Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

6th March 2019

Wirral University Teaching Hospital NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 6 MARCH 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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	5.1.2 Board Action Log Board Secretary	d	Page 17
6	**Chief Executive's Report** Chief Executive	d	Page 18
7. Quality and Safety			
7.1	**Patient Story** Head of Patient Experience	p	
7.2	**Focused Review of Infection Prevention Control Improvement Plan** Director of Nursing, Director of Governance & Quality	d	Page 22
8. Performance & Improvement			
8.1	**Integrated Performance Report**		
	8.1.1 Quality & Performance Dashboard and Exception Reports Chief Operating Officer, Medical Director, Director of Nursing & Midwifery, Director of Workforce, Director of Governance & Quality	d	Page 37
	8.1.2 Month 10 Finance Report Acting Director of Finance	d	Page 44
9. Workforce			
9.1	**2018 National NHS Staff Survey** Director of Workforce	d	Page 62

10. Governance

10.1	**Report of Finance Business Performance and Assurance Committee** Chair of Finance Business Performance and Assurance Committee	d	Page 68
10.2	**Report of Trust Management Board** Director of Quality & Governance	v	
10.3	**Report of Programme Board** Steve Sewell	d	Page 71
10.4	**CQC Action Plan Progress Update** Director of Quality & Governance	d	Page 91
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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 3rd April 2019.	v

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

30th JANUARY 2019

**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
Chris Clarkson◇	Non-Executive Director

In attendance

Natalia Armes	Director of Transformation & Partnerships
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
Mike Gill	NHS Providers [Observer]
Joe Gibson*	Project Transformation
Charlotte Wright*	Member of the Public / Patient Story
Marsha Parton-Murphy*	Patient Experience Team

Apologies

David Jago	Director of Finance
Paul Moore	Director of Quality and Governance (Non voting)
Paul Charnley	Director of IT and Information
Dr Simon Lea	Associate Medical Director, Diagnostics & Clinical Support
Dr King Sun Leong	Associate Medical Director, Medical & Acute
Mr Mike Ellard	Associate Medical Director, Women & Childrens
Dr Ranjeev Mehra	Associate Medical Director, Surgery

*Denotes attendance for part of the meeting
◇ Due to adverse weather conditions arrival was during the meeting

Reference	Minute	Action
BM 18-19/169	**Apologies for Absence** Noted as above.	
BM 18-19/170	**Declarations of Interest** There were no Declarations of Interest.	
BM 18-19/171	**Chair's Business** The Chair welcomed all those present to the monthly Board of Directors meeting. In opening the meeting, the Chair informed the Board of Directors that recent discussions with the Clinical Commissioning Group (CCG) had reviewed the	

Reference	Minute	Action
	command centre analysis which had highlighted areas of poor practice such as access to nursing home beds. Whilst discussions such as these can be challenging as change is required by all parties to have a positive impact on patient flow, the outcome could lead to improvement of the overall patient experience. In addition, discussions are continuing with the Community Trust in relation to patient flow at the front door and mitigations put in place to reduce the number of stranded patients. As mentioned previously 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. It was acknowledged at the recent A&E Board that the decision making process requires clarification along with a clear understanding of all services being commissioned which impact patient flow. To support this at the forthcoming away day the Board to reviews its processes and consider opportunities to influence patient flow across the local health economy. **The Board of Directors acknowledged the hard work of all concerned during a period of high demand and as a consequence had led to minimal impact on elective surgery in comparison with previous years.**	
BM 18-19/172	**Key Strategic Issues** Board members apprised the Board of key strategic issues and matters worthy of note. **Mr John Sullivan, Non-Executive Director** – apprised the Board of concern regarding management of health & safety processes within the Trust due to the number of reported injuries and subsequent claims which had been reviewed at the Workforce Assurance Committee. Therefore the Board were requested to support an independent H&S audit and requested the Director of Quality & Governance to initiate the appropriate adviser. **Director of Nursing & Midwifery** – informed the Board that the Clatterbridge League of Friends are celebrating 65 years and all would be welcome to attend the celebrations on Friday 1st February. During the staff forums it had been highlighted that one of the reasons staff felt undervalued was due to poor quality of the staff facility area. The staff room has now been refurbished and reopened. The Director of Nursing & Midwifery also reported the success of the pilot scheme for Nursing Associates, all six had qualified and now had roles in the Trust. **Deputy Director of Finance** – apprised the Board that the recent planning meeting with the CCG, WUTH's plans were closely aligned to that of the CCG. **Medical Director** – Dr Stevenson informed the Board that the second co-hort of the top leaders programme was now underway. This feedback has been very positive. In addition, a programme run by the GMC 'Duties of a doctor' will be offered to all newly appointed consultants and SAS doctors The	**PM**

Reference	Minute	Action
	programme will run on an annual basis. An engagement event for consultants 'The big debate' has been arranged for the evening of Tuesday 26th February to discuss transformational programmes, including outpatient services, with senior clinicians. Feedback will be provided at the next Board meeting. **Chief Operating Officer** – the Board was apprised that at the recent Wirral Overview & Scrutiny Committee (OSC) whilst some concerns were raised under the umbrella of 'privatisation of NHS services' there was recognition by some council members for WUTH's approach to step down beds ie the facility on the Clatterbridge site. Mr Middleton reported that the turnaround time of the Clatterbirdge T2A beds is now 3 weeks in direct contrast to the community T2A beds whose turnaround varies between 4.5 and 6 weeks. **Mr John Coakley, Non-Executive Director** – requested the Board receives feedback following actions as a consequence of recent patient stories. The Board were advised that a 'Customer Relation Strategy' has been drafted and encompasses a number of areas such as outcomes and themes, it will also capture the lessons learned to improve the patient experience. This could be reflected within the Strategy discussions at the forthcoming away day. **Mrs Sue Lorimer – Non-Executive Director** – sought clarification regarding accountability for Divisions and Corporate departments to work within budget to ensure the Trust will be able to deliver its control total. The Board were assured that this matter was highlighted as part of the budget setting process across the Trust and had informed discussion at the Divisional Performance Reviews (DPR's). The Board noted that the Director of Transformation & Partnerships, Natalia Armes and Non Executive Director, Jayne Coulson had no items to report.	
BM 18-19/173	**Board of Directors** **Minutes** The Minutes of the Board of Directors Meeting held 19th December 2018 were approved as an accurate record. **Action Log** In agreeing the Board Action Log, Board members also gave assurance that actions would be reviewed, addressed and actioned as required.	
BM 18-19/174	**Chief Executives' Report** The Chief Executive apprised the Board of the key headlines contained within the written report. **Serious Incidents** - in December 2018 the Trust declared four incidents that crossed the threshold for reporting as a serious incident. One within the Division of Medicine and Acute, one within Diagnostic & Clinical Support Division and two within the Division of Women and Children's.	

Reference	Minute	Action
	In all cases investigations are underway and Duty of Candour properly applied. **Major Incident – External power supply failure -** as a consequence of the power failure affecting the CH43 and CH49 postcode areas of Wirral on Sunday 13th January a major incident was declared by the Executive Director on-call (Incident Commander). 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. 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. **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. 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. **Quality Assurance visit – Antenatal and Newborn (ANNEB) –** following the Public Health England Quality Assurance team visit on 3rd December to review all aspects of the ANNB screening programme, a draft report has been received for review and accuracy checking. The final report is expected in February 2019. **Millennium Upgrade –** took place on 18th/19th January. 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. Due to reporting delays, this matter had now been outsourced until the issues are resolved. To encourage visibility across the Trust and for Board members to have	

Reference	Minute	Action
	greater understanding of services provided by the Trust a schedule of visits to be co-ordinated for Board meeting dates. Mr Middleton confirmed that the 6 facet survey was due for completion in March and this would then be utilised to inform the external advice that has been sourced to support a review of the Trusts estates and facilities management. ***The Board noted the information provided in the January Chief Executive's Report.***	
BM 18-19/175	**Strategy Update** The report provided the Board an outline of progress to date regarding the development of a Trust Strategy. A series of workshops across specialities and divisions have taken place to encourage engagement and inspire staff contribution. Participation at these events has been high and staff have felt empowered to highlight where things have not worked well in the past and provided alternative suggestions. The strategy will reflect external factors such as the NHS Long Term Plan and have a golden thread from Ward to Board to demonstrate what success looks like. The Long Term Plan will be a focus of the Strategy discussion at the away day in February and will seek to consider new models of delivery and source best practice options. In summary to ensure a golden thread is achieved broader stakeholder engagement continues and it was acknowledged that some elements of the strategy would be driven top to bottom whilst others would be bottom up. Work is underway with the creative partner to develop the story boards that will need to look and feel different to ensure staff buy in. ***The Board noted progress to date regarding the development of a Trust Strategy.***	
BM 18-19/176	**Patient Story** The Board was joined by Charlotte Wright, who apprised the Board of her brother's recent experience as a patient. Her brother was usually a very healthy and active young man, at the age 21. For a period of approximately 18 months prior to admission to WUTH he had suffered a long term cough. On returning home from a music festival he had deteriorated and was taken to the walk-in-centre who referred him to A&E. He was diagnosed with pneumonia and admitted to receive treatment and subsequently discharged. A week later he was taken back to A&E, admitted and then transferred to HDU due to clinical need. Following further investigations and treatment he was discharged 10 days later. He was then referred to Haematology outpatients where he underwent further tests and then referred to Haematology at the Royal Liverpool Hospital for a bone marrow biopsy. The	

Reference	Minute	Action
	results showed he had Chronic Eosinophilic Leukaemia (CEL). Throughout this rollercoaster of emotions for all the family it was the care and compassion which was focused and tailored to him that made the ordeal a bit more bearable. The family wished to thank all the staff involved in caring for her brother and the support offered to the wider family at such a traumatic time. On behalf of the Board, the Chair expressed his thanks and appreciation to Charlotte for sharing her experience. ***The Board noted the positive feedback received from Miss Wright on behalf of her brother and family.***	
BM 18-19/177	**Infection Prevention & Control Performance Report** The Board were provided an update pertaining to the current health care associated infection position and the proposed improvements with IPC practices within the Trust. The report outlined the Trust's current position of HCAI April – December 2018: • *Clostridium difficile* • MRSA • Carbapenemase producing *Enterobacteriaceae* (CPE) • *E. coli* The Director of Nursing & Midwifery went on to explain that due to operational pressures bed occupancy was running between 95-100% which impacts the Trusts ability to fully comply with all elements of IPC measures. An outbreak of Carbapenemase Producing Enterobacteriaceae (CPE) on 3 wards was reported and the Trust is working closely with Public Health England (PHE) and the CCG to manage the outbreak. A review of all areas has been completed with some environmental issues highlighted eg availability of side rooms and cleaning processes. An urgent review of CPE screening policy is planned to ensure adherence to PHE requirements. There has been an outbreak of Cdiff on ward 23, to date 8 patients have acquired this infection. All Clostridium Difficile Toxins (CDTs) have been ribotyped and all have the 027 strain which is most virulent strain, producing most toxins and increased episodes of diarrhoea. Again the Trust is working closely with PHE and the CCG to ensure all actions in place are appropriate. Due to this outbreak concern was raised that the Trust would breach the threshold of 28 avoidable cases, as of 25th January the Trust has reached 26 cases. A further focus on hand hygiene compliance is under way emphasising back to basics including ward environment including the provision for hand washing facilities and cleaning standards and the need to reenergise signage posters etc. Competency for nursing staff shared and being assessed at ward level as part of perfect ward. Identified need from recent audits competency to shared and assessed with medical staff, and support staff	

Reference	Minute	Action
	porters, domestics, IT. ***The Board noted the current HCAI position and the progress to date. Due to concerns raised primarily regarding the improvements being embedded across the organisation the Board requested a focused review of the improvement plan to be provided at the meeting.***	**GW**
BM 18-19/178	**Quality & Performance Dashboard and Exception Reports** The report provides a summary of the Trust's performance against agreed key quality and performance indicators. 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. Of the 58 indicators with established targets or thresholds 34 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: • Medicines storage – review and standardisation of metrics. • Hand hygiene – introduced increased visibility to highlight individuals responsibility to decontaminate hands and further training to be provided for non clinical staff • VTE – introduction of reminder within Cerner has seen a significant improvement in performance • Safer bundle: discharges – Executive's supported focus on SHOP process and Patient Flow Improvement Group monitoring discharges. Process under review as there has been no improvement in discharge timing. • 4 hour waits – need to expedite discharges to improve performance • Referral to treatment (RTT) - discussions with CCG ongoing following recent changes to national guidance and the impact for WUTH • Cdiff - eight cases are currently being reviewed. The Chair of Audit Committee expressed concern that at the last meeting, the Committee had written off losses in relation to medicines storage and stressed the need for staff to be aware of the consequences of poor storage ie the financial impact for the Trust. The Board expressed a concern regarding the continued poor performance regarding hand hygiene. The Director of Nursing reported that whilst monitoring of hand hygiene competencies are being monitored via the Perfect Ward app following recent audits it was apparent that competencies need to shared and assessed with medical staff, and support staff porters, domestics, IT. As previously discussed further training will be provided for these staff groups. Interim support has been brought in whilst a recruitment process is undertaken for the IPC lead. The Chief Operating Officer reported that the Trust continued to work with NWAS in relation to ambulance handovers pilot and had on average seen	

Reference	Minute	Action
	improvement in recent weeks. Due to constraints of the layout of ED, WUTH have provided support by the on-call matron to monitor patients to release ambulance crews for patients above 1 hour. NWAS and WUTH are reporting data to confirm operating 2 systems and how this impacts compliance. 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%. It has been identified that the capacity in two key modalities is not resilient enough, therefore 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. Compliance with the threshold is expected to be February 2019. ***The Board noted the current performance against the indicators to the end of December 2018.***	
BM 18-19/179	**Month 9 Finance Report** The Deputy Director of Finance apprised the Board of the summary financial position. At the end of month 9, the Trust reported an actual deficit of £24.8m versus planned deficit of £20.9m, an adverse to plan position of £3.9m. The underlying deficit given deployment of non-recurrent resources of £2.3m at month 9 is c £27.1m. The underlying income (£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 key driver of the variance is the under-performance elective, both surgery and medicine and day case both in activity and case mix, outpatients and pay (net of pension changes) – back pay in surgery. The Deputy Director of Finance reported that cash is better than plan at £6.6m as a result of capital slippage and working capital movements. There were no significant balance sheet variances – in line with cash management approach and capital slippage. Capital expenditure is £2.9m YTD against full year programme of £13.0m. Significant schemes in progress include MRI scanner, GDE, PACS, Estates backlog and medical equipment. Additional key aspects apprised to the Board included: • Elective income which continues to under-perform against plan although the run rate has improved from Q1. (£700k per month to £400k per month) • Non-pay pressures associated with out-sourcing both elective activity and diagnostics, noting that elective outsourcing is expected to reduce significantly in Q4. • Pay pressures in medical pay and acute care nursing have been mitigated with vacancies in other area's, predominately corporate and non medical and acute nursing. • CIP is currently achieving plan but the plan is profiled to deliver more in Q4 and in addition a proportion of the delivery (£2.9m) is non-recurrent against vacancies/non-pay.	

Reference	Minute	Action
	The Trust committed to a forecast deficit position of (£27.3m) with NHSI at the meeting in January following the December meeting where delivery of the planned position of (£25.0m) was sought. Discussion took place to regarding the risks of not achieving forecast for months 10 – 12. The Deputy Director of Finance advised that Divisions are reviewing mitigations to address risk of activity being off plan and how to mobilise solutions. It was agreed that future reports should articulate the current position and the actions undertaken to address gaps. ***The Board noted the M9 finance performance and the risks regarding impact of winter electives and non-elective case mix not transpiring as expected.***	**KE**
BM 18-19/180	**NHSI Changes to Forecast Protocol** The Deputy Director of Finance apprised the Board that as the Trust has been forecasting to NHSI deterioration in its financial position and its ability to meet its agreed financial value since the beginning of Q3 the Board has to follow an agreed protocol in respect of changes to the forecast outturn position. As this can only be completed at quarterly reporting point it is required for the Month 9 reporting period. As part of the protocol the Board is required to sign off an Assurance Statement containing the key elements of assurance: finance and governance ***The Board noted the NHSI changes to forecast protocol and confirmed the statements contained in the Assurance Statement.***	
BM 18-19/181	**2019/20 NHS Operational Planning Guidance** The Deputy Director of Finance provided an overview of the 2019/20 Planning Guidance issued in January and advised of the control total issued on 15th January 2019. 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. Due to the timing of Trust Board meetings the Board were requested to delegate to FBPAC the approval of the draft Operational Plan and agreement of the Control Total. An invitation to all Board members was offered to attend the FBPAC meeting on 8th February 2019. ***The Board noted the 2019/20 NHS Operational Planning Guidance and delegated to FBPAC the approval of the Draft Operational Plan submission and agreement of the Control Total.***	**KE/AL**
BM 18-	**Report of Finance, Business, Performance & Assurance Committee**	

Reference	Minute	Action
19/182	Ms Sue Lorimer, Non-Executive Director apprised the Board that the Committee confirmed support for the business cases in relation to the supply of natural gas and telephony upgrade reviewed in detail at Trust Management Group. ***The Board noted the verbal update of the Finance, Business, Performance & Assurance Committee.***	
BM 18-19/183	**Report of the Charitable Funds Committee** Ms Sue Lorimer, Non-Executive Director apprised the Board that the Committee approved the Charity's Annual Report & Accounts 2017/18. The Committee had considered appeal options 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. ***The Board noted the approval of the Charity's Annual Report & Accounts 2017/18 and the appeal preferred choice for works at the Neonatal Unit.***	
BM 18-19/184	**Report of Trust Management Board** The Chief Executive provided a summary report of the Trust Management Board (TMB) meeting on 23rd January 2019. The reports outlines matters agreed by the TMB for escalation to the Board. TMB considered and agreed in principle a 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. The proposal to be considered at FBPAC in February 2019. ***The Board noted the report of the Trust Management Board and approved the recommendation to procure the supply of gas for 4 years through the COCH framework.***	
BM 18-19/185	**Report of Workforce Assurance Committee** Mr John Sullivan, Non-Executive Director apprised the Board that the Committee agreed to complete a gap analysis of the WUTH Workforce	

Reference	Minute	Action
	improvement agenda with the NHS Long Term Plan and present conclusions and recommendations at its next meeting. The Committee received a staff story from a disabled part time long serving member of 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. 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 received a 'deep dive' on band 5 nurse recruitment, retention and demographics. 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. ***The Board noted the report of the Workforce Assurance Committee and acknowledge the approach to undertake an independent Health & Safety Audit as mentioned earlier in the meeting.***	
BM 18-19/186	**Report of the Quality Committee** Mr John Coakley, Non-Executive Director, apprised the Board of the key aspects from the recent Quality & Safety Committee, held on 24th January 2019. 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 key areas of improvement were: • Adherence to NICE guidelines • Medicine storage • VTE prophylaxis • Water safety management • Overnight bed moves • Pressure ulcers • Ward accreditation • Serious incident management Some of the areas for escalation are: • Mortality reviews • Infection control	

Reference	Minute	Action
	• Hand hygiene • Bedding in of revised palliative care staffing ***The Board noted the Quality Committee report, approved CNST Maternity Incentive Scheme Year 2 and noted that the Chair of the Quality Committee would be the Board level champion for this programme.***	
BM 18-19/187	**Report of Programme Board** Joe Gibson, External Assurance provided a summary of the Trust's change programme and the independent assurance ratings undertaken to assess delivery. He advised that it had been agreed at Executive Management Group (EMT) that the Quality, Safety & Governance programme should be aligned to the 4 workstreams identified in the Quality Strategy. In addition as IT enhanced (paperless) was business as usual this should be across all programmes. The Board were informed that the programme team had been strengthened with the appointment of experienced individuals to support senior managers. Whilst the Board acknowledged the positive progress to date there were some areas of concern highlighted during the discussion: • Review legacy of some programmes and ensure fully defined including benefits and efficiencies. • Financials within programmes to be reflected in the Trusts forecast outturn • Annual review of entire programme to be built in the schedule • Clinical variation – not assured at present so alternative reporting via Quality Committee proposed • Workforce planning tool – pilot to established in Women's & Children June '19. • IT programmes internal / external priorities to be aligned. It was recognised that the recent modifications to the governance processes versus business as usual culminated with the changes within the leadership teams has led to discussions on strengthening the relationships, establishing objectives and the support required for the triumvirate to be held to account. ***The Board noted the Trust's Change Programme assurance report and recognised the need to improve the visibility of the programme and ensure all elements including finance, CIP and workforce are reflected in the programme.***	
BM 18-19/188	**Report of the Audit Committee** Mr Steve Igoe, Non Executive Director provided a verbal update following meetings held on 29th November 2019 and 22nd January 2019. At its meeting in November 2018 the Committee approved the proposed revisions to the Standing Financial Instructions (SFI's) with the exception of the thresholds regarding waiver approval limit and business cases. The Committee had requested benchmarking information regarding these two	

Reference	Minute	Action
	elements which was provided at the January 2019 meeting with revised thresholds which the Committee subsequently approved. The revised SFI's were circulated to Board members electronically. At its January meeting the main focus related to year end processes with the support of internal and external audit. ***The Board noted the verbal report of the Audit Committee and acknowledge the approach to undertake an independent Health & Safety Audit as mentioned earlier in the meeting.***	
BM 18-19/189	**CQC Action Plan progress Update** The Medical Director apprised the Board that the report provided progress pertaining to the CQC Action Plan. The Medical Director outlined the 5 actions identified as 'red-rated' following confirm and challenge meetings and were reported as exceptions for this reporting period. The 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. She 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. Whilst the Board recognised the improvement clarification was sought in relation to progress against the Well-led actions due to the 'inadequate' rating at the previous inspection, particularly in some of the workforce metrics. The Board were advised that Divisions/Corporate Departments were now accountable for compliance against these metrics with challenge at the DPR's and performance reported in the Quality dashboard. The Board were informed that significant progress had been made regarding the divisional risk registers and the output of this review would inform the corporate risk register and the Board Assurance Framework (BAF) 2019/20. ***The Board noted the progress to date of the CQC Action Plan and acknowledged the invitation to visit wards to provide assurance that actions are embedded.***	
BM 18-19/190	**EU Exit Operational Readiness Guidance for the Health and Care System** The Chief Operating Officer apprised the Board of the guidance issued by the Department of Health & Social Care in early January 2019. 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.	

Reference	Minute	Action
	The Trust has set up a 'No deal' EU Exit Planning Team with senior management representation in line with the seven areas identified in the guidance. The EU Exit Planning Team will evaluate the outcomes from actions detailed in the EU Exit Operational Readiness Guidance. ***The Board noted the contents of the report and were assured that the potential EU Exit impact on Trust business continuity is being proactively managed as information becomes available.***	
BM 18-19/191	**BAF / Risk Register** The Board noted that development of the 2019/20 BAF is underway and will be considered at a Board development session.	
BM 18-19/192	**Any Other Business** There was no other business to report.	
BM 18-19/193	**Date of next Meeting** Wednesday 6th March 2019.	

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Chair

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Date

Board of Directors Action Log
Updated – 30 January 2019

Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 30.01.19						
1	BM 18-19/172	Undertake an independent H&S audit	**PM**	Complete	April '19	Proposal to commission independent audit approved at TMB 28.2.19
2	BM 18-19/177	Provide a focused review of the IPC improvement plan to be provided at the next meeting	**GW**	Complete	March '19	See agenda item 7.2
3	BM 18-19/179	Finance report to articulate the current position and the actions undertaken to address gaps for 2018/19	**KE**	Complete	March '19	Included in the Month 10 Finance Report
4	BM 18-19/181	2019/20 NHS Operational Plan – invitation to all Board members to attend February FBPAC to approve draft plan for submission to NHSI	**KE/AL**	Complete	March '19	
Date of Meeting 28.11.18						
7	BM 18-19/144	Provide an updated overview of the Trust risk profile	**PM**	Complete	March '19	See agenda item 10.5
Date of Meeting 27.9.18						
5	BM 18-19/104	Review of Information and Coding Assurance Report to FBPAC	**PC/DJ**	Complete - Trajectory to address back log under review and process map identifying timeframes being produced	February '19	To be monitored via Information governance and Coding Group reporting to Risk Management Committee

Board of Directors	
Agenda Item	6
Title of Report	Chief Executive's Report
Date of Meeting	6.3.2019
Author	Janelle Holmes, Chief Executive
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

This report provides an overview of work undertaken and any important announcements in February 2019.

Serious Incidents

During January 2019 two serious incidents were declared by the Trust. The first incident relates to a patient for whom administration of enoxaparin may have contributed to a bleed. The second relates to patients whose death certificates documented Clostridium Difficile as part 1a.

In both cases full investigations are underway and duty of candor has been undertaken.

Millennium Upgrade

Whilst the large majority of issues generated after the 2018 Cerner Upgrade have been resolved there are still some final issues that need to be resolved. Of the 97 issues raised we are now down to 17 Service Requests open with Cerner, of which the only Critical or High issues are within Radiology.

Cerner have had various people on site in radiology since the problems began. They have undertaken extensive investigations into the problem leading them to isolate two Cerner programmes which seem to be conflicting with each other. They have not as yet got a complete root cause analysis so we do not have a final end date for the issue. Cerner UK have agreed to compensate the Trust for any radiology reporting work we have had to outsource.

We have purchased and are in the early stages of implementation of a new PACS (Picture Archive and Communication System) which will alleviate some of these issues and will be operational during Q1.

EU Brexit Planning

The Trust EU Exit Planning Team, in line with the DHSC EU Exit Operational Readiness Guidance, continues to prepare for a 'no-deal' scenario should the UK leave the EU without a ratified deal. This work is carried out with the support of the NHS England local and regional EU Exit Teams.

The DHSC has ensured that suppliers have built up stock to provide additional resilience and is confident that if Providers do not deviate from their current ordering patterns, the supply of medicines and other medical supplies will be uninterrupted in the event of exiting the EU without a deal. National contingency arrangements have also been put in place to enable the continued movement of these products in the event of disruption. Delivery of products to customers is envisaged to follow normal patterns; however, subject to the variation in the flow of supplies that may result, some flexibility might be required in terms of delivery windows, including night-time or weekend deliveries. The Trust will work to comply with this request. There is a clear instruction that NHS Providers should not stockpile products. A WUTH EU Exit intranet page has been set up to provide information for staff.

Wirral A&E Delivery Board

There are a number of actions being overseen by the Board in support of System Performance.

These include:

- Wirral University Teaching Hospital being one of 6 Trusts piloting a NWAS Improvement Programme to reduce average ambulance handover times.
- Physicians supporting 'inreach' Emergency Department.
- Executive review of stranded and superstranded patients with collaboration by partners to support activity pertaining to the overall SAFER bundle. It was also agreed that the review would be expanded to include providers of Mental Health Care and Wellbeing.
- The agreement to support and develop further 7 day working across all System Providers.

A number of priorities remain for the A&E Delivery Board that include; ambulance handover and turnaround times, Transfer to Assess readmissions and the National 4 hour standard.

The A&E Delivery Board also received a paper outlining a high-level approach to reduce Non-elective attendances and admissions for 2019/20, linked to the National Operational Planning Guidance. A wide ranging number of priorities had been recommended that included:

- Integrated Urgent Care Clinical Assessment via the NHS 11 Service.
- Community Services and a review of the Better Care Fund.
- Improved use of technology / telehealth linking to a new operating model for integrated SPA [Single Point of Access], with an emphasis on assisting to reduce hospital admissions.

Update on the New Royal and maintaining the current Royal

The Trust has received notification that Board at Royal Liverpool and Broadgreen University Hospital are working closely with Laing O'Rourke and external advisors on a fully costed assessment of all the works needed to complete the new hospital, which is expected by the end of March.

Whilst the Department of Health and Social Care have outlined their commitment to supporting the funding of the new hospital, the final costings and the additional capital and revenue funding required will be set out in a business case that they will submit for approval to the Department of Health.

In the meantime, additional capital funding to maintain patient safety and ensure they can continue to provide services in the existing hospital has been provided by the Department.

They will continue to keep stakeholders informed of progress.

RCN Midwifery Awards

Congratulations to our Maternity Service who have been nominated for the Royal College of Midwifery Maternity Service of the Year Award 2019.

The hard work and dedication of our staff in supporting our women and families has led to the nomination for this prestigious national award. We wish them well for the award ceremony on 5th March in London.

NHS Staff Survey Results

Baroness Dido Haring, Chair NHS Improvement has stated that the staff survey results published at the end of February underline the need to change and improve the culture of the NHS to make sure every member of staff is supported to develop and thrive.

A key part of the workforce implementation plan is looking at how we can make the NHS the best place to work for current and future staff and to improve our leadership capabilities at team, organisation and system levels.

A summary of the Trusts outcomes are contained in agenda item 9.1.

CQC Trust Level Outlier Report

In January 2019, the CQC published the results of 2018 survey of women's experience of maternity care. This confirmed that WUTH is included in the top 9 Trusts which achieved better than expected results.

Out of the 9 Trusts, WUTH achieved 85 positive responses (highest score) and the least negative responses (6 overall). A copy of the report is available via the CQC website: https://www.cqc.org.uk/sites/default/files/20190129_mat18_outliers.pdf

NHS Providers – Fit & Proper Person Test

Tom Kark, QC was commissioned by the Secretary of State for Health to review the scope, operation and purpose of the Fit & Proper Person Test (FPPT). The review has identified a range of issues with the Fit and Proper Person Test and the way it is currently interpreted and applied. It concludes that the FPPT does not ensure directors are fit and proper for the post they hold, nor does it stop people who are unfit from moving around the system.

The review makes 7 recommendations and the Secretary of State for Health has already confirmed that the government will accept two of the recommendations: that all directors should meet specified standards of competence to sit on the board of any health providing organisation, and the creation of a central database holding relevant information about qualifications and history about each director (including NEDs). Baroness Dido Haring (Chair, NHS Improvement) has been asked by the Health Secretary to consider the remaining recommendations and how they can be implemented.

As the recommendations would normally be the subject of a full consultation, NHS Providers have written to Baroness Harding to seek her assurance that she will create a full and proper consultation process.

As yet no timeframe for implementation of the recommendations has been identified. Trust policy will be updated to reflect the changes once the guidance is received and the Board will be kept informed of updates relating to this matter.

Janelle Holmes
Chief Executive
March 2019

Board of Directors	
Agenda Item	7.2
Title of Report	Focused review of Infection Prevention & Control improvement plan
Date of Meeting	6 March 2019
Author	Gaynor Westray, Director of Nursing & Midwifery / Director of Infection Prevention & Control
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)**	Gaps Lack of assurance around hand hygiene compliance and cleaning standards
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 ensure the Board of Directors are up to date on the progress of the Infection Prevention and Control (IPC) Improvement Plan, and to highlight to the Board by exception any elements of the plan that are not on track or at risk of not meeting target dates for implementation. Therefore requiring a focused approach to ensure improvements are achieved and embedded across the organisation.

2. Background

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.

The IPC improvement plan was initially developed following a peer review from Manchester Royal Infirmary in November 2017. The IPC improvement plan has been reviewed and further updated in December 2018. This updated version was presented and discussed at the Patient safety and Quality Board and the Trust Infection Prevention and Control Group. (Appendix 1 – improvement plan)

3. Current position

There are 22 improvement actions associated with infection prevention and control. Although there has been progress against the agreed improvement plan, the Board requested further assurance as to the outstanding actions required and the timescale expected to address these actions as there remains a concern around the increased incidence of infections and the recent outbreaks. Intelligence from the post infection reviews has identified that compliance with the 'basic' standards of good practice around cleaning, and hand hygiene within the non clinical staff groups are the key areas to focus and address. The facilities and enironment has also been highlighted with particular focus required to 'de-clutter' clinical areas and the lack of hand wash basins on the entrance to each ward The current operational pressures within the Trust has resulted in a high bed occupancy of betweem 95-100%, and this has had an impact on the ability to cohort nurse patients with healthcare acquired infections.

Action: Safe Clean Environment

Adhering to and monitoring cleaning standards are vital for maintaining infection control and instilling public confidence. To support this approach the 'Big Debate' for domestics and porters is scheduled Friday 1 March 2019, these sessions will provide an opportunity to discuss the wider Trust agenda and reinforce their role and impact on patient safety and patient experience.

Hotel services have recently developed education and training framework for band 1 and band 2 staff (domestic and portering staff) to ensure knowledge and skills are appropriate to the role.

All ward areas have been reviewed by Divisions and IPC team in January 2019. Identified areas of priority including storage facilities for ward equipment, and refurbishment requirements.

The Trust has Implemented the Environmental Auditing and Reporting system with support of Divisional senior nurses and IPC team to ensure quality assurance which will become part of the wider Hotel Services reporting and auditing system. The introduction of the upgraded MIC4C Cleaning Audit software will further demonstrate the Trusts ongoing commitment to ensure the provision of a clean and safe hospital. The upgraded MIC4C Cleaning Audit software is a powerful tool which helps users to provide a clean, safe and risk free environment. It was developed to conform to Department of Health standards of cleanliness, to drive safe environment standards and ultimately encourages quality improvements. A review of this software is currently underway.

Action: Hand Hygiene

Handwashing is the single most important way to prevent the spread of infection. Hand decontamination has a dual role to protect both the patient and the health care worker from acquiring micro-organisms which may cause them harm. The environmental review confirmed that most wards do not have adequate hand washing facilities on the entrance to ward. Although alco gel available, hand washing with soap and water is essential for physically soiled hands and for management of specific infections e.g. *Clostridium Difficile*. Estate managers are reviewing the costs and timescale for installing hand washing basins in the entrance of each ward. This review is expected end of February 2019.

All ward managers now using perfect ward App to complete weekly review of hand hygiene compliance across all staff groups, challenging poor practice and supporting staff to ensure understanding of requirement to adhere to Trust policy. Improvement has been noted in February audits.

Hy-genie tool is being reviewed by the DIPC and IPC team as an innovative method for increasing hand hygiene compliance of staff. Hy-genie involves sensors in staff ID badges and wall mounted detectors next to all gel and soap dispensers this will record the date and time of hand hygiene opportunities taken. Staff and managers will have access to personalised, individual report any time via an online dashboard. This allows staff to take ownership of your personal hand hygiene performance. Individuals can compare their results to the average for their job role. Reports will enable line managers and Infection Prevention & Control teams to help with education if staff groups need support with hand hygiene to improve performance. Meeting held in January 2019 with Dr. Richard Cooke as part of Innovation Hub at Alder Hey. First pilot site is Alder Hey with clinical evaluation in progress. If the evaluation is positive additional Trusts to be recruited to join the trial, WUTH has expressed a keen interest to be part of the next cohort. The Trust is currently awaiting the outcome of this proposal.

4. Summary

The priority to ensure a safe clean clinical environment is essential to support further reduction in the incidence of infection. Focused work with key staff groups will ensure understanding of individual roles and requirement to comply with Trust policy regarding Hand hygiene. All actions will be monitored via the Trust Infection Prevention and Control Group and reported to Patient Safety and Quality Board.

5. Recommendation

Board of directors is asked to note the current work streams to support planned progress identified in 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.

Infection Prevention and Control - Improvement Plan
Reviewed / updated February 2019

The progress with the Improvement plan will be monitored by the Infection Prevention and Control Group (IPCG) and reported to Patient Safety and Quality Board by exception.

Issue	Action Required	Lead	Target Date	Evidence Source	RAG Rating	Progress Update
1. Safe clean ward environment, including de-clutter, adequate storage, minor works,	• Ward by ward review by divisions to determine issues re Storage, IPC, estates, hand wash basins, cleaning, and equipment • Identify suitable dedicated storage facilities for mattresses. • Review solutions for improving provision of hand wash basins in domestic room and clinical areas	Div DoN Estates	March 2019	• Option appraisal for storage of mattresses developed for discussion/decision. • Risk assess current approach to lack of handwashing basins.		26/06/18 – discussed at IPCG, to be escalated to Q&SC 09/10/18 IPC met with decontamination unit to reconfigure environment to create mattress store. Works schemes to be identified and supported by Estates. **Dec 18** – division review of each ward area to be completed and presented to DiPC end of Jan 19 Feb 19 - To triangulate with C4C outstanding estate actions and prioritise Feb 19 -Review of hand wash wash basin on entrance to each ward underway
2. Provision of hand wash basins on Ward 30 ensuite bathrooms	• Review solutions for improving provision of hand wash basins clinical areas	DiPC Estates	May 2019	• Risk register entry		Dec 2018 - Work to improve ensuite and hand hygiene facilities on Ward 30 has been approved Start date May 2019

3. Thermal disinfection of patients water jugs and lids	• IPC / DIPC / Hotel services to meet to plan a process / schedules to address	IPC / DIPC / Hotel Services	March 2019	• SOP in place for standard processes and programme for thermal disinfection.		Pilot completed re use of dishwasher further actions required November 2018- meeting held with Head of Hotel Service and Head of Estates and a number of actions agreed: HS to complete an options appraisal by 12/11/2018. **Dec 2018** - Options appraisal completed by Hotel Services, approved by DIPC and COO for all jugs and lids to be processed through dishwashers. Disposable water cups to be reviewed at PFEG and N&H steering group February 2019 – Business case has been revised by Hotel Services. Hotel Services to meet with DIPC and COO in early March 2019 to review and agree strategy. Currently providing a reactive service only
4. Water safety – to reduce the risk of Legionella and Pseudomonas: flushing of water outlets, 2 x weekly for Legionella and	• All areas to complete appropriate water safety checks and provide evidence of compliance	Divisions / Estates	March 2019	• L8 Guard to report 100% compliance • Water safety group to report and escalate concerns of non-compliance		Compliance at ward level needs to improve with effective escalation in division and accountability PSQB agreed expectation of 100% flushing compliance end of November 2018.

daily in augmented care facilities for Pseudomonas						February 2019 – Improved compliance noted in January 2019 with APH achieving 98% compliance and CBH 94%. Divisions checking that all areas are correctly identified within the report
5. Launch ANTT across the Trust	• Develop plan & policy for Trust wide roll out of ANTT, with targeted high risk areas first.	IPCT/ CST	March 2019	• Roll out plan is in place and adhered to. Monthly monitoring via IPCG		21/06/18 – ANTT proposal paper presented to CCG and approved 1/8/2018 ANTT training to continue throughout August 2018 through Clinical Skills. 09/18 Trial to start in ED and Critical Care 5/9/2018 Further implementation meeting with Clinical Skills and revised implementation plan for the Trust. All areas to be compliant by February 2019. **Dec 2018** –business case approved re change of product. Nurse Educators within Medicine and Acute Division. Revised implementation plan has been produced to support Trustwide implementation by September 2019. Feb 2019 – Meeting held to discuss progress with

						ANTT. Competency assessments to be added on OLM to provide assurance of progress against plan. Audit of compliance to be undertaken 3 months after ANTT has been embedded in each individual area as per ANTT guidance.
6. Location and visibility of Alcohol hand rub throughout the Trust.	• Review visibility and placement of IPC stations and dispensers for Alcohol hand rub ensuring safety issues are considered.	Proc Team/ IPCT	March 2019	• Chosen products are in place – (based on Effective and efficient use of resources) • Hand hygiene audits on Perfect Ward mobile app		February 2019 – Trial of Deb Alcohol Hand Foam and soap completed on Ward 36, Emergency Department and Critical Care, as well as Neonatal Unit. Company due to undertake a site survey at February ahead of Trust wide roll out throughout March and to review stands and key messages relating to hand hygiene.
7. Review and update Induction and Mandatory Training package, including eLearning packages to include decontamination / cleaning.	IPC to meet with L&D to update training package and e-learning	IPCT/ L&D	March 2019	• Updated IPC induction and mandatory training package available		February 2019 – E-learning packages are now available 3 yearly for non-clinical staff and every other18 months for clinical staff. All other IPC packages have been reviewed and updated, with additional time allotted for face to face mandatory training for clinical staff.

8. Clear protocols for IPC screening for frontline staff to follow	• Recommended changes to IPC screening to be reviewed and changes agreed by IPCG	Micro / IPCT	March 2019	• Recommended changes to strategy have been agreed by DIPC / IPCG • Agreed changes have been discussed with CCG and PHE at IPCG		No change to MRSA screening strategy. 26/06/18 – CPE screening paper presented to IPCG. ADN for IPC to review strategy and costings. 1/8/2018 ADN for IPC met with Divisional Manager for Clinical Laboratories to discuss costs and availability. Division Manager to develop cost analysis for September 2018 Board update. 27/09/18 CPE readmission screening to be planned with Microbiology. Microbiology testing to be reviewed with lab to introduce readmission screening (8th November 2018). Dec 2018 - CPE screening for patients readmitted within 12 months remains outstanding. IT solution is now available to automatically request screen. Further review of resource implications for Laboratory outstanding **Dec 18** meeting scheduled for Jan 19 to review (PHE, DiPC, MD, Micro, Clinical support)

						February 2019 – Introducing screening for patients readmitted within 12 months will have resource implications to Laboratory. Further work in progress to identify impact. Task and Finish Group identified to review and agree CPE Policy.
9. Risk based mechanism required to ensure that appropriate patients with infection risk are identified in a timely way	• Drive improved compliance with screening requirements through the use of automatically generated compliance reports for CPE and MRSA screening. • IPC work processes to be reviewed to determine if any IT solutions can support IPCT to improve ways of working	IT / IPCT	March 2019	• Screening reports are generated automatically and improvement trajectory is being met and monitored via IPORT. • IPCT processes to be included in comprehensive review of IPCT • IT updates to be provided to IPCG		IT reporting system is currently being changed, once completed IPC IT Analyst will work with IT to develop appropriate reports. Ward staff have the ability to access the M Page Portal to view patient daily screening compliance. 27/06/18 – IPC IT analyst to confirm when changes made to Data Warehouse to then progress with developing report. 11/10/2018 IT report system ready to test for 'go live' November 2018. 29/11/18 – IPC IT analyst met with Head of Business Intelligence to review IPC requirements for automatic reporting Bi weekly IT meetings held to review progress with IPC requirements. 2/08/18 IT meeting with

						IPC and awaiting total system upgrade in September 2018 before IPC changes can be implemented 11/10/18 No IT solution in place, queries taken wider to Cerner Millennium for a solution. 25th October 2018 IPC to test the system with a 'go live' in November 2018. February 2019 – Delay in auto alerting due to potential changes to CPE screening strategy. Auto reporting remains outstanding. Unable to progress until CPE policy agreed (as above)
10. Reduction of Gram negative bloodstream infections (GNBSI) by 50% up to 2021	• Fulfill requirements of Wirral Wide IPC Providers Forum GNBSI Action Plan to support national reduction	IPCT/ ADNs/ HOM	March 2019	• Progress with actions against the Wirral Wide IPC Providers Forum GNBSI Action Plan will be monitored via IPCG		Representatives from WUTH are due to participate in NHSI UTI Collaborative; first meeting 24th May 2018 26/06/18 – Second meeting planned for 28th June 2018 1/08/2018 – 3rd UTI collaborative planned for 27th September 2018 4th UTI collaborative 30th October 2018. February 2019 – Wirral wide IPC Provider Forum met in January and agreed reduction in GNBSI to a priority for the Wirral Health

						Economy
11. **Lack of isolation facilities on Critical Care and Emergency Department**	• Investigate feasibility of using pods to create additional isolation facilities when required • Increase provision of side rooms across the Trust	Divisions / Estates	March 2019	• Review of current pod systems available • Feasibility study reviewed by Divisions and recommendations presented to IPCG		26/06/18 – DDoN for DCS confirmed at IPCG that a scoping exercise is planned to improve environment of Critical Care, including isolation facilities. 10/10/18 Ongoing discussions around the availability / cost of Pods as a temporary measure until major upgrade to estates **Dec 2018** – Five additional side rooms as part of the winter plan -completion January 2019. IPC to work with Divisions for best use of side rooms. Two additional side rooms agreed for Critical care Further review of ED required February 2019 – work to provide 2 temporary additional side rooms on ITU due to commence in March 2019
12. **Review of cleaning schedules/processes / cleaning standards and metrics (C4C) /**	• IPC to meet with HS to review cleaning processes and enhanced cleans for patients with known / suspected infections	IPC / DIPC / HS	March 2019	• HS and Staff Side met and agreed changes to practices and start times to support IPC • IPC to give daily updates to HS on		Cleaning schedules, credits for cleaning (C4C) scores. Further assurance required as to standard of cleans, and process reviewed to ensure check

cleaning products				beds / bays affected that require enhanced cleans		and sign off of cleans, therefore changed to amber. **Dec 18** improvement in cleaning reported Roll out of Chlor clean across Trust commenced Sign off process in place February 2019 – 'Big Debate' planned for 1st March with Domestics. Review of upgraded MIC4C cleaning audit software underway. It is designed to conform to DH standards of cleanliness, to drive safe environment standards and encourage quality improvements.
13. Leadership in IPCT.	• Undertake comprehensive review of team structure, roles and responsibilities including necessary development requirements	ADN IPC	November 2018	• Paper reviewing structure, roles and responsibilities has been presented to DIPC • Improved ways of working have been identified and incorporated into day to day work of IPCT		**Dec 18** Matron for IPC in post Interim support January 2019 for three month period until substantive post recruited to. Secondment into team – expression of interest February 2019 – successfully recruited to ADN for IPC, due to be in post mid May 2019
14. Leadership within divisions to be strengthened	• Increase engagement of IPC Ambassadors	IPCT/ ADNs/ HOM	September 2018	• IPC Ambassadors have been identified in each clinical area and have agreed to roles and responsibilities		IPC Ambassadors meetings to be held quarterly, **Dec 18** meetings in June and November 18, with good attendance. February 2019 –

				• Attendance list of IPC Ambassadors provided to ADNs to monitor attendance/ ensure attendance from each Directorate		Divisions have plans for Quality Matrons to be in post; Medicine and Acute from March 2019 and Surgery from May 2019. Clear job plans will be created.
15. Development and introduction of an IPC element to ward/department accreditation framework	• TOR to be developed and aligned to Trust ward/department accreditation programme • Undertake staff/patient engagement exercise • Complete a pilot prior to roll out	IPCT ADN / Div DoN	March 2019	• Pilot to be completed in each division (areas to complete a self-assessment initially) • Based on Trust values and national IPC requirements		26/06/18 – ADN for IPC working with Corporate Lead Nurse on accreditation programme. 11/10/18 – IPC continue to support the Corporate ADN to develop the accreditation framework. 15/10/2018 Perfect Ward Mobile App commenced for hand hygiene audits. Ward accreditation to start on 5/11/2018 Dec 18 - complete
16. Review of Hydrogen Peroxide Vaporisation (HPV) for IPC cleans	• IPC / Hotel Services to review HPV processes in the absence of a decant ward	IPC / HS	March 2019	• IPC cleaning schedule for 2018 / 2019		Review completed. Training and education completed for domestic staff September 2018. Prioritisation for HPV for areas following PIR and periods of increased incidence (PII) rated amber until practice embedded. Dec 18 reactive HPV programme await decant ward April 19
17. Divisions require accurate key IPC performance	• Review IPC Monthly Dashboard to ensure Divisional level IPC Key Performance Indicators are clearly displayed.	HS/IPCT	June 2018	• Divisional Quality dashboard including IPC key performance		An overall data dashboard has been created for Divisions indicating number of HAI

indicators				indicators will be available		on each ward. Data submitted to corporate team for quality assurance dashboard.
18. **Divisional Accountabilities need to be embedded to ensure clinical and operational ownership**	• TOR and standing agenda items for Divisional IPC Meetings will be reviewed to ensure they incorporate IPC management and are standardised.	Divisions	July 2018	• Divisional IPC TORs have been agreed reviewed by IPCG • Reports to IPORT reflect Divisional accountabilities and clinical/ operational ownership		Draft Divisional IPC meetings TORs have been completed and Divisions are required to update the template with Divisional membership. Assurance required ensuring reports to IPORT reflect accountability and ownership. 26/06/18 – Discussion at IPCG for all Divisions to submit reports to next IPORT July 2018. Dec 18 Divisional IPC meeting in place reporting to IPORT
19. **Review process and develop SOP for post infection reviews and alert organisms**	• Clinical/Divisional engagement required for completing PIRs (SBAR and RCA)	IPC / Divisions	September 2018	• Clinician and Ward Manager present SBAR at Divisional IP meeting; RCAs at IPORT Avoidable harm RCA are presented to SI Panel • Duty of Candour letter is sent • Lessons learnt to be discussed at Divisional IPC meetings, evidenced in minutes/ assurance report		Dec 18 – divisional IPC meeting in place, Divisional representation at IPORT SI panel receives report as required for discussion and learning

				• Improvement plans are presented by divisions to IPORT		
20. Review process and develop SOP for C. diff post infection reviews	• DIPC / Infection Control Doctor / Pharmacy / IPC to meet with division to review each hospital attributable case	DIPC / IPC	September 2018	• C. diff executive review themes to be discussed at IPCG		Cdiff executive review meeting established Aug 18, chaired by DIPC with challenge to divisions. Learning identified from each review. Themes identified and actioned accordingly.
21. Development of Anti-microbial resistance processes	• Identify lead for AMR • Review role and capacity of antimicrobial pharmacist • Review of national guidance • Review governance to address actions from audits	Pharmacy / IPCT	November 2018	• Lead identified • Reports to IPORT reflect accountabilities • Outcomes actions in response to audits are evident		AMR lead is antimicrobial stewardship team. National guidance review as part of AST standard agenda items. Currently compliant. Monthly stewardship assurance reports to IPCG and IPORT. Audit action plans part of stewardship risk register entry.
22. IPC policies are available and up to date	• Develop IPC Policy tracker to easily identify when policies are due for review.	IPCT	June 2018	• IPC Policy tracker is monitored at IPCG		IPC policy tracker has been developed and will be presented to IPCG in June 2018. 26/06/18 – policy tracker discussed at IPCG.

Board of Directors	
Agenda Item	8.1.1
Title of Report	Quality and Performance Dashboard
Date of Meeting	6th March 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 January 2019.

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 January 2019:

- 41 are currently off-target or failing to meet performance thresholds
- 17 of the indicators are on-target

There are no indicators that were previously GREEN showing 2 consecutive months at RED ; therefore there are no IDAs required in this month's report.

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 January 2019.

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

February 2019

	Indicator	Objective	Director	Threshold	Set by	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	2018/19	Trend
Safe	Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	Safe, high quality care	DoN	≤0.19 per 1000 Bed Days	WUTH				0.27	0.18	0.28	0.23	0.23	0.18	0.17	0.18	0.18	0.25	0.22	
	Eligible patients having VTE risk assessment within 6 hours of decision to admit.	Safe, high quality care	MD	≥90%	WUTH	58.7%	69.2%	60.1%	65.0%	70.4%	76.9%	81.5%	69.2%	75.0%	77.0%	68.9%	78.9%	81.3%	74.4%	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital.	Safe, high quality care	MD	≥95%	SOF	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	97.0%	95.0%	96.0%	95.6%	95.6%	95.4%	95.2%	95.0%	96.3%	97.0%	95.9%	95.3%	95.5%	95.7%	
	Pressure Ulcers - hospital acquired grade 2 and above	Safe, high quality care	DoN	New metric	WUTH															
	Serious Incidents declared	Safe, high quality care	DQ&G	≤4 per month	WUTH	6	10	6	6	14	13	3	2	1	3	2	4	2	5	
	Never Events	Safe, high quality care	DQ&G	0	SOF	0	1	0	0	0	0	1	0	0	0	0	0	0	1	
	CAS Alerts not completed by deadline	Safe, high quality care	DQ&G	0	SOF	1	3	0	0	1	5	1	0	0	0	0	0	1	8	
	Clostridium Difficile (avoidable)	Safe, high quality care	DoN	≤28 for FY18-19, as per mthly trajectory	SOF	1	1	3	4	1	3	1	3	0	3	4	2	7	28	
	E.Coli infections	Safe, high quality care	DoN	≤42 pa (Max 3 per mth)	WUTH	4	1	2	4	2	6	7	2	3	5	4	2	3	38	
	CPE Colonisations/Infections	Safe, high quality care	DoN	To be split	WUTH	16	13	10	11	14	17	18	18	15	13	23	9	10	148	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	DoN	0	National	0	0	1	0	0	0	0	0	0	0	1	0	0	1	
	IPC Audit of Practices and Procedures (random areas)	Safe, high quality care	DoN	≥90% (Perfect Ward)	WUTH	73%	73%	78%	83%	81%	78%	77%	78%	74%	75%	75%	76%	79%	78%	
	Hand Hygiene Compliance	Safe, high quality care	DoN	100%	WUTH	89%	94%	99%	95%	97%	88%	89%	90%	81%	87.0%	85.0%	76.0%	83.0%	87.1%	
	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%	78%	70.2%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	DoN	≥95%	WUTH	90.6%	89.9%	89.5%	89.2%	-	-	87.4%	-	85.6%	90.4%	91.5%	91.4%	91.6%	91.6%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	DoN	≥95%	WUTH	81.3%	80.7%	82.5%	84.8%	-	-	82.7%	-	82.2%	86.0%	87.2%	87.1%	87.6%	87.6%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	DoN	≥95%	WUTH	83.6%	83.8%	85.2%	85.6%	-	-	85.6%	-	86.5%	87.2%	91.7%	91.4%	93.6%	93.6%	
	Nursing Vacancy Rate	Safe, high quality care	DHR	≤6.5%	WUTH	6.50%	6.89%	6.83%	6.57%	7.11%	7.20%	10.24%	10.20%	9.25%	7.90%	7.90%	7.47%	8.97%	8.97%	
	Consultant Vacancy Rate %	Safe, high quality care	DHR	≤6.5%	WUTH	7.47%	8.26%	9.68%	6.95%	6.93%	6.58%	7.62%	6.87%	6.45%	6.88%	7.90%	6.48%	8.58%	8.58%	
	Sickness absence % (12-month rolling average)	Safe, high quality care	DHR	≤4%	SOF	4.69%	4.71%	4.77%	4.78%	4.82%	4.84%	4.84%	4.87%	4.91%	4.94%	4.93%	4.94%	4.95%	4.81%	
	Short-term sickness (in month rate)	Safe, high quality care	DHR	TBC	WUTH	2.42%	2.19%	2.20%	1.79%	2.04%	2.04%	2.03%	2.24%	2.35%	2.43%	2.19%	2.36%	2.93%	2.24%	
	Long-term sickness (in-month rate)	Safe, high quality care	DHR	TBC	WUTH	2.97%	2.10%	2.19%	2.18%	2.33%	2.65%	2.95%	2.79%	2.55%	2.76%	2.81%	3.09%	2.79%	2.69%	
	Care hours per patient day (CHPPD)	Safe, high quality care	DoN	TBC	WUTH	7.1	7.2	7.1	7.2	7.3	7.4	7.6	7.5	7.1	6.9	7.1	7	7.3	-	

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

February 2019

	Indicator	Objective	Director	Threshold	Set by	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	2018/19	Trend
Effective	SHMI	Safe, high quality care	MD	≤100	SOF	–	–	99.49	–	–	97.06	–	–	–	–	–	–	–	97.06	
	HSMR	Safe, high quality care	MD	≤100	SOF	88.0	88.0	88.0	88.7	93.0	93.0	95	95	92	92	–	–	–	98.1	
	Mortality Reviews Completed	Safe, high quality care	MD	≥75%	WUTH	–	–	–	–	–	–	–	–	–	–	–	–	52%	52%	
	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	MD / COO	≥33%	National	14.3%	14.8%	14.6%	14.9%	14.3%	13.9%	12.9%	14.1%	13.1%	15.4%	16.4%	14.6%	14.3%	14.4%	
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	Safe, high quality care	MD / COO	≤156 (WUTH Total)	WUTH	412	417	422	418	405	341	386	387	411	383	408	397	437	397	
	Length of stay - elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	3.9	7.4	4.0	3.8	4.3	3.8	5.2	4.1	4.2	4.3	3.8	4.8	3.0	4.1	
	Length of stay - non elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	5.1	5.2	5.4	5.1	5.2	5.1	5.4	5.0	4.9	5.3	5.1	5.0	5.2	5.1	
	Emergency readmissions within 28 days	Safe, high quality care	COO	TBC	WUTH	849	840	814	886	923	873	913	961	888	936	925	916	903	912	
	Delayed Transfers of Care	Safe, high quality care	COO	TBC	WUTH	11	12	9	13	12	13	13	6	18	12	17	14		11.4	
	% Theatre Utilisation	Safe, high quality care	COO	≥85%	WUTH	78.3%	79.1%	79.8%	85.9%	86.6%	88.6%	86.7%	92.3%	89.2%	88.9%	87.1%	86.0%	81.7%	87.3%	

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Caring	Same sex accommodation breaches	Outstanding Patient Experience	DoN	0	SOF	12	18	16	18	22	10	8	16	14	19	18	15	20	160	
	FFT Recommend Rate: ED	Outstanding Patient Experience	DoN	≥95%	SOF	92%	87%	82%	85%	90%	91%	89%	89%	86%	87%	84%	92%	85%	88%	
	FFT Overall Response Rate: ED	Outstanding Patient Experience	DoN	≥12%	WUTH	12.0%	13.0%	12.0%	13.0%	9.0%	8.0%	11.0%	12.0%	11.0%	10.0%	11.0%	10.0%	11.0%	11%	
	FFT Recommend Rate: Inpatients	Outstanding Patient Experience	DoN	≥95%	SOF	98%	97%	97%	98%	97%	98%	98%	98%	97%	98%	98%	98%	98%	98%	
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	DoN	≥25%	WUTH	15.0%	18.0%	18.0%	15.0%	15.0%	20.0%	25.0%	14.0%	22.4%	24.0%	18.0%	18.0%	19.0%	19%	
	FFT Recommend Rate: Outpatients	Outstanding Patient Experience	DoN	≥95%	SOF	95%	94%	94%	95%	95%	94%	95%	94%	94%	94%	95%	94%	95%	95%	
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	DoN	≥95%	SOF	97%	98%	100%	97%	97%	99%	96%	100%	100%	96%	100%	100%	99%	98%	
	FFT Overall response rate: Maternity (point 2)	Outstanding Patient Experience	DoN	≥25%	WUTH	15%	54%	35%	31%	54%	46.0%	37.0%	17.0%	28.2%	11.0%	19.0%	37.0%	27.0%	31%	

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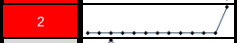
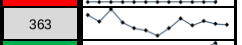
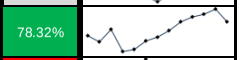
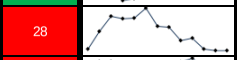
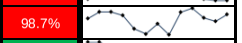
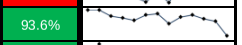
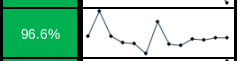
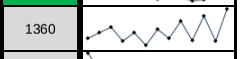
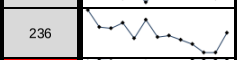
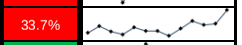
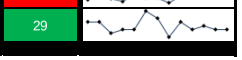
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	NHSI Trajectory for 2018/19	SOF	78.5%	78.3%	74.4%	80.3%	83.5%	83.4%	85.6%	83.6%	77.8%	77.8%	75.2%	75.0%	74.0%	79.6%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	0	0	0	0	0	0	0	0	0	0	0	2	2	
	Ambulance Handovers >30 minutes	Safe, high quality care	COO	TBC	National	528	427	623	414	327	291	213	326	474	371	440	393	379	363	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory for 2018/19 (80% by 31 March 2019)	SOF	76.4%	75.6%	77.3%	74.3%	74.6%	75.7%	76.3%	77.2%	78.3%	78.98%	79.34%	80.08%	78.32%	78.32%	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory for 2018/19 (zero by 31 March 2019)	National				66	67	79	57	56	40	43	30	28	28	28	
	Diagnostic Waiters, 6 weeks and over - DM01	Safe, high quality care	COO	≥99%	SOF	98.8%	99.2%	99.2%	99.0%	98.2%	97.9%	98.5%	97.9%	99.2%	99.4%	98.9%	98.6%	99.1%	98.7%	
	Cancer Waiting Times - 2 week referrals	Safe, high quality care	COO	≥93%	National	97.0%	96.9%	94.9%	94.2%	93.4%	95.2%	95.7%	92.3%	94.5%	95.2%	93.9%	93.1%	88.1%	93.6%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis	Safe, high quality care	COO	≥96%	National	97.0%	99.1%	97.0%	96.5%	96.4%	95.5%	98.2%	96.3%	96.2%	96.8%	96.7%	96.9%	96.9%	96.6%	
	Cancer Waiting Times - 62 days to treatment	Safe, high quality care	COO	≥85%	SOF	85.8%	86.4%	88.1%	87.0%	86.1%	87.8%	85.4%	87.9%	85.7%	85.1%	85.3%	86.2%	89.5%	86.6%	
	Patient Experience: Number of concerns received in month - Level 1	Outstanding Patient Experience	DoN	TBC	WUTH	123	134	144	118	134	110	140	123	155	119	165	118	178	1360	
	Patient Experience: Number of complaints received in month - Levels 2 to 4	Outstanding Patient Experience	DoN	TBC	WUTH	43	31	30	34	23	36	24	25	22	19	13	13	27	236	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	DoN	100%	National	96%	100%	97%	32%	81%	95%	72%	75%	80%	100%	100%	100%	100%	83.5%	
	First written response within policy timescale	Outstanding Patient Experience	DoN	100%	WUTH	19%	35%	22%	14%	32%	23%	23%	11%	29%	48%	39%	41%	76%	33.7%	
	Number of re-opened complaints	Outstanding Patient Experience	DoN	≤5 pcm	WUTH	4	4	1	2	2	7	5	0	4	2	3	2	2	29	

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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	35	33	
	Duty of Candour compliance (for all moderate and above incidents)	Outstanding Patient Experience	DQ&G	100%	National	-	-	-	-	-	-	-	-	100%	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	37	334	66	46	42	38	56	38	40	750	
	% of staff that completed all core MAST in the preceding 12 months	Safe, high quality care	DHR	≥95%	WUTH				73.0%		74.8%	75.1%	82.0%	81.4%	82.2%	82.8%	81.5%	81.7%	81.7%	
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	84.3%	83.4%	83.3%	84.9%		81.1%	79.7%	78.2%	77.5%	78.4%	83.8%	84.5%	84.6%	84.6%	

	Indicator	Objective	Director	Threshold	Set by	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	2018/19	Trend
Use of Resources	I&E Performance		DoF	On Plan	WUTH	-2.315	-1.614	6.485	-4.259	-2.337	-2.659	-3.139	-3.426	-2.334	-1.246	-1.445	-4.038	-1.755	-1.755	
	I&E Performance (Variance to Plan)		DoF	On Plan	WUTH	-2.624	-0.424	0.162	-0.296	-0.103	-0.340	-0.184	-0.515	-0.319	-0.121	-0.761	-1.127	-1.002	-1.002	
	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	-41.6%	-44.0%	-43.8%	-34.1%	-36.3%	-27.2%	-22.1%	-15.4%	-11.7%	-10.6%	-5.4%	-6.1%	-13.9%	-13.9%	
	NHSI Agency Ceiling Performance		DoF	NHSI cap	NHSI	4.3%	15.7%	21.8%	17.8%	1.1%	20.7%	-28.8%	-5.4%	8.7%	-11.1%	-7.4%	-0.5%	11.9%	0.7%	
	Cash - liquidity days		DoF	NHSI metric	WUTH	-19.6	-19	-11.7	-15.5	-12.5	-13.3	-13.5	-14.4	-12.7	-12.0	-13.0	-12.5	-12.9	-12.9	
	Capital Programme		DoF	On Plan	WUTH	53.1%	51.2%	3.9%	-25.3%	9.8%	32.9%	45.0%	4.9%	5.2%	35.8%	41.4%	50.3%	62.3%	62.3%	

Board of Directors	
Agenda Item	8.1.2
Title of Report	Month 10 Finance Report
Date of Meeting	6 March 2019
Author	Shahida Mohammed – Acting Deputy Director of Finance
Accountable Executive	Karen Edge Acting 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

Month 10 Finance Report 2018/19

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 January (Month 10) and the cumulative outturn position for FY19 against plan.

The year to date adjusted financial performance position is an actual deficit of (£26.6m) against a plan of (£21.7m), therefore (£4.9m) worse than plan. The underlying deficit excluding the deployment of non-recurrent resources of some £2.3m at month 10 is (c£28.9m).

The patient related income position is £1.3m better than plan, however this includes £5.1m relating to MSK and income CIP added in year, hence the underlying position is (£3.9m) worse than plan. The main areas driving this position are the under performance in elective and daycase activity, which is 2,629 spells (6.1%) behind plan, with a corresponding financial impact of (c£4.7m), and Outpatients attendances and procedures which are showing an adverse variance of (5,610) (2.2%), and a financial consequence of (£0.9m). There is also an under-performance in neonatal cot days of (£0.6m). Non-elective activity has underperformed significantly in month against plan decreasing the cumulative position to (816) spells year to date, however from a financial perspective the complexity of case-mix has remained strong generating an additional £0.2m, which has supported the overall position. Further mitigation of the under performance against the income plan has been the benefit of the MSK block contract of £1.7m 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 £3.4m for Mths 1-10, is showing as above plan in income with the contra entry in pay costs. There remains a £0.3m pressure for the AFC pay reform in the position.

The overall expenditure position is higher than plan by (£10.9m). However, pay includes the AFC pay reform as discussed above (£3.4m) and is offset in income. Non pay includes (£3.3m) associated with the MSK contracts which were not included in the original plan, as the contract was signed part way through 18/19, this is also offset by income. The underlying expenditure position is therefore (£4.2m) worse than plan.

The underlying pay position is £0.1m better than plan and is largely due to non-clinical vacancies which are delivering non-recurrent CIP and supporting the pay position by c£1.1m. Pay pressures continue in acute care to staff the Emergency Department and acute unplanned beds. Medical budgets are a pressure in some specialties where there are key critical gaps covered by agency. 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 is closely managed, it is marginally below the NHSI cap.

Non pay is showing an underlying financial pressure overall of (c£4.2m) largely due to undelivered CIP of (c£2.6m) which has been partially mitigated non-recurrently in pay, outsourcing costs (c£1.6m); which were needed to deliver the patient waiting times in a number of surgical specialties from transfers earlier in the year, and pressures relating to the discharge unit that was opened in late November for medically optimised patients.

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 (£1.8m) against a planned deficit of (£0.7m), therefore some (£1.1m) worse than plan.

Performance in January against the initial forecast (excluding the readmission penalty originally forecast for month 12) was a shortfall of (c£0.7m). The Trust has not experienced the expected activity levels of non-elective activity, continuing pressures on the elective programme and pay costs resulting from operational flow issues are the main contributing factors.

The delivery of cost improvements is (c£0.1m) below plan as at the end of M10 and the forecast for the year is currently c£9.5m of which £0.7m remain as plans in progress to deliver. Of the £7.8m delivered to date, £2.0m is non-recurrent as it relates to vacancies. The plan was largely profiled to be achieved during the latter part of the year with a challenging Q4, based on current assumptions there will be a shortfall of (c£1.5m). The recurrent CIP for 2019/20 is c£7.4m at M10 and has been reflected in the 19/20 Draft Plan.

As part of the Winter Capacity planning the Trust opened the “step down” facility (T2A) beds part way through November 2018. This Ward manages 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 January were £6.2m, exceeding plan by £4.1m. This is primarily due to positive working capital movements, capital outflows below plan and above plan PDC received, offset by EBITDA below plan.

As stated the Trust had planned a deficit of (£25.0m); this will not be possible to deliver. The main reasons are the system only partially funding the “step-down” facility, the loss of elective activity in the early part of the year, and outsourcing costs. In addition the implications of the AFC pay reform costs show a pressure of (c£0.3m).The Trusts revised its forecast following a meeting with NHSI in early January, the expectation from the Regulator that the Trust should be able to deliver a deficit of (c£27.3m).

The Trust outlined its assumptions in accepting this position and the key risks in delivery. In particular, the assumption that non-elective activity would continue to over-perform in terms of activity in line with the earlier part of the year and that the casemix would become more complex over the winter period as experienced during quarter 4 of 2017/18.

The Trust has not experienced the expected activity levels in non-elective activity and in December, the casemix was also lower than anticipated. This along with some smaller pressures on the elective programme and pay costs increasing to manage operational flow resulted in a shortfall against the forecast position of (c£0.8m) in December, and a further shortfall of (c£0.7m) in January.

The Trust is reviewing all available mitigation but is unlikely to fully recover the shortfall to date and there remains a risk that the position will deteriorate further in February and March if non-elective activity continues on the more recent trend.

This is detailed in section 5 of this report.

3. Financial performance

2.1 Income and expenditure

Month 10 Financial performance	Annual Plan £'000	Current period Plan £'000	Current period Actual £'000	Current period Variance £'000	Month 10 Forecast £'000	Month 10 Actual £'000	Month 10 Variance £'000	Year to date Plan £'000	Year to date Actual £'000	Year to date Variance £'000
Income from patient care activity	307,162	26,521	27,149	628	28,005	27,149	(856)	256,525	257,810	1,285
DOH - Pay Reform Income	0	0	343	343	173	343	170	0	3,388	3,388
Income - PSF	0	0	0	0	0	0	0	0	0	0
Other income	29,428	2,493	2,691	198	2,821	2,691	(130)	24,473	25,595	1,122
Total operating income	336,589	29,014	30,183	1,168	30,999	30,183	(816)	280,998	286,793	5,795
Employee expenses	(247,732)	(20,612)	(21,246)	(634)	(21,081)	(21,246)	(165)	(206,834)	(210,102)	(3,268)
Operating expenses	(101,875)	(8,097)	(9,678)	(1,580)	(9,727)	(9,678)	49	(85,893)	(93,503)	(7,610)
Total operating expenditure	(349,607)	(28,710)	(30,924)	(2,214)	(30,808)	(30,924)	(116)	(292,727)	(303,605)	(10,879)
EBITDA	(13,018)	305	(742)	(1,046)	191	(742)	(933)	(11,729)	(16,812)	(5,084)
Depreciation and net impairment	(8,160)	(693)	(704)	(11)	(680)	(704)	(24)	(6,774)	(6,786)	(11)
Capital donations / grants income	0	0	41	41		41	41	0	168	168
Operating surplus / (deficit)	(21,178)	(388)	(1,405)	(1,017)	(489)	(1,405)	(916)	(18,503)	(23,431)	(4,928)
Net finance costs	(4,105)	(365)	(350)	14	(349)	(350)	(2)	(3,368)	(3,207)	160
Actual surplus / (deficit)	(25,282)	(753)	(1,755)	(1,003)	(838)	(1,755)	(918)	(21,871)	(26,638)	(4,767)
Reverse capital donations / grants I&E impact	243	20	(24)	(45)	20	(24)	(45)	202	35	(168)
Adjusted financial performance surplus/(deficit) [AFPD] including PSF	(25,039)	(733)	(1,779)	(1,047)	(818)	(1,779)	(962)	(21,668)	(26,603)	(4,935)
Less provider sustainability fund (PSF)	0	0	0	0		0	0	0	0	0
Adjusted financial performance surplus/(deficit) [AFPD] excluding PSF	(25,039)	(733)	(1,779)	(1,047)	(818)	(1,779)	(962)	(21,668)	(26,603)	(4,935)

- In Month 10 there has been a further (£1.0m) deterioration in the position with a year to date deficit of (c£4.9m) against plan. The M10 position was also (c£0.7m) worse than forecast (net of readmissions £0.3m) largely due to deterioration in NHS clinical income.
- The main driver of this position is the underperformance of the elective programme which is YTD (c£4.7m) 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 (£3.9m) worse than plan.
- The overall income position also includes the AFC pay reform funding of £3.4m YTD.
- Although total expenditure is (c£10.9m) worse than plan, the underlying expenditure position is (£4.2m) overspent. The underlying pay is £0.1m underspent YTD but includes a significant level of vacancies supporting both the CIP position and offsetting medical staffing pressures in acute care and critical gaps. The underlying non pay is (c£4.3m) over plan and reflects earlier outsourcing pressure for elective capacity, the discharge unit pressures and the 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	1,198	1,019	(179)	(14.97%)	7,053	5,723	(1,330)	(18.86%)
Daycase	6,486	6,696	210	3.23%	35,852	34,553	(1,299)	(3.62%)
Elective excess bed days	541	425	(116)	(21.41%)	3,354	2,269	(1,085)	(32.36%)
Non-elective	8,357	7,585	(772)	(9.24%)	38,606	37,790	(816)	(2.11%)
Non-elective Non Emergency	859	902	43	4.99%	4,384	4,363	(21)	(0.48%)
Non-elective excess bed days	1,744	1,493	(251)	(14.41%)	8,102	8,374	272	3.36%
A&E	15,739	14,511	(1,228)	(7.80%)	77,681	76,267	(1,414)	(1.82%)
Outpatients	47,442	46,109	(1,333)	(2.81%)	250,680	245,070	(5,610)	(2.24%)
Diagnostic imaging	4,572	5,200	628	13.74%	24,515	25,573	1,058	4.32%
Maternity	1,076	949	(127)	(11.80%)	5,310	4,926	(384)	(7.23%)
Total NHS patient care income	88,014	84,889	(3,125)		455,538	444,908	(10,629)	

- The main specialities driving the under performances in elective and daycase activity are Colorectal, Ophthalmology, Urology and Trauma and Orthopaedic surgery. The revised surgical recovery programme has been enacted, however during the month the Division were 170 spells below the forecast position. The underperformance was predominantly in Urology, and Anaesthetics. Part of the in-month position reflects reduced bed capacity and staff sickness.
- Demand for emergency care during January was below plan levels, increasing the previous under 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, Gastro, Respiratory Medicine, Oral, and Trauma and Orthopaedics.
- The forecast position for electives and emergency activity has been revised following the M10 position.

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	3,885	3,371	(513)	(13.22%)	22,620	19,120	(3,499)	(15.47%)
Daycase	4,069	4,247	177	4.35%	23,219	22,037	(1,182)	(5.09%)
Elective excess bed days	131	107	(25)	(18.82%)	810	560	(250)	(30.84%)
Non-elective	16,232	16,030	(203)	(1.25%)	74,154	74,350	196	0.26%
Non-elective Non Emergency	1,966	2,088	123	6.24%	10,279	10,107	(172)	(1.67%)
Non-elective excess bed days	428	369	(59)	(13.75%)	1,995	2,055	61	3.04%
A&E	2,199	2,129	(69)	(3.16%)	10,852	11,046	194	1.78%
Outpatients	5,381	5,246	(134)	(2.49%)	28,455	27,544	(911)	(3.20%)
Diagnostic imaging	366	409	43	11.61%	1,957	1,949	(8)	(0.41%)
Maternity	966	821	(145)	(14.98%)	4,571	4,288	(284)	(6.20%)
Non PbR	11,305	11,527	221	1.96%	57,423	57,924	501	0.87%
HCD	2,569	2,710	141	5.50%	12,844	13,250	406	3.16%
CQUINs	1,125	1,070	(56)	(4.96%)	5,627	5,262	(365)	(6.49%)
MSK Sub Contracts	0	1,034	1,034	0.00%	0	3,443	3,443	0.00%
MSK back to Block	0	451	451	0.00%	0	1,698	1,698	0.00%
Other	0	9	9	0.00%	0	1,401	1,401	0.00%
Total income from patient care (SLAM)	50,622	51,617	995	1.97%	254,806	256,034	1,228	0.48%

- Within the overall year to date position there are certain key areas under performing significantly, elective and daycases, which is showing a deficit of (£4.7m), reflecting both activity and casemix reductions, outpatient attendances are (c£0.9m) 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 £3.4m, (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 £1.7m.
- Other PbR areas are not significantly behind plan, Births improved during the month by 55 deliveries reducing the previous under recovery by £0.2m. Neonatal activity is showing a cumulatively underperformance of (£0.6m), this reflects under performance in quarters 1 and 2, during December and January the plan has been achieved. 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.
- 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 M10 is showing a YTD over-spend of (c£10.9m) against plan. Excluding YTD costs associated with MSK of (£3.3m), and AFC pay reform costs of (£3.4m), which were not included in the original there is an under-lying overspend of (c£4.2m) of which pay is £0.1m underspent and non-pay is (c£4.3m) overspent.

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	Year to date Plan £'000	Year to date Actual £'000	Year to date Variance £'000
Substantive	(225,643)	(18,743)	(19,018)	(275)	(188,482)	(189,604)	(1,121)
Bank	(6,662)	(556)	(997)	(441)	(5,555)	(7,420)	(1,865)
Medical Bank	(7,057)	(588)	(606)	(18)	(5,880)	(6,127)	(247)
Agency	(7,469)	(650)	(550)	100	(6,166)	(6,197)	(31)
Other - Apprenticeship levy	(900)	(75)	(75)	(0)	(750)	(754)	(4)
Total	(247,732)	(20,612)	(21,246)	(634)	(206,834)	(210,102)	(3,268)

- Performance against the 18/19 plan for pay costs in M10 is an overspend of (£0.6m) and YTD (£3.3m) worse than plan. However, the plan excluded the AFC pay reform funding of (c£3.4m) year to date which is offset in income. Hence the underlying pay position (i.e. adjusted for pay award funding) is c£0.1m underspent YTD.
- The underlying pay position includes substantive vacancies (adj. for pay award funding) offset with significant use of bank, agency and other non-core pay.
- The agency figure is c£0.6m for January, which is slightly below the NHSI cap, this reflects a review of agency accruals. Cumulatively the agency spend is also in line with the NHSI ceiling of £6.2m.
- There are significant pressures on the medical budgets with high use of non-core in the clinical divisions to cover key critical gaps in some specialties and to staff acute medical areas. Nursing budgets are underspent particularly for qualified nurses but substantive recruitment initiatives are progressing slowly. In addition bank nurses are supporting escalation beds and staffing the front door during the challenging winter months. Non- clinical vacancies continue and non-recurrently they are supporting delivery of the CIP target. Pay CIP is £1.1m better than plan however to note all 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	Year to date Plan £'000	Year to date Actual £'000	Year to date Variance £'000
Purchase of Healthcare - Non NHS	(2,583)	(92)	(742)	(650)	(2,216)	(7,037)	(4,821)
Supplies and services - clinical	(35,475)	(2,916)	(3,016)	(100)	(29,641)	(29,241)	400
Drugs	(25,395)	(2,109)	(2,230)	(121)	(21,178)	(21,298)	(120)
Consultancy	0	0	(92)	(92)	0	(554)	(554)
Other	(46,583)	(3,673)	(4,302)	(628)	(39,633)	(42,159)	(2,526)
Total	(110,035)	(8,790)	(10,382)	(1,592)	(92,667)	(100,289)	(7,622)

- Non pay expenditure is (c£1.6m) overspent in M10 and year to date (YTD) is (c£7.6m) above plan however the plan excludes the MSK contract costs of c£3.3m YTD which are offset in income. Hence the underlying non-pay position (adjusted for MSK) is (c£1.1m) overspent in M10 and (c£4.3m) overspent YTD driven by the following :-
- Purchase of Healthcare – Non NHS (Outsourcing) adjusted for MSK is (c£0.1m) over plan in M10 and (c£1.6m) YTD. In-mth the pressure is largely due to the costs associated with the discharge unit outsourced to Four Seasons for medical optimised patients. The YTD pressures includes earlier outsourcing costs to Spire in relation to gaps in elective capacity earlier in the year for a number surgical specialties (Orthopaedics, Pain and ENT) of (c£1.0m), the discharge unit open since late November of (c£0.3m) and further radiology non NHS outsourcing pressures of (c£0.3m) to manage capacity gaps.
- Clinical supplies is a small pressure in M10 but remains underspent YTD reflecting the low levels of elective activity in earlier months and the associated prostheses/clinical supplies spend.
- Drug costs are above plan in-month and YTD; the high cost drugs element is (£0.2m) and is offset as a variance in clinical income.
- Consultancy costs continue in-mth largely to support transformation and governance.
- In Other the CIP variance is (c£0.7m) in-mth and (c£2.6m) YTD. The CIP plan was heavily weighted to non pay as the £4.0m unidentified gap at the time of submitting the plan was allocated to non pay.

2. Financial performance

2.4 CIP by programme

Programme	Director	YTD			In Year Forecast						Recurrent Savings					
		NHSI Plan £k	Actual £k	Variance £k	NHSI Plan £k	Fully Develope £k	Variance £k	Pipeline £k	Total £k	Variance £k	NHSI Plan £k	Fully Developed £k	Variance £k	Pipeline £k	Total £k	Variance £k
Transformation																
Improving Patient Flow	Anthony Middleton	500	1,117	**617**	1,000	1,337	**337**	0	1,337	**337**	1,000	1,337	**337**	0	1,337	**337**
Improving Productivity	Anthony Middleton	382	622	**240**	478	706	**228**	123	828	**350**	478	860	**382**	399	1,260	**782**
Collaboration	Janelle Holmes	665	628	**(37)**	952	812	**(140)**	0	812	**(140)**	952	86	**(866)**	0	86	**(866)**
Digital Wirral	Paul Charnley	833	1,006	**172**	1,000	1,182	**182**	78	1,260	**260**	1,000	1,000	**0**	0	1,000	**0**
Sub total - transformation		**2,380**	**3,373**	**993**	**3,430**	**4,037**	**607**	**201**	**4,237**	**807**	**3,430**	**3,283**	**(146)**	**399**	**3,683**	**253**
Cross cutting workstreams																
Workforce	Helen Marks/ Tracy Fennell	112	292	**180**	134	330	**196**	20	350	**216**	134	19	**(115)**	0	19	**(115)**
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	402	389	**(13)**	500	454	**(46)**	18	472	**(28)**	500	360	**(140)**	35	395	**(105)**
Procurement and Non Pay	Jane Christopher	904	311	**(593)**	1,150	344	**(806)**	11	356	**(794)**	1,150	201	**(949)**	0	201	**(949)**
Tactical and transactional		0	0		0	0		0			0	0		0		
Divisional and Departmental	Divisional Directors	1,521	3,447	**1,927**	1,936	3,637	**1,701**	423	4,060	**2,125**	1,936	2,810	**874**	258	3,068	**1,132**
Unidentified		2,614	0	**(2,614)**	3,850	0	**(3,850)**	0	0	**(3,850)**	3,850	0	**(3,850)**	0	0	**(3,850)**
Total		**7,932**	**7,812**	**(120)**	**11,000**	**8,802**	**(2,198)**	**674**	**9,476**	**(1,524)**	**11,000**	**6,673**	**(4,327)**	**692**	**7,365**	**(3,635)**

- In Month 10 the CIP delivery is (c£0.7m) below plan, reflecting the increased profile in Q4. YTD CIP performance is now (c£0.1m) below the NHSI plan.
- Included in the actual YTD delivered position of £7.8m is c£2.0m of in-year vacancies that have supported CIP delivery for 2018/19 non recurrently.
- The CIP forecast largely remains a flat trajectory for the remaining two months of the year and will result in a (c£1.5m) under-delivery for the year.
- Of the £9.5m full year CIP forecast there are £8.8m of fully developed schemes that should deliver and a further £0.7m of plans in progress (pipeline). Work needs to continue to progress the remaining £0.7m pipeline schemes to ensure delivery.
- Based on the M10 position the recurrent CIP gap is (c£3.6m), this is a significant pressure and is accounted for as part of the 2019/20 Draft plan.

3. Financial position

3.1 Statement of Financial Position (SOFP)

Actual as at 01.04.18 £'000		Month-on-month movement	Plan as at 31.01.19 £'000	Actual as at 31.01.19 £'000	Variance (to plan) £'000	Forecast 31.03.19 £'000	Plan 31.03.19 £'000
	Non-current assets						
159,754	Property, plant and equipment	⇧	160,346	157,905	(2,441)	162,874	160,148
12,763	Intangibles	⇧	12,538	11,581	(957)	13,891	12,369
903	Trade and other non-current receivables	⇩	903	844	(59)	842	903
173,420		⇧	**173,787**	**170,330**	**(3,457)**	**177,607**	**173,420**
	Current assets						
4,171	Inventories	⇧	4,171	4,290	119	4,290	4,171
18,423	Trade and other receivables	⇧	20,848	22,772	1,924	18,321	18,424
0	Assets held for sale	⇨	0	0	0	0	0
7,950	Cash and cash equivalents	⇩	2,044	6,182	4,138	4,009	1,773
30,544		⇧	**27,063**	**33,244**	**6,181**	**26,620**	**24,368**
203,964	**Total assets**	⇧	**200,850**	**203,574**	**2,724**	**204,228**	**197,788**
	Current liabilities						
(32,538)	Trade and other payables	⇩	(31,302)	(35,745)	(4,443)	(37,172)	(27,752)
(3,224)	Other liabilities	⇧	(3,224)	(4,400)	(1,176)	(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)		⇩	**(36,149)**	**(41,769)**	**(5,620)**	**(42,020)**	**(32,609)**
(6,840)	**Net current assets/(liabilities)**	⇩	**(9,086)**	**(8,525)**	**561**	**(15,400)**	**(8,240)**
166,580	**Total assets less current liabilities**	⇩	**164,701**	**161,805**	**(2,896)**	**162,208**	**165,180**
	Non-current liabilities						
(8,812)	Other liabilities	⇧	(8,527)	(8,528)	(1)	(8,471)	(8,470)
(49,258)	Borrowings	⇩	(69,234)	(69,235)	(1)	(73,224)	(73,221)
(2,318)	Provisions	⇧	(2,163)	(2,488)	(325)	(2,455)	(2,131)
(60,388)		⇩	**(79,924)**	**(80,251)**	**(327)**	**(84,150)**	**(83,826)**
106,192	**Total assets employed**	⇩	**84,777**	**81,554**	**(3,223)**	**78,058**	**81,366**
	Financed by Taxpayers' equity						
77,575	Public dividend capital	⇨	78,031	79,575	1,544	80,031	78,031
(12,259)	Income and expenditure reserve	⇩	(34,130)	(38,897)	(4,767)	(42,849)	(37,541)
40,876	Revaluation reserve	⇨	40,876	40,876	0	40,876	40,876
106,192	**Total taxpayers' equity**	⇩	**84,777**	**81,554**	**(3,223)**	**78,058**	**81,366**

Capital asset variances	£m
Capex underspend	-4.2
Donations above plan	0.2
18/19 additional funding balance	0.6
Total variance of capital assets to plan	**-3.4**

Cash variances	£m
EBITDA and donation income below plan	-5.1
Working capital movements	5.6
Capital expenditure (cash basis) below plan	2.0
PDC received above plan	1.5
Other minor variances above plan	0.1
Total variance of cash to plan	**4.1**

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				6,786
Loan repayment	(1,015)	(1,015)	(1,015)	0				(508)
Finance lease	(60)	(60)	(60)	0				(49)
Additional funding per plan	3,250	3,250	3,250	0				3,250
Additional external (donations / grant) funding	0	185	185	0				168
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**				**11,647**
Expenditure - schemes								
Divisional priorities - *Medicine and Acute Care*		238	217	21	217	92	125	83
Divisional priorities - *Surgery*		372	582	(210)	582	461	121	409
Divisional priorities - *Women and Children's*		553	554	(1)	554	369	185	286
Divisional priorities - *Clinical Support and Diagnostics*		1,910	1,994	(84)	1,994	1,643	351	303
Divisional priorities - *Clinical Support and Diagnostics* - MRI	1,050	1,518	1,518	0	1,518	1,518	0	107
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	1,406	1,395	973
Informatics	500	536	587	(51)	587	577	10	351
Switchboard		700	700	0	700	0	700	0
Estates - backlog maintenance	1,500	3,430	3,864	(434)	3,864	2,653	1,211	1,638
Car park		0	0	0	0	0	0	0
Cerner		(400)	(400)	0	(400)	(400)	0	(400)
All other expenditures		(193)	(163)	(30)	(163)	(163)	0	(163)
Urgent and Emergency Care		0	0	0	0	0	0	n/a
Contingency [3]	1,180	1,326	0	1,326	0	0	0	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	179	0	168
Total expenditure (accruals basis) [5]	**10,791**	**12,976**	**12,433**	**543**	**12,433**	**8,335**	**4,098**	**3,755**

[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.
[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] **Current forecast capital underspend is £0.5m**

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	**6,578**	**2,231**	**4,347**	**7,950**	**7,950**	**0**	**7,950**	**7,950**
Operating activities								
Surplus / (deficit)	(1,755)	(752)	(1,003)	(26,638)	(21,870)	(4,768)	(30,590)	(25,282)
Net interest accrued	154	170	(16)	1,290	1,430	(140)	1,610	1,806
PDC dividend expense	191	191	0	1,910	1,910	0	2,292	2,292
Unwinding of discount	4	3	1	6	30	(24)	7	6
Operating surplus / (deficit)	(1,405)	(388)	(1,017)	(23,432)	(18,500)	(4,932)	(26,681)	(21,178)
Depreciation and amortisation	704	693	11	6,786	6,774	12	8,177	8,160
Impairments / (impairment reversals)	0	0	0	0	0	0	0	0
Donated asset income (cash and non-cash)	(41)	0	(41)	(168)	0	(168)	(168)	0
Changes in working capital	(283)	(286)	3	2,727	(2,859)	5,586	1,722	(996)
Investing activities								
Interest received	10	3	7	100	30	70	113	48
Purchase of non-current (capital) assets [1]	(614)	(1,959)	1,345	(7,732)	(9,768)	2,036	(9,685)	(12,444)
Receipt of cash donations to purchase capital assets	0	0	0	35	0	35	90	0
Financing activities								
Public dividend capital received	0	456	(456)	2,000	456	1,544	2,456	456
Net loan funding [2]	1,300	1,300	0	20,028	20,028	0	24,027	24,027
Interest paid	(61)	0	(61)	(864)	(818)	(46)	(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	(60)	(60)	0	(70)	(70)
Total net cash inflow / (outflow)	**(396)**	**(187)**	**(209)**	**(1,768)**	**(5,906)**	**4,138**	**(3,941)**	**(6,177)**
Closing cash	**6,182**	**2,044**	**4,138**	**6,182**	**2,044**	**4,138**	**4,009**	**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	-5.1
Working capital movements	5.6
Capital expenditure (cash basis) below plan	2.0
PDC received above plan	1.5
Other minor variances above plan	0.1
Total variance of cash to plan	**4.1**

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%	-13.9	3	-12.9	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%	-2.9	4	-4.3	4	-2.5	4
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	-7.7%	4	-9.3%	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	-1.6%	3	0.0%	1
Financial controls	**Agency spend (%)**	Distance of agency spend from agency cap	20%	-1.2%	1	-0.7%	1	0.0%	1
	Overall NHSI UoR rating				**3**		**3**		**3**

UoR rating summary

- The Trust has marginally underspent against the agency cap, improving the risk rating to 1. The Trust will continue to focus on reducing spend in this area to maintain the *Agency spend* rating of 1.
- The *Distance from financial plan* metric is currently below plan as a result of the year-to-date EBITDA.
- The month 10 UoR rating is 3 overall, which matches the 2018/19 plan UoR rating of 3.
- Forecast UoR rating is 3.

5. Forecast

The forecast position discussed in the previous (Mth 9) Board report was a deficit of (£27.8m), this included the deterioration of the position against the period 9 forecast of (c£0.8m).

The table below details the actual performance in Mth 10 compared to the initial Month 8 forecast which shows a further deterioration of (c£0.7m).

				Month 8 Forecast			Difference Mth 10 (Forecast v Actual)		Difference Mth 9 (Forecast v Actual)	
	Mth 8 YTD Actual £000	Actual Mth 9 £000	Actual Mth 10 £000	Forecast Mth 11 £000	Forecast Mth 12 £000	Total £000	Forecast Mth 10 £000	Mth 10 Variance £000	Forecast Mth 9 £000	Mth 9 Variance £000
Income from patient care activity										
Elective/Daycase	33,540	3,599	4,019	4,329	4,662	**50,149**	4,380	(361)	3,957	(358)
Elective excess bed days	453	45	62	30	38	**628**	30	32	21	24
Non-elective	58,330	7,954	8,366	7,733	8,613	**90,996**	9,223	(857)	8,321	(367)
Non-elective Non Emergency	8,019	988	1,100	920	1,150	**12,177**	1,002	98	1,003	(15)
Non-elective excess bed days	1,686	253	116	202	223	**2,480**	229	(113)	217	36
A&E	8,916	1,036	1,094	1,026	1,132	**13,204**	1,132	(38)	1,132	(96)
Outpatients	22,297	2,324	2,922	2,667	2,804	**33,014**	2,962	(40)	2,383	(59)
Diagnostic imaging	1,540	201	207	178	191	**2,317**	198	9	157	44
Maternity	3,466	415	407	421	466	**5,175**	466	(59)	466	(51)
Non PbR	46,398	5,663	5,863	5,494	6,498	**69,916**	5,350	514	5,475	188
HCD	10,540	1,212	1,498	1,337	1,337	**15,924**	1,337	161	1,337	(125)
CQUINs	4,192	454	616	525	346	**6,133**	525	91	525	(71)
MSK Sub Contracts	2,410	398	635	482	482	**4,407**	881	(246)	463	(65)
MSK back to Block	1,247	108	358	59	98	**1,870**	290	68	-	108
Other	1,381	0	5	300	300	**1,986**		5		0
TOTAL NHS INCOME	**204,417**	**24,650**	**27,266**	**25,703**	**28,340**	**310,376**	**28,005**	**(739)**	**25,457**	**(807)**
Other patient care income	472	53	55	59	59	**698**	59	(4)	59	(6)
Non-NHS: private patients & overseas	256	29	41	26	27	**379**	27	14	26	3
Injury cost recovery scheme	713	53	85	90	90	**1,031**	85	0	90	(37)
Non NHS: Other	17	2	2	2	3	**26**	2	0	2	0
TOTAL PATIENT CARE INCOME	**205,875**	**24,787**	**27,449**	**25,880**	**28,519**	**312,510**	**28,178**	**(729)**	**25,634**	**(847)**
Other Income	22,835	3,241	3,074	2,789	2,804	**34,743**	2,821	253	2,840	401
TOTAL TRUST INCOME	**228,710**	**28,028**	**30,524**	**28,669**	**31,323**	**347,253**	**30,999**	**(475)**	**28,474**	**(446)**
Pay										
Medical & Dental	(45,923)	(5,849)	(6,066)	(5,751)	(5,750)	**(69,339)**	(5,796)	(270)	(5,793)	(56)
Nursing and midwifery	(45,659)	(5,482)	(5,908)	(5,700)	(5,704)	**(68,453)**	(5,717)	(191)	(5,680)	198
Scientific, Therapeutic & Technical	(20,277)	(2,555)	(2,614)	(2,574)	(2,574)	**(30,594)**	(2,574)	(40)	(2,577)	22
Support to clinical staff	(39,490)	(5,258)	(5,135)	(4,994)	(4,982)	**(59,859)**	(5,005)	(130)	(4,982)	(276)
Non medical, non clinical staff	(15,939)	(2,424)	(1,524)	(1,967)	(1,701)	**(23,555)**	(1,989)	465	(1,979)	(445)
TOTAL PAY COSTS	**(167,288)**	**(21,568)**	**(21,247)**	**(20,986)**	**(20,711)**	**(251,800)**	**(21,081)**	**(166)**	**(21,011)**	**(557)**
Non Pay										
Supplies and services - clinical	(23,049)	(3,176)	(3,016)	(2,973)	(2,932)	**(35,146)**	(3,003)	(13)	(3,009)	(167)
Drugs	(17,107)	(1,960)	(2,230)	(2,159)	(2,158)	**(25,614)**	(2,159)	(71)	(2,159)	199
Purchase of HealthCare from Non NHS Bodies	(5,640)	(655)	(742)	(751)	(746)	**(8,534)**	(838)	96	(761)	106
Other	(33,954)	(4,366)	(4,394)	(4,463)	(4,324)	**(51,501)**	(4,407)	13	(4,456)	90
TOTAL NON PAY COSTS	**(79,750)**	**(10,157)**	**(10,382)**	**(10,346)**	**(10,160)**	**(120,795)**	**(10,407)**	**25**	**(10,385)**	**228**
Net Finance costs	(2,516)	(342)	(350)	(339)	(363)	**(3,910)**	(349)	(1)	(342)	0
Monthly Actual/FOT surplus/(deficit)	**(20,844)**	**(4,039)**	**(1,455)**	**(3,002)**	**89**	**(29,251)**	**(838)**	**(617)**	**(3,264)**	**(775)**
Reverse capital donations/grants I&E impact	35	24	(24)	20	20	**75**	20	(44)	20	4
Monthly Actual/FOT surplus/(deficit)	**(20,809)**	**(4,015)**	**(1,479)**	**(2,982)**	**109**	**(29,176)**	**(818)**	**(661)**	**(3,244)**	**(771)**
Monthly Plan surplus/(deficit)	**(18,044)**	(2,891)	(733)	(2,679)	(692)	**(25,039)**	(733)		(2,891)	
Variance (Forecast v Actual)	(2,765)	(1,124)	(746)	(303)	801	**(4,137)**	(85)	**(661)**	(353)	**(771)**

5. Forecast

The deterioration from the forecast position for both months 9 and 10 is detailed above. The movement relates primarily to the under performance in elective, non elective activity, and pay costs exceeding initial assumptions.

- Although the revised Surgical recovery programme has been enacted, during month 9 (excluding orthopaedics, as this is part of the MSK "block" contract), actual spells delivered were (236) below forecast, with a financial consequence of (£0.1m) and for month 10 (184) spells below the expected position impacting the position by (£0.2m). The underperformance was predominantly in Urology, and Anaesthetics activity, the financial impact reflects casemix variation. Part of the activity under performance is due to reduced bed capacity and staff sickness.
- Demand for emergency care during December was (110) spells below forecast equating to (£0.2m), for January the position was (397) spells below the Mth 8 forecast with a financial consequence of (c£0.9m).
- Pay costs exceeded forecast in Mth 9 due to the increased provision for pension costs which was mitigated by other income (£0.2m). In addition, higher costs than expected were seen in support services, and non clinical staff; this was offset by underspends in non pay (£0.2m). In January the pay position reflects operational pressures and ensuring key areas were safely staffed during pressure periods, sometimes at premium rates.

Given the Trust year to date actual deficit is (£26.6m), it is extremely unlikely that a deficit of (£27.3m) as predicted at Mth 8 or the revised forecast of (£27.8m) following with M9 performance will be achieved over the remaining months of the year. Even if the February and March forecast as estimated in Month 8 were delivered the "best" outcome would be a deficit of (£29.2m).

Following the Mth 10 position the revised forecast now predicts the "most likely" outturn will be a deficit of (c£30.5m) this is detailed in the table below.

5. Forecast

Wirral University Teaching Hospital NHS Foundation Trust

Revised forecast outturn based on Mth 10	Trust Forecast outturn as at Mth 8	YTD Actual Mth 10	Forecast outturn based on M10			Movement of forecast outturn M8 v M10
			Mth 11 £000	Mth 12 £000	Total £000	
Income from patient care activity						
Elective/Daycase	50,868	41,158	3,886	4,717	49,761	(1,107)
Elective excess bed days	572	560	34	42	636	64
Non-elective	92,220	74,350	7,482	8,240	90,072	(2,148)
Non-elective Non Emergency	12,094	10,107	917	1,148	12,172	78
Non-elective excess bed days	2,557	2,055	192	213	2,460	(97)
A&E	13,338	11,046	1,012	1,119	13,177	(161)
Outpatients	33,113	27,543	2,679	2,813	33,035	(78)
Diagnostic imaging	2,264	1,948	178	192	2,318	54
Maternity	5,285	4,288	407	451	5,146	(139)
Non PbR	69,539	57,924	5,553	5,912	69,389	(150)
HCD	15,888	13,250	1,334	1,334	15,918	30
CQUINs	6,113	5,262	535	290	6,087	(26)
MSK Sub Contracts	4,319	3,443	574	569	4,586	267
MSK back to Block	1,694	1,713	198	(7)	1,904	210
Other	1,981	1,386	300	300	1,986	5
TOTAL NHS INCOME	**311,847**	**256,033**	**25,281**	**27,333**	**308,647**	(3,200)
Other patient care income	708	578	56	56	690	(18)
Non-NHS: private patients & overseas	362	327	28	28	383	21
Injury cost recovery scheme	1,068	852	90	90	1,032	(36)
Non NHS: Other	26	21	2	2	25	(1)
TOTAL PATIENT CARE INCOME	**314,011**	**257,811**	**25,457**	**27,509**	**310,777**	**(3,234)**
Other Income	34,089	29,150	2,760	2,892	34,802	713
TOTAL TRUST INCOME	**348,100**	**286,961**	**28,217**	**30,401**	**345,579**	**(2,521)**
Pay						
Medical & Dental	(69,013)	(57,838)	(6,001)	(5,807)	(69,646)	(633)
Nursing and midwifery	(68,460)	(57,049)	(5,853)	(5,853)	(68,755)	(295)
Scientific, Therapeutic & Technical	(30,576)	(25,445)	(2,576)	(2,574)	(30,595)	(19)
Support to clinical staff	(59,453)	(49,883)	(5,125)	(5,114)	(60,122)	(669)
Non medical, non clinical staff	(23,075)	(19,887)	(1,650)	(1,228)	(22,765)	310
TOTAL PAY COSTS	**(250,577)**	**(210,102)**	**(21,205)**	**(20,576)**	**(251,883)**	**(1,306)**
Non Pay						
Supplies and services - clinical	(34,966)	(29,241)	(3,016)	(2,927)	(35,184)	(218)
Drugs	(25,742)	(21,298)	(2,158)	(2,162)	(25,618)	124
Purchase of HealthCare from Non NHS Bodies	(8,736)	(7,037)	(724)	(719)	(8,480)	256
Other	(51,304)	(42,713)	(4,454)	(3,928)	(51,095)	209
TOTAL NON PAY COSTS	**(120,748)**	**(100,289)**	**(10,352)**	**(9,736)**	**(120,377)**	**371**
Net Finance costs	(3,909)	(3,207)	(339)	(363)	(3,909)	0
Monthly Actual/FOT surplus/(deficit)	**(27,134)**	**(26,637)**	**(3,679)**	**(274)**	**(30,590)**	**(3,456)**
Reverse capital donations/grants I&E impact	115	35	20	20	75	(40)
Monthly Actual/FOT surplus/(deficit)	**(27,019)**	**(26,602)**	**(3,659)**	**(254)**	**(30,515)**	**(3,496)**
Plan surplus/(deficit)	(25,039)	(21,668)	(2,679)	(692)	(25,039)	0
Variance	**(1,980)**	**(4,934)**	**(980)**	**438**	**(5,476)**	**(3,496)**

Most of the movement is in relation to the clinical income position, this namely relates to the elective programme and the recent performance in non elective spells. The pay forecast has also been amended following the operational pressures in both December and January.

5. Forecast

There still remain a number of operational risks for the remainder of the year including:

- Winter funding from the CCG is assumed to be £0.6m, as agreed, so far the CCG have only committed to £0.5m.
- Operational pressures leading to further cancellations in the elective programme
- A reduced casemix in emergency care
- Additional penalties not included such as C-Diff exceeding the "allowed" trajectory, and other contractual movements.
- CQUIN milestones not delivered in quarter 4
- HMRC's decision to "overturn" the previous "exempt" treatment of VAT charges in relation to medical staffing as part of a "direct engagement" service model which was previously reclaimable. This has been appealed by the "managed service" provider. This will impact the position by (c£0.2m) in 2018/19.
  For 2019/20 the Trust is exploring a number of options to minimise/mitigate any VAT exposure. Obviously ensuring any model that is selected satisfies VAT compliance with HMRC.

Mitigations:

- The Trusts assumption on "step-down" funding is based on the 50/50 risk share agreement reached with partners earlier in the year. The Trust has written to the CCG reminding them of this agreement.
- Recovery of elective work from de-escalation of elective areas with non-elective patients

Cash funding – The Trust has matched its borrowings to the initial plan deficit of (£25.0m) throughout 2018/19, which is consistent with plan and prior Board approvals. In order to protect the Trust's cash position going forward, it is recommended that the Director of Finance is enabled to authorise any additional borrowings in Q1 of 2019/20 which will be required based on the actual outturn for 2018/19, which as shown is forecast to be (c£5.5m) higher than the plan deficit of (£25.0m) Although this is technically "drawn" in the subsequent financial year, this 'Q1 catch up' is an allowed feature of the Trust's borrowings arrangement.

The Executive Board is asked to note the contents of this report and approve the recommendation for additional Q1 borrowing in line with the final 2018/19 deficit.

Karen Edge
Acting Director of Finance
March 2019

Wirral University Teaching Hospital
NHS Foundation Trust

Item 9.1 - 2018 National NHS Staff Survey

Results and summary

NHS Staff Survey 2018

Board	
Agenda Item	9.1
Title of Report	NHS Staff Survey 2018 results
Date of Meeting	Wednesday 6th March 2019
Author	Mike Baker (Associate Director of Communications, Marketing and Engagement)
Accountable Executive	Helen Marks (Executive Director of Workforce)
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	Gaps
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Noting
Data Quality Rating	Gold - externally validate
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

This paper highlights the outcome of the NHS staff Survey for 2018. It also explains changes in the process feedback for 2018 as well as a summary table of the key findings, actions and next steps.

A number of staff engagement events highlighting the results will have already taken place prior to the Board meeting of Wednesday 6th March.

This paper includes a hyperlink for members to view and read the full 170 page report and the 18 page Directorate Report.

2. Background

The NHS Staff Survey, undertaken by independent external organisation, Quality Health, took place between September and November 2018.

This was an **all** staff survey for 2018 rather than a sample size survey as undertaken the previous year. Questionnaires were issued to 5,953 staff. 53% of staff were sent a paper version of the survey with 47% of staff being issued an email version.

The Trust received 2,660 completed questionnaires yielding a response rate of 45.4%. compared to 2017 Staff Survey when the Trust only received 382 which was 31% of a random sample size of 1250 staff.

This response rate of 45.4% was **above** the national acute response rate of 44%.

3. Findings of the 2018 NHS Staff Survey

The full findings, confirmed by the Survey Coordination Centre, can be found by visiting the first link below. The second link takes you to the Directorate Report:

- **https://www.wuth.nhs.uk/media/11136/nhs_staff_survey_2018_rbl_full.pdf**
- **https://www.wuth.nhs.uk/media/11185/nhs_staff_survey_2018_rbl_directorate.pdf**

It is important to note that there has been considerable change in the reporting of the results. This change follows a review last year by the national Survey Coordination Centre. Updates include the following:

- **New summary indicators** - the old style Key Findings have been replaced by 10 themes
- **The 10 themes** - these are now scored 0-10 rather than 1-5 as previous
- **Reduced number of summary indicators** - question-level benchmarking
- **User friendly** - the Survey Coordination Centre has made the benchmark report more visual and accessible.
- **Staff engagement score** - this is calculated using the same questions as in previous years but adjusted to a scale of 0-10.

The following page outlines the 10 themes. These themes provide a balanced overview of organisational performance on staff experience. A set of questions from the staff survey feed into each theme. The number varies between 3 and 9 questions.

The table outlines our WUTH score, the average acute score, the best acute score, the worse acute score and finally comments about the theme findings:

THEME	WUTH SCORE	AVERAGE ACUTE SCORE	BEST ACUTE SCORE	WORSE ACUTE SCORE	COMMENTS FROM QUALITY HEALTH
Equality, Diversity & Inclusion	9.2	9.1	9.6	8.1	A small percentage of staff reported experiencing discrimination at work in the past 12 months. This is lower than the rest of the sector. The score is better than the sector in regards to experiencing discrimination from patients or service users.
Health & Wellbeing	5.6	5.9	6.7	5.2	Nearly half (42%) of staff reported feeling unwell due to work related stress in the past 12 months - significantly worse than the sector score of 39%. Well over half (61%) of staff said they had come into work in the past 3 months, despite not feeling well enough to perform their duties.
Immediate Managers	6.4	6.7	7.3	6.2	Half report positively around the recognition they are given for good work. Two thirds feel the immediate manager values their work . Staff were significantly less than the sector average that they get clear feedback from their immediate manager on their work.
Morale	5.9	6.1	6.7	5.4	The overall theme score was similar to the sector. Around a fifth report that work relationships are strained – significantly worse than the sector average. Like the rest of the sector, a third of staff feel they have unrealistic time pressures.
Quality of Appraisals	5.1	5.4	6.5	4.6	81% of staff reported having an appraisal in the past 12 months. The overall score is significantly lower than the sector score. Staff agreed that appraisals helped them improve how they do their job and helped them agree clear objectives. This was lower than the sector average.

Quality of Care	7.3	7.4	8.1	7.0	The percentage of staff who said they are able to deliver the sort of care they aspire to has increased since 2017. Over three quarters of staff (78%) were satisfied with the care they deliver to patients. A high percentage (88%) felt their role makes a difference to patients.
Safe Environment – Bullying & Harassment	7.7	7.9	8.5	7.1	The overall score was similar to sector average. The percentage of staff saying they've experienced harassment, bullying or abuse from patients/services users, their relatives or other members of the public is slightly better than the sector average.
Safe Environment – Violence	9.4	9.4	9.6	9.2	The overall score for staff experiencing violence from patients/public, managers or other colleagues is the same as the sector average. All questions in this theme have similar scores to the sector average and have not changed significantly since 2017.
Safety Culture	6.3	6.6	7.2	6.0	The overall score was similar to the sector. However, every question score in this theme was significantly worse than the sector average. Around half of staff feel those who are involved in an error, near miss or incident are treated fairly and are given feedback about any change made. 65% of staff would feel secure raising concerns about unsafe clinical practice.
Staff Engagement	**6.7**	**7.0**	**7.6**	**6.4**	**Slightly lower than in 2017 (6.89)**

The Trust has not seen a significant deterioration across the themes, therefore a fair assumption could be made that the interventions that have been put in place are assisting in stabilising the Trust's position. However, there still remains a great deal of work to undertake in the coming months to address areas that require improvement.

4. Next Steps

The following actions are planned:

- An informative and easy to understand presentation slide deck and social media animation will be created for staff. This will give a top line and easy to digest summary of the results.
- In addition to providing colleagues with with a presentation slide deck and email/website/social media updates, face-to-face presentations are to be fronted by the Executive team to go through the slide deck with leaders/colleagues. This presentation and slide deck will also be an opportunity to build the recent work around values and behaviours as well the work being undertaken around shaping a new vision for the organisation.
- Divisional Triumvirates and Corporate Heads of Service will receive more detailed information relating to their areas in order for plans to developed to address the issues identified within their areas
- The organisational development team will cross reference the findings with the corporate themes that were shaped last year to identify and gaps and areas of concern.

5. Recommendations

The Board is asked to:

- Note the contents of the above report

BOARD OF DIRECTORS	
Agenda Item	10.1
Title of Report	Report of the Finance Business Performance and Assurance Committee
Date of Meeting	6.3.2019
Author	Sue Lorimer, Chair of the Finance, Business Performance and Assurance Committee
Accountable Executive	Karen Edge, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	4, 7, 8 4a, 7a, 7b, 7d, 8a, 8c, 8d, 5, 6, 7, 8, 9, 16, 17, 20
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Finance, Business, Performance and Assurance Committee 8th February 2019

This report provides a summary of the work of the FBPAC which met on the 8th February 2019. Key focus areas are those which address the gaps in assurance in the Board Assurance Framework and areas of development work to bring to the attention of the Board of Directors.

1. Chair's Business

SL expressed concern with the proposals provided to the Committee in relation to the Annual plan for 2019/20. The plan revealed a significant amount of cost pressures including new posts for which the approval process was unclear. This had resulted in the need for a CIP higher than the Trust has previously achieved, substantial pressures to be managed within Divisions and was

reliant on the ward closures planned in the Step Down ward business case taking place in a timely fashion. The information did not provide assurance that the plan would deliver.

2. 2019/20 Capital Plan

The committee received a detailed report on the proposed Capital programme for 2019/20 which included detailed capital plans for 2019/20 and 2010/21. This was earlier than usual and had been decoupled from the Annual Budget, as the available resource for capital was known and lessons learned from previous year's required early approval in order that the programme could be mobilised as soon as possible into the new financial year. The committee was informed of the risk based approach applied to the development of the programme and the exceptions to this approach which included strategic capital spend and completion of 2018/19 schemes. The committee received assurance on the alignment with the Trust strategy, the six facet survey and the classification of backlog maintenance. The ADoF outlined the process for approval of individual schemes which was planned for completion by July 2019. The Committee had received delegated authority from the Board of Directors and approved the Capital Programme subject to the normal business case limits applying to individual schemes.

3. 2019/20 Annual Plan

The ADoF presented the committee with a summary of the 2019/20 Budget and the bridge from the 2018/19 Budget. The committee were concerned with the list of pressures included in the report and assurance was sought on the ability of Divisions to manage the pressures. The committee was informed that the list included legacy issues and did not provide sight of the ability of the Divisions to manage the pressures through budget savings. The Budget as presented was the interim position and the Executive team were reviewing the position in detail with a view to presenting the final budget in April. The ADoF advised that a significant proportion of the pressures were being managed by the Divisions through underspends in other areas, particularly vacancies. The Committee requested additional assurance of the management of pressures and the timescales for final approval including Divisional sign off of their budgets. The Committee also sought assurance on the plan to close beds as outlined in the step down business case which was provided by the COO. The Committee discussed the CIP within the 2019/20 plan which provided an outline of how the 3.5% target would be delivered and structured across 'business as usual', transformation and QIPP. The Committee received assurance on the improvement in governance and performance of the current transformation programme and the confidence this provided in delivery for the coming year. The committee were informed that the completion of the detailed scheme initiation and approvals would be finalised by the beginning of April. The Committee remained concerned with the financial governance process, budget controls and the authorisation process.

The committee determined that there was insufficient assurance to approve the 2019/20 plans and requested further work to be completed as follows:

- Detailed assurance on the ability of Divisions to manage the cost pressures set out in the draft plan.
- Detailed assurance on CIP governance including a timetable which did not backload to Q4 2019/20
- Development of a robust plan for the 2 ward closures set out in the Step Down ward business case
- An internal audit review of budgetary control to be completed in Q4, terms of reference to be agreed between the Chair of Audit Committee and the ADoF.

The committee concluded that the Control Total should not be accepted at this interim stage and the CIP should be reduced to 2.5% for the draft submission.

4. Ward Based Nursing Establishment Review

The DoN presented the paper to the Committee which outlined a review of ward based nursing and the provision of safe staffing across inpatient wards. This provided a consistent approach to safe staffing with standardised support roles and professional judgement on adaptation to minimum staffing levels in certain areas. A review of the budgeted 'headroom' proposed a reduction from 25% to 23% and this would fund the changes with a balance of £103k remaining. The chair requested that subject to the DoN identifying the shortfall in funding the review was approved.

5. Trainee Nurse Associate Business Case

The DoN presented the paper to the Committee and it was outlined that an investment of £339k was required to support the continued roll out of the Trainee Nurse Associate programme which resulted in positive career development for junior staff and was a strategy to mitigate the shortfall in Band 5 recruitment. The Committee noted the benefits but requested that the DoN rework the business case such that the cost pressure would be managed within current budgets in year.

6. Reference Cost Analysis – Non Elective short-stay

The ADoF presented an update paper requested by the committee on the impact of high levels of short stay NEL activity on the Trust NEL RCI. The analysis showed that the RCI would increase from 82 to 95 if the Trust had a comparable level of short stay NEL activity as peer. An alternative proposition was that the level of activity was appropriate given the significant work the Trust had invested in the ambulatory care model. The DDoF explained that new tariff arrangements would mitigate the risk that commissioners would dispute the level of activity counted.

7. SLR Plan

The committee received an update of the SLR plan for roll out and reporting.

8. Implementation of Aseptic Anti-Touch Technique

The DoN presented the above business case which resulted from changes in the guidance and concerns in relation to infection control. A change of product and staff training was required to reduce HCAI and promote patient safety. The paper would also be presented at the Quality Committee. The financial implications of £71k were outlined and agreed.

9. Reports from other committees

The committee received and noted the report from:

- Finance and Performance Group

10. Items for the Risk Register

- Financial plan and impact from the regulator
- Internal Audit plan and confidence in assurance

11. Recommendations to the Board

- Arrange an extra-ordinary meeting of the Board to discuss the Annual plan.

Board of Directors	
Agenda Item	10.3
Title of Report	Report of Programme Board
Date of Meeting	6 March 2019
Author	Joe Gibson, External Assurance Steve Sewell, Delivery Director
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 Programme Board (20th February), change programme and the independent assurance ratings undertaken to gauge the confidence of delivery. The supporting assurance evidence has been discussed at the Programme Board Meeting (the membership of which includes two non-executive directors) held on Wednesday 20th February where the key themes discussed were the successful delivery of the MSK Project and the current status of the Perioperative Care project. The Board of Directors is asked to determine any required changes to the reporting format.

2. Background

The attached assurance report has been undertaken by Joe Gibson, External Assurance, and provides a detailed oversight of assurance ratings per programme along with the programme delivery narrative including key milestones and performance against intended benefits. The Report of the Programme Board is being further refined and this will include ongoing development of benefit trajectories and SPC charts so there is visibility of progress across the change programmes, measureable at a process and outcome level.

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

3. Programme Board - Key Agenda Discussions

3.1. Programme Dossier

The Board received an initial iteration of a Dossier summarising the key components (e.g. high level milestones, benefits, lead, description) of each project within the overall change programme. Further work was acknowledged, however this summary view was appreciated with the aim of having a version for use by 1st April. Aligned to the Dossier was an agreed approach to project stages and the approved documents required to enter the next stage of the process.

3.2 MSK Integrated Service

The Board received an excellent presentation outlining the initial goals, timescales, outcomes and challenges for this project. The Board congratulated the service on their significant outcomes and closed the project, recognising its successful transition to normal operations. Further enhancements to the MSK service are being considered and a review will determine the approach to delivery of these.

3.3 Perioperative Deep Dive

As part of a regular feature, the Board reviewed the Perioperative Project aiming to deliver a step change through: running 95% of core theatre sessions, reduce on the day theatre cancellations by 5%, and reducing the number of theatre sessions cancelled within 28 days of surgery by 50%. The Project received support for the prioritisation of key IT enabler work.

3.4 External Assurance

The expectations and approach for the external assurance process were reiterated and assurance ratings reviewed, leading to the recommendations for Trust Board requested in section 6 of this report.

4. 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 transparency of governance and the confidence levels around delivery and benefits.

5. Conclusion
   Performance against the agreed standards for programme and project management is still falling short; however, there has been gradual improvement across a range of assurance indicators since the last report. The issue now is that the improvements in governance have not been matched by an improvement in delivery. Pace is not matching the ambition. In particular, the definition of benefits, underpinned by robust plans, is lacking in those areas highlighted by the ratings. The actions to improve are noted in the assurance statements of this report and independent monitoring will continue to measure progress and provide assurance.

6. Recommendations
   The Board of Directors are asked to note the Trust's Change Programme assurance report and consider the following recommendations from the Programme Board:

   a. Sponsor a review of the GDE/Digital Programme – given the pattern of assurance ratings – with a view to the agreement of a new Digital 'mandate'.
   b. Decide what actions will be taken, with partners, to put the Healthy Wirral programme on to a sound footing in terms of governance and capability (including a robust assessment of the benefits that will accrue to the Trust).
   c. Expedite the decision on the strategy for a joint pathology service so that the programme can be initiated and benefits realised.

Change Programme Assurance - Trust Board Report - March 2019

J Gibson – External Programme Assurance

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Workforce Planning

- The **'Workforce Planning'** project was initiated at the Programme Board on 20 Dec 18. Since the last report, significant progress has been made in establishing the governance regime and providing assurance evidence. There is now a need to define the benefits sought and plan the entire project life cycle. The engagement with the assurance process is tangible and encouraging.

Improving Patient Flow

- **'Ward Based Care for Earlier Discharges'** has seen a significant improvement in assurance ratings. Outstanding concerns are the absence of evidence that the plan is being tracked and that all benefits are subject to measurement.
- The **'Command Centre'** project plan - beyond the Millennium upgrade - shows a 'go live' date of June 2019; however, no evidence is available to demonstrate that this plan is being actively tracked. Moreover, there remains an absence of any metrics by which benefits might be measured.
- **'Transformation of Discharge Services'** has seen a modest improvement in ratings this month but significant issues remain. The overall plan appears to end in July 2019 and formatting issues make the whole unclear. The evidence of measurement of KPIs appears to have been last updated in August 2018.

Operational Transformation

- The **'Perioperative Medicine Improvement'** programme is again reporting key performance indicators are off track and the programme needs to develop a detailed plan for 2019/20; benefits mapping of the 'to be' state in September 2019 is underway.
- The **'Outpatients Improvement'** programme has achieved the required standards of governance. There is now a need to provide evidence of weekly tracking of the overall plan and focus is being brought to bear on the delivery of near term improvement targets which currently remain off-track.
- The **'Diagnostics Demand Management'** has made significant strides and is currently achieving the majority of the assurance standards. The EA/QIA needs to be signed off and the detailed work to refine the benefits realisation planning completed.

Quality, Safety & Governance

- The four projects for **'Quality, Safety and Governance'**, arising from the revised Quality Strategy, are yet to be initiated at Programme Board. Assurance reporting will commence once the projects are established.

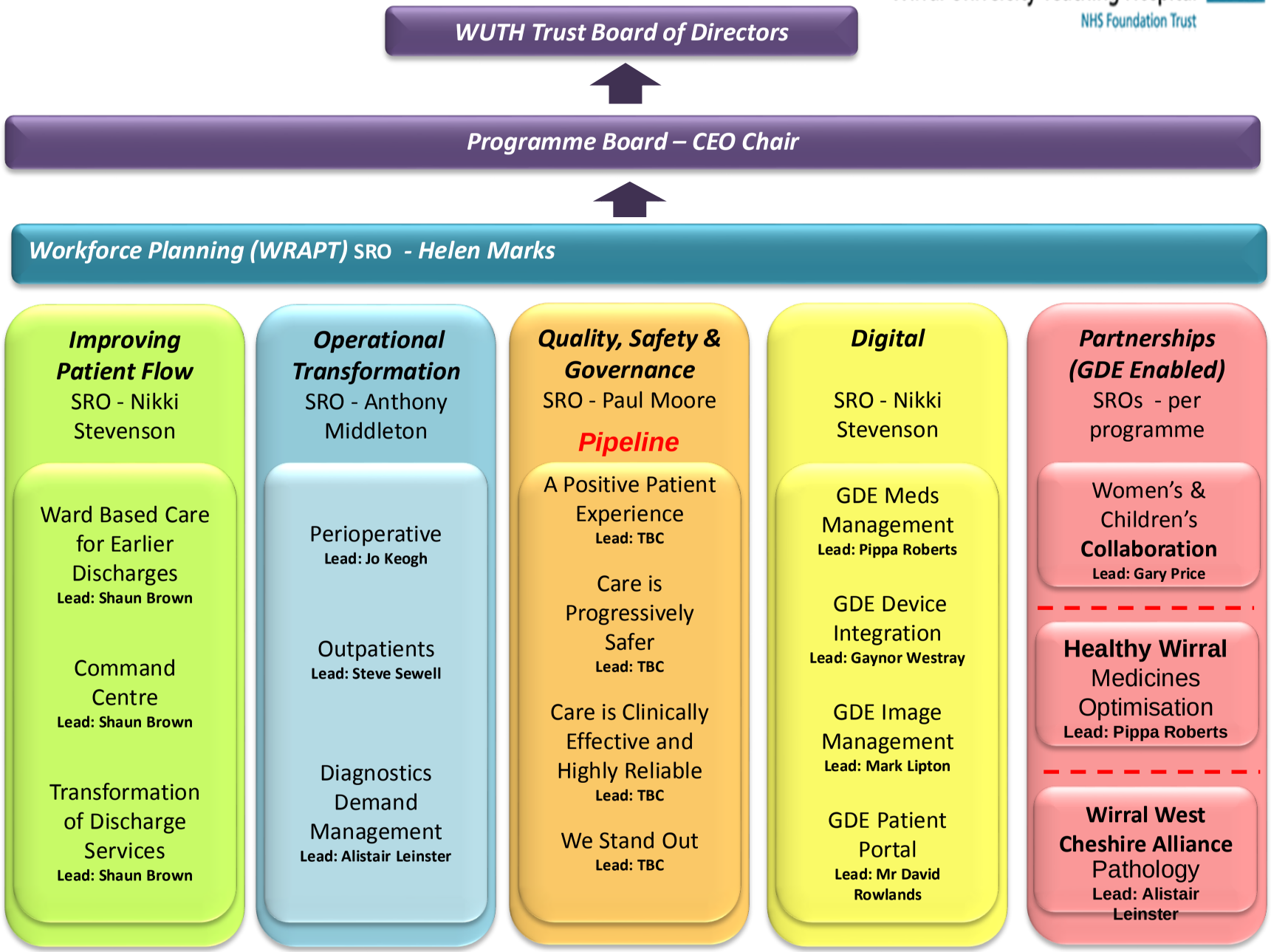
Digital

- **'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; however, the overall rating for delivery remains red due to the absence of any measurable success criteria for the project.

Partnerships

- The **'Womens & Childrens'** partnership programme is now green rated in terms of governance; however, the delivery remains red rated due to the lack of a current plan.
- 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 has previously been reported as 50% - £250k - delivered.
- For the **'WWC Alliance: pathology'** programme the ratings for both governance and delivery remain at amber. Overall, the programme awaits a Trust Board decision on the commitment to enter into a collaborative service framework.

Wirral University Teaching Hospital NHS
NHS Foundation Trust



Workforce Planning - Programme Assurance Update – 11th February 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Helen Marks	Ann Lucas	Andy Hanson	Design	Amber	Red

Independent Assurance Statement

1. Scoping document available as endorsed at the Programme Board on 20 Dec 18; a PID (dated 1 Feb 19) has been drafted with benefits to have metrics identified with benefits start dates and estimated financial benefits. **2. & 3.** Names of the project team on this dashboard are now complete and a high level description taken from the PID. **4.** There is no evidence or ToRs for a governing 'project group'. **5.** EA/QIA in draft are available and need to be signed off. **6.** High level planning dates (pilot stage) are in the PID but there needs to be a trackable plan that exists as a stand alone document. **7.** There are benefits outlined in the PID but no metrics or start dates attached; it is stated that these will be completed following the pilot stage. **8 & 9.** There is a risk register but no evidence of issue management to date. **Most recent assurance evidence submitted 11 Feb 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
1. Programme One - Workforce Planning (WRAPT)														
1	**Workforce Planning**	The Trust recognises that a co-ordinated effective workforce planning process, aligned to all other strategic and operational plans, needs to be developed. A workforce plan will address skill shortages, support the long term sustainability of service transformation projects and ensure congruence of goals between divisions.	Helen Marks											

Ward Based Care for Earlier Discharges - Programme Assurance Update - 15th February 2019

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

Independent Assurance Statement

1. Scoping document available as endorsed at the Programme Board on 20 Dec 18; this has now been supplemented by the Ward Rounds SOP documentation of 9 January 2019. It is not clear if the project mandate template remains to be completed. **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 meetings up to 23 Jan 19 are in evidence. Trello Board is in use for this project. **4.** ToRs for the governing project group are available. **5.** EA/QIA are now signed off. **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. The SHOP model adoption is being measured to 15 Jan 19 but no evidence of measurement of other defined benefits. **8 & 9.** There is now evidence of risk and issue management in the form of a RAID Log. **Most recent assurance evidence submitted 15 Feb 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
2. Programme Two - Improving Patient Flow														
2.1	**Ward Based Care for Earlier Discharges**	Patients are able to access the right care at the right time in the right place	Nikki Stevenson		●	●	●	●	●		●	●	●	●

Transformation of Discharge Services - Programme Assurance Update – 11th February 2019

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

Independent Assurance Statement

1. The scope document comprises a draft PID, TDSS v0.3 uploaded 11 Feb 19, for the 'Transformation of Discharge Services Sustainability Programme' which is in DRAFT until signed off by the Project Team. **2.** Project Team names are now complete on this dashboard. **3.** The 'Transformation of Discharge Services Sustainability Programme Board' has Terms of Reference (v6 dated February 2019) and there is also an action log; however, notes of the monthly meetings would add to the governance (e.g. for EA/QIA). **4.** There is now a comprehensive communications plan, 8 Feb 19, and this will need tracking to assure delivery of the wide staff engagement aspired to. **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 but some of the formatting/detail is unclear. **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 and were reviewed on 7 Feb 19. **Most recent assurance evidence submitted 11 Feb 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
2. Programme Two - Improving Patient Flow														
2.3	**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.	Nikki Stevenson											

Command Centre - Programme Assurance Update - 11th February 2019

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

Independent Assurance Statement

1. The PID (v0.3 dated 30 Aug 18) lacks metrics by which benefits will be measured. There is now a 'Commend Centre Phase 1', February 2019, slide pack documented with further, updated, objectives and a high level plan through to mid-2019. **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. However, updates to PFIG, to Dec 18, are in evidence. **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 from Aug 18 but doesn't appear to have been updated for 6 months and there is no 'date of last review' information for the risks. **Most recent assurance evidence submitted 11 Feb 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
2. Programme Two - Improving Patient Flow														
2.2	**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	Nikki Stevenson		●	●	●	●	●		●	●	●	●

Perioperative Medicine Improvement – Programme Assurance Update – 15th February 2019

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

Independent Assurance Statement

1. 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'. There is now also evidence of 'Scheduling Management' process review and 'TCI Session' **2.** A Project Team is in place with a wide range of activity in evidence. **3.** The Perioperative Medicine Steering Group is governing with comprehensive action logs to record progress. **4.** There is evidence of wider stakeholder engagement but no communications plan available. **5.** The QIA has now been re-validated and signed off on 14 Feb 19. **6.** The milestone plan v3 uploaded 4 Feb 19 is being transferred to a new format (there are some technical issues with the current version in MS Project); once reformatted, a review of the plan by the Steering Group would be advisable. **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 15 Feb 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3. Programme Three - Operational Transformation														
3.1	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.	Anthony Middleton											

Outpatients Improvement - Programme Assurance Update - 11th February 2019

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

Independent Assurance Statement

1. The 'Trust-wide OP Operational Structure - Workstream Brief' v0.1 has vision, approach and aims in a concise format with context explained in 'WUTH Outpatients Review' v0.5 dated 16 Oct 18. There is also a 'Programme Development Scope' dated Nov 18. **2.** A project team is in place. **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 4 Feb 19; 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.** There is now a comprehensive 'Outpatients Communications and Engagement Plan' draft v1.1 Jan 19; this will need tracking to assure delivery. **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 trajectories featured in the OPD Highlight Report for January 2019; this shows the benefits off track. **8 and 9.** There is a RAID Log in evidence with risks and issues last reviewed on 7 Feb 19. **Most recent assurance evidence submitted 7 Feb 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3. Programme Three - Operational Transformation														
3.2	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 experience.	Anthony Middleton											

Diagnostics Demand Management - Programme Assurance Update - 11th February 2019

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

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); this has been supplemented by 'Unwarranted Variation & Demand Management: Pathology Tests', A. Bamber. **2.** A project team is defined. **3.** Meetings are commencing with divisional leads and the programme governance forum is being 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/EA have been drafted and need to be signed off. **6.** A comprehensive milestone Gantt chart plan has been developed and is being tracked. **7.** There is a High level Driver Diagram and now a comprehensive document describing baselines, targets and trajectories together with a financial profile; benefits currently appear to be RAG rated 'Amber' by the project . **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 7 Feb 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3. Programme Three - Operational Transformation														
3.3	**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	Anthony Middleton		●	●	●	●	●		●	●	●	●

Digital: GDE Medicines Management – Programme Assurance Update – 11th February 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	P Roberts	L Tarpey	Implementation	Amber	Red

Independent Assurance Statement

1. OPD PID v2 dated 16 Jan 19 (no metrics). AMS PID v3, 25 Oct 18, 1 benefit of £187k CQUIN (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' (no metrics). Paper Charts PID v1, 23 Oct 18, 1 benefit to improve safety (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 meetings available to Dec 18/ Jan 19. 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 v4 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 v 25 Jan 19, largely up to date**. 7.** No evidence of tracking benefits. **8 & 9.** Risks & Issues: RAID Log v14, 5 Feb 19, requires 'date of last review' column for risks. **Most recent assurance evidence received 7 Feb 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
5. Programme Five - Digital														
5.1	Meds Management	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 both. This meeting will support prioritisation of work for both BAU and GDE projects.	Nikki Stevenson											

Digital: GDE Device Integration – Programme Assurance Update – 11th February 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Gaynor Westray	Michelle Murray	Implementation	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 are ECG project meetings of 26 Nov 18 and 6 Feb 19. PIDs yet to be approved in a 'Project Board'. **4.** 'Vitalslink Communication Plan', 30102018; however, it is a schedule for Project Board and not evidence of stakeholder engagement. **5.** No EA/QIA in evidence. **6.** Infusion Pumps project plan, 25 Jan 19, needs to show completion/progress of tasks. 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 v0.4 dated 11 Jan 19 completes in Mar 19 and appears on track. **7.** No evidence of tracking of benefits. **8 & 9.** There is a consolidated RAID Log for the 4 projects, updated on 28 Nov 18. **Most recent assurance evidence received 6 Feb 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
5. Programme Five - Digital														
5.2	Device Integration	SRO to arrange for this field to be populated as well as 'programme core team names'	Nikki Stevenson											

Digital: GDE Image Management - Programme Assurance Update - 11th February 2019

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

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 're-start meeting' of 1 Feb 19 but notes do not have a title/topic of the meeting; 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). Med Photo Project Plan of 25 Jan 19 does not yet appear to be 'tracked' and the same is true of the Theatre Project Plan of 25 Jan 19 **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 1 Feb 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
5. Programme Five - Digital														
5.3	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 processes.	Nikki Stevenson											

Digital: GDE Patient Portal - Programme Assurance Update - 11th February 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Nikki Stevenson	Mr David Rowlands	Katherine Hanlon	Implementation	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 although no evidence of this meeting received to date. **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, v1.4 of 23 Jan 19, is tracked but behind schedule. **7.** No evidence of benefits/metrics tracking. **8 & 9,** Risks and Issues: RAID Log, 7 Feb 19, captures risks and issues and these were - for the most part - last reviewed at the Project Board of 27 Jul 18 as recorded in the minutes. One risk appears to have been reviewed on 7 Feb 19.
Most recent assurance evidence received 7 Feb 19.

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
5. Programme Five - Digital														
5.4	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 electronic medical record (EMR). The patient portal is essential for remote surveillance and self-management of patients living beyond cancer. This may allow for patients to be managed remotely, reducing the amount of follow ups required in hospital.	Nikki Stevenson											

Partnerships: Women & Children's - Programme Assurance Update - 11th February 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
TBD	Gary Price/Joe Downie	Amy Barton	Implementation	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.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
6. Programme Six - Partnerships (GDE Enabled)														
Collaboration - Women and Children														
4.2	**Women and Childrens**	The Cheshire and Mersey STP calls for local solutions for women and children's services to address workforce and quality challenges	Natalia Armes											

Healthy Wirral: Medicines Management - Programme Assurance Update - 11th February 2019

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

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 Healthy Wirral' and there is a PID in draft, 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.** Governance 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 are shown in 'Adalimumab Biosimilar Implementation: January 2019 Update'. **8 and 9.** No evidence that risks and issues are identified, assessed and managed/mitigated. **Most recent assurance evidence submitted 25 Jan 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
6. Programme Six - Partnerships (GDE Enabled)														
Collaboration - Healthy Wirral														
4.4	**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.	Mike Treharne, DOF CCG											

WWC Alliance: Pathology - Programme Assurance Update - 11th February 2019

Exec Sponsor	Programme Lead	Transformation Lead	Stage of Development	Overall Governance	Overall Delivery
Karen Edge	Alistair Leinster	TBD	Design	Amber	Amber

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 and there is a risk register in evidence; however, the risk register would benefit from having a 'date of last review' column. **Most recent assurance evidence submitted 14 Jan 19.**

PMO Ref	Programme Title	Programme Description	SRO/ Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
6. Programme Six - Partnerships (GDE Enabled)														
Collaboration - Wirral West Cheshire Alliance														
4.5	**Pathology**	For WUTH and COCH to form a joint pathology service across the two Trusts which will deliver against indicative NHSI savings targets, provide operational benefits, reduce a number of current operational risks and position both Trusts for future broader regional collaboration.	David Jago											

BOARD OF DIRECTORS	
Agenda Item	10.4
Title of Report	CQC Action Plan Progress Update
Date of Meeting	6 March 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**	Provided for **assurance** to the Board **The Board is invited to receive and consider this report**
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	To be confirmed
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

CQC ACTION PLAN UPDATE REPORT
POSITION AS AT 14TH FEBRUARY, 2019

1. PURPOSE

1.1 The purpose of this report is to ensure the Board of Directors are up to date on the progress of the CQC Action Plan, and to highlight to the Board, 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 to the Board 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

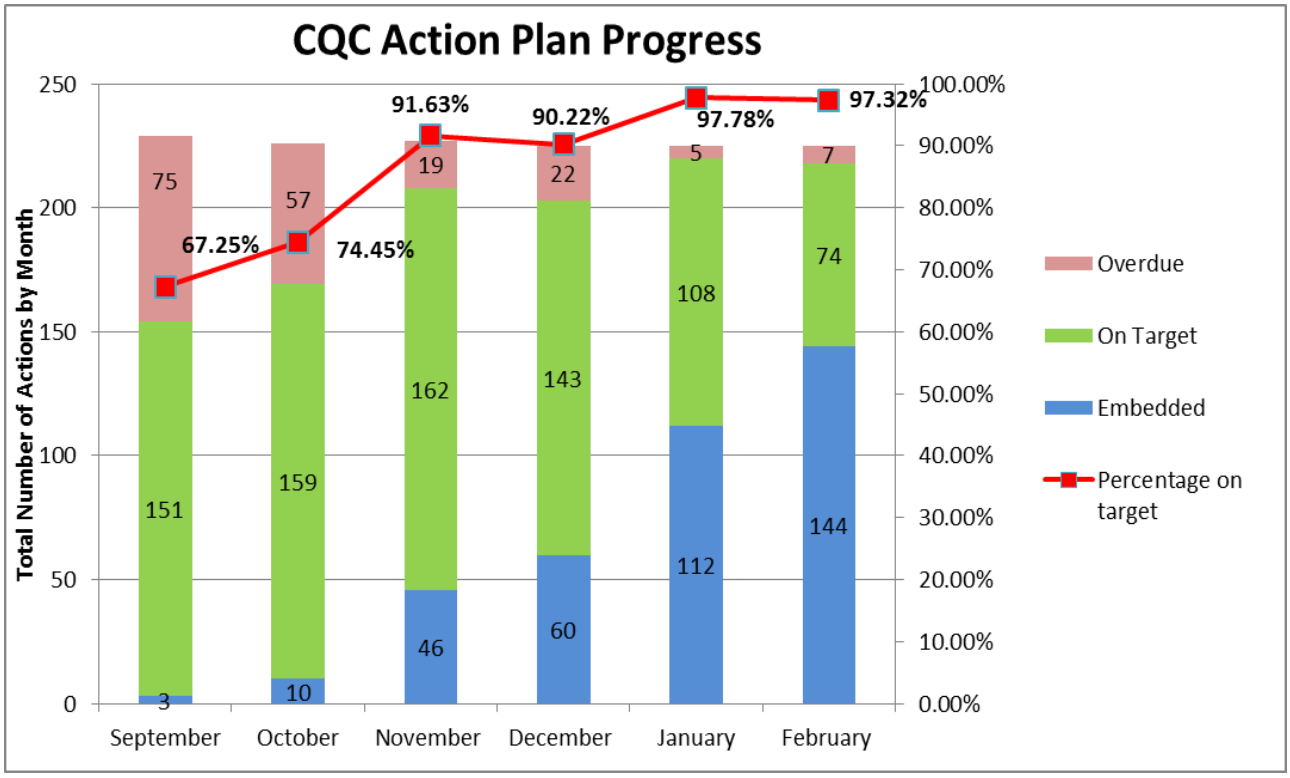
3.1 The CQC inspected the Trust in March and May 2018. The outcome of the inspection was as follows:

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 – February 2019



5. EXCEPTIONS

Following the *Confirm and Challenge* meetings held week commencing 5th February 2019, there are 7 actions which have been 'red-rated' and 1 'amber-rated' actions and are to be reported as exceptions for this reporting period

Overdue actions concern operational matters and refer to medicines storage, medicines management, ED Assessment protocols, performance dashboards and premise and equipment remedial works recommendations. 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 in this reporting period with **32** 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. RECOMMENDATION

The Board of Directors are invited to:

- consider and where necessary discuss corrective actions to bring the CQC Action Plan back on track; and
- advise on any further action or assurance required by the Board.
- Note the significant improvement in month

ANNEX A

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: 05/02/2019** Progress in this area is unsatisfactory; this was escalated to the Board in January 19. Chief Nurse reported to the Board the actions that were being taken to accelerate improvement. The Chief Nurse advised that a re-audit will take place in March 19. Therefore, the compliance figures will not change until that point. However, the Chief Nurse anticipated substantial improvements will be demonstrated based on the intelligence she and the Director of Pharmacy have received.	01/11/2018	
191	Should Do	Medical Care (Acute & Medical Division)	**"MEDICINES STORAGE** The service should ensure the safe and proper storage of medicines on the wards. "	Provide assurance report of compliance to PSQB	Chief Nurse	Effective	**Updated: 05/02/2019** One criterion on Quality Performance dashboard relates to Meds storage, detail presented at MSOP. As at Dec 18 performance Trust wide has slightly improved, performance was 78%. Assurance cannot be provided to PSQB until the results of the March 19 audit are confirmed.	31/12/2018	
107	Must Do	Urgent And Emergency Care (Acute & Medical Division)	**MEDICINES MANAGEMENT** The service must ensure that all medicines, including controlled drugs and patient group directions are managed in line with trust policy and legislation.	**Controlled Drugs :** Implement formal action plan developed from Q1 2018/19 audit results (30/9/18). Impact is not expected to be fully evident until Q3 audit. Q2 audit is being planned for August/September 2018. Strengthen corporate and divisional accountability	Executive Director of Nursing and Midwifery	Safe	**Updated: 05/02/2019** Perfect ward to be used as compliance reporting tool. Next Pharmacy led audit is planned for March 19. Nursing teams have been asked to provide details of what key actions are being taken to address these issues and the additional steps that being taken to bring this under control	31/01/2019	
108	Must Do	Urgent And Emergency Care (Acute &	**MEDICINES MANAGEMENT** The service must ensure that all medicines, including controlled	**PGDs :** - Implement action required as a result of March 2018 audit	Executive Director of Nursing and	Safe	**Updated: 05/02/2019** The Trust can demonstrate that it is documenting and reporting against standard;	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
		Medical Division)	drugs and patient group directions are managed in line with trust policy and legislation.	(especially staff and clinical manager signatures and ensuring staff signed checked against establishment). Pharmacy will re-audit December 2018. - Expand monthly matron spot checks to include PGDs - Strengthen corporate and divisional accountability (1/10/18)	Midwifery		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.		
173	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.	As part of the performance review, ensure that maternity dashboard is reviewed at each formal meeting	Executive Director of Quality & Governance	Well Led	**Updated: 05/02/2019** Dashboard to be presented as part of Divisional Performance review standard suite of documentation. No evidence received to confirm that this had been included in January 19 meeting pack.	31/11/2018	
104	Should do	Corporate / Trust-Wide Issues	**MEDICINES TEMPERATURES** The service should ensure that staff monitor the drugs room temperature and take action to address the temperature if it is outside of an appropriate range. **SLUICES AND MEDICINES ROOMS** The service should ensure all sluice areas and medication rooms in the unit are secure and that refrigerators in the medical room and packed appropriately. **Maternity :** The service should ensure that all drugs fridges are secure, used for their intended purpose and checked as per recommendations.	Conclude discussions on case for change to introduce air conditioning in selected/all medicines storage areas due to temperature excursions >25 degrees	Executive Director of Nursing and Midwifery	Effective	**Updated 09.02.2019** Conclusion has been reached - Defined outcome and risk assessment has been undertaken, residual numbers of rooms that do not currently have air conditioning have been identified. Assessment has been undertaken and a work plan has been developed. We have prioritised a number of rooms, 10 priorities out of a number of circa 30 rooms. Implementation/delivery plan to be developed.	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
208	Should 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 SOPs (1/8/18)	Chief Operating Officer	Effective	**Updated 04.02.2019** Transposed reporting arrangements within our data capture systems have been identified. Trial of triage only process is being launched in February 19 with consultant colleagues.	01/09/2018	
33	Must Do	Corporate / Trust-Wide Issues	**PREMISES & EQUIPMENT** **Surgery:** The trust must ensure all premises are maintained and fit for purpose. The service should ensure the paediatric theatre recovery area is suitably decorated for children **Critical Care:** The service must ensure that the unit provides a suitable environment for patients, staff and visitors. The trust must ensure plans are developed to indicate when facilities will comply with national standards The service should review the reception and entry system arrangements for visitors to the unit.	Agree a trajectory for completion of the remedial works	Chief Operating Officer	Effective	**Updated 04.02.2019** Remedial works plan was presented to EMT 28th January 19 and will be further presented at TMB in February 19. Outline plans cost 14 million against a capital budget of 7m. A review of the new CQC standards for critical care will be undertaken and a gap analysis will be carried out.	31/01/2019	

ANNEX B (Embedded actions in January 2019)

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
29 (1)	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 access to fire escapes is not obstructed. A report to be provided setting out the assurance to Risk Management Committee	Chief Operating Officer	Well Led	**Updated 04/02/2019** Assurance provided to the risk management committee, the fire officer was satisfied that fire escape where free from obstruction at the time of audit. Draft risk committee reports and the minutes and summary report for Management Board to be submitted as evidence.	31/10/2018	
47 (2)	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.	Establish a mechanism to enable Ward to Board reporting which ensures visibility, consistency and accuracy for all selected indicators or measures across all Wards and clinical Departments	Director of IT and Information	Well Led	**Updated 05.02.2019** Power BI can be downloaded from app store - providing managers with immediate access to reporting tools	31/12/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
49 (3)	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.	To supplement the Quality Dashboard, introduce exception reporting template to help focus on those measures which are not under prudent control at the time of reporting	Director of IT and Information	Well Led	**Updated 05.02.2019** Completed and IDA's are reported. Process and system in place but a further review will be undertaken, particularly around trajectories.	31/10/2018	
50 (4)	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.	Introduce, where appropriate, time series analysis and the use of statistical process control charts to understand variation and improve performance	Director of IT and Information	Well Led	**Updated 05.02.2019** Completed embedded process	31/10/2018	
51 (5)	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.	Commission independent third line assurance, e.g. from Mersey Internal Audit Agency, of data quality for a sample of quality metrics upon which the Board rely for performance and assurance	Director of IT and Information	Well Led	**Updated: 05/02/2019** Completed - Independent report commissioned and output report with recommendations received.	31/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
58 (6)	Must Do	Corporate / Trust-Wide Issues	**RECORDS MANAGEMENT** **Medicine :** The service must ensure that records are kept secure at all times so that they are only accessed and amended by authorised people. **Surgery:** The service should ensure all medical records are stored securely. **Maternity:** The service must ensure that women's care records are kept securely in locked cabinets at all times.	Review and assure the security of records during transit	Director of IT and Information	Well Led	**Updated: 05/02/2019** Completed - SOP has been agreed confirming arrangements	01/09/2018	
59 (7)	Must Do	Corporate / Trust-Wide Issues	**RECORDS MANAGEMENT** **Medicine :** The service must ensure that records are kept secure at all times so that they are only accessed and amended by authorised people. **Surgery :** The service should ensure all medical records are stored securely. **Maternity :** The service must ensure that women's care records are kept securely in locked	Commission audit by MIAA of records storage and security	Director of IT and Information	Well Led	**Updated: 05/02/2019** Report has been received and is being considered	31/1/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
			cabinets at all times.						
102 (8)	Should Do	Corporate / Trust-Wide Issues	**MEDICINES TEMPERATURES** The service should ensure that staff monitor the drugs room temperature and take action to address the temperature if it is outside of an appropriate range. **SLUICES AND MEDICINES ROOMS** The service should ensure all sluice areas and medication rooms in the unit are secure and that refrigerators in the medical room and packed appropriately. **Maternity:** The service should ensure that all drugs fridges are secure, used for their intended purpose and checked as per recommendations.	Strengthen corporate and divisional accountability	Executive Director of Nursing and Midwifery	Effective	**Updated: 05/02/2019** Completed – embedded process	01/12/2018	
111 (9)	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: 05/02/2019** Chief Nurse has confirmed that the appropriate training is in place and a briefing note to be issued to PSQB - a video blog has also been released.	01/11/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
112 (10)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Communicate to frontline staff the importance of adhering to professional standards for recording patient interventions within the patient record	Executive Director of Nursing and Midwifery	Effective	**Updated: 05/02/2019** Chief Nurse has confirmed that the appropriate training is in place and effective communications have been issued	01/01/2019	
39 (11)	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**HAND HYGIENE** The service should ensure that all staff are compliant with hand hygiene in between providing direct care and treatment to patients.	Restate the Trust's standards for hand hygiene and environmental cleanliness to frontline staff	Executive Director of Nursing and Midwifery, Executive Medical Director	Safe	**Updated: 05/02/2019** We have seen an improvement in compliance for nursing workforce. A wider trust wide campaign has been launched. Hand wash basins are being provided at the entrance of each ward	01/10/2018	
40 (12)	Should Do	Critical Care (Diagnostics and Clinical Support Division)		Include metric within Ward Accreditation reporting process that monitors and responds to hand hygiene standards	Director of Nursing	Safe	**05.02.2019-** Embedded process - improvement can be demonstrated via Perfect ward app.	01/11/2018	
143 (13)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Review products used, and promotion of hand hygiene Trust-wide	Executive Director of Nursing and Midwifery, Executive Medical Director	Safe	**Updated: 05/02/2019** Product review has taken place and Chief Nurse is satisfied	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
144 (14)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Include metric within Ward Accreditation reporting process that monitors and responds to hand hygiene standards	Executive Director of Nursing and Midwifery, Executive Medical Director	Safe	**Updated: 05/02/2019** Confirm and Challenge meeting confirmed embedded process	01/10/2018	
145 (15)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Challenge and drive accountability for compliance as part of the proceedings of PSQB	Executive Director of Nursing and Midwifery, Executive Medical Director	Safe	**Updated: 05/02/2019** Confirm and Challenge meeting confirmed embedded process	01/10/2018	
168 (16)	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	Adopt the convention whereby divisional risks are reviewed at least monthly at the Risk Management Committee	Executive Director of Quality & Governance	Well Led	**Updated: 05/02/2019** Confirm and Challenge meeting confirmed embedded process - on business cycle RMC Business cycle	30/11/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
			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.						
178 (17)	Must Do	Corporate / Trust-Wide Issues	**COMPETENCY ASSESSMENTS AND MANDATORY TRAINING** **Emergency Department :** The service must ensure that all staff complete full competency assessments to undertake their roles and that this is recorded in line with trust policy. The service should ensure that mandatory training is completed by all staff in a timely way. **Medicine :** The service should ensure a record is maintained when role specific competencies are achieved. The service should improve mandatory and safeguarding	Establish online training and courses, where appropriate, to meet staff training needs	Executive Director of Workforce	Well Led	**Updated: 05/02/2019** Confirm and Challenge meeting confirmed embedded process , we are beginning to see traction in compliance rates	30/09/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
			training compliance across all staff groups. **Critical Care :** The service should ensure that the unit meets the trust target of 95% for completion of mandatory training and for protecting vulnerable people training. **Maternity:** The service should ensure that mandatory training, safeguarding training and appraisal compliance is increased.						
179 (18)	Must Do	Corporate / Trust-Wide Issues	**COMPETENCY ASSESSMENTS AND MANDATORY TRAINING** **Emergency Department :** The service must ensure that all staff complete full competency assessments to undertake their roles and that this is recorded in line with trust policy. The service should ensure that mandatory training is completed by all staff in a timely way. **Medicine :** The service should ensure a	Establish monthly assurance and variance reporting against the 'Core Ten'	Executive Director of Workforce	Well Led	**Updated: 05/02/2019** Mandatory training is now included in Quality dashboard and through monthly DPR review process	**30/11/2018**	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
			record is maintained when role specific competencies are achieved. The service should improve mandatory and safeguarding training compliance across all staff groups. **Critical Care :** The service should ensure that the unit meets the trust target of 95% for completion of mandatory training and for protecting vulnerable people training. **Maternity:** The service should ensure that mandatory training, safeguarding training and appraisal compliance is increased.						
211 (19)	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.	To review the service provision of the MET team to ensure that the service provision meets the needs of those patients who are escalated to it (including out of hours). Develop an action plan to meet any identified shortfalls	Executive Medical Director	Should Do	**Updated: 05/02/2019** Confirm and Challenge meeting confirmed embedded process	30/11/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
212 (20)	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 the standard and completion of training associated with recognising and responding and escalating clinical deterioration such as vital sign measurement & recording. Develop an action plan to meet any identified training needs	Executive Medical Director	Should Do	**Updated: 05/02/2019** Confirm and Challenge meeting confirmed embedded process	30/11/2018	
16 (21)	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: 05.02.2019-** Evidence satisfies action and confident that this has been embedded.		
22 (22)	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.	Audit compliance to verify that breaches, where they occur, have been record properly	Chief Operating Officer	Caring	**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	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
23 (23)	Must Do	Medical Care (Acute & Medical Division)	**USE OF ESCALATION AREAS** 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.	Confirm which areas are 'designated escalation areas'	Chief Operating Officer	Safe	**04/02/2019 -**SOP's have been developed for designated escalation areas, and designation areas will be included in the policy.	10/10/2018	
25 (24)	Should Do	Medical Care (Acute & Medical Division)	**USE OF ESCALATION AREAS** 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		**05/02/2019 -** Submitted to Risk Committee December 18. Confirm and Challenge meeting satisfied an embedded process	10/10/2018	
26 (25)	Should Do	Medical Care (Acute & Medical Division)	**APPRAISAL** The service should ensure all staff has an up to date appraisal.	Monitor performance of staff appraisals rates through the divisional performance meetings - Tracking	Executive Director of Nursing & Midwifery, Executive Medical Director	Well Led	**05.02.18 -** Reporting mechanisms and controls are in place - compliance is being monitored and performance managed and this forms part of the monthly Divisional Performance Review process	21/11/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
66 (26)	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 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	**05.02. 2019 -** agreed protocols is in place. Embedded process	31/10/2018	
88 (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.	Actively encourage and promote participation in FFT survey across the Trust	Executive Director of Nursing & Midwifery,	Responsive	**05.02.2019 -** Introduced touch pad kiosks – we have seen an increase in response rates. In addition we have launched text message reminder service and child friendly icons	01/10/2018	
122 (28)	Should Do	Critical Care (Diagnostics and Clinical Support Division)	**BANK / AGENCY STAFF** The service must ensure that staff employed to cover duties are aware of ongoing audits and adhere to processes and guidance in the same way.	Review the protocol for local induction to incorporate a requirement to inform temporary workers of ongoing audits and practice requirements	Executive Director of Nursing and Midwifery	Effective	**05/02/2019-** Received confirmation that NHSP verification checklist process is being used	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
201 (29)	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 Develop systems allowing staff to be reallocated to areas of high acuity and staff shortage 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	**05.02.2019 –** received confirmation that systems are in place to monitor safe staffing and are running	01/10/2018	
202 (30)	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 :**	Develop systems allowing staff to be reallocated to areas of high acuity and staff shortage	Executive Medical Director, Director of Nursing & Midwifery.	Safe	**05.02.2019 -** Staffing Oversight tracker and SOP have been developed. Heat map is produced on a daily basis	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
			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.						
184 (31)	Should Do	Corporate / Trust-Wide Issues	**INNOVATION** The trust should consider how innovation is promoted within the trust.	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	Executive Medical Director	Effective	**05.02.2019 –** Review has been undertaken and the trust has taken the decision to not pursue but we are exploring the opportunity of partnering with Liverpool Health academy	21/11/2018	
185 (32)				Increase and promote participation in research		Effective	**05.02.2019 –** Increased promotion and participation can be evidenced. Satisfied embedded process	16/1/2018	

Board of Directors	
Agenda Item	10.5
Title of Report	Risk Management Report
Date of Meeting	6th March 2019
Author	Paul Moore, Director of Quality & Governance
Accountable Executive	Paul Moore, Director of Quality & Governance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All Principal risks
Level of Assurance • **Positive** • **Gap(s)**	Positive: Progress with risk management development Gaps:
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

This report provides the Board with:

a. an overview of the work undertaken to date on developing risk management at the Trust;
b. a synopsis of the divisional risk profiles following the reconstruction of risk registers and how they map to the Board's primary risk scenarios; and
c. outlines our intended next steps to drive the transition from our current position to operating at a highly adaptive and mature approach to risk management.

This risk profile suggests the Trust is exposed to a high number of higher-level risks. This may be linked to the level of maturity and a tendency to be introspective and reactive to the identification and response to risk. As risk management maturity develops we would expect to see the risk profile shift to the right (more lower level (managed) risks identified) as a more proactive and anticipatory approach becomes embedded and better control is established.

2. Background

The CQC inspection report published in July 2018 identified that the risk management system was applied inconsistently throughout services and risk registers and action plans to mitigate the risks were not always reviewed in a timely way. Subsequent review by the Director of Quality & Governance indicated that the Board's risk management system, when taken as a whole, was operating at a low level of maturity.

An Enterprise-wide Risk Management approach was subsequently adopted to drive the rapid development of risk management thereby enabling the Board to establish greater control over the process of identification, assessment and control of risk. To achieve this, a number of activities were implemented at pace:-

- Risk master classes were delivered by the Director of Quality & Governance to over 140 leaders within the Trust and also across the wider health system to raise awareness, understand the basic concepts involved in contemporary risk management and support the efforts to accelerate adoption of the risk process.

- A risk horizon was developed by the Executive to develop our understanding of the most important risks facing the Organisation over a 5-year horizon. The risk horizon exercise identified six strategic risk scenarios and a selection of specific risk vectors (the precise mechanism through which a risk scenario could materialise) which may, if not mitigated effectively, compromise organisational success – see appendix 1.

- Risk Policy was simplified and rationalised to clarify more directly the risk management process to be used.

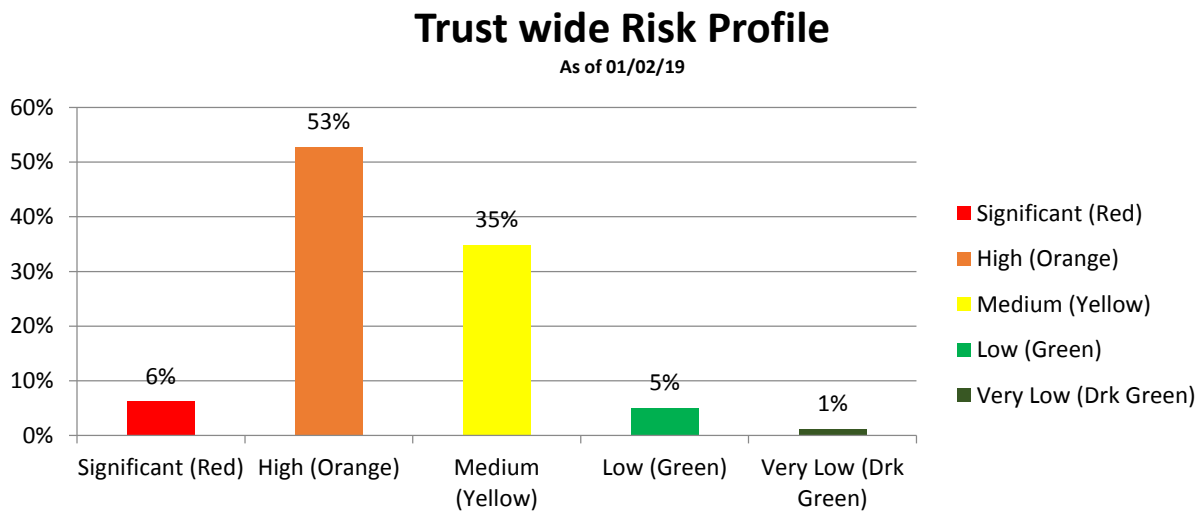
- The Risk Management Committee was formed, and a cycle of business developed to drive accountability and assurance regarding risk management. RMC meets monthly and reports to the Trust Management Board. Reporting and escalation conventions have been established.

- It was agreed that further work should be undertaken to ensure risk registers are developed and updated. As a result of this:

  - Introduced electronic web-enabled risk recording. Risk Register Web went live on 1st September 2018. This is accessible to all staff with access to the Trust's network. Once a risk is entered it is subject to an approval and validation process involving senior management;
  - Facilitated risk workshops took place with each division and some corporate functions. The workshops delivered education on the risk management process to be adopted within the Trust; shared the output of the risk horizon exercise and encouraged each division to consider their risks to objectives in light of the identified risk scenarios;
  - Individual training and support delivered to risk owners to help them with the use of Ulysses (Safeguard) in managing risks;
  - All divisions and corporate functions have reviewed, or are currently finalising, their risk registers for relevancy and accuracy.

3. Update

The current risk profile, based on current 'live' risks on risk register is:-



Synopsis of Significant Risks

In February the RMC reviewed all significant risk exposures and other reportable risks (i.e. residual risks ≥10). The Head of Quality Governance advised that these risks are live and continue to be reviewed by risk owners. Reporting of significant risks has evolved following conclusion of the reconstruction of divisional risk registers. There are 169 live risks on risks registers across the Trust. 6% (n=9) of risks are currently rated significant with a residual risk score of ≥15. These risks are of necessity priority risk areas.

53% of risks are currently rated high risk with a residual risk score of 10-12. At face value, it would appear the Trust is over-exposed to risk, indicating the Trust is not yet able to keep risk under sufficient control. This conclusion was supported by the RMC and action is

being taken to challenge the control environment, examine the requirement for contingency plans and re-evaluate exposure in light of the residual risk remaining after treatment.

The significant operational risks as they are currently reflected in the report can be mapped to the six risk scenarios as follows:

- ***Workforce capacity and capability*** *(primarily staffing, vacancy rates)*
- ***Financial sustainability***
- ***Failure in standard of care*** *(primarily infection prevention & control, Pharmacy*
- *robot)*
- ***Overwhelming demand/operational pressure*** *(adequacy of patient flows)*
- ***Stakeholder confidence*** *(HTA Licences – Mortuary)*

The RMC considered that there is, at present, not enough emphasis in the risk profile on:

- **financial risks** (such as insufficient income/volatility, expanding financial deficit, backlog maintenance, equipment replacement, delivery of CIP);
- **strategic workforce risks** (such as levels of employee satisfaction, aggregate exposure to non-completion of mandatory training, vacancies, growth in sickness/absence, anticipated demographic challenges such as supply of new recruits and colleagues eligible for retirement in next 3-5 years); and
- **Estate and environmental risk**.

Senior leaders were invited to consider and assess exposure to these risks in their areas so that any unseen material risk can be identified and addressed through the risk management processes accordingly.

Divisional Risk Reviews

All four Clinical Divisions have reviewed their risk registers and had taken a decision to rebuild the risk profile to reflect more directly the risks at divisional level which could, if not mitigated, threaten the achievement of the Board's objectives.

Women's & Children's Division

- The risk register continues to evolve.
- One risk currently qualifies for reporting to the RMC (i.e. there is only 1 risk rated 10 or more on the Women's & Children's risk register at time of report). This risk concerns **compliance with NICE Clinical Guideline 128 – Autism**. The gap in control had been addressed and this risk will be reduced accordingly.
- The RMC explored the apparent absence of risks ≥10 from the report and expected there to be risks relating to the Estate (NNU), staffing levels, margin on maternity income, consultant vacancy, wider strategic risks associated with provision of level-3 NNU services locally, management of medical outliers on Ward 54, possibly others which could represent a material threat to the delivery of divisional objectives. Division agreed these are potential risks and would review as a team and report back.

Surgery Division

- There are five 'reportable' risks. They concern:

  — **Financial unsustainability** (Significant Risk=16) – reflecting degree of financial control in division;
  — **Insufficient capacity to meet demand for care resulting in failures to deliver access to timely care** (Significant Risk=16);
  — **Insufficient patient flow impacting upon the elective programme** (High Risk=12);
  — **Errors in the administration of medicines** (High Risk=12); and
  — **Errors in the prescribing of medicines** (High Risk=12).

- The Division agreed to continue to develop the risk profile, giving more consideration to other potential risks which could represent a material threat to the delivery of divisional objectives such as: staffing levels, Theatre culture, environment of care, infection prevention & control, and patient experience – cancellations of planned care.

Diagnostics & Clinical Support Services Division (including Pharmacy)

- There are nine 'reportable' risks. They concern:

  — **Ability to step down and discharge patients from the ICU once stable** (High Risk=10) – this having an impact on mix sex accommodation breaches, but also (potentially) impacting adversely on admissions to ICU and the elective programme;
  — **Reporting and acting upon abnormal/unexpected clinical findings** (High Risk=12) impacting on delayed diagnosis and/or delayed clinical intervention;
  — **The viability of the Biochemistry Service** due to ongoing staffing challenges (Significant Risk=16); and
  — [Risk of] **Loss of HTA Licence in the Mortuary** (Significant Risk=15 – advised had been reviewed prior to meeting and downgraded to 9 after risk treatment).
  — [Risk of] **permanent loss of the Pharmacy robot at Clatterbridge Hospital** (Significant Risk=16). RMC were advised that approval to replace the robot was granted following approval of the Capital Plan 2019/20. The Chief Pharmacist provided reassurance that contingency plans are in place should the robot become unserviceable and the Department could function, but advised this would be insufficient to provide an efficient service to the hospital should the robot become permanently unserviceable;
  — **Failure/breakdown of walk-in fridge in central Pharmacy stores** (High Risk=12). RMC were advised that approval to replace the fridge was granted following approval of the Capital Plan 2019/20. Contingencies in the event of complete and permanent failure are currently limited;
  — **Supply chain failure** exacerbated by a 'no-deal' Brexit (High Risk=12). The Chief Pharmacist advised that the frequency of shortages of critical medicines has intensified. The Chief Pharmacist advised that the Trust is

working in concert with NHS England and other providers to minimise disruption and maintain supply. Contingencies developed include limiting the use of medicines where this is possible, using alternatives where these can be sourced, using unlicensed medicines under carefully controlled circumstances. The scale of any adverse impact would be assessed on a case-by-case basis, and depend upon the nature of the supply problem and the specific drug in short supply;

- [Potential breach of] **patient confidentiality in the Pharmacy reception area** (High Risk=10). The RMC felt more control could be applied to respond more effectively and the Chief Pharmacist agreed to take that away and consider;
- [Potential breach of] **compliance with Falsified Medicines (EU) Directive** in respect of counterfeit medicines entering the supply chain (High Risk=10). The Chief Pharmacist advised that achieving sufficient control and compliance is dependent upon the installation of a 'central recording system' at an estimated cost of £40k.

- The Division agreed to continue to develop the risk profile, giving more consideration to other potential risks which could represent a material threat to the delivery of divisional objectives such as: staffing levels, condition of the physical estate, equipment replacement, lifecycle maintenance, backlog maintenance, wider workforce challenges such as retirements and recruitment challenges.

Division of Medicine and Acute

- There are 10 'reportable' risks. They concern:

  - **Exposure to Hospital Acquired Infection** (Significant Risk=16). The RMC were advised of the control framework in operation to prevent and control hospital acquired infection – this has been escalated to Quality Committee and Board;
  - [Risk of] **incomplete medical records** caused by volume of loose documents used and relied upon in the Acute Medical Unit (High Risk=10). The Chief Information Officer will review and consider the extent to which loose documents can be digitised and, if not, filed timeously.
  - [Risk of] **insufficient patient flow** (Significant Risk=16). RMC advised that given the severe congestion experienced on almost a daily basis with the resultant impact on planned care, standard of care and reliance on escalation areas, this risk is under-estimated and should be rated at 25 (Impact 5 X likelihood 5). There is insufficient control over patient flow. This is subject to a transformation programme intervention and overseen by PFIG;
  - [Unsustainable] **Nursing vacancy rate** (Significant Risk=16);
  - [Risk of] **Non-completion of role specific training** relevant to the needs of staff groups (High Risk=12). The division outlined a range of controls were being deployed to mitigate this potential risk;
  - [Unsustainable] **Consultant vacancy rate** (High Risk=12);
  - [Risk of] **overcrowding in the Emergency Department** during periods of high demand (High Risk=12);

- [Risk of] **failure to achieve and maintain financial sustainability** (High Risk=12). The RMC advised that this risk may be under-estimated and would require review;
- [Risk of] **unserviceable cardiac catheter laboratory** due to equipment failure/ageing equipment (High Risk=12). The RMC advised that this risk may be under-estimated and would require review; and
- [Risk of] a **challenge or delays concluding the Nephrology service tender** (High Risk=10). A tender process is underway.

Corporate Risk Reviews

Corporate Nursing Function

- There are five 'reportable' risks. They concern:

  - [Risk of] **insufficient nursing staffing levels** (Moderate Risk=9). The RMC advised that this risk may be under-estimated when viewed on aggregate. The Deputy Director of Nursing & Midwifery agreed to review and reassess aggregate exposure.
  - [Risk of] **Serious infectious outbreak** (Significant Risk=16);
  - [Risk of] **Inadequate environmental cleaning and decontamination** (High Risk=12);
  - [Risk of] **Failure to realise the benefits of the electronic care record** due to insufficient nursing engagement and utilisation (Moderate Risk=9); and
  - [Risk of] **failure to learn from service user feedback** (moderate Risk=9).

Human Resources & Organisational Development Function

- The HR & OD function have taken part in a facilitated risk workshop and rebuilt their risk register.
- HR risks had been identified and assessed from a departmental point of view. Further development of the risk register will take a more strategic view of the workforce risks.

Estates & Facilities Function

- The RMC agreed to set aside the majority of the time available at the next meeting to consider Estates & Facilities risks.

4. Next Steps

In order to ensure that the Trust continues to improve the risk management system the following steps will be undertaken:-

a. Focus on ensuring all corporate functions have a fit for purpose risk register with a particular focus on Finance, Estates and Informatics. Reports to be presented to the Risk Management Committee **12th March 2019**.

b. Further development of Ulysses (Safeguard) risk management system to simplify the extraction and analysis of risk intelligence to enable the transformation needed to achieve prudent control across the risk profile – **30th March 2019**

c. Development of e-learning package to support the continued efforts of education and awareness of risk across the organisation – **30th March 2019**

d. Conclude recruitment of Head of Risk and Patient Safety to enable sufficient specialist support progression from introspective, reactive risk management of risk to a proactive and anticipatory approach **June 2019**

5. Conclusion

Progress has been made on developing a robust risk management system, however momentum will be stepped up in the coming months to ensure it is adequately embedded and improved to enable a greater maturity to be established.

6. Recommendations

The Board are asked to consider the contents of the report and approve the next steps identified.