Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

30th January 2019

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 30 JANUARY 2019
COMMENCING AT 9AM IN THE BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

1	**Apologies for Absence** Chair	v	
2	**Declarations of Interest** Chair	v	
3	**Chair's Business** Chair	v	
4	**Key Strategic Issues** Chair	v	
5	**Board of Directors**		
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7	**Strategy Update** Director of Transformation & Partnerships	d	Page 22
8. Quality and Safety			
8.1	**Patient Story** Head of Patient Experience	v	
8.2	**Infection Prevention & Control Performance Report** Director of Nursing & Midwifery	d	Page 28
9. Performance & Improvement			
9.1	**Integrated Performance Report**		
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10. Governance

10.1	**Report of Finance Business Performance and Assurance Committee** Chair of Finance Business Performance and Assurance Committee	v	
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10.3	**Report of Trust Management Board** Chief Executive	d	Page 75
10.4	**Report of Workforce Assurance Committee** Chair of Workforce Assurance Committee	d	Page 78
10.5	**Report of Quality Committee** Chair of Quality Committee	d	Page 82
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10.7	**Report of Audit Committee** Chair of Audit Committee	v	
10.8	**CQC Action Plan Progress Update** Medical Director	d	Page 117
10.9	**EU Exit Operational Readiness Guidance for the Health and Care System** Chief Operating Officer	d	Page 139

11. Standing Items

11.1	**Items for BAF/Risk Register** Chair	v
11.2	**Any Other Business** Chair	v
11.3	**Date and Time of Next Meeting** Wednesday 6th March 2019.	v

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

19 DECEMBER 2018

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

Sir David Henshaw	Interim Chair
Janelle Holmes	Chief Executive
Jayne Coulson	Non-Executive Director
Dr Nicola Stevenson	Medical Director
Sue Lorimer	Non-Executive Director
Anthony Middleton	Chief Operating Officer
John Sullivan	Non-Executive Director
Gaynor Westray	Director of Nursing and Midwifery
John Coakley	Non-Executive Director
Helen Marks	Director of Workforce
Steve Igoe	Non-Executive Director
Paul Moore	Director of Quality and Governance (Non voting)

In attendance

Natalia Armes	Director of Transformation & Partnerships
Paul Charnley	Director of IT and Information
Dr Ranjeev Mehra	Associate Medical Director, Surgery
Mr Mike Ellard	Associate Medical Director, Women & Childrens
Dr King Sun Leong	Associate Medical Director, Medical & Acute
Karen Edge	Deputy Director of Finance
Andrea Leather	Board Secretary [Minutes]
Mike Baker	Communications & Marketing Officer
John Fry	Public Governor
Steve Evans	Public Governor
Jane Kearley*	Member of the Public
Craig Barker*	Member of the Public / Patient Story
Shelley Gallimore*	Member of the Public / Patient Story
Sue Milling-Kelly*	Patient Experience Team

Apologies

David Jago	Director of Finance
Chris Clarkson	Non-Executive Director
Dr Simon Lea	Associate Medical Director, Diagnostics & Clinical Support

*Denotes attendance for part of the meeting

Reference	Minute	Action
BM 18-19/150	**Apologies for Absence** Noted as above.	
BM 18-19/151	**Declarations of Interest** There were no Declarations of Interest.	
BM 18-19/152	**Chair's Business** The Chair welcomed all those present to the monthly Board of Directors meeting. In opening the meeting, the Chair reminded the Board of Directors that following recent local health economy discussions the establishment of a command centre, led by WUTH to support patient flow at the front door was agreed. This was established for a trial period with the outcomes discussed	

Reference	Minute	Action
	at the Urgent Care Board meeting held the previous day and the forthcoming Chair/Chief Executive meeting later this week. At the Urgent Care Board meeting it was acknowledged that it was hard to establish the effectiveness of the command centre as the system was not running optimally. The UC Board accepted the failure to deliver on key areas agreed previously, namely reduction of stranded patients by 27% across the economy eg 337 patients over 7 days with a target of 228 by end of Q3. The current position is 307 patients after the introduction of additional beds in M3 (Clatterbridge) and therefore the system needs to agree what needs to be implemented to mobilise Q4. The Chief Operating Officers of each organisation were tasked to provide detail of actions to be implement to ensure achievement of the original agreement. The command centre model will continue via dial in with a named individual representing each strategic partner with authority to escalate to Director/CEO. Discussion took place regarding the mitigations put in place to achieve the agreed 27% reduction of stranded patients, were the original assumptions incorrect and what were the consequences to strategic partners for getting it wrong. It was recognised that acuity was higher than expected and therefore had impacted on length of stay, this is now being monitored by Wirral Community Trust. M3 is now fully utilised and is operating well working with the partner. **The Board of Directors supported the escalation of these matters at the Chair/CEO's meeting later this week.**	
BM 18-19/153	**Key Strategic Issues** Board members apprised the Board of key strategic issues and matters worthy of note. **Associate Medical Director Women & Children's** – Mr Ellard apprised the Board that a peer review in antenatal and new born had recently been undertaken with positive feedback received. In addition NHS Resolutions would be reducing the CNST premiums in 2019/20 and that a review of previous claims going back 15 years was under way to establish any trends. The outcomes are to be reported back to the Board. **Mrs Sue Lorimer – Non-Executive Director** – advised that at the recent Finance, Business, Performance & Assurance Committee it was recognised that WUTH CNST premium was higher than other organisations. She reported that the Committee will receive a 'deep dive' presentation encompassing service line reporting (SLR), deficits and divisions contribution to Trust budget, this information will then inform the finance strategy. **Mrs Jayne Coulson, Non-Executive Director** – reported the positive progress to date regarding the outpatients review and highlighted the paper driven processes currently in place that could be networked. **Mrs John Coakley, Non-Executive Director** – raised a query regarding the number of EU staff and the Trust plans post Brexit. NHS providers recently received a letter from Matt Hancock, Secretary of State for Health & Social Care outlining the Governments preparations for a 'no deal' scenario.	

Reference	Minute	Action
	Providers are advised that local stockpiling is unnecessary and could cause shortages in other areas which would put patient care at risk. The Trust is undertaking an internal gap analysis in relation to business continuity should the 'no deal' scenario materialise. **Medical Director** – Dr Stevenson apprised the Board that NHS Improvement and NHS England had issued a directive to remove ambulance waits above one hour to address patient flow issues. To address this additional triage provision will be provided with back up provided by the matrons. In addition North West Ambulance Service (NWAS) have piloted the handover process after 15 minutes between 10am to 4pm. The trial was effective and as some patients were discharged from the corridor NWAS are also analysing data to establish if patients should/should not have been brought to the hospital. They may undertake a further handover trial out of hours to ascertain if there is any impact. **Deputy Director of Finance** – Mrs Edge apprised the Board that a working group had been established to consider the deficit drivers and service line reporting with the outcome to inform the financial strategy. The planning guidance for 2019/20 from NHSI has not yet been issued, it is expected imminently. **Director of Nursing & Midwifery** – the Board were informed that the Trust had recently experienced and outbreak of CDifficile on ward 38 with 6 patients with toxin positive. This exceeds the threshold for November to 19 reported avoidable cases. Work has now been completed to ensure enhanced environmental cleaning and HPV of all areas of the word. There is also increased incidence of Carbapenemase Producing Enterobacteriaceae (CPE) colonisation on wards 24 and 36. This has been difficult to manage due to lack of side room facilities, the 5 additional side rooms are to be opened as part of the 18 additional beds to be provided on the Arrowe Park site. Cleaning standards has been raised as a concern which will be addressed at a meeting with hotel services. Improvement plans to address the current situation have been developed and shared with the CCG, CQC and Public Health England. The Director of Nursing & Midwifery also reported the improved performance regarding complaints as a result of the introduction of the new process and partnership working between PRT and Divisions. **Director of Quality and Governance** – the Board were informed that the draft Quality Strategy had been circulated for consultation to senior leaders. The deadline for feedback is mid January and the final copy will be produced in February. **Mr John Sullivan, Non-Executive Director** – apprised the Board that the recent clinical excellence awards review had shown a breadth of contribution with 62 applications across a range of specialties. To encourage better engagement between consultants and NED's it would be helpful for NED's to have greater clarity of the role of a consultant. Mr Sullivan attended one of the Values & Behaviours workshops which had a good cross section of staff groups. He queried the lack of attendance of	

Reference	Minute	Action
	clinicians at such sessions and it was agreed that this staff group could be addressed through other mechanisms to ensure their participation. **Associate Medical Director, Surgery –** Dr Mehra apprised the Board that the changes on the Clatterbridge site were working effectively. Following a recent ophthalmology review the division had been approached to be an exemplar service. The Board of Directors requested that thanks be passed on to the team. **Director of Workforce** – Mrs Marks advised the Board that the Values & Behaviours workshops have been well attended and received positive feedback. The topic has also been delivered at team meetings and via the quality bus. The national staff survey response rate was 45%. The output would be discussed in detail at the Workforce Assurance Committee and reported to the Board. The team were thanked for all the hard work to encourage staff participation. **Mr Steve Igoe, Non-Executive Director** – apprised the Board that the year end process has been clearly mapped in agreement with external auditors. Discussions regarding the local indicator for the quality report will take place with the Council of Governors. **Director of IT and Information** – Mr Charnley apprised the Board that the Cerner upgrade had now been fully tested and will now go live in January. The Chief Information Officer (CIO) from NHSE is to assess the GDE milestones with sign off expected in January. Discussions with the Countess of Chester regarding the MOU regarding the Cerner contract are reaching conclusion and the final copy of the MOU will be discussed at the meeting of Chief Executive's. **Director of Transformation and Partnerships** – Mrs Armes apprised the Board that Trusts are to submit a 5 year plan in summer 2019 with reference to Healthy Wirral from a system perspective. The Board noted that the Chief Operating Officer, Anthony Middleton had no items to report.	
BM 18-19/154	**Board of Directors** **Minutes** The Minutes of the Board of Directors Meeting held 28 November 2018 were approved as an accurate record with the following minor amendments: **Present** (page 1), Steve Igoe – remove 'Associate' **Item BM 18-19/142** (page 7), para 3 – revise wording to read *'It was noted that the Board wished to see the drivers of the deficit work progressed in order to inform the development of a financial strategy.'* **Action Log** In agreeing the Board Action Log, Board members also gave assurance that actions would be reviewed, addressed and actioned as required.	

Reference	Minute	Action
BM 18-19/155	**Chief Executives' Report** The Chief Executive apprised the Board of the key headlines contained within the written report. **Serious Incidents** - in November 2018 the Trust declared two incidents that crossed the threshold for reporting as a serious incident. In both cases investigations are underway and Duty of Candour properly applied. **New NHS Executive Group: Regional Directors announced** - Bill McCarthy appointed as NHS North West Regional Director. He is expected to formally lead the team from April 2019. His biography to be circulated to Board members. **Cheshire & Merseyside Health & Care Partnership** - sets out how the health and care system can remain fit for the future. The latest edition of the Partnership stakeholder bulletin contains an article on the 'Seacombe birthing suite' as part of the Trusts community midwifery service. A link to the bulletin was provided. **NHSI Provider Bulletin** - **Changes to Seven Day Hospital Services measurement** - the Board assurance framework is the new approach to measuring progress in implementing seven day hospital services (7DS). This new measurement system replaces the previous self-assessment survey and consists of a standard measurement and reporting template, which all providers of acute services will complete with self-assessments of their delivery of the 7DS clinical standards. A trial period of December – February '19 will enable the Board to discuss and provide assurance. Following this Trust's will be required to implement the Board assurance process in full from March 2019 with supporting evidence from local audits to allow the Board of Directors to give formal assurance of the self-assessment. **Wirral Community NHS Foundation Trust (WCT)** - earlier this year WCT consulted with stakeholders regarding a change of name. In recognition of the feedback received in relation to the importance of the word 'community' which highlights the value of community services and the important role they continue to play with their partners supporting both the health and care needs of the population they serve they have reconsidered the proposed option. They have notified stakeholders that WCT is to be renamed Wirral Community Health and Care NHS Foundation Trust. The change of name will be phased in over the coming months in the most cost effective way. **2018/19 Trust Financial Position** – a conference call based on month 6 submission was held the previous week. The main focus was the planned deficit of £25m and the actions to achieve these namely: locking down activity, CQuins and risks to the cost improvement programme. ***The Board noted the information provided in the December Chief Executive's Report.***	AL
BM 18-19/156	**Patient Story** The Board was joined by Mr Barker and his partner Ms Gallimore, who	

Reference	Minute	Action
	apprised the Board of events following his initial admission in September 2017 with right-sided abdominal pain. He explained that his appendix was removed and he was discharged the following day and did not receive a follow-up appointment. He continued to feel unwell on and off during the next 12 months. In November 2018 he attended the out of hours service as he was again suffering severe pain on the right side and was referred to the Surgical Assessment Unit (SAU). He was admitted and informed that following the appendectomy the appendix had been sent for histology, the results had shown a rare cancerous tumour – neuroendocrine tumour. He was traumatised and very distressed at the news and that he should possibly have received treatment. Subsequently Mr Barker was referred to a specialist at Royal Liverpool Hospital to undergo further investigation relating to his condition. The Medical Director explained that ultimately she is responsible for the care Mr Barker received and apologised for the poor communication during his admissions. A meeting was to be arranged with the Associate Medical Director to address Mr Barker's concerns. Mr Barker thanked the nursing staff who had cared for him during both admissions, they were wonderful. On behalf of the Board, the Chair expressed his thanks and appreciation to Mr Barker and his partner for sharing this experience and the lessons to be learnt to improve communications with patients. ***The Board noted the feedback received from Mr Barker and acknowledged the lessons learned as a consequence of a review by the SUI panel.***	
BM 18-19/157	**Learning from deaths – mortality review and dashboard** National guidance requires Trusts to review 100% of deaths in care to gather learning and improve patient experience. Current performance is at 25% with an agreed trajectory to be fully compliant by Q4 2019/20. A query was raised as to why progress was not gather traction and was the trajectory achievable particularly over the winter period. It was highlighted that previously reviews were only completed by clinicians within medicine and therefore a review of the process was undertaken a decision for all clinicians to contribute. The Medical Director believes the trajectory would be achievable and will appraise the Board if there was any impact over the winter period. A communication has been sent to all consultants and SAS doctors regarding the revised PMR with the expectation for all to contribute. Training has been provided and further sessions will be provided in February 2019. Safety bites bulletins on learning from deaths to be disseminated trust wide on a quarterly basis. ***The Board noted the learning from deaths report and the trajectory to be compliant by Q4 2019/20.***	

Reference	Minute	Action
BM 18-19/158	**Quality & Performance Dashboard and Exception Reports** The report provides a summary of the Trust's performance against agreed key quality and performance indicators. Due to the earlier timing of this month's Board of Directors meeting, the full Issue, Decisions and remedial Action (IDA) exceptions reports were not available. They will be incorporated again for future months. Of the 55 indicators with established targets or thresholds 36 are currently off-target or failing to meet performance thresholds. The lead Director for each of these indicators provided a brief synopsis of the issues and the actions being taken. Areas of focus for discussion were: • Referral to treatment (RTT) - NHSI have stood down the support provided regarding quality of data as the information is now robust and compliant • Cdiff - three cases are currently being reviewed • FFT - kiosks now in place at the front entrance, ED, Women & Children's and Clatterbridge • Same sex accommodation – breach of this target is within critical care. Two additional side rooms are being implemented with an overall improvement plan to be developed. The Board expressed a concern regarding the number of indicators that are not yet compliant within the 'safe' domain. The Director of Quality & Governance reported that progress had been made since the previous month and whilst our focus has been on the rapid reconstruction of essential quality governance systems and processes, it would take longer for the benefits of those changes to be visible in the performance report. In response to a question regarding preparation for CQC inspection, the Director of Quality & Governance agreed that it remains of paramount importance to demonstrate progress in both the 'safety' and 'well-led' domains. It is his belief that there is now greater control and accountability for quality following the changes that have been introduced. He invited the Board to allow more time for those changes to become embedded across the organisation. The Director of Quality & Governance reported good progress across a number of indicators including: • Falls per 1000 bed days – incidence is much lower than the England average • Serious Incidents – threshold maintained since July 2018 • Never events – Zero for four consecutive months • CAS alerts – no overdue alerts for three consecutive months • Harm free care – remains consistent. The Director of Nursing reported that following the relaunch of hand hygiene competencies Divisions are to audit compliance via the Perfect Ward app. Monitoring of the compliance will be through the Infection Control report to Patient Safety & Quality Board. The Medical Director informed the Board that the VTE had reduced slightly and she would expect to see an improvement January onwards following the redesigned process within Cerner which provides an automatic prompt. The Director of Workforce advised the Board that individual plans for long	

Reference	Minute	Action
	term sickness are now in place and will be reviewed on a monthly basis. A new policy for short term sickness will be launched in January '19 and includes the nationally used framework, Bradford Factor. The revised appraisal documentation will be introduced in January and HR business partners will support senior leaders to implement. Of the 10 core elements of mandatory training, only 3 now require face to face training, the others are all delivered via e-learning. A recruitment campaign is due for launch in the new year encompassing social media, Trust website, video and will also reflect the collaborative working with Wirral Borough Council. The pace of change and the impact across the organisation is monitored closely at EMT to ensure the Trust has the appropriate systems in place to monitor compliance and hold people to account. Whilst positive feedback is received from staff, the organisation feels different, appropriate support is in place the level of change can be hard going. is The Board acknowledged that the preparations for the forthcoming CQC inspection must provide a compelling narrative to bring to the fore the many improvements that have been implemented to enhance the quality of care for patients. The thresholds (target) for all indicators are to be reviewed with the relevant Executive lead to meet internal, local and national requirements but enabling flexibility and stretch for the organisation. In addition, there will be the scope to review and consider the range of indicators required to provide effective Board assurance. The revised indicators to be reviewed at Trust Management Board prior to discussion at Trust Board. ***The Board noted the current performance against the indicators to the end of November 2018.***	
BM 18-19/159	**Month 8 Finance Report** The Deputy Director of Finance apprised the Board of the summary financial position. At the end of month 8, the Trust reported an actual deficit of £20.8m versus planned deficit of £18.0m, an adverse to plan position of £2.8m. This is after the application of £2.2m non recurrent balance sheet support pointing to an underlying deficit closer to £23m. The underlying income (£3.2m) worse than plan. The key driver of the variance is the under-performance elective and day case activity than plan predominately from earlier in the year. Improvements are being seen in the levels of activity delivered although it is not expected that the under-performance can be recovered in year. Other income is £0.5m better than plan, mainly the result of specific projects which offsets expenditure. The Deputy Director of Finance outlined to the Board that the likely forecast outturn deficit at the end of month 8, at circa £27.8m. Negotiations continue in relation to a risk share with WH&CCG in respect of both the step down ward and additional 18 beds at APH as part of the winter plan and system wide bed modelling work undertaken.	

Reference	Minute	Action
	Additional key aspects apprised to the Board included: • Expenditure position in month is £0.5m worse than plan and relates to medical pay pressures, some non-recurrent payments in month and supporting staffing gaps through professional fees. • CIP was £0.6m above plan. For the full year the Trust is currently forecasting £8.5m of fully developed schemes with a further £1.9m of plans in progress. • Cash balances at the end of November were £5.8m versus a plan of £1.9m driven by robust working capital management and below plan capital expenditure. • Capital programme has been reviewed by the Chief Operating Officer and Deputy Director of Finance which has confirmed forecast outturn and allocation of contingency with risks reported. It was noted that the Board wished to see the drivers of the deficit work progressed in order to inform the development of a financial strategy. ***The Board noted the M8 finance performance and the risks regarding impact of winter electives.***	
BM 18-19/160	**Trust Flu Immunisation Position** The Director of Workforce apprised the Board of the current take up rate of the flu vaccine in front line employees of 82.3%. The Trust is required to provide a position statement on Flu at the February 2019 meeting and to complete a self assessment checklist which was included within the report. Work is underway to address the areas that require improvement and to look at what actions can be taken to continuously improve our figures through the winter period. The self assessment framework will also be used as a blueprint to plan for next year's flu campaign. The Board thanked the team for the support provided. ***The Board noted the current position in relation to the number of healthcare workers with direct patient contact being vaccinated.***	
BM 18-19/161	**6 monthly Nurse Staffing Report** The Director of Nursing & Midwifery apprised that Board of the planned and actual nursing and care support staffing levels during June - September 2018. The report was considered in detail at the recent Patient, Safety & Quality Board meeting. The ward staffing establishment was reviewed and agreed at the Trust Management Board (TMB) meeting earlier this month, this triangulated approach to staffing decisions of right staff, right skills right place and time. A review will be commenced in January 2019 again using the SCNT tool for general wards and the recognised model Baseline Emergency Staffing Tool (BEST) for the Emergency Department. The Trust will continue to use this methodology until Cerner is able to launch Clairvia (real time acuity and dependency based on clinical entries to each individual patient), an options appraisal will be presented to Wirral Digital Board January 2019.	

Reference	Minute	Action
	The Trust continues to work towards compliance with the requirements of NHS England, the CQC and the NQB Guidance in relation to the Hard Truths response to the Francis Inquiry. With a focus on mandatory training compliance to be at 95% by 31 March 2019 and incorporating AHP into CHPPD data by January 2019. ***The Board noted the six monthly nurse staffing report and the safe staffing declaration.***	
BM 18-19/162	**Report of Finance, Business, Performance & Assurance Committee** Ms Sue Lorimer, Non-Executive Director apprised the Board that at the Finance, Business, Performance & Assurance Committee held on 18th December the Committee had approved a business case for the Carestream Picture Archive and Communication System (PACS), circa £800k within the capital programme 2018/19. The business case had been reviewed in detail at the Trust Management Board meeting. ***The Board noted the report of the Finance, Business, Performance & Assurance Committee.***	
BM 18-19/163	**Report of Trust Management Board** The Director of Quality & Governance provided a summary report of the Trust Management Board (TMB) meeting on 12th December 2018, a copy of the report to circulated. The reports outlines matters agreed by the TMB for escalation to the Board. To ensure triangulation of assurances the Trust Management Group received reports from the Patient Safety & Quality Board, Programme Board and the Quality and Performance Dashboard. ***The Board noted the verbal report of the Trust Management Board and approved the recommendation of a 23% uplift in relation to the ward based nursing establishment.***	**AL**
BM 18-19/164	**Report of Workforce Assurance Committee** Mr John Sullivan, Non-Executive Director apprised the Board of the wide range of improvements and initiatives put in place in 2018 by the Trust's Workforce directorate. Whilst it is appropriate to focus on workforce risks and associated assurance, it was also important to recognise successful workforce interventions and thank the staff responsible. The Committee received a staff story from a junior doctor at the Trust. The story highlighted the potential damage caused by inappropriate staff behaviours and the patient safety risk that can accompany internal conflicts. The Committee agreed it was a powerful reminder of how far the culture needs to change as this was just one department. The Committee were assured that the incident had been followed up and corrective and preventative actions taken. The Workforce Repository and Planning Tool (WRaPT) project will be progressed through the Programme Board with the scope to be agreed at the	

Reference	Minute	Action
	December meeting. A pilot of the tool is planned for the Women & Children Division. The goal is for a Trust wide workforce plan to be in place by end June 2019. The Committee will receive a 'deep dive' on band 5 nurse recruitment, retention and demographics to be presented on a Divisional basis at its next meeting. ***The Board noted the report of the Workforce Assurance Committee.***	
BM 18-19/165	**CQC Action Plan progress Update** The Director of Quality and Governance apprised the Board that the report provided progress pertaining to the CQC Action Plan. He requested the Board consider this report as provisional assurance due to the timing of the meeting ie 7 days earlier than would normally be expected. The Director of Quality & Governance advised that some actions have been 'red-rated' following confirm and challenge meetings on the basis that assurance was not yet available at the time of report. Colleagues are continuing to source and review evidence of progress, and will do so up to and including 31st December 2018. Therefore it is anticipated that there will be an improvement on the overall position against the plan for December which will be confirmed and reported to the Board in January 2019. He reported the very encouraging progress to date particularly with regards to the actions identified as 'blue' which are those that have been completed and embedded. The CQC 'insight tool' is reviewed by the Quality & Safety Committee. To ensure accuracy of data Executive leads have been identified to sign off all submissions. The CQC 'insight tool' uses old data, sometimes from as far back as 2015 and therefore the Board and Committees should bear this in mind when reviewing the report. ***The Board noted the progress to date of the CQC Action Plan and that the month end December data would be presented to the Board in January 2019.***	
BM 18-19/166	**BAF / Risk Register** The Board Secretary advised the Board that templates for each of the Assurance Committees had now been provided in relation to the BAF 2018/19 which enables the Board to received robust assurances. The process for development of the 2019/20 BAF is underway which will be considered at a Board development session. ***The Board noted the report and agreed to receive the next report in a year for the period 2018/19.***	
BM 18-19/167	**Any Other Business** There was no other business to report. In concluding the meeting, Board members reflected on a more strategic	

Reference	Minute	Action
	focus during discussions throughout the meeting which in turn led to constructive challenge and greater transparency. This is particularly pertinent due to the pace of change across the organisation and the Board thanked staff for their contribution during this time.	
BM 18-19/149	**Date of next Meeting** Wednesday 30th January 2019.	

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Chair

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Date

Board of Directors Action Log
Updated – 19 December 2018

Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 19.12.18						
1	BM 18-19/136	Circulate copy of TMB report – 12/12/18	**AL**	Complete	January '19	Circulated via email 24.12.18
Date of Meeting 28.11.18						
1	BM 18-19/136	To consider topics to improve collaborative working with partners and prevent duplication, ideas to be forwarded to Chair via Chief Executive.	**Exec Directors**	Complete	January '19	Meeting between Chair's, CEO's and MD's taken place and agreed 3 areas of focus: • admission avoidance, • ED (front door) • EGRES – patient flow
2	BM 18-19/137	Invite 'Top Leaders Programme' speaker to a future Board development session.	**HM**	Complete	January '19	Invite to all Board members to attend final day of 1st cohort – Friday 21st June, 9.00am – 2.00pm
5	BM 18-19/143	Programme Management work streams to identify timeframes for delivery eg 12 months, 2-3 years or 4-5 years.	**HM,NS, AM,DJ, PM**	Complete	January '19	See agenda
6		Prepare communication for staff to stress the importance of the change programme and the support available to divisions and corporate areas to achieve the plan.	**SS**	Complete	January '19	The Strategic Transformation Team have engaged specific Communications and Engagement expertise to build and begin to deliver a communications and engagement strategy that supports the need for change across all programmes.

7	BM 18-19/144	Provide an updated overview of the Trust risk profile	**PM**	Risk Management Committee reviewing revised risk registers – Divisions/Corporate. Report to next meeting.	March '19	Revised risk registers to be aligned with new strategic objectives/BAF 2019/20
Date of Meeting 1.11.18						
4	BM 18-19/119	IPC Improvement Plan to identify timeframes to monitor future progress	**GW**	Complete	January '19	See agenda
7	BM 18-19/123	Report outlining the local impact assessment of tariff proposals to be provided at the next meeting.	**DJ**	Complete	December 2018	See agenda
8		detailed planning paper will be brought to a future Board of Directors meeting when detailed guidance is received early in December 2018	**NA**	Complete	January 2019	See agenda
	BM 18-19/123	Future 'freedom to speak up reports' to include comparisons with Trusts who provide better engagement	**HM**	Complete	January 2019	Progress reports to be presented to Workforce Assurance Committee – frequency to be determined.
Date of Meeting 27.9.18						
5	BM 18-19/104	Review of Information and Coding Assurance Report to FBPAC	**PC/DJ**	Discussed at Oct FBPAC the need for clarity on risks raised and mitigating action of GDPR non compliance.	February 2019	Revised report to Feb '19 FBPAC

Board of Directors	
Agenda Item	6
Title of Report	Chief Executive's Report
Date of Meeting	30.1.2019
Author	Janelle Holmes, Chief Executive
Accountable Executive	Janelle Holmes, Chie 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 2019.

Serious Incidents

During December 2018 four serious incidents were declared by the Trust; one within the Division of Medicine and Acute, one within Diagnostic & Clinical Support Division and two within the Division of Women and Children's.

The first incident relates to the misplacement of an IVC filter. The second was an MRSA bactaraemia. The third, related to a Patient fall during their admissions and the fourth incident was a pulmonary embolism in a post-natal patient, resulting in an emergency readmission and treatment.

In all four cases, full investigations are underway and duty of candor has been undertaken.

Major Incident – External Power Supply Failure, 13th January '19

On Sunday 13th January, at around 13:20 Scottish Power confirmed that a power cut had affected the CH43 and CH49 postcode areas of Wirral, which included the hospital.

Both of the hospital generators automatically provided an essential power supply to pre-determined critical areas to maintain life-saving treatment where needed.

A major incident was declared by the Executive Director on-call (Incident Commander) at 13:44, which involved a formal hospital command team being called onto site and set up in the Major Incident Room at Arrowe Park Hospital. As part of the Major Incident declaration, all key departments were informed via a call or bleep from Switchboard and the on-call consultants being called on-site. The call out, in and out of hours, is tested four times a year, in line with the NHS England Emergency Preparedness, Resilience & Response Framework, to ensure that the correct numbers are held by Switchboard. This process ran smoothly; on-site staff, and 'called in' staff as they arrived, carried out the required actions immediately to ensure patient safety which were formally documented by the loggist. The Trust power failure action cards were fully utilised. NWAS came on site to support the command team and an emergency divert, via NHS England, was secured for 2 hours from 14:05, this was later extended to 17:00. As the lifts were not operational, visiting was temporarily suspended, to ensure safety. Power was fully reinstated in the Trust by 16:05, with the incident being stood down at 16:11.

Overall the major incident was managed successfully with no harm reported to any patients, staff or visitors. With any such incident, there will always be areas for improvement. Following the 'hot' debrief, held the next morning, it was apparent that a review of essential power sockets is required to ensure that staff are aware of where they are, and what is to be connected. It is also necessary to review all areas to ensure that essential power is installed where necessary.

A 'cold' debrief will be undertaken with NHS England within the next couple of weeks to ensure our plans are appropriately updated and continue to be as safe and robust as possible.

12 hour breaches

On the 6th January the hospital experienced exceptionally high pressures on its urgent care system, during which two patients, one who with confirmed Flu A+ and the other who had very active diarhoea were cared for in ED beyond the 12 hour trolley wait standard. As both of these patients posed infection risks to other patients side rooms were required, which were unavailable at the time.

As the pressures were so considerable, and following the Trust's escalation process the Chief Operating Officer and Executive on Call reported to site to offer direction and coordination. Steps were taken to use capacity on the elective orthopedic ward to create movement and flow for urgent admissions.

The on-call manager personally ensured that the 2 patients were kept informed of the reasons for the delay. In line with the 'NHS England 12 hour breaches of the A&E waiting times standard (North)', a '12 hour breach 48 hour' report was produced and submitted to the Wirral CCG to provide assurance in the following areas:

- the patients were admitted into a ward that was clinically appropriate for their condition
- they received an assessment of the impact on the clinical condition of the patient as a consequence of the delay
- there was robust pressure area management for risk assessed
- the patients' nutrition and hydration was adequately maintained
- the patients' privacy and dignity was maintained in terms of toileting or bathing
- the patients emotional and psychological care was considered; they were able to have their family remain with them
- the patients received their own routine or newly commenced medications.

Operational Planning 2019/20

The Trusts is required to submit an interim plan on the 12th February with the final plan due for submission on 4th April 2019.

The operational plan submissions must include:

- finance return
- activity and performance trajectory return
- workforce return
- triangulation return
- operational plan narrative
- assurance statements
- an STP-led contract and plan alignment template

A report outlining the requirements in further detail is included within the NHS Operational Planning Guidance Paper.

Long Term Plan

The NHS Long Term Plan was published on Monday 7 January 2019; this sets a number of priorities to make the NHS fit for the future.

A key theme of the plan is prevention, and it outlines 500,000 lives could be saved over the next ten years by focusing on prevention and early detection.

The focus is to make the population 'fit for the future' by:

- Enabling everyone to get the best start in life;
- Helping communities to live well; and
- Helping people to age well.

The plan also includes measures to:

- Improve out-of-hospital care by supporting primary medical and community health services;
- Provide better care for major health conditions, such as cardiovascular disease, respiratory conditions and diabetes;
- Support those admitted to hospital with smoking/alcohol addiction;
- Support older people through more personalised care and stronger community and primary care services; and
- Make digital health services a mainstream part of the NHS, so that in five years' time, patients in England will be able to access online GP consultations.

As part of the Strategy development work currently underway, the priorities for transformational change and improvement will be identified and robust delivery plans established. This will be completed for the Trust and work is also underway at a local level with Healthy Wirral Partners to develop a Wirral system plan.

The final timetable for the plan submission is yet to be clarified although this is anticipated for the autumn.

Quality Assurance visit – Antenatal and Newborn (ANNEB)

Public Health England Quality Assurance team visited the Antenatal and Newborn (ANNB) Screening Service on the 3rd December 2018.

The team visited and reviewed all aspects of the ANNB screening programme and concluded the visit by feeding back positively on their findings. Since the last visit in 2015 the team acknowledged that a significant amount of work had been undertaken in improving the delivery of the screening programme.

A draft report has been received into the Trust for review / accuracy checking with the final report due in February 2019.

It is pleasing to note that there were no significant concerns identified and feedback to the team was extremely positive.

Millennium Upgrade

Starting on Friday 18th January evening to Saturday morning the Trust upgraded Millennium to the latest code version available (2018), this ensures the Trust is on the most current and secure platform and in a position to take the latest updates of functionality. During this time there was no access to Wirral Millennium, and downtime protocols took place.

One of the major components of the upgrade was the transition to a new PACS viewer within Millennium, there were a number of high profile issues raised following the transition and the Trust have now worked through the majority of the problems with Cerner who have been on site.

Overall there were around 97 issues raised since go-live and more than 30 Informatics staff worked over the weekend with Cerner to get these resolved. By Wednesday 70 of these issues had been resolved and Informatics continue to work with Cerner to resolve the outstanding issues."

New NHS Executive Group: Regional Directors

In December the new NHS Executive Group: Regional Directors were announced with Bill McCarthy appointed as NHS North West Regional Director.

It was envisaged that the new joint regional structures are to take effect from 1st April 2019 and Richard Barker**,** NHS England's regional director for the North and Lyn Simpson, Executive Regional Managing Director (North) would continue in their current roles.

Bill has now agreed a start date with NHSE/NHSI of 1st February 2019. He will spend February meeting local leaders to discuss their ambitions and concerns with a focus on the 10 year plan. March will be establishment and handover month as Bill and Richard get their senior teams and operating models in place in readiness for 1st April.

Janelle Holmes
Chief Executive
January 2019

Board of Directors	
Agenda Item	7
Title of Report	Progress Update Strategy Development
Date of Meeting	30th January 2019
Author	Natalia Armes, Director of Transformation and Partnerships
Accountable Executive	Janelle Holmes, Chief Executive 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	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Strategy Development Progress Update

Why the approach to strategy development is important

Wirral University Teaching Hospital NHS Foundation Trust

"A strategy that is at odds with a company's culture is doomed.
Culture trumps strategy every time" **Harvard Business Review**

Vision
- Long term commitment
- A few bold aims
- Clear success criteria
- Robust delivery plan
- Inspiring and engaging

Culture
- The way we do things
- Empowered and engaged staff
- Patient and family centred

Leadership
- Leadership at every level
- Empowered and engaged staff
- Commitment to long term plan

Ownership & Accountability
- Empowered colleagues and patients to make decisions
- Acting and delivering against commitments

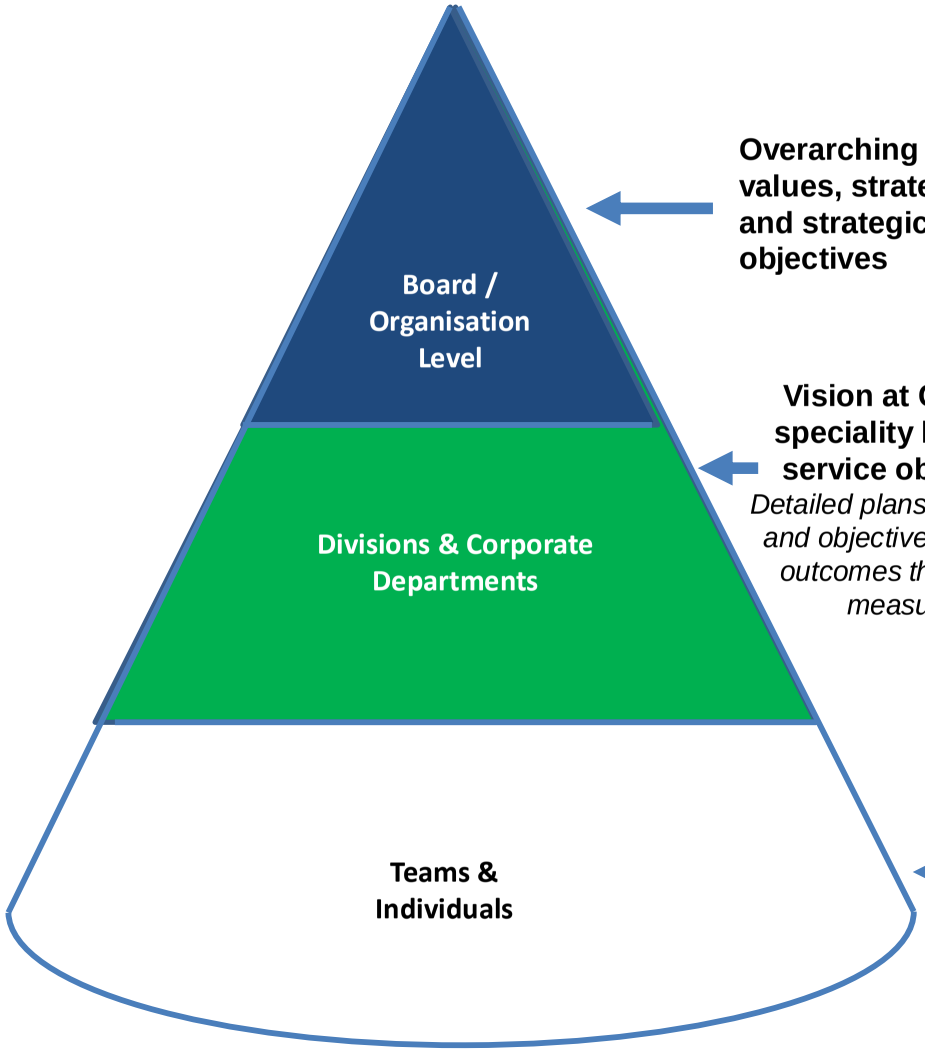
Underpinned by effective and meaningful communication & engagement

Strategy Development: Input Sources

Wirral University Teaching Hospital NHS Foundation Trust

Strategy Development Framework

Wirral University Teaching Hospital NHS Foundation Trust



Overarching Vision, values, strategies and strategic objectives

Our Vision	Our Values
Our Goals	Our Purpose

Vision at Clinical / speciality level and service objectives

Detailed plans, milestones and objectives to deliver outcomes that can be measured.

Plan on a page		
	Vision:	Priorities:
Division / Department		
Speciality / Directorate		
	Outcome Measures	Milestones
Basic		
Better		
Best		

Measures and Appraisal objectives

Value based Performance appraisal

My Personal Objectives:	
How will I contribute to the delivering the Trust Strategy?	
Objectives • . • .	Actions • . • .
How do I demonstrate the behaviours of the Trust's Values?	

Milestone Plan and Next Steps

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Action	Status	Date
Engagement & Communication		
Values & Behaviour engagement sessions (over 1000 staff engaged)	**Completed**	25/01/2018
Division and speciality level workshops (over 85 clinicians involved)	On Track	Various held between Nov - March
Executive led roadshows and other methods for staff engagement	On Track	Throughout Feb- March
Board Development Day	On Track	Scheduled for 27.02.19
Council of Governors working group	On Track	Scheduled for 18.03.19
Creative Partner Contract Award	**Completed**	14.01.2019
Creative Partner Commencing	On Track	4.02.2019
Patient and Partner Engagement	On Track	During February and March
Analysis and development		
Analysis of external sources (includes demand and capacity modelling linked to site strategy)	On Track	Jan – March
Presentation of feedback of insight, analysis and emerging themes / strategic items that require decision	On Track	28th March 2019 – TMB 3rd April 2019 - Board
Develop robust delivery plan – 5 year improvement plan (inc. success criteria and benefits realisation plan)	On Track	May 2019
Consultation Period of overarching Vision and Values	On Track	8th to 18th April
Trust Board Final Sign off	On Track	23rd April 2019
Launch of new Vision and Values (Detailed launch plan developed)	**On Track**	**29th April 2019**
Make milestones meaningful to personal and team service objectives	On Track	May – June 2019
Integrate strategy delivery into BAU performance monitoring, DPR, Programme Board as applicable with milestones tracked and communication updates on how we are progressing against plans.	On Track	Ongoing post launch

Board of Directors	
Agenda Item	8.2
Title of Report	Infection Prevention & Control Performance Report
Date of Meeting	30 January 2019
Author	Gaynor Westray, Director of Nursing & Midwifery / Director of Infection Prevention & Control Lorraine Young, Matron for IPC.
Accountable Executive	Gaynor Westray, Director of Nursing & Midwifery / Director of Infection Prevention & Control.
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1, 2 and 12
Level of Assurance • **Positive** • **Gap(s)**	Positive Progress with IPC improvement plan Current Gaps System wide operational pressure with negative impact on patient flow resulting in bed occupancy of between 97-99%
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Discussion
Data Quality Rating	
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

The purpose of this report is to update and inform the Board of Directors of the current healthcare associated infection (HCAI) performance. The Health and Social Care Act 2008, updated 2015 (Code of practice on the prevention and control of infections) clearly identifies criteria to ensure that patients are cared for in a clean environment, which minimises the risk of acquiring a HCAI. This report outlines the Trust's current position of HCAI from 1 April 2018 to 31 December 2018 relating to:

- Clostridium difficile (C.diff)
- MRSA
- Carbapenemase Producing Enterobacteriaceae (CPE)
- E.coli

This paper also provides high level progress against actions within the Infection Prevention and Control improvement plan, and to highlight to Board of Directors by exception, any elements of the plan that are not on track or at risk of not meeting target dates for implementation. The detail associated with this paper and the improvement plan is being closely examined, critiqued and monitored by Patient Safety and Quality Board.

2. Background

Healthcare associated infection remains a top priority for the public, patients and staff and remains one of the Trust's strategic objectives. Avoidable infections are not only potentially devastating for patients and healthcare staff, but consume valuable healthcare resources.

The Chief Nurse is the Director of Infection Prevention & Control (DIPC). The DIPC provides assurance to the Board that systems are in place and correct policies and procedures are adhered to across the organisation to ensure safe and effective healthcare. A comprehensive IPC service is provided Trust wide by the IPC Team and the IPC nurses provide a seven day out of hour's on-call service.

3. Healthcare Associated Infection Summary Report

The IPC Team is currently reviewing a number of processes within the Trust to reduce the incidence of avoidable healthcare associated infections. The processes being reviewed include going 'back to basics' with cleaning, hand hygiene, skin disinfection, education and training to ensure the delivery of safe clean care. In addition, The Director of Infection Prevention & Control, supported by the IPC Team is undertaking weekly *C.diff* executive reviews.

Trust current position of HCAI from 1 April 2018 to 31 December 2019.

- *Clostridium difficile* avoidable cases – 21 against a threshold of 20 cases (Total threshold of 28 cases for 2018 / 2019)
- MRSA Bacteraemia – 1 against a threshold of zero cases
- MRSA (Non-Bacteraemia) – 30 cases (currently no threshold)
- CPE all confirmed colonisation cases (through screening) – 112 cases deemed to be hospital acquired, 180 cases in total (currently no threshold)
- *E.coli* – 34 against a threshold of 36 cases

System wide operational pressure has had a negative impact on patient flow within the Trust resulting in bed occupancy of between 97-99%. Evidence is available to support that when bed occupancy is above 85% in an acute hospital there is increased risk to patient safety and specifically in the management of HCAI.

Clostridium difficile avoidable cases

The below table provides a breakdown of avoidable *C.diff* cases by month.

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Threshold	1	3	5	7	9	12	15	17	20	23	26	28
Cases	4	1	3	1	3	0	3	4	2			
Total	4	5	8	9	12	12	15	19	21			

Themes identified at the *C.diff* weekly executive review meetings for December 2018 have been period of increased incidence on wards 27 and 38. With concerns raised regarding environmental cleaning, including increased clutter on wards. Insufficient isolation facilities have also been identified resulting in a delay in transferring symptomatic patients to side rooms. A ward by ward review is currently being undertaken by the divisions to fully understand the environmental, storage, cleaning and equipment issues. This review will be completed and presented to DiPC at the end of January 2019.

MRSA Bacteraemia

A RCA for the MRSA bacteraemia is being undertaken by the Division of Medicine with support from IPC. The outcome of this will be discussed at both Serious Incident review panel and PSQB.

Carbapenemase Producing Enterobacteriaceae (CPE)

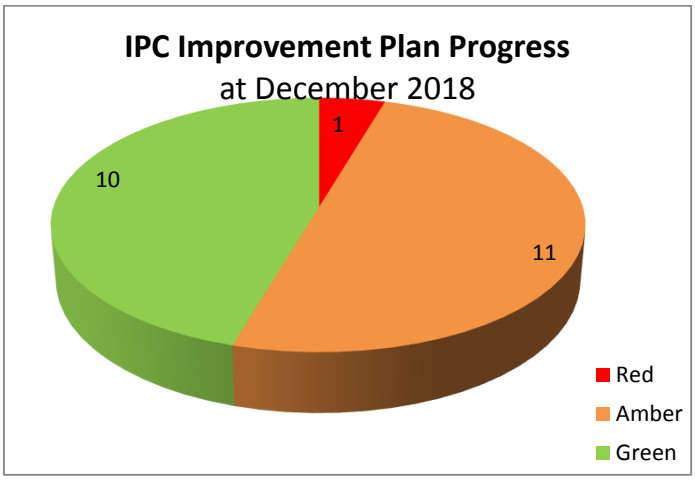
An outbreak of CPE was confirmed on wards 21, 24 and 36 during November and December 2018. Public Health England has supported the Trust at the weekly CPE outbreak meetings with key actions being the recommendation to close the ward to admissions and attention to enhanced cleaning and HPV of the clinical environment.

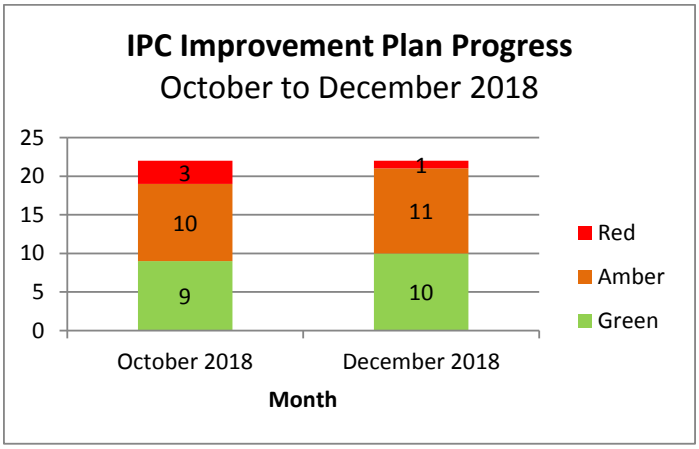
Due to operational pressure and impact on patient flow, there has been a need to undertake a risk assessment for the opening of beds previously closed for infection prevention and control. This has been in conjunction with the IPC team.

4. Infection Prevention and Control - Improvement Plan

The IPC improvement plan has been reviewed and updated in December 2018 acknowledging the improvements made and also confirming plans to improve further. This updated version was presented and discussed at the Patient safety and Quality Board and the Trust Infection Prevention and Control Group.

The IPC improvement plan was initially developed following a peer review from Manchester Royal Infirmary in November 2017. The improvement plan has been developed further to now include a total of 22 actions of which progress has been made as highlighted below.





Actions for escalation:

Amber:

Action 9 - Risk based mechanism required to ensure that appropriate patients with infection risk are identified in a timely way. Review of CPE screening planned for January 2019 with MD, DiPC, Consultant Microbiologist, IPC team, Clinical Support and PHE.

Action 11 - Lack of isolation facilities on Critical Care and Emergency Department – Work has been approved for two additional side rooms for ITU, and a review of the ED environment is planned.

Red:

Action 1- Safe clean ward environment, including de-clutter, adequate storage, minor works, is an action that remains red although plans are in place to review each ward area and reported back to DiPC by End of January 2019. Plans to address all actions identified will need to be prioritised and agreed with divisions, recognising the impact on bed base to enable work to be carried out.

5. Summary

The IPC Team continues to work with all wards and departments to reduce the incidence of avoidable healthcare acquired infections. The priority to ensure a safe clean clinical environment is essential to support further reduction in the incidence of infection.

Further assurance around compliance with IPC measures at ward and department level is required from the divisions / corporate services. This will be monitored via the Trust Infection Prevention and Control Group and reported to Patient Safety and Quality Board.

6. Recommendation

Board of directors is asked to note the current Trust HCAI position and progress made with the IPC improvement plan, recognising the challenges associated with the Infection Prevention and Control agenda and the operational pressure around patient flow and high bed occupancy.

BOARD OF DIRECTORS	
Agenda Item	9.1.1
Title of Report	Quality and Performance Dashboard
Date of Meeting	30th January 2019
Author	WUTH Information Team 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 2018.

2. Background

This Quality and Performance Dashboard is designed to provide an accessible oversight of the Trust's performance against key indicators. The additional exception report provides a summary of the remedial action being undertaken where indicators are not meeting the established targets or thresholds for the standards.

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 58 indicators with established targets that are reported for December:

- 34 are currently off-target or failing to meet performance thresholds
- 24 of the indicators are on-target

The metrics included are under review with the appropriate Director to consider the appropriateness and value of inclusion, and also the performance thresholds being applied. A revised version of metrics and performance will be included in future reports to the Board of Directors, as the changes to metrics are approved.

Also under consideration are the criteria for requiring an exception report, or Issue, Decision, Action (IDA) summary. The previous approach has been to include IDA summaries for all metrics that are 'Red' for the most recent month, excluding the Use of Resources metrics as there is a separate financial report to the BoD.

This can result in a lot of exceptions being reported repeatedly for metrics that are continually not at threshold, but not materially changing. The proposed criteria for requiring an IDA summary from now on is any metric that newly fails its threshold for two consecutive months. The initial IDA also now requires an expected date of achievement of threshold. If a metric does not achieve by that expected date, an updated IDA summary would also be required.

And to provide assurance on all performance measures not achieving threshold, on a quarterly basis all metrics that have been 'Red' for the preceding six months would require an updated IDA summary. The next quarterly IDA summaries on such metrics will be in April 2019, on performance up to and including March.

On this criteria, the only metric this month requiring an IDA summary is "Diagnostic Waiters, 6 weeks and Over".

4. Next Steps

WUTH remains committed to attaining standards through 2018-19.

5. Conclusion

Performance against many of the indicators is not where the Trust needs to be. The actions to improve are noted in the exceptions on the qualifying metrics and this report in future will provide monitoring and assurance on progress.

6. Recommendation

The Board of Directors is asked to note the Trust's current performance against the indicators to the end of December 2018.

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

January 2019

	Indicator	Objective	Director	Threshold	Set by	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 YTD	13 month Trend	In-year 2018/19 Trajectory
Safe	Falls per 1000 occupied bed days reported on Ulysses (excluding lowered to floor incident)	Safe, high quality care	DoN	≤4.8 per 1000 Bed Days	WUTH	1.40	1.30	1.50	1.30	1.90	2.20	1.50	2.00	2.30	1.20	1.75	1.11	1.78	1.75		
	Eligible patients having VTE risk assessment within 6 hours of decision to admit.	Safe, high quality care	MD	≥95%	WUTH	64.3%	58.7%	69.2%	60.1%	65.0%	70.4%	76.9%	81.5%	69.2%	75.0%	77.0%	68.9%	78.9%	73.6%		
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital.	Safe, high quality care	MD	≥95%	SOF	95.4%	95.3%	95.6%	95.2%	95.3%	95.3%	94.7%	95.3%	95.0%	95.6%	95.6%	95.6%	95.2%	95.3%		
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	DoN	≥95%	National	94.3%	97.0%	95.0%	96.0%	95.6%	95.6%	95.4%	95.2%	95.0%	96.3%	97.0%	95.9%	95.3%	95.7%		
	Serious Incidents declared	Safe, high quality care	DQ&G	≤48 pa (= 4 per month)	WUTH	11	6	10	6	6	14	13	3	2	1	3	2	4	48		
	Never Events	Safe, high quality care	DQ&G	0	SOF	0	0	1	0	0	0	0	1	0	0	0	0	0	1		
	CAS Alerts not completed by deadline	Safe, high quality care	DQ&G	0	SOF	1	1	3	0	0	1	5	1	0	0	0	0	0	7		
	Clostridium Difficile (avoidable)	Safe, high quality care	DoN	≤28 for FY18-19, 2.42 per month	SOF	2	1	1	3	4	1	3	1	3	0	3	4	2	21		A M J J A S O N D J F M
	E.Coli infections	Safe, high quality care	DoN	≤42 pa (No more than 3 per month)	WUTH	2	4	1	2	4	2	6	7	2	3	5	4	2	35		
	CPE Colonisations/Infections	Safe, high quality care	DoN	TBC	WUTH	20	16	13	10	11	14	17	18	18	15	13	23	9	138		
	MRSA bacteraemia - hospital acquired	Safe, high quality care	DoN	0	National	0	0	0	1	0	0	0	0	0	0	0	1	0	1		
	IPC Audit of Practices and Procedures (random areas)	Safe, high quality care	DoN	≥75% (gold)	WUTH	77%	73%	73%	78%	83%	81%	78%	77%	78%	74%	75%	75%	76%	77%		
	Hand Hygiene Compliance	Safe, high quality care	DoN	100%	WUTH	94%	89%	94%	99%	95%	97%	88%	89%	90%	81%	87.0%	85.0%	76.0%	87.6%		
	Medicines Storage audits - % of areas fully compliant	Safe, high quality care	DoN	100%	WUTH	-	52%	51%	52%	57%	70%	69%	71%	74%	72%	73%	60%	78%	69.3%		
	Surgical Site Infections (data once per year over 3 months)	Safe, high quality care	DoN	TBC	WUTH	Indicator Under development															
	Surgical Safety Checklist Compliance	Safe, high quality care	MD	100%	WUTH	Indicator Under development															
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	DoN	≥95%	WUTH	90.9%	90.6%	89.9%	89.5%	89.2%	-	-	87.4%	-	85.6%	90.4%	91.5%	91.4%	89.2%		
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	DoN	≥95%	WUTH	81.1%	81.3%	80.7%	82.5%	84.8%	-	-	82.7%	-	82.2%	86.0%	87.2%	87.1%	85.0%		
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	DoN	≥95%	WUTH	84.6%	83.6%	83.8%	85.2%	85.6%	-	-	85.6%	-	86.5%	87.2%	91.7%	91.4%	88.0%		
	Nursing Vacancy Rate	Safe, high quality care	DHR	≤6.5%	WUTH	6.09%	6.50%	6.89%	6.83%	6.57%	7.11%	7.20%	10.24%	10.20%	9.25%	7.90%	7.90%	7.47%	7.47%		
	Consultant Vacancy Rate %	Safe, high quality care	DHR	≤6.5%	WUTH	7.75%	7.47%	8.26%	9.68%	6.95%	6.93%	6.58%	7.62%	6.87%	6.45%	6.88%	7.90%	6.48%	6.48%		
	Sickness absence % (12-month rolling average)	Safe, high quality care	DHR	≤4%	SOF	4.61%	4.69%	4.71%	4.77%	4.78%	4.82%	4.84%	4.84%	4.87%	4.91%	4.94%	4.93%	4.94%	4.80%		
	Short-term sickness (in month rate)	Safe, high quality care	DHR	TBC	WUTH	1.92%	2.42%	2.19%	2.20%	1.79%	2.04%	2.04%	2.03%	2.24%	2.35%	2.43%	2.19%	2.36%	2.16%		
	Long-term sickness (in-month rate)	Safe, high quality care	DHR	TBC	WUTH	2.88%	2.97%	2.10%	2.19%	2.18%	2.33%	2.65%	2.95%	2.79%	2.55%	2.76%	2.81%	3.09%	2.68%		
	Care hours per patient day (CHPPD)	Safe, high quality care	DoN	TBC	WUTH	7.1	7.1	7.2	7.1	7.2	7.3	7.4	7.6	7.5	7.1	6.9	7.1	7	-		

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

January 2019

	Indicator	Objective	Director	Threshold	Set by	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Effective	SHMI	Safe, high quality care	MD	≤100	SOF	94.04	-	-	99.49	-	-	97	-	-	-	-	-	-	99		
	HSMR	Safe, high quality care	MD	≤100	SOF	89.0	88.0	88.0	88.0	88.7	93.0	93.0	95	95	95	-	-	-	91		
	Mortality Reviews Completed		MD		WUTH	Indicator Under Development															
	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	DoN	≥95%	WUTH	-	-	-	-	44%	59%	71%	78%	67%	74%	84%	87%	83%	71.9%		
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	COO/ DoN	≥33%	National	15.0%	14.3%	14.8%	14.6%	14.9%	14.3%	13.9%	12.9%	14.1%	13.1%	15.4%	16.4%	14.6%	14.4%		
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	Safe, high quality care	COO/ DoN	≤156	WUTH	369	412	417	422	418	405	341	386	387	411	383	408	397	393		
	SAFER BUNDLE: Expected date of discharge achieved	Safe, high quality care	COO/ DoN	TBC	WUTH	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
	Length of stay - elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	5.0	3.9	7.4	4.0	3.8	4.3	3.8	5.2	4.1	4.2	4.3	3.8	4.9	4.3		
	Length of stay - non elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	5.2	5.1	5.2	5.4	5.1	5.2	5.1	5.4	5.0	4.9	5.3	5.1	5.0	5.1		
	Emergency readmissions within 28 days	Safe, high quality care	COO	TBC	WUTH	891	849	840	814	886	923	873	913	961	888	936	925	917	914		
	Delayed Transfers of Care	Safe, high quality care	COO	TBC	WUTH	14	11	12	9	13	12	13	13	6	18	12	17	14	11.4		
	NICE Guidance Compliance (Assessment & Gap Analysis)	Safe, high quality care	DQ&G	100%	WUTH	-	-	71.0%	72.0%	72.0%	73.0%	73.0%	73.0%	73.0%	74.0%	74.0%	98.0%	98.0%	98%		
	% of national clinical audits participation / % required	Safe, high quality care	DQ&G	100%	National	-	-	-	-	87.5%	87.5%	87.5%	87.5%	87.5%	87.5%	87.5%	95.0%	95.0%	95.0%		
	% Theatre Utilisation	Safe, high quality care	COO	≥85%	WUTH	82.9%	78.3%	79.1%	79.8%	85.9%	86.6%	88.6%	86.7%	92.3%	89.2%	88.9%	87.1%	86.0%	87.9%		

Quality Performance Dashboard

January 2019

	Indicator	Objective	Director	Threshold	Set by	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Caring	Same sex accommodation breaches	Outstanding Patient Experience	DoN	0	SOF	16	12	18	16	18	22	10	8	16	14	19	18	15	140		
	FFT Recommend Rate: ED	Outstanding Patient Experience	DoN	≥95%	SOF	88%	92%	87%	82%	85%	90%	91%	89%	89%	86%	87%	84%	92%	88%		
	FFT Overall Response Rate: ED	Outstanding Patient Experience	DoN	≥25%	WUTH	11.0%	12.0%	13.0%	12.0%	13.0%	9.0%	8.0%	11.0%	12.0%	11.0%	10.0%	11.0%	10.0%	11%		
	FFT Recommend Rate: Inpatients	Outstanding Patient Experience	DoN	≥95%	SOF	98%	98%	97%	97%	98%	97%	98%	98%	98%	97%	98%	98%	98%	98%		
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	DoN	≥25%	WUTH	17.0%	15.0%	18.0%	18.0%	15.0%	15.0%	20.0%	25.0%	14.0%	22.4%	24.0%	18.0%	18.0%	19%		
	FFT Recommend Rate: Outpatients	Outstanding Patient Experience	DoN	≥95%	SOF	95%	95%	94%	94%	95%	95%	94%	95%	94%	94%	94%	95%	94%	94%		
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	DoN	≥95%	SOF	93%	97%	98%	100%	97%	97%	99%	96%	100%	100%	96%	100%	100%	98%		
	FFT Overall response rate: Maternity (point 2)	Outstanding Patient Experience	DoN	≥25%	WUTH	30%	15%	54%	35%	31%	54%	46.0%	37.0%	17.0%	28.2%	11.0%	19.0%	37.0%	31%		

Quality Performance Dashboard

January 2019

	Indicator	Objective	Director	Threshold	Set by	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	≥95%	SOF	78.4%	78.5%	78.3%	74.4%	80.3%	83.5%	83.4%	85.6%	83.6%	77.8%	77.8%	75.2%	75.0%	80.2%		A M J J A S O N D J F M
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
	Ambulance Handovers >30 minutes	Safe, high quality care	COO	TBC	National	651	528	427	623	414	327	291	213	326	474	371	440	393	361		
	Patients leaving ED without being seen	Outstanding Patient Experience	COO	<=5%	WUTH	3.9%	2.3%	3.0%	4.3%	2.8%	2.8%	1.4%	1.7%	1.5%	2.3%	2.2%	2.0%	2.3%	2.1%		
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	≥92%	SOF	77.7%	76.4%	75.6%	77.3%	74.3%	74.6%	75.7%	76.3%	77.2%	78.3%	78.98%	79.34%	80.08%	77.2%		A M J J A S O N D J F M
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	0	National	11	30	51	69	66	67	79	57	56	40	43	30	28	52		A M J J A S O N D J F M
	Diagnostic Waiters, 6 weeks and over - DM01	Safe, high quality care	COO	≥99%	SOF	98.7%	98.8%	99.2%	99.2%	99.0%	98.2%	97.9%	98.5%	97.9%	99.2%	99.4%	98.9%	98.6%	98.6%		
	Cancer Waiting Times - 2 week referrals	Safe, high quality care	COO	≥93%	National	97.4%	97.0%	96.9%	94.9%	94.2%	93.4%	95.2%	95.7%	92.3%	94.5%	95.2%	93.9%	93.2%	94.2%		
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis	Safe, high quality care	COO	≥96%	National	97.0%	97.0%	99.1%	97.0%	96.5%	96.4%	95.5%	98.2%	96.3%	96.2%	96.8%	96.7%	97.3%	96.6%		
	Cancer Waiting Times - 62 days to treatment	Safe, high quality care	COO	≥85%	SOF	85.9%	85.8%	86.4%	88.1%	87.0%	86.1%	87.8%	85.4%	87.9%	85.7%	85.1%	85.3%	93.0%	87.0%		
	Cancelled outpatient appointments	Outstanding Patient Experience	COO	TBC	WUTH	5304	6437	5808	3451	6131	6035	6515	6862	6771	6183	7098	6641	5728	57964		
	Cancelled elective admissions - TCIs	Outstanding Patient Experience	COO	TBC	WUTH	316	711	307	345	206	190	243	218	234	203	266	277	174	2011		
	Cancelled Operations (on the day of planned surgery)	Outstanding Patient Experience	COO	TBC	WUTH	30	12	27	20	9	26	15	8	2	7	7	17	11	102		
	Did Not Attend - Outpatient Appointments	Outstanding Patient Experience	COO	≤6.5%	WUTH	9.1%	8.6%	8.0%	8.1%	8.3%	8.6%	8.2%	8.7%	8.9%	8.7%	8.3%	8.4%	8.6%	8.5%		
	Appointment slot issues (Outpatient Utilisation)	Outstanding Patient Experience	COO	TBC	WUTH	1730	1532	1703	1812	2325	2477	3646	3868	4076	4117	4383	5075	5285	3917		
	Patient Experience: Number of concerns received in month - Level 1	Outstanding Patient Experience	DoN	TBC	WUTH	68	123	134	144	118	134	110	140	123	155	119	165	118	1182		
	Patient Experience: Number of complaints received in month - Levels 2 to 4	Outstanding Patient Experience	DoN	TBC	WUTH	21	43	31	30	34	23	36	24	25	22	19	13	13	209		
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	DoN	100%	National	100%	96%	100%	97%	32%	81%	95%	72%	75%	80%	100%	100%	100%	81.6%		
	First written response within policy timescale	Outstanding Patient Experience	DoN	100%	WUTH	50%	19%	35%	22%	14%	32%	23%	23%	11%	29%	48%	39%	41%	29.0%		
	Number of re-opened complaints	Outstanding Patient Experience	DoN	≤5 pcm	WUTH	6	4	4	1	2	2	7	5	0	4	2	3	2	27		

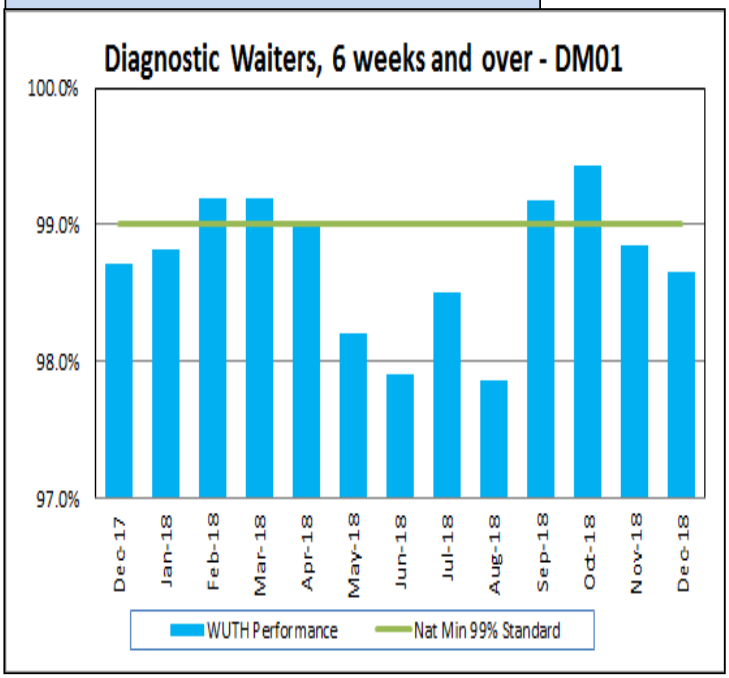
Quality Performance Dashboard

January 2019

	Indicator	Objective	Director	Threshold	Set by	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Well-led	Staff Friends and Family Test - overall engagement score	Safe, high quality care	DHR	≥3.88	National	–	3.75	–	–	3.60	–	–	3.72	–	3.63	–	–	–	3.65		
	Live employee relations cases	Safe, high quality care	DHR	≤30	WUTH	–	25	22	29	30	33	35	36	32	29	23	30	32	33		
	Duty of Candour compliance (for all moderate and above incidents)	Outstanding Patient Experience	DQ&G	100%	National	–	–	–	–	–	–	–	–	–	100%	100%	100%	100%	100.0%		
	Number of patients recruited to NIHR research studies	Outstanding Patient Experience	MD	650 for FY18/19 (= average 55 per month)	National	–	–	–	–	53.00	37.00	334.00	66.00	46.00	40.00	35.00	50.00	36.00	697		
	% Mandatory Training compliance	Safe, high quality care	DHR	≥95%	WUTH	–	–	–	have	73.0%	–	74.8%	75.1%	82.0%	81.4%	82.2%	82.8%	81.5%	81.5%		
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	85.5%	84.3%	83.4%	83.3%	84.9%	–	81.1%	79.7%	78.2%	77.5%	78.4%	83.8%	84.5%	84.5%		

	Indicator	Objective	Director	Threshold	Set by	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Use of Resources	I&E Performance		DoF	On Plan	WUTH	-3.712	-2.315	-1.614	6.485	-4.259	-2.337	-2.659	-3.139	-3.426	-2.334	-1.246	-1.445	-4.038	-24.883		
	I&E Performance (Variance to Plan)		DoF	On Plan	WUTH	-2.898	-2.624	-0.424	0.162	-0.296	-0.103	-0.340	-0.184	-0.515	-0.319	-0.121	-0.761	-1.127	-3.766		
	NHSI Risk Rating		DoF	On Plan	NHSI	3	3	3	3	3	3	3	3	3	3	3	3	3	3		
	CIP Forecast		DoF	On Plan	WUTH	-38.4%	-41.6%	-44.0%	-43.8%	-34.1%	-36.3%	-27.2%	-22.1%	-15.4%	-11.7%	-10.6%	-5.4%	-6.1%	-6.1%		
	NHSI Agency Ceiling Performance		DoF	NHSI cap	NHSI	19.6%	4.3%	15.7%	21.8%	17.8%	1.1%	20.7%	-28.8%	-5.4%	8.7%	-11.1%	-7.4%	-0.5%	-0.5%		
	Cash - liquidity days		DoF	NHSI metric	WUTH	-17.5	-19.6	-19	-11.7	-15.5	-12.5	-13.3	-13.5	-14.4	-12.7	-12.0	-13.0	-12.5	-12.5		
	Capital Programme		DoF	On Plan	WUTH	68.6%	53.1%	51.2%	3.9%	-25.3%	9.8%	32.9%	45.0%	4.9%	5.2%	35.8%	41.4%	50.3%	50.3%		

Diagnostic Waiters, 6 weeks and over - DM01



Executive Lead: Chief Operating Officer

Issue: The trust has a target of a minimum 99% of patients awaiting diagnostic tests to be within 6 weeks. This has not been achieved for the last two months, and 2018/19 YTD performance is 98.6%.

Decision: Capacity in two key modalities is not resilient enough.

Action: Departments in the two key areas of echocardiography and urodynamic CMGs are working on recovery trajectories to reduce the number of patients waiting that breach this standard.

Expected Month Threshold to be Achieved:
February 2019

Board of Directors	
Agenda Item	9.1.2
Title of Report	Month 9 Finance Report
Date of Meeting	30 January 2019
Authors	Shahida Mohammed – Assistant Director of Finance Julie Clarke – Assistant Director of Finance Deborah Harman – Assistant Director of Finance
Accountable Executive	David Jago Director of Finance
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**	To discuss and note
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

The Trust did not accept the Control Total issued by NHSI for 2018/19 of a surplus of £11.0m; it is hence unable to access the Provider Sustainability Fund (PSF) of £12.5m.
The Trust submitted a plan to NHSi which delivers a deficit of (£25.0m), this includes a Cost Improvement Programme (CIP) of £11.0m

The following summary details the Trust's financial performance during December (Month 9) and the cumulative outturn position for FY19 against plan.

The year to date adjusted financial performance position is an actual deficit of (£24.8m) against a plan of (£20.9m), therefore (£3.9m) worse than plan. The underlying deficit given deployment of non-recurrent resources of some £2.3m at month 9 is c £27.1m.

The patient related income position is £0.7m better than plan, however this includes £4.2m relating to MSK and income CIP added in year, hence the underlying position is (£3.6m) worse than plan. The main areas driving this position are the under performance in elective and daycase activity, which is 2,664 spells (6.7%) behind plan, with a corresponding financial impact of (c£4.4m), and Outpatients attendances and procedures which are showing an adverse variance of (4,801) (2.1%), and a financial consequence of (£0.8m). There is also under-performance in maternity (£0.2m) and neonatal (£0.6m). Non-elective activity has under performed by (278) spells year to date, however from a financial perspective the complexity of case-mix has remained strong generating an additional £0.5m, which supporting the overall position. Further mitigation of the below income plan position has been the benefit of the MSK block contract (£1.4m) and the release of the accrual related to the Sepsis dispute (£1.3m) which has now been concluded with Wirral CCG.

In addition the pay reform funding of £3.0m for Mths 1-9, is showing as above plan in income with the contra entry in pay costs. Other income is better than plan by £0.9m but these relate to specific projects which are offset in expenditure as well as one-off income in M9 of £0.4m to mitigate the pension provision increase in pay.

The overall expenditure position is higher than plan by (£8.7m). However, pay includes the AFC pay reform as discussed above (£3.0m) and is offset in income but a further £0.3m AFC pressure is in pay. Non pay includes (£3.0m) associated with the MSK contracts which were not included within the original plan given in year contract sign off and again is offset in income. The underlying expenditure position is therefore (£2.6m) worse than plan.

The underlying pay position is £0.4m better than plan and is largely due to non-clinical vacancies which are delivering non-recurrent CIP. High levels of qualified nurse vacancies continue and consequently result in a high use of bank nurses. The agency spend is largely to cover medical gaps and remains under scrutiny and is marginally above the NHSI cap. Non pay is showing an underlying financial pressure overall of (£3.0m) partly a result of outsourcing costs to deliver the patient waiting times in a number of surgical specialties from transfers earlier in the year and undelivered CIP which has been delivered non-recurrently in pay.

The overall I&E position includes £2.3m of non-recurrent balance sheet support (including Sepsis).

In month, the position is an actual deficit of (£4.0m) against a planned deficit of (£2.9m), therefore some (£1.1m) worse than plan.

The forecast for December was a deficit of (£3.2m), so (c£0.8m) worse. This includes the release £0.2m non – recurrent central support included in the income position.

The delivery of cost improvements is £0.6m above plan as at the end of M9 and the forecast for the year is £10.3m (£1m red risk rated). There remains a (£0.7m) gap still unidentified but work is on-going to crystallise further opportunities to close this gap. Of the £7.0m delivered to date £2.9m is non-recurrent where vacancies have mitigated the delivery of recurrent CIP. The plan for the delivery of cost efficiencies has been largely profiled to be achieved during the latter part of the year with a challenging Q4. The recurrent CIP for 2019/20 is £9.5m at M9 but further opportunities including the outpatient productivity programme are progressing recognising some risk in recurrent income schemes.

As part of the Winter Capacity planning the Trust opened the "step down" facility (T2A) beds part way through November. This Ward will manage the previously significantly high numbers of "medically optimised" patients within the acute bed base, reflecting a lack of alternative support within the health and social care system and consequent adverse impact on flow. The facility will cost the Trust (£1.2m) for 2018/19, Wirral CCG has agreed to fund c£0.5m, the remaining cost will be a pressure for the Trust.

Cash balances at the end of December were £6.6m, exceeding plan by £4.3m. This is primarily due to positive working capital movements, capital outflows below plan and above plan PDC received, offset by EBITDA below plan.

In early January 2019, during a monthly review meeting with NHSI, the Trust raised that the "likely" forecast outturn position was (c£27.5m), partly the result of the system only partially funding the "step-down" facility and the earlier year loss of elective activity and outsourcing costs. Further risks to the financial forecast include continued operational pressures facing the Trust during Winter and the potential adverse impact this could have on the Elective recovery programme and assumptions in regard to non-elective activity.

Whist NHSI were sympathetic, they were clear that the Trust had planned to deliver a deficit of (£25.0m) at the beginning of the year, and the expectation would be for this to be delivered. However previous meetings (pre-Christmas) were referenced, where the "most likely" outturn had been discussed, and from these meeting the expectation from the regulator was that a deficit of (c£27.0m), albeit with mitigations could be possible. On that basis, NHSI stated that the expectation is that (£27.0m) is a "manageable" position. As there is a shortfall against the original plan submitted to NHSI, the Trust will be required to gain formal agreement of the increased deficit in line with the NHSI protocol. This is detailed in the additional paper.

The deterioration against forecast in Month 9 of £0.8m is therefore a further risk to the agreed position with NHSI and close scrutiny of the Q4 forecast and mitigations are being secured from the Divisions. This is detailed in Section 5.

3. Financial performance

2.1 Income and expenditure

Month 9 Financial performance	Annual Plan £'000	Current period Plan £'000	Current period Actual £'000	Current period Variance £'000	Month 9 Forecast £'000	Month 9 Actual £'000	Month 9 Variance £'000	Year to date Plan £'000	Year to date Actual £'000	Year to date Variance £'000
Income from patient care activity	307,162	24,488	24,787	299	25,634	24,787	(847)	230,004	230,662	658
DOH - Pay Reform Income	0	0	329	329	339	329	(10)	0	3,045	3,045
Income - PSF	0	0	0	0	0	0	0	0	0	0
Other income	29,428	2,440	2,914	474	2,501	2,914	413	21,980	22,904	924
Total operating income	336,589	26,929	28,031	1,102	28,474	28,031	(443)	251,984	256,610	4,627
Employee expenses	(247,732)	(20,430)	(21,568)	(1,138)	(21,012)	(21,568)	(556)	(186,221)	(188,856)	(2,634)
Operating expenses	(101,875)	(8,366)	(9,473)	(1,107)	(9,701)	(9,473)	228	(77,796)	(83,825)	(6,030)
Total operating expenditure	(349,607)	(28,796)	(31,041)	(2,245)	(30,713)	(31,041)	(328)	(264,017)	(272,681)	(8,664)
EBITDA	(13,018)	(1,867)	(3,010)	(1,143)	(2,239)	(3,010)	(771)	(12,033)	(16,071)	(4,038)
Depreciation and net impairment	(8,160)	(684)	(684)	0	(684)	(684)	0	(6,082)	(6,082)	0
Capital donations / grants income	0	0	(3)	(3)		(3)	(3)	0	127	127
Operating surplus / (deficit)	(21,178)	(2,551)	(3,697)	(1,145)	(2,923)	(3,697)	(774)	(18,115)	(22,026)	(3,911)
Net finance costs	(4,105)	(360)	(341)	18	(342)	(341)	(0)	(3,003)	(2,858)	145
Gains / (losses) on disposal	0	0	0	0		0	0	0	0	0
Actual surplus / (deficit)	(25,282)	(2,911)	(4,038)	(1,128)	(3,265)	(4,038)	(774)	(21,118)	(24,883)	(3,766)
Reverse capital donations / grants I&E impact	243	20	24	3	20	24	3	182	59	(123)
Reverse net impairments other than DEL impairments	0	0	0	0	0	0	0	0	0	0
Adjusted financial performance surplus/(deficit) [AFPD] including PSF	(25,039)	(2,891)	(4,015)	(1,124)	(3,245)	(4,015)	(771)	(20,935)	(24,824)	(3,889)

- In Month 9 there has been a further (£1.1m) deterioration in the position with a year to date deficit of (c£3.8m). The M9 position was (c£0.8m) worse than forecast largely due to deterioration in NHS clinical income.
- The main driver of this position is the underperformance of the elective programme which is (£4.4m) below plan. This is behind the expected elective recovery trajectory. Excluding MSK sub-contract variations which are offset in expenditure and the benefit of the MSK "block" arrangement, the underlying contract income position is YTD (£3.6m) worse than plan.
- Against forecast other income is £0.4m better due to the release of provisions to offset a pension provision increase in pay of £0.4m.
- Pay against forecast was (£0.6m) worse than forecast due to the pension provision and minor non-recurrent pressures largely in Surgery (WLIs/backdated pay). The underlying plan variance is £0.4m ytd underspent (adjusted by £3m AFC funding) which reflects vacancies and the over-delivery of CIP that mitigate staffing pressures in Medicine.
- Non pay although better than forecast in M9 is (c£3m) above plan YTD and reflects outsourcing pressures and CIP under-delivery.
- It has to be noted the overall year to date position also includes £2.3m non-recurrent balance sheet support.

3. Financial performance

2.2 Income

Activity

	Activity							
	Current month				Year to date			
	Plan	Actual	Variance	%	Plan	Actual	Variance	%
Income from patient care activity								
Elective	561	492	(69)	(12.34%)	6,416	5,196	(1,220)	(19.01%)
Daycase	3,084	3,148	64	2.08%	32,449	31,005	(1,444)	(4.45%)
Elective excess bed days	250	185	(65)	(26.13%)	3,064	2,029	(1,035)	(33.78%)
Non-elective	4,056	3,822	(234)	(5.76%)	34,305	34,027	(278)	(0.81%)
Non-elective Non Emergency	439	454	15	3.31%	3,965	3,915	(50)	(1.25%)
Non-elective excess bed days	845	1,020	175	20.69%	7,203	7,901	698	9.70%
A&E	7,869	7,082	(787)	(10.01%)	69,811	68,838	(973)	(1.39%)
Outpatients	21,044	20,520	(524)	(2.49%)	224,282	219,481	(4,801)	(2.14%)
Diagnostic imaging	2,039	2,539	500	24.50%	21,982	22,911	930	4.23%
Maternity	538	448	(90)	(16.72%)	4,772	4,425	(347)	(7.28%)
Total NHS patient care income	40,726	39,710	(1,017)		408,249	399,729	(8,520)	

- The main specialities driving the under performances in elective and daycase activity are Colorectal, Ophthalmology, Urology and Trauma and Orthopaedic surgery. “Booked” activity is being monitored on a weekly basis by the Surgical Division, the focus is to enact remedial action plans to ensure the position does not deteriorate further. Clinical Haematology has over performed which is partially mitigating the position.
- Demand for emergency care during December was below plan levels, reducing the previous over performance; this is across a number of specialities. Performance in emergency Upper GI surgery is exceeding plan, and has mitigated the overall position.
- Outpatient activity is under performing significantly particularly in relation to outpatient first attendances and procedures, the main area is Cardiology, due to gaps in the medical workforce, Gastro, Respiratory Medicine, Oral, and Trauma and Orthopaedics.

3. Financial performance

Income

Income	Current month				Year to date			
	Plan £'000	Actual £'000	Variance £'000	%	Plan £'000	Actual £'000	Variance £'000	%
Income from patient care activity								
Elective	1,793	1,632	(161)	(8.99%)	20,528	17,381	(3,147)	(15.33%)
Daycase	1,900	1,968	67	3.54%	21,050	19,758	(1,292)	(6.14%)
Elective excess bed days	61	45	(16)	(25.50%)	739	499	(241)	(32.54%)
Non-elective	7,816	7,964	149	1.90%	65,738	66,285	547	0.83%
Non-elective Non Emergency	999	988	(12)	(1.18%)	9,313	9,006	(306)	(3.29%)
Non-elective excess bed days	208	253	45	21.51%	1,775	1,939	164	9.25%
A&E	1,099	1,036	(64)	(5.78%)	9,753	9,952	200	2.05%
Outpatients	2,382	2,324	(58)	(2.43%)	25,456	24,621	(835)	(3.28%)
Diagnostic imaging	163	201	38	23.26%	1,754	1,741	(12)	(0.71%)
Maternity	483	415	(68)	(14.17%)	4,088	3,881	(207)	(5.07%)
Non PbR	5,566	5,658	93	1.67%	51,683	52,056	373	0.72%
HCD	1,284	1,213	(72)	(5.57%)	11,560	11,753	193	1.67%
CQUINs	563	454	(109)	(19.34%)	5,064	4,646	(418)	(8.26%)
MSK Sub Contracts	0	398	398	0.00%	0	2,808	2,808	0.00%
MSK back to Block	0	108	108	0.00%	0	1,355	1,355	0.00%
Other	0	4	4	0.00%	0	1,386	1,386	0.00%
Total income from patient care (SLAM)	24,317	24,660	343	1.41%	228,500	229,067	567	0.25%

- Within the overall year to date position there are certain key areas under performing significantly, elective and daycases, which is showing a deficit of (£4.4m), reflecting both activity and casemix reductions, outpatient attendances are (c£0.8m) below plan, this is predominantly in outpatient first attendances and procedures. The revised elective recovery plan is being closely managed, although it is not expected the under performance in the earlier part of the year will be recovered.
- The overall position is mitigated following the commencement of the MSK "prime provider" contract from July 2018, which was not included in the original plan submitted to NHSI. This is supporting the income position by £2.8m, (some of this will be offset in expenditure due to payments to sub-contractors e.g. Wirral CT for Physio services). In addition, as this is a "block" contract, there is an additional cumulative benefit of £1.4m.
- Other PbR areas are not significantly behind plan, with the exception of Births which are (£0.3m) behind plan equating to (94) births, and Neonatal activity is cumulatively underperforming by (£0.7m), given the unpredictable nature of this activity and the reliance on the Neonatal network for a large proportion of this work, it is difficult to predict the recovery of this. There is an expectation that the position will improve.
- Included in the position is the successful conclusion with Wirral CCG of the disputed coding of Sepsis activity, during 17/18. This supported the position by c£1.3m, and other balance sheet support of £0.1m, this is recorded in the "Other" category in the above table.

2. Financial performance

2.3 Expenditure

- The overall expenditure position as at the end of M9 is showing an YTD over-spend of (£8.7m) against plan but excluding MSK of £3m YTD and AFC reform funding of £3m is an underlying overspend in total expenditure of (£2.7m).

The pay and other operating expenses for the Trust are detailed below.

2.3 .1 Pay

Pay analysis	Annual Plan £'000	Current period Plan £'000	Current period Actual £'000	Current period Variance £'000	Month 9 Forecast £'000	Month 9 Actual £'000	Month 9 Variance £'000	Year to date Plan £'000	Year to date Actual £'000	Year to date Variance £'000
Substantive	(225,643)	(18,573)	(19,517)	(944)	(18,886)	(19,517)	(631)	(169,739)	(170,586)	(846)
Bank	(6,662)	(556)	(722)	(166)	(655)	(722)	(67)	(4,999)	(6,423)	(1,423)
Medical Bank	(7,057)	(588)	(627)	(39)	(724)	(627)	97	(5,292)	(5,521)	(229)
Agency	(7,469)	(638)	(627)	11	(669)	(627)	42	(5,515)	(5,647)	(132)
Other - Apprenticeship levy	(900)	(75)	(74)	1	(76)	(74)	2	(675)	(679)	(4)
Total	(247,732)	(20,430)	(21,568)	(1,138)	(21,010)	(21,568)	(558)	(186,221)	(188,856)	(2,634)

- The pay position in M9 is showing a net overspend of (£1.1m) and YTD is (£2.6m) worse than plan. However, the plan excluded the AFC pay reform funding of (c£3.0m) year to date which is offset in income. Hence the underlying pay position (i.e. adjusted for pay award funding) is c£0.4m underspent YTD.
- In-month the substantive pay position is showing the impact of a £0.4m increase in the pension provision that has been mitigated in other income. This month there were further non-recurrent pressures in Surgery of c£0.1m (WLIs/backdated pay).
- The underlying pay position shows substantive vacancies offset with significant use of bank, agency and other non-core pay. The bank figure is above plan and is largely due to supporting the substantive nursing vacancies and acuity particularly in the Medicine division. There remains substantial nursing vacancies across the Trust that bank are being used to cover gaps however fill rate remains low. Workforce plans and recruitment initiatives are continually under review with a proposed strategy on trainee nurse associate roles
- The agency figure is £0.6m this month and YTD is £31k above the NHSI ceiling of £5,616k ytd.
- Vacancies in Clinical Support and Corporate continue and non-recurrently they are supporting delivery of the CIP target.
- Pay CIP delivery is £1.2m higher than the NHSI plan at £1.7m ytd however to note £1.1m of this is non-recurrent. The CIP plan was heavily weighted to non-pay.

2. Financial performance

2.3.3 Non pay

Non pay analysis	Annual Plan £'000	Current period Plan £'000	Current period Actual £'000	Current period Variance £'000	Month 9 Forecast £'000	Month 9 Actual £'000	Month 9 Variance £'000	Year to date Plan £'000	Year to date Actual £'000	Year to date Variance £'000
Purchase of Healthcare - Non NHS	(2,583)	(92)	(655)	(563)	(761)	(655)	106	(2,124)	(6,295)	(4,171)
Supplies and services - clinical	(35,475)	(2,916)	(3,176)	(260)	(3,009)	(3,176)	(167)	(26,725)	(26,225)	500
Drugs	(25,395)	(2,109)	(1,960)	148	(2,159)	(1,960)	199	(19,069)	(19,068)	1
Consultancy	0	0	(96)	(96)	(39)	(96)	(57)	0	(462)	(462)
Other	(46,583)	(3,933)	(4,269)	(336)	(4,417)	(4,269)	148	(35,959)	(37,857)	(1,898)
Total	(110,035)	(9,050)	(10,157)	(1,107)	(10,385)	(10,157)	228	(83,877)	(89,907)	(6,030)

- Non pay expenditure is (£1.1m) overspent in M9 and YTD is (£6.0m) above plan but the plan excludes the MSK contract costs of £3m year to date which are offset in income. The underlying non-pay position (adjusted for MSK) is (c£3.0m) overspent YTD of which CIP is a major variance (£1.8m). Clinical supplies reflect the low levels of elective activity in earlier months and the associated prostheses/clinical supplies underspend.
- Drug costs are below plan in-month and YTD; the high cost drugs element is (£0.2m) and is offset as a variance in clinical income.
- The position includes outsourcing costs to Spire in relation to gaps in elective capacity earlier in the year of c£1.7m for a number surgical specialties (Orthopaedics, Pain and ENT) with further radiology non NHS spend of £1.2m and the MSK contract of £3.0m.
- In other CIP delivery against the original plan is (£1.8m) lower and is partially offset in pay. The original plan was heavily weighted to non pay as the £4m unidentified gap at the time of submitting the plan was allocated to non pay. Again similar to pay £0.6m of the £3.2m YTD non pay CIP position is non-recurrent.
- In Q1 £0.3m supported the non pay position non-recurrently and was allocated to the divisions.

2. Financial performance

2.4 CIP by programme

Programme	Director	YTD NHSI Plan £k	YTD Actual £k	YTD Variance £k	In Year Forecast NHSI Plan £k	In Year Forecast Fully Developed £k	In Year Forecast Variance £k	In Year Forecast Pipeline £k	In Year Forecast Total £k	In Year Forecast Variance £k	Recurrent Savings NHSI Plan £k	Recurrent Savings Fully Developed £k	Recurrent Savings Variance £k	Recurrent Savings Pipeline £k	Recurrent Savings Total £k	Recurrent Savings Variance £k
Transformation																
Improving Patient Flow	Anthony Middleton	250	1,007	**757**	1,000	1,337	**337**	0	1,337	**337**	1,000	1,337	**337**	0	1,337	**337**
Improving Productivity	Anthony Middleton	333	532	**198**	478	716	**238**	144	859	**381**	478	860	**382**	749	1,610	**1,132**
Collaboration	Janelle Holmes	521	536	**15**	952	812	**(140)**	25	837	**(115)**	952	998	**46**	100	1,098	**146**
Digital Wirral	Paul Charnley	750	878	**128**	1,000	1,143	**143**	117	1,260	**260**	1,000	1,000	**0**	0	1,000	**0**
Sub total - transformation		**1,855**	**2,953**	**1,099**	**3,430**	**4,008**	**578**	**285**	**4,293**	**863**	**3,430**	**4,195**	**766**	**849**	**5,045**	**1,615**
Cross cutting workstreams																
Workforce	Helen Marks/ Tracy Fennell	101	258	**158**	134	319	**184**	39	358	**223**	134	19	**(115)**	30	49	**(85)**
Estates & Site Strategy	Dave Sanderson	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Pharmacy and Meds Management	Pippa Roberts	353	361	**9**	500	461	**(39)**	39	500	**(0)**	500	360	**(140)**	35	395	**(105)**
Procurement and Non Pay	Jane Christopher	780	295	**(485)**	1,150	345	**(805)**	716	1,061	**(89)**	1,150	201	**(949)**	300	501	**(649)**
Tactical and transactional		0	0		0	0		0			0	0		0		
Divisional and Departmental	Divisional Directors	1,313	3,137	**1,824**	1,936	3,609	**1,673**	510	4,119	**2,183**	1,936	3,050	**1,114**	433	3,483	**1,547**
Unidentified		2,006	0	**(2,006)**	3,850	0	**(3,850)**	0	0	**(3,850)**	3,850	0	**(3,850)**	0	0	**(3,850)**
Total		**6,408**	**7,006**	**598**	**11,000**	**8,741**	**(2,259)**	**1,590**	**10,331**	**(669)**	**11,000**	**7,824**	**(3,176)**	**1,648**	**9,472**	**(1,528)**

- YTD CIP performance is £0.6m ahead of the NHSI plan as at the end of M9 but the CIP delivery profile significantly increases in Q4.
- For the full year the Trust is currently forecasting £8.7m of fully developed schemes with a further £1.6m of plans in progress (pipeline) and opportunities. £0.7m remains unidentified at this stage.
- Included in the pipeline is c£1m of schemes that have a red risk rating that is unlikely to deliver this year with £0.7m relating to procurement schemes.
- Work needs to continue to progress the remaining pipeline schemes to deliver.
- Discussions are ongoing with NHSI in relation to the risks around the forecast.

3. Financial position

NHS Wirral University Teaching Hospital NHS Foundation Trust

3.1 Statement of Financial Position (SOFP)

Actual as at 01.04.18 £'000		Month-on-month movement	Plan as at 31.12.18 £'000	Actual as at 31.12.18 £'000	Variance (to plan) £'000	Forecast 31.03.19 £'000	Plan 31.03.19 £'000
	Non-current assets						
159,754	Property, plant and equipment	⇧	159,242	157,782	(1,460)	165,501	160,148
12,763	Intangibles	⇧	12,167	11,541	(626)	11,041	12,369
903	Trade and other non-current receivables	⇧	903	856	(47)	855	903
173,420		⇧	**172,312**	**170,179**	**(2,133)**	**177,397**	**173,420**
	Current assets						
4,171	Inventories	⇧	4,171	4,224	53	4,224	4,171
18,423	Trade and other receivables	⇧	20,606	20,569	(37)	18,309	18,424
0	Assets held for sale	⇨	0	0	0	0	0
7,950	Cash and cash equivalents	⇧	2,231	6,578	4,347	2,117	1,773
30,544		⇧	**27,008**	**31,371**	**4,363**	**24,650**	**24,368**
203,964	**Total assets**	⇧	**199,320**	**201,550**	**2,230**	**202,047**	**197,788**
	Current liabilities						
(32,538)	Trade and other payables	⇩	(30,727)	(33,214)	(2,487)	(31,746)	(27,752)
(3,224)	Other liabilities	⇩	(3,224)	(4,403)	(1,179)	(3,224)	(3,224)
(1,074)	Borrowings	⇨	(1,075)	(1,076)	(1)	(1,076)	(1,076)
(548)	Provisions	⇨	(548)	(548)	0	(548)	(548)
(37,384)		⇩	**(35,574)**	**(39,241)**	**(3,667)**	**(36,594)**	**(32,609)**
(6,840)	**Net current assets/(liabilities)**	⇧	**(8,566)**	**(7,870)**	**696**	**(11,944)**	**(8,240)**
166,580	**Total assets less current liabilities**	⇧	**163,746**	**162,309**	**(1,437)**	**165,453**	**165,180**
	Non-current liabilities						
(8,812)	Other liabilities	⇧	(8,556)	(8,556)	0	(8,471)	(8,470)
(49,258)	Borrowings	⇩	(67,939)	(67,940)	(1)	(73,224)	(73,221)
(2,318)	Provisions	⇩	(2,178)	(2,504)	(326)	(2,455)	(2,131)
(60,388)		⇩	**(78,673)**	**(79,000)**	**(327)**	**(84,150)**	**(83,826)**
106,192	**Total assets employed**	⇩	**85,073**	**83,309**	**(1,764)**	**81,304**	**81,366**
	Financed by Taxpayers' equity						
77,575	Public dividend capital	⇧	77,575	79,575	2,000	80,031	78,031
(12,259)	Income and expenditure reserve	⇩	(33,378)	(37,142)	(3,764)	(39,603)	(37,541)
40,876	Revaluation reserve	⇨	40,876	40,876	0	40,876	40,876
106,192	**Total taxpayers' equity**	⇩	**85,073**	**83,309**	**(1,764)**	**81,304**	**81,366**

Capital asset variances	**£m**
Capex underspend	-2.2
Donations above plan	0.1
Total variance of capital assets to plan	**-2.1**

Cash variances	**£m**
EBITDA and donation income below plan	-4.0
Working capital movements	5.6
Capital expenditure (cash basis) below plan	0.7
PDC received above plan	2.0
Other minor variances above plan	0.1
Total variance of cash to plan	**4.3**

3. Financial position

3.2 Capital expenditure

	2018/19 NHSI capital plan £'000	Full year Budget [1] £'000	Full year Forecast [2] £'000	Variance £'000	Full year Forecast [2] £'000	Green light schemes [4] £'000	Variance £'000	YTD Actual £'000
Funding								
Depreciation	8,160	8,160	8,160	0				6,082
Loan repayment	(1,015)	(1,015)	(1,015)	0				(508)
Finance lease	(60)	(60)	(60)	0				(46)
Additional funding per plan	3,250	3,250	3,250	0				3,250
Additional external (donations / grant) funding	0	185	185	0				127
Public Dividend Capital (PDC) - GDE	456	456	456	0				0
Public Dividend Capital (PDC) - Urgent and Emergency Care	0	2,000	2,000	0				2,000
Total funding	**10,791**	**12,976**	**12,976**	**0**				**10,905**
Expenditure - schemes								
Divisional priorities - *Medicine and Acute Care*		238	238	0	238	92	146	48
Divisional priorities - *Surgery*		372	559	(187)	559	439	120	296
Divisional priorities - *Women and Children's*		438	443	(5)	443	300	143	286
Divisional priorities - *Clinical Support and Diagnostics*		1,864	1,731	133	1,731	1,542	189	180
Divisional priorities - *Clinical Support and Diagnostics* - MRI	1,050	1,518	1,518	0	1,518	1,518	0	110
Divisional priorities - contingency [3]	500	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Informatics - *Digital Wirral / Global Digital Exemplar*	2,811	2,801	2,801	0	2,801	2,003	798	863
Informatics	500	536	545	(9)	545	525	20	280
Estates - backlog maintenance	1,500	3,430	3,719	(289)	3,719	1,361	2,358	1,250
Car park		0	0	0	0	0	0	0
Cerner		(400)	(400)	0	(400)	(400)	0	(400)
All other expenditures		(193)	(153)	(40)	(153)	(153)	0	(153)
Urgent and Emergency Care		0	0	0	0	0	0	n/a
Contingency [3]	1,180	2,187	1,016	1,171	1,016	0	1,016	n/a
Reallocated funding	3,250	n/a	n/a	n/a	n/a	n/a	n/a	n/a
NHSI plan subtotal	**10,791**							
Donated assets	0	185	179	6	179	138	41	127
Total expenditure (accruals basis) [5]	**10,791**	**12,976**	**12,196**	**780**	**12,196**	**7,365**	**4,831**	**2,887**

[1] This is the NHSI plan, adjusted for approved business cases including additional donated, leased and PDC funded spend.

[2] Current forecast includes slippage from 2017/18.

[3] Funding is transferred as business cases are approved. Contingency forecast includes £0.8m for Switchboard and £0.2m for Mortuary Refurb, which are expected to be approved this year.
- Switchboard project estimated to be £1.1m in total, with £0.8m in 2018/19 and £0.3m in 2019/20.
- Mortuary Refurb project is estimated to be £0.3m in total, with £0.2m in 2018/19 and £0.1m in 2019/20.

[4] Green light schemes are those for which a feasible capital bid form has been approved, the scheme is expected to deliver in year and order(s) have been raised.

[5] **Remaining contingency / capital underspend forecast £774k**

3.3 Statement of Cash Flows

	Month			Year to date			Full Year	
	Actual	Plan	Variance	Actual	Plan	Variance	Forecast	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening cash	**5,776**	**1,894**	**3,882**	**7,950**	**7,950**	**0**	**7,950**	**7,950**
Operating activities								
Surplus / (deficit)	(4,038)	(2,911)	(1,127)	(24,883)	(21,118)	(3,765)	(27,344)	(25,282)
Net interest accrued	150	166	(16)	1,136	1,260	(124)	1,614	1,806
PDC dividend expense	191	191	0	1,719	1,719	0	2,292	2,292
Unwinding of discount	0	3	(3)	2	27	(25)	3	6
Operating surplus / (deficit)	(3,697)	(2,551)	(1,146)	(22,027)	(18,112)	(3,915)	(23,436)	(21,178)
Depreciation and amortisation	684	684	(0)	6,082	6,081	1	8,160	8,160
Impairments / (impairment reversals)	0	0	0	0	0	0	0	0
Donated asset income (cash and non-cash)	3	0	3	(127)	0	(127)	(127)	0
Changes in working capital	(781)	(285)	(496)	3,010	(2,573)	5,583	(1,929)	(996)
Investing activities								
Interest received	12	3	9	90	27	63	113	48
Purchase of non-current (capital) assets [1]	(336)	(508)	172	(7,118)	(7,809)	691	(11,195)	(12,444)
Financing activities								
Public dividend capital received	2,000	0	2,000	2,000	0	2,000	2,456	456
Net loan funding [2]	3,000	3,000	0	18,728	18,728	0	24,027	24,027
Interest paid	(76)	0	(76)	(803)	(818)	15	(1,586)	(1,845)
PDC dividend paid	0	0	0	(1,189)	(1,189)	0	(2,335)	(2,335)
Finance lease rental payments	(6)	(6)	0	(54)	(54)	0	(70)	(70)
Total net cash inflow / (outflow)	**802**	**337**	**465**	**(1,372)**	**(5,719)**	**4,347**	**(5,833)**	**(6,177)**
Closing cash	**6,578**	**2,231**	**4,347**	**6,578**	**2,231**	**4,347**	**2,117**	**1,773**

[1] Outflows due to the purchase of non-current assets are not the same as capital expenditure due to movements in capital creditors.
[2] Support funding currently comprises a working capital facility, and 'uncommitted loans', issued by DHSC and administered by NHSI.

Cash variances	£m
EBITDA and donation income below plan	-4.0
Working capital movements	5.6
Capital expenditure (cash basis) below plan	0.7
PDC received above plan	2.0
Other minor variances above plan	0.1
Total variance of cash to plan	**4.3**

4. Use of Resources

4.1 Single oversight framework

UoR rating (financial) - summary table

	Metric	Descriptor	Weight %	Year to Date Plan		Year to Date Actual		Full Year Plan	
				Metric	*Rating*	*Metric*	*Rating*	*Metric*	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-13.3	3	-12.2	3	-12.9	3
Financial sustainability	**Capital service capacity (times)**	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	-3.3	4	-4.6	4	-2.5	4
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	-8.3%	4	-9.7%	4	-7.4%	4
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.0%	1	-1.4%	3	0.0%	1
Financial controls	**Agency spend (%)**	Distance of agency spend from agency cap	20%	-1.8%	1	0.6%	2	0.0%	1
	Overall NHSI UoR rating				**3**		**3**		**3**

UoR rating summary

- The Trust has marginally overspent against the agency cap, increasing the risk rating to 2. The Trust needs to continue its focus to reduce the spend in this area to bring the *Agency spend* rating back down to 1.
- The *Distance from financial plan* metric is currently below plan as a result of the year-to-date EBITDA.
- The month 9 UoR rating is 3 overall, which matches the 2018/19 plan UoR rating of 3.
- Forecast UoR rating is 3.

5. Forecast

The forecast scenarios as discussed in the December 2018 Board report detailed the range of deliverables from the "best case" (£25m) which is Plan, to a forecast deficit of (£27.8m) "most likely" and "worst case" of (£29.5m).

The table below details the actual performance in Mth 9 compared to the required position to maintain the trajectory needed during quarter 4 to deliver the "most likely" deficit of (£27.8m).

			Month 8 Forecast				Difference Mth 9 (Forecast v Actual)	
	YTD Mth 8 Actual £000	Actual Mth 9 £000	Forecast Mth 10 £000	Forecast Mth 11 £000	Forecast Mth 12 £000	Total £000	Forecast Mth 9 £000	Mth 9 Variance £000
Income from patient care activity								
Elective/Daycase	33,540	3,599	4,380	4,329	4,662	**50,510**	3,957	(358)
Elective excess bed days	453	45	30	30	38	**596**	21	24
Non-elective	58,330	7,954	9,223	7,733	8,613	**91,853**	8,321	(367)
Non-elective Non Emergency	8,019	988	1,002	920	1,150	**12,079**	1,003	(15)
Non-elective excess bed days	1,686	253	229	202	223	**2,593**	217	36
A&E	8,916	1,036	1,132	1,026	1,132	**13,242**	1,132	(96)
Outpatients	22,297	2,324	2,962	2,667	2,804	**33,054**	2,383	(59)
Diagnostic imaging	1,540	201	198	178	191	**2,308**	157	44
Maternity	3,466	415	466	421	466	**5,234**	466	(51)
Non PbR	46,398	5,663	5,749	5,594	6,323	**69,727**	5,475	188
HCD	10,540	1,212	1,337	1,337	1,337	**15,763**	1,337	(125)
CQUINs	4,192	454	525	525	346	**6,042**	525	(71)
MSK Sub Contracts	2,410	398	482	482	482	**4,254**	463	(65)
MSK back to Block	1,247	108	290	59	98	**1,802**	-	108
Other	1,381	0	200	200	200	**1,981**		0
TOTAL NHS INCOME	**204,417**	**24,650**	**28,205**	**25,703**	**28,065**	**311,040**	**25,457**	**(807)**
Other patient care income	472	53	59	59	59	**702**	59	(6)
Non-NHS: private patients & overseas	256	29	27	26	27	**365**	26	3
Injury cost recovery scheme	713	53	85	90	90	**1,031**	90	(37)
Non NHS: Other	17	2	2	2	3	**26**	2	0
TOTAL PATIENT CARE INCOME	**205,875**	**24,787**	**28,378**	**25,880**	**28,244**	**313,164**	**25,634**	**(847)**
Other Income	22,835	3,241	2,821	2,789	2,804	34,490	2,840	401
TOTAL TRUST INCOME	**228,710**	**28,028**	**31,199**	**28,669**	**31,048**	**347,654**	**28,474**	**(446)**
Pay								
Medical & Dental	(45,923)	(5,849)	(5,796)	(5,751)	(5,750)	**(69,069)**	(5,793)	(56)
Nursing and midwifery	(45,659)	(5,482)	(5,717)	(5,700)	(5,704)	**(68,262)**	(5,680)	198
Scientific, Therapeutic & Technical	(20,277)	(2,555)	(2,574)	(2,574)	(2,574)	**(30,554)**	(2,577)	22
Support to clinical staff	(39,490)	(5,258)	(5,005)	(4,994)	(4,982)	**(59,729)**	(4,982)	(276)
Non medical, non clinical staff	(15,939)	(2,424)	(1,989)	(1,967)	(1,201)	**(23,520)**	(1,979)	(445)
TOTAL PAY COSTS	**(167,288)**	**(21,568)**	**(21,081)**	**(20,986)**	**(20,211)**	**(251,134)**	**(21,011)**	**(557)**
Non Pay								
Supplies and services - clinical	(23,049)	(3,176)	(3,003)	(2,973)	(2,932)	**(35,133)**	(3,009)	(167)
Drugs	(17,107)	(1,960)	(2,159)	(2,159)	(2,158)	**(25,543)**	(2,159)	199
Purchase of HealthCare from Non NHS Bod	(5,640)	(655)	(838)	(751)	(746)	**(8,630)**	(761)	106
Other	(33,954)	(4,366)	(4,407)	(4,463)	(4,024)	**(51,214)**	(4,456)	90
TOTAL NON PAY COSTS	**(79,750)**	**(10,157)**	**(10,407)**	**(10,346)**	**(9,860)**	**(120,520)**	**(10,385)**	**228**
Net Finance costs	(2,516)	(342)	(349)	(339)	(363)	**(3,909)**	(342)	0
Monthly Actual/FOT surplus/(deficit)	**(20,844)**	**(4,039)**	**(638)**	**(3,002)**	**614**	**(27,909)**	**(3,264)**	**(775)**
Reverse capital donations/grants I&E impa	35	24	20	20	20	**119**	20	4
Monthly Actual/FOT surplus/(deficit)	**(20,809)**	**(4,015)**	**(618)**	**(2,982)**	**634**	**(27,790)**	**(3,244)**	**(771)**
Monthly Plan surplus/(deficit)	**(18,044)**	(2,891)	(733)	(2,679)	(692)	**(25,039)**	(2,891)	
Variance (Forecast v Actual)	(2,765)	(1,124)	115	(303)	1,326	**(2,751)**	(353)	**(771)**

5. Forecast

As shown above there is deterioration against forecast of (c£0.8m), most of this is in relation to the clinical income position, offset slightly by national allocations which had been forecast to be delivered later in the year. Pay costs exceeded forecast due to the increased provision for pension costs which is mitigated by other income. In addition, higher costs than expected were seen in support services, and non clinical staff, this was mitigated by underspends in non pay.

Clearly the deterioration against the Mth 9 forecast position demonstrates that the shortfall in clinical income areas needs to be recovered and the trajectory for quarter 4 needs to be maintained for the remainder of the year as a minimum, thus ensuring the position is delivered.

The quarter 4 position includes the following:

- Elective recovery plan (including a benefit from the MSK block contract),
- Increase in non-elective income as part of winter profiling
- Improvement in CIP delivery
- Potential contract penalties, CQUINs and PLCPs
- Release of RTT reserve.
- Offsetting these are the anticipated winter costs (step down ward) as part of the winter plan.
- Reduced outsourcing costs reflecting no new transfers being made since Q2 and the release of central reserves.

Risks - The key risks to income are non-delivery of Q3/Q4 CQUIN milestones, operational pressures leading to cancellations in the elective programme, a reduced casemix in emergency care, additional penalties associated with a higher than contract level of avoidable readmissions and other contractual movements.

The Executive Board are asked to note the contents of this report.

Karen Edge
Deputy Director of Finance
January 2019

Board of Directors	
Agenda Item	9.1.3
Title of Report	NHSI Changes to Forecast Protocol
Date of Meeting	30th January 2019
Author	Karen Edge
Accountable Executive	Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 8c, 8d
Level of Assurance • **Positive** • **Gap(s)**	Gaps: Financial performance below plan and risks to delivery over the winter period
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval Required
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

1. Executive Summary

The Trust has been forecasting to NHSI deterioration in its financial position and its ability to meet its agreed financial plan value submitted to NHSI since the beginning of Q3.

NHSI requires provider Boards to follow an agreed protocol in respect of changes to their forecast outturn position. This can only be completed at quarterly reporting points and hence is required for the Month 9 reporting period.

The protocol includes the following requirements:

1. A discussion with NHSI Executive Regional Managing Director and Regional Director of Finance with regard to the deterioration of the financial position
2. A recovery plan forms part of the engagement above
3. An Assurance Statement signed off by specific Board members

The protocol is included at the end of this report.

2. Discussion with NHSI & Recovery Plan

The Director of Finance and the Chief Executive discussed the Trust financial position with NHSI Executive Regional Managing Director and Regional Director of Finance on the 14th December. The Trust proposed the likely forecast with all known mitigations as being £27.3m. The Trust was asked to consider a recovery plan to deliver the £25.0m planned deficit.

A further meeting was arranged for the 10th January and attended by the Chief Executive, Deputy Director of Finance, the NHSI Regional Director of Finance and Acting Delivery and Improvement Director. At this meeting recovery actions were discussed and discounted and a position of £27.3m was agreed to be put forward to the Trust board for agreement as part of the Month 9 reporting process.

The presentation that was discussed is included at the end of this report and which highlights remaining risks in regard to delivery of this position.

3. Assurance Statement

The Assurance Statement is included in Appendix 1.

The key elements of the Assurance:

Finance

The Board is sighted and committed to delivery of all recovery actions and options available to it to support delivery of the original financial plan.

The FBPAC has received detailed reports on the forecast position and recovery actions since Month 4 and every month thereafter.

The Board Finance Report has included reference to the potential adverse financial forecast outturn position against plan since Month 5.

Governance
Commissioners have been informed and opportunities for support have been explored.

The Trust openly reports, along with Healthy Wirral partners its current financial position and forecast which is noted at the Healthy Wirral Executive Delivery Group.

Wirral Care & Commissioning Group is experiencing their own financial challenges in meeting their agreed control total and additional support has been provided to the system through NHSE. These support arrangements have considered the opportunity to agree a system control total and/or to agree a financial year end settlement. The financial gap between the two parties' positions was considered too large to bridge through either of these mechanisms.

The senior clinical decision making body within the Trust has been informed and engaged in recovery actions.

Senior clinical leaders have been involved in the development of recovery actions through representation at EMT, DPR's and Divisional Finance meetings. In addition, the Medical Director has presented the financial position to the Medical Board for consideration and support actions.

The Trust Executive committee, Finance Committee and Board have considered and agree the proposed financial forecast revision and recovery actions.

EMT, TMB and FBPAC has received detailed reports on the forecast position and recovery actions since Month 4 and every month thereafter.

4. Recommendation

The Board is recommended to confirm the statements included in the document in Appendix 1.

20181203 WUTH Financial Position - FIN

2018-19 Protocol-for-changes-t

2018-19 Adverse Changes to Forecast Protocol - Board Assurance Statement

Trust Name Wirral Hospital University Hospitals Trust

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (notes below)

Board Response

Where a provider plans to make an adverse change to an in-year forecast it must be reported through the national reporting process and accompanied with this Board Assurance Statement which has been signed by the Trust Chair, Chief Executive, Director of Finance and the Audit Committee Chair

For finance:

The Board has been fully briefed on the planned adverse change to forecast and has adhered to the NHS Improvement protocol for ***'Adverse Changes to the In-Year Forecasts'*** prior to requesting the change	Confirmed
All reporting revisions are accompanied with detailed actions and the trust will continue to explore all options to recover the position and achieve delivery of the original financial plan.	Confirmed
The Board is fully committed to the delivery of the Trust recovery plan and will actively monitor the recovery plan milestones	Confirmed
In advance of formally reporting a forecast outturn variance from plan the Trust has discussed the financial deterioration and remedial actions with the NHS Improvement Regional Managing Director and Regional Director of Finance	Confirmed

For governance:

Relevant commissioners have been informed of the position and all opportunities for support have been explored and the recovery actions agreed	Confirmed
The senior clinical decision making body within the Trust has been engaged with and are party to the identification and delivery of the recovery actions	Confirmed
The Trust Executive Committee, Finance Committee and Board have considered and agree the proposed financial forecast revision and recovery actions	Confirmed

Board Declaration

I can confirm that in my capacity as a member of the Trust Board, I understand the financial forecast, its key drivers and where there has been a variance signalled, I can confirm that we will continue to explore all options to recover the position and deliver the original plan that was signed off by this Trust Board and that these actions have been and will be considered in full by Clinical Decision Making Groups, the Finance Committee, and the Board as a minimum.

Signed on behalf of the board of directors

Signature		Signature	
Name	Janelle Holmes	Name	Sir David Henshaw
Capacity	Chief Executive	Capacity	Chair
Date		Date	

Signature		Signature	
Name	Karen Edge	Name	Steve Igoe
Capacity	Finance Director	Capacity	Audit Committee Chair
Date		Date	

Sent via Email

Jill Copeland
Delivery & Improvement Director

3 Piccadilly Place
Manchester
M1 3BN

3 December 2018

Janelle Holmes
Chief Executive
Wirral University Teaching Hospitals NHS Foundation Trust

Dear Janelle

2018/19 Trust Financial Position

I have been made aware that the Trust has some significant risks to its ability to deliver the financial plan for 2018/19, with a possible negative impact of up to £5m. This is a challenging position for the Trust to be in at this stage in the financial year, but one that we hope can be resolved so that the Trust delivers the agreed financial plan signed off by the Board. Through our routine interactions, NHS Improvement understand the main drivers of financial risk are the Trust's slippage in the delivery of elective activity, under-performance in schemes and the investment in additional capacity for winter. I note that the elective activity has continued to underperform despite the implementation of recovery plan measures early in the year and this has contributed to the Trusts adverse financial position. I also understand that efforts to negotiate additional income from local commissioners to support increased costs and pressures associated with non-elective activity have not yet proven successful.

It would therefore be beneficial to arrange a meeting between yourself and David Jago, with Jonathan Stephens (NHS Improvement Operational Regional Director of Finance), Ann Bracegirdle (NHS Improvement Head of Finance for Cheshire & Merseyside) and myself to discuss the Trust's financial position and the action you are taking to recover and deliver the plan for the year. Key areas of discussion in that meeting will include:

- Review of performance compared to annual plan for 2018/19
- Explanation of work the Trust has done in identifying financial mitigations, the limitations of those actions and the options for further improvements.
- Progress of working with commissioners on system efficiencies and savings.
- The impact of current financial pressures on the 2019/20 financial plan.
- Opportunities for NHS Improvement support.

The financial risk you have identified is significant; it is therefore important to act promptly to address the potentially complex underlying causes as well as taking all appropriate steps to mitigate the impact in this year.

Yours sincerely

Jill Copeland
Delivery and Improvement Director (Cheshire and Merseyside)

Copy to:
Jonathan Stephens, Regional Director of Finance (North), NHS Improvement
Ann Bracegirdle, Head of Finance (Cheshire and Merseyside), NHS Improvement
David Jago, Director of Finance, Wirral University Teaching Hospitals NHS Foundation Trust

Protocol for Changes to an In-Year Financial Forecast

1. Introduction

1.1 NHS trusts and foundation trusts submitted financial plans for 2018/19. These plans were quality impact assessed and signed off by individual provider Boards prior to submission.

1.2 The achievement of financial balance, whilst maintaining the quality of healthcare provision, is a key objective for all organisations. The future success of the NHS depends on providers and Clinical Commissioning Groups (CCGs) delivering or over achieving the plans that they have signed up to and provider Boards must take organisational and personal accountability for meeting their financial and performance commitments.

1.3 In exceptional circumstances it may be necessary for an NHS trust or foundation trust Board to reconsider its planned forecast outturn position. In this event, the provider Board's primary focus must be the identification and delivery of a recovery plan that demonstrates the mitigating actions being implemented that ensure any proposed revision to forecast outturn is minimised, managed and fully recovered at the earliest possible time.

1.4 To demonstrate the highest standards of governance and for purposes of consistency and transparency, the protocol set out below should be followed by all provider Boards considering the reporting of a deterioration in the forecast outturn against their planned position for the year.

1.5 The introduction of this protocol by NHS Improvement should not be taken by provider Boards as permission to deteriorate financial positions. All reporting revisions must be accompanied by the actions required to return to planned positions.

2. Protocol

2.1 Revisions to forecast outturns can only be made once a provider's plan for the year has been agreed and only at the quarterly reporting points in the year and can only be made through the standard quarterly reporting process.

2.2 **However, in advance of formally reporting a forecast outturn variance from plan**, Trusts are required to have discussed the financial deterioration with the NHS Improvement Executive Regional Managing Director and Regional Director of Finance.

2.3 This engagement must be underpinned with a provider prepared

detailed report that clearly exemplifies:

- The key financial drivers for the deterioration;
- An analysis of the underlying causes;
- The actions being taken to address the deterioration and evidenced confirmation that:
    - ❖ Relevant commissioners have been informed of the position and all opportunities for support have been explored and the recovery actions agreed;
    - ❖ The senior clinical decision making body with the provider has been engaged with and are party to the identification and delivery of the recovery actions;
    - ❖ NHS trust / foundation trust Executive Committee, Finance Committee and Board have considered and agree the proposed financial forecast revision and recovery actions.

2.4 This recovery plan described must explicitly reference:

- Details of the additional measures immediately implemented to improve financial control and working capital/cash management, including capital programme review. This will include all discretionary spend, agency/locum spend, supplies and consumable spend and delegated commitment range and levels.
- Details of how the provider is reviewing:
    - ❖ The affordability of planned investments to improve service quality and performance;
    - ❖ The acceleration of the delivery of productivity opportunities identified by the Carter Review;
    - ❖ The acceleration of proposals for sub-scale service consolidation or closure;
    - ❖ The impact on patient safety and experience of recovery actions;
- The demonstration of quarter on quarter improvement in income and expenditure run-rate from the point the revision is submitted and how Cost Improvement Programmes (CIP) delivery is being maximised.

2.5 When a formal revision to outturn forecast under this protocol is made through the national reporting process, it must be accompanied by an Assurance Statement signed by the NHS trust/ foundation trust Chair, Chief Executive, Director of Finance, and Audit Committee Chair in respect of the organisation's adherence to this protocol and their commitment to the delivery of the recovery plan. This statement will be addressed to the Chair and Chief Executive of NHS Improvement and will be formally reported to NHS

Improvement's Board.

2.6 Monitoring arrangements will be determined by the Executive Regional Managing Director to ensure that focus and delivery is maintained.

Board of Directors	
Agenda Item	9.1.4
Title of Report	2019/20 NHS Operational Planning Guidance
Date of Meeting	30th January 2019
Author	Karen Edge
Accountable Executive	Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
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 Impact Assessment Undertaken • **Yes** • **No**	No

2019/20 Planning Guidance Update

Introduction

Interim planning guidance was published on the 21st December with the final guidance being issued on the 10th January and control totals being advised on the 15th January. This is later than anticipated and the full impact analysis is yet to be completed to inform the Trust Operational budget for 2019/20.

The guidance recognises the £20.5bn investment the Government has committed to the NHS by 2023/24 and which is conditional upon the development of a Long Term Plan. 2019/20 is the foundation year which will see changes to the financial framework in which NHS providers operate and the expectations in respect of service delivery and improvement.

The Trust is required to submit an interim plan on the 12th February with the final plan being due on the 4th April.

There follows the key points from the guidance and early indications of the impact of the control total on the Trust.

System Planning

A system operating plan at STP level is required; this will include an overview document outlining key deliverables and detailing activity assumptions, capacity, efficiency, workforce and winter plans. Additionally, a system data aggregation exercise showing provider and commissioner activity alignment and phasing of elective and non-elective will be required.

System control totals will be set for each STP and will be the sum of individual organisation control totals. Net-neutral changes can be agreed subject to approval by Regional Directors.

Financial settlement

The uplift in national tariff is set at 3.8% and includes the costs of the Agenda for Change pay reforms centrally funded in 2018/19 and the impact of changes to the Clinical Negligence Scheme for Trust contributions in 2019/20.

A proportion of the Provider Sustainability Fund (PSF) c40% has been transferred into tariff prices and the impact of this is excluded from the 3.8% uplift. This equates to £1bn nationally.

CQUIN will be reduced by 50% to 1.25% with the balance being transferred into tariff prices and the impact of this is excluded from the 3.8% uplift. In addition, the CQUIN scheme will be simplified focusing on a smaller number of indicators which support national policy objectives.

The increase to the NHS employers pensions contributions advised by Government will be resourced separately by a central funding allocation.

The national efficiency factor will be 1.1%, bringing the net tariff uplift to 2.7%.

A new approach to payment for emergency care is to be introduced. The 'blended' approach will cover A&E attendances, ambulatory emergency care and non-elective admissions. It comprises a fixed element

of 100% of the value of expected activity with a variable element set at 20% for activity above and below this baseline.

The Marginal Rate Emergency Tariff (MRET) and the 30-day readmissions rules are to be abolished. Those providers, including WUTH, who are still subject to these penalties in contracts, will receive this funding centrally in order that it is cost neutral between commissioners and providers.

The Market Forces Factor (MFF) has been revised and the impact on providers is to be transitioned over 5 years and is included in the Tariff prices rebasing.

Financial framework for Providers

2019/20 is the first year of the financial reset which aims to move all providers back to financial sustainability and builds towards the removal of control totals in 2020/21.

Control Totals will be rebased for all providers in 2019/20. They will be stretching, deliverable and reflect the changes in tariff and the financial architecture.

Provider Sustainability Funding (PSF) is to be reduced to £1.25bn and will be available to those Trusts that accept their control total. It will be earned by reference to delivery of the control total as the single measure.

A Financial Recovery Fund (FRF) is to be introduced to support those providers with historic deficits to move to financial sustainability and is dependent upon acceptance of the control total. This is non-recurrent funding with the aim being to move providers into recurrent balance through an agreed financial recovery plan over a number of years.

For providers in deficit, there is an expectation that a further 0.5% efficiency, over and above the 1.1% tariff efficiency, will be delivered and this is a component part of the control total.

Providers who sign up to control totals will be exempt from most contract financial sanctions.

Productivity and Efficiency

The minimum efficiency ask of the NHS is 1.1% per year over the next 5 years. There is an expectation that there is a focus on enabling greater staff productivity through both digital technology and transforming models of care to patients.

Systems will be required to work with the NHS Rightcare programme on the national priority initiatives for Cardiovascular and Respiratory conditions in 2019/20. A further pathway should also be selected locally.

National guidance to standardise and limit access to 17 evidence-based interventions is to be introduced, focusing on those treatments that should only be undertaken in exceptional circumstances or where specific clinical criteria has been met.

Provider efficiency plans should be focused on opportunities identified through the Model Hospital and the GIRFT programme. Key areas that should be addressed include:

- Transformation of Outpatient services including digitally enabled models of delivery
- Clinical workforce productivity including e-rostering and e-job planning standards
- Procurement savings through the NHS benchmarking tool (PPIB)
- Estates optimisation including energy efficiency and space utilisation
- Corporate services including simplification of the contracting process and reducing transactional costs
- Rollout of pathology and imaging networks
- Medicines optimisation including electronic prescribing and biosimilars

NHS Standard Contract

The final version of the contract will be published in February and the national deadline for signature of existing contracts is 21st March. Where agreement cannot be reached, there will be a dispute resolution process, however given the focus on system working, entering this process will be seen as a failure of local system relationships and leadership.

New arrangements will apply for contract sanctions for 52-week breaches whereby there will be financial sanctions for both commissioner and provider of £2,500 each per breach, the use of the withheld funding will be determined by regional teams.

Operational plan requirements

The long term plan notes a number of priorities in transforming urgent and elective care. The operational standards for RTT, A&E and Cancer remain although they will be subject to a Clinical Standards Review that will report recommendations in year. The deliverables that require trajectories in 2019/20 include:

- A model of Same Day Emergency Care (SDEC) should be introduced that increases the proportion of acute admissions discharged on the same day from a fifth to a third. The model should be embedded and operating 12 hours a days, seven days a week by September 2019. The activity is to be recorded through a new dataset.
- Further improvements in long stay patients (>21 days) bed occupancy and local targets for >7 days and >14 days length of stay.
- Continued reductions or maintenance in the delayed transfers of care (DToC) rate.
- UTC's should meet minimum standards
- Zero tolerance of >30min Ambulance handover and no corridor care
- Faster treatment at an alternative provider should be offered to those patients waiting more than 6 months
- Improvement in the waiting list position
- No >52-week breaches
- Collection of 28-day faster diagnosis standard for Cancer services

WUTH Financial Control Total and PSF, FRF and MRET funding for 2019/20

The Trust control total is £0.0m break-even and the assumed changes from the rebased baseline position of £25m are outlined in the table in Appendix 1.

The key points to note are that the starting point for the movements is an underlying expected baseline of £25.0m. This is in line with the Trust plan for 2018/19 and hence assumes a realistic, although stretching position from which to progress.

The impact of changes to prices which comprise, PSF, CSNT and other changes (MFF, inflation and price relativities) move the position to ££20.5m deficit. The Trust is currently running the new prices through the commissioning software to confirm the actual impact.

A further efficiency ask of 0.5% for those providers in deficit equates to an expected improvement of £1.7m, moving the position to £18.8m.

MRET central funding relating to the abolition of MRET and 30-day readmission sanctions of £6.3m moves the position to £12.5m deficit. This is expected to be transferred into resources in 2020/21.

Provider Sustainability Funding (PSF) dependent upon acceptance of the control total reduces the deficit by £6.9m to £5.7m. PSF is non-recurrent and subject to future reforms.

The £5.7m deficit position is the recurrent position for the Trust prior to national support through the Financial Recovery Fund which brings the position and control total to break-even.

The changes to the financial framework are complex and need to be worked through in detail prior to the Board being asked to consider acceptance of the control total.

A further update will be provided to FBPAC in February prior to the draft operational plan submission and to Board on the 2nd April prior to the final submission on the 4th April.

Appendix 1

Financial control total	£ million
Rebased baseline position excluding PSF	**-25.042 Deficit**
£1bn PSF transferred into urgent and emergency care prices	7.319
CNST net change in tariff income and contribution[1]	-0.479
Other changes[2]	-2.331
Subtotal before efficiency	**-20.533 Deficit**
Additional efficiency requirement up to 0.5%	1.729
2019/20 control total (excluding PSF, FRF and MRET funding)	**-18.804 Deficit**
MRET central funding	6.282
Subtotal before PSF and FRF allocations	**-12.522 Deficit**
Non recurring PSF allocation	6.872
Subtotal before FRF allocation	**-5.650 Deficit**
Non recurring FRF allocation	5.650
2019/20 control total (including PSF, FRF and MRET funding)	**0.000 Breakeven**

Board of Directors	
Agenda Item	10.2
Title of Report	Report of the Charitable Funds Committee
Date of Meeting	30 January 2019
Author	Sue Lorimer, Chair of the Charitable Funds Committee
Accountable Executive	David Jago, Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8. Strategic Objective – Enabled by financial, commercial and operational excellence
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
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 Charitable Funds Committee 23 January 2019

This report provides a summary of the work of the Charitable Funds Committee which met on 23 January 2019.

1. Head of Fundraising Report

Progress since October has included the *Christmas lights switch on* and *National Elf Service Day* based at Arrowe Park and examples of community-led and staff-led fundraising. The APH Charity Office opening has been slightly delayed due to complications with contractors, but

should be open within February, and a *contactless donation point* will be installed shortly afterwards. There have now been a number of volunteer sign-ups, and interviews for the Community and Events Fundraiser are being held in the first week of February. The Committee were pleased to note the positive engagement of staff in fundraising initiatives initiatives.

2. Appeal

The fundraising and finance team are now confident that the Charity having laid good groundwork is ready to progress a funding appeal. The Director of Finance led a scoping exercise for items to raise funds for but had limited response. Two recently emerging options are for works at the Neonatal Unit and Children's Outpatients.

The pros and cons of each option were discussed in detail, with particular regard to the risks and opportunities of partnership working with IncuBabies (independent charity) on a Neonatal Unit appeal. This proposal had support from EMT, the Charity team, and the division.

Approval was granted to pursue 'due diligence' governance measures in relation to working with IncuBabies on the *more significant* Neonatal Unit proposal including drafting 'terms of engagement' documentation and further investigation of the project plans. Whilst this work is being undertaken, appeal preparation tasks (detailed 'private phase' planning) will be undertaken by the Head of Fundraising, which will enable the Charity to move with pace once a final decision is reached.

3. Finance Report

The income, expenditure and closing positions, as at 30 November 2018, for each of the Charity's 'Big 8' funds were reviewed, and results were consistent with previous reports. A new basis for the apportionment of overheads to the 8 funds was approved, as was a variation to the Charity's Treasury Management Policy that will permit greater returns on funds held.

4. Research Expenditure

A paper addressing the governance of research expenditure for NHS charities was presented for noting and discussion. This was as in response to questions from the Committee regarding the exclusion of fundraising for research expenditure in the Trust's Charity Expenditure Guidance document. The paper set out the issues to be addressed should the Trust decide to lift the exclusion and the potential governance risks. It included a case study and prevailing Charity Commission guidance. The Committee agreed that the expenditure guidance document would be reviewed again should there be a clear opportunity for research fundraising but was content to allow the exclusion to remain for the time being.

5. Annual Report and Accounts 2017/18

The Charity's Annual Report and Accounts was signed on behalf of the Corporate Trustee. The quality of the report was commended, with the *Achievements* section showing to stakeholders the effect that donations can make to patient care.

6. Recommendations to the Board of Directors

The Committee wishes to bring to the Board's attention the following items.

- Recommendation of the Charity's Annual Report and Accounts 2017/18 for final approval.
- A 'direction of travel' has been established in terms of the appeal to commence in 2019, with 'due diligence' and detailed planning work already underway.

Board of Directors

Subject:	Proceedings of the Trust Management Board	**Date:** 23/1/19	
Prepared By:	Andrea Leather, Board Secretary		
Approved By:	Janelle Holmes, Chief Executive		
Presented By:	Janelle Holmes, Chief Executive		
Purpose			
For assurance		**Decision**	
		Approval	
		Assurance	**X**

Risks/Issues	
Indicate the risks or issues created or mitigated through the report	
Financial	**Risk associated with non-delivery of financial control total based on M9 outturn.**
Patient Impact	**Several areas currently represent a potential risk to quality or safety of care – exposure to infection, venous thromboembolism prevention, nursing vacancy rates and complaints responsiveness in line with policy and water safety management.**
Staff Impact	**Staff vacancy, attendance management and completion of core-10 mandatory training requirements represent a risk to workforce effectiveness**
Services	**None identified**
Reputational/ Regulatory	**Several areas currently represent a potential risk to compliance with CQC Registration Regulations – particularly those areas highlighted under patient impact above.**

Committees/groups where this item has been presented before

Trust Board, PSQB

Executive Summary

1. **Executive Summary**
   - The Trust Management Board (TMB) met on 23/1/2019. This paper summarises the proceedings of the TMB and those matters agreed by the TMB for escalation to the Board of Directors.

2. **Quality, Performance and Use of Resources Dashboard**
   - TMB received the revised Quality Performance Dashboard in the new format covering the 9 months ended 31st December 2018.
   - There are currently 34/58 indicators in the new dashboard outside tolerance.
   - The metrics included are under review with the appropriate Director to consider the appropriateness and value of inclusion, and also the performance thresholds being applied. A revised version of metrics and performance will be included in future reports to the Board of Directors, as the changes to metrics are approved.
   - TMB noted the proposed changes regarding the criteria for requiring an exception reports, or Issue, Decision, Action (IDA) summary:
     - any metric that newly fails its threshold for two consecutive months
     - the initial IDA also now requires an expected date of achievement of threshold. If a metric does not achieve by that expected date, an updated IDA summary would also be required.
     - to provide assurance on all performance measures not achieving threshold, on a quarterly basis all metrics that have been 'Red' for the preceding six months would require an updated IDA summary. The next quarterly IDA summaries on such metrics will be in April 2019, on performance up to and including March.
   - Whilst progress is being made across a number of indicators TMB considered the matters of concern for escalation, in particular:

- **VTE.** *TMB noted the escalation regarding VTE indicator and the positive impact the revised IT process is having to support compliance.*
- **Medicines Storage.** *TMB recognised the different approaches to interpreting the metrics for this indicator, these have now been rationalised. It should be noted that due to the change in metrics the indicator may remain the same for January and February should see an improvement. Benchmarking exercise to be undertaken to gain clarity regarding metrics and thresholds at other Trusts, feedback to be provide at a future meeting.*
- **Safer bundle – stranded patients.** *TMB requested report to next meeting outlining process to manage patient, escalation process and the trajectory for improvement.*
- ***Referral to treatment – cases exceeding 52 weeks**. Report to be provided to next meeting summarising issues (internal / external) and changes that could be implemented to achieve national target.*
- **Hand hygiene**. *TMB acknowledged the drop in compliance and noted this was as a consequence of a more comprehensive monitoring. Interim support has been introduced to support IPC with implementation of new processes and more prominent signage to be launched.*

3. Use of Resources

- M9 deficit – off plan by £3.8m
- Deficit is being driven by lower than planned elective and day case activity.
- Divisions working with finance business partners to agree actions to get activity back on track.

4. Natural Gas Supply

- TMB recommendation to Board of Directors to approve the proposal to procure its supply of gas for 4 years through the COCH framework.

  NOTE: As the contract must be awarded by January and would normally have been considered at FBPAC prior to Board the business case was shared with FBPAC members for consideration ahead of the meeting.

5. Attendance Management Solutions

- TMB considered the proposal to introduce an additional approach for reducing absence from the workplace which would be complimentary to the Trust's Attendance Management policy and associated managerial HR&OD activities.
- TMB approved in principle with proposal to be considered at next FBPAC. Consider potential opportunity to include as operational plan CIP for 2019/20.

6. Accommodation and Tax Implications

- TMB approved the benefit in kind accommodation process.

7. Retirement Policy

- TMB considered the revised Retirement policy and process.
- Whilst TMB agreed in principle to reduce the 'retire and return' leaver period which does not break continuous service they requested a further revision to the policy be presented at a future meeting before approving.
- Further revision to policy to capture leadership sign off ie triumvirate, option to approve for a 12 month period and then reviewed annually – what impact would this have on retention / succession planning. Appendix 1 – process to clearly define who has what responsibilities.

8. Report of the Finance & Performance Group

- TMB received and considered the report from the FPG meeting held on 14/12/2018.
- The report outlined the month 8 financial position (including CIP), cancer activity and delivery plan and the capital finance report.

9. Report of the Patient Safety & Quality Board

- TMB received and considered the report from the PSQB meeting held on 20/12/2018.
- TMB noted the positive performance progress to date and the indicators that are the focus for improvement.
- TMB were advised of the progress made to water safety management following the escalation of compliance concerns in the previous meeting. It was confirmed at PSQB that **for the month ending 30th November 2018 the Trust had achieved 95% compliance with twice weekly flushing of low use water outlets – reported as the highest ever achieved at the Trust**. There remained some concern regarding compliance within Delivery Suite and Occupational Therapy which are being investigated by the respective Divisional Directors of Nursing for those areas.

10. Report of the Risk Management Committee

- TMB received and considered the report from the Risk Management Committee meeting held on 17/12/2018.
- The significant progress to date was noted whilst it was acknowledged that risk owners continue to develop their risk profiles these would be finalised by end of January '19.
- The risk profile for the Trust being developed which will culminate with the 2019/20 BAF.

11. SOP – Criteria for Admitting patients to Ward 1 and Cardiac Day Ward

- TMB considered the SOP's to admit patients to Ward 1 and the Cardiac Day Ward, it was agreed that the 'low acuity' patients needs to be clearly defined in both SOP's. Process needs to specify that patients may only be moved to these wards if due for discharge the next day and outline the escalation process. Revised processes to be discussed at EMT.

Written on behalf of the Chief Executive by
Andrea Leather
Board Secretary
25/01/2019

BOARD OF DIRECTORS	
Agenda Item	10.4
Title of Report	Report of Workforce Assurance Committee
Date of Meeting	30.1.2019
Author	John Sullivan
Accountable Executive Director	Helen Marks
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	
Level of Assurance	Gaps
Purpose of the Paper	To note
Reviewed by Executive Committee	Workforce Assurance Committee
Data Quality Rating	
FOI status	Minutes may be disclosed in full
Equality Impact Assessment Undertaken	

1. Background

The sixth meeting took place on Tuesday 22nd January 2019. The committee unfortunately had two out of three NEDs absent and was therefore not quorate.

2. Key Agenda Discussions

2.1 Chair's Business

The Chair introduced the NHS Long Term Plan issued since the last meeting. And in particular Chapter 4 titled ***'NHS staff will get the backing they need'***. The chapter has eight sections:

- A comprehensive new workforce implementation plan
- Expanding the number of nurses, midwives, AHPs and other staff
- Growing the medical workforce
- International recruitment
- Supporting our current NHS staff
- Enabling productive working
- Leadership and talent management
- Volunteers

It was proposed and agreed to complete a gap analysis of the WUTH Workforce improvement agenda with the NHS Long Term Plan and present conclusions and recommendations at the next Workforce Assurance Committee.

2.2 Staff Story

The committee received a staff story from a disabled part time long serving member of WUTH staff. The story highlighted the needs of disabled staff who return to work after a disabling absence as well as areas of poor and good management practice at WUTH. Sharon Landrum (Diversity & Inclusion Lead at WUTH) supported the presenter and highlighted the positive role being played by this staff member in the newly formed WUTH Disability Staff Network. The committee agreed it was a powerful reminder of how far the management of WUTH staff with disabilities needs to change. However, the new approach to managing long term sickness absence will assist in these changes. The committee thanked the staff member for her courage and contribution to improvements in how staff with disabilities is managed in future at WUTH.

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2.3 Cycle of Business

The Executive Director of Workforce presented a forward calendar of Committee topics and reports. The structure and clarity of future agenda items were welcomed.

2.4 Workforce Agenda --- report from the Surgery Division

The Surgery Division leadership were represented by Jo Keogh, Divisional Director, Dylan Edwards, Divisional Director of Nursing and Becky Thompson, HR Business Partner. The improvements in long term sickness case management and staff communications were recognised. It was highlighted that Theatres was the area of most workforce concern within the Division. High levels of short term absence, cultural and behavioural issues were reported as an issue. A sense of isolation from the rest of the Division and the Trust was also discussed. The Committee agreed to use the upcoming 2018 Staff Survey results to examine values and behaviours responses in this particular of the Trust of most workforce concern.

2.5 Health and Well Being

The committee received a comprehensive report on the work being undertaken in relation to Staff Health and Well Being. The committee noted and supported the work being done to sustainably improve the sickness absence position.

However, the committee expressed its concern regarding the number, nature and costs of the reportable lost time injuries at the Trust. A rule of thumb estimate of the real total cost of the current lost time injury performance is ~ £ 5 million / year. The committee supported the approach to conduct an independent Health & Safety Audit including an analysis of the lost time injury incidents and subsequent compensation claims.

2.6 Band 5 Nursing 'deep dive' --- recruitment and retention

The committee received an outline of the current position for band 5 nurse vacancy levels, the challenges the Trust faces in recruiting and retaining these staff and the actions being taken in response to this. Although the Trust band 5 vacancy levels are better than the national average, we are still far short of our ideal numbers and this issue is particularly significant in the Medicine & Acute Division.

The external environment for nurse recruitment will remain challenging for the foreseeable future and the numbers retiring will not abate soon. The Trust recognises the challenges it is facing and is taking pro-active steps to address the situation. A new Recruitment & Retention Working Group will also provide the oversight and governance of the various work streams established to improve the Trust's position.

It was acknowledged the good work of the comms and engagement department in relation to the new recruitment campaigns and recognition from NHS England as an exemplar.

2.7 Workforce Risk Register

The Trust's workforce risks have been described and reviewed and all relevant risks have been input to the Trust's risk management system. Work will continue with the Risk Team to identify, monitor and control the Trust's workforce risks.

2.8 Workforce Dashboard

The Workforce KPIs were reported to the committee. The committee noted the recent improvements in staff appraisal rates and recognised Women & Children's Division for now meeting the Trust's target compliance.

3. Review of meeting

Members of the committee highlighted the staff story, the planned structure of the future meetings and the Division in person reports as extremely positive. However, it was suggested for the need for more scrutiny, which may have been limited to the absence of NED colleagues on this occasion. It was also proposed that there needs to be a prudent control of workforce risks.

4. Next Meeting

27th March 2019 2pm to 4pm

5. Recommendations to the Board of Directors

- To note the contents of this report
- To support the approach to undertaken an independent Health & Safety Audit
- To continue to support the mitigation and control of workforce risks e.g. large number retirements and employee engagement

BOARD OF DIRECTORS	
Agenda Item	10.5
Title of Report	Report of Quality Committee
Date of Meeting	24.1.2019
Author	John Coakley
Accountable Executive Director	Medical Director / Director of Nursing & Midwifery
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	
Level of Assurance	Gaps
Purpose of the Paper	To note
Reviewed by Executive Committee	Quality Committee
Data Quality Rating	
FOI status	Minutes may be disclosed in full
Equality Impact Assessment Undertaken	

1. Background

The meeting took place on Thursday 24th January 2019. The committee was quorate.

2. Key Agenda Discussions

2.1 CNST Maternity Incentive Scheme Year 2

In 2018/19 the NHS Resolution CNST discount scheme resulted in a Trust discount of approximately £1million. Year 2 of the scheme for 2019 - 2020 was launched in December 2018 and is worth a potential £590k reduction. This year's criteria is more demanding than last. The Board need to be aware of this scheme and approve it. The committee noted the requirements and actions to date:

- Evidence to demonstrate that the Trust has transitional care services to support avoiding term admissions to the NICU
- Evidence that the safety champions (obstetrician and midwife) meet bimonthly with the Board level champion who will sponsor MNHSC and implement monthly feedback to staff.

The Director of Nursing and Midwifery is the Executive Sponsor of Maternity Safety. The Quality Committee will receive further updates on the scheme on behalf of the Trust Board in 2019 prior to final submission to NHS Resolution in August 2019. The Chair of QC has volunteered to be the Board level champion for this programme.

2.2 CQC Action Plan Assurance

The CQC quality improvement plan has 225 specific items to address all the concerns by 31st March 2019. Since September the number of blue items (embedded) has increased from three to 112, green (on track) decreased from 151 to 108 and red (overdue) decreased from 75 to five. This is good progress.

2.3 CQC Insight Tool

This tool gives trusts an overview of how the CQC sees their organisations. There is a significant amount of information contained within the tool, not all of it accurate or timely.

There have been concerns about how information is submitted and there is now Executive Director sign off of information prior to submission to check for errors and omissions. There are also concerns about the relevance and timeliness of some of the items, which can be over a year out of date. The Director of Quality & Governance now checks this tool on a regular basis.

2.4 Terms of Reference

The revised Terms of Reference were approved.

2.5 Progress

There has been progress or clarity on the following items:

- Adherence to NICE guidelines
- Medicine storage
- VTE prophylaxis

- Water safety management
- Overnight bed moves
- Pressure ulcers
- Ward accreditation
- Serious incident management

2.6 Areas for escalation

- Mortality reviews
- Infection control
- Hand hygiene
- Bedding in of revised palliative care staffing

3. Next Meeting

26th March 2019 9am to 11am

4. Recommendations to the Board of Directors

- To note the contents of this report.
- To approve CNST Maternity Incentive Scheme Year 2 and note the Chair of QC to be the Board level champion for this programme.
- To note the revised Terms of Reference.

Board of Directors	
Agenda Item	10.6
Title of Report	Report of Programme Board
Date of Meeting	30.1.2019
Author	Joe Gibson, External Assurance Natalia Armes, Director of Transformation & Partnerships
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

1. **Executive Summary**

This report provides a summary of the Trust's change programme and the independent assurance ratings undertaken to assess delivery. This report has been discussed at the Programme Board Meeting (the membership of which includes two non-executive directors) held on Wednesday 16th January and the intention is this reporting format will be provided on a monthly basis. The Board of Directors is asked to note this change programme assurance report and determine any required changes to the reporting format and specify any programmes of interest that require further discussion at Board.

2. **Background**

This report is intended to provide the Board of Directors with an accessible oversight of the Trust's performance of the Improvement Programmes of work against key assurance measures. The report has been undertaken by Joe Gibson, External Assurance and provides a detailed oversight of assurance ratings per programme along with the independent assurance statement and programme delivery narrative including key milestones and performance against intended benefits.

The Change Programme Assurance report is work-in-progress and will develop further iterations over time. This will include development of benefit trajectories and SPC charts so there is visibility of progress across all improvement activities and this is measureable at a process and outcome level.

Please refer to the first two pages of the Change Programme Assurance Report which provides a summary of each Programme and highlights key issues and progress.

3. **Next Steps**

WUTH remains committed to the delivery of all Improvement Programmes detailed within the report and will continue with external assurance processes to maintain visibility of progress

4. **Conclusion**

Performance against the assurance indicators across all programmes is not where the Trust needs to be. The actions to improve are noted in the assurance statements of this report and continued independent monitoring will continue to measure progress and provide assurance.

5. **Recommendations**

The Board of Directors are asked to note the Trust's Change Programme assurance report and determine any required changes to the reporting format and specify any programmes of interest that require further discussion at Board.

Change Programme Assurance - Trust Board Report - January 2019

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Workforce Planning

- The 'Workforce Planning' programme of work was initiated at the Programme Board on 20 Dec 18; to date no assurance evidence has been submitted to External Programme Assurance.

Improving Patient Flow

- The 'Commend Centre' project work is still being held up due to delays in the upgrade to Millennium by Cerner; it is understood that this is now planned to go ahead on the 18 Jan 19. The plan for the 'Command Centre' beyond the Millennium upgrade has now been submitted for External Programme Assurance and shows a 'go live' date of June 2019..
- The patient flow work stream has now been divided into two programmes: 'Ward Based Care for Earlier Discharges' and 'Transformation of Discharge Services'
- Across the work stream the 3 programmes are all rated 'amber' for governance and 'red' in terms of delivery.
- The Programme 'Digital Care Pathways' is yet to be initiated at Programme Board.

Operational Transformation

- The 'Perioperative Medicine Improvement' programme is reporting key performance indicators are off track and the programme needs to develop a detailed plan for 2019/20.
- The 'Outpatients Improvement ' programme has cemented the governance requirements; however, initial benefits realisation (quick measures to support the 2018/19 plan) has not made the difference that was hoped for so the team is re-doubling efforts on short term gains and has postponed drafting of the long term plan for one month while doing so.
- The 'Diagnostics Demand Management' continues to mature and has drafted a good early expression of benefits. Good engagement is reported with AMDs and a wider project board is being convened for early March to gain full clinical engagement and focus on potential quick wins.
- The 'Paperless' programme of work is yet to be defined and initiated at Programme Board.

Partnerships

- While aspects of the governance of the 'Womens & Childrens' partnership programme with CoCH are amber rated, the delivery remains red rated due to the lack of a current plan; however, recent meetings were focused on addressing this issue and evidence is awaited.
- The Healthy Wirral 'Medicines Management' programme continues to be amber rated for governance and the delivery remains red rated due to the absence of a plan. The 'Biosimilars' savings target of £500k is reported as 50% - £250k - delivered.
- For the 'WWC Alliance: pathology' programme, significant assurance evidence has been received since the last report and further evidence has been received since these ratings were compiled. The result is that both governance and delivery have now moved from red to amber rating.

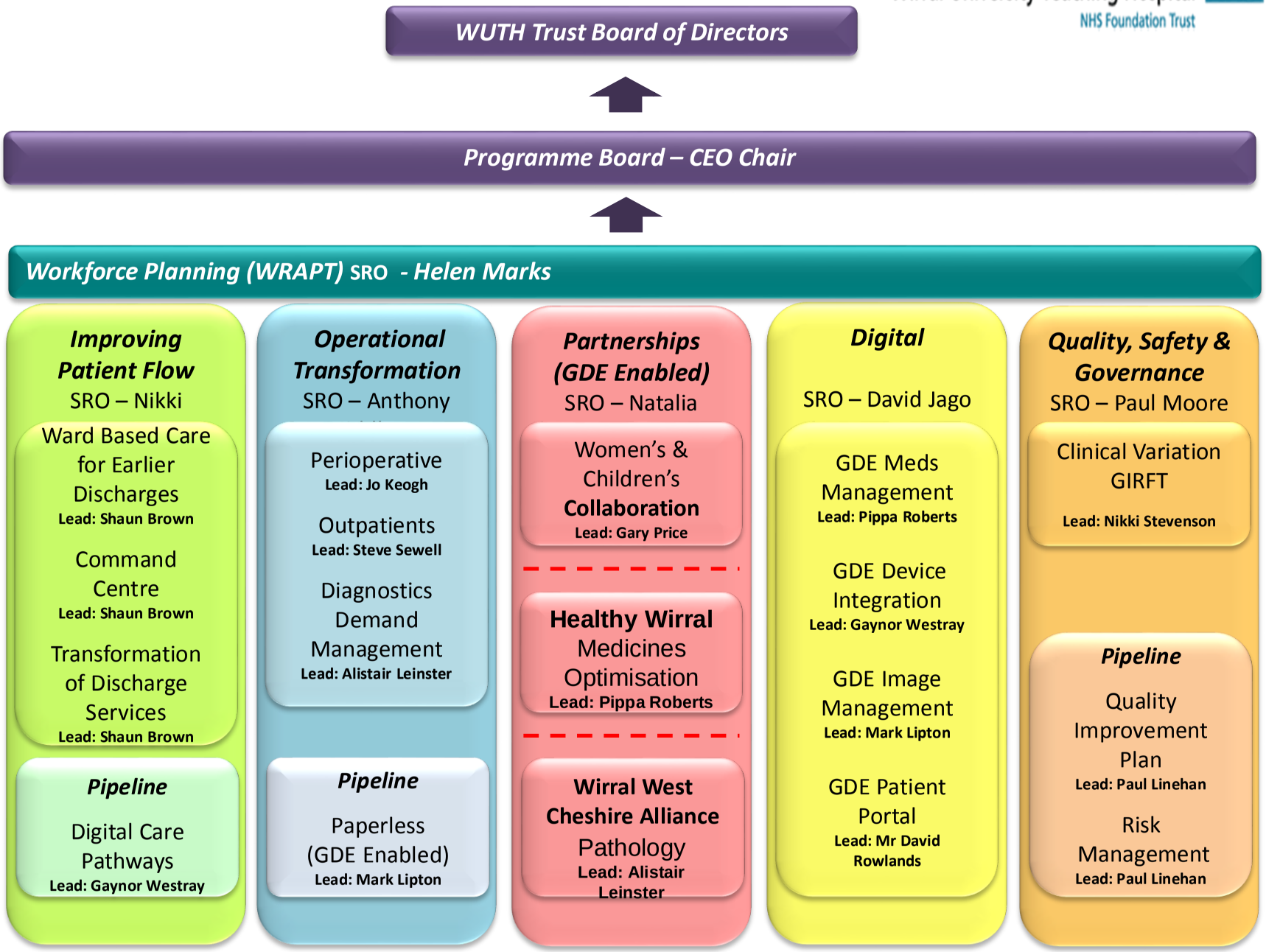
Digital

- 'GDE Medicines Management' project is amber rated for governance and red rated for delivery; the key issue is a lack of defined benefits.
- 'GDE Device Integration' project is remains red rated for both governance and delivery; the key issue of a lack of credible measures for success.
- 'GDE Image Management' project is red rated for both governance and delivery; the key issue is a lack of defined benefits.
- 'GDE Patient Portal' project is amber rated for governance and has 3 green ratings for delivery; however, the overall rating for delivery remains red due to the absence of any measurable success criteria for the project.
- External Programme Assurance has provided additional guidance and advice to GDE project managers – re- the assurance ratings – at a session on 27 Nov 18 and subsequently.

Quality, Safety & Governance

- The programmes for 'Clinical Variation GIRFT' is yet to submit any evidence for External programme Assessment.

Wirral University Teaching Hospital NHS
NHS Foundation Trust



Command Centre Programme Assurance Update – 10th January 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Shaun Brown	Katie Bromley	Fully Developed	Amber	Red

Independent Assurance Statement

1. The PID lacks metrics by which benefits will be measured. **2. & 3.** Evidence of documented project meetings is now out of date vis-a-vis the governance described in the PID; this is assumed to be due to the hiatus caused by the Cerner implementation slippage. **4.** The PID outlines a comprehensive communications plan but this needs to be tracked. **5.** There is no EA/QIA. **6.** Further delays have been reported regarding the Cerner implementation and the latest CapMan Plan v0.2 20181211 shows Conversion (GO LIVE DATE) as 17 Jun 19. **7.** As described above, there are no metrics for the benefits to be measured by. **8 & 9** There is a RAID Log but it is undated (and without a version number) and there is no 'date of last review' information for the risks. **Most recent assurance evidence submitted 11 Dec 18.**

Programme Title	Programme Description	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
Command Centre	To implement a new real time bed management system, including a re-design of all relevant processes and practices to enable accurate reflection of the bed state											

Programme Board

Patient Flow Improvement Programme: Command Centre

Wirral University Teaching Hospital NHS Foundation Trust

Programme Overview (Rationale and Impact)

The key aim of this programme is to improve the overall patient flow within the Trust by not just implementing the technology but working with all the impacted staff to establish consistent and efficient ways of working. The first phase of this programme is focussed on the Acute hospital bed base, but further phases will provide a system wide view to enable real time reporting of all health economy beds.

Currently within Wirral University Teaching Hospital bed tracking is done by time consuming manual processes and the Bed Management team are unsure of the current state of beds within the hospital at any one time resulting in constant phone calls and visits to the wards and meetings to find out potential discharges and free beds. The Trust struggles to manage patient flow in an efficient manner as the information required to do so is not readily available to the right teams. This contributes to a significant amount of time lost for Operational and clinical staff which could be utilised on direct patient care and also impacts the 4 hour Urgent Care Standard.

The technology will provide the staff with a real time and accurate view of the patient bed state and will automatically generate and allocate tasks to the relevant teams (including porters & cleaning teams) which will reduce the time spent arranging these activities, delays in response times and free nursing staff to perform more direct care. Ultimately this should enable patients to be moved to the appropriate bed or discharged more efficiently improving flow through the hospital and providing ED with egress from the department in order to free up ambulance crews.

Programme actions on 'Assurance Statement'	Target date
• Whilst delivery of the IT element of the programme remains uncertain, the process and culture workstreams will be re-launched from January. • The PID will be reviewed to ensure it reflects the re-launched projects	• Tba • Tba

Programme Progress/Milestones

- Due to the delay of the Cerner upgrade, the capacity manager test system will potentially not be available until February. This has resulted in a delay with the overall programme, however, the Patient Flow Improvement Group has tasked the team with moving forward on the process and culture elements.
- Whilst the IT delivery element of the plan is available, the wider programme plan has yet to be developed. The Programme will re-launch in the new year to re-engage with the workstream leads as identified during the initial launch.
- There have also been some intermittent problems with the electronic whiteboards which has been escalated to Cerner, and a re-launch of these is proposed in January in line with the Ward Based Care for Earlier Discharges project.

Items for Escalation to the Programme Board (recommendations for action)

Transformation of Discharge Services Programme Assurance Update – 10th January 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Shaun Brown	Katie Bromley		Amber	Red

Independent Assurance Statement

1. The scope document comprises the 'Transformation of Discharge Services Sustainability Programme Diagram' (Issue date November 2017). **2.** Project Team names need to be completed on this dashboard. **3.** The 'Transformation of Discharge Services Sustainability Programme Board' has Terms of Reference (v2 dated April 2018) which need an 'issue date' and there is also an action log; however, notes or minutes of the monthly meetings would add to the governance and audit trail (e.g. for EA/QIA). **4.** There is stakeholder map but this dates from Sep 2017 and will need to be re-validated as still accurate and relevant; however, there is no evidence of a communications plan or wider staff engagement. **5.** EA/QIA have been completed for an 'Independent Provider Led Discharge Unit'. **6.** There is a 'Transformation of Discharge Services Sustainability Plan' v0.5 which commenced in April 2017 and is due to complete by 30 July 2019. **7.** KPIs show information from August 2018 but nothing more recent and the tracking mechanisms are not clear. **8 and 9.** Risks and issues are featured in a RAID Log which is undated; it is understood that the risks will be reviewed at the next project meeting. **Most recent assurance evidence submitted 8 Jan 19.**

Programme Title	Programme Description	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
Transformation of Discharge Services	To reduce patients length of stay in acute hospital beds by early identification of patients able to be discharged through transfer to assess home and bed based pathways.		●	●	●	●	●		●	●	●	●

Ward Based Care for Earlier Discharges – 10th January 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Shaun Brown	Jane Hayes-Green		Amber	Red

Independent Assurance Statement

1. Scoping document available as endorsed at the Programme Board on 20 Dec 18; a PID or equivalent will be required. **2. & 3.** Names of the project team on this dashboard are now completed. An agenda and minutes for the Ward Based Care for Earlier Discharges meeting of 19 Dec 18 are in evidence. **4.** ToRs for the governing project group are available. **5.** No EA/QIA available to date. **6.** A High level Plan was presented with the scoping document, a 'trackable' detailed plan is required in addition. **7.** KPIs are defined within the scoping document but there is no evidence, to date, of tracking available for assurance purposes. **8 & 9.** There is no evidence of risk and issue management to date. **Most recent assurance evidence submitted 9 Jan 19.**

Programme Title	Programme Description	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
Ward Based Care for Earlier Discharges	Patients are able to access the right care at the right time in the right place		●	●	●	●	●		●	●	●	●

Programme Board

Patient Flow Improvement Programme: Ward Based Care for Earlier Discharges/ Transformation of Discharge Services

Wirral University Teaching Hospital NHS Foundation Trust

Programme Overview (Rationale and Impact)

This programme is a Trust wide response to improving patient flow by focussing on reducing length of stay for our patients, particularly those who have been in an acute bed for over 7 days, and reducing delays on the day of discharge to enable 33% of patients to be discharged by noon. This is an NHSi target which if achieved will support:

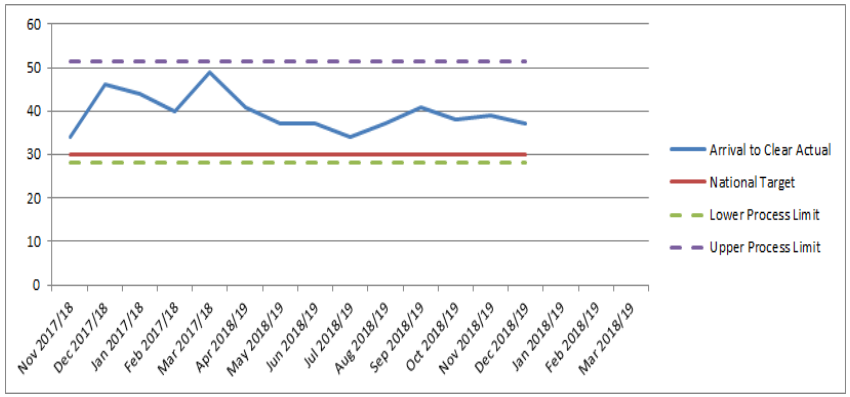
- A reduction in non clinical delays to discharge.
- A reduction in bed occupancy levels which will provide the flexibility within the acute bed base to move admitted patients to the most appropriate bed at all time.
- Better flow of admitted patients out of AED and ACU.
- An improvement in ambulance handover times, thereby minimising any delays in NWAS crews being released to respond to emergency calls.

The programme includes 2 workstreams: Ward Based Care for Earlier Discharges and Transformation of Discharge Services (TDS). The former has been re-scoped and is being presented to Programme Board, the latter is an existing programme which delivered Transfer to Assess pathways in September 2017.
Through the PFIG programme, the Trust commissioned and opened it's own 30 bed step down ward for medically optimised patients to increase discharges for medically optimised patients – The Grove Discharge Unit (GDU).

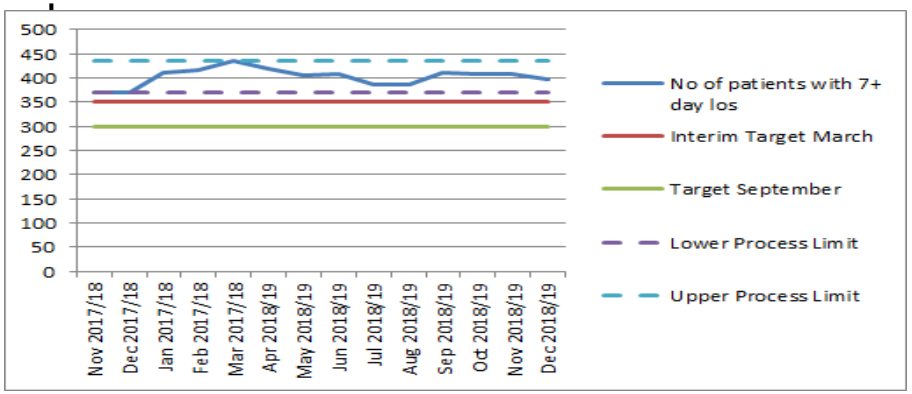
Programme actions on 'Assurance Statement'	Target date	Programme Progress/Milestones
• **Transformation of Discharge Services**: The scope document has now been updated with the date of agreement (April 2018)	• Complete	• Rollout of SHOP model commenced in Medicine on 2nd Jan – findings of first 3 days presented to Patient Flow Improvement Group on 7th Jan and Ward Based Care Project Team on 9th Jan. • Rota for intensive ward support to implement SHOP model ends on 18th Jan • Shop audit findings report to be completed on 22nd Jan and presented to Ward Based Project Team on 23rd Jan • Present Project overview & SHOP findings to Clinical Leads & Clinical Directors on 24th Jan away day • Audit of effectiveness of Early Discharge Ward Support team to be presented to PFIG on 12th Feb. • Commence rollout of SHOP model in Surgery on 28th Jan
• A matron has now been identified to join the TDS workstream, so whilst the Terms of Reference has been updated to reflect the November 2017 approval, this will be now reviewed to ensure if reflects recent changes to the group.	• Feb 19	
• The group acknowledges the feedback on KPIs and comms and engagement – both of these are being developed.		
• The risk log has been updated with a risk review date, risks are a standing item on the monthly agenda.	• Jan 19	
• Key decisions or items for note are recorded on the action log, but minutes will be recorded from December meeting	• Dec 19	
• **Ward Based Care:** PID, QIA, detailed project plan & risk/issue log are under development.	• Dec 19	
• KPI tracking to be commenced, dedicated report produced on the BI portal to support measurement	• Jan 19 • Jan 19	

Items for Escalation to the Programme Board (recommendations for action)

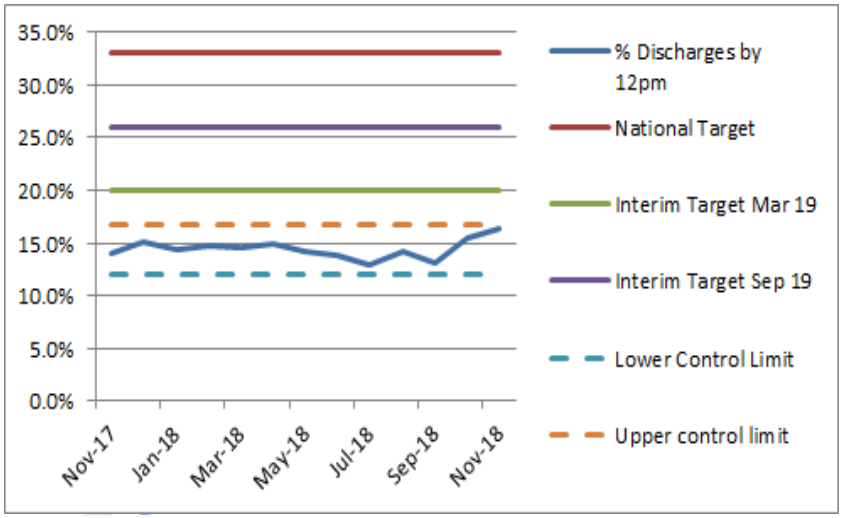
Ambulance Arrival to Clear



Number of patients with length of stay of >7



% of discharges by 12 noon



Time 33% of discharges is currently met = chart to be devised

Perioperative Medicine Improvement– 10th January 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Jo Keogh	Vicky Clarke	Delivery	Green	Red

Independent Assurance Statement

1. Team names on this dashboard to be completed. The scope document dated 1 Sep 18 needs to be completed (metrics for measures) and approved; the only measure mentioned is: 'Reduce specialty level variation so that all lists are achieving 85% utilisation target'. **2.** A Project Team is in place with a wide range of activity in evidence up to 10 Jan 19. **3.** The Perioperative Medicine Steering Group is governing and the minutes/notes from that meeting directing the project. **4.** There is evidence of detailed presentation explaining the work of the project and a range of evidence of wider stakeholder engagement. **5.** The QIAs, signed in February and May 2017 should be re-validated after over 1 year in place and cognisant of the development of the project. **6.** The milestone plan dated 03.10.18v2 completes on 15 Feb 19; there is no evidence of further milestones through 2019 other than the 'High Level Plan' v3 and this completes in April 2019. **7.** KPIs are developed and the assessment of the status at 4 Jan 19 is red. **8 and 9.** Evidence in place concerning risk and issue management but 'date of last review' information is required.
Most recent assurance evidence submitted 10 Jan 19.

Programme Title	Programme Description	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
Perioperative	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.											

Programme Board
Perioperative Medicine Improvement

Wirral University Teaching Hospital NHS Foundation Trust

Programme Overview (Rationale and Impact)

- Improved visibility and delivery of utilisation of core theatre sessions by specialty
- Greater standardisation of the pre-operative pathway across all sites and specialties, whilst introducing more proportionate levels of assessment.
- More immediate access to investigations, diagnostics (for example, x-ray, echo, cardiology and haematology) and pharmacy.
- Enhanced IT systems to support real-time monitoring and enhanced reporting .

Programme actions on 'Assurance Statement'	Target date
• Scope Document review has taken place and a revised scope document was made available for Programme Board for December 18 meeting	11/12/2018
• Revised project plan is under development to include all new programme initiatives, such as Three Phase Recovery and TCI service review	Ongoing Ongoing.
• KPI's and improvement trajectories have now been agreed and set, progress monitoring is now taking place weekly via Theatre Resource Group due to KPI's being off track	20/12/2018
• An initial benefits realisation meeting has taken place. A further session is planned with Finance lead and STT 14 Jan 19. Updated benefits profiles will be agreed and presented at February 19 Programme Board	01/02/2019 08.01.2019 Ongoing
• QIA has been updated and awaits sign off	
• Risk & Issues are monitored monthly at Perioperative medicine steering group 9th January 19	

Programme Progress/Milestones

- There has been some significant slippage on IT work plan and is set to extend beyond the original 4 week delay timeframe to 8 weeks – operational plans are being developed to support IT roll out plans to help mitigate delays
- The Division is currently undertaking a feasibility study on the implementation of a 3 phase recovery unit. Estate remedial works proposals are being developed.
- Funding to support Intra-Operative IT initiatives Such as implementation of tracker screens and hardware upgrades will be funded by GDE monies.
- TCI process review continues. Operational leads have been identified to lead on this improvement initiative, supported by transformation colleagues. A project scoping session took place w/c 7 Jan 19Project scope document, delivery milestones and improvement trajectories will be suggested for review and sign off. The meeting will be an indication of what the TCI process should look like in order to facilitate improvements in DNA's and appropriate list utilisation.
- A fit and well questionnaire is 'in development' and a trial version will be available for end of January 19. This has been slightly delayed in order for the project team to take some learning from peer organisations and review the systems that they have in place. The purpose of which is to reduce the number of face to face appointments for patients with significant co-morbidities, increase pre-op throughput, which will in turn feed a 'surgical pool' of patients fit for surgery.
- Telephone pre-op arrangements will be introduced, in the first instance for patients when pre-op has expired. It is expected that this system will be in place from February 19

Items for Escalation to the Programme Board (recommendations for action)

- IT delivery timeframes slipped by a further eight weeks which will push back the timeframes for all IT related items, which will have a significant impact on the perioperative improvement programme initiatives.

Outpatients Improvement Programme Assurance Update – 10th January 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Steve Sewell	Sarah Thompson	Delivery	Green	Amber

Independent Assurance Statement

1. The 'Trustwide OP Operational Structure - Workstream Brief' v0.1 describes the overall vision, approach and aims in a concise format while the context is explained in detail in the 'WUTH Outpatients Review' v0.5 dated 16 Oct 18. **2.** A project team is in place; one name needs to be completed on this dashboard. **3.** The 'Outpatients Transformation Group' is in place with ToR agreed at the meeting of 1 Nov 18 and documents to evidence the meeting of 3 Dec 18; this is supplemented by evidence of how this reports into the 'Operational Transformation Steering Group' (agenda and actions in evidence) through to 7 Jan 19. **4.** Some evidence of stakeholder engagement is available and an 'Interim Engagement & Communications Plan' v0.11 dated Nov 18 is available. **5.** A QIA has been signed and submitted. **6.** The Trello' Board' is being used to create and track milestones; moreover, a high level summary of near term milestones, to Jan 19, is now available (uploaded 27 Dec 19) and would benefit from weekly tracking. **7.** KPIs are now in place, with agreed metrics in the project assurance folder, from the (High Level) 'Clinical Capacity Benefits Map' again on the 'Trello Board'. **8 and 9.** Risks and issues are recorded on a detailed RAID Log uploaded 4 Jan 19 with risks and issues reviewed on 27 Dec 18; **Most recent assurance evidence submitted 4 Jan 19.**

Programme Title	Programme Description	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
Outpatients Improvement	To design and implement 21st century outpatient services to meet the needs of the Wirral population. Goals/Expected Benefits: to achieve the planned outpatient activity for 18/19 by March 2019; to design a Trust Wide Operational Structure for outpatients that is able to create and manage a consistent operational framework for outpatients right across the Trust; to design and implement 21st Century Outpatients and eliminate paper from outpatient processes; improve patient											

Programme Board
Outpatients Improvement Programme

Wirral University Teaching Hospital
NHS Foundation Trust

Programme Overview (Rationale and Impact)

To design and implement 21st century outpatient services to meet the needs of the Wirral population.

Goals/Expected Benefits:

- To achieve the planned outpatient activity for 18/19 by March 2019.
- To design a Trust Wide Operational Structure for outpatients that is able to create and manage a consistent operational framework for outpatients right across the Trust.
- To design and implement 21st Century Outpatients and eliminate paper from outpatient processes
- Improve patient experience

Key Prog. Metrics	YTD Plan	YTD Actual	YTD Variance
To achieve contracted activity plan for:			
Medicine first appt.	21,506	19,640	-1,866
Medicine follow up	45,962	48,916	2,954
Surgery first appt.	35,252	33,837	-1,415
Surgery follow up	66,344	72,495	6,151
W&C first appt.	10,939	11,447	508
W&C follow up	12,963	13,430	467

Programme actions on 'Assurance Statement'	Target date
• HR Lead to be confirmed	31 Jan 19
• Interim communication and stakeholder plan to be refreshed in January 19	31 Jan 19

Programme Progress/Milestones

- Meetings being held with DMs to discuss progress/barriers with clinic utilisation action plans, agree next steps and to share good practice. Breast action plan to be submitted by end of January.
- 6 week view of clinics, vacant rooms and room utilisation now available. Room utilisation is 75%-80% . Weekly capacity meetings being used to fill vacant rooms and confirm nursing availability.
- Consultant leave and cancellation process being reviewed further. Roles and responsibilities being clarified.
- Agreed that Lymphedema will move into VCH beginning of February. Lease agreement to be signed off by Execs to progress building of sluice.
- Partial booking to be rolled out to remainder of specialties
- Virtual clinics working group being set up to trial this in Nephrology, Gastro, Respiratory, Colorectal, Urology and Diabetes.
- Second Operational Structure Workshop being held end of January to review draft Trust Wide OP structure.
- Outpatients programme being developed with three workshops being held in January focusing on

Items for Escalation to the Programme Board (recommendations for action)

- Please note the inclusion of the exception report – attached.

Exception Report

Diagnostics Demand Management Assurance Update– 10th January 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	Will Ivatt	Opportunity	Amber	Amber

Independent Assurance Statement

1. BOSCARD together with 'Initiation Pack' delivered to Programme Board give a concise yet comprehensive scope and approach (which will also make use of an initiative identification template and a prioritisation matrix). **2.** A project team is defined and the names of individuals need be completed on this dashboard matrix. **3.** Meetings are commencing with divisional leads and now the programme governance forum will need to be put in place. **4.** There is some evidence of stakeholder engagement and a forward looking communications plan will need to be developed. **5.** A QIA will need to be signed off. **6.** There is an action planning log in the RAID Log ; a comprehensive milestone plan will be required in due course. **7.** There is a High level Driver Diagram and now a comprehensive document describing baselines, targets and trajectories that will need to be agreed in the project governance forum. **8 and 9.** Risks and issues are recorded; risk register now needs the 'date risk last reviewed' column to be completed with dates. **Most recent assurance evidence submitted 9 Jan 19.**

Programme Title	Programme Description	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
Diagnostics Demand Management	This programme aims: to reduce spend on diagnostic testing to acceptable levels as indicated by NHSI Model Hospital Data; to reduce demand for pathology tests (costs, patient experience); to reduce the number of units of blood transfused into patients (risk, cost); to create a template to reduce demand for diagnostic imaging (& other projects); and											

Programme Board
Demand Management - Pathology

Wirral University Teaching Hospital NHS Foundation Trust

Programme Overview (Rationale and Impact)
To reduce volume of and spend on diagnostic testing to levels as indicated by NHSI Model Hospital Data: • To reduce demand for pathology tests (costs, patient experience) • To reduce the number of units of blood transfused into patients (risk, cost) • Create a template to reduce demand for diagnostic imaging (& other projects)

Key Prog. Metrics	Baseline	Q2 Ave	Q4 Target
• Total number of tests	9.34m tests 2.4m samples		Targets to be set for 2019/20
• Overall pathology spend	£15.53m		
• Balancing measures to be reviewed – e.g. LOS	t.b.a.		
• Specific measures in line with proposals			

Programme actions on 'Assurance Statement'	Target date
• **QIA** - Scoping and detailed analysis of potential activities required, changes, risks and benefits will feed into QIA. QIA will be drafted once analysis completed.	31.01.18 31.01.18
• **Targets and trajectories** - Key metrics identified. Completion of analysis will identify realistic benefits, targets and timescales.	*Ongoing*
• **Risks and Issues** – 'Date last reviewed column' now included within logs (added 14.12.18). Risks reviewed as standard during project meetings	*Complete Feb 19*
• **Key roles** – identify key roles – clinical lead, IT rep	
• **Meet with AMDs –** meeting planned	

Programme Progress/Milestones

Feasibility:
- Initial feasibility undertaken with high-level potential benefits identified
- Benchmarking undertaken to identify Trust position against comparators for test per capita, overall spend, cost per test

Analysis
- Scoping of all areas of analysis undertaken; all key areas identified
- Initial engagement with Clinicians through opportunity identification sessions

Quick Wins:
- Two workshops undertaken to identify opportunities to reduce demand / spend

Items for Escalation to the Programme Board (recommendations for action)

- Requires support of Divisions to progress – initial meeting with AMDs planned for Feb '19

Partnerships: Women & Children's Assurance Update – 10th January 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
TBD	Gary Price/Joe Downie	Amy Barton	-	Green	Red

Independent Assurance Statement

1. Scope is in: 'Appendix 1, Wirral and Western Cheshire Women and Children's Alliance objectives and key performance indicators: Summary. Revised November 18 Overview'; a more detailed PID will be required in due course. **2.** 'Programme Core Team' in place together with support from the STT; name to be completed on this dashboard. **3.** ToR for the 'Women's & Children's Alliance – South of the Mersey Leadership Delivery Group' are in evidence. The W&C Alliance record of attendance / action log / minutes are available to 15 Nov 18. **4.** There is evidence of strategic engagement concerning the programme together with evidence of communications with stakeholders concerning specific initiatives. **5.** QIA and EA drafted and due to be signed off w/c 10 Dec 18. **6.** There is no current milestone plan in evidence; the programme lead states that the Seacombe Hub is now delivered and milestone plans for the South Wirral Hub, and the other new programmes, are being developed. **7.** There are 10 KPIs associated with the scope and these are being RAG rated by the programme: 3 Green, 3 Amber, 4 Red. **8 and 9.** Risks and Issues updated in RAID log of Nov 18 showing no live risks or issues (need to verify that the programme of 6 work streams has no current risks or issues). **Most recent assurance evidence received 7 Dec 18.** It is understood that outstanding issues will be discussed at the meeting (agenda in evidence) of 11 Jan 19.

Programme Title	Programme Description	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
Womens and Childrens	The Cheshire and Mersey STP calls for local solutions for women and children's services to address workforce and quality challenges											

Programme Board
Partnerships: Women & Children's

Wirral University Teaching Hospital
NHS Foundation Trust

Programme Overview (Rationale and Impact)

- The Cheshire and Mersey Health and Care Partnership has a programme for Women's and Children's Services as part of the Acute Care programme. This work calls for local solutions and collaboration to tackle Workforce shortages and to meet national clinical standards.
- WUTH is seeking to collaborate with colleagues in local acute trusts to support the acute care challenges and with Wirral based partners to support to local system challenges. We have 6 work streams under this programme

Programme actions on 'Assurance Statement'	Target date
• A more detailed PID for the Child and Family Hub is now being developed as we have secured the £70K from the HCP, this is the key metric that now needs completing in order for the delivery stage to move to Amber. It will include the milestones and key performance indicators for the hub	• Jan 19

Key Prog. Metrics	Baseline	Q4 Target
• Increase in homebirths	• 17/8 data	Double 17/18
• Secure funding for Hub		£70k secured
• Secure funding for APNPs		£40k secured
• 1 shared service with CoCH end 18/19		Fertility to be delivering shared service

Programme Progress/Milestones

- The governance for the programme has now been independently assessed as green
- As part of local Wirral based collaboration the freestanding midwifery lead unit team at Seacombe has now resulted in 3 X number of homebirths for Wirral compared to this time last year. This supports the clinical agendas of continuity of care and improved outcomes. John Moore's University have been commissioned to research the success of the centre by the Cheshire and Mersey Health and Social Care Partnership
- WUTH and CoCH have been successful in their bid for £70k to develop a shared child and family hub from the Cheshire and Mersey HCP and the programme plan for that work is now being developed

Items for Escalation to the Programme Board (recommendations for action)

- The latest updated version of the QIA needs board level sign off and will be taken to DoN and MD December 19
- Through the budget setting process opportunities to support the funding of a shared strategic lead between WUTH and CoCH for nursing and midwifery need to be developed

Partnerships: Healthy Wirral: Medicines Optimisation Assurance Update – 10th January 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Mike Treharne, DOF CCG	TBD	Pippa Roberts	-	Amber	Red

Independent Assurance Statement

1. 'Scope' is represented in a High Level document dated 12 Dec 18 which describes: 'Medicines Optimisation Programme Board is an enabling programme of work supporting the Healthy Wirral Programme' and there is also a PID being drafted that was uploaded on 13 Dec 18. **2.** Notes from Wirral Integrated Pharmacy/ MO Group of 4 Oct 18 are available; no minutes of the 'Medicines Optimisation Programme Board'. **3.** **G**overnance structure shows how the 'Medicines Optimisation Programme Board' relates to the 'Healthy Wirral Executive Delivery Group' and the 'Healthy Wirral Programme Board'; version 5 of the Programme Board ToR needs a date to show when the document was authorised. A General Practice Clinical Pharmacist (GPCP) Implementation Group meets, ToR Issue 3 signed off June 2018. Biosimilars has ToRs dated April 2018, met in September 2018. **4.** There is evidence of GPCP stakeholder engagement and communications. **5.** There is no EA/QIA assessment. **6.** There is no milestone plan. **7.** Some KPIs are being tracked in terms of activity for GPCP but no sense of target thresholds for output / outcome. Biosimilar financial savings report received for Adalimumab on 7 Dec 18. **8 and 9.** No evidence that risks and issues are identified, assessed and managed/mitigated. **Most recent assurance evidence submitted 13 Dec 18.**

Programme Title	Programme Description	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
Medicines Optimisation	The Medicines Value Programme for Wirral has been established to improve health outcomes from medicines through improving patient information, making best use of the clinical skills of pharmacists and pharmacy technicians, and implementing clinically effective prescribing and medicines reviews to ensure we are getting the best value from our medicines expenditure.											

Programme Board
Medicines Optimisation – Healthy Wirral

Wirral University Teaching Hospital NHS Foundation Trust

Programme Overview (Rationale and Impact)

The Medicines Value Programme for Wirral has been established to improve health outcomes from medicines through improving patient information, making best use of the clinical skills of pharmacists and pharmacy technicians, and implementing clinically effective prescribing and medicines reviews to ensure we are getting the best value from our medicines expenditure.
It aims to:
-Enable people to access treatment that is clinically effective, based on the latest scientific discovery, at as low a price as possible
- Support people to take their medicines as intended, with appropriate medicines reviews, so that they get the health outcomes they want

Key Prog. Metrics	Baseline	Q2 Ave	Q4 Target
GPCP • has activity data only to date . • Practices increased from initial 9 to 13 – eta Nov 18			
• Biosimilar Saving	• 0	• 250k	500k
• Other TBC			

Programme actions on 'Assurance Statement'	Target date
• PID in draft to be submitted to Programme Board once meeting date agreed	• Feb 2019
• Agenda and mins for PB available when meets	• Feb 2019
• Structure considered to be hierarchical – for redesign	• Jan 2019
• EI QIA paperwork to be completed once available	• Dec 2019
• PIDS with associated milestones, KPIS and RAID logs to be written for underpinning projects	• Jan 2019

Programme Progress/Milestones

- Multidisciplinary Board unable to convene meeting due to CSU diary commitments. Suggestion to use existing medicines committee chaired by GP as PB. Agreed informally with CCG and CSU Dec/Jan19 – Paper describing to Feb CCG Meds Management Meeting.
- Presented at Senate on HW MO work to date and GPCP. 2wte recruited (one started Jan19/ one to start Mar19).
- Continued work with NHSE Grove Discharge Unit asked for 3/7 Care Home work for onsite support at WUTH for GPs.
- Biosimilar adalimumab work ongoing. 300 patients consulted and to date 3 cautious re switch.
- Agreed funding support for pharmacist 0.5wte. Agreed to scope AMR , Safety and practice work review with CSU as first step.

Items for Escalation to the Programme Board (recommendations for action)

Partnerships: WWC Alliance: Pathology Assurance Update – 10th January 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
David Jago	Alistair Leinster	TBD	-	Amber	Red

Independent Assurance Statement

1. The scope document comprises the 'Strategic Pathology Collaboration Wirral and West Cheshire: Current Positon and Next Steps' dated October 2018 and submitted to the Trust Board on 1 November 2018. **2.** Project Team names need to be populated on this dashboard. **3.** The 'Wirral & West Cheshire Pathology Service Transitional Management Team' has Terms of Reference (undated) and minutes of the meetings of 21 Sep 18 and 14 Nov 18 are available; however, the meeting schedule and prepared for of 13 Dec 18 was 'cancelled due to low numbers'. **4.** There is evidence of stakeholder engagement by means of the notes of a 'Whole Lab Meeting' of 19 July 2018 but no evidence of a communications plan or wider/subsequent staff engagement. **5.** There is no EA/QIA. **6.** There is a 'WWC Pathology Timeline' Plan in evidence but appears to be subject to significant delays (5 Months) and the tracking of the plan is not clear (last update looks like Sep 18). **7.** KPIs (...Next Steps paper - Oct 18) are potential savings from a joint COCH / WUTH Pathology service are estimated to be between £1.6m and £2.6m; these from procurement and staffing savings. **8 and 9.** The '...Next Steps paper refers to issues and risks as topics but there is no evidence of risk or issue assessment to date.
Most recent assurance evidence submitted 4 Jan 19.

Programme Title	Programme Description	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
Pathology	NHSI has proposed radical reconfiguration of pathology services in England. This is in response to Lord Carter's review of operational efficiency of the NHS, and their own analysis, in order to reduce costs and unwarranted variation. Proposals are to group laboratories into hub and spoke models, with COCH and WUTH assigned to the "North 4" pathology network, centered around Liverpool Clinical Laboratories (LCL). There is however a more immediate opportunity for WUTH											

Programme Board
Pathology Collaboration

Wirral University Teaching Hospital
NHS Foundation Trust

Programme Overview (Rationale and Impact)

- Establishing a Pathology Collaboration between Wirral and West Cheshire hosted by a single Trust to reduce operating costs via 3-year timeline
- High Level analysis revealed potential saving i.r.o. £1.6m to £2.6m
- LTS Consulting are undertaking a piece of work that focuses analysis of potential staffing savings in blood sciences and histology as well as the use of estate
- Potential non-pay spend savings via joint or regional managed service tender

Key Prog. Metrics	Baseline	Post implementation Target
• Baseline budget for WUTH pathology - reduction	• £15.53m	
• Overall Staffing	• BS & Histo = 126	
• Non-pay spend (MESC)	• ~£2.5m	
• Turn around time (1hr and cancer)	• Maintain delivery	
• UKAS accreditation	• Maintain accreditation	

Programme actions on 'Assurance Statement'	Target date
• Project Team populated on dashboard.	*complete*
• Updated timeline	*complete*
• Risks and issues identified and discussed at monthly TMT meetings as standing agenda item	*ongoing*
• Completion of Board paper with recommendation on hosting model, will include: • QIA / EIA to be completed in line with preferred hosting option	20.02.19 *Currently in draft*
• A wider communications plan and staff engagement to be announced after Trust Boards agree the hosting model, building on previous comms.	28.02.19

Programme Progress/Milestones

Feasibility / Analysis:
- LTS (external consultancy provided by NHSI) have produced a draft report following detailed review of WUTH and COCH services
  - A final report will be made available by 10th January 2019
- Benchmarking undertaken via NHSI - used by LTS
  - Identification and analysis of NHSI data underway
- Initial engagement with clinicians via clinical stakeholder groups to design Target Operating Model

Requirements:
- Joint procurement and Managed Equipment Service Contract - agreed regionally COCH progressing
- Cerner Pathnet roll out at CoCH

Items for Escalation to the Programme Board (recommendations for action)

- A decision on hosting is required (Trust Boards February 2019)
- Executive attendance at TMT, including appointment of chair

Digital: GDE Medicines Management Assurance Update – 10th January 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
David Jago	P Roberts	L Tarpey	-	Amber	Red

Independent Assurance Statement

1. OPD Project Scope dated 4 Dec 18. AMS PID v3, 25 Oct 18, 1 benefit of £187k CQUIN (but no metrics). MAT NNU PID v2, 23 Oct 18, 1 benefit from EPMA for maternity / neonates; baseline but no target. MED Eye PID v4, 25 Oct 18, 1 benefit 'closed loop meds admin' but no metrics. Paper Charts PID v1, 23 Oct 18, 1 benefit to improve safety etc but no metrics. The ePMA in OPD PID added 4 Jan 19; metrics required for benefits.**2.** The 'Programme Core Team' names on dashboard incomplete. **3.** ToR (undated) for Medicine GDE meeting available. Notes of VTE Project Board Meeting of 13 Dec 18 and MAT & NNU Project Board available for 3 Jan 19. No minutes of Project Boards described in the PIDs; however, there are notes of 'GDE Meetings' up to 4 Dec 18. PIDs yet to be approved by the 'Project Board'. **4.** Comms Plans outlined in the PIDs but only AMS has evidence of a 'live' (v3 12 Oct 18) list of actions. **5.** No EA/QIA in evidence. **6.** Milestone Plans: AMS PP v2 20180119 (date?) complete but 2 overdue comms actions; Mat and NNU PP v3 dated 9 Sep 18, appears largely on track; MED Eye PP v1, 16 Oct 18, largely up to date but overdue actions undated. Paper Charts PP v3 20181101, largely up to date but overdue Comms actions**.** New 'Pharmacy Worklist' Plan will be complete by Jan 19. **7.** No evidence of tracking benefits. **8 & 9.** Risks & Issues: RAID Log v12, 4 Dec 18. **Most recent assurance evidence received 4 Jan 19.**

Programme Title	Programme Description	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
Meds Management	This meeting exists to monitor progress of the agreed and ratified GDE Medicine programme. To ensure that appropriate resources are available to meet the requirements of the programme and objectives and benefits are identified and realised. There is also an acknowledgement that it is essential that BAU work for the Pharmacy service is carried out in parallel. It is understood that BAU and GDE projects will impact on each other as essentially the same resources are required for											

Programme Board
Medicines Management

Wirral University Teaching Hospital
NHS Foundation Trust

Programme Overview (Rationale and Impact)

- Programme comprises a number of different projects that aim to enhance various areas within Pharmacy and Medicines management by utilising the latest technology available
- To bring the Trust in line with the Local Service Delivery plan and focus on key areas with the aim to improve patient safety and overall patient care.
- Prioritised areas : Digitising remaining paper charts, Closed Loop Medication, Antimicrobial Stewardship, EPMA Outpatients and Digital Chemo Trials

Programme actions on 'Assurance Statement'	Target date
• GDE Meds Management Group to sign of all PIDS	31/01/2019
• Conduct full benefits review for all projects prioritising those already in flight	31/01/2019
• Keep Project plans and Risk and Issue Logs updated	Ongoing

Key Prog. Metrics	Baseline	Q2 Ave	Q4 Target
• TBD			

Programme Progress/Milestones

Completed
- Anti-microbial Stewardship – **Feb 2018**
- Digitising first 5 paper charts – **March 2018**
- Digitising Chemotherapy Trials – **October 2018**
- Pharmacy Worklist Update - **October 2018**

Outstanding
- Maternity and Neonatal EPMA – **Jan 2019**
- VTE Updates completed – **May 2019**
- Closed Loop Medication – **May 2019**
- EPMA Outpatients – **June 2019**

Items for Escalation to the Programme Board (recommendations for action)

Digital: GDE Device Integration Assurance Update – 10th January 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
David Jago	Gaynor Westray	Michelle Murray	-	Red	Red

Independent Assurance Statement

1. Infusion Pumps GDE PID v0.3, 02112018; benefits = save nurses time, prevent inaccurate data into EPR (no metrics). PCECG GDE PID v0.3, 01102018; benefits marked 'tbc'. Vitalslink GDE PID v0.7, 31102018; benefits: a. save nurses time @ £696,911 per annum = more time to care b. ensure all basic observation results are recorded accurately - details provided for Mar - May 18 has shown a decrease "in error" rate to 0.1119% (but no stated baseline). SECA PID v0.3 dated 1 Nov 18 has objectives but lacks metrics to measure. **2.** 'Programme Core Team' names on dashboard to be completed. **3.** Only minutes in evidence of an ECG project meeting held on 26 Nov 18 between the Clinical Lead, Programme Manager and Project Manager. PIDs yet to be approved in a 'Project Board'. **4.** 'Vitalslink Communication Plan', 30102018; however, it is a schedule of submission dates to Project Board and not evidence of stakeholder engagement. **5.** No EA/QIA in evidence. **6.** Device Integration Project Plan v0.10 4 Dec 2018 shows many elements completed but overdue 'Go Live' in Paediatrics since June 2018; plan now completes Feb 19. PCECG Project Plan v0.3 dated 4 Dec 18 completes in Mar 19 and currently appears on track. **7.** No evidence of tracking of benefits yet submitted. **8 & 9.** There is a consolidated RAID Log for the 4 projects, updated on 28 Nov 18. **Most recent assurance evidence received 4 Jan 19.**

Programme Title	Programme Description	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
Device Integration	SRO to arrange for this field to be populated as well as 'programme core team names'											

Programme Board
Device Integration

Wirral University Teaching Hospital
NHS Foundation Trust

Programme Overview (Rationale and Impact)
• Programme is mainly focussed around integrating key medical devices with Wirral Millennium • Automation of recording results will free up time for clinical and nursing staff to provide direct patient care • Reduction in transcription errors will improve overall patient safety • Key areas: Observation Machines, ECG machines, Infusion Pumps

Key Prog. Metrics	Baseline	Q2 Ave	Q4 Target
• Nursing time saved recording observations enabling more time for direct care	• 58, 275 hours	• 4,995 hours	• 31, 635 hours
• Reduction in observation recording errors	• 0.2161%	• 0.119%	• 0.09%

Programme actions on 'Assurance Statement'	Target date
• Establish regular Project Meetings for the ECG Team	31/01/2019
• First Device Integration Board Meeting to take place in early Feb – Review PIDs, Benefits and Risks and Issues	05/02/2019
• Identify Nursing lead and establish relevant governance structure for Infusion Pumps	
• Ensure all future meetings and associated minutes/actions are documented	05/02/2019

Programme Progress/Milestones

Completed
- ECG integration in ED – **March 18**
- Welch Allyn integration for all Adult Inpatients – **Nov 18**

Outstanding
- Welch Allyn Integration Paediatrics – **Jan 2019**
- Trust Wide ECG integration – **March 2019 TBC**
- Infusion Pump integration – **May 2019**

Items for Escalation to the Programme Board (recommendations for action)

Digital: GDE Image Management Assurance Update – 10th January 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
David Jago	Nikki Stevenson	Michelle Murray	-	Red	Red

Independent Assurance Statement

1. Scope comprises: PID Bronchoscopy PID v0.2 02112018, PID Colposcopy v0.1 02112018, Theatres Image Mgt PID 02112018, PID Medical Photography; 09112018; 1 benefit cited - for all 4 projects - is that all clinical images will be stored electronically in one central location (PAC's), therefore clinicians can access the images more efficiently. **2.** The 'Programme Core Team' names on dashboard yet to be completed. **3.** No evidence of governance or meetings other than references at GDE Programme Board; all PIDs yet to be approved at a Project Board. **4.** There is a 'Colposcopy Comms Plan' v0.1 02112018 which is a schedule of submission dates to Project Board and not evidence of stakeholder engagement. **5.** No EA/QIA in evidence. **6.** A Bronchoscopy Project Plan, 06092018, describes activities from 24 Apr 18 to 20 Sep 18 but does appear to be tracked / updated (a Colposcopy PP 07112017 started and finished in Nov 17 has been submitted but not clear why). **7.** No evidence of tracking of benefits yet submitted. **8 & 9. Risk and** Issue Logs are in use for each project and need updating. **Most recent assurance evidence received 7 Dec 18.**

Programme Title	Programme Description	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
Image Management	This project aims to deliver: Digital images and reports from Bronchoscopy examinations stored within the EMR via the PACS Network; Provide Excellent services to: our colleagues, quality services, clinician led changes to improve services, eliminating unwanted clinical variation; To maximise value: in the solutions and Wirral Millennium; Clinicians will have all images they need available to them electronically; Improved clinical safety; Opportunity to review clinical											

Programme Board
Image Management

Wirral University Teaching Hospital
NHS Foundation Trust

Programme Overview (Rationale and Impact)

- Image management programme contains a number of projects relating to consolidating the storage of all clinical images around the Trust into the PACS archive and ensuring the are digitally available in Millennium.
- The projects will make a huge contribution to having a single electronic patient record which at the moment is split between paper and digital
- The projects are aimed at the following areas: Medical Photography, Colposcopy, Bronchoscopy, Theatre Stackers, Cardiac and Endoscopy

Programme actions on 'Assurance Statement'	Target date
• Establish Med Photo Board following Dr Lea's nominations for clinical representation	19/02/2019
• Review and update Risk and Issue Logs with stakeholders for all projects	19/02/2019
• Agree scope, benefits, metrics and sign off PIDS for Medical Photography and Theatre Stackers once governance structure established	19/02/2019

Key Prog. Metrics	Baseline	Q2 Ave	Q4 Target
• Contributing to a single electronic patient record by storing clinical images in Millennium	• TBC	• TBC	• TBC

Programme Progress/Milestones

Completed
- Colposcopy Images stored centrally in PACS – **Nov 17**
- Bronchoscopy images stored centrally in PACS – **Nov 18**

Outstanding
- Medical Photography images stored centrally in PACS – **May 2019 TBC**
- Theatre Stackers images stored centrally in PACS – **July 2019**
- Endoscopy images stored centrally in PACS - **June 2019**
- Cardiac images stored centrally in PACs - **TBC**

Items for Escalation to the Programme Board (recommendations for action)

- Still no agreed Clinical Lead for Theatre Stackers

Digital: GDE Patient Portal Assurance Update – 10th January 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
David Jago	Mr David Rowlands	Katherine Hanlon	-	Amber	Red

Independent Assurance Statement

1. PID v1.3, 25 Oct 18, states it was approved by project board on 28 Jun 17. There are 3 benefits reducing follow-up O/P appts for Urology, Colorectal and Breast but no baseline or target metrics (except £28k benefit cited for Urology). Patient Story defines patient benefit. **2.** The 'Programme Core Team' names on this dashboard to be completed. **3.** Minutes of the Project Board available to 26 Sep 18; however, the meeting of 21 Nov 18 was cancelled due lack of quoracy and the decision was taken, due to 'dwindling attendance' to cancel the meeting of 12 Dec 18 - the next meeting will be 23 Jan 19. **4.** There is a Comms Plan, v4 24 Oct 18, which has some activities recorded but lacks forward looking schedule. **5.** No EA/QIA in evidence. **6.** Milestone Plan, v1.2 of 25 Oct 18, is tracked and up to date but does not yet indicate the status of delivery for actions related to testing of Gynaecology (14 Sep to 5 Oct 18). **7.** No evidence of benefits/metrics tracking. **8 & 9,** Risks and Issues: RAID Log, 24 Oct 18, captures risks and issues and these were last reviewed at the Project Board of 27 Jul 18 as recorded in the minutes. **Most recent assurance evidence received 7 Dec 18.**

Programme Title	Programme Description	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
Patient Portal	One of the pieces of functionality Cerner Millennium offers is a “patient portal”. Through patient portal individuals can have real-time access to specific requests such appointment changes and clinical information that can be viewed in the Cerner Millennium electronic medical record (EMR). The patient portal is essential for remote surveillance and self - management of patients living beyond cancer. The portal, along with a robust tracking system will allow for patients											

Programme Board
Patient Portal

Wirral University Teaching Hospital
NHS Foundation Trust

Programme Overview (Rationale and Impact)
• Patient Portal aims to provide patients with better access to their health record and enable proactive management of their own health care. • Provides the ability to place patients under remote surveillance and reduce the need for physical follow up appointments which in turn increases capacity to see new patients

Programme actions on 'Assurance Statement'	Target date
• Review risks and issues at Project Board and update documentation	31/01/2019
• Submit Portal 'Next steps' paper to Programme Boards	05/02/2019
• Conduct full benefits review and update relevant documentation	05/02/2019

Key Prog. Metrics	Baseline	Q2 Ave	Q4 Target
• Urology – Reduction in follow ups and increased capacity for new Patients	• 0 additional new appts	• TBC	• 65 new appointment slots
• Breast – Reduction in follow ups and increased capacity for new Patients	• 0 additional new appts	• TBC	• TBC
• Colorectal – Reduction in follow ups and increased capacity for new Patients	• 0 additional new appts	• TBC	• TBC

Completed
- Roll out to Maternity and Diabetes– **Nov 17**
- Roll out to Colorectal, Breast and Urology – **June 18**

Outstanding
- Trust wide roll out – **Feb 2019 TBC**

Items for Escalation to the Programme Board (recommendations for action)

Clinical Variation GIRFT – Programme Assurance Update – 10th January 2018

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	TBC	TBC		Red	Red

Independent Assurance Statement

No assurance evidence received to date

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors	
Agenda Item	10.8
Title of Report	CQC Action Plan progress Update
Date of Meeting	30 January 2019
Author	Paul Moore, Director of Quality & Governance
Accountable Executive	Janelle Holmes, Chief Executive
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)**	To be confirmed.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Discussion
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

CQC ACTION PLAN UPDATE REPORT
POSITION AS AT 19TH JANUARY, 2019

1. PURPOSE

1.1 The purpose of this report is to update on the progress of the CQC Action Plan, and to highlight, by exception, any elements of the plan that are not on track or at risk of not meeting target dates for implementation. This report also provides assurance on those actions that have been embedded (completed and sustained for a period of 3 months or more).

2. BACKGROUND OR CONTEXT

2.1 The CQC Action Plan brings together the actions required to address the CQC compliance concerns identified following inspection in March 2018. The plan takes account of: (i) all the 'must do' and should do' recommendations contained within the inspection reports; and (ii) some improvement interventions identified locally as immediate quality priorities by the Trust. After sufficient progress has been made the plan will evolve to incorporate matters highlighted as high risk within the Quality & Risk Profile for WUTH, and develop into the tactical plan to drive and deliver the Trust's Quality Strategy.

2.2 The CQC Action Plan has implications for NHS Improvement's enforcement undertakings and, in this regard, the Board is committed demonstrating, no later than August 2019, that: (i) it has addressed all the 'must do' and 'should do' recommendations to the CQC, NHSI and CCG satisfaction; (ii) is no longer considered by CQC to be inadequate in the well-led domain; and (iii) has improved against all CQC domains rated as inadequate or requires improvement when compared to the CQC's inspection findings.

3. ANALYSIS

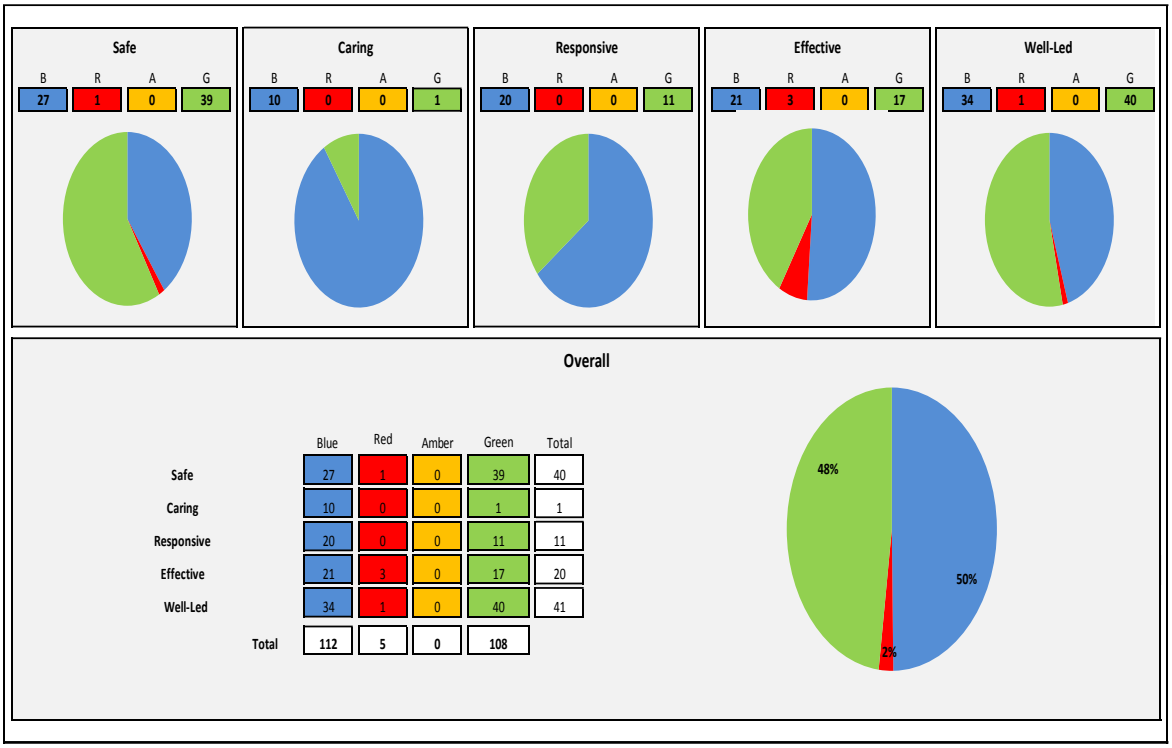
3.1 The CQC inspected the Trust in March and May 2018. The outcome of the inspection was as follows:

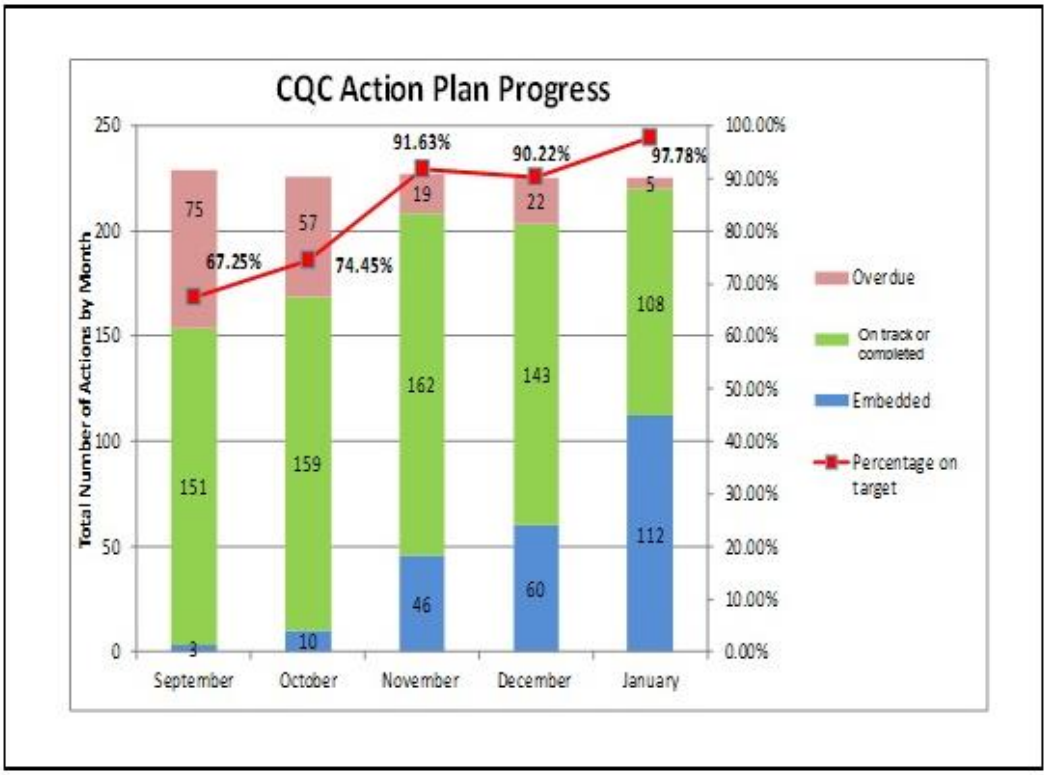
Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well Led	Inadequate	
OVERALL	REQUIRES IMPROVEMENT	

The Trust has developed a quality improvement action plan to address all concerns identified by the CQC. The quality improvement action plan has **225** specific actions/work-plans for implementation by **(31st March 2019).**

The delivery of the quality improvement action plan is reviewed monthly and performance is reported through to the Board at each formal meeting.

4. CQC Action Plan Progress – January 2019





5. EXCEPTIONS

Following the *Confirm and Challenge* meetings held week commencing 7th January 2019, there are 5 actions which have been 'red-rated' and are to be reported as exceptions for this reporting period. As expected we have seen an encouraging improvement from December's reported position.

Overdue actions concern operational matters and refer to medicines storage, risk reporting tools, Pain Management & ED Assessment protocols and Clinical issues in regards to MEWS system upgrade, which is an external issue. For reference the detail of overdue actions is set out in **Annex A**.

In **Annex B** we draw the Board's attention to 'embedded' actions (i.e. those actions completed and sustained for 3 months or more). In line with expectations set out in the plan, the number of embedded actions has increased significantly in this reporting period with 52 actions moving into the embedded category. This can be interpreted by the Board as positive evidence of implementation, and the progressive work that is happening across the Trust to address each element of the action plan.

6. POTENTIAL IMPLICATIONS (of failing to deliver the plan)

Risks (associated with failing to deliver the CQC action plan) include:

I. Service users are exposed to unacceptable levels of harm arising from inadequate compliance with CQC fundamental standards of care;
II. The Trust fails to comply with CQC Registration Regulations and has it's Certification of Registration revoked; and/or
III. A failure to resolve basic compliance concerns in respect of CQC regulations leads to further NHSI enforcement undertakings and compromise the Trust's Provider Licence.

The CQC Action Plan provides the means of improving control over these risks alongside the Trust pre-existing organisational control framework.

7. NEXT STEPS

The report will be presented at the next Board meeting.

ANNEX A

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
167	Must Do	Corporate / Trust-Wide Issues	"RISK REGISTER This issue affects all divisions but the report highlighted the Critical Care, Medicine and End of Life Care core services Critical Care : The provider must ensure that where risks are identified, measures are taken to reduce or remove the risks with a timescale that reflects the level of risk and impact on people using the service. Medicine : The service should ensure that all identified risks are placed on the risk register and that they are regularly reviewed and action implemented in a timely way. End of Life Care : The service should review the way their risks are recorded so there is a record of them in one place which corresponds to those on the divisional risk registers.	Review and refresh the divisional risk profile	Executive Director of Quality & Governance	Well Led	**UPDATED 15.01.2019** – Delayed due to sustained operational pressures across divisional triumvirates. All divisions have confirmed the actions they are taking to refresh and re-populate divisional-level risk register. This work is progressing, but not at the pace required. Awaiting receipt of Divisional risk registers. Expected to be received by Monday 21st January 19. Recovery anticipated in February. Output will be used to refresh the Corporate Risk Register and Board Assurance Framework	30/11/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
190	Should Do	Medical Care (Acute & Medical Division)	**"MEDICINES STORAGE** The service should ensure the safe and proper storage of medicines on the wards. "	Rectify defects identified through the existing quarterly audits in all wards and departments	Executive Medical Director	Effective	**Updated: 16/01/2019** Progress in this area is unsatisfactory; compliance with medicines storage deteriorated in December 2018. Additional Confirm & Challenge meetings took place with Director of Pharmacy to escalate compliance concerns and secure the assurances needed to demonstrate progress against this action. It has been highlighted that the current audit used to demonstrate compliance is very detailed and burdensome. There is opportunity to simplify and rationalise the assessment to assist colleagues to comply and the Director of Pharmacy has taken steps in this direction. We are focussing on simplifying the audit process and driving accountability at ward-level for compliance. A review will take place in early February. The Quality Committee will scrutinise the position on the Board's behalf at their meeting to be held on January 2019.	01/11/2018	
111	Should do	Urgent And Emergency Care (Acute & Medical Division)	**Pain Management** The service should ensure that pain management is recorded appropriately and that pain relief is administered in a timely manner when needed.	Review and provide assurance on the adequacy of pain management training and completion to PSQB	Executive Director of Nursing and Midwifery	Effective	**Updated: 08/01/2019** On line training packages are now available to staff Compliance and adoption rates of these training cannot as yet be evidenced. A review is underway with Pain Management Leadsto considered including pain management training as part of the 'role specific/ essential training programme'.		

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
208	Must Do	Urgent And Emergency Care (Acute & Medical Division)	**INITIAL ASSESSMENT** The service must ensure that patients receive an initial assessment within 15 minutes of arrival, in line with trust policy and Royal College of Emergency Medicine standards.	Ensure practice within ED adheres to Trust policy – all patients to be assessed within 15 minutes of booking in – by reinforcing existing Standard Operating Procedures (1/8/18)	Chief Operating Officer	Effective	**Updated: 10/01/2019** The Trust can demonstrate that it is documenting and reporting against standard; however, it is not yet able to demonstrate compliance with national standards. Investment has been made to increase nursing capacity in ED. Performance is reported daily via ED dashboard and monitored through Patient Flow Improvement Group (PFIG). A review will be undertaken of the current triage system.	01/09/2018	

210	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**mews SCORES** The service should ensure that patients who have an increased modified early warning score are monitored and escalated for further review, in line with trust policy.	Review and develop the policy for recognising and responding to the signs of clinical deterioration (to incorporate the requirement to implement NEWS2)	Executive Medical Director, Executive Director of Nursing and Midwifery	Safe	**Updated: 15/01/2019** Implementation of NEWS2 has commenced but an unanticipated technical issue with the Trust's Wirral Millennium (Cerner) system will require addressing before any further progress can be made. Subject to the response from Cerner, implementation of NEWS2 may be delayed. This matter has been escalated internally and with the system vendor.	01/11/2018	

ANNEX B (Embedded actions in January 2019)

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
13 (1)	Should Do	Corporate / Trust-Wide Issues	**PERFORMANCE REPORTING** **Trust wide :** The trust should ensure that divisional review of performance is undertaken effectively. **Emergency Department :** The service must ensure that there are effective systems in place to monitor the service provided and that when areas for improvement are identified, actions to make improvements are completed in a timely manner.	Design a consistent divisional dashboard that ensures review of all performance (operational and financial) metrics	Chief Operating Officer	Well Led	**UPDATED 10/01/2019 -** Embedded process. Divisional dashboards are produced monthly.	01/11/2018	
14 (2)	Should Do	Corporate / Trust-Wide Issues		Implement divisional performance reporting dashboard on a monthly basis	Chief Operating Officer	Well Led	**UPDATED 10/01/2019** Evidence satisfies action and confident that this has been embedded.	31/08/2018	
16 (3)	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**MAJOR INCIDENT EQUIPMENT** The service should ensure that staff are able to access major incident equipment in a timely manner and that major incident equipment is checked and maintained in line with trust policy.	Obtain assurance from ED departmental lead that the Major Incident equipment is kept secure, checked regularly and accessed by authorised personnel only	Chief Operating Officer	Safe	**UPDATED 10/01/2019** Evidence satisfies action and confident that this has been embedded.	31/08/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
17 (4)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Report assurance to the Risk Management Committee	Chief Operating Officer	Safe	**UPDATED 10/01/2019** Evidence satisfies action and confident that this has been embedded.	31/08/2018	
20 (5)	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**STORAGE IN ED** The service should consider ways to make sure that all equipment in the department is stored appropriately.	Review and develop the supply chain management so that storage requirements are kept to an absolute minimum			**UPDATED 10/01/2019 -** Full review has taken place no changes are recommended	01/11/2019	
21 (6)	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**MIXED SEX BREACHES** The department should consider ways to ensure that all breaches of mixed sex accommodation in the emergency department review unit are recorded appropriately.	Clarify precisely the arrangements to record mixed sex accommodation breaches in ED	Chief Operating Officer	Caring	**UPDATED 10/01/2019** - Meetings have been held with the departmental leadership team, satisfied if there was a breach it will be recorded.	01/10/2018	
22 (7)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Audit compliance to verify that breaches, where they occur, have been record properly	Chief Operating Officer	Caring	**UPDATED 10/01/2019 -** Evidence submitted confirms Trust appropriately reports mixed sex accommodation breaches.	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
25 (8)	Should Do	Medical Care (Acute & Medical Division)	The service must ensure they assess the risk to health and safety of patients when accommodating patients in escalation areas and do all that is practicable to mitigate any risks. Care and treatment of patients with higher acuity must take place in appropriate areas that are safe for such use.	Provide assurance to the Risk Management Committee that all wards and departments have in place an up to date COSHH folder with relevant in date risk assessments and material safety data sheets to demonstrate compliance with COSHH regulations	Chief Operating Officer	Effective	**UPDATED 10/01/2019 -** Completed in 17th December 18. Risk Committee was satisfied with assurances provided from the health and safety manager.	01/10/2018	
30 (9)	Must Do	Corporate / Trust-Wide Issues	**HEALTH & SAFETY Surgery :** The trust must ensure systems and processes are in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. **Emergency Department :** The service should ensure that health and safety risk assessments are kept up to date.	Carry out a site survey at APH and CBH to ensure that extension leads are compliant with all safety requirements and only PAT-tested leads are in use. A report to be provided setting out the assurance to Risk Management Committee	Chief Operating Officer	Well Led	**UPDATED 10/01/2019 -** Completed in 17th December 18. Risk Committee was satisfied with assurances provided from the health and safety manager.	01/12/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
38 (10)	Should Do	Critical Care (Diagnostics and Clinical Support Division)	**GAS CYLINDERS** The service should ensure that storage of gas cylinders is in line with the policy and best practice.	Implement actions from pharmacy audit (Data from March 2018) that is undertaken every 2 years. All orders placed for new racking for all areas found deficient (1/11/18). The key action was to install medical gas racking, which was ordered March 2018 as a result of audit.	Chief Operating Officer	Well Led	**UPDATED 10/01/2019** CAS alert fully complied with the evidence of compliance is on the CAS system.	30/09/2018	
39 (11)	Should Do	Critical Care (Diagnostics and Clinical Support Division)	**HAND HYGIENE - SIGNS** The service should consider ensuring there are adequate signs on entry to the unit instructing visitors to wash their hands.	Include metric within Ward Accreditation reporting process that monitors and responds to hand hygiene standards	Director of Nursing	Safe	**UPDATED 08/01/2019** – Embedded process and improvement can be demonstrated via Perfect Ward app.	01/01/2019	
46 (12)	Must Do	Corporate / Trust-Wide Issues	**PERFORMANCE INFORMATION** The trust must ensure that all information that is used for managing performance is accurate and up to date. **NATIONAL GUIDANCE** The trust should ensure that compliance with national guidance is monitored.	As part of the 'Ward to Board' project, review the data set used to provide assurance and manage performance. This will clarify more directly which indicators are prioritised for use by the Board (this should be based on the Single Oversight Framework)	Director of IT and Information	Well Led	**UPDATED 08/01/2019** Embedded process and improvement can be demonstrated via Perfect Ward app	01/10/2018	
52 (13)	Must Do	Corporate / Trust-Wide Issues		Review current processes for the emergency repair and routine maintenance of equipment and develop costed plan (EBME)	Director of IT and Information	Effective	**UPDATED 08/01/2019** - A review has taken place and we are reviewing contract arrangements with suppliers.		

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
64 (14)	Should Do	Medical Care (Acute & Medical Division)	**HEALTH PROMOTION** The service should ensure they provide health promotion services to support national priorities to improve the population's health.	The service will reinforce the Public Health England (PHE) Evidence into Action strategy and the wider One You initiative that is already addressing the risks of: tobacco, alcohol and obesity and will harness the work on chemical and environmental risks such as UV radiation	Executive Director of Nursing & Midwifery, Executive Medical Director	Well Led	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/11/2018	
65 (15)	Should Do	Medical Care (Acute & Medical Division)	**PRIVACY & DIGNITY** The service should ensure the privacy and dignity of patients is maintained at all times	The service will ensure privacy and dignity signs are provided for beds and patient areas which are designed to be attached to curtains or doors whilst care and treatment is carried out. Signs give a clear message to visitors to 'ask permission' before entering	Executive Director of Nursing & Midwifery, Executive Medical Director	Effective	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/10/2018	
66 (16)	Should Do	Medical Care (Acute & Medical Division)		The service will develop a protocol for patients being treated in non-standard escalation areas so that they have arrangements put in place to maintain their privacy and dignity	Executive Director of Nursing & Midwifery, Executive Medical Director	Caring	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.		

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
67 (17)	Must Do	Corporate / Trust-Wide Issues	**COMPLAINTS** **Trust wide :** The trust must ensure that complaints are managed effectively in line with trust policy. The service should ensure that they provide information to patients and relatives so that they are aware of how to raise a concern or complaint.	Review the complaints process and amend to ensure pace is injected into the handling mechanism	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/09/2018	
68 (18)	Must Do	Corporate / Trust-Wide Issues		Clarify role and responsibilities for complaints handling at divisional and corporate levels	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	30/11/2018	
69 (19)	Must Do	Corporate / Trust-Wide Issues		Introduce a mechanism for more robust performance management of complaints responsiveness (25-working days unless otherwise agreed with complainant)	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	30/11/2018	
73 (20)	Must Do	Corporate / Trust-Wide Issues		Introduce a mechanism to capture and performance manage the delivery of complaint actions (this is promoting and embedding learning within front line teams)	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	30/11/2018	
74 (21)	Must Do	Corporate / Trust-Wide Issues		The Trust will provide assurance that leaflets are available to guide people who use services on how to raise a concern or complaint	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	30/11/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
79 (22)	Must Do	Medical Care (Acute & Medical Division)	**NUTRITION & HYDRATION** The service must ensure patients' nutrition and hydration needs are met including supporting patients to eat and drink.	Review Nutrition and Hydration policy and procedures to ensure they are fit for purpose in all clinical areas	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Nutrition and hydration policy reviewed and approved by PSQB in November 2018	01/11/2018	
81 (23)	Must Do	Medical Care (Acute & Medical Division)		Add a metric regarding MUST compliance in the Quality Dashboard	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** MUST compliance monitored monthly - data is available and confirm and challenge meetings are underway. Challenge is to include in Quality report	01/10/2018	
82 (24)	Must Do	Medical Care (Acute & Medical Division)		Audit compliance with MUST	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019**: evidence of ongoing audits is available	01/10/2018	
83 (25)	Must Do	Medical Care (Acute & Medical Division)		Hold divisional teams to account for performance in the Divisional Performance Review meetings	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Completed, two cycles of divisional performance review where MUST indicators have been included.	01/10/2018	
84 (26)	Must Do	Medical Care (Acute & Medical Division)		Develop for each area an escalation protocol to be followed in the event of escalation being required. The protocol must set out: - Equipment required to provide care in escalated areas - Arrangements for medical review - Arrangements for the provision of food and hydration - Standards for observation - How pressure area care, privacy and dignity are to be maintained	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
				- Provisions for medicines management and storage. - Confidentiality of medical records - Access to Cerner in escalation areas					
85 (27)	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**FRIENDS AND FAMILY TEST** The service should consider ways to improve the response rate of both staff, patients and relatives in order make further improvements to the service.	Introduce electronic capture and recording of FFT responses	Deputy Director of Nursing & Midwifery, Head of Patient Experience	Responsive	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/10/2018	
86 (28)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Introduce text message alerts to increase response rates in ED	Deputy Director of Nursing & Midwifery, Head of Patient Experience	Responsive	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded- breakdown of response rates and vehicle for review confirmed as DPR meeting.	01/10/2018	
87 (29)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Introduce text message alerts to increase response rates in ED	Deputy Director of Nursing & Midwifery, Head of Patient Experience	Responsive	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded- breakdown of response rates and vehicle for review confirmed as DPR meeting.	01/10/2018	
109 (30)	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**PAIN MANAGEMENT** The service should ensure that pain management is recorded appropriately and that pain relief is administered in a timely manner when needed.	Review the Pain Management Pathway and the standards for recording pain management as part of the patient pathway to be clarified	Executive Director of Nursing and Midwifery	Effective	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
110 (31)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Review the Pain Management Pathway and the standards for recording pain management as part of the patient pathway to be clarified	Executive Director of Nursing and Midwifery	Effective	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	31/10/18	
112 (32)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Review the Pain Management Pathway and the standards for recording pain management as part of the patient pathway to be clarified	Executive Director of Nursing and Midwifery	Effective	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	31/10/18	
114 (33)	Should Do	Medical Care (Acute & Medical Division)	**RESUSCITATION TROLLEYS** The service should ensure that all resuscitation trolleys across the service are regularly checked and emergency equipment has the appropriate portable appliance tests carried out. **Surgery :** The service should ensure any emergency equipment in areas accessible to the public without a constant staff presence should be secure.	All ward and departmental managers to provide assurance to PSQB for at least 3 months uninterrupted daily checks	Executive Director of Nursing and Midwifery	Responsive	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	31/10/18	
116 (34)	Should Do	Medical Care (Acute & Medical Division)		Hold ward / departmental managers to account for delivery of daily checks at divisional performance review meeting	Executive Director of Nursing and Midwifery	Responsive	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	31/10/18	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
117 (35)	Should Do	Medical Care (Acute & Medical Division)		Consider introducing a managed process for restocking and sealing the trolleys	Executive Director of Nursing and Midwifery	Responsive	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	31/10/18	
118 (36)	Should do	Medical Care (Acute & Medical Division)		Purchase and install at least one pair of ligature cutters to be kept on the resus trolley in every area	Executive Director of Nursing and Midwifery	Responsive	**UPDATED 08/01/2019 -** Assurance submitted - signature sheet process has been put in place for monitoring and audit purposes	01/10/2018	
123 (37)	Should do	Critical Care (Diagnostics and Clinical Support Division)	**ANTT** The service should monitor and audit nursing staff carrying out aseptic non touch technique when administering medication.	Review, and where necessary, revise mandatory infection control training to enhance awareness of non-touch technique	Executive Director of Nursing and Midwifery	Safe	**UPDATED 08/01/2019 -** Assurance submitted; ANTT project plan, train the trainers rolling out in all critical care areas - phased roll out plan trust wide has been developed	01/10/2018	
125 (38)	Should do	Critical Care (Diagnostics and Clinical Support Division)		Provide assurance to PSQB that ANTT is compliant within the service	Executive Director of Nursing and Midwifery	Safe	**UPDATED 08/01/2019 -** Assurance submitted to PSQB in November 18.	01/10/2018	
136 (39)	Should Do	Medical Care (Acute & Medical Division)	**NURSING LEADERSHIP** The service should ensure there are sufficient managers at senior nurse and clinical lead level to run a service providing high quality sustainable care. **LEADERSHIP VISIBILITY** The service should improve the visibility of leaders and improve communication between staff at ward level and leaders.	Review senior nursing assurance and provide assurance to PSQB that the nursing rotas are arranged so that shifts have adequate senior nursing leadership	Divisional Director of Nursing (Acute & Medical)	Well Led	**UPDATED 08/01/2019 -** Assurance submitted to PSQB in November 18.	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
153 (40)	Must Do	Corporate / Trust-Wide Issues		Introduce a mechanism to capture and performance manage the delivery of serious incident actions (this is promoting and embedding learning within front line teams).	Executive Director of Quality & Governance	Well Led	**UPDATED 08/01/2019** Satisfied PSQB is tracking the actions. Actions to be included in DPR standard suite of documentation. PL to pick up with John Halliday	01/10/2018	
172 (41)	Should Do	Maternity Services (Women's & Children's Division)	**PERFORMANCE MONITORING** The service should ensure that the performance dashboard is completed monthly for all fields and consider a review of governance roles.	Establish monthly performance review of Women's and Children's division	Executive Director of Quality & Governance	Well Led	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/11/2018	
180 (42)	Should Do	Corporate / Trust-Wide Issues	**CULTURE** The trust should ensure that culture within the trust is improved.	Monitor progress via the Workforce Assurance Committee against identified measures of success	Executive Director of Workforce	Well Led	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/11/2018	
182 (43)	Should Do	Corporate / Trust-Wide Issues	**STAFFING ISSUES** The trust should consider how there is a trust oversight of all staffing issues.	Review existing management information relating to staffing issues reported to Board and committees to ensure that there is appropriate visibility of relevant indicators	Executive Director of Workforce	Well Led	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded	01/11/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
183 (44)	Should Do	Corporate / Trust-Wide Issues	**STAFFING ISSUES** The trust should consider how there is a trust oversight of all staffing issues.	Implement monthly reporting of staff indicators within the divisional dashboards	Executive Director of Workforce	Well Led	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded		
184 (45)	Should Do	Corporate / Trust-Wide Issues	**RAISING CONCERNS** **Emergency Department :** The service should ensure that staff are able to raise concerns when needed and that they are acted on in a timely manner. **Medicine :** The service should ensure that staff feel valued and supported and they are able to speak up and are listened to when they do so.	Relaunch and raise the profile of the FTSU Guardian and how staff can access them	Executive Director of Workforce	Well Led	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded. Relaunch of programme has taken place		
185 (46)	Should Do	Corporate / Trust-Wide Issues		Review the mechanism for providing assurance to the Board on concerns raised with the FTSU Guardians to confirm that it is effective and sufficient to meet the Board's assurance needs	Executive Director of Workforce	Well Led	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded	31/10/2018	
188 (47)	Should Do	Corporate / Trust-Wide Issues		Consider the appropriate level and benefit of the Trust's participation in the Academic Health Sciences Network, and Collaboration for Leadership in Applied Health Research and Care (CLAHRC), and whether to work more closely with TrustTech	Effective	Executive Medical Director	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
189 (48)	Should Do	Corporate / Trust-Wide Issues		Increase and promote participation in research	Effective	Executive Medical Director	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded	01/11/2018	
200 (49)	Should Do	End of life Care (Acute & Medical Division)	**DEATH CERTIFICATION** The service should ensure that the issue with the timely completion of medical cause of death certificates is recorded and monitored via the relevant risk register.	Review and develop processes for ensuring timely and accurate death certification	Executive Medical Director	Responsive	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded	31/10/2018	
201 (50)	Must Do	Corporate / Trust-Wide Issues	**SAFE STAFFING** **Emergency Department :** The service must ensure that appropriate numbers of nursing and medical staff are available at all times. **Medicine :** The service must deploy sufficient staff with the appropriate skills on wards and on the acute medical unit, medical short stay ward and ambulatory care unit **Surgery :** The trust must ensure there are enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.	Include metric within Ward Accreditation reporting process that monitors and responds to national safe staffing standards	Executive Medical Director, Director of Nursing & Midwifery.	Safe	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	31/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
202 (51)	Must Do	Corporate / Trust-Wide Issues		Develop systems allowing staff to be reallocated to areas of high acuity and staff shortage	Executive Medical Director, Director of Nursing & Midwifery.	Safe	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded	31/10/2018	
209 (52)	Must Do	Urgent And Emergency Care (Acute & Medical Division)		Establish a clinical audit of 15 minute assessment standards within ED	Chief Operating Officer	Effective	**UPDATED 08/01/2019** Dashboard and ED reporting metrics agreed as evidence	01/11/2018	

Board of Directors	
Agenda Item	10.9
Title of Report	Update on the Trust planning and preparedness in the event of March 2019 no deal EU Exit
Date of Meeting	30th January 2019
Author	Helen Nelson Corporate Directorate Manager Operations
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 as local planning is in place with support from NHSE EPPR Cheshire & Merseyside. Any gaps will be highlighted at the WUTH planning meeting scheduled for 24th January.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval Required
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

On the 2nd January 2019 the Trust's Chief Executive Officer received the 'EU Exit Operational Readiness Guidance' from the Department of Health & Social Care via NHS England.

The guidance has been developed and agreed with the NHSE England and Improvement and lists the actions that providers and commissioners of health and care services in England should take if the UK leaves the EU with a ratified deal – a 'no deal' exit.

The guidance was received by the Executive Management Team on 7th January where it was agreed that a paper was to be produced for the Board of Directors on 30th January to provide assurance on the preparedness of the Trust for a March 2019 no-deal scenario.

In preparation for a 'no deal' exit, the Department of Health & Social Care has set up a national Operational Response Centre (ORC). This will lead and support, on responding to any disruption to the delivery of health and care services that may be caused, or affected by EU Exit. NHS England and Improvement will work closely with the ORC and will operate at national, regional and local levels to enable rapid support on emerging local incidents and escalation into the ORC as required. The North West regional EU Exit lead can be contacted via England.euexitnorthwest@nhs.net.

In line with current Emergency, Planning, Resilience & Response (EPRR) processes, WUTH will continue to work under the direction and support of the NHS England Cheshire & Merseyside (C&M) EPRR team. The regular Local Health Resilience Partnership (LHRP) Practitioner and Strategic meetings include an EU Exit standing agenda item, with the C&M EU Exit Project Manager included in the membership for support.

The Government is focusing 'no deal' exit planning on seven areas:

- Supply of medicines and vaccines
- Supply of medical devices and clinical consumables
- Workforce
- Reciprocal healthcare
- Research and clinical trials
- Data sharing, processing and access

WUTH 'No deal' EU Exit Planning Team

The Trust has set up a 'No deal' EU Exit Planning Team with senior management representation in line with the seven areas above. The meeting is scheduled to take place on Thursday 24th January to review progress with the instruction detailed in Annex A of the guidance – Card 1 Action card for providers. The full document is available on the Emergency Planning intranet page – EU Exit.

https://www.wuth.nhs.uk/media/10957/eu_exit_operational_readiness_guidance.pdf

Risk assessment and business continuity planning

The Trust has 'in-date' business continuity plans that are available on the Emergency Planning intranet page. These are in line with the NHSE England EPRR Core Standards and as such are reviewed annually. The next review is scheduled for February 2019. The Trust has achieved 'Substantial Assurance' at the 2018/19 EPRR Core Standard assessment and was visited by Paul Dickens Regional Head of EPRR North as this Trust was held as an exemplar site for Emergency Preparedness. As such, Jim Deacon, Head of Emergency Planning C&M has confirmed that no further work is required to our current business continuity plans.

Local EU Exit readiness preparation already undertaken:

Self-assessment of supply chain risks

The Trust was required to submit a self-assessment of potential risk to the supply chain – this was submitted by the requested deadline, to NHSI on 30th November 2018.

The approach taken by NHSI has been to work with a cohort of the biggest suppliers of clinical supplies and equipment to initiate national contingency arrangements- rather than each Trust having to agree their own plan. Local contingency plans are required where the supplier is NOT on the central list and where the Trust has assessed that there could be a potential risk to supplies in the event of UK leaving the EU with no deal.

Since the submission of the self -assessment by NHSI has expanded the list of suppliers who they will engage with at a national level.

NHS supply chain – contingency plan
NHS Supply Chain (NHS SC) is the largest distributor of clinical and non-clinical supplies to the NHS. The Trust spends c.£10m p.a with NHS SC- covering an extensive range of frequently used mainly clinical products.

NHS SC holds over 30,000 stocked product lines and has a robust contingency strategy in place with guaranteed priority entry ports at Dover and Calais. In addition they have increased their warehousing capacity by 30% and their distribution capability. Using actual usage data from Providers they are building stock in anticipation of a no deal Brexit (and also because of changes to the NHS SC operating model- all NHS Providers are being directed to purchase 80% of their consumables from NHS SC from April 2019).

Anecdotally, the larger and more critical suppliers have stated that in the event of disruption to their supply chains they will prioritise the supply of goods to those distribution channels that benefit the largest number of customers (ie NHS SC).

The Procurement team has analysed the Trust's spend on clinical consumables and in anticipation of Brexit and compliance with the Operating Model has changed the supply route for over 600 different products (£1.6M of spend) with products now coming via NHS SC rather than direct from manufacturers/suppliers or other distributors. The new ordering arrangements will be effective from 14th January 2019 and will improve the security of supply of the Trust's clinical consumables requirements in the months following Brexit. This has been achieved with a minimal financial impact to the Trust -£400 overall.

Supply of medicines and vaccines

The Pharmacy Department EU Exit Lead is in the process of assessing the risk from the supply chain perspective. The Director of Pharmacy is attending the national meeting on the 29th January held by Chief Pharmacists England which will provide further instruction. The initial instruction has been to not stockpile medicines locally; registered pharmacy professionals must always consider the consequences for patients of their actions. As we know from managing normal medicines shortages, instances of individual organisations stockpiling can risk additional pressure on the availability of medicines for patients in other areas of the country.

Summary of the work underway across government and the NHS:

- **Medicine Supply Assessment**: The government has undertaken a comprehensive assessment of medicines supply to identify products that have a manufacturing touch point in the EU or wider European Economic Area (EEA) countries.

- **Six Week Stockpile:** DHSC has received very good engagement from industry on developing a six-week stockpile of prescription only medicines and pharmacy medicines to ensure supply for patients is maintained across the NHS. DHSC has also secured contract agreements for additional warehouse space for stockpiled medicines, including ambient, refrigerated and controlled drug storage.

- **Alternative Transport Routes**: Government has reviewed transport routes for all medicines and plans are being developed with industry for re-routing where necessary. The government has agreed that medicines and medical products will be prioritised on alternative routes to maximise the ability for supply to continue unimpeded after 29 March 2019. In the event of a 'no deal' scenario this additional transport capacity and prioritisation includes prescription only medicines and pharmacy medicines, general sales list medicines and unlicensed medicines, including specials and investigational medicinal products used in clinical trials and vaccines.

- **Vaccines:** Public Health England manages significant stockpiles of vaccine for the national immunisation programme and in addition is working closely with vaccine suppliers to ensure replenishment of stockpiles continues in the event of supply disruption in the UK. In addition, DHSC is leading separate contingency plans outlined above, which includes locally procured vaccines.

- **Clinical Research including Trials**: Participation of and recruitment into clinical research including trials should continue as normal unless specific instructions from an individual sponsor or formal communications are received. Investigational medicinal products (IMPs) have been prioritised on alternative routes to ensure that the flow of all these products continues unimpeded after 29 March 2019.

- **Unlicensed Medicines**: DHSC have met all key unlicensed and specials suppliers and asked them to ensure that by March 2019 they have a minimum of six weeks additional supply in the UK in case of a 'no deal' scenario. In addition, unlicensed medicines and specials manufactures to ensure sufficient ingredients in the UK to ensure continuity of supply.

- **Operational Guidance**: National operational guidance for the NHS has been produced in December 2018 by DHSC, with support from NHS England and NHS Improvement.

- **Serious Shortage Protocol**: The government has also put in place legislation to enable Ministers to issue protocols that, where appropriate, enable community pharmacies to dispense against a protocol instead of a prescription without going back to the prescriber first. Any protocol will be developed with input from clinicians and could cover dispensing a different quantity, pharmaceutical form, strength or a generic or therapeutic equivalent.

EU Settlement Scheme

In July the Trust agreed to participate in a pilot being run by the Home Office to test a process they have developed for an EU Settlement Scheme, as a result of the Brexit vote. This will provide an opportunity to help provide reassurance to individuals who are resident EU citizens and who want to continue to work in the UK. It will also enable the Home Office to get feedback to refine the scheme for a national phased roll out commencing early this year.

The pilot will allow EU citizen staff on the WUTH payroll, to apply for UK immigration status. The pilot will be time limited and will consist of Home Office staff setting up a kiosk in the Trust and allocating short appointments for staff to make applications in person. Individuals who choose to participate will not have to re-apply once the scheme opens more widely.

37 members of staff participated in the pilot scheme held at WUTH.

Not all our staff have declared and recorded their nationality in the ESR system but 140 were identified as EU citizens.

The Trust is working on getting nationality details recorded in ESR – this is being done through drop in sessions and also through Diversity and Inclusion training sessions.

The Home Office pilot for WUTH employees, who are EU citizens, will be a positive step towards the Trust retaining valued staff in a situation where it might be at risk of losing them

2. Background

Full details provided within the Executive summary

3. Key Issues/Gaps in Assurance

Any gaps or concerns identified following the planning meeting on 24th January will be reported via an EU Exit Update Report to the Trust Management Board's February meeting.

4. Next Steps

The EU Exit Planning Team will evaluate the outcomes from the actions detailed in the EU Exit Operational Readiness Guidance at the WUTH meeting scheduled for Thursday 24th January.

5. Conclusion

Local planning is in place with support from EPRR C&M, in line with the EU Exit Operational Readiness Guidance.

6. Recommendations

The Board is asked to approve the contents of this paper and be reassured that the potential EU Exit impact on Trust business continuity is being proactively managed as information becomes available.