 days		20/21	In Development												
		19/20													
Flu Vaccination Rate		20/21							52.40%	65.66%	68.57%				
		19/20							58.60%	71.70%	79.70%	82.10%	82.80%		
COVID Vaccination Rate		20/21	In Development												
		19/20													
Lateral Flow		20/21	In Development												
		19/20													
WOVEN - Data Quality Report	10,000	20/21	8,863	8,724	8,566	8,546	8,508	8,250	9,678	9,800	9,834				
		19/20	9,970	9,975	9,980	9,970	9,920	9,905	9,604	9,506	9,509	8,994	8,990	9,037	

Dashboard Data Definitions/Source

Wirral University Teaching Hospital NHS Foundation Trust

Indicator Name	Data Source	Definition
Total Staff WTE	ESR	Total number of staff Whole Time Equivalent - excludes Bank and Locum contracts and Lead Employer Dr's
Sickness Rate – In Month	ESR	Calculation: Absence FTE/Available FTE for the month. Figures include all sickness absences including Covid-19 sickness
Sickness Rate – Rolling 12 Months	ESR	Calculation: Cumulative Absence FTE/Cumulative Available FTE for the previous 12 months. Figures include all sickness absences including Covid-19 sickness
Sickness – Over 28 Days	ESR	The number of open ended sickness absences that are over 28 days in length
Sickness Rate – MSK	ESR	The sickness reason of S12 Other Musculoskeletal Problems, as a % of the total sickness absence
Sickness Rate – Anxiety/Mental Health	ESR	The sickness reason of S10 Anxiety, Stress, Depression & Other Psychiatric illnesses , as a % of the total sickness absence
Return to Work (RTW)	ESR	Based on the number of closed absences that have a RTW recorded within ESR
Turnover Rate – In-Month	ESR	Calculation: Leaver FTE/Total FTE for the month
Turnover Rate – Rolling 12 Months	ESR	Calculation: Total Leaver FTE/Average FTE for the previous 12 months
Vacancy Rate – Trust	ESR	Budgeted FTE – Actual FTE = Vacancy FTE. Vacancy FTE is then expressed as a % of the Budgeted FTE
Vacancy Rate – Qualified Nurses	ESR	Budgeted FTE – Actual FTE = Vacancy FTE. Vacancy FTE is then expressed as a % of the Budgeted FTE for the Nursing & Midwifery staff group. All grades
Vacancy Rate –Clinical Nursing Support Workers	ESR	Budgeted FTE – Actual FTE = Vacancy FTE. Vacancy FTE is then expressed as a % of the Budgeted FTE for the Additional Clinical Services - Unqualified Nursing. All grades
Appraisal Rate	ESR	In-date Appraisals for all ESR staff excl. Mat Leave, Career Break, Locum/Bank, Recharges, Suspended, NED, Chair, LTS and New (first 3 Months)
Core Mandatory Training	ESR	In-date Training for all ESR staff excl. Mat Leave, Career Break, Locum/Bank, Recharges, Suspended, NED, Chair, LTS and New (first 3 Months)
Agency Spend as % of Spend	Finance	Calculation: Agency Spend/Total Spend
Agency Shifts over cap rate	PlusUs/NHSP/ Local Information	This is the number of agency shifts that breach the NHSi Price caps for shift type/grade
Health Risk Assessments – All	HRA Form	Completed Health Risk Forms for all ESR staff except Contractors and Recharges.
Health Risk Assessments – BAME	HRA Form	Completed Health Risk Forms for all ESR staff except Contractors and Recharges. Only staff with Ethnic Codes D-SE (NHSE/I Guidance)
Risk Assessments – At-Risk	HRA Form	Completed Health Risk Forms for all ESR staff except Contractors and Recharges. Only staff with High Risk Conditions (NHS Website)
Recruitment – Time to Recruit	Trac	Average number of working days from Advert Close to Employee Start
Recruitment – Roles Outstanding >90 Day	Trac	**In Development**
Flu Vaccination Rate	Consent Form	Completed Flu vaccination consent forms for all ESR staff except Contractors and Recharges.
COVID Vaccination rate		**In Development**
Lateral Flow		**In Development**
WOVEN – Data Quality Report	ESR	Score - Each organisation starts with a perfect score (10,000) and loses a proportional amount of that score for each problem detected by the validation process. Each validation is scored individually and is equally weighted. The overall score is derived from the sum of the scores for the individual validations and is scaled out of 10,000.

Board of Directors	
Agenda Item	20-21/ 223
Title of Report	Month 9 Finance Report
Date of Meeting	27/01/21
Author	Robbie Chapman Julie Clarke Jillian Burrows
Accountable Executive	Claire Wilson Chief Finance Officer
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Gaps: Financial performance below plan
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Contents

1.1 Table 2: Financial position – M9

Month 9 Financial Position	Forecast (Mth 9) £'000	Actual (Mth 9) £'000	Variance £'000	Year To Date Actual £'000	Annual Budget £'000	Year End Forecast £'000	Variance £'000
NHS income - patient care	27,373	22,974	(4,398)	166,335	364,926	227,558	(137,368)
Income Guarantee	0	4,380	4,380	62,743	0	83,657	83,657
National Top-up	3,213	3,207	(6)	24,970		34,591	34,591
Additional top up	0	0	0	2,846	0	2,846	2,846
Covid 19 income	2,007	2,359	352	6,101	11,451	12,417	966
Non NHS income - patient care	370	466	96	3,296	4,693	4,286	(407)
Other income	2,122	2,079	(43)	36,966	28,640	43,269	14,629
Total Income	**35,085**	**35,465**	**381**	**303,258**	**409,710**	**408,623**	**(1,087)**
Employee expenses	(22,977)	(23,064)	(87)	(200,608)	(272,730)	(270,430)	2,299
Operating expenses	(10,228)	(10,370)	(142)	(87,365)	(124,437)	(120,037)	4,400
Covid 19 costs	(1,107)	(957)	150	(10,151)	(7,889)	(13,278)	(5,389)
Total expenditure	**(34,311)**	**(34,390)**	**(79)**	**(298,124)**	**(405,056)**	**(403,745)**	**1,311**
Non Operating Expenses	(326)	(592)	(266)	(3,210)	(4,515)	(4,189)	326
Actual Surplus / (deficit)	**447**	**483**	**36**	**1,923**	**139**	**689**	**550**
Reverse capital donations / grants I&E impact	23	23	0	108	140	140	0
Surplus/(deficit) - Control Total	**470**	**506**	**36**	**2,031**	**279**	**829**	**550**

1.2 The year to date (YTD) position is a surplus of of £2.031m. This is an improvement compared to the plan submitted to the Board in October and broadly in line with the revised forecast submitted to NHSI in November.

1.3 The M9 position is a surplus of £0.5m. This is an improvement compared to the balanced plan submitted to the Board in October and broadly in line with the revised forecast submitted to NHSI in November.

1.4 Income reflects the reduced activity in respect of patient care offset by the income guarantee funding arrangement. We received £4.4m in respect of the income guarantee in month and have now received £62.7m YTD.

1.5 We no longer receive additional top up income but our COVID-19 activity is allocated on the basis of our expenditure in the first 3 months of the pandemic along with the reimbursement of direct costs.COVID-19 income was £2.4m in M9 of which £1.8m is the block funding, £0.3m of income for the testing programme and a further £0.3m for the vaccination programme. The vaccination testing income was not included in our forecast.

1.6 Expenditure reflects reduced activity in respect of elective activity and lower employee costs due to high vacancy rates offset by COVID-19 costs. However, at M9 expenditure is £0.1m above forecast, with lower COVID-19 costs offset by higher operational costs. Further detail is discussed later in the report.

1.7 We currently forecast a year end surplus of £0.8m, an improvement of £0.5m against plan and in line with the forecast submitted to NHSI in November. However, with changes to the way in which activity with the independent sector is funded it is likely that our forecast will improve.

1.8 Cash balances at the end of M9 were £44.7m. The early payment of block income is forecast to end in February 2021 and as a result cash balances are expected to reduce significantly in March 2021.

1.9 The Trust has recorded capital spend of £8.4m against a year to date budget of £12.7m. The full year capital forecast is currently £13.1m.

2. Background

2.1 The funding regime is consistent with the prior period and will remain in place until the end of the financial year. Initial indications are that the current financial regime will remain in place until at least Q2 of 2021/22.

3. Dashboard and risks

3.1 Mth 9 Performance Dashboard

	Indicator	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	2020/21
Use of Resources	I&E Performance (monthly actual)	0.00	0.00	0.00	0.00	0.00	0.00	0.78	0.74	0.51	2.031
	I&E Performance Variance (monthly variance)	0.00	0.00	0.00	0.00	0.00	0.00	0.39	0.53	0.34	1.262
	NHSI Risk Rating	2	2	2	2	2	2	2	2	2	2
	CIP Performance	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	NHSI Agency Performance (monthly % variance)	9.8%	25.9%	27.4%	25.0%	34.5%	22.3%	12.1%	0.5%	10.2%	21.5%
	Cash - liquidity days	-97.4	-98.4	-98.2	-98.0	-97.9	-16.3	-15.0	-15.6	-17.4	-17.4
	Capital Programme (cumulative)	101.0%	100.4%	61.1%	53.0%	44.6%	42.1%	41.8%	46.2%	66.3%	66.3%

3.2 Risk summary (as per risks identified in risk register)

3.2.1 Risk 1 – Failure to manage financial position

- The revised M7-M12 financial envelope is dependent on cost management alongside the delivery of activity trajectories; winter; the management of covid activity and the centrally funded vaccination and testing programmes. This is being monitored closely by the Executive team.

3.2.2 Risk 2 – Failure to deliver CIP

- The M7-M12 CIP target was £0.5m. The Trust's cost improvement programme was put on hold after the onset of the 2nd wave of COVID-19 but is offset by non-recurrent reductions in expenditure. Planning has begun for a more challenging CIP target for 2021/22.

3.2.3 Risk 3 – Failure to complete capital programme

- The revised capital plan for 2020/21 is dependent upon the delivery of a significant level of estates work and will require careful planning to ensure that operational capacity is not disrupted in the final quarter of the financial year. Whilst significant progress has been made in M9 we are still behind the required trajectory but now have the required capacity in place to delivery the programme in line with current forecast.

4. Financial Performance

4.1 Income

4.1.1 The Trust has received £303.3m YTD, a reduction of £1m against plan but a £0.4m improvement against the forecast submitted to NHSI in November.

Table 3: Income analysis for M9.

	Forecast (Mth 9)	Actual (Mth 9)	Variance	Year To Date Actual	Plan	Year End Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective & Daycase	4,240	3,189	(1,052)	20,361	50,743	33,033	(17,709)
Elective excess bed days	83	52	(30)	534	993	782	(212)
Non-elective	8,419	7,122	(1,298)	59,840	101,455	85,088	(16,367)
Non-elective Non Emergency	974	855	(119)	8,862	11,755	11,781	26
Non-elective excess bed days	355	226	(129)	1,076	4,270	2,141	(2,129)
A&E	1,273	1,150	(123)	9,729	15,354	13,548	(1,806)
Outpatients	3,022	2,496	(526)	17,908	36,419	26,966	(9,453)
Diagnostic imaging	187	213	25	1,222	2,257	1,783	(474)
Maternity	480	419	(61)	3,952	5,787	5,391	(396)
Non PbR	7,092	5,931	(1,161)	49,717	86,416	70,844	(15,572)
HCD	1,259	1,403	144	11,584	15,327	15,361	34
CQUINs	189	189	0	1,707	2,273	2,274	0
National Top up	3,213	3,207	(6)	27,836	34,647	37,577	2,930
Income Guarantee	0	4,380	4,380	62,743	0	62,743	62,743
Other patient care income	114	(35)	(150)	738	1,113	1,082	(31)
COVID-19 Income	2,007	2,359	352	6,101	11,451	12,417	966
Non-NHS: private patient & overseas	12	23	11	52	125	89	(36)
Injury cost recovery scheme	42	123	81	548	684	673	(11)
Total Patient Care Income	32,963	33,303	340	284,509	381,069	383,572	2,503
Other operating income	2,122	2,158	36	18,744	28,640	25,046	(3,594)
Other non operating income		5	5	5		5	5
Total income	35,085	35,465	381	303,258	409,709	408,623	(1,092)

4.1.2 The under-performance in patient care activity income across elective, non-elective, outpatients and non-PbR is offset by the income guarantee as reflected in the table above. This reflects the lower non-COVID-19 activity in the hospital until the end of the month, when admissions increased significantly.

4.1.3 COVID-19 income in M9 of £2.4m reflects an additional £0.3m for the vaccination programme costs incurred in December and income of £0.1m to support lateral flow testing.

4.1.4 We currently forecast income of £408.6m, a reduction of of £1.1m against plan. However, with additional funding in respect of the vaccination programme this is expected to increase.

4. Financial Performance

4.2 Expenditure: Pay

4.2.1 The Trust has spent £200.6m on pay costs YTD, a reduction of £2.3m against plan but £0.1m higher than M9 forecast. Table 4 details pay costs by staff group and Table 5 details pay costs by pay category type.

Table 4 Pay costs by staff type (excluding COVID-19)

Pay analysis	Forecast (Mth 9) £'000	Actual (Mth 9) £'000	Variance £'000	Year To Date Actual £'000	Plan £'000	Year End Forecast £'000	Variance £'000
Consultants	(3,934)	(3,868)	66	(32,822)	(44,154)	(44,564)	(410)
Other medical	(2,599)	(2,596)	3	(22,708)	(31,676)	(30,229)	1,447
Nursing and midwifery	(6,127)	(6,120)	7	(54,220)	(73,957)	(72,729)	1,229
Allied health professionals	(1,293)	(1,358)	(65)	(11,442)	(15,473)	(15,336)	137
Other scientific, therapeutic and technical	(510)	(517)	(8)	(4,531)	(6,122)	(6,060)	62
Health care scientists	(1,040)	(1,059)	(20)	(9,234)	(12,381)	(12,355)	27
Support to clinical staff	(4,321)	(4,169)	152	(37,136)	(51,035)	(49,964)	1,070
Non medical, non clinical staff	(3,070)	(3,289)	(219)	(27,753)	(36,893)	(38,181)	(1,288)
Apprenticeship Levy	(83)	(87)	(4)	(762)	(1,039)	(1,012)	27
Total	(22,977)	(23,064)	(87)	(200,608)	(272,730)	(270,430)	2,299

Table 5: Pay analysis by pay type

Pay analysis	Forecast (Mth 9) £'000	Actual (Mth 9) £'000	Variance £'000	Year To Date Actual £'000	Plan £'000	Year End Forecast £'000	Variance £'000
Substantive	(20,669)	(20,887)	(218)	(184,605)	(245,331)	(248,090)	(2,759)
Bank	(967)	(854)	113	(6,517)	(11,009)	(9,128)	1,881
Medical Bank	(560)	(531)	29	(4,251)	(7,294)	(5,601)	1,694
Agency	(697)	(705)	(8)	(4,473)	(8,057)	(6,600)	1,457
Apprenticeship Levy	(83)	(87)	(4)	(762)	(1,039)	(1,012)	27
Total	(22,977)	(23,064)	(87)	(200,608)	(272,730)	(270,430)	2,299

4.2.2 The Trust's YTD underspend on pay costs is wholly attributable to reduced spend on bank and agency compared to plan. This is offset by an increase in substantive pay.

4.2.3 In M9 we spent more on substantive staff costs than forecast due to provisions for ongoing employee disputes. This was partially offset by lower than expected bank. Agency costs are in line with forecast.

4.2.4 In M9 the lower bank costs were largely in Medicine with less demand on wards with COVID outbreaks; displaced bank nurses required to support the COVID vaccination programme and lower ED bank spend.

4.2.5 We currently forecast year end pay costs of £270.4m, a reduction of of £2.3m against plan.

4. Financial Performance

4.3 Expenditure: Non-Pay

4.3.1 Non-pay expenditure YTD is £87.4m, £5.9m lower than plan. However, non pay costs were £0.1m higher than the M9 forecast.

Table 6: Non-pay analysis (excluding COVID-19 costs)

Non Pay Analysis (exc Covid)	Budget (Mth 9) £'000	Actual (Mth 9) £'000	Variance £'000	Year To Date Actual £'000	Annual Budget £'000	Year End Forecast £'000	Variance £'000
Supplies and services - clinical	(2,859)	(2,909)	(50)	(22,688)	(34,910)	(31,260)	3,650
Supplies and services - general	(388)	(382)	6	(3,194)	(5,065)	(4,338)	726
Drugs	(1,868)	(2,068)	(200)	(16,867)	(23,508)	(22,659)	849
Purchase of HealthCare - Non NHS Bodies	(454)	(431)	23	(4,289)	(7,197)	(7,440)	(243)
CNST	(1,079)	(1,079)	0	(9,710)	(12,894)	(12,947)	(53)
Consultancy	0	0	(0)	0	(411)	0	412
Other	(2,670)	(2,603)	67	(22,606)	(29,982)	(30,653)	(670)
	(9,318)	(9,471)	(153)	(79,354)	(113,967)	(109,296)	4,671
Depreciation	(910)	(898)	11	(8,011)	(10,430)	(10,741)	(311)
	(10,228)	(10,370)	(142)	(87,365)	(124,397)	(120,037)	4,360

4.3.2 Increased expenditure on Drugs in M9 was due to greater use of high cost drugs in the two clinical divisions. In Surgery the increase was largely colorectal drugs. In Medicine this related to gastroenterology and rheumatology.

4.3.3 We currently forecast year end non-pay costs of £120m, a reduction of of £4.3m against plan. However, due to changes in funding arrangements in respect of purchase of healthcare from non-NHS bodies it is possible we will spend significantly less in respect of non-pay costs.

4. Financial Performance

4.4 Expenditure: COVID–19

4.4.1 We incurred a further £1m of COVID-19 costs in M9, bringing the year to date spend to £10.2m.

Table 9: YTD COVID-19 revenue costs

COVID-19 COSTS	Apr (M1) £'000	May (M2) £'000	Jun (M3) £'000	Jul (M4) £'000	Aug (M5) £'000	Sep (M6) £'000	Oct (M7) £'000	Nov (M8) £'000	Dec (M9) £'000	Year to Date £'000
Medical Staff	(263)	(386)	(204)	(199)	(37)	(165)	(84)	(52)	(64)	(1,453)
Other Clinical Staff	(367)	(626)	(574)	(560)	(126)	(293)	(272)	(470)	(373)	(3,661)
Non Clinical Staff	(182)	(52)	(47)	(105)	(37)	(58)	(32)	(44)	(132)	(689)
Total Pay	(812)	(1,065)	(824)	(863)	(200)	(516)	(388)	(566)	(568)	(5,803)
Clinical Supplies	(189)	(591)	70	(99)	(122)	(68)	(42)	(207)	(177)	(1,426)
Other Non-Pay	(556)	(140)	(333)	(627)	(233)	(273)	(395)	(153)	(211)	(2,922)
Total Non-Pay	(746)	(731)	(263)	(726)	(355)	(341)	(437)	(361)	(388)	(4,348)
Total Covid Expenditure	**(1,558)**	**(1,796)**	**(1,087)**	**(1,589)**	**(555)**	**(857)**	**(825)**	**(927)**	**(957)**	**(10,151)**

4.4.2 £0.6m of our COVID-19 costs in M9 related to pay with £0.4m on non pay. This is consistent with the rest of the year.

4.4.3 The COVID-19 YTD position is £10.2m of which £0.3m is vaccination costs and £0.4m is testing costs. The latter costs are both funded centrally outside the Cheshire & Merseyside Healthcare Partnership envelope.

4.4.4 The £0.3m of vaccination costs will, subject to conditions and validation, be reimbursed in M10. Of the £0.3m, £0.2m related to start-up costs including minor works, equipment and fixtures and fittings.

	Month 9 Covid Position (£k)	Dec (M9) £'000	Year to Date £'000
Trust COVID Vaccination	**Total income**	**316**	**316**
	Medical Staff	(111)	(111)
	Other Clinical Staff		0
	Non Clinical Staff		0
	Total Pay	**(111)**	**(111)**
	Clinical Supplies	(111)	(111)
	Other Non Pay	(205)	(205)
	Total Non-Pay	**(316)**	**(316)**
	Total Covid Expenditure	**(111)**	**(111)**

5. Financial Performance

5.1 Statement of Financial Position (SOFP)

5.1.1 The movement in total assets employed at M9 is the movement in capital spend off-set by the movements in trade receivables and payables.

Actual as at 31.03.20 £'000		Actual as at 30.11.20 £'000	Actual as at 31.12.20 £'000	Variance (monthly) £'000	Month-on-month movement
	Non-current assets				
161,492	Property, plant and equipment	160,454	162,692	2,238	⇧
14,029	Intangibles	13,211	13,126	(85)	⇩
723	Trade and other non-current receivables	620	611	(9)	⇩
176,244		**174,285**	**176,429**	**2,144**	⇧
	Current assets				
3,991	Inventories	4,010	4,262	252	⇧
24,375	Trade and other receivables	17,349	14,858	(2,491)	⇩
0	Assets held for sale	0	0	0	⇨
5,931	Cash and cash equivalents	44,926	44,721	(205)	⇩
34,297		**66,285**	**63,841**	**(2,444)**	⇩
210,541	**Total assets**	**240,570**	**240,270**	**(300)**	⇩
	Current liabilities				
(41,874)	Trade and other payables	(39,675)	(38,706)	969	⇧
(3,000)	Other liabilities	(35,074)	(34,861)	213	⇧
(85,234)	Borrowings	(1,126)	(1,144)	(18)	⇩
(2,926)	Provisions	(2,825)	(3,228)	(403)	⇩
(133,034)		**(78,700)**	**(77,939)**	**761**	⇧
(98,737)	**Net current assets/(liabilities)**	**(12,415)**	**(14,098)**	**(1,683)**	⇩
77,507	**Total assets less current liabilities**	**161,870**	**162,331**	**461**	⇧
	Non-current liabilities				
(2,588)	Other liabilities	(2,516)	(2,507)	9	⇧
(6,274)	Borrowings	(5,722)	(5,717)	5	⇧
(7,304)	Provisions	(6,689)	(6,649)	40	⇧
(16,166)		**(14,927)**	**(14,873)**	**54**	⇧
61,341	**Total assets employed**	**146,943**	**147,458**	**515**	⇧
	Financed by				
	Taxpayers' equity				
80,106	Public dividend capital	164,268	164,268	0	⇨
(65,492)	Income and expenditure reserve	(64,052)	(63,537)	515	⇧
46,727	Revaluation reserve	46,727	46,727	0	⇨
61,341	**Total taxpayers' equity**	**146,943**	**147,458**	**515**	⇧

5.1.2 Cash and current liabilities (deferred income) remain high in year due to the early receipt of NHS block income under the amended NHSI regime for 2020/21. Cash balances will reduce to normal levels in March 2021 and it is expected that funding flows with return to their usual timings in 2021/22.

5. Financial Performance

5.2 Capital Expenditure – December 2020

	Full Year Budget			Full Year Forecast		YTD	
	NHSI plan	Mvmnts	Trust Budget[1]	Forecast	Variance	Actual	Distance to Go
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Funding							
Net depreciation	10,467		10,467	10,467	0	7,850	
Loan repayment	(1,015)		(1,015)	(1,015)	0	(508)	
Finance lease	(60)		(60)	(60)	0	(45)	
2019/20 funding rolled forward	1,348		1,348	1,348	0	1,348	
Asset disposal proceeds	0		0	0	0	0	
Total Internally Generated Funding	10,740		10,740	10,740	0	8,646	
PDC (Public Dividend Capital) - UTC	500		500	420	80	0	
PDC - COVID-19	0	925	925	925	0	279	
PDC - Critical Infrastructure Repair	0	1,434	1,434	1,434	0	0	
PDC - Urgent & Emergency Care	0	1,441	1,441	1,441	0	0	
PDC - Restoration of Cancer Services	0	792	792	792	0	0	
PDC - Critical Care	0	664	664	664	0	0	
PDC - Cyber Security	0	40	40	40	0	0	
External Funding - donations/grants	0	132	132	132	0	0	
Total funding	**11,240**	**5,428**	**16,668**	**16,588**	**80**	**8,925**	
Expenditure							
Prior year(s) capital commitments	3,526	(180)	3,346	3,249	97	2,238	1,011
Estates	4,383	(372)	4,011	1,404	2,607	270	1,134
Informatics	575	(93)	482	449	33	446	3
Medicine and Acute	300	186	486	534	(48)	105	429
Clinical Support and Diagnostics	369	306	675	711	(36)	610	101
Surgery	1,363	256	1,619	1,359	260	1,010	349
Women and Children's	0	67	67	67	0	23	44
Other	0		0	0	0	0	0
Contingency[2]	224	(228)	(4)	0	(4)	0	0
UTC / Hospital upgrade programme	500	(80)	420	420	0	294	126
COVID-19 response	0	925	925	986	(61)	982	4
Critical Infrastructure Repair	0	1,434	1,434	1,228	206	189	1,039
Urgent & Emergency Care	0	1,508	1,508	1,716	(208)	1,304	412
Restoration of Cancer Services	0	792	792	792	0	766	26
Critical Care	0	664	664	0	664	0	0
Cyber Security	0	40	40	47	(7)	55	(8)
Donated assets	0	132	132	132	0	131	1
Total expenditure (accruals basis)	**11,240**	**5,357**	**16,597**	**13,094**	**3,503**	**8,423**	**4,671**
Capital programme funding less expenditure	**0**	**71**	**71**	**3,494**	**(3,423)**	**502**	
Capital expenditure	11,240	5,357	16,597	13,094		8,423	
NBV asset disposals	0	0	0	0		0	
Donated assets	0	(132)	(132)	(132)		(131)	
CDEL impact	**11,240**	**5,225**	**16,465**	**12,962**		**8,292**	

5.2.1 The BAU capital plan at M9 remains in line with M8 at £16.6m. Actual YTD spend totals £8.4m (£5.3m M8). Significant progress was made in M9 with the ED upgade phase 1 being almost completed. The most significant schemes still to progress are the Urgent and Emergency Care upgrade at £1.2m and Cath Lab Refurbishment at £0.9m.

5.3 Statement of Cash Flows – December 2020

	Month Actual £'000	Year to date Actual £'000	Full Year Forecast £'000	Full Year Plan £'000
Opening cash	**44,926**	**5,931**	**4,009**	**4,009**
Operating activities				
Surplus / (deficit)	483	1,923	(249)	(249)
Net interest accrued	19	173	2,141	2,141
PDC dividend expense	309	2,782	2,085	2,085
Unwinding of discount	(1)	(11)	8	8
(Gain) / loss on disposal	89	89	0	0
Operating surplus / (deficit)	899	4,957	3,985	3,985
Depreciation and amortisation	900	8,028	9,219	9,219
Impairments / (impairment reversals)	0	0	0	0
Donated asset income (cash and non-cash)	0	(95)	0	0
Changes in working capital	(438)	35,698	(4,933)	(4,933)
Investing activities				
Interest received	0	12	98	98
Purchase of non-current (capital) assets [1]	(1,597)	(7,955)	(15,749)	(15,749)
Sales of non-current (capital) assets	0	0	0	0
Receipt of cash donations to purchase capital assets	36	132	0	0
Financing activities				
Public dividend capital received	0	84,163	456	456
Net loan funding	0	(84,392)	8,999	8,999
Interest paid	(1)	(378)	(2,177)	(2,177)
PDC dividend paid	0	(1,330)	(2,086)	(2,086)
Finance lease rental payments	(5)	(51)	(72)	(72)
Total net cash inflow / (outflow)	**(205)**	**38,790**	**(2,260)**	**(2,260)**
Closing cash	**44,721**	**44,721**	**1,749**	**1,749**

[1] Outflows due to the purchase of non-current assets are not the same as capital expenditure due to movements in capital creditors.

5.3.1 We have not received any new PDC in month. The YTD receipts reflect the conversion of revenue support and capital loans.

5.3.2 As detailed in 5.1, cash balances remain high due to early payment of block contract income. This continued arrangement, and the anticipated break-even position, will reduce the likelihood of the need for in-year support in the form of additional Public Dividend Capital (PDC). This position is actively managed by the Financial Services team.

5. Financial Performance

5.4 Treasury

Borrowings summary December 2020

	Initial Loan Value	Loan Term	Interest rate (fixed)	Loan Balances Mar 20	Loan Repayment Sept 20	Loan Balances Dec 20	Forecast Repayment 20/21	Forecast Closing Balances Mar21
	£'000	Years	%	£'000	£'000	£'000	£'000	£'000
1. ITFF capital loan	7,500	10	1.96	3,375	(375)	3,000	(375)	2,625
2. ITFF capital loan	6,500	25	4.32	3,848	(133)	3,715	(133)	3,583
3. Interim revolving working capital support	23,289	5	3.50	23,289	(23,289)	0	0	0
4. Uncommitted interim revenue support	40,389	3	1.50	40,389	(40,389)	0	0	0
5. Uncommitted interim revenue support	20,206	3	3.50	20,206	(20,206)	0	0	0
	97,884			91,107	(84,392)	6,715	(508)	6,208

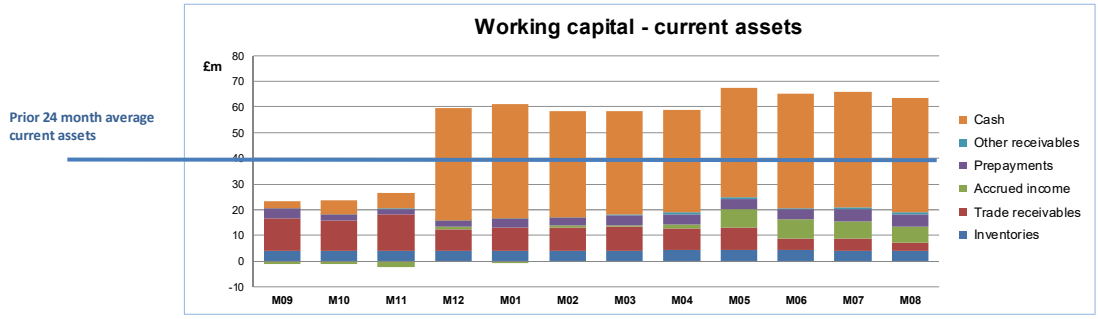
This table does not include finance lease balances, which are included in Borrowings balances in the SoFP.
All listed borrowings are with the Department of Health and Social Care (DHSC).

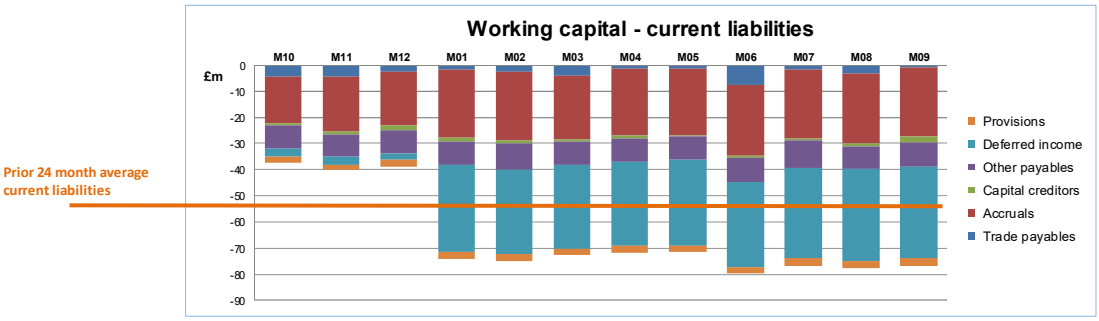
5.4.1 As part of reforms to the NHS cash regime, £83.9m of interim revenue support and working capital loans were repaid in September by the issue of additional Public Dividend Capital. Interest charges on these loans prior to repayment have also been waived in year.

5.4.2 The Trust's remaining borrowings, comprising capital loans, will remain on existing terms and will be repaid at a level of £1m per year.

5.5 Working capital profiles by month

5.5.1 2020/21 working capital shows the impact of early NHS Block receipts. The profiles below show December (M09) working capital balances in the context of the previous 12 months, compared with an average of the previous 2 financial years. The credit risk associated with aged debt is monitored quarterly by the Audit Committee.





5.6 Single oversight framework: Use of Resources (UoR) rating (financial) summary table

	Metric	Descriptor	Weight %	Year to Date Actual	
				Metric	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-17.4	4
Financial sustainability	**Capital service capacity (times)**	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	3.7	1
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	0.5%	2
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.6%	1
Financial controls	**Agency spend (%)**	Distance of agency spend from agency cap	20%	-9.0%	1
	Overall NHSI UoR rating				**2**

5.6.1 The liquidity rating of 4 remains unchanged from 2019/20. The capital service capacity metric remains at 1 and has been significantly improved from a 4 in 2019/20 as a result of the year to date surplus position and the cessation of interest charges on all but capital borrowings. The M9 UoR rating is 2 and this rating is expected to continue for the remainder of the year.

Board of Directors	
Agenda Item	20/21 224
Title of Report	Infection Prevention and Control Board Assurance Framework
Date of Meeting	27th January 2021
Author	Jay Turner Gardner, Assistant Director of Infection Prevention and Control/ Deputy DIPC Hazel Richards, Chief Nurse and Director of Infection Prevention and Control
Accountable Executive	Hazel Richards, Chief Nurse and Director of Infection Prevention and Control
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	4, 5, 6.
Level of Assurance • **Positive** • **Gap(s)**	Positive • Performance against the PHE mandatory surveillance infections • 7 IPC BAF standards – Significant assurance • 10 Key Actions: infection prevention and control and testing – Compliant Gaps • Over trajectory for MRSAb (2 cases YTD) • 4 IPC BAF standards – Limited Assurance
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Executive Summary

This report provides assurance against 3 key areas of infection prevention and control (IPC):
1. Performance against the PHE mandatory surveillance infections
2. Version 1.4 of the NHSE IPC Board Assurance Framework*
3. 10 Key Actions: infection prevention and control and testing

The report provides on update on COVID-19 outbreaks and IPC activity with CQC and NHSE/I.

*The Board of Directors is asked to note that due to the timing of publication of V1.4, overlap with the previous version being presented through our governance structures and now the third surge, this report has not been presented at the Infection Prevention & Control Group meeting, PSQB or Quality Committee. However, given the significance of the content to the effective management of the pandemic, the Board is asked to receive this, without delay.

2. Background

The purpose of this report is to provide the Board of Directors with data, guidance and assurance relating to infection prevention and control.

2.1 PHE & HCAI Public Health England's Data Capture System provides an integrated data reporting and analysis system for the mandatory surveillance of Staphylococcus aureus, Escherichia coli, Klebsiella, Pseudomonas aeruginosa bacteraemia and Clostridioides difficile infections. Each month the Director of Infection Prevention and Control submits the Trust data on each of these infections. Current performance can be seen in **Appendix 1**.

2.2 The Trust continues to experience outbreaks of COVID-19 in inpatient and staff areas.

2.3 The Board of Directors has previously received the '*Infection Prevention and Control Board Assurance Framework'* (IPC BAF NHS England, 2020). The framework is structured around the existing 10 quality standards set out in the '*Infection Prevention Control Code of Practice* (2008)' which links directly to Regulation 12 of the '*Health and Social Care Act* (2008)'. The IPC BAF is largely specific to COVID-19 but also includes IPC practices in general regarding other infections. Previous versions have been received by the Board and this report includes the latest version (1.4), (**Appendix 2**)

2.4 In addition to this, NHSE published "**10 Key Actions: infection prevention and control and testing**". This was published on 17 November 2020 and updated on 23 December 2020 (**Appendix 3**). This report details our progress against these actions.

2.5 The CQC scheduled an IPC Focused Review for 12 January 2021; however in light of the surge of COVID-19, they have postponed the inspection for later in Q4. The Chief Nurse/DIPC now has weekly calls with the Inspection Manager to keep them appraised of the surge situation.

2.6 Weekly calls have also been instigated by the Chief Nurse/DIPC with the Senior Clinical Lead at NHSE/I for the same reason.

3. Current Position

3.1 The current performance against the mandatory surveillance infections is improved on previous years' performance with the exception of MRSAb (2 cases in 2020/21). Please refer to **Appendix 1**.

3.2 During December the Trust declared 4 new COVID-19 ward outbreaks, involving 57 patients and 27 staff. Up to 18 January 2021 the Trust has declared 6 new outbreaks, involving 77 patients and 13 staff. The Trust has also declared 2 staff only outbreaks in January involving 10 staff.

3.3 The Trust has completed a further assessment against the latest version of the IPC BAF V1.4. The completed IPC BAF is in **Appendix 2**. The supporting evidence documents are now stored on a shared drive, managed by the Governance Support Unit; rather than embedding, as we had done previously.

The table below details the assurance rating assigned by the Chief Nurse/DIPC and Deputy DIPC.

IPC BAF Standard	V1.0	V1.2	V1.4 (current)	Summary rationale for rating
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 risks posed by their environment and other service users.	Significant	Limited	Significant	
2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Limited	Limited	Limited	Demand and supply for Hotel Services, as the number of COVID-19 wards and bed occupancy increases.
3 The use of antimicrobials to optimise patient outcomes and manage adverse effect.	Significant	Significant	Significant	
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.	Limited	Significant	Significant	
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.	Significant	Significant	Limited	The rapid increase in patients with COVID-19 and high occupancy levels means that timely isolation is often challenged.
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.	Limited	Significant	Significant	
7 Provide or secure adequate isolation facilities.	Limited	Significant	Limited	The demand for single rooms and COVID-19

				wards has increased significantly. Meaning it is not always possible to isolate in a timely way.
8 Secure adequate access to laboratory support as appropriate.	Significant	Significant	Limited	The demand for rapid and point of care testing for COVID-19 cannot be matched by the supply; meaning patients can wait up to 24 hours for results.
9 Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infection.	Limited	Significant	Significant	
10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Significant	Limited	Significant	
11 The Trust can demonstrate effective and knowledgeable leadership in relation to IPC at all levels, relevant to roles.	Limited	Limited	Significant	

3.4 The Trust has completed a controls and compliance assessment against the "**10 Key Actions for IPC**" (NHS December 20, **Appendix 3**). We have assessed ourselves as **COMPLIANT** against all the standards. Updates to these actions are presented at Clinical Advisory Group and changes made as required.

4. Conclusion

The Trust is performing well against the majority of the mandatory surveillance infections. However, significant challenges exist in preventing COVID-19 transmission due demand and supply of rapid testing, ability to isolate in a timely way due to high occupancy levels and maintaining high standards of cleaning during the current surge. There areas of significant assurance against the IPC BAF standards and the Trust is complaint with the newly published "10 Key Actions for IPC".

5. Recommendations

The Board of Directors is asked to note the contents of this report, acknowledge the controls in place to mitigate and / or minimise the levels of risk associated with the surge of COVID-19.

IPC BAF Report to Board of Directors 27 January 2021
Appendix 1

COVID-19 Infection Prevention and Control Board Assurance Framework

Effective infection prevention and control is fundamental to our efforts. This board assurance framework was developed by the NHS to support all healthcare providers to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19-related infection prevention and control guidance and to identify risks.

- **The first version of this framework was published on 4 May 2020; updates on 22 May are highlighted in yellow.**
- **Additional Assurances since the first version submitted at WUTH are highlighted in green.**
- **Version 1.4 was published in October 2020; updates are highlighted in pink**

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	Risk assessment templates used in all entrances e.g. Adult ED, Children's ED and Maternity. Infection alerts are on Cerner for all patients with a previous IP alert organism. On admission Cerner initiates admission screening as per specific screening policy i.e. CPE, MRSA COVID.	Adherence to policy	Audits completed by Environmental Matron. Daily report generated to monitor adherence to policy. Screening compliance data to be reported Monthly at IPCG Guidance available on emergency admission of extremely vulnerable patients
• patients with possible or confirmed COVID-	Screening/swabbing policies and SOPs are in	Potential asymptomatic patients	Risk assessments in place.

19 are not moved unless this is essential to their care or reduces the risk of transmission	place for clinical pathways e.g. pre-op/elective and emergency pathways. Patient admissions to appropriate ward as outlined in the ward escalation plan. Bed management operating procedures in place to monitor COVID-19 results and appropriate allocation of beds. Local policy regarding result being known before patient leaves ED/Assessment area to ensure correct placement first time	who are cohorted may be in incubation phase, therefore risk of infecting other patients. When ED and Assessment areas are full to capacity, patients will be risk assessed by a senior clinician and placed in the areas that presents the least risk.	Patients with COVID symptoms are transferred to a designated ward awaiting lab confirmation, pts with positive results transferred to another ward. Contact tracing in place for pts who have been exposed to positive patients. Re-admission policy of previous COVID +ve pts Swabbing policy for day 0 , 3 and 6, and thereafter every 7 days Audit of swabbing compliance
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Transfer and discharge procedures in place, pre-swabbing process in place for discharge to social care, all patients provided with discharge advice leaflets. New Collaborative guidance introduced		Cerner amendment required to mandate swab request and result prior to discharge. Audit of documentation in place to monitor adherence to standard. Local guide for discharging patients available including CRC and WNRU pathway
• monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice	A WUTH Quick COVID audit has been developed which is completed weekly along with an IP&C monthly inspection which is part of WISE. Daily hand hygiene audits are completed on Outbreak wards	Demand for Hotel Services not always matched by supply	Additional staff recruited. Re-training of supervisors.
• monitoring of compliance with PPE, consider	A WUTH COVID PPE audit has been developed		Lessons learnt from audits fed

implementing the role of PPE guardians/safety champions to embed and encourage best practice	which is completed weekly. Don and doffing competence developed and training in place.		back to the divisions 7 day delivery of required stock to the wards
• staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	Local Policies and procedures for testing and isolation available. WUTH staff contact tracing team active On-site POD for real time staff testing open x 7 days week. Mass Staff asymptomatic testing completed. Lateral flow testing rolled out for asymptomatic staff and staff with symptoms advised to remain off and go to have a PCR swab taken in the onsite swabbing POD Staff screening considered during outbreak control meetings.	Staff get tested in the community and we do not have evidence of the results When staff contacted by the COVID app to say they have been in contact with someone with COVID and they need to isolate. Not always possible to know when or who they were exposed to. Staff not consistently turning off the app when in clinical environment.	Communications via the daily bulletin and associated posters available Staff tested positive in the community are re-tested if they present at ED Staff have to show evidence of the message received via text to their manager
• training in IPC standard infection control and transmission-based precautions are provided to all staff	Additional H/H training, PPE donning and Doffing competency rolled out trust wide Extensive fit testing programme using qualitative method. Cleaning and decontamination training rolled out to all wards 'Clean between' Ward manager Action Card and Nursing Cleaning checklist	Staff not always following precautions	Doffing and Donning training video on the intranet. Link to training resources on Intranet Regular IPC walk rounds by the IPC team observing staff practice and addressing and issues in real time with staff
• IPC measures in relation to COVID-19 should be included in all staff Induction and	IPC measures included in mandatory training which is via e-learning and the IPC team present at induction.		

mandatory training			
• all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	Posters available throughout the Trust on walls/ floors/lift doors Lifts have a poster stipulating how many people are allowed in for each journey HANDS.FACE.SPACE. posters throughout the trust Lift doors have hand hygiene messages on them Posters on office doors stipulating how many staff allowed	Staff not adhering to policy all of the time	Frequent messages via comms Point prevalence audits by senior teams Letter sent to all staff from HR reminding them of the policy with hands.face.space. Weekly point prevalence audit of all non-ward areas to support compliance to policy
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	All posters and literature reflect national guidance. Donning and Doffing programme developed that is competency based. Posters available for different levels of PPE Checklist for opening a red ward		Documents available on intranet for staff about how to put on and remove a surgical mask Poster available to show staff how to and how not to wear a surgical mask Local induction for all new staff on the ward
• patients and staff are protected with PPE, as per the PHE national guidance	Local policies reflecting national guidance are updated regularly and available on the intranet. Staff are updated to changes via regular communications updates, messages reiterated by Staff Support Team. Posters displaying correct use of PPE in all clinical areas. Information leaflets and videos available to down load for ongoing education. Daily sit rep of ward stock availability in place to ensure appropriate supply to meet demand. Comprehensive fit testing plan and reporting mechanisms via BI. PPE managed via command and control structure.	National supply of FFP3 masks limited and unable to stipulate the model and manufacture of mask required locally.	Ongoing Fit testing schedule to ensure staff are fit tested to available masks. Trust plan for FFP2 in event of FFP3 depletion. Donning and doffing training in all areas Training and education of staff when stock changes Poster available for staff on

	Patient covid awareness packs given and asked to wear a surgical face masks		correct glove selection to ensure correct choice for procedure Audit patient mask wearing by Environmental Matron
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	PHE/GOV updates are shared at daily meetings, current guidance revised to reflect the changes , reviewed via Clinical Advisory Group, and approved and operationalised via command and control structure. Training plans and staff support team to continually update. Dedicated COVID-19 site on Internet updated each time new local guidance reflecting national updates are made. National guidance reviewed daily and local sop's reviewed to reflect any changes	Staff not knowing that changes have been made Local policies not been updated as national policies change	Messages reiterated via Staff Support Team and senior management during walk rounds, communications are sent 3 x week. Daily text sent to staff as and when needed SNMT review adherence to guidelines when completing weekly walk rounds. Leaflets and posters printed and taken to wards to replace previous version when changes are made. Version control on leaflets and posters Agenda item at CAG regarding updating policies and process for updating intranet
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	As above changes managed via control command structure. IPC papers regularly to monthly PSQB, Quality Committee and Trust Board re IPC position. Risk Register articulates level of risk. COVID-19 risk register in place to monitored via Risk Management Committee.		All meetings where social distancing cannot be maintained are captured by Microsoft teams.
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	As above, risks in relation to COVID-19 included in the Risk Register along with other IP risks. All risks reflected in BAF. Head of Governance		Electronic reminders when risk is due for review

	attends gold command meetings. Risks reviewed at Risk Management Board.		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	IPC Environmental and Perfect Ward audits are reported by exception to the Infection Prevention and Control Group. Clinical system able to flag patient specific infection history. Swabbing protocols. RCA/PIR process for alert organisms. Communicable diseases outbreak management operational guidance followed. Mandatory training compliance reported Surveillance programme for all alert organisms and weekly reporting to the divisions.		Weekly hospital onset infection review meeting chaired by the Chief nurse/DIPC . Updated IPC side room prioritisation and guidance on patients who are shielding is available Environmental risk assessments available for staff and pt areas
• that Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	Daily data submissions via the daily nosocomial sitrep are signed off by the Chief executive or Chief nurse who is the Director of Infection prevention and Control (DIPC)	Data submission is incorrect and there is no validated process	Process developed locally to ensure sign off of data at three different levels to avoid mis-reporting
• ensure Trust Board has oversight of ongoing outbreaks and action plans.	DIPC included in mins from outbreaks. Outbreak updates delivered by the lead for IPC at CAG and SILVER command meetings. Weekly call with all NEDS, briefed on IPC position. IPC reports to Board		Outbreak updates within IPC reports at monthly IPCG meeting
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	e-Roster system and flexing of shifts to ensure staff skills and deployment is are appropriate to requirement. IPC mandated training continues on induction	Potential gaps in general training records, some records manual and not electronic. Not all general training is	Recruitment to a new developed post - Environmental Matron who will work in collaboration with Estates/IPC/Ward/ Matrons.

COVID-19 isolation or cohort areas	and as part of Core Skills. Clinical skill and simulation training re-commenced. Upskilling training days for clinical staff e.g. Specialist Nurses/ AHP's/Research. Videos - donning and doffing video and demonstrations at fit testing sessions. Training recorded on ESR. Theatres and ITU - recorded on OLM.	competency assessed nor does staff self-declare compliance with course preparation e.g. pre-course reading material Some training is only face to face as there are no e-learning modules.	Discussions ongoing with Training, IPC and BI to develop a regular compliance report. Manual processes currently in place to monitor compliance. Adding self-declaration on the intranet to keep a record of training that can be audited. Reviewing additional on line training opportunities. Daily review of rotas by senior nursing team's staff deployed appropriately following daily risk assessment of areas. Fit testing procedures in place Add hoc training available by the IPC team and practice based educators. Training resources available on the intranet
• Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	Video available on intranet with the latest guidance that can be accessed in all areas by Hotel Services. Specific training has been provided by the IPC team for cleaning staff including enhanced donning and doffing and fit testing. SOP available.	Variability in standards of cleaning. COVID-19 related sickness particularly out of hours.	Recruitment drive, review of current roles within the team. Cleaning delivery and assessment of standards now a collaborative approach between E&F and the nursing teams Joint walk rounds and audits commenced with supervisor and matrons. to assess standards of cleanliness of the wards. Assessment process being agreed for Estates / facilities and clinical

			teams to assess all clinical areas cleanliness. Standards of cleaning concerns escalated to local supervisor to address .
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	IPC Trust policy and procedures/flow charts. Decontamination policy. Decontamination equipment guidelines. Increased cleaning in line with national guidance using chlorine based disinfectant. Cleaning information shared. Posters on what to use updated. Antiseptics and clinical disinfectant policy available . Hydrogen Peroxide Vapour cleaning utilised. UV light cleaning utilised Disinfection wipes in use effective against Coronaviruses.	Rooms not cleaned to standard required. Delays can occur due to availability and demand on hotel services	Decontamination awareness week regarding the correct use of the disinfectant wipes has taken place Terminal clean procedure checked following completion by ward manager or equivalent. Additional staff recruited and trained.
• increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Hotel Services coordinate three additional enhanced cleans ensuring disinfection of all high touched horizontal surfaces on all wards where patients with known or suspected COVID are nursed. Enhanced cleaning is instigated on wards where there are clusters/outbreak of infection identified. Enhanced cleans are completed for all patients with known or suspected CDI/CPE/Norovirus..	Vacancies within the Facilities domestic teams so frequency of cleaning requirements not always maintained. Standards of cleaning across the Trust are variable. C4C audits not completed when wards have outbreaks The wards only receive the overall C4C audit score , not the report Not all areas are cleaned twice per day	Increased capacity of team through agency support, and WUTH staff providing additional hours Perfect Ward Audits monitoring standards. IPC audits monitoring standards reported to IPCG/ Executive CDI panel. The wards now receive the full C4C report Walk rounds of the wards with supervisor and matrons to review standards and agree actions.

			Increased senior leadership capacity to support compliance in some areas (ITU) Guidance is communicated through the command structure from NHSE/PHE regarding items that can be used more than once. C4C audits completed by E&F and now include the ward matron
• attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas.	All toilets are cleaned three times a day across site.and more frequently when they have multiple users. In area where there is known or suspected infection, where enhanced cleans have been requested these areas are then cleaned more frequently than twice per day. HPV cleans are completed of all bathrooms /toilets where enteric precautions have been required Ward Manager checklists	Vacancies within the Facilities domestic teams so frequency of cleaning requirements not always maintained. Standards of cleaning across the Trust are variable.	Hotel services report on a monthly basis to the IPCG of all HPV cleaning, Enhanced cleaning and terminal cleaning that is both requested and completed. Resources identified to increase the Domestic cleaning team to support more frequent cleaning.
• cleaning is carried out with neutral detergent, a chlorine-based disinfectant in the form of a solution at a minimum strength of 1,000 ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	Chlorine based disinfection is used throughout the Trust as standard by the domestic teams.	Staff do not know how to use the products correctly.	Training completed by the supplier of the chlorine disinfectant product. Awareness week held by the IPC team with the assistance of the supplier of the disinfectant wipes, entitled 'clean between ' week. Adenosine triphosphate (ATP) testing is completed by the IPC Team in areas where patients with infections are nursed to test the efficacy and effectiveness of the cleaning. UV torch is used as part of the

			Evaluclean system-florescent markers are used leaving non visible marks and following cleaning a UV light is used to detect if the area has been cleaned.
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products as per national guidance	Contact times are followed as per manufacturer guidelines	Unable to check that people are allowing the correct contact time	Remind staff all the time of the contact time needed. Posters developed reminding staff of the contact time
o 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or bodily fluids	WUTH has a Domestic Service Cleanliness model that conforms to the Department of Health guidelines on the specification for the planning, application, measurement and review of cleanliness services in hospitals. The standards are governed by the following legislation: • National Specifications for Cleanliness in the NHS 2007 • The Revised Healthcare Manual 2009 • PAS 5748 specification 2014	Items are found dusty following walk rounds	C4C audits completed monthly by Estates and facilities team with a matron present. IPC complete environmental audits on an ongoing annual programme. Ward matrons complete walk rounds of all areas with supervisors to check standards at add hoc periods when concerns are raised
o electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	Flyers devised, including the non-ward based areas to ensure that admin and secretaries who predominantly use electronic equipment have advice on when and how to clean and what with .	Staff not being aware of the guidance. Staff not knowing what products to use or how to order them	Posters/leaflets developed reminding staff to clean mobile phones, desk phones, tablets, desktops and keyboards least twice daily and also detailing the products to use and the order codes. Bags of the appropriate wipes and leaflet were made up and

			delivered to all of the office areas that are outside of a ward* and department*. *These areas have the products available all of the time
○ rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Policies and procedures available to ensure these areas are addressed		All areas where CVOVID patients are nursed receive enhanced cleaning – which is at least twice per day.
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Standard procedures in place as per Trust IPC policy. Included in IPC mandatory training and uniform policy. Managed service assurance from national accredited service provider that all linen is laundered according to NHS standards.	Adherence to policy	New sop was revised following PHE guidance for COVID and circulated and is available on the trust intranet
• single use items are used where possible and according to Single Use Policy	Single use policy. Training provided to all staff re the appropriate use of single use products.		Pulp products available for disposal of al bodily fluids Single use B/P cuffs in use Single use guidance within the Decon policy
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Decontamination Policy IPC Audits Cleaning standards agreed. C4C audit		Audits of cleanliness of Patient shared equipment completed via perfect ward app Use of the UV light and ATP to monitor cleaning standards
• ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Cleaning check list devised for all ward areas initially and now in development for non-clinical areas. Escalation procedure devised for cleaning failures	Shortfalls in staffing reflects on the cleaning standards	C4C audits completed by dedicated domestic team 'Light pen' audits take place which are completed by the IPC team. IPC audits/ point prevalence

			audits for all areas Resources increased to provide more domestic staff
• ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	Ventilation group meet once per month Ventilation policy and ToR available Guidelines developed on the importance of opening all windows on a frequent basis.	Not all windows can open Staff not aware of the need to open windows.	Estates have checked all windows to ensure that they open Comms information regarding opening windows Opening of windows x 3 day is contained in the ward managers checklist. The requirement to open windows included in the local COVID risk asessment.
• there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	Chlor-clean is the disinfectant of choice for all horizontal surfaces cleaned by domestics throughout the trust pre-COVID. Clinell disinfectant wipes were introduced to the trust for all staff cleaning pre-covid 70% alcohol wipes used for cleaning all electronic equipment i.e. key board, telephones, computers, pens. Staff mobile phones.	Staff not aware how to use chlor-clean Shortages of wipes due to national demand	Staff are trained in the use of chlor-clean Posters available in all domestic cupboards and ward sluices about the correct dilution and preparation Procurement have identified alternative wipes should the ones we use have a sudden shortage in supply.
• review and ensure good ventilation in admission and waiting areas to minimize opportunistic airborne transmission	Ventilation policy available Co2 monitoring in place across different areas. Pressures tested for negative and positive rooms. All windows serviced and can now be opened. Guidance available to wards on frequency of opening to support flow of fresh air. Air purifiers expected w/c 25 January	Many clinical areas may not have adequate ventilation due to bay doors being fitted a few years ago and vents are in the main corridors	Guidance given tot wards on opening bay doors and windows as appropriate Fan and air conditioning guidance developed reflecting new guidance released from PHE.

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	Ward based antimicrobial stewardship ward rounds undertaken by Consultant Medical Microbiologist (CMM) with antimicrobial pharmacist and ward based clinical team. This was commenced as a pilot on; • gastroenterology (once weekly) • orthogeriatrics (once weekly). The pilot was then extended to: • Acute Care (three times weekly) • Elderly Care ward 22 (once weekly) • Respiratory (twice weekly) • Older persons admission unit (once weekly) Antimicrobial stewardship team (AST) meetings (quarterly). To recommence Q2.		Updates reported at the monthly IPCG
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	Monthly stewardship reports completed and on the agenda at the IPCG monthly meeting		Updates reported at the monthly IPCG
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	Trust wide visiting guidance developed based on national guidance. Currently being updated with reasonable adjustments. Divisional and trust communications.	Currently unrestricted access to building. Staff not heeding to the	Lock down protocol in development and to commence early June 2020. Lockdown of the site commenced

visiting patients in a care setting	Leaflets available	guidance.	June 20 and staff signposted to where they could and couldn't enter Staff and visitors have separate entrance and exits Guidance on visiting under review national as guidance changes Leaflets available for visitors regarding arranged visits
• Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	Clear signage across the Trust including ward entrances identifying the category of ward it is in relation to COVID-19and what the correct PPE is for that area.		
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	Current information available on the website. Browse Aloud technology which enable easy read and alternative language options. Interpreter contract in place to include sign language, ability to do remotely. Family support team available.	Staff not able to access the intranet	Communication update daily and then reduced to twice per week in August, this has links for staff to easily download current data . Browsealoud available on our website which allows you to view web pages and documents in enlarged text, translated into different languages, they can also be read aloud. It's the orange icon on the top right of the website. Patient leaflets also have a line on them to say they can be ordered in large print, braille and on tape if required. East read leaflets available through EIDO PHE also have easy read leaflets available
• infection status is communicated to the	Captured within discharge summary.	Staff forget to hand over	Question asked during admission

receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Cerner transfer document. Verbal handover. C-Diff letter sent to GP's from IPC	infection status	and discharge pathway about infection status
• There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	Patient admission leaflet available and is given to all new admissions within a Patient COVID safety pack. Posters on walls have Hands.Face.Space logo's Poster developed stating that all patients and visitors must wear a fluid repellant surgical mask	Patients and visitors non compliant with policy	Patient leaflet and poster state that patients may be asked to leave if they do not help us to help them by wearing a face mask Ward staff walk round after every meal offering patients a clean face mask Alternative arrangements are made following a risk assessment for those patients who cannot wear a face mask due to clinical condition Clinicians ask and encourage patient's to wear a face mask when on ward rounds.
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: • screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	Screening programme follows national guidelines . Local screening is day of admission (day 0) then day 3 then day 6 and local screening guidelines for outbreak and also screening of patients who have been in contact with a patient with COVID. There has been a 'COVID-19 Screening Quick Guide' developed There is an 'Enhanced screening strategy for	Staff do not follow screening guidance	Compliance is monitored using an electronic reporting system which is reviewed daily to promote adherence to policy Discussed at daily safety huddles

	inpatients in WUTH' available.		
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non-COVID-19 cases to minimise the risk of cross-infection as per national guidance	Reconfiguration of adults and Children's ED and Maternity Services pathways to allow appropriate triage processes. Appropriate signage displayed at all entrances. Additional reconfiguration in other clinical areas in line with surge plan. All admissions are swabbed and COVID-19 status is displayed on Cerner. Several testing methods available to meet the needs of the patient. Flow chart developed for easy reference to what tests to complete Intranet has policies that cover all pt pathways Range of posters available to cover all patient pathways for display on associated doors	Audit of all admissions to ensure swabs taken.	
• staff are aware of agreed template for triage questions to ask	List of questions available for all new admissions and attendances at ED		
• triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	Policies and protocol are in place Admission of Known or Recent Positive COVID -19 Patients Flow Chart' developed	Staff not following policy.	All staff made aware of policies at staff 'safe space' huddles
• face coverings are used by all outpatients and visitors	Mask holders available at all entrances to the hospital with posters asking and informing how to us	Patient unable to wear a face covering due to clinical condition Patients not aware of the need	Guidance available if the patient can't wear a face covering Managed patient entrances, and

	Posters advertising the requirements for staff and patients and visitors to wear surgical masks at all times and at entrances, visitors are asked to change face covering to surgical mask by security staff. Posters asking visitors to replace face covering with face mask when entering the hospital SOP developed on how social distancing can be promoted for patients attending out-patients for appointments.	to wear a face mask Patients do not have a face mask	surgical masks are offered on entry to the hospital. Volunteers at patient entrances to support and help with patient/visitor enquiries.
• face masks are available for patients with respiratory symptoms	Managed patient entrances, masks are offered on entry to the hospital. Mask holders available at all entrances to the hospital. There is local guidance for assessment of those who report difficulties wearing a surgical face mask' 'PPE and Alternatives for Respiratory Protection for COVID-19' guidance available Different styles of mask are available for those with breathing difficulties.	Patients not aware they have to wear masks Patients refusing to wear masks Patients do not have a supply of face mask	Posters advertising the requirements for staff and patients to wear surgical masks at all times Leaflet and posters informing patients that if they refuse to wear a mask and they are able they may be asked to leave as they are putting others at risk. Patient COVID safety bags contain face masks
• provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	Patient leaflet available and pt provide with a pack containing face masks and advice regarding their use – 'Your Inpatient Stay' Supply given in patient pack on admission and replenished by ward staff Guidance available on assessment of those who report difficulties wearing a surgical face mask'	Patients refusing to wear face masks	Guidance developed for staff when pt refuses to wear a mask Posters giving clear guidance on the requirement for all patients to wear a surgical mask at all times

• mask usage is emphasized for suspected individuals	All patients are now asked to wear a mask, symptomatic or not and local guidance has been developed on how we can reduce the risk if they cannot	Patient refuses to wear a mask	Guidance developed for staff when patient refuses to wear a mask
• ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff	Areas completed a risk assessment with H&S and IP to look at how to reduce the risk and screens introduced where needed. All inpatient areas have Perspex curtains around every bed.	Staff have not completed the checklist to make their areas COVID secure	Managers asked to ensure teams have submitted and compliance is reviewed
• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	Contact tracing takes place for all patients confirmed with COVID Locally developed Patient leaflet informing about Coronavirus testing is given to all new admissions	Contact tracing does not take place until confirmed Positive.	IPC follow up all confirmed COVID patients daily
• for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Following a positive result the IP team start to complete contact tracing of patients who the positive patient has come across on their patients journey Policy developed for management of newly suspected cases and exposed patients on a ward .	Potential outbreak if not carried out in a timely manner	Daily checks by the IP team
• patients with suspected COVID-19 are tested promptly	IPC Policy in place. Re-testing protocols. Bed escalation plan according to patient infection status and clinical presentation. Number of beds reduced on wards to enable social distancing and reduce the risk of nosocomial infection. Risk assessments completed for admissions and patients cohorted or allocated side rooms accordingly.	Delay in testing	Compliance report in development with Cerner
• patients that test negative but display or go	SOPs in place, patients are risk assessed and swabbed (where appropriate) eg Maternity,	Staff don't screen the patients as per policy	Chairs in the waiting room are marked to ensure social distancing

on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly	Cancer, Outpatients and Radiology. Virtual appointments are / will be offered where appropriate, Designated COVID-19 areas in all departments. Policy developed Contact tracing takes place for all patients confirmed with COVID by the IPC team	Patients are discharged before results are known and they are a contact	measures are in place. Patients contacted at home by the IPC team to inform them that they have been in contact with a positive patient and to be aware of symptoms and what to do if they get them, leaflet also sent to then with the advice.
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Screening policy developed for all patients, in pts or out pts. Information available regarding shielding patients		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	One way system in use in the areas which will allow. Separate entrances and exits available for staff and patients. Staff only allowed to use catering facilities to avoid unnecessary visitors to the trust using facilities.	Visitors attending the hospital out of hours	Patient entrances are manned by staff who question visitors regarding purpose of visit. Staff entrances are electronically activated with a swipe card
• 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	IPC mandated training for all employees. Video remains on line and latest guidance available on intranet and in clinical areas. Specific training has been provided for facilities, estates and contactors including	Not all training records are held centrally. Ad-hoc arrangements need to be formalised for the future.	Process is being developed to ensure all records are updated on OLM. Currently managed manually.

	enhanced donning and doffing and fit testing. PPE displays at main reception. Daily monitoring of application of PPE standards. IPC standards re-iterated to all outside contractors.		
• 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	PPE policy COVID-19 protocols follow PHE guidance FIT testing sessions Demonstrations of DON / DOF processes at each session. Glove selection guide available	Competency framework not formally assessed	Audit of PPE protocols completed by IPC team when visiting every ward and advice and support given in real time. Compliance assessed visa COVID perfect ward audit . Posters available to update staff and revised as guidance is reviewed by PHE Compliance to PPE training reported by exception to IPCG
• a record of staff training is maintained	OLM maintained Local records available	Not all records on OLM Audit required	Manual records in place , plan for development of BI portal for live recording of training records
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	CAS alerts are managed through GSU team, reported to PSQB. Head of Governance attends Gold Command Meetings. Re-use of PPE is overseen by the IPC team Trust policies in line with national guidance re reuse of PPE.		Communications to staff to remind them to Datix any issues Re-use of PPE is managed by Estates and IPC / monitored via control and command structure and PPE daily meeting
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	Ulysses Incident Reporting System – COVID section. Incident Management Policy GSU process in place monitoring of incident management. H&S rep attends all Outbreak meetings and breeches in PPE are an agenda item		Three times a week COVID-19 Perfect Ward Audit Daily Hand Hygiene Audit

• adherence to PHE national guidance on the use of PPE is regularly audited	Audit of PPE protocols completed by IPC team when visiting every ward and advice and support given in real time COVID-19 Perfect Ward audit completed three times a week.	Frequency reduced due to PPE requirements and social distancing	Adding the hand hygiene competency for all staff to the ANTT Policy for all staff Perfect ward app includes audit of PPE for COVID
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: ○ hand hygiene facilities including instructional posters ○ good respiratory hygiene measures ○ maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care ○ frequent decontamination of equipment and environment in both clinical and non-clinical areas ○ clear advice on use of face coverings and facemasks by ○ patients/individuals, visitors and by staff in non-patient facing areas	Hand hygiene technique as a visual picture is available at every hand hygiene sink on the soap dispenser Patient leaflet available regarding how to behave in a safe manner Social distancing guidelines available Checklists developed for identifying high touch surfaces and which staff group cleans what i.e. Domestics and nurses. Local PPE guide covering all patient contact scenario available 'Wearing A Mask Do's And Don'ts' poster available and displayed around the trust	Staff not aware of the annual campaign of **catch it, bin it, kill it**. Staff and patients not aware of the trust policies and protocols Staff and domestics not aware of changes in practice	Environmental cleaning audits completed National **Catch it! Bin it! Kill it!** Posters on display throughout the trust in patient and non-patient areas Posters for staff regarding PPE use and when to wear what Checklist visible as an aide memoire on the wards for Domestics to identify when cleaning has taken place and at what frequency Key IPC measures included in the perfect ward/wise audits
• staff regularly undertake hand hygiene and observe standard infection control precautions	Process in place for hand hygiene audits and standard IPC observations. Handwashing competence to be approved as part of ANTT protocol for ALL staff. Staff Support team Uniform policy Trust Communications	Variability of standard of hand hygiene compliance	Monitoring of compliance via CDI panel, IPCG, Corporate ward reviews. Matrons perfect ward audits Monitored via matrons audit – perfect ward. H/H assessment reviewed and changed
• the use of hand air dryers should be avoided in all clinical areashand dryers in toilets are associated with greater risk of	Hand dryers are not in any clinical areas where there are clinical hand hygiene sinks Audit completed, there are no hand dryers in	Staff use hand dryers as they thought that was cleaner than using a paper towel.	Review /options appraisal underway of all patient/staff/visitor toilets that

droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	any staff clinical areas. Paper towels have now been installed in all visitor toilets Posters on visitors toilets regarding the need for hand hygiene following using the toilet. Paper towels installed above the sink and not in direct splash field.		have hand dryers and the cost of replacing these with hand towels, including waste bins Rationale cascaded to staff regarding paper towels v hot air driers.
• guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Hand hygiene posters are available reflecting information within the hand hygiene policy regarding the importance of drying hands well with paper towels		Re-iterate the importance of hand drying versus air drying
• staff understand the requirements for uniform laundering where this is not provided for on site	Policy developed regarding scrubs use and uniform policy re-iterated for all other areas	Staff leave the site in uniform	Messages via communications on a frequent basis reminding staff of the standards Weekly and monthly audits at all staff entrances and exits by the senior team to check compliance to the 'non travelling in uniform policy'
• All staff understands the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	SOP including flow chart in place explaining how to contact absence line and swabbing referrals. Trust intranet COVID-19 site. All pathways revised in line with new symptoms guidance and communicated to staff via Trust communications. Policy available for 'Symptomatic staff and household member swabbing and return to work' Poster developed following national guidance to give advice and information for staff on isolation at home when family members have COVID	Staff attend work with symptoms Staff are not aware of symptoms	COVID-19 Perfect ward audit to be completed three times a week. Contains a question regarding symptoms. Staff are asked at every safety huddle if they have had symptoms – low threshold Lessons learnt resulting from staff absences /outbreaks when staff have attended work with symptoms is shared with Teams

• a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	Daily report produced by the by IPC team with details of contacts / blocked beds throughout the trust, this also covers other infections not just COVID Trust wide Sit reps completed and circulated daily IPC COVID sit rep available. Weekly reports from OH regarding positive staff members Staff testing data received at frequent intervals during the day Local SOP 'Criteria for rapid COVID testing' based on national guidance. Local SOP 'Enhanced screening strategy for inpatients in WUTH' based on National guidelines.		
• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported	'Management of COVID-19 Case Cluster Outbreaks' policy Outbreak meetings take place on a regular basis following the declaration of an outbreak Agenda for outbreak meetings follow yhe IPC 10 point guide. Electronic reporting of Outbreaks once declared, including ongoing updates of any changes, which has replaced the IIMARCH report. Following national guidelines all COVID infections that are determined probable or definite hospital onset trigger a local RCA. If an outbreak is declared, once it is closed a	Outbreaks are missed National guidelines are not followed Electronic reporting of all Outbreaks within 48 hrs of the first meeting	Daily updates of positive cases IPC receive the 4 hrly report of symptomatic staff that have been screened via the onsite screening POD. Weekly report from the contact tracing team identifying areas of work of positive staff to look for links and possible cross infection.

	Table top exercises is arranged to discuss mitigations introduced to bring the outbreak to a close and the lessons learnt during the investigation and management of the process.		
• robust policies and procedures are in place for the identification of and management of outbreaks of infection	'Management of COVID-19 Case Cluster Outbreaks' policy available with clear information regarding roles and responsibilities on how an Outbreak is determined and the action to take	Staffing pressures result in no local ownership of the Outbreak. Bed pressure has a significant impact on following policy and guidelines	Policy discussed and agreed at CAG. Roles and responsibilities agreed at clinical advisory group. Senior teams support attendance at Outbreak meetings. Using a risk assessment approach any deviation from the guidelines involves Infection Prevention . Outbreaks have agendas and are minuted and shared with divisional teams
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: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	SOP is available regarding social distancing. There is a patient pathway available for all admissions, classified as RED/AMBER/GREEN/SILVER areas and where Theatre has a local a BLUE pathway Designated entrances for patients/staff/visitors One way system for patient traffic around the hospital	Pathways cross as staff are not aware of any changes	Wards identified for different pathways. Wards do not have mixed pathways Pathways are reviewed daily and sop revised as needed Multi-disciplinary staff groups informed and information cascaded
• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand	Local policy for 'Bed Management of COVID or Suspected COVID' following national guidelines	Staff /patients/visitors do not follow the guidance	Wards have posters outside to signify category of risk (Red/Amber/Green/Silver)

the different risk areas	Designated entrances to the building at WUTH and CBH for staff / patients/ visitors that are signposted . Free standing signposts/ barriers / Perspex screens used when required to promote one way movement and segregation for staff /patients/visitors.		Perspex Screens and retractable screens available across the site to assist with segregation.
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	SOP in place identifying designated wards for patients with suspected or confirmed COVID-19 Designated areas in ED and Critical Care and all assessment areas for all patients with known or suspected COVID Side rooms utilized whenever possible and toilets and bathrooms designated for use	Limited availability of side rooms resulting in cohort areas. Lack of side rooms does not mean that this can always happen. Not all side rooms or cohort areas have ensuite facilities.	Operationalised with up to date daily bed escalation plans. Monitored via command and control structure. Charting processes in place Bed base reviewed by Bed Manager continually Ward categories updated to reflect COVID prevalence in the hospital
• 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 are admitted when possible to a single negative pressure room / area or a neutral pressure room. Cohort areas are identified when no single rooms are available Isolation policy available Decontamination policy available. All efforts are made to continue with isolation/cohorting of patients with alert organisms.		Ventilation management included within the IPC strategy. Designated toilet for pts with known or suspected infections
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	SOPs in place Isolation policy Standard IPC precautions are adhered to for all		IPC guidance updated to include COVID for prioritisation of side room use based on the organisms and risk of transmission

	patients Ward audits		Identified cohort areas when isolation is not possible
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: • ensure screens taken on admission given priority and reported within 24hrs	Admission screening policy available and reviewed as National guidance changes 'WUTH COVID-19 Screening Policy'	Staff forget to take the screens Not all results are available within 24 hrs due to capacity Insufficient rapid screens and point of care tests due to national restrictions	Compliance to the screening policy is now electronic and all staff review their own areas each day to promote adherence to the guidelines. Screening is discussed at each staff huddle Daily turnaround of results are reviewed and those that are longer than 24hrs to be returned are investigated
• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	This is reported on the dashboard daily	Not all results are available within 24 hrs due to capacity	Daily turnaround of results are reviewed and those that are longer than 24hrs to be returned are investigated
• testing is undertaken by competent and trained individuals	SOP in place, authorised by the Clinical Director, the process has been validated (to UKAS accreditation standard) and staff have been trained appropriately and this has been logged.		
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	All urgent suspected COVID-19 tests are processed in-house with a 2 hour TAT using the Cepheid GeneXpert test (other tests referred out). We monitor TATs for assurance. Our trust testing algorithm is based on PHE guidance. COVID Screening in place: a) Diagnostic testing of patients	Staff are observed, standards of documentation vary regarding competencies.	Competency sign off process for approval.

	b) Discharge screening of patients to Nursing homes and CRX/WNRU c) Screening of elective cancers surgeries d) Screening of staff e) Screening of admissions f) Criteria for rapid testing		
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	IPC review all COVID positive patients to ensure that they follow the individual patient pathway. The information team liaises with the IPC analyst prior to sign off by the CEO of all the data to ensure data is accurate.	Failure to follow policy during escalation and the demand for beds	Compliance to testing and reporting of results is monitored daily via a daily sit rep SOP's reviewed and revised in lines with national guidance and staff informed of all updates
• screening for other potential infections takes place	All admissions are screened in line with the local screening guidance. - Routine diagnostics operational in lab - Systems and SOPs exist in Laboratory for screening all alert organisms (eg MRSA, VRE, C-diffcile, CPE, etc).		

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	All IPC Policies and COVID related Policies (including SOPS) are available to all staff via intranet and these are also cascaded when first ratified by communications in the bi-weekly comms update	Staff may not always follow Policies and guidance Staff may not always view the intranet	IPC Staff on call provided 24/7 Annual mandatory IPC training Add hoc learning sessions take place with staff as and when required Specialist areas have adapted previous educational material to incorporate COVID guidelines Matrons study days and link nurse programme has been re-launched. A 6 week IPC campaign has

			commenced looking at key IPC areas Posters, pull ups, leaflets and information in comms regarding the campaign Videos and links sent out to inform staff of relevant IPC information
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Command structure. Bronze Command communicate changes after each meeting via Trust Communications Guidance on the intranet reviewed on an ongoing basis to ensure it is current.		
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Waste disposal policy based on national standards. There is a SOP based on national guidelines available for the 'Management of linen and waste from patients with known or suspected covid-19'	Waste contractor cannot meet unprecedented demand. Staff do not follow the policy	Reviewing contract provision / safe onsite waste storage been identified. Facilities team informed of all wards status to ensure that the correct waste bags are available and laundry and waste is collected as per policy
• PPE stock is appropriately stored and accessible to staff who require it	The Trust has a dedicated secure COVID-19 PPE store. Stock issues and receipts are managed electronically, and reported to the ICC on a daily basis. PPE stocks are topped up daily (7 days) to all areas identified in the Ward Escalation Plan and other areas agreed by the Command Centre. Additional PPE stock is held in the Bed Bureau in case of out of hour's shortages, and there is a second emergency PPE store room, the	Stock deliveries via the national PPE Dedicated Distribution channel are regular Inability to request a preferred manufacturer and model of FFP3 masks from the centre has meant that there is a requirement for staff to be fit tested on available stock.	CMHP has also established a **Mutual Aid** programme, and is developing a system to ensure a more equitable distribution of stock across the region based on accurate daily "burn rate" data provided by each trust. Requests for PPE in very short supply (less than 48 hours in stock) are raised via **NSDR** (National Supply Disruption Route). Fulfilment rates are

	details of which are known to the Manager on-call. PPE Distribution Hubs have been created to manage and control the distribution of those PPE items in limited supply (specifically FFP3 masks) whilst ensuring staff have access to PPE when required. There is a weekly multi-disciplinary group who met to discuss processes in place including stock availability.		variable and dependent on the number of COVID-19 patients being treated and the volume of stock held by the Trust. Ongoing fit testing programme in place by a dedicated team to ensure staff are tested on the current stock. Environmental group and a PPE group meet weekly and discuss issues- both report into H&S group. PPE concerns are escalated to the clinical advisory group and documented
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	Risk assessments are being completed for all staff which includes mitigating actions and control measures to protect those at risk. This is being centrally co-ordinated and supported with clinical advice from Occupational Health, HR advice and staff side representatives. BI portal reporting of Trust position Guidelines and risk assessments are available regarding 'Reducing risk for BAME' staff. Staff in high risk groups for medical or other reasons have been supported to work from home or reassigned to low risk areas.	Adequacy of the risk measures and controls not yet reviewed	A process is being put in place managed by the Occupational Health team to review and assess measures and controls identified and ensure implemented ensuring a hr follow up review is carried out Information has been placed on the intranet and regularly communicated to all staff within the Trust who wish to access available wellbeing support services. Guidance available on the HR section of the intranet regarding staff shielding , working from home assessments, support for

	Other staff working in high risk areas have been supported through the provision of wellbeing hubs, counselling services, floor walkers (via staff support team), night time welfare calls, distribution of food donations, wellbeing packs and information as well as communications and training regarding PPE. Information has been placed on the intranet and regularly communicated to all staff within the Trust who wish to access available wellbeing support services.		staff shielding returning to work.. Advice available for managers and employees on how to manage staff regarding COVID 19
• staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported	A risk assessment tool is available regarding 'Reducing risk for BAME' staff.	Staff do not complete the risk assessment with their staff	Data on BAME staff and completion of risk assessments are escalated to senior management to enable them to support managers to complete the risk assessment with their BAME staff.
• that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	Policy available following national guidelines 'WUTH Approach to Reducing Risk for BAME Workforce'	Staff do not complete the risk assessment with their staff	Data on BAME staff and completion of risk assessments are escalated to senior management to enable them to support managers to complete the risk assessment with their BAME staff and all other staff who fall into the at risk groups.
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	Masks are tested using two methods, one using a hood and sprays to identify the closest fit, the other using The Portacount Fit Testing Machine Fit testing is based on PHE national guidance The outcome of the fit testing process is recorded on paper for the Hood Method , which is no longer undertaken and fit testing training is captured within the BiPortal	Variable approaches to cleaning the masks when they were first introduced.	Cleaning SOP (developed by IP&C team) and link to Elipse company video (demonstrating filter changes) circulated to staff recorded as having an Elipse Mask Divisional Fit Test Leads have identified all staff using a reusable mask and circulating cleaning SOP and filter changing process video as required.

	(Portacount Machine) which is downloaded into a monthly report. Reports can be pulled from all portacount machines detailing individual staff fit testing history. Link to training resources available on intranet		IP&C have provided a list of masks that they had distributed prior to fit test centralisation
• staff who carry out fit test training are trained and competent to do so	All staff who are 'fit testers' have been initially trained by the designated company. Once staff have been trained a local competency is undertaken to provide assurance .	No competency available for staff who have undergone the training Staff may fit test staff without completing the competency training	Fit testing competency produced by the manager of the fit testing team. Records kept for all staff who have undertaken the fit testing competency and they are not allowed to 'fit test;' others unless they have completed the competency ..
• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	There is a guideline available containing the process. – 'SOP COVID-19 -FFP3 Mask Fit Testing' There is a guideline available for those staff that have facial hair and require to be fit tested to enable them to undertake their clinical role. 'COVID-19 Trust Policy for Fit Testing, PPE and Facial Hair'	Staff may use the mask that they were not fit tested to Supply may become compromised	All staff are given the details of the mask they are fit tested to. Procurement are given information regarding as to which areas require which masks to ensure correct masks are available for all staff
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	Information is downloaded from the computer that is used for recording the fit testing stages for each individual , and the staff name and assignment number is used , this information is kept centrally		Policy in place to capture the process
• for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	Each stage of the fit testing process is recorded electronically, staff who fail the fit testing process at any time of the sequence have this recorded. Staff are tested on at least 3-5 disposable masks that are available, those that fail on all disposables are then tested on re-usable half masks,if these fail then the hood is the last	As there is no choice of model of FFP3 mask available and we have to use what is delivered there is the potential to not have the mask that staff need.	Staff records are pulled when shortages are predicted of certain masks and staff are asked to re-attend the fit testing dept to be re-tested on another mask.

	option.		
• for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	There is a guideline available for those staff who have facial hair and require to be fit tested to enable them to undertake their clinical role . 'COVID-19 Trust Policy for Fit Testing, PPE and Facial Hair' Staff who are unable to wear face protection and RPE are re-assigned to other areas as per national guidelines .		Staff who do not undertake clinical roles who cannot wear and form of face protection are advised and encouraged to work from home.
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	Managers work closely with Occupational health and HR to ensure that staff who are unable to continue with their current role due to their inability to wear a mask are managed as per agreed guidelines .	Increased demand on occupational health may prevent the capacity to help each member of staff	Recruitment to occupational health and associated teams
• following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	Managers work closely with Occupational health and HR to ensure that staff who are unable to continue with their current role due to their inability to wear a mask are managed as per agreed guidelines .	Increased demand on occupational health may prevent the capacity to help each member of staff	Recruitment to occupational health and associated teams
• Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the Board	Fit testing reports into the Health and safety committee, includes results of those passed and those failed. Safety Management Assurance Committee receives reports from H&S including all reportable incidents to HSE. BOD receives monthly report on RIDDORs and Serious Incidents		
• consistency in staff allocation is maintained, with reductions in the movement of staff between the different areas and the cross-over of care pathways between planned and elective care pathways and urgent and	Staff do not move between different categorised areas	Shortages of staff may result in unplanned staff movement	Daily meetings to discuss staffing and advice. Local risk assessment completed if staff need to move.

emergency care pathways, as per national guidance			Staff advised to move down categories not up as the risk reduces Staff advised to shower and change uniform if they have to moveduring shift It is advised that staff go directly to the ward they have been moved to when they start duty. Staff are only moved for clinical need and following local risk assessment.
• all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Policies available regarding social distancing and the use of PPE *Guidance for assessment of those who report difficulties wearing a surgical face mask* *Guidance when outpatients do not wear a face covering* *COVID-19* *precautions, social distancing & non-compliance - HR Guidance* *FAQs* *PPE and Alternatives for Respiratory Protection for COVID-19*		SOP regarding the use of face masks , what type and what to do if there are problems with wearing one for staff and pts
• consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	Staff start and finish times staggered along with break times and staff working from home if their role allows		
• health and care settings are COVID-19 secure workplaces as far as practical, that is,	Risk assessments are available for all departments that are RAG rated once	Departments not completing risk assessments or not rating them	Support given from the Environmental safety matron

that any workplace risk(s) are mitigated maximally for everyone	complete. *'COVID-19 Risk Assessment Form'* The assessments are reviewed weekly by the Environmental group who review the mitigations that have been introduced in all areas to reduce the risks and advice given regarding appropriate actions	accurately	
• staff are aware of the need to wear facemask when moving through COVID-19 secure areas	All staff wear FRSM wherever they work, the only time face mask can be removed is when a member of staff is in a room alone		Posters available Comms on a weekly basis Daily audits of staff practice. Staff work as a team to promote the wearing of face masks at the right time and in the correct manner
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	A central absence team is in place for all staff to report absence of any kind and also to report return to work. Policy available for internal track and trace process.	Not all staff are reporting absence via this central team and instead reporting directly to manager who are entering absence details directly into ESR	A reconciliation has been carried out between the central absence team daily records and the information directly input into ESR to ensure all absence is captured Absence team to carry out regular 'chaser' calls to managers with 'open' absences and regularly send out text messages to staff who have passed their predicted return to work date
• Staff that test positive have adequate information and support to aid their recovery and return to work.	HR department make contact with all staff who are on long term sick with COVID-19 to check on their welfare and establish a predicted time frame to return to work. HR guidance is also available on the Trust internet and details how been widely and frequently circulated in Trust communication bulletins. Policy available regarding care and management of staff who are shielding that		The HR team will regularly contact divisions to ask them to update their staff list of people who are shielding. An agreed line of questions / advice is followed including questions to checking if people are shielding or WFH SOP available regarding track and trace for staff with a positive COVID result

	reflects the national guidelines. Details of all COVID-19 related absence is sent to the testing team enabling all individuals to be assessed for swabbing in accordance with the agreed criteria and SOP Managers also have access to the testing team to refer any individual they deem needing a swab test All staff who receive a positive result are notified accordingly by a clinician on behalf of the Trust Occupational Health service. Any concerns and questions are addressed and advice is given as requested. Follow up support is also available if required. Policy available re : COVID-19 : Symptomatic Staff Swabbing and Return to Work Standard Operating Procedure HR speak to people who have tested positive following the end of their isolation period when they telephone the absence line to notify of their return to work or continuation of symptoms. Staff are signposted to their GP or 111 service if they need medical advice.		
11. The Trust can demonstrate effective and knowledgeable leadership in relation to IPC at all levels, relevant to roles.			
Key lines of enquiry	Evidence	Gaps in evidence	Progress
• Trust staff know where to find current IPC guidelines in relation to COVID and other related infections	Regular communication via e-mail giving links to the intranet regarding new policies and revision of old policies New link to weekly CAG updates		

• facilitate implementation of new clinical standards regarding COVID and other infections			Local sops ratified and available on the intranet
• support teams in nominating IPC champions	Link nurses have been identified from each area and meetings commenced		Protected time if risk assessment allows
• motivate individuals to engage in day-to-day IPC duties	Relevant IPC audits are completed H/H Environment Commode Clinical lead identified Cleaning checklist available for all high touch areas		
• support teams in completing investigations regarding HCAI and deliver improvements required in a timely manner	Timely completion of RCA's Outbreak investigations Lessons learnt shared with the teams	Time allowed for staff to complete RCA	Action plans discussed at monthly Divisional IPC meetings Exceptions to action plans shared at the monthly IPCG
• recognise the importance of guidelines to support clinical practice	National guideline used as a baseline for local policies		Local SOP's developed in a timely manner during COVID pandemic as PHE released guidance Audits introduced to capture new standards
• maintain progress on reducing HCAI's	Timely completion of RCA's Peer review of standards		
• recognise the importance of IPC within the Divisions	Monthly MDT divisional IPC meetings Standard agenda item at monthly DPR Support given to recruit to a new post of 'Environmental safety matron – IPC'	Attendance by Divisional Clinical leads not consistent at IPCG. Attendance at investigation meetings following identification of HCAI not consistent	Environmental safety matron links in across all divisions to offer help and support to all levels of staff. Environmental safety matron works in collaboration with facilities and estates management teams to support the divisions

Appendix 1

MIAA classification

Level of Assurance	Description
High	Our work found some low impact control weaknesses which, if addressed would improve overall control. However, these weaknesses do not affect key controls and are unlikely to impair the achievement of the objectives of the system. Therefore we can conclude that the key controls have been adequately designed and are operating effectively to deliver the objectives of the system, function or process.
Significant	There are some weaknesses in the design and/or operation of controls which could impair the achievement of the objectives of the system, function or process. However, either their impact would be minimal or they would be unlikely to occur.
Limited	There are weaknesses in the design and / or operation of controls which could have a significant impact on the achievement of the key system, function or process objectives but should not have a significant impact on the achievement of organisational objectives.
No	There are weaknesses in the design and/or operation of controls which [in aggregate] have a significant impact on the achievement of key system, function or process objectives and may put at risk the achievement of organisational objectives.

Meticillin resistant *Staphylococcus aureus* bacteraemia (MRSA)

*Table 1 below provides a breakdown of **MRSA bacteraemia** by month.*

Table 1

MRSA Bacteraemia													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2018/19	0	0	0	0	0	0	0	1	0	0	0	2	3
2019/20	0	0	0	0	0	0	0	0	1	0	0	0	1
2020/21	0	1	0	1	0	0	0	0	0				2

In 2020/21 we have reported 2 MRSA bacteraemia by month end December. This is an increase of 2 when compared to the same period in 2019/20.

Meticillin-sensitive *Staphylococcus aureus* bacteraemia (MSSA)

*Table 2 below provides a breakdown of **MSSA bacteraemia** by year and month.*

Table 2

MSSA bacteraemia													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2018/19	2	1	5	1	1	2	0	4	1	2	0	3	22
2019/20	3	5	1	0	2	1	1	2	1	3	3	2	24
2020/21	4	1	1	0	0	2	2	3	0				13

In 2020/21 we have reported 13 MSSA bacteraemia by month end December. This is a reduction of 19% (3) when compared to the same period in 2019/20.

Gram-negative bloodstream infections (BSIs)

E-coli

*Table 3 below table provides a breakdown of **E.coli bacteraemia** by month.*

Table 3

E.coli bacteraemia													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
2018/19	4	2	6	7	2	4	5	4	3	8	4	4	53
2019/20	6	3	3	4	7	2	5	6	6	8	9	1	60
2020/21	6	3	4	6	4	2	3	2	0				30

In 2020/21 we have reported 30 E.coli bacteraemia by month end December. This is a reduction of 29% (12) when compared to the same period in 2019/20.

Klebsiella

*Table 4 below table provides a breakdown of **Klebsiella bacteraemia** by month.*

Table 4

Klebsiella bacteraemia													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
2018/19	0	2	3	3	3	1	1	0	0	2	0	1	16
2019/20	4	3	1	2	1	1	1	4	3	2	0	0	22
2020/21	0	1	1	1	0	0	2	1	1				7

In 2020/21 we have reported 7 Klebsiella bacteraemia by month end December. This is a reduction of 65% (13) when compared to the same period in 2019/20.

Pseudomonas

*Table 5 below table provides a breakdown of **Pseudomonas bacteraemia** by month.*

Table 5

Pseudomonas bacteraemia													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
2018/19	0	1	0	2	0	3	0	0	0	0	1	0	7
2019/20	1	1	1	1	1	2	0	1	0	0	0	1	9
2020/21	1	0	1	1	1	1	2	0					7

In 2020/21 we have reported 7 Pseudomonas bacteraemias by month end December. This is a reduction of 13% (1) when compared to the same period in 2019/20.

Gram Negative cumulative

*Table 6 below provides a breakdown of **all gram negative bacteraemia** by year and month.*

Table 6

Gram - Negative bacteraemia													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total\Trajectory*
2017/18	2	5	5	12	6	10	13	7	6	8	7	3	84
2018/19	4	5	10	12	5	8	6	4	2	11	5	6	78
2019/20	11	7	5	7	9	5	6	11	9	10	9	2	91
Trajectory 2020/21	6	6	6	6	7	6	6	7	7	7	7	6	77*
Actual 2020/21	7	4	6	8	5	3	7	3	1				44
2021/22 (15% reduction)													71*
2023/24 (50% reduction)													42*

In 2020/21 we have reported 44 Gram Negative bacteraemia by month end December. This is a reduction of 37% (26) when compared to the same period in 2019/20. We are currently 13 cases under our cumulative trajectory for 2020/21.

Clostridium difficile (CDI)

*Table 7 below table provides a breakdown of **Clostridium difficile infections** by year / month.*

Table 7

Clostridium difficile													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	19	9	11	5	6	7	8	6	7	4	4	3	89
Trajectory 2020/21	7	7	7	7	7	8	8	7	8	7	8	7	88
2020/21	6	5	5	1	4	1	5	10	8				45

In 2020/21 we have reported 45 *Clostridium difficile* infections by month end December. This is a reduction of 42% (33) when compared to the same period in 2019/20. We are currently 18 cases under our cumulative trajectory for 2020/21.

COVID IPC BAF Report to Board of Directors 27 January 2021
Appendix 3

Key Actions: Infection Prevention & Control and Testing (published 23 December 2020, NHSE/I)

Organisations: It is the board's responsibility to ensure that:

10 point plan		Controls	Compliance
1	Staff consistently practice good hand hygiene and all high touch surfaces and items are decontaminated multiple times every day with systems in place to monitor adherence	Ward checklist available for all staff to identify high touch areas and cleaning is in collaboration with the Cleaning Team to ensure these areas are completed three times per day. ATP and light pen are also used to monitor cleaning standards along with C4C (Cleaning audits). Hand hygiene audits completed 3 x week, in Outbreak/Red wards and ED completed daily	compliant
2	Staff maintain social distancing (2M+) in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace	Signage available along all corridors, including floor signs, audit of compliance ongoing by all staff when in work and results of a weekly point prevalence audit shared at CAG. Messages to staff via Trust-wide communications. Car sharing avoided whenever possible with guidance that if there is an exception to this all staff in the car have to wear a mask, two people per car, passenger to sit in the back of a car and windows to be open.	compliant
3	Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings, with systems in place to monitor adherence. Movement of staff between COVID and non-COVID areas is minimised	Local policies and procedures reflect national guidance for the use of PPE, this guidance is available on the intranet and is displayed on posters throughout each ward. Donning and doffing video and related competencies are completed by all ward managers and practice based educators with their teams, including medical staff. There are mask stations with gel at patient and staff entrances and exits and it is mandatory for all staff, clinical and non-clinical to wear fluid repellent surgical masks at all times, compliance is	compliant

		audited x 2 per week and fed back to senior teams for action. If staff are moved then it is for a full shift, if they are moved midway they have to shower and change. Staff are moved up the level of risk rather than down wherever possible.	
4	Moving patients increases their risk of transmission of infection. For urgent and emergency care, hospitals should adopt pathways that support minimal or avoid patient bed/ward transfers for the duration of their admission (unless clinically imperative). The exception will be patients who need a period of care in a side room or other safe bed while waiting for their COVID test results. On occasions when it is necessary cohort COVID or non-COVID patients because of bed occupancy, then reliable application of IPC measures must be implemented. Is also imperative that any vacated areas are cleaned as per guidance.	Local SOP has been ratified to reflect guidance and compliance is monitored daily and fed back to the clinical teams. The IPC Team, 7 days a week, advise and guide on patient placement, particularly when suitable rooms or wards not available in a timely way. When patients are moved it is documented. There is cleaning guidance available and incident forms are completed when clinical decision based on bed capacity overrules the guidance.	compliant
5	Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse, and the Board Assurance Framework is reviewed and evidence of reviews is available	Daily submissions are signed off by the nominated Executive, each version of the BAF is reviewed by the Divisions and evidence collated which is then presented through our governance meetings and then to Board. The exception is V1.4 of the IPC BAF which has gone directly to BoD in January.	compliant
6	Where bays with high numbers of beds are in use, they must be risk assessed, and where 2metres cannot be achieved, means of physical segregation of patients are strongly considered. The concept of 'bed, chair, locker' should be implemented. All wards should be effectively ventilated	All of the ward areas, including the assessment areas have been reviewed to determine if patients are 2m* distanced. The measurement was taken from the middle of each patient's bed. Out of the 39 in-patient areas reviewed, 38 areas have beds that are over 2m apart*, distances range from 2.1m to 2.8m. The area where 2m cannot be achieved is UMAC trollies,	compliant

		which is 1.9m. In acknowledgement that the 2m distance will be breached at times when staff and patients move around and give/receive care, clear Perspex curtains have been installed throughout the Trust to provide a further barrier. All wards have social distancing posters in use with gel and face mask dispensers available throughout the wards. Natural ventilation is encouraged throughout the trust, and windows have all been maintained in order to allow opening at least 3 x day to allow fresh air to circulate where mechanical ventilation is not available. Where possible beds are all now configured to follow 'bed, chair, locker' to encourage social distancing when patients move around their bed area.	
7 Staff are tested			
a	Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff . Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing	Staff are issued with lateral flow antigen test kits and management monitor twice weekly completion. Staff enter results electronically onto advised system, any staff identified as positive on Lateral flow test, remain off work and have a re-test to confirm using PCR before they can return to work. Staff who are symptomatic do not complete lateral flow, they attend for a PCR test via the testing POD.	compliant
b	If your trust has a high nosocomial rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control /public Health team. Such cases must be appropriately recorded, managed and reported using agreed regional/national escalation systems.	Local PHE colleagues are invited to all outbreak meetings and receive all minutes, nosocomial rates are discussed and any additional patient and staff testing is agreed and completed as part of the outbreak mitigations. Local meetings have taken place with CCG, PHE and representative from NHSI/E NW to discuss local nosocomial rates and actions introduced to mitigate further incidences. All outbreaks are reported	compliant

		using the 'New' national electronic system.	
8 **Patients are tested**			
a.	All emergency patients must be tested at admission, whether or not they have symptoms	All admissions to the trust are tested as per local policy which reflects national guidance; adherence to the policy is audited daily and fed back to the admission areas. All in-patients receive a COVID awareness pack to include them in our efforts to keep them safe during their hospital care episode.	compliant
b.	Those who go on to develop symptoms of COVID-19 after admission must be retested at the point symptoms arise.	We have a low threshold for testing, and all patients and staff are tested at the first signs of symptoms no matter how mild they are to ensure that we capture staff and patients with the virus at the soonest possible time to avoid further harm	compliant
c.	Those who test negative on admission must have a re-test on day 3 of admission, and again between 5-7 days post admission	Local policy reflects national guidance and all patients are tested at day of admission and again at day 3 and day 6, following this we have also introduced screening every 7 days for those patients that remain in hospital after day 6.	compliant
d.	Sites with high nosocomial rates should consider testing COVID negative patients daily.	Nosocomial rates are discussed daily and during outbreak meetings, screening frequencies are determined on a case by case basis using a risk assessment approach. Weekly screening has been introduced. Current capacity would not support daily testing.	compliant
e.	Patients being discharged to a care home must be tested 48 hours prior to discharge and must only be discharged when their test result is available. Care homes must not accept discharged patients unless they have that person's test result	Local policy reflects this national guideline and the policy is audited every time we have a discharge. In addition the hospital IPC team contact the community IPC team when any patient is discharged to a care home who has had a negative swab but have been in contact with	compliant

	can safely care for them	someone who has a positive swab. Patient leaflet is available .Both Teams work in collaboration and share data regarding outbreaks to ensure safe transfer of all patients into and out of hospital.	
f.	Elective patient must be tested within 3 days before admission and must be asked to self-isolate from the day of the test until the day of admission	Local policy reflects this national guidance and audits are completed to support compliance. Patient leaflet is available.	compliant
Systems – Local Systems must:			
9	Assure themselves, with commissioners, that a trust's infection prevention and control interventions (IPC) are optimal, the Board Assurance Framework is complete, and agreed action plans are being delivered	The BAF is shared with local commissioners and CQC and the agreed action plans are reviewed by local committees and reported to the BoD for assurance.	compliant
10	Review system performance and data; offer peer support and take steps to intervene as required	Daily Tactical and Strategic system meetings in place from January 2021, to ensure optimal patient flow and risk minimisation.	compliant

Completed by: Jay Turner - Gardner – Associate Director of Nursing – Infection Prevention / Deputy DIPC and Hazel Richards, Chief Nurse/ DIPC

Date: 18 January 2021

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Standardised Hospital Mortality

Board of Directors 27 January 2021

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Background

Wirral University Teaching Hospital NHS Foundation Trust

- Board Assurance Framework PR4.2
- Rising SHMI
- A calculation of expected mortality based on other patients in England with similar coding characteristics
- Recorded diagnosis in the 1st FCE and a maximum of 20 comorbidities according to the Charlson index
- Northwest higher than England average and WUTH risen to above expected range reported last quarter (Q4 19-20)
- CUSUM alerts – Pneumonia, UTI, Cerebrovascular disease, COPD
- Coding staffing – on risk register
- A care issue, documentation issue, system issue?

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Current monitoring /controls

Wirral University Teaching Hospital NHS Foundation Trust

- Mortality review group weekly – links complaints, SI, coroner, medical examiner
- Medical Examiner scrutiny of all cases
- LFDs quarterly – ME, SJRs, PMRs, DR Foster - PSQB, board

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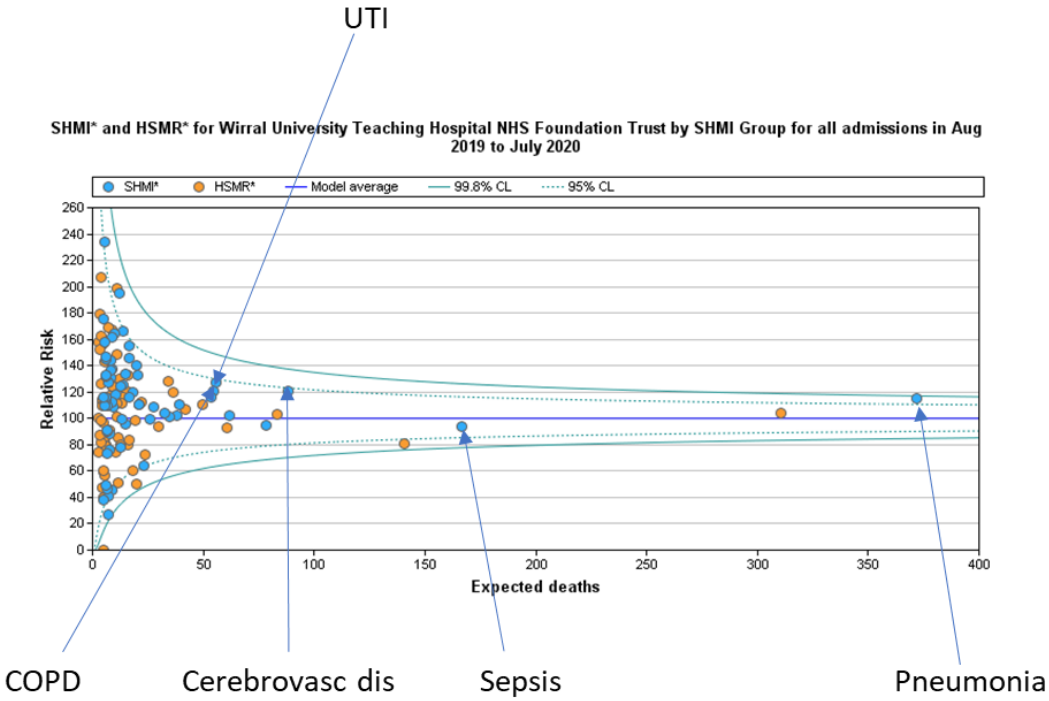
- Dr Foster analysts
- AQUA data
- National specialty audit reports – respiratory, stroke
- GIRFT
- Acute trust experience in reducing SHMI (medical and coders)

Dr Foster data

Wirral University Teaching Hospital
NHS Foundation Trust



- Pneumonia
- Cerebrovascular disease
- COPD
- UTI
- Sepsis

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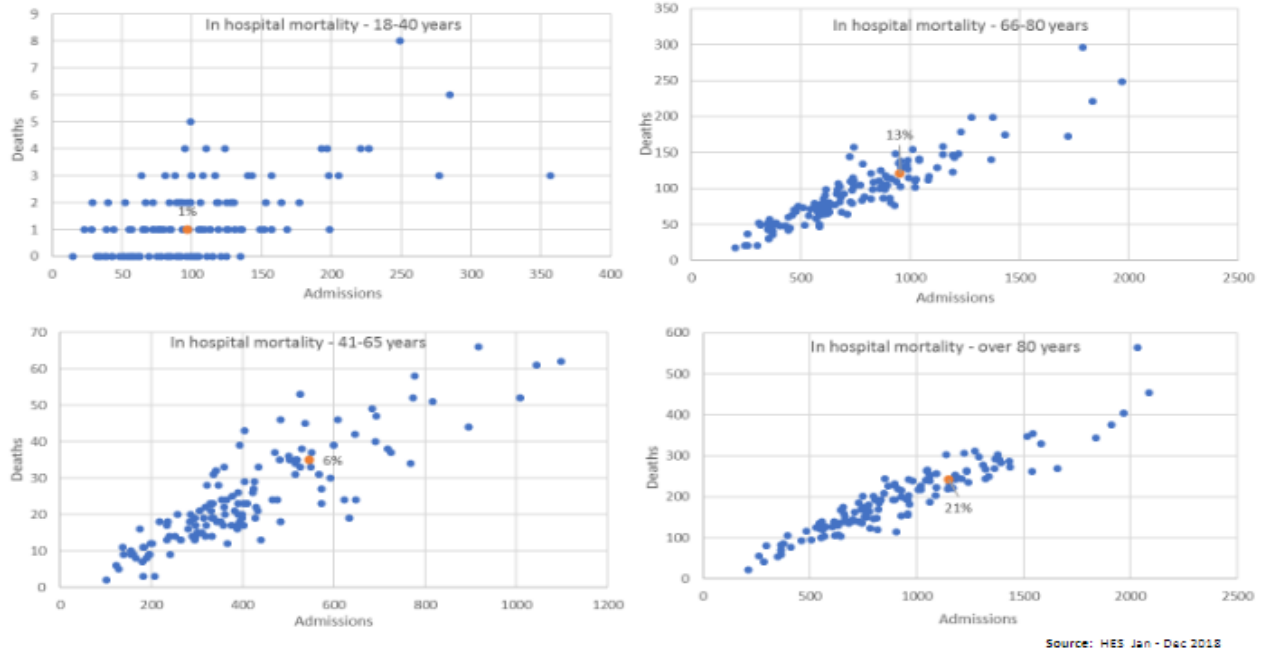
Pneumonia

Wirral University Teaching Hospital
NHS Foundation Trust

11.7 Pneumonia – scatterplot showing in-hospital mortality rate by age band



Source: HES Jan - Dec 2018

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Pneumonia Type + Mortality

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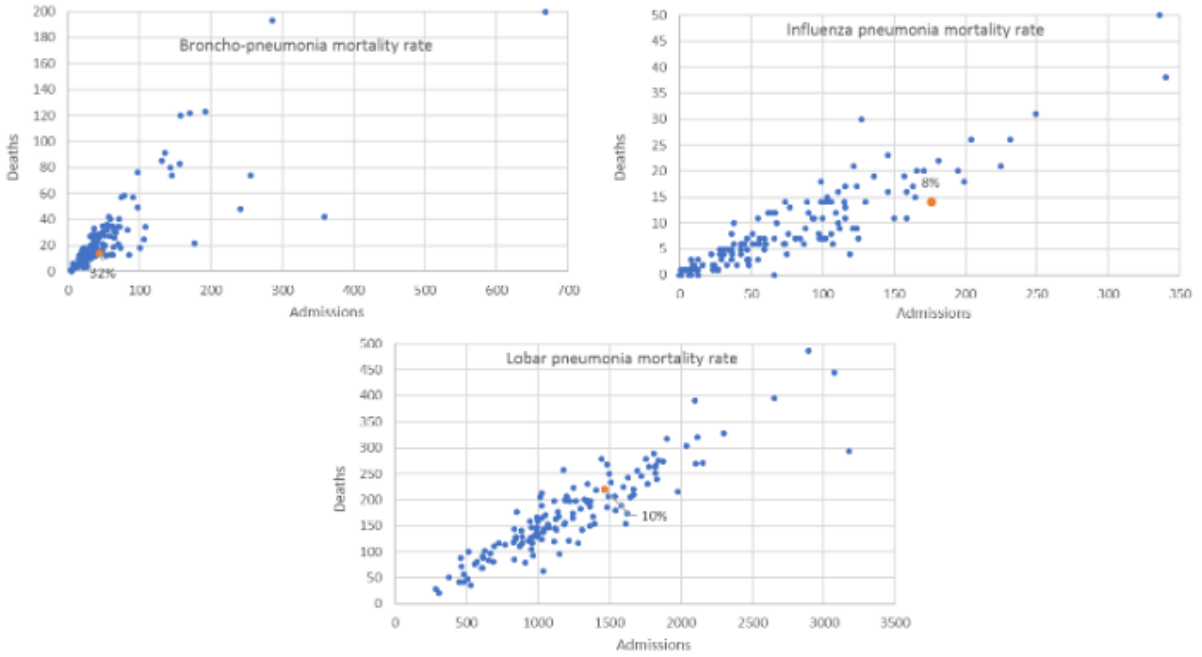
NHS Foundation Trust

Bronchopneumonia	32 %
Lobar	10%
Viral	8%

Most pneumonia documented on CERNER as community or hospital acquired

11.9 Pneumonia – scatterplot showing in-hospital mortality rate by type of pneumonia



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Observed numbers for pneumonia lowermost quartile

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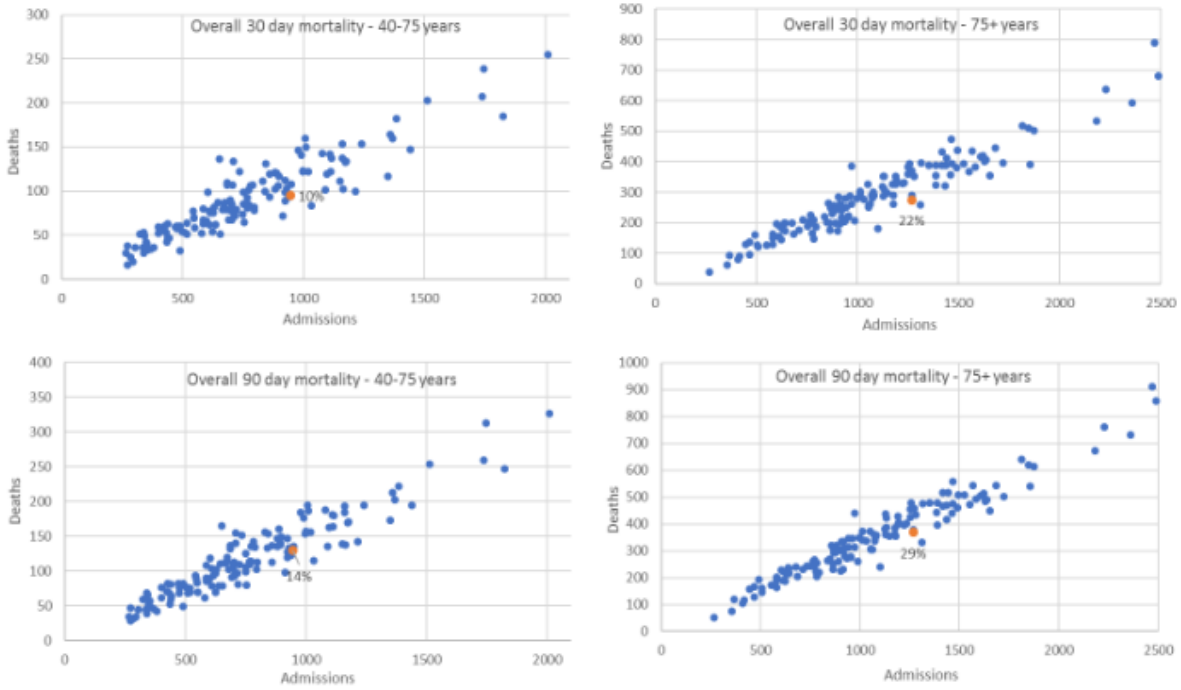
NHS Foundation Trust

11.11 Pneumonia – scatterplot showing overall mortality rates (in and out of hospital)



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COPD

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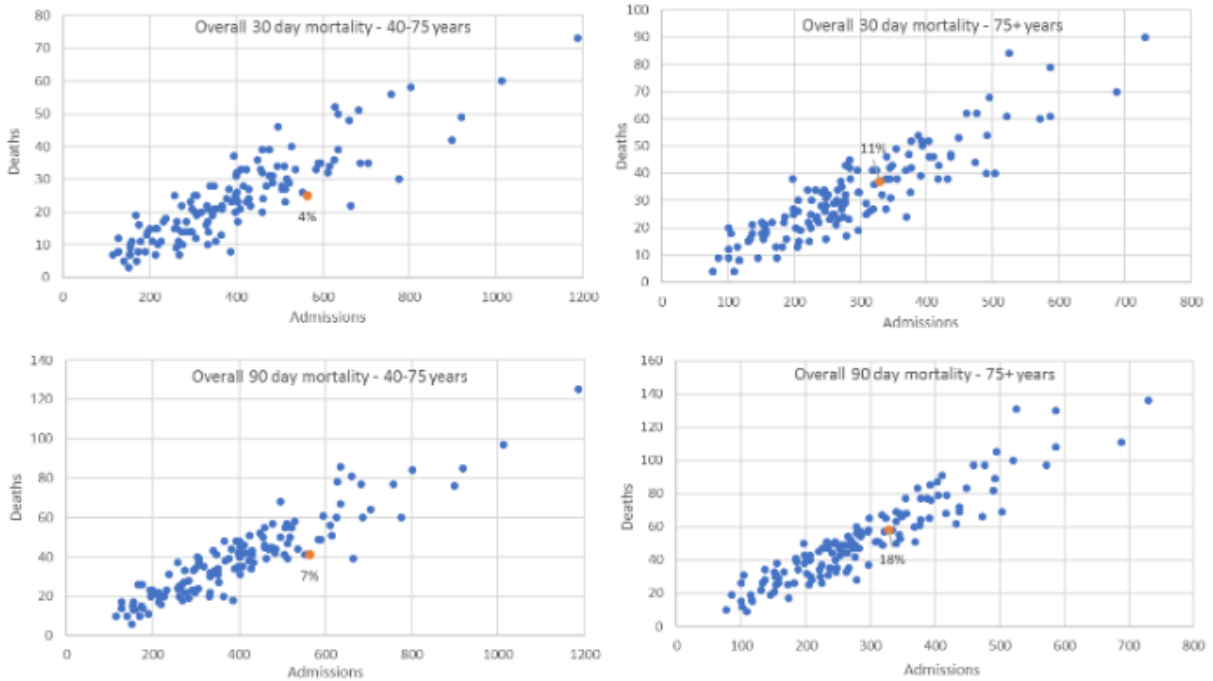
- COPD mortality rates mid range >75 years, low 40-74

12.8 COPD – Scatterplot showing mortality rates (in and out of hospital) by age group



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SSNAP audit data for 2019

Wirral University Teaching Hospital NHS Foundation Trust

SCN	North West Coast SCN
Trust	Wirral University Teaching Hospital NHS Foundation Trust
Team name	Arrowe Park Hospital
Team type	Routinely admitting team
Number of patients (with known stroke type)	1282
Case ascertainment	90%+
Level of consciousness on arrival:	
0 (fully conscious)	84.2% (1079)
1	7.8% (100)
2	4.0% (51)
3 (fully unconscious)	4.1% (52)
Patients with fully completed NIHSS	100.0% (1282)
SMR (Standardised Mortality Ratio)	1.02 **Your team is not an outlier for mortality**
Number of deaths (observed)	194
Number of expected deaths	191
Crude Mortality	15%

- SSNAP is stroke physician care output
- GIRFT highlighted high coding for non specific cerebrovascular disease rather than ischaemia or haemorrhage
- Not all CVD managed by stroke physicians (DME,crit care, MSSW etc)
- Stroke team review all of their cases for coding but not others

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UTI

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- Review of cases n= 45 (+10 above expected), final diagnosis
- UTI = 5
- Sepsis = 9
- Metastatic cancers (urology, lung, haem) = 10
- COVID = 2
- Pneumonia = 6
- Others = 10
- Sepsis HSMR 26 lower than expected

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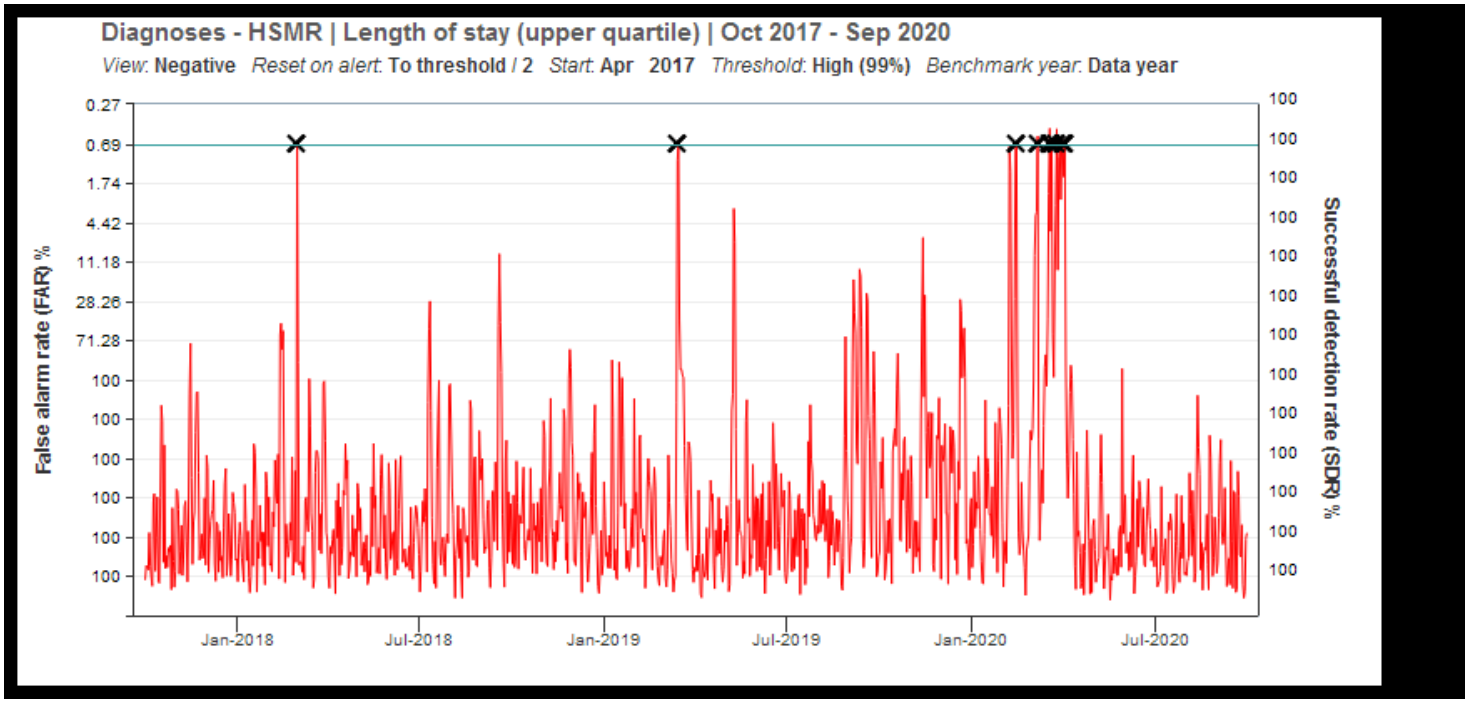
Length of Stay



WUTH depth of coding always shown to be above average

Coding of comorbidities in order of what is documented

However WUTH not capturing Charlson co-morbidities either through documentation or ensuring they are included in the top 20 codes

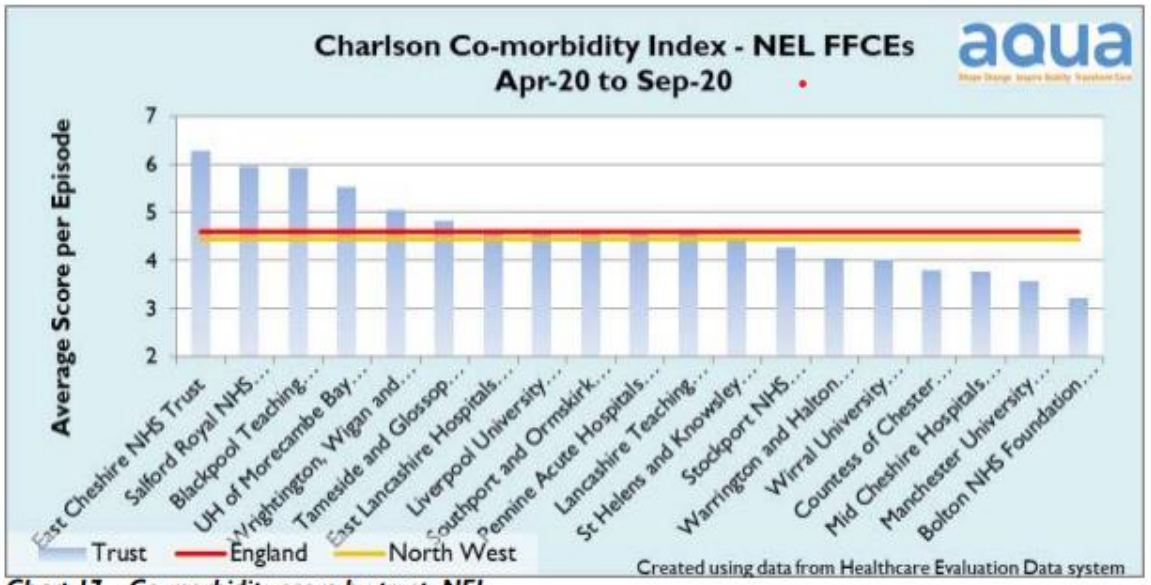


Chart 17 – Co-morbidity score by trust, NEL

Charlson Comorbidity score

Condition Name	ICD10 codes	Score
Acute myocardial infarction	I21, I22, I23, I252, I258	5
Cerebral vascular accident	G450, G451, G452, G454, G458, G459, G46, I60-I69	11
Congestive heart failure	I50	13
Connective tissue disorder	M05, M060, M063, M069, M32, M332, M34, M353	4
Dementia	F00, F01, F02, F03, F051	14
Diabetes	E101, E105, E106, E108, E109, E111, E115, E116, E118, E119, E131, E135, E136, E138, E139, E141, E145, E146, E148, E149	3
Liver disease	K702, K703, K717, K73, K74	8
Peptic ulcer	K25, K26, K27, K28	9
Peripheral vascular disease	I71, I739, I790, R02, Z958, Z959	6
Pulmonary disease	J40-J47, J60-J67	4
Cancer	C00-C76, C80-C97	8
Diabetes complications	E102, E103, E104, E107, E112, E113, E114, E117, E132, E133, E134, E137, E142, E143, E144, E147	-1
Paraplegia	G041, G81, G820, G821, G822	1
Renal disease	I12, I13, N01, N03, N052-N056, N072-N074, N18, N19, N25	10
Metastatic cancer	C77, C78, C79	14
Severe liver disease	K721, K729, K766, K767	18
HIV	B20, B21, B22, B23, B24	2

The impact of poor data quality

	Patient 1	Patient 2
Age & Sex	81, male	81, male
# FCE's	2	2
Primary Diagnosis	Acute myocardial infarction	Non specific chest pain
Charlson Score	14	0
Risk of Mortality	27%	0.1%
Tariff Generated	£4643	£985

- Conflict in coding
- High value coding, and mortality coding different

Other trusts experiences

Wirral University Teaching Hospital NHS Foundation Trust

- Tameside, Salford, Queen Elizabeth
- Clinician coder regular engagement
- Pneumonia coding – bronchopneumonia only
- Utilising DR Foster expertise
- Audit software for coding

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Conclusions

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- Crude mortality rate is higher than regional average
- No systemic issues identified with patient care from ME or MRG
- Issues identified with documentation, coding (priorities of income vs mortality vs comorbidity) and LoS.
- Specialty respiratory and stroke national audits show mortality rates within / lower end of range
- GIRFT reports highlighted coding issues with stroke and respiratory reports
- Sepsis cases lower than expected (MIAA audit awaited)
- UTI review showed that 9 had sepsis on admission
- Charlson comorbidity scores under reported

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Actions

Wirral University Teaching Hospital NHS Foundation Trust

- Coding manager reviewed coding practices
- CERNER - folder of comorbidities and to explore autopopulation from past episodes , streamlining Diagnosis Options
- Coder’s priorities coding of Charlson comorbidities early in the encounter
- Audit software now available to check coding quality and to monitor through PSQB
- Education package for clinical staff
- Robust mechanisms to be put in place to review and if necessary correct coding before NHS digital submission closure
- Await MIAA sepsis audit

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Board of Directors	
Agenda Item	20-21/226
Title of Report	Monthly Safe Staffing Report
Date of Meeting	27 January 2021
Author	Tracy Fennell - Deputy Chief Nurse Johanna Ashworth-Jones- Senior Analyst, Corporate Nursing Team
Accountable Executive	Hazel Richards - Chief Nurse and Director of Infection Prevention and Control (DIPC)
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1,2,4,6. Nurse Staffing is scored as 16 within Medicine and Acute
Level of Assurance • **Positive** • **Gap(s)**	Positives. • The Trust has robust systems and processes in place to monitor and flex staffing to meet the changing demands of the organisation and patient requirements. • The Trust has approved a time limited incentive scheme to encourage uptake of additional duties • The Trust is currently recruiting an additional 100 international nurses that are expected to be in the Trust in April 2021 Gaps. • The Trust has seen an increase in ward based registered nurse vacancies to 26% • The Trust has seen an increase in RN sickness rates to above 8 % (M9).
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Discussion
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No	No

1. Executive summary

The dashboard provides an oversight of areas related to the provision of nurse staffing, both RN and CSW. In M8, the Trust saw the benefit of the nursing incentive payment scheme and a number of indicators improved. However, M9 and beyond has seen a deterioration, largely due to increasing prevalence of COVID-19 and staff self-isolating; thereby reducing staffing levels, often to the minimum and at times below that.

The Trust has implemented a number of measures to improve the position through use of the nurse staffing incentive scheme, block bookings from a wide range of nursing agencies to support gaps, redeployment of senior nursing staff to work clinically and redeployment of non-ward based nursing staff in line with the Winter Staffing Escalation Plan.

Additional funding has been secured from NHSE to support the recruitment of up to 100 international nurses before April 2021. This will impact positively on the number of vacancies.

2 Current position: reaas to note

2.1 Vacancies

The Trust has seen further increases in RN vacancy rates to 26% M9.

2.2 Sickness

RN sickness rates in M9 6.49% and CSW rates at 8.18% (month absence rate). RN sickness rates were seen to spike at the end of M8 early M9 to 8.96% with a COVID sickness rate of 2.8% (Bronze Dashboard 4 Dec 2020). This was compounded further with a number of staff self-isolating due to being high risk contacts.

2.3 Safe Staffing Oversight Tracker (SSOT) review

During M8 the SSOT recorded 243 shifts that fell below minimum staffing levels for RNs; this is a significant reduction on M7 of 454. However this increased significantly again in M9 to 499.
Senior Nurses are required to make a professional judgement and apply a RAG rating ahead of the shift, on whether wards are safely staffed, and to take action to improve the situation as required; eg move staff. A retrospective review is then undertaken to identify any potential or actual harms that may have occurred. These will be recorded on the SSOT and compared to incident data.

The RAG descriptors are:

- “red” if wards are at high risk of care standards diminishing;
- “amber” signifying medium/low risk or;
- “green” no risk.

There were no shifts with a professional judgment rating of red during M8 and 9.

2.4 Impact on Care

Late Medications:	582 patients - 46 shifts - 9 wards / clinical areas
Delayed News:	239 patients - 29 shifts - 9 wards / clinical areas
Delayed Observations:	287 patients - 32 shifts - 10 wards / clinical areas

Incident reports will be reviewed for triangulation to identify any potential harm as a result of staffing levels.

2.5 Staff moves

There were 164 staff moves during M8 compared with 140 in M7. This was due to the number of closed beds and wards during this period, due to infection control reasons. Moves were considered essential to ensure wards with higher patient acuity had appropriate staffing.

Data is not currently available for M9, however will be updated in the dashboard for M10 report. It is anticipated that the number of moves for M9 will be high due to sickness and vacancies.

2.6 Safe staffing incidents

In M8, 25 incidents were reported for nursing and midwifery staffing which is a significant reduction on the previous month (75) with all these incidents recorded as low or no harm.

There was just one area with a high frequency of staffing incidents reported which was also highlighted in M7. This was for the Delivery Suite where safe staffing escalation processes were used appropriately. This area did not feature as a high frequency reported area during M9.

There was an increase in reported incidents during M9 with a total of 90. These are currently under review.

3. Actions to mitigate risks

In response to reduced staffing, a review of nursing processes has been undertaken to support frontline teams to release time to care for patients. Following a meeting with Ward Managers the following has been proposed and agreed by the Executive Team on 19 January 21:

- A number of medication processes have already been streamlined (approved at Clinical Advisory Group 11 January 2021and enacted during Surge One).
- Incidents and complaints management will be led by the Divisional Governance Support Teams, to release Ward Manager time to provide clinical care and leadership.
- Some nurse records (eg fluid balance, intentional rounding) will convert to paper for a time limited period. Processes have been agreed for inputting into Cerner.
- Reduction in the Perfect Ward Audit schedule.

To ensure oversight is maintained, the Corporate Nursing Team will continue to monitor standards of safety and quality using the mini WISE/ spot check programme.

Nurse staffing meetings are now twice daily and a Matron is on a late duty every day to oversee safe staffing. Staffing concerns are reported in Bronze Command each day.

4. Conclusion

Whilst improvements were seen in M8, these have been compromised in M9 due to increased pressure from COVID-19 and vacancies. Twice daily nurse staffing meetings support the safe deployment of staff in a timely way. The high vacancy rate should reduce into the new financial year when the 100 plus international nurses come into the Trust.

5. Recommendations

The Board of Directors are requested to note the contents of report and controls in place to minimise the impact of reduced nurse staffing levels.

Appendix 1 Safe Staffing Assurance Dashboard July to December 2020.

	Safe Staffing Board Assurance Dashboard 2020							
Data Source	Indicator	Jul	Aug	Sept	Oct	Nov	Dec	Spark line
Corporate Nursing	Care Hours Per Patient Day - Total		9.6	8	8.5	10.1	9.5	
Corporate Nursing	Care Hours Per Patient Day - Registered Nurses		4.8	3.8	4.1	5.2	4.8	
Corporate Nursing	Care Hours Per Patient Day - CSW's		4.2	3.5	3.7	4.1	3.8	
Corporate Nursing	National Fill rates RN Day		79%	76%	83%	84%	85%	
Corporate Nursing	National Fill rates CSW Day		76%	86%	89%	94%	88%	
Corporate Nursing	National Fill rates RN Nights		94%	72%	79%	81%	82%	
Corporate Nursing	National Fill rates CSW Nights		97%	90%	104%	100%	99%	
Corporate Nursing	Trust Occupancy Rate	57.20%	66.90%	79.50%	79.50%	76.10%	79.30%	
Corporate Nursing	Occupancy Rate - APH	63.10%	72.10%	81.50%	79.10%	76.00%	79.90%	
Corporate Nursing	Occupancy Rate - CBH	16.00%	24.90%	51.90%	46.10%	39.00%	37.90%	
Workforce	Vacancy Rate (Band 5 RN's)	18.46%	18.05%	16.94%	16.61%	24.38%	25.00%	
Workforce	Vacancy rate (Band 5 inpatient wards)	20.57%	20.16%	18.73%	17.11%	25.99%	26.80%	
Workforce	Vacancy Rate - All RN (All grades)	9.81%	9.90%	9.40%	8.67%	14.10%	14.57%	
Workforce	Vacancy Rate (CSW's)	5.89%	5.86%	7.86%	7.77%	12.76%	12.19%	
Workforce	Sickness Rate - RN	5.69%	6.12%	6.38%	6.80%	6.95%	6.49%	
Workforce	Sickness Rate - CSW	10.46%	9.58%	10.09%	8.82%	7.59%	8.18%	
Workforce	Absences Rate - RN	4.84%	2.36%	2.60%	1.55%	1.76%	1.50%	
Workforce	Absences Rate- CSW	4.96%	3.33%	3.17%	1.55%	2.17%	1.56%	
Corporate Nursing	Number of Professional Judgment Red Shifts		1	0	0	0	0	
Corporate Nursing	Number of RN Red Shifts		359	445	454	243	499	
Corporate Nursing	RN Red Shift Impact : Number of Falls		7	9	17	4	19	
Corporate Nursing	RN Red Shift Impact : Number of Falls with Harm		0	1	1	0	0	
Corporate Nursing	RN Red Impact : Meds Errors / Misses		3	0	7	1	27	
Corporate Nursing	RN Red Impact : Patient relative complaints		2	0	3	0	0	
Corporate Nursing	RN Red Impact : Staffing incident submitted		6	16	18	7	23	
Corporate Nursing	RN Red Impact : Special 1:1 (uncovered)		3	7	9	0	26	
Corporate Nursing	RN Red Impact: Missed Breaks		14	26	26	10	107	
Corporate Nursing	RN Red Impact: Delayed / Missed Obs		10	19	122	1	287	
Corporate Nursing	RN Red Impact: Delayed / Missed nMEWS		12	33	12	31	239	
Corporate Nursing	RN Red Impact: Delayed / Missed Pressure Care		3	14	24	23	145	
Corporate Nursing	RN Red Impact : Delayed Meds		8	20	127	6	582	
Governance support	Number of SI's where staffing has been a contributing factor	0	0	0	0	0	TBC	
Corporate Nursing	Total Number of staffing incidents	30	53	80	75	25	90	
Complaints team	Formal complaints in relation to staffing issues	0	0	0	0	1	0	
Complaints team	Informal Concerns raising staffing levels as an issue	0	0	0	1	0	0	
Complaints team	Patient Experience feedback raising staffing levels as a concern	0	0	0	0	0	0	
Corporate Nursing	Staff Moves		232	329	140	164	TBC	
NHS Professional	Number of RN hours requested	19909	22878	24734	28432	31103	28638	
NHS Professional	Number of CSW hours requested	20155	25196	25007	32505	28386	30651	
NHS Professionals	% of requested filled RN's	67.80%	62.80%	61.70%	60.20%	72.70%	58.90%	
NHS Professionals	% of requested CSW filled	86.30%	80.20%	76.50%	71.10%	85.30%	68.10%	
NHS Professionals	% of Agency staff used RN	3%	3%	3%	2%	6%	1%	
NHS Professionals	% of Agency staff used CSW	0	0	0	0	0%	0%	

Board of Directors	
Agenda Item	20-21/227
Title of Report	Change Programme Summary, Delivery & Assurance.
Date of Meeting	27th January 2021
Author	Clare Jefferson, Head of Service Improvement
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Choose an item	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

PROGRAMME SUMMARY

1. Overview

The Programme Board planned for 20th January 2021, along with the Programme Steering Group meeting scheduled for 11th January 2021, were both cancelled by Gold Command due to operational pressures throughout the organisation as a result of the Covid Pandemic.

The three Transformation Programmes each held their Steering Group meetings during the week commencing 4th January 2021. The information presented at these, coupled with the Programme and associated Project information held in PM3/ S:Drive PM3 folder has informed the Assurance review presented.

PROGRAMME STATUS

In terms of the overall ratings assessments there has been an improvement, compared to December, with all but one rating Green for Governance and the majority rating Green for Delivery. Further action should be taken to continue this trend to improve upon delivery of the planned changes for the Patient Flow and Outpatient transformation programmes.

1.1. Governance Ratings

For January, six of the seven 'live' programmes were green rated for Governance, with one attracting an amber rating; this is based upon the PM3/ S:Drive PM3 evidence.

1.2. Delivery Ratings

January saw five programmes green rated for Delivery while two were amber rated. For the sake of clarity, amber ratings remain indicative of substantive issues albeit considered within the competency of the programme/project team to resolve. The areas for attention are, in particular, the definition and realisation of benefits and robust planning.

The assurance ratings are leading indicators of whether the desired grip and pace are being achieved, resulting in a more significant 'shifting of the dials' in terms of the desired improvement.

ASSURANCE

2. Programme Assurance - Ratings

The attached assurance report has been undertaken by the Head of Service Improvement and provides a detailed oversight of assurance ratings per programme / project. The report provides a summary of the assurance as a gauge of the confidence in eventual delivery and the actions needed to improve those confidence levels are described in the assurance statements for each.

3. Recommendations

The Board of Directors is asked to note the Trust's Change Programme Assurance Report and consider the following recommendation:

6.1 That the Board of Directors requests Senior Responsible Owners / Executive Sponsors to direct their projects to further improve confidence in delivery.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Change Programme Summary

Programme Assurance
January 2021

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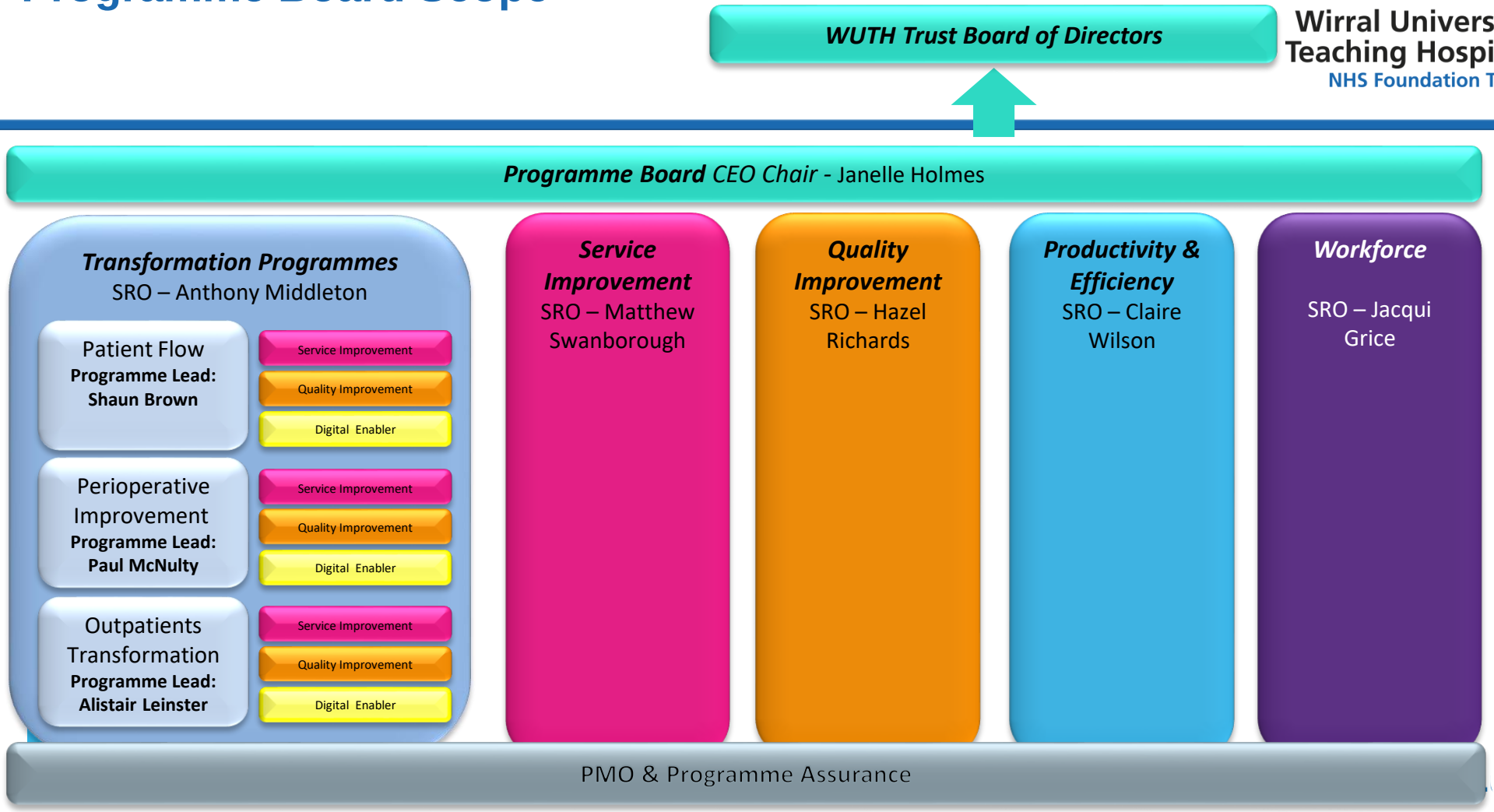
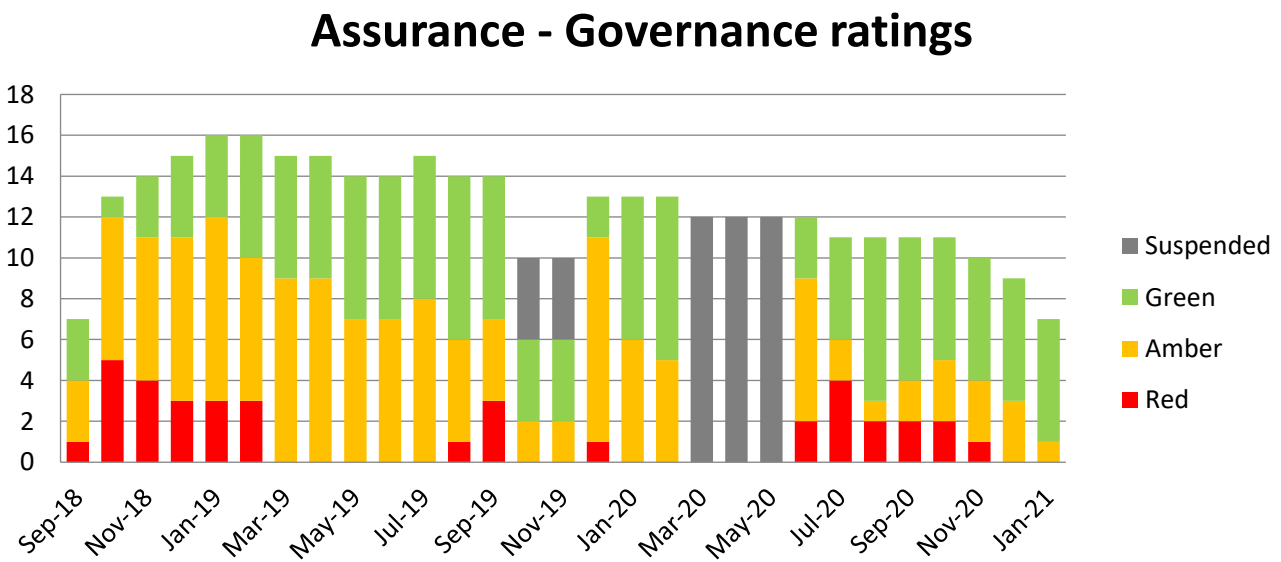
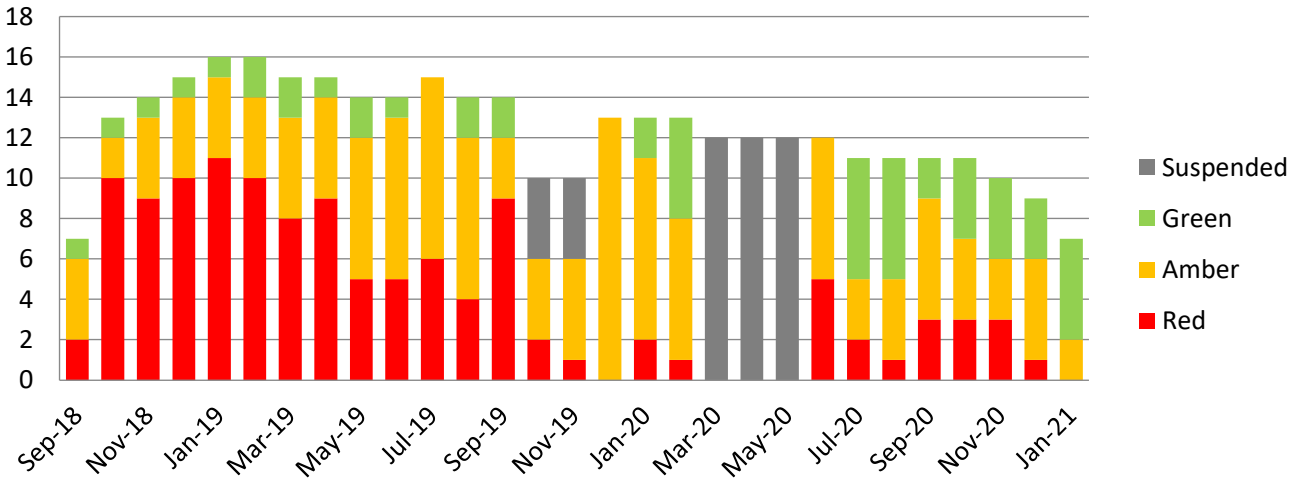
Programme Board Scope




Assurance - Governance ratings
18
16
14
12
10
8
6
4
2
0
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
Jul-20
Sep-20
Nov-20
Jan-21
Suspended
Green
Amber
Red

Assurance - Delivery ratings



Wirral University Teaching Hospital
NHS Foundation Trust

Programme Assurance Ratings

17 January 2021

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Change Programme Assurance Report -
Trust Board Report - January 2021 - Top 3 Priority Projects - Summary

Programme Assurance

Wirral University Teaching Hospital
NHS Foundation Trust

Improving Patient Flow	Governance	Amber	Delivery	Amber

- Metrics for Bed Occupancy and Average Length of Stay are within Flow Programme targets at 86% and 6.4 days respectively. Metrics for 21 day+ LOS and time spent in ED exceed Programme targets with 99 LLOS patients and 245 minutes respectively. *The Programme has been impacted by a high level of demand for services due to Covid.*

- The programme is planning to focus, over the next 3 months, improvement work on a small number of key standards in the Flow Vision. Aims for measurable improvement within a specified period of time are being developed.

- **A plan is in development to identify improvements which will contribute to an increase in the number of Discharges before Midday, including the associated benefits to staff and patients; what will improve, by how much and by when. This will be tracked by those accountable for delivery and assurance.**

Perioperative Medicine Improvement	Governance	Green	Delivery	Green

- The revised PID v0.5 dated 4 Mar 20, as approved by the Programme Board - including an extensive schedule of benefits and measures - remains extant. The programme has devised revised trajectories and these are now being monitored for evidence of the planned improvements.

- **The KPIs declared by the programme, as agreed by the Programme Board, continue to show the positive impact of the changes the programme is driving.**

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Change Programme Assurance Report -
Trust Board Report - January 2021 - Top 3 Priority Projects - Summary

Programme Assurance

Wirral University Teaching Hospital NHS Foundation Trust

Outpatients Improvement	Governance	Green	Delivery	Amber

- **Overall Aim:** The Outpatients programme was re-focussed (Programme Board on 18th March) to deliver, at pace, radical solutions to keep patients away from the hospital sites; this was to be achieved by providing outpatients services by remote (non-Face-to-Face) means.

- **Overall Progress: December figures have continued to be adjusted (Obstetrics removed) to reflect Model hospital reporting. This has increased overall performance.** As the programme reports: the Trust has attained the national 'overall' **25%** Non-F2F target in December at **33%** (was 34% in November); the **60%** 'follow-up' non-F2F target was not achieved, reported at **33%** (was 36% in November). **The QIA/EA has been revised following feedback from Dr Nicola Stevenson and Hazel Richards and action taken as instructed; revised QIA has been resubmitted for Clinical Executive level Sign Off.**

- **Compliance and Exceptions:** The programme team continues to work with 37 specialties, across 4 divisions, to identify clinical exceptions that would permit a face-to-face consultation to occur.

- **Targets resolved: As agreed at the Programme Board, 18 November 2020, the programme targets for overall delivery by remote means have been confirmed using a comprehensive bottom-up approach of analysis and validation of exceptions with Divisions:**
  - For total appointments Non-F2F%, i.e. New + FU attendances, no intervention is needed and this figure will continue to be monitored for assurance.
  - For total Follow Up Appointments Non-F2F%, an action plan and trajectory have been developed to achieve: 45% by Mid-February 2021 (what the predicted level was based on Divisional Submissions June 2020) and 60% by end of May 2021 (NHSE target for follow up appointments Non F2F). This will continue to be worked on at Programme level.

Note 1: The programme cites Simon Stevens - 3rd Phase of NHS response to Covid letter, dated 31 Jul 20: Overall 25% Non-F2F, FU appts 60% Non-F2F.
Note 2: Divisional submissions by specialty - Programme Board 19 Aug 20 - gives % Non-F2F Trust-wide: New appts 37% Non-F2F, FU appts 45% Non-F2F.

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Improving Patient Flow - Programme Assurance Update – 17 January 2021

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Shaun Brown	Jane Hayes-Green	Implementation	Amber	Amber

Independent Assurance Statement

1. The 'Vision for Patient Flow' v2 is uploaded to PM3. 'Scope' is the 'PID for Patient Flow' presented at the Prog. Steering Group 9 Nov 20 and contains 22 objectives the Programme is seeking to achieve. The Programme team agreed at the Patient Flow Steering Group meeting 5 Jan 21 to concentrate resource on achieving an improvement in 'Discharge before Midday' this now needs to be clearly defined. **2. & 3.** ToR updated Oct 20 is uploaded to PM3. Action Tracker available up to meeting of 5 Jan 21.
4. There is a Comms Plan uploaded in PM3; milestones have been added to the Programme Project in PM3 to track delivery. **5.** QIA for the Programme was approved at the Patient Flow Steering Group meeting 5 Jan 21 and is awaiting Exec sign off. **6.** Programme and associated Projects are effectively managed in PM3 - significant delays noted to the 'discharge' project due to complete 30 Oct 20 however it is acknowledged there are now only two outstanding tasks. **7.** The Flow dashboard was reviewed at the Patient Flow Steering Group meeting 5 Jan 21 and 'Discharge by Midday' identified as the objective to focus on; a plan for 'how much, by when' needs to be developed for this KPI.
8. & 9. Programme risks and issues are managed in PM3 (updated 14 Jan 21). **Most recent assurance evidence submitted 16 Jan 21.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
2. Transformation Programmes - Improving Patient Flow														
2.1	**Patient Flow Programme**	The Flow programme will work to ensure that all patients receive care and treatment in accordance with the standards within the Trust Flow Vision V2.0 The Flow programme will implement and monitor projects to support the delivery of the flow standards in the Flow Vision	Anthony Middleton		●	●	●	●	●		●	●	●	●

Perioperative Medicine Improvement – Programme Assurance Update – 17 January 2021

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Paul McNulty	Charlotte Wainwright	Implementation	Green	Green

Independent Assurance Statement

1. The revised PID v1.0 dated 3 Mar 20 was signed-off by the Project Steering Group (and is updated by the Oct 20 'Scope' slide). The Exception Report and Re-start Plan (post-COVID Wave 1) was approved by the Programme Board in June 2020. **2.** As well as the Steering Group, there is also a 'Patient Safety and Experience Project Group' and an 'Operational Excellence Project Group'. **3.** The Perioperative Steering Group has ToRs revised in Jan 20 and there is evidence of meetings up to 5 Jan 21. **4.** There is a Comms Plan in place which is tracked. **5.** The renewed QIA signed off 4 Dec 20 is evidenced in PM3 **6.** Programme and associated Projects are effectively managed in PM3 (any delays in the 'EBF' and 'Theatre Scheduling' projects are RAG rated separately for that project line). **7.** KPIs are defined and on track. 8 & 9.Programme risks and issues are managed in PM3 (all reviewed in Dec 20/Jan 21). **Most recent assurance evidence submitted 16 Jan 21.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3. Transformation Programmes - Perioperative Improvement														
3.1	**Perioperative Programme**	The specific focus/brief of the Theatre Productivity Group, to achieve our objectives, was to: Reconfigure the Theatre Schedule; Enable the planning of theatre staff and anaesthetics; implement a system to track and monitor 45 week usage; reduce specialty level variation so that all lists are achieving 85% utilisation target; implement a weekly process to enable prospective and retrospective assessment of session utilisation.	Anthony Middleton		●	●	●	●	●		●	●	●	●

DIGITAL ENABLEMENT: Theatre Scheduling - Project Assurance Update – 17 January 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Paul McNulty	Ged Hussey	Implementation	Green	Green

Independent Assurance Statement

1. The Theatre Scheduling PID v1.0 Final (v3 dated 27 Feb 20) approved by the Perioperative Steering Group on 28 Jul 20. **2.** The Perioperative Digital Enabler projects are discussed at the 'Operational Excellence Project Group' evidence of meeting 11 Dec 20. **6.** The Theatre Scheduling project plan in PM3 shows that 'post-implementation enhancements' have been completed. Closure report in development for sign off at the Perioperative Steering Group meeting Feb 21. **8 & 9.** Project risks and issues are managed in PM3 (all reviewed in Dec 20). **Most recent assurance evidence submitted 17 Jan 21.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3. Transformation Programmes - Perioperative Improvement														
3.2a	**Theatre Scheduling** (Digital Enablement - Perioperative Care)	The objective of this project is to implement informatics developments to support operational changes and help streamline and improve theatre processes from pre-op through to recovery and discharge.	Anthony Middleton		●	●					●		●	●

DIGITAL ENABLEMENT: Electronic Booking Form- Project Assurance Update – 17 January 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Paul McNulty	Ged Hussey	Implementation	Green	Green

Independent Assurance Statement

1. The PID, CPO 1091, (undated but) uploaded 26 Nov 20, defines the project and was approved at the next Steering Group on 1 Dec 20. **2.** The Perioperative Digital Enabler projects are discussed at the 'Operational Excellence Project Group' evidence of meeting 11 Dec 20. **6.** The milestone plan on PM3 has been updated to reflect agreed revised Milestones all of which are on track **8&9.** Project risks and issues are managed in PM3; no open risks recorded and 1 open issue last updated 11 Jan 21. **Most recent assurance evidence submitted 17 Jan 21.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3. Transformation Programmes - Perioperative Improvement														
3.2b	**Electronic Booking Form** (Digital Enablement - Perioperative Care)	Project benefits as defined at the meeting of 17 Dec 19: Data quality for planned procedures would be improved as new booking forms have additional procedures and information resulting in better quality of patient information in the EPR. Review and re-build of the procedure catalogue will allow accurate information in the EPR (demonstrating the surgery teams are better able to schedule / manage their resources).	Anthony Middleton		●	●					●		●	●

Outpatients Improvement - Programme Assurance Update – 17 January 2021

Exec Sponsor	Programme Lead	Service Improvement Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	Jordon Bailey	Implementation	Green	Amber

Independent Assurance Statement

1. The PID v4.0 was agreed by Outpatients Transformation Steering Group (OTSG) on 30 Nov 20. The key benefits are defined therein. **2.&3.** Project Team ToR v2.0, authorised 10 Jun 20, and there is evidence of meetings up to 6 Jan 21. **4.** There is a Comms Plan in place which is tracked. **5.** QIA/EA has been revised following feedback from Dr Nicola Stevenson and Hazel Richards and action taken as instructed; revised QIA awaits sign-off at clinical executive level. **6.** Programme and associated Projects are effectively managed in PM3 (any delays in the 'OPR' and 'Attend Anywhere' projects are RAG rated separately for that project line). **7.** Non F2F trajectory is in place and being tracked the Programme has initiated a Vision and KPI RI project to identify additional KPIs to monitor as part of the programme. **8. & 9.** Programme risks and issues are managed in PM3 (all reviewed in Jan 21). **Most recent assurance evidence submitted 16 Jan 21.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
4. Transformation Programmes - Outpatients														
4.1	**Outpatients Programme**	The primary focus of the programme is to ensure Value at Every Encounter. This is value to the patient, the Clinician(s) and the Trust. To the patient, the aim is to ensure that they are provided with the diagnosis, treatment, or information that they need. To the clinician, the aim is to ensure that every time they see a patient, they have the information and time they need to provide a quality clinical encounter. For the Trust, the aim is to ensure a high quality, clinical encounter, with no waste of resource and which results in positive patient experience/feedback.	Anthony Middleton		●	●	●	●	●		●	●	●	●

DIGITAL ENABLEMENT: Outpatients One Patient Record - Project Assurance Update – 17 January 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	Nickee Smyth	Implementation	Green	Green

Independent Assurance Statement

1. The project is defined in the PID v2.0 dated 3 Jul 20 which is uploaded to PM3. **2.** There is a project team ToRv2.0 as approved on 31 Jul 20. There is an Action Tracker and Attendance Log for project meetings up to 17 Dec 20. **6.** The PM3 milestone plan shows revised dates for 5 milestones, agreed by Programme team, all of which are now tracking green. **8&9.** Project risks and issues are managed in PM3 (all reviewed in Dec 20/Jan 21). **Most recent assurance evidence submitted 17 Jan 21.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
4. Transformation Programmes - Outpatients														
4.2a	**Outpatients One Patient Record** (Digital Enablement - Outpatients Improvement)	The key deliverables from this project are: - Removing Case Notes from Outpatients - Reducing the amount of paper produced within the Outpatient environment - Solutions to make unavoidable paper available electronically.	Anthony Middleton		●	●					●		●	●

DIGITAL ENABLEMENT: Attend Anywhere - Project Assurance Update – 17 January 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	Michelle Murray	Implementation	Green	Green

Independent Assurance Statement

1. The project is defined in the PID v0.6 dated 8 Apr 20 which is uploaded to PM3. **2.**There is a Project Group Action Log and record of meetings up to 16 Dec 20. **6.** PM3 shows the majority of key milestones were completed on time. Remaining milestones have revised dates for which they are now on track and a project closure date has been set for 19 Feb 21 **8.&9.** Project risks and issues are managed in PM3 (Evidence of review in Dec 20/Jan 21). **Most recent assurance evidence submitted 17 Jan 21.**

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
4. Transformation Programmes - Outpatients														
4.2b	**Attend Anywhere** (Digital Enablement - Outpatients Improvement)	Attend Anywhere is a video consultation platform. It is a web based product which enables clinicians to conduct video consultations with outpatients. The objective is to make Attend Anywhere available as a third option for outpatient consultations, alongside telephone and face to face. It is envisaged that this platform would be used in both scheduled clinic settings and also in unscheduled settings such as 'Hospital at Home'.	Anthony Middleton		●	●					●		●	●

Board of Directors	
Agenda Item	20-21/228
Title of Report	EU Exit End of Transition Period Preparedness Report
Date of Meeting	27 January 2021
Author	Helen Nelson Corporate Directorate Manager Operations/Emergency Planning Officer
Accountable Executive	Anthony Middleton Chief Operating Officer/Accountable Emergency Officer
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Bronze - qualitative data
FOI status	Entire document is exempt under FOI
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Executive Summary

The UK left the EU and entered the transition period which lasted until 31 December 2020. During this transition period the UK prepared for the UK's future trading relationship with the EU.

The NHS has provided an operational response, led by Professor Keith Willett, Strategic Incident Director for EU Exit. In line with this response, the Trust has reviewed the work previously undertaken in

preparation for EU Exit. The Trust has stood up its EU Exit Planning Team, which is overseen by the EU Exit Senior Responsible Officer (SRO), Anthony Middleton Chief Operating Officer. This team supported the Trust's preparedness prior to 31 December and will subsequently support the incident management stage from January 2021.

The Trust has not identified any significant risks during this process. A Chair's summary report was provided to the Board of Directors on 2 December 2020.

Planning meetings
The Trust has participated in the four EU Exit TP workshops between November and January, chaired by Professor Willett and the Wirral EU Exit Coordination Group chaired by the Wirral Council, to ensure that the Trust has informed, safe and robust plans in place. Internal planning meetings have taken place during November, December and January and will continue to meet to consider national guidance and feed into the Trust's command structure.

Daily Sitrep
The NHSEI EU exit daily sitrep reporting commenced on 23/12/20. Any EU exit related issues that are expected to impact business critical services are reported into the Trust's command structure via the daily Bronze meetings with Silver and Gold escalation as required. The escalation flowchart is available on the EU Exit intranet page.

EU Exit Intranet page
Information for staff is available via the EU Exit intranet page. This includes information for staff on the EU Settlement Scheme, and guidance and letters received from Government.

Action taken
In line with the EU Exit Operational Readiness Guidance 7 key areas identified nationally, have completed a risk assessment/plan. At the request of Professor Willett, the risk assessment was updated to reflect the current pandemic and winter pressure.

A UK:EU Trade and Cooperation Agreement has been reached and the Future Relationship Bill was passed by by Parliament on 30th December. The UK's new relationship with the EU will be in place from 1st January 2021.

2. Next Steps
In line with EU Exit Operational Readiness Guidance' from the Department of Health & Social Care, this report will be noted at the Board of Directors in January 2021.

3. Conclusion
Local planning is in place with support from EPRR C&M, in line with the EU Exit Operational Readiness Guidance. Any EU exit related issues expected to impact business critical services will be escalated via the Trust's command structure.

4. Recommendations
The Board is asked to approve the contents of this paper and be reassured that the Trust complies with the EU Exit national guidance and is proactively managing any potential impact on Trust business continuity.

Board of Directors	
Agenda Item	20-21/229
Title of Report	Review of Progress against Undertakings
Date of Meeting	27 January 2021
Author(s)	Jill Hall, Interim Director of Corporate Affairs
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	PR1, PR3, PR6
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Purpose of the Report

The purpose of the report is to advise the Board of Directors of progress against the revised enforcement undertakings issued by NHS Improvement on 24 July 2020.

2. Background

Enforcement undertakings under Section 106 of the Health & Social Care Act 2012 were originally applied to the Trust on 5 August 2015. An additional licence condition under S111 of the Health & Social Care Act 2012 was subsequently imposed on 7 August 2015. Both the undertakings and the additional licence condition related to:

- The need for the Trust to secure delivery of services on a financially sustainable basis; and
- The need for the Trust to ensure compliance with the A&E four hour target on a sustainable basis.

Revised enforcement undertakings, which superseded the undertakings applied in August 2015, were issued by NHS Improvement on 23 March 2018. The issues set out in the revised undertakings dated 24 July 2020 continue to relate to financial sustainability and sustainable performance against the A&E four hour target.

The Board of Directors formally endorsed the revised undertakings during a meeting held on 5 August 2020 and agreed to review progress against the undertakings on a two monthly cycle commencing in September 2020. Progress against each of the relevant undertakings is detailed in subsequent sections of this report.

3. Financial Sustainability (inc Financial Recovery Plan)

The Trust is operating in an emergency finance regime for 2020/21 which was introduced to support the national response to the COVID-19 pandemic. The Trust has reported a surplus of £1.9m to month 9 of 2020/21 which is in line with expectations given the temporary funding mechanisms in place.

The financial envelopes and detail behind the financial framework for the period from 1 October 2020 to 31 March 2021 have now been confirmed and the Trust has submitted a break-even financial plan to NHS Improvement. However, delivery against this plan will be dependent upon the levels of COVID-19 activity seen by the Trust over the winter period and our ability to continue to restore the elective programme.

The 2020/21 favourable financial position would enable our cash position to be protected in this unprecedented year.

The Trust began a significant programme of work supported by PA Consulting in the spring of 2020 in order to support the 2020/21 £14m CIP programme. This work was paused whilst operational focus shifted to the emergency response, but the Trust will reinstate this work in preparation for 2021/22.

Alongside this, a long term financial plan is currently being developed which will underpin the Trust's financial strategy and recovery plan which is due for completion in Quarter 3 2020/21.

4. Sustainable Delivery of Accident & Emergency Services

The Trust aims to be compliant against the National Constitutional 4 Hour standard of 95%. Whilst the Trust is currently performing in line with comparator organisations, it has not consistently achieved the 95% target over an extended period of time.

A full review of systems and processes has led to the development of a number of improvement workstreams both internally at hospital level and externally at system level.

Internal Actions and Assurance
A range of internal key performance indicators are tracked and managed internally to actively and dynamically support patient flow. In addition, a series of improvement workstreams are in place with delivery managed by the Patient Flow Improvement Group and reported to Programme Board through to Trust Board.

System Actions and Assurance
As achievement of the standard is a recognised indicator of Patient flow performance across the Wirral Health and Social Care System, Executive and System Leadership is in place to deliver system improvements. Reporting is via the System Chair and Chief Executive Group of the Healthy Wirral Partners Board. The Trusts internal improvement plans are mapped through to the Healthy Wirral Programme, which has a dedicated Unscheduled Care workstream. This consists of Pre Hospital Improvement, Hospital Improvement and Discharge / Out of Hospital Care Improvement.

Aligned to this work is the Hospital Upgrade Programme with the completion of the outline Business Case ready for submission later this year. The Programme will support the redevelopment of the onsite Urgent Treatment Centre and Emergency Department, to improve Patient flow, streaming and turnaround.

5. CQC Action Plan

The revised undertakings dated 24 July 2020 specifically state that; *the Licensee will provide NHS England and Improvement with evidence of progress against its CQC action plan on those areas pertaining to financial governance and use of resources.* The actions relating to 'Must Do' and 'Should Do' recommendations have been reviewed and there are no recommendations or actions which relate to either financial governance or use of resources.

Executive Directors are reviewing the separate Use of Resources report from the CQC inspection to ensure that any identified areas for improvement have been incorporated in relevant action plans. A full report on progress against CQC Action Plans was included in a separate agenda item for the Board of Directors meeting on 3 December 2020.

6. Board Development

The Board approved a Board Development programme which was planned to be delivered by NHS Providers commencing this month. Due to the current pandemic it has been agreed with NHS Providers to postpone the programme and review the delivery timetable when pressures on the Trust due to the pandemic have eased.

7. Progress / Outcomes from the Wirral System Improvement Board

The System Improvement Board meetings were suspended during the first wave of Covid-19. NHSE/I resumed these meetings with the first held in October and were scheduled to be held monthly. In view of the current Covid surge, the North West regional Executive have advised that until further notice these meetings will be held on alternate months to maintain oversight of the systems improvement journey.

8. Recommendations

The Board of Directors is recommended to:

- Receive and note the content of the report.

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 20/21-230

Public Board of Directors
27 January 2021

Title:	Charitable Funds Annual Report and Accounts
Responsible Director:	Claire Wilson
Presented by:	Claire Wilson

Executive Summary *Contextual and background information pertinent to the situation / purpose of the report.*
Presentation of the audited Charitable Funds Annual Report and Accounts 2019/2020 for approval together with the External Audit Independent Examination Report and the Recommendations Letter.

Recommendation: (e.g. to note, approve, endorse) *What action / recommendation is needed, what needs to happen and by when?*	
Approval	
Which strategic objectives this report provides information about:	
Continuous Improvement	Yes
Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)	
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)	
Charity Commission compliance	
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)	
N/A	
Specific communications and stakeholder /staff engagement implications	
N/A	
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)	
N/A	
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)	
N/A	
Previous considerations by the Board / Board sub-committees	Draft Annual Report and Accounts approved by the Charitable Funds Committee in November 2020.
Background papers / supporting information	Charitable Funds Annual Report and Accounts 2019/20 Independent Examination Report Recommendations letter Letter of representation

BOARD OF DIRECTORS MEETING IN PUBLIC
27 January 2021

Charitable Funds Annual Report and Accounts 2019/20

Purpose

The purpose of this paper is to present the Charity's Annual Report and Accounts 2019/20 (Appendix One) to the Board for approval.

Introduction / Background

The Corporate Trustee is required each year to prepare its Annual Report and Accounts in accordance with Part 8 of the Charities Act 2011 and the Charities (Accounts & Reports) Regulations 2008. The Charity's exemption from audit has been exercised - external scrutiny through independent examination has been deemed appropriate for the Charity as its transactions and balances fall significantly below statutory thresholds. The Charity's independent examiner is Grant Thornton UK LLP.

The deadline for the submission of the final independently examined 2019/20 Annual Report and Accounts to the Charity Commission is 31 January 2021.

The draft Annual Report and Accounts were presented to the Charitable Funds Committee on 10 November 2020. The independent examination was completed during weeks commencing 4 and 11 January 2021. Some minor presentational amendments have been identified by the review and these have been amended. The Independent Examination Report is attached at Appendix Two.

Two recommendations have been made in relation to the management of the Charitable Funds bank accounts and these are being actioned by management. The recommendations letter is attached at Appendix Three.

Conclusions

Once approved, the Annual Report and Accounts 2019/20 will be presented to the Charity Commission in advance of the 31 January deadline and arrangements will be made to make it available to the general public, grantors and donors via the internet.

Recommendations to the Board

The Board is asked to:

- Approve the Annual Report and Accounts following the independent examination.
- Note the Independent Examination Report.
- Approve the signing of the Representations Letter by the Chief Finance Officer (Appendix Four).

Grant Thornton

Corporate Trustee
Wirral University Teaching Hospital NHS Foundation
Trust Charitable Fund
Arrowe Park Hospital
Arrowe Park Road
Upton
Wirral
CH49 5PE

Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester
M3 3EB

T +44 (0)161 953 6900
F +44 (0)161 953 6901

19 January 2021

Dear Sirs

Wirral University Teaching Hospital NHS Foundation Trust Charitable Fund – Independent Examination of 2019-20 Annual Report and Accounts

We are pleased to report that we have completed our independent examination of Wirral University Teaching Hospital NHS Foundation Trust Charitable Fund's (the Charity) 2019-20 Annual Report and Accounts.

An ISA compliant audit was not required for 2019-20 since the Charity's transactions and balances were below the necessary thresholds. As such, we do not issue a formal Audit Findings Report on completion of our work. However, in the course of examination, we identified two recommendations which we would like to bring to the attention of the Corporate Trustee.

Recommendation One – Review of Bank Mandate Controls

It was identified during our examination that the controls around bank mandates require strengthening. Currently, there are bank accounts held by the Charity where the only authorised signatories are no longer are employed at the Trust. This is a control weakness and a potential fraud risk.

It is therefore recommended that:

1) the Charity should immediately review all authorised signatories for each bank account held;

2) the Charity should ensure that staff responsibilities with regards to bank signatory authorisation is reviewed as part of the formal exit process when staff leave the Trust/Charity. Where a staff member had access, this should be removed immediately on leaving the Trust.

Recommendation Two – Arrangements for Online Banking

It was identified during our examination that only one of the Charity's three active bank accounts have been set up for online banking. The absence of online banking for all accounts limits the Charity's ability to monitor and review transaction activity on a timely basis. It also enables the independent examiner to authenticate the year end bank balance more easily.

It is therefore recommended that:

1) the Charity should consider setting up online banking access for all active bank accounts held.

We would like to thank all members of the finance team for their assistance and responsiveness throughout the independent examination. Our Independent Examiners' Report has been included in the committee papers.

Yours faithfully

Grant Thornton (UK) LLP

BOARD OF DIRECTORS	
Agenda Item	20-21/231
Title of Report	Report of the Audit Committee
Date of Meeting	15 January 2021
Author	Steve Igoe, Non-Executive Director
Accountable Executive	Claire Wilson, Chief Finance Officer
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Audit Committee

This report provides a summary of business conducted during a meeting of the Audit Committee held on 15th January 2021.

1.Internal Audit

a) **Progress report:**
Since the previous report the following reviews had been finalized:

- IT infrastructure (Limited Assurance)
- Cyber security controls (moderate assurance)

Whilst a substantial number of issues had been raised in these reports, they had been commissioned by the new IT Director and CFO to establish a baseline position to inform further work in addressing key weaknesses.

The Committee took assurance that work was progressing well in resolving the matters raised and there was evidence of a more detailed project plan with critical milestones to be achieved over the coming months to further strengthen the environment.

Two reviews on the plan that had been suspended (safer standards for invasive procedures and tissue viability) as a result of the impact of COVID were agreed to be replaced by work to be done by MIAA in facilitating a workshop on the BAF and risk appetite and a further session to present and agree a refreshed BAF.

b) Anti-fraud:

Work continued on a business as usual approach in relation to these issues. Given the work being overseen by the Audit Committee in relation to a number of HR matters the Auditor confirmed further work in relation to payroll and recruitment issues.

The Auditor was asked to review their earlier positive assessment for the trust in such matters in the light of the further information on control weaknesses recently discovered by the Trust.

2.Tracking Audit Actions

The Interim Director of corporate Affairs reported on continued positive engagement and resolution of these issues. A positive assurance was also received in relation to further work on hospitality and gifts and conflicts of interest.

3.Annual Accounts and External Audit

The Committee was updated on the outcome of the recent procurement process to appoint external auditors.

Details were still unconfirmed in relation to the year-end timetable however indications were that draft accounts would be required by 27th April with audit completion due by 15th June. The annual report format was expected to be largely unchanged although there was still some confusion as to the requirements of and for the Quality Account.

The committee received and reviewed a first draft of the going concern statement to be included in the accounts. It was noted that this is broadly similar to that included in the previous year and will be subject to further detailed review on the basis of any central guidance and closer to the year-end deadline. A similar review was undertaken of key accounting policies. They were approved subject to any further necessary update once further guidance is received.

4.Code of Governance gap analysis and action plan

The Interim Director of Corporate Affairs introduced the report and plan to update the Committee on progress to date and on further gaps identified as part of the process. The report and plan were noted, and it was agreed to update the committee at future meetings as necessary.

5.Financial assurance report and tender waivers

The Committee received these regular reports. It was noted that the volume of tender waivers is down 25 % year on year although that is to be expected given the impact of COVID 19. There was some discussion in relation to retrospective requisition approval and it was agreed that in some instances the system may be flagging approvals that are inevitable given the nature of the supply.

6.Committee Evaluation

A draft pro forma for completion was discussed and approved for use in undertaking a self-evaluation of the operation of the Audit Committee. It was noted that a similar process would be undertaken for all other assurance committees.

7.Risk Management committee report

The report was reviewed by the Committee who noted that the contents were as expected. There was some comment on the inconsistent use of the WHO checklist which is mandatory and has been for some time. It was agreed that the completion of this should be enforced and the Chair agreed to bring this forward to the notice of the Board.

7.Audit Committee work plan

This was agreed subject to some potential variation in relation to timings as a result of central guidance relating to year and a recognition of the ongoing work of the Committee in overseeing the remedial work on the HR control environment.

S J Igoe
Chair of Audit Committee
19th January 2021

Agenda Item	20-21/232
Title of Report	Communications and Engagement Monthly Report
Date of Meeting	27 January 2021
Author	Sally Sykes, Director of Communications and Engagement
Accountable Executive	Jacqui Grice, Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Staff Survey assurance Reputation and stakeholder risks
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Discussion
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Analysis completed Yes/No **If yes, please attach completed form**	No

1. Executive Summary

The Board members are asked to note this report on activity since its last meeting in the areas of staff engagement and communications, campaigns, media and social media, charitable fundraising and stakeholder relations.

2. Background

This is the report of the Director of Communications and Engagement, providing an update on the team's work to generate proactive media and social media coverage of WUTH, to keep staff informed of critical matters to help them work safely and to keep patients safe.

3. Key Issues/Gaps in Assurance

Whilst some data like social media statistics are verifiable, the Trust currently does not have a media evaluation agreement in place. This is being addressed and quotes have been obtained from the NHS framework supplier Kantar Media.

Staff engagement is measured in the annual NHS Staff Survey and does provide a robust benchmark for both year on year changes and comparisons with other acute Trusts. This year's survey has concluded with WUTH achieving a 41% completion rate, an increase on last year's figure of 38%. The full survey results are expected mid to end February 2021.

Charitable fundraising is measured by the funds raised, but is also a significant factor in staff engagement in both staff involvement in fundraising and benefitting from funds raised for staff and patient wellbeing.

There is separate assurance of charity activities provided through the Board committee for charitable fundraising and there is an annual report for the charity. Assurance is also provided through accountabilities and returns to the Charity Commission.

4. Conclusion

There has been a significant amount of activity in support of the Trust's objectives and the Board is asked to note the progress in the report.

5. Recommendations

None

Report of the Director of Communications and Engagement

Campaigns, media, social media, internal communications, staff engagement and stakeholder relations

Campaigns

- We supported the introduction of the new NHS 111 First service for accident and emergencies on 24th November 2020. A full communications plan covered patient and staff communications and the service has been introduced successfully.

- We developed a campaign with local partners in the CCG, GPs, Wirral Community Trust, Wirral Partnership Trust and Wirral Council, including an advert in the Wirral Globe, use of the matrix road signs run by Wirral Council, social media, a video with the Chief Nurse and a media release directing people to contact NHS 111 in the first instance, where it is not an emergency.

  Consider alternatives to hospital if not urgent during Covid | Wirral Globe

- We continued to provide extensive support to the WUTH vaccination hubs and the national launch with patient facing materials and advice, social media, broadcast media and staff communications. The Arrowe Park hub for staff and those of partner organisations was launched 11 January 2021.

Media

The team has continued to produce proactive news stories from the wealth of positive work being done by staff, volunteers, clinicians and fundraisers.

- We provided a number of seasonal healthcare reminders for Christmas and New Year especially in support of adhering to restrictions locally.

- We also provided this film from a member of our midwifery team delivering babies over Christmas - Hero midwives delivering Merseyside's 2020 Christmas Day babies - Liverpool Echo

- We promoted the fact that two of our colleagues are featured in a major art exhibition at Tate Liverpool https://www.wirralglobe.co.uk/news/18944007.covid-tate-exhibition-features-wirral-nhs-worker/

- We highlighted the £1m investment in our Emergency Department at Arrowe Park which was covered in The Echo and The Globe

The increased number of COVID-19 patients in hospital has been covered locally as the NHS and our hospitals deal with the current post Christmas surge in cases http://www.wirralglobe.co.uk/news/18980658.rise-wirral-case-rate-now-impacting-hospital-admissions/

Media Statements

- We provided a response on a patient complaint to the Liverpool Echo about being turned away for a cancer procedure because he had travelled to his appointment on the bus. Communications with patients are being clarified on the website and in direct to patient communications.

- We provided a statement to the Echo and The Globe when two nurses were fined for parking inappropriately in a patient car park and on yellow hatched lines respectively. We made the point that car parking is free to our staff on production of ID badge to the card reader.

Internal Communications and staff engagement

- We maintained a schedule of two or more staff 'In Touch' Bulletins a week with important information on PPE, clinical guidance, staff wellbeing and support; and charity updates.

- We regularly signposted staff wellbeing and issued weekly bulletins each on the topics of safety and guidance from the Clinical Advisory Group.

- All staff were invited an 'In Touch Forum' on Thursday, 14th January from 12 noon to 1pm, where the Executive Team gave a situation update about our hospitals – COVID-19, vaccination hubs and ongoing winter pressures. 240 people attended and over 50 questions were put to the Execs. We ran another session on 20th January and intend to continue weekly sessions, which staff have said they found really useful

- We have partially rolled out the next phase of our 'Together we will' vision and values branding with new lift wraps on all the elevators at Arrowe Park Hospital- also featuring infection prevention and control hand washing messages.

- We recognise the many challenges our staff are facing during the COVID-19 pandemic and are extremely thankful for everything they do in keeping our patients as safe as possible. We regularly promote the range of staff support available along with some national services on the health and wellbeing website pages. We are making information even more accessible with a payslip leaflet, wellbeing posters and a wellbeing services directory folder for every ward and key departments in the hospitals. We have developed a distinctive identity for health and wellbeing communications for staff.

.Charity

- The Charity team's main focus in December was to support staff across the Trust. A series of activities such as free breakfasts, staff room hampers and a small token gifts and thank you card were shared across all sites. Further support was also secured from local business including Unilever, Moreton Bakeries and Typhoo.

- The Head of Fundraising is developing 2 initiatives for staff rest areas – 1) a series of quiet rooms near staff workspaces where they can take a break and 2) a more substantial proposal to upgrade staff breakout spaces near the restaurants at both hospitals.

- Over 400 rainbow flowers were sent to donors, which in turn prompted further sales in the New Year. Total income has exceeded £15,000 with profit in excess of £8000 to date.

- Positive relationships have also been established with Industrial Fragrances and Vauxhall Ellesmere Port. The Head of Fundraising is currently in discussion with the senior leadership team at Vauxhall about various options to support WUTH Charity this year.

- The teams focus continues to be staff support by and also development work for the Charity including, a lottery campaign, increase general Charity awareness and visibility and to plan COVID safe activities for the summer such as a Parachute Jump.

Stakeholders

- As covered in the campaigns section above, we worked across the system to signpost the best healthcare options for Wirral residents this winter.
- We have provided a communications update for the CCG to use with primary care on our elective programme, COVID-19 situation, vaccination hubs and ED investments.
- Healthwatch have launched a patient feedback section of their website to cover the vaccination experience and despite the challenges of rebooking owing to changes in the follow up dose interval, we have had some very positive feedback from patients about the hubs. Healthwatch is collecting the feedback and asking people to 'Spare 5' by giving their response which takes less than 5 minutes. The feedback will be important in supporting Wirral System intelligence on the vaccine in the coming months – the Healthwatch website is **here**.
- There is also a leaflet on our website for the public entitled **Healthwatch Wirral - Tell us about your experience**

Sally Sykes
Director of Communications and Engagement

Trust Management Board	
Agenda Item	20-21/233
Title of Report	Appointment of New Non-Executive Director / Appointment to Board Committees
Date of Meeting	27 January 2021
Author	J Hall, Interim Director of Corporate Affairs
Accountable Executive	Sir David Henshaw, Trust Chairman
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Bronze - qualitative data
FOI status	Entire document is exempt under FOI
Equality Analysis completed Yes/No **If yes, please attach completed form.**	No

1. Purpose

The Board of Directors is asked to note the membership of the Boards committees following the appointment of Steve Ryan as Non-Executive Director with effect from 18 January 2021.

On taking up the role, Steve will be Chair of the Quality Assurance Committee and be a member of the Finance, Business and Performance Committee, Charitable Funds Committee and the Remuneration and Appointments Committee.

Appendix 1 sets out membership to the Boards sub-committees and other interests and posts the Non-Executive Directors hold in the Trust.

Non-Executive Directors Portfolios 2021/2022

Board Assurance Committee	Chair	NED Membership
Board of Directors	Sir David Henshaw	Steve Ryan Steve Igoe Sue Lorimer John Sullivan Jayne Coulson Chris Clarkson
Audit Committee	Steve Igoe	John Sullivan Jayne Coulson
Quality Commitee	Steve Ryan	Steve Igoe Chris Clarkson
Finance, Business Performance & Assurance Committee	Sue Lorimer	Steve Ryan Chris Clarkson
Charitable Funds Committee	Sue Lorimer	Steve Ryan Jayne Coulson
Workforce Assurance Committee	John Sullivan	Chris Clarkson Jayne Coulson
Safety Management & Assurance Committee	Steve Igoe	John Sullivan Chris Clarkson
Remuneration Committee	Sir David Henshaw	Steve Ryan Steve Igoe Sue Lorimer John Sullivan Jayne Coulson Chris Clarkson
Capital Committee	Sir David Henshaw	Steve Igoe Sue Lorimer Chris Clarkson

Council of Governors	Chair	NED Attendees
Council of Governors	Sir David Henshaw	Steve Ryan Steve Igoe Sue Lorimer John Sullivan Jayne Coulson Chris Clarkson

Other Posts held

Deputy Chair	John Sullivan
Senior Independent Director	Steve Igoe
Chair of Organ Donation Committee	John Coakley from 1.1.19 Steve Ryan from 18.1.21
Staff Guardian	Jayne Coulson
Non-Exec Director Lead for Security	John Sullivan
Non-Exec Director Lead for Procurement	Steve Igoe Sue Lorimer
Member of programme Board	John Sullivan Chris Clarkson
Member - Employee Based Awards Panel	Jayne Coulson Steve Ryan
Board Champion - CNST (Maternity)	Steve Ryan
Attendee - Risk Management Committee	Steve Igoe
Cyber Security	John Sullivan